LESBIAN, GAY, AND BISEXUAL CLIENT EXPERIENCES AND THERAPEUTIC PRACTICE WITH SEXUAL MINORITIES: AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS

A dissertation submitted

by

REBECCA SHEPARD GOETTSCHE

to

PACIFICA GRADUATE INSTITUTE

in partial fulfillment of
the requirements for the
degree of

DOCTOR OF PHILOSOPHY
in
CLINICAL PSYCHOLOGY

With an emphasis in
DEPTH PSYCHOLOGY

This document has been
accepted for the faculty of
Pacifica Graduate Institute by:

Dr. Oksana Yakushko, Chair

Dr. Diana Sharpe, Reader

Dr. Susan L. Morrow, External Reader

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

NOVEMBER 17, 2014

ABSTRACT

Lesbian, Gay, and Bisexual Client Experiences and Therapeutic Practice with Sexual Minorities: An Interpretive Phenomenological Analysis

by

REBECCA SHEPARD GOETTSCHE

Despite some indications that treatment experiences have been improving (Liddle, 1999), LGB clients still receive discriminatory treatment (Bieschke, Paul, & Blasko, 2007). Even clinicians who wish to offer affirmative therapy hold unconscious negative biases due to growing up within a heterosexist culture (Bieschke et al., 2007). Utilizing Interpretive Phenomenological Analysis (Smith, Flowers & Larkin, 2009), this qualitative study explored the therapeutic experiences of seven LGB individuals in order to inform competent treatment with this population. Participants provided accounts through semi-structured interviews, which were validated using participant review. Specifically, the research focused on cross-orientation dyads, although experiences in therapy with shared-orientation dyads were also examined.

The results of this study are presented within five domains. Self-Categorization contextualizes participant accounts by discussing chosen identity terminology, variations of visibility, and the impact of categorical conceptions of identity. Identifying Others, Identifying Allies notes ways in which participants identified the cultural competence of practitioners. Navigating Heterosexism discusses the pervasive influence of heterosexism on individual's expectations of therapeutic experiences. Additionally, participants reviewed situations wherein clinicians expressed judgment or lack of knowledge, which highlight how therapists can more effectively respond to cultural

ruptures. Preferring Therapist Identities explores participants' therapeutic preferences and discusses benefits and challenges embedded within shared-orientation and cross-orientation therapeutic dyads. Finally, Understanding Therapeutic Practices identifies practices that support affirmative therapeutic work regardless of the clinician's sexual orientation. Underlying principles of competent cross-cultural therapy with LGB clients were proposed, which emphasize the importance of clinician self-reflection in order to provide nonjudgmental acceptance, discuss sexuality with ease, value different ways of approaching relationship, and decrease therapist defensiveness.

While this study found that several participants preferred sexual minority therapists, the results also suggest that there are significant benefits to working with culturally competent heterosexual clinicians. Participants described benefiting from the experience of acceptance from a member of the dominant culture, which provided a corrective experience to internalized heterosexism. These accounts indicate that, with training and self-reflection, heterosexual clinicians can provide uniquely supportive therapeutic experiences to LGB individuals. Recommendations are provided concerning cultural competent practice and ways to approach cultural misunderstanding.

Keywords: Counseling, Multicultural Competence, Heterosexism, Microagression, Allies

Acknowledgments

Conducting this research has been one of the most incredible and challenging experiences of my life, and its accomplishment has been supported by a number of people. First and foremost, I am deeply grateful to my participants. While I literally could not have completed this project without their participation, they gave me much more than their responses. I was humbled by their generosity and the thoughtfulness with which they related to their experiences with me. Their excitement about this project nurtured and refueled my dedication through challenging times and my commitment to them encouraged me to give this analysis the time and space it deserved. Moreover, I have been inspired by their courage and strength in overcoming and growing through experiences of heterosexism in life and psychotherapy and, in many cases, their continued commitment to seeking the support they deserve for themselves.

I am also extremely thankful for the continual support of friends, family, and colleagues who believed in my ability to thoughtfully and effectively complete this project. I am particularly grateful for the support my husband has provided. He reminded me of my capacities during times when I lacked faith in myself, sincerely understood and held the value of this work, recovered files at crucial junctures, and creatively modified workspaces to facilitate my productivity. Additionally, this undertaking could not have happened without the incredible support of my family, who made striving for a PhD a possibility. Finally, I would like to express my appreciation for my committee members, who encouraged my work and thoughtfully read and reflected on this substantial piece of writing. I am especially indebted to my Chair, Dr. Oksana Yakushko, who was incredibly patient with my questions, anxieties, ideas, and

second-guessing. She has been an incredible mentor and I have been extremely fortunate to have this experience of working so closely with her. I hope to engage with my professional and personal life with the dynamic commitment and soulful connection that I consistently witnessed from her.

Table of Contents

The style used throughout this dissertation is in accordance with the *Publication Manual of the American Psychological Association* (6th Edition, 2009) and Pacifica Graduate Institute's *Dissertation Handbook* (2014-2015).

Introduction

Relevance of Topic to Clinical Psychology

Attending to the unique needs of clients who are Lesbian, Gay, and Bisexual (LGB) is an increasingly important task for psychologists. The American Psychological Association recently updated the guidelines for treatment of this population to attend to this need (APA, 2012). This call to the profession represents a significant step from historical pathologization, but ethical treatment of LGB individuals is not yet adequately available (Eubanks-Carter, Burckell, & Goldfried, 2005). Despite governing bodies issuing statements encouraging affirmative responses to individuals holding LGB identities, the treatment that LGB clients receive is still at times inadequate and discriminatory (Bieschke, Paul, & Blasko, 2007). Unfortunately, even clinicians who would like to offer affirmative therapy may hold negative biases that they are unaware of as a result of growing up within a discriminatory culture (Bieschke et al., 2007). Furthermore, studies consistently show that counselors are inadequately trained in the experiences and treatment issues of LGB clients (Burke, 1989; Burke & Douce, 1991; J. A. Murphy, Rawlings, & Howe, 2002; Phillips & Fischer, 1998).

LGB clients have been found to utilize mental health services more than their heterosexual counterparts, further necessitating the ethical treatment of this population (Cochran, Sullivan, & Mays, 2003; M. A. Jones & Gabriel, 1999; Liddle, 1997; Morgan, 1992). According to a national survey conducted by Liddle (1997), lesbians and gay men respondants reported seeing more therapists in their lifetime (4.32 vs. 3.08), and seeing those therapists for longer durations (82 sessions vs. 29 sessions), than respondents identifying as heterosexual. This increased utilization is likely due to the impact of

stressors resulting from having an identity that goes against the norms of dominant culture (Bieschke et al., 2007; Herek & Garnets, 2007). It may also be the case, however, that LGB people have seen a higher numbers of therapists due to experiences of inadequate care requiring them to seek additional therapists.

In addition to conventional life stressors, concern about passing as heterosexual in unsafe environments, exposure to negative perceptions of their identity, and lack of acknowledgement of their relationships are additional challenges facing this population (Greene, 1994). There is evidence to suggest that identifying as a sexual minority is associated with increased risk for suicide attempts (Meyer, 2013), self-injurious behavior (Balsam, Beauchaine, Mickey, & Rothblum, 2005), substance abuse (DiPlacidio, 1998), diminished physical health (Durso & Meyer 2013; Meyer, 1995, 2003; Ross, 1990), and psychological disorders such as depression and anxiety (Cochran & Mayes, 2000, 2009; Meyer, 2013; Omoto & Kurtzman, 2006). However, research consistently supports the contention that these negative health outcomes are mediated by social influences and not a result of sexual identifications per se (Meyer, 2003, 2010, 2013; Szymanski, Kashubeck-West, & Meyer, 2008a).

In an age of increasing political discourse on this topic, it may be tempting to believe that this population is being responded to and acknowledged. Rights are slowly being offered to LGBTQ individuals state by state and country by country. While these are extremely significant victories, there are other consequences of the political debate. Unfortunately, the widespread debates over thes issues provide forums for vitriolic speeches expressing powerful heterosexism (Rotosky, Riggle, Horne, & Miller, 2009; Russell, 2000; Stevenson, 2007). In the locations where these campaigns occur,

researchers have found increases in depression, anxiety, and PTSD in LGB people (Rotosky et al., 2009; Russell, 2000). There are additional challenges for LGB families who are navigating access to rights and experiences of discrimination in this changing political landscape (C. J. Patterson, 2007). While engaging in activism can provide an avenue of action, coping, and support, it also exposes LGB people to negative affect and anti-gay propaganda (Levitt et al., 2009; Russell, 2000; Russell & Richards, 2003). Withdrawal can provide protection from these messages but also can lead to isolation (Levitt et al., 2009; Russell, 2000; Russell & Richards, 2003). Therefore, balance is recommended between these internal and external coping processes for those individuals who are impacted by political campaigns.

Sexual minority status differs from some other dimensions of diversity in that it is not always visible to others how a person identifies (Fassinger, 1991). According to Matthews (2007), it is therefore important to provide affirmative counseling to all clients because it is not possible to know a client's sexual orientation without discussing the matter. If a clinician does not bring up the topic of sexual orientation or assumes the client is heterosexual, clients are then responsible for disclosing their LGB status. Disclosure can be a difficult and perilous act given the uncertainty of responses to this information and the potential for discrimination (Bieschke et al., 2007). Furthermore, decisions about when and with whom to disclose information about sexual orientation are influenced by complex personal and contextual influences (Mohr & Fassinger, 2003). As a result, therapists may treat clients whom identify as lesbian, gay, or bisexual without being aware of this identification (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). In fact, studies show that individuals do not always disclose their identities to

health care professionals (Durso & Meyer, 2013; M. St. Pierre, 2012). While not disclosing an LGB identity may be an attempt to avoid destructive experiences, not disclosing a sexual minority status can create emotional distress and prevent individuals from benefiting from community membership and support (Meyer, 2013). Ethical treatment of LGB individuals requires clinicians to avoid making assumptions about sexual orientation and express acceptance of diverse sexual orientations (Matthews, 2007).

Defining sexual orientation. The prevalence of sexual minorities differs from 1-21% of the population depending on how it is defined (Savin-Williams, 2006). Sexual orientation is a complex term that

> Refers to the constellation of affective, cognitive, and behavioral characteristics that constitute an individuals' sense of self as a sexual and intimately relational being. These include such factors as self-labeling, beliefs and schemas, feelings and preferences, behavioral expression, and societal and sexual minority community expectations and roles. (Fassinger & Arseneau, 2007, p. 30)

In research, sexual orientation can be defined in reference to sexual attraction, sexual behavior, or the assertion of a sexual minority identity (Savin-Williams, 2006). Taking these varying approaches to sampling makes contextualizing and applying findings to the larger population difficult. The tendency to compare sexual minority individuals to heterosexual individuals also ignores the rich diversity of experiences and individuals within the LGB community (Worthington & Reynolds, 2009).

Terms used to refer to this community have changed over time, and differ with respect to age cohort, geographic location, cultural background, and spiritual

identifications (Fassinger & Arseneau, 2007). Furthermore, identifications can change across an individual's lifespan (Fassinger & Arseneau, 2007). Sexuality is usually defined by an individual's personal gender identity of male or female and whether they are attractive to the same gender (homosexuality), the opposite gender (heterosexuality), or both (bisexuality). This construction highlights the socially accepted gender binary of male or female, though there is evidence to suggest that gender occurs beyond these two choices (Fausto-sterling, 1993, as cited in Moradi, Mohr, Worthington, & Fassinger, 2009). While the terms *same-sex* and *opposite-sex* are often used to define relationships, this vocabulary implicitly communicates that there are only two sexes, excluding intersex as a valid sex category. Furthermore, this conceptualization suggests that attractions are more connected to genitalia than whole gendered beings. I will use the terms *same-gender* and *different-gender* in order to privilege the chosen gender identifications of the people involved and avoid perpetuating the binary idea of sex and gender.

The original term *homosexual* is generally no longer used due to its emphasis on sexuality over other aspects of relationships (Fassinger, 1991) and its connection to a pejorative medical history (Morrow, 2012; Ritter & Terndrup, 2002). The term *gay* was adopted due to its positive connotations (Clark, 1987, as cited in Fassinger, 1991), though this word is now used primarily to refer to *gay men*, with the term *lesbian* distinguishing women's experiences of gay identities (D. R. Atkinson & Hackett, 1998). Alternate identifications are also available, some individuals may not wish to identify in any manner, and terminology will continue to evolve with the evolving population (Fassinger & Arseneau, 2007). *Sexual minority* is a term meant to encompass all individuals who do not identify with a heterosexual sexual orientation (Ritter & Terndrup, 2002). Therefore,

I will use sexual minorities interchangeably with LGB to refer to the experiences of lesbians, gay men, and bisexual individuals. Furthermore, I will specify what particular section of the population I am referring to when research is limited to specific sexual minority experiences. When referencing individuals who are sexually oriented towards those of the opposite sex, I will utilize the term heterosexual. *Straight* is a term that is commonly used to designate those with a heterosexual orientation. However, I will follow D. R. Atkinson and Hackett (1998) in avoiding this term due to its connocations of normalcy, and, thus, pathology of those outside of this identification.

LGBTQ is an acronym often used to group together sexual and gender minorities identifying as lesbian, gay, bisexual, or transgender. This acronym continues to expand to include other experiences, such as of those who identify as questioning, queer, intersex, and ally (LGBTQQIA, Morrow, 2012). The word *queer*, which has been reclaimed from being used pejoratively against members of this community, is also frequently used as an overarching term to contain the multiplicity of experiences of sexual and gender minorities (Morrow, 2012). While combining these experiences reflects common experiences of isolation, invisibility, and discrimination, it also conflates sexual and gender concerns and ignores important differences between the various identities (Fassinger & Arseneau, 2007). These variations in terminology reflect the continual development and social construction of identities (Broido, 2000). As the social climate and field of psychology evolves, researchers and clinicians must continually strive to "find a common language among themselves and with their research participants and clients" (Morrow, 2012, p. 417).

Stigma, stressors, and strengths. LGB individuals cope with experiences of discrimination due to their sexual orientation at an alarming rate. While overt discrimination of LGB individuals has decreased in recent years (Morrison & Morrison, 2008), covert and overt forms of discrimination are still continual threats and significant psychological stressors for LGB people (Herek, 2009). A national survey using probability sampling demonstrated that $1/5^{th}$ of respondents reported experiences of harassment or violence and $1/10^{th}$ of respondents were the victims of housing or employment discrimination (Herek, 2009). Herek further noted that experiences of violent crime are more common for gay men than lesbians or bisexual individuals, whereas legal discrimination occurred more commonly to gay men and lesbians than bisexual individuals, which they believed was due to gender role expectations and increased visibility (Herek, 2009). Other studies have found more drastic numbers, with 80% of LGB survey respondents reporting verbal harassments, 44% reporting violent threats, 33% having been followed or chased, and 25% having objects thrown at them (Berrill, 1992; as cited in Szymanski, 2009). Experiences of such discrimination are highly correlated with psychological distress (Szymanski, 2006, 2009; Szymanski & Meyer, 2008). Moreover, there is some indication that crimes that are the result of sexual prejudice are more destructive than crimes that are not related to such bias (Herek, Gillis, & Cogan, 1999).

Ritter and Terndrup (2002) have stated that, "the social, cultural, and political oppression of sexual minority groups is maintained by homophobia and heterosexism" (p. 12). "Homophobia" was originally coined by Weinberg (1972) to express "the dread of being in close quarters with homosexuals—and in the case of homosexuals themselves,

self-loathing" (p. 4, as cited in Herek, Gillis, & Cogen, 2009). This word has received extensive criticism because it emphasizes an individual reaction at the expense of acknowledging the socially influenced and constructed nature of prejudice (Herek, 1994; Kitzinger, 1996; Pachankis & Goldfried, 2013; Szymanski & Chung, 2003). As a result, some researchers argue for the use of the term "homonegativity" to reference individual's negative feelings and behaviors towards sexual minorities (Hudson & Ricketts, 1980; Moradi et al., 2009; Morrow, 2000; Szymanski et al., 2008a). Additionally, Herek (2000a) prefers the term "sexual prejudice" to "homophobia" because it emphasizes social context, does not make assumptions about underlying pathology, and avoids value-judgements.

Herek (1995) defined heterosexism as "the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community" (p. 321). Heterosexism manifests itself through "heteronormative assumptions [which] refer to automatic unconscious beliefs and expectations that reinforce heterosexuality and heterosexual relationships as the ideal norm" (McGeorge & Carlson, 2011). On an institutional level, heterosexism provides different rights and protections to individuals based on their sexual orientation and discriminates against sexual minorities in custody, adoption, marriage, employment, and housing (ACLU, 1999, 2004, as cited in Stevenson, 2007). McGeorge and Carlson (2011) have noted that institutional heterosexism leads to heterosexual privilege, in which individuals who identify with the socially sanctioned sexual identity are conferred with unearned benefits, of which they are often unaware, though heterosexism also occurs interpersonally. Pachankis and Goldfried (2013) prefer the term "heterocentricism" because they feel it

expresses the systemic nature of this process and highlights the fact that these assumptions are often a result of lack of awareness as compared with the bias that underlies homophobia. Alternately, "heterosexism" is preferred by some scholars due to its implicit acknowledgement of the role that gender has in the oppression of sexual minorities (Herek 1994, Szymanski & Chung, 2003; Szymanski et al., 2008a) and the similarities with the oppression of women and people of color (Ritter & Terndrup, 2002).

Because all people grow up in a heteronormative culture, even individuals who believe in equal rights can unintentionally communicate heterosexual bias (Shelton & Delgado-Romero, 2011). Homonegativity and heterosexism often occur in implicit forms of discrimination called microagressions, which "are communications of prejudice and discrimination expressed through seemingly meaningless and unharmful tactics" (Shelton & Delgado-Romero, 2011, p. 210). Microagressions are difficult to identify because they often come from well-intentioned people and are easily explained away (D.W. Sue et al., 2007). They are insidiously destructive due to this ambiguity, because individuals who experience them are less likely or able to seek support and protection than those who experience overt discrimination (Hodson, Dovidio, & Gaertner, 2010). In contemporary culture, they often take the form of a joke, further disallowing their targets from defending themselves (Platt & Lenson, 2013). Additionally, they can represent an accumulation of multiple injustices and, in doing so, create a general environment of hostility that is often unconsciously internalized (D.W. Sue 2010). One form of microagressions, microinvalidations, are theorized to be the most destructive because they subtly deny the reality of individuals and groups of people (D. W. Sue, 2010). The assumption that all people are heterosexual is one such message that serves to invalidate

LGB people's lifestyles (Shelton & Delgado-Romero, 2011). This assumption ignores and invalidates the relationships of LGB people and forces them to continually come out to others (Herek, 1996).

Prejudicial perspectives and experiences are often internalized and used to construct and negotiate an individual's self-esteem; this process can be referred to as internalized homophobia, internalized homonegativism, or internalized heterosexism (Szymanski et al., 2008a). Empirical work indicates that this internalized, self-directed, form of prejudice is particularly destructive (Meyer, 2003). Elevated levels of internalized heterosexism are associated with increased psychological distress (Meyer, 1995, 2003; Szymanski, Kashubeck-West, & Meyer, 2008b), decreased levels of outness and community membership (Meyer, 1995; Shidlo, 1994; Szymanski et al., 2008b), feelings of isolation (Szymanski & Chung, 2001), decreased relationship quality (Balsam & Szymanski, 2005; Otis, Rostosky, Riggle, & Hamrin, 2006), identity confusion (Balsam & Mohr, 2007), and decreased self-esteem (Szymanski et al., 2008b). Further, similar findings have been identified in studies of LGB people in Australia, Mexico, Israel, and Turkey (Szymanski & Kashubeck-West, 2008d). Fortunately, there is evidence from a sample of women that indicates that these links can be mediated by self-esteem and social support (Szymanski & Kashubeck-West, 2008c).

However, gender influences multiple aspects of LGB identification, with women and men differing in their management of identity, coming out process, and emotional expressions of distress (Szymanski et al., 2008b). Two studies have indicated that lesbian and bisexual women experience lower levels of internalized heterosexism and less sensitivity to stigma than gay and bisexual men (Balsam & Mohr, 2007; Mohr &

Fassinger, 2000). According to a study by Szymanski and Chung (2003), feminist attitudes can provide a coping resource against heterosexism; specifically, holding such attitudes is associated with decreased internalized heterosexism as a result of their emphasis on the beneficial support of female relationships and the rejection of traditional gender role expectations. Furthermore, among lesbian, gay, and bisexual individuals, data from a recent national study indicate that lesbian women demonstrate the lowest rates of psychological disorders, with bisexual men and women reporting the highest rates of depressive and anxiety disorders. Gender differences are likely related to the increased stigma towards gay men than lesbian women in the US and the way in which traditional gender roles are often used to enforce hetersexism (Herek, 2002; Kite & Whitley, 1996), which will be discussed futher in the review of literature. There are also important differences in disclosure, identity status, and community memberships for bisexual individuals, which likely influence experiences of internalized heterosexism (Balsam & Mohr, 2007). For this reason, Szymanski and Carr (2008) encourage clinicians to attend to clients' conceptualizations of gender roles as they relate to LGB status and to assist clients in understanding and modifying these relationships, particularly with male clients.

The most commonly noted mechanism by which minority status becomes associated with increased levels of mental and physical illness is the minority stress theory (Meyer, 2003, 2010, 2013). This theory posits that minority groups experience unique stressors of external and internal prejudice, which leads to increased burdens and decreased resources. According to Meyer (2010),

> Applied to the mental health of LGB people, this leads us to hypothesize that if stress is a cause of disorders, then LGB people, who are exposed to unique minority stressors, will have a higher incidence of disorders than heterosexuals. (p. 448)

Meyer (2003) has argued this occurs through three primary stress processes: (a) externally induced stress through rejection, harassment, or discrimination; (b) a state of mind characterized by expectation and vigilance around experiencing sexual prejudice; and (c) the internalization of negative social messages. At some point in the development of an LGB identity, individuals often conceal their identity in order to avoid these negative influences. However, this concealment is particularly destructive (DiPlacido, 1998), both because it prevents individuals from connecting to other LGB individuals (Meyer, 2003) and leads to illness through psychoneuroimmunological processes (Meyer, 2013).

The Minority Stress hypothesis is supported by studies that indicate a high prevalence of psychological disorders in LGB individuals and the pervasive nature of harassment and discrimination (Szymanski & Ikizler, 2013). For example, in 2009, Szymanski found that roughly half of a sample of 210 gay and bisexual men experienced unfair treatment, heterosexist verbal asaults, and prejudicial statements from family members periodically in the past year. Furthermore, research has indicated that experiences of heterosexism are associated with significant psychological demoralization, depression, and distress (Herek et al., 1999; Meyer, 1995; N. G. Smith & Ingram, 2004; Szymanski, 2009).

However, research conducted with LGB people of color does not consistently

support this hypothesis (Meyer, 2010). Minority stress theory would suggest that LGB people of color experience minority stressors from two identities and thus experience double the potential distress. On the contrary, LGB people of color and LGB white people experience a similar prevalence of psychological disorders (Kessler et al., 2005; Meyer, Dietrick, & Schwartz, 2008). Though a 2010 comparison between samples of LGB people of color and LGB white people indicated some differences in outness, no differences were found in levels of internalized heterosexism or perceived stigma (Moradi et al., 2010). According to Moradi et al. (2010), these findings indicate that instead of increased risk, individuals of color indicate greater levels of resilience to societal stressors. This resilience may provide individuals with a sense of competence in coping with stress or may reflect the possession of strategies and resources to cope with stress (Meyer, 2010). It may also be the case that resilience results from aspects of community membership. According to L. S. Brown (2008), considering the benefits of

> other minority identies give us a hint as to what some of these protective factors might be; perhaps learning early in life to resist racism, classism, sexism, or anti-Semitism may, in turn, make it easier to find the lies inherent in heterosexism as one integraties an LGB identity into one's adult sense of self. (p. 642)

Therefore, membership to other disadvanged groups may provide important coping skills resulting from collective experiences of oppression. Meyer (2010) has also stressed the importance of group resources to combat heterosexism, noting that community is needed to provide alternative norms, values, role models, and affirmative social support. These findings emphasize the complex influence of social context on individual psychology, providing the foundation for another conceptualization of the influence of heterosexism.

Feminist theory has been offered as an alterative explanation of the influence of heterosexism on LGB individuals (L. S. Brown, 1994; Rotosky & Riggle, 2002; Szymanski, 2005, 2006). According to feminist theory, personal challenges are often connected to the external social, cultural, and economic forces within which individuals exist, therefore, "many of the problems experienced by persons with limited power in society can be conceptualized as reactions to oppression" (Szymanski et al., 2008a, p. 513). Similar to minority stress theory, feminist theory posits that psychological distress is a direct result of external and internalized experiences of rejection, harassment, discrimination, prejudice (Szymanski, 2005). Feminist theory stresses the importance of analyzing the role and function of oppression (L. S. Brown, 1994), providing further explanation for the increased resilience in individuals who identify with other disadvantaged identities. Finally, feminist theory provides a model for healing through egalitarian relationship (Szymanski, 2005), supporting the importance of exposure to affirmative messages through community membership and positive role models (Szymanski et al., 2008a).

Along with acknowledging the significant negative experiences that LGB individuals face in American society, it is also important to note the resilience of LGB people of all backgrounds. Growing up in a largely heterosexual world, LGB individuals experience and manage discrimination early in their lives, which could potentially lead to a more flexible capacity for managing differences (L. S. Brown, 1989; Riggle, Whitman, Olson, Rostosky, & Strong, 2008). A recent qualitative study by Riggle et al. (2008) identified several positive aspects of having a lesbian or gay identity. Some benefits noted concern the development of healthy social support, the development of empathy for

themselves and others, and increased opportunities to develop nonnormative relationships. Gay and Lesbian individuals reported experiencing significant social support in being part of the larger gay and lesbian (or LGBTQ) community and appreciated the freedom to create families of choice (Barker, Herdt, & de Vries, 2006). Riggle et al. (2008) found that experiences of rejection led individuals to choose to engage with people who were more supportive of their relationships, thus encouraging supportive social networks. Additionally, individuals noted experiencing deeper personal connections to others as a result of their process of pursuing authentic self-understanding. This personal understanding was believed to lead to deep compassion for oneself as well as others, and often led people to engage in social justice activism. Finally, respondents noted that they felt freer to explore varying gender, sexual, and relational roles due to being placed outside of conventions. As researchers acknowledge the challenges of living as a minority, it is extremely important to emphasize the strengths and capacities that are connected to this experience as well.

Clinical treatment of LGB individuals. In early Greek culture, there is evidence to suggest that same-gendered relationships were tolerated and considered healthy, at least for men (Fassinger, 1991). Furthermore, cross-cultural reactions to same-gender relationships vary, as was indicated by a 1951 survey of world-wide sexual practices, which demonstrated that 64% of cultures considered it to be appropriate for a portion of the community to be engaged in same–sex sexual behavior (Ford & Beach, as cited in D. R. Atkinson & Hackett, 1998). However, since the medieval ages, western religious views have influenced laws and facilitated societal intolerance and discrimination in western culture (Fassinger, 1991). These religious and social forces have influenced the

field of psychology (D. R. Atkinson & Hackett, 1998), which has in turn perpetuated discrimination against sexual minorities by pathologizing moral concerns (Morin, 1977). In fact, until 1973, same sex attraction was considered a mental illness (Bradford, Ryan, & Rothblum, 1994; Baron 1996).

Empirical research on sexuality was not involved in early diagnostic conceptualizations, which according to Morin (1977), reflected Victorian ideals. Freud's theories on sexuality considered same-gender attraction and behavior to be a relatively benign developmental arrest (Herek & Garnets, 2007; Morin, 1977). However, post-Freudians argued that a same-gendered orientation was pathological in comparison to a healthy heterosexual orientation (Herek & Garnets, 2007). They developed theories of etiology and treatments aimed at curing the condition, in addition to prohibiting LGB individuals from analytic training (Eubanks-Carter et al., 2005). When the *Diagnostic and Statistical Manual (DSM*) for mental disorders was developed, psychoanalytic thinking was the primary orientation of mental health treatment and the result was that "homosexuality" was categorized as a "sociopathic personality disturbance," for which many individuals sought treatment (Herek & Garnets, 2007, p. 356). Treatment involved extensive, and at times invasive, attempts to cure the problematic sexual orientation by utilizing aversion therapy, horomones, castration, and lobotomies (Herek & Garnets, 2007). In the *DSM II*, "homosexuality" was recategorized as a form of sexual deviance, at which point psychiatrist, counselors, and advocates began fighting for the removal of this disorder from diagnostic nomenclature (Eubanks-Carter et al., 2005).

Two important empirical projects supported the argument that same-gendered attraction did not constitute a pathological orientation and eventually led to the

depathologization of "homosexuality". The first were the Kinsey studies, in which volunteers were interviewed in order to assess a range of sexual behaviors. Kinsey, Pomeroy, and Martin (1948) found that sexual behavior with same-gendered individuals was much more common than people had previously suspected (Fassinger, 1991). Additionally, in 1957, Hooker conducted psychological testing with matched samples of opposite- and same-gender attracted individuals and found no differences in pathology (Herek & Garnets, 2007). The studies by Kinsey et al. (1948) and Hooker (1957), along with increased activism around gay rights, brought the conversation into the American Psychiatric Association and eventually led to the removal of "homosexuality" from the DSM in 1973 (Baron 1996). Additionally, the American Psychological Association followed their example in 1975 declaring that

> homosexuality, per se, implies no impairment in judgment, stability, reliability, or general social or vocational capabilities. Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations. (Conger, 1975, p. 633)

The APA has since established a Committee on Lesbian, Gay, and Bisexual Concerns and the Association of Lesbian and Gay Psychologists, which became Division 44 (Bradford et al., 1994). Along with the APA, Division 44 created "Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients" in 2000, which were revised in 2012.

These were significant accomplishments and milestones in the history of psychological treatment; however, these acts have not resulted in automatic affirmative

treatment for LGB individuals by any means. While "homosexuality" was removed from the DSM, in 1980, it was replaced by a diagnosis of "ego-distonic homosexuality", allowing for conversion treatments and pathological perspectives to continue (Eubanks-Carter et al., 2005). Further, over a third of those voting on the original decision in 1973 were opposed to depathologizing "homosexuality" (Marmor, 1980, as cited in Baron, 1996). According to Campos and Goldfried (2001), following the full removal of "homosexuality" from diagnostic nomenclature, the decreased emphasis on changing sexual orientation led to an overall decrease of interest in sexual orientation research in the literature. These scholars further argue that research on sexual minority issues since then has been done by LGB identified professionals and has been consistently ignored by mainstream psychologists. Nonetheless, some important changes were initiated by these acts, and awareness of biased treatment continues to encourage more effective training and more affirmative practice (Fassinger, 1991).

In 1991, a task force was commissioned by the APA in order to assess the in practice application of the 1975 nondiscriminatory resolution, which surveyed of 2,544 psychologists to assess the situation and identify exemplary and inadequate therapy practices (Garnets et al., 1991). Garnets et al. found that a vast majority of respondents worked with at least one gay client. While a majority of respondents reported inadequate training and education on therapeutic work with LGB individuals, they nonetheless reported feeling competent to work with these clients. Furthermore, accounts of biased practice were common, with over half of respondents reporting on episodes of innapropriate care including those that involved treating the client's sexuality as pathological and in need of cure. The survey by Garnets et al. (1991) highlighted that in

some ways very little had changed since depathologization, with several respondents openly expressing disagreement with APA's resolution. At the same time, this survey provided guidelines for more affirmative practice, including acknowledging and recognizing the effects of socialized prejudice, seeking specific education and training, regarding same-gender sexual orientations as valid and healthy, supporting clients in developing a positive gay, lesbian, or bisexual identity, being open about the clinician's sexual orientation, and adequately attending to other aspects of clients' lives and emotional process. Garnets et al. (1991) concluded that through the implementation of their practices, effective treatment was possible for therapists of all sexual orientations.

Though some research has indicated that therapists held more positive views of LGB people than the general public (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000), there is much evidence to suggest that clinicians hold significant biases around LGB issues (Casas, Brady, & Ponterotto 1983; Gelso, Fassinger, Gomez, & Latts, 1995; Glen & Russel, 1986). Two notable studies have studied automatic and unconscious biases through the identification of errors in processing information about clients. Casas et al. (1983) found that more errors occurred with gay and lesbian than heterosexual clients when information was congruent with cultural stereotypes. These researchers theorized that errors occured partially due to increased difficulties processing information about individuals with whom people are unfamiliar, though they noted that regardless of the mechanism, the result is less adequate treatment of LGB clients. This finding was confirmed in 1995, when Gelso et al. found that more recall errors were made when therapists were engaging with lesbian than heterosexual clients. Research consistently shows that male clinicians tend to evidence more heterosexist biases than their female

counterparts (Barrett & Mcwhirtier, 2002; A. V. Bowers & Bieschke, 2005; Matthews, Selvidge, & Fischer 2005), highlighting the complex relationship between sexuality and gender. Significant bias exists against bisexual clients as well, though much more research is needed in this area (Fox, 2000; Herek, 2002; Mohr, Israel, & Sedlacek, 2001).

Recent literature depicts a complex picture in which biased treatment and discrimination still occur (Biaggio, Orchard, Larson, Petrino, & Mihara, 2003; R. Bowers, Plummer, & Minichiello, 2005; Greene, 2007; Phillips, 2000), while increased attention, understanding, and affirmation concerning sexual minority issues is also evident (Bieschke et al., 2000; Bieschke et al., 2007; Liddle, 1999). In 1998, Phillips and Fisher surveyed graduate students and found that 94% of doctoral level students scored as nonhomophobic. Further, in 2005, Kilgore, Sideman, Amin, Baca, and Bohanske surveyed 437 APA psychologists and found that 58% of respondents reported holding a gay-affirmative orientation to therapy; these findings signify a significant improvement from the 5% reported to Garnets et al in 1991, though it also suggests there is still much to be done. The study by Kilgore et al. (2005) also established that 92% of respondents reported believing that holding an LGB identity was acceptable, and only 4% reported considering a same sex orientation to be a psychological disorder. A study of LGB clients' experiences in therapy also indicates that, since the 1980s, clinical services have been improving (Liddle, 1999). Both Liddle (1999) and Kilgore et al. (2005) argue that increased attention to training and education and changing social views are responsible for these changes. Indeed, Kilgore et al. (2005) found that younger therapists received more education on LGB issues, as well as reported increased exposure to LGB individuals.

Inadequate education has been a cited consistently as a significant issue and the little training that does occur on this topic tends to reflect social heterosexist biases (Biaggio et al., 2003; Burke, 1989; Burke & Douce, 1991; Croteau, Bieschke, Phillips, & Lark, 1998; Graham, Rawlings, Halpern, & Hermes, 1984; Liddle, 1996; Phillips & Fischer, 1998). The assumption that all people are heterosexual has undoubtedly influenced the absence of material and training hours on LGB specific challenges (Phillips, 2000). There is also evidence of covert biases in class material, interactions with faculty and supervisors, and practica and internship training (Pilkington & Cantor, 1996). A critical study by Phillips and Fischer (1998) found that a majority of trainees felt unprepared to work with LGB clients, being assigned an average of zero articles on LGB concerns, experiencing almost no identified LGB faculty or supervisors, and over half of students reporting never being asked to reflect on heterosexism by their coursework and training. In a similar survey by J. A. Murphy et al. (2002), 28% of psychologists noted receiving zero formal training on working clinically with LGB people. Further, most respondents who did receive training sought it out independently in the form of articles, books, or continuing education. Regarding those that received formal training, 10% took a class focused on work with this population and 22% reported receiving some form of training from their graduate school. J. A. Murphy et al. (2002) noted that their survey was restricted by a very low rate of response (28%), and while the low response rate limits their findings, they theorized that it is also a result of problems with education and training around LGB issues and clients.

It is extremely important for educational institutions to continue to develop inclusive training programs that include formal education on working with LGB clients,

LGB concerns, and the influence of societal bias. Further, it is recommended that training programs include members of the LGB community as supervisors, students, and professors (Biaggio et al., 2003) and that practicum and internship training involves experience with LGB clients (O'Shaughnessey & Spokane, 2012). Such inclusion is particularly important because exposure to members of different cultural groups is one of the most effective ways of reducing bias against that group (Herek & Glunt, 1993). Additionally, to raise clinicians' awareness around the influence of bias, training should include exploration of heterosexism, socialization, and personal ideas about sexuality (Eubanks-Carter et al., 2005).

How bias influences therapy. Prejudicial experiences can be particularly damaging to clients when they occur in therapy, due to the vulnerability of the therapeutic encounter and the therapist's position of authority. Furthermore, therapeutic healing is understood to occur in the presence of therapeutic empathy and neutrality, both of which are compromised by the presence of bias (McHenry & Johnson, 1993). Because most LGB clients have experienced sexual prejudice in previous experiences, they may be sensitive to bias from therapists (Fell, Mattiske, & Riggs, 2008). Therefore, even subtle microagressions can lead to clients feeling misunderstood and terminating prematurely (Constantine, 2007; Constantine & Sue, 2007; Dorland & Fischer, 2001; D. W. Sue et al., 2007; D.W. Sue, 2010).

According to Shelton and Delgado-Romero (2011), "the power of sexual orientation microaggressions rest in their ability to stealthily debilitate the therapeutic environment for the purpose of continued indoctrination of systemic oppression" (p. 219). If the role of social prejudice is not identified, then the status quo of heterosexism

is perpetuated and the client reexperiences sexual prejudice. When bias is subtle and difficult to recognize, it is challenging for the therapeutic dyad to address and work through (Shelton & Delgado-Romero, 2011). Unacknowledged, biased treatment can create a retraumatization of previous experiences of unresolved discrimination for the client (R. Bowers et al., 2005). Stated another way, McHenry and Johnson have noted that, "when these biases are denied, the outcome of therapy for the therapist becomes a perpetuation of his/her homophobic belief system while the outcome for the client becomes one of minimal growth and the perpetuation of self-hatred" (1993, p. 149).

A common expression of subtle bias is the assumption that clients are heterosexual, which is powerfully invalidating and exclusionary (Dorland & Fischer, 2001). This assumption can be communicated through the clinician's language as well as by forms and office material. Often, such heterosexism is expressed through the automatic use of opposite gendered pronouns to discuss partners, that is, using he, husband, or boyfriend with female clients, and she, girlfriend, or wife, for male clients. Further, relying on legal terms like marriage or divorce emphasizes the normalcy of heterosexism, highlights relational options to which LGB individuals do not always have access, and denies the validity of other long-term relationship identifications. Even when well-meaning clinicians express this assumption, there can be dramatic effects on the therapeutic relationship. For example, a study by Dorland and Fischer (2001) found that pseudoclients reading vignettes that included heterocentric language reported less interest in continuing treatment or disclosing information with therapists than those vignettes that were free of such bias.

Both discounting and overemphasizing sexual orientation can communicate

disrespect to LGB clients (A. C. Bernstein, 2000; R. Bowers et al., 2005, Burckell & Goldfried, 2006; Dworkin, 2000; Garnets et al., 1991; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Morrow, 2000). Minimizing the impact or avoiding conversation about sexual orientation can indicate the counselor's discomfort and lack of competence or communicate that the client's sexual orientation is inappropriate or pathological. Additionally, Garnets et al. (1991) note that assuming that all clients are the same regardless of sexual orientation is invalidating to the particular experiences of LGB individuals. This assumption is similar to the "colorblind" approach to racial differences, which denies the important experience of people's ethnic identity and minority status (D. W. Sue, Bucceri, Lin, Nadal, & Torino, 2007). At the same time, therapists can express bias by overfocusing on sexual orientation, which occurs when counselors exclude other topics and emphasize the influence of LGB status on the clients concerns (R. Bowers et al., 2005; Burckell & Goldfried, 2006; Garnets et al., 1991; Israel et al., 2008). Overemphasizing the role of sexuality can communicate that a same-gender sexual orientation is problematic or pathological in itself, a message that perpetuates historical cultural, and clinical discrimination.

A more direct form of this bias occurs when therapists believe an LGB status to be pathological and in need of change through conversion, reparative, or reorientation therapy. The APA (2013) states that conversion efforts "represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self esteem when sexual orientation fails to change" (p. 1). Despite APA resolutions against the practice, there are still therapists who practice therapy aimed at converting LGB clients to become heterosexual (Johnson, 2012).

Research that supports conversion therapy suffers from significant methodological flaws concerning definitions and measures of heterosexuality (Bieschke et al., 2000; Haldeman, 1994, 2000; Morrow & Beckstead, 2004). A majority of clients seeking this therapy do not experience changes in their sexual orientation (Shidlo & Schroeder, 2002). Furthermore, according to Bieschke et al. (2007), research exploring the harm or helpfulness of this type of therapy suggests that it produces significant harm, leading them to assert that conversion therapies are unethical practices. Even researchers who acknowledge possible benefits of this practice for some clients oppose the use of this therapy due to the negative outcomes and the potential for the same benefits to be conferred from more affirmative therapies (Beckstead & Morrow, 2004).

Given the prevalence of heterosexism, it is difficult to discern a client's informed choice to seek conversion therapy from the influence of heterosexist norms (Gonsiorek, 2004). As Morrow and Beckstead (2004) state, "the choice to change orientation is unclear as long as religious, familial, and societal pessures make same-gender attractions unacceptable" (p. 645). The influence of the therapist's perspective is also significant; discussing the evolution an affirmative treatment stance, Marmor (1996) notes that as affirmative values increased, client self-rejection decreased. Conversion therapy is often sought by people who experience significant internalized heterosexism, hold strong religious identities, or are in early phases of LGB identity development (Tozer & Hayes, 2004). The therapist's authority can be used to innapropriately impose values on the client either towards or against an LGB identity (Beckstead & Israel, 2007; Drescher, 1999). Therefore, it is important that clinicians respect clients' identities, concerns, and beliefs, while also exploring potential outcomes and options with them (Beckstead &

Israel, 2007). It is recommended that clients presenting with sexual orientation conflicts be educated about sexual orientation conversion research, supported in understanding the influence of external and internalized prejudice on their experience, and provided space to explore and define their sexual orientation identity (Beckstead & Morrow, 2004).

Affirmative therapeutic approaches. It is an obligation of clinical psychologists and other practitioners to act in ways that promote the welfare of individuals clinicians come in contact with, as is indicated by the beneficence principle in the APA code of ethics (2010, p. 3). Due to the historical, and contemporary, mistreatment of LGB clients, it is imperative that affirmative therapeutic services be available to this population. There is no specific modality of affirmative therapy designated to treat LGB clients, instead recommendations for affirmative treatment emphasize the acquisition of appropriate cultural knowledge on the part of the therapist and the development of a therapeutic alliance defined by acceptance and understanding (Johnson, 2012). Therapists need to express their approval and acceptance directly in order to provide an alternative message to the abundant societal prejudice (Israel et al., 2008). Additionally, Baron (1996) recommends that therapist be sensitive to the ways in which questions of acceptance arise in the transference and countertransference.

Greene (2007) emphasizes that LGB clients represent a unique population requiring skills and knowledge beyond what is offered in ordinary clinical training. It is important that therapists seek out training on their own, and do not use their clients to learn information about cultural norms and language (R. Bowers et al., 2005). Many LGB clients present with similar problems to heterosexual clients, such as relationship concerns, anxiety, depression, and self esteem (Murphy et al., 2002). However, these

common concerns are influenced by social influences of heterosexism and homophobia in important ways (Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010). Additionally, this population experiences unique challenges of discrimination, identity development, the management of multiple identities, coming out, legal and workplace concerns, and family estrangement (APA, 2012). Clinicians need specific training about LGB experiences regarding the role of external and internalized heterosexism, as well as the potential for a positive LGB identity (Eubanks-Carter et al., 2005).

Personal attitudinal exploration and evaluation of internalized heterosexism is an essential prerequisite to working with this population (L. S. Brown, 1996). Heterosexual therapists are recommended to increase their exposure to LGB individuals and community norms (Lyons et al., 2010) as well as to reflect on their own sexual identity development (Morrow, 2000). Because heterosexuality is the norm, not having reflected on these issues is often a privilege of being heterosexual (McGeorge & Carlson, 2011). The importance of the exploration and awareness of these attitudes is supported by multiple therapist accounts of their work with this community (A. C. Bernstein, 2000; Dworkin, 2000; Mcwilliams, 1996; Milton, Coyle, & Legg, 2005). A belief system that sees LGB identities as healthy and normal expressions of sexuality and a general comfort discussing same sex sexual practices is crucial when working with this population (A. C. Bernstein, 2000; Burckell & Goldfried, 2006; Isreal et al., 2008; Milton et al., 2005). If a clinician believes that being LGB indicates mental illness, then they will be unable to offer culturally competent services and would do best to refer them to a clinician who can (Garnets et al., 1991). It is particularly important for the therapist to avoid the use heterosexist language and initiate discussions about the role of culure and sexual

orientation in the client's life and experience of therapy (Lyons et al., 2010). Furthermore, therapists are advised to beware of making assumptions that someone identifies as LGB based on a same-gender sexual experience, thus alienating individuals who are not ready to identify that way or experience a bisexual orientation (Dworkin, 2000). Finally, it is important for therapists to acknowledge and value diverse types of relationships, and not to believe that monogamy is the only healthy way of relating to others (Dworkin, 2000).

Working with the LGB population requires therapists to be aware of social dynamics in addition to intrapsychic processes (Israel et al., 2008; Morrow, 2004). Therapists wishing to work with this population need to be collaborative with their clients, identifying mutual goals (Israel et al., 2008) and at times including activism in their work (Pachankis & Goldfried, 2013). According to Morrow (2004), counselor training often encourages neutrality over advocacy; however, due to the historical and contemporary climate, ethical practice with LGB clients necessitates counselors to take a more direct stand against injustice.

Research Problem and Question

Statement of the problem. LGB people are significant therapy consumers (Cochran et al., 2003; M. A. Jones & Gabriel, 1999; Liddle, 1997; Morgan, 1992). It is likely that they will work with heterosexual therapists at some time in their life, because of the minority status of LGB clients. For example, 2003 study determined that 42% of 314 therapists reported working with LGB clients, and 91% of those therapists were heterosexual (Ford & Hendrick). This likelihood highlights the imperative that heterosexual therapist be more educated about meeting the needs for this population.

Unfortunately, it has been shown in many studies that counselor education on this topic is clearly inadequate (Burke, 1989; Buhrke & Douce, 1991; Garnets et al., 1991; Liddle, 1996; Phillips, 2000) and that clients have historically received biased services (R. Bowers et al., 2005; Garnets et al., 1991; Greene, 2007; Phillips, 2000). At the same time, there are improvements in services received (Liddle, 1999). Additionally, it may be particularly therapeutic to experience affirmative treatment from a heterosexual therapist as a counterbalance to societal heterosexism (Mair & Izzard, 2001).

Consequently, when an LGB-identified client enters treatment with a heterosexual therapist, there exists the potential for both beneficial and biased treatment. It is in the best interest of the field of psychology and LGB clients that the manifestations of both potentials are explored. Research indicates that things are improving in the treatment of LGB clients and that when affirmative care is offered, LGB clients experience considerable benefits from psychotherapy (Liddle, 1999). Therefore, there is hope for LGB clients to receive increasingly affirmative care in the future. However, this potential will only come to fruition if researchers and clinicians remain committed to understanding the social and personal dynamics operating to marginalize and pathologized individuals.

Cross-cultural literature has been exploring the impact of different types of client therapist matching for several decades. The results are nuanced and diverse depending on the construct in question. Gender, ethnic identities, and cognitive styles have been explored in studies that will be surveyed in the literature review. This research suggests that each of these demographic constructs have varying impacts on the therapeutic relationship and outcome. Literature on sexual orientation matching has been

inconsistent and has come from specific methodological positions. Much of the literature about this cross-cultural dyad has been quantitative, utilizing pseudo clients (D. R. Atkinson, Brady, & Casas, 1981; Borden, Lopresto, Sherman, & Lyons, 2010) or survey designs (Burckell & Goldfried, 2006; M. A. Jones, Botsko, & Gorman, 2003), or has been focused on the therapist's perspective (Berkowitz, 2005; A. C. Bernstein, 2000; Chojnacki & Gelberg, 1995; Dillon et al., 2004; McWilliams, 1996). Qualitative research on the client's experience has been largely absent from the contemporary dialogue, despite the fact that this type of research has been noted to be well suited to this issue (Croteau & Talbot, 2000).

This study aimed to fill the gap in the research by exploring the experience of LGB clients in therapy with heterosexual therapist, contrasting their experience with one other therapist of any orientation. I was interested in providing an in-depth look at the personal experiences of a several clients in order to identify practices and themes that can inform culturally competent clinical practice with LGB clients. Additionally, it was my hope that these accounts offer some examples of clinician behaviors that are deemed unhelpful by clients, offering more information about behaviors that may be best avoided. The more researchers can understand about these complex forces, the more aware and proactive counselors can be moving forward.

Research question. This research expands the current scholarship on this issue by giving voice to the client's phenomenological experience. Focusing on the client's experience will provide a forum for the individuals who can speak as insiders on the full range of challenges and benefits to their treatment experience. I was curious about how differences have been discussed and worked with clinically, how difference in sexual

orientation impacts the working alliance, whether the clinician's sexual orientation was discussed openly, the experience of therapeutic ruptures, and how ruptures have been worked through. Specifically, I was interested in understanding the client's experience of this cross-cultural dyad and what they felt was and was not helpful in working with a heterosexual therapist.

Researcher Reflexivity

Autobiographical origins of researcher's interest in the topic. I think that an important part of my role as a researcher is to continually reflect on how my subjectivity is interacting with my research. The approach I am taking to this research project encourages researcher reflexivity, and the significance of this reflexive process will be argued in my discussion of methods. Sharing about my autobiographical interest in the topic begins this process and is intended to help the reader situate my research. Ideally, being transparent about my stance allows readers to make their own assessments about this project and the resulting propositions.

My personal interest in this topic comes from being a heterosexual therapist who has worked closely with the LGBTQ community throughout my clinical training. My experience of becoming an ally, wondering about my effectiveness, and building cross-cultural therapeutic alliances informs my interest in and perspective on this topic. I have been very curious about this area of difference in my own therapeutic relationships and how it may impact the client's sense of safety and my therapeutic effectiveness. Early on, I worried that I would unintentionally say something discriminatory and that my clients may see me as a perpetrator of oppression. During the beginning stages of my work, it is possible I thought about my sexual orientation more than my clients did, as

they were engaged in their own experience. As I continued my training, I gained experience, knowledge, and confidence. This increased competence enabled me to allow my clients to have a wider range of reactions to me, understanding that the experiences they were working through in the therapeutic relationship were more important than my wish to be seen as an ally.

Cross-cultural therapeutic alliances have always been a focus of interest in my clinical work, as all therapeutic dyads are cross-cultural to some extent. It is not my intention to wash away important cultural distinctions, or give equal weight to identities that have different historical and contemporary consequences. Still, the vast diversity of individuals and experiences leads the constructs of similarity and difference to have important implications for psychotherapeutic work. I take very seriously the idea that there are many ways to live a fulfilling life. I do not believe there are any answers to problems that can be applied across the board. Instead, people must seek what is right for themselves, which is determined by complex conscious, unconscious, sociocultural, familial, and historical dynamics. I believe that my role as a therapist is to facilitate individuals in identifying, clarifying, and creating a life and relationships that are right for them, despite similarities or differences.

One of the most rewarding aspects of psychotherapy, for me, is engaging with diverse individuals and discovering what is true and important to each person. This interest has resulted from, and been informed by, international travel in cultures extremely different than my own. I enjoy seeing unique solutions to common problems, broadening my awareness of the challenges facing humanity, and finding common ground in suffering, joy, and relationships. This interest is coupled with humility around

my ability to interpret and understand these cultures, and a constant awareness and questioning of my own assumptions and perceptions. I find the parallel process of exercising caution in my assumptions and interpretations with my clients to be a worthy and engaging challenge, and I have appreciated exercising and expanding these critical reflective capacities with my research participants.

I enjoy working with the LGBTQ population and particularly appreciate working with clients around acceptance of their identity in the face of societal or familial rejection. I feel honored to offer acceptance for who they are and how they express themselves sexually and romantically. Sexual orientation seems to me to be such a personal and human expression that I see the discrimination against these individuals as a blatant assault on freedom of expression and the pursuit of happiness. LGBTQ issues are fundamentally humanitarian issues; they are issues resulting from political control over personal lives. The LGBTQ population is one of too many groups of people that are told they are less than due to their identities; some of which are biologically determined and others of which people have a right to construct in response to their own needs and experiences. Through this research, I hope to expand on my own capacity to serve these clients as well as offer information to the field on how to best meet the needs of LGB individuals. I feel that increasing the fields understanding of affirmative treatment can be supported by exploring the phenomenological experience of LGB clients and the meaning these clients have made of that experience.

Reflexivity and presuppositions. In the interest of reflection and transparency, I would also like to be open about the presuppositions I held going into this research. I do not believe that people can step completely outside of their perspective to attain a neutral

stance. However, actively questioning assumptions and considering alternative explanations can facilitate researchers awareness of their position in relation to the topic and research participants.

From the inception of this study I have been aware of my hopes for this research. I would like to be fully transparent in stating that it would please me to find that the treatment of LGBTQ individuals has improved somewhat from the egregious history of pathologizing, judging, and attempting to convert and control. I am admittedly interested in the potential for ally-work to provide acceptance and healing in relationship to a representative of the dominant heterosexual culture. However, given what I have heard anecdotally from my clients and other clinicians, I know that people continue to be mistreated by clinicians who are either consciously or unconsciously discriminatory. The occurrence of inappropriate treatment is also corroborated by the literature (R. Bowers et al., 2005; Garnets et al., 1991; Greene, 2007; Phillips, 2000). It is very likely that there will be some instances of improvement and others of continued discrimination. Regardless of where the results fall on this continuum, I feel that this research can highlight interventions that promote more competent multicultural practice with clients who share some common ground with the participants. The reverse is also true: determining particular aspects of negative therapeutic experiences could ascertain how discrimination is manifesting in the current climate and provide information about preventing these experiences. Additionally, both sorts of findings can offer directions for future research on this topic.

Reflexivity also involves awareness of my own presuppositions about the topics I will be engaging with in this research project. I believe in that human beings are social

animals, who thrive most when they have a community. Communities can come in many of forms, large and small, and ideally consist of individuals that offer respect, support, and safety. Relationships have been the site of much of my own growth, as well as injury, and these relational values are undoubtedly a part of what brought me to this profession. When clients and I have been able to repair a rupture in the therapeutic alliance, I have seen significant improvements and my interest in how these types of events have been weathered in my research participants' experiences of therapy is a result of this value.

My relational values also inform my frustration with discrimination against people on the basis of what could be a healing and supportive part of life. Restricting and controlling how individuals are allowed to connect and love is completely reprehensible to me. I am, however, a proponent of exerting control over individuals who are acting in hateful and destructive ways towards others. America has a social climate in which public discourses are controlled by a select group of people who, at times, marginalize, denigrate, or ignore the voices of others. As such, it is the responsibility of people who can be a part of the conversation to include marginalized voices. I believe that psychologists and other scientists have an obligation to consider the impact of their research and to try to advance the needs of individuals who have less access to this form of power.

In terms of sexual orientation, my experience with clients has shown me that whatever the underlying factors determining their sexual orientation; whether they be biological, autobiographical, psychological, or social; sexual orientation is not usually a choice. It is not a choice because of its very real influences, but also because sexual

orientation is not a three-option checklist. The categorizations that researchers, and myself, use in the study of the lesbian, gay, and bisexual population are largely artificial (Moradi et al., 2009). They allow scientists to distinguish a group of people and from another so that practical differences can be discussed. It is my opinion, and the opinion of many important scholars on sexual identity (APA, 2008; Kinsey et al., 1943; Savin-Williams & Vrangalova, 2013) that sexual orientation exists on a continuum from same-gender to different-gender attraction.

Scientists draw artificial distinctions to facilitate discussions about sameness and difference, but these categories do not mirror reality. In fact, I am not of the belief that language can describe reality accurately. Languages approximate reality as much as possible so that people can communicate with others and make sense of their experiences. It is unclear to me at what point an individual experiencing same-gendered orientation stops being bisexual and becomes a lesbian woman or gay man. Therefore, the distinctions I will be making are not ideal, but they are pragmatic. I hope that sharing dialogues about sexual orientation will lead to more awareness and research on the matter, leading to more useful distinctions.

I strongly believe that the continual process of reflecting on my assumptions about this research topic is an important part of doing rigorous research. Individuals are shaped by their experiences, and people's experiences are filtered through their particular perspective, identity, beliefs, and historical context. If researchers are not explicit about the position from which they work, the research that results is questionable. I intend to continue this process throughout each stage of the project and expect to be identifying further presuppositions with which I approach the world throughout my lifetime.

Literature Review

In order to place this study in the context of psychological knowledge, it is useful to consider the existing literature. As this study concerns the influence of sexual orientation difference on the psychotherapy relationship, it is worthwhile to consider research on the influence of other types of difference. Empirical investigating of this topic began in the field of cross-cultural psychology and multiculturalism. Therefore, central tensions in the field of multicultural therapy will be explored, along with current understandings of prejudice and the development of multicultural competence. According to Israel and Selvidge (2003), multicultural research, particularly ethnic matching research, has a great deal to offer researchers and practitioners interested in competence with the LGB community. In the interest of exploring the role of various facets of identity on the therapeutic process, research on the effects of ethnic, gender, and sexual orientation matches and mismatches will be explored at length.

Gender and sexual orientation are mutually influencing social categories that organize people's experience of themselves and others (Fassinger & Richie, 1997). Gender differences that have been recognized in the behavior and attitudes of clients and clinicians will be noted. However, understanding these differences requires special attention to the ways in which gender socialization influences all individuals in western culture. This discussion of gender will be followed with a review of the existing research on the treatment experiences and preferences of LGB clients, as well as an exploration of the unique benefits and challenges that sexual minority and heterosexual therapists face in this work. Additionally, the role of heterosexual allies in the lives of LGB individuals

will be surveyed along with an exploration of what motivates individuals to become allies to the sexual minority community.

In order to balance this exploration of therapeutic processes dependent on therapist and client characteristics, I will survey research concerning the influence of factors that are universal to all treatments. I will specifically analyze the role of the therapeutic alliance and what factors support the development of a positive therapeutic relationship. Self-disclosure is one therapist technique that has been repeatedly noted to influence the therapeutic alliance (Barrett & Berman, 2001; Zur, 2011), and as such, literature on the influence of therapist self-disclosure will be reviewed. Furthermore, disclosure issues have special significance when working with LGB clients, who often have to disclose their sexual identity to others (Fassinger, 1991), making the exploration of this topic important for those interested in working with people identifying as LGB or exploring an LGB identity. Lastly, the need for further research on this topic will be discussed.

Multicultural Considerations in the Therapeutic Relationship

Multicultural psychology. As society continues to be defined by multiple cultures, identifications, and languages, the field of psychology is increasingly acknowledging the relevance of multicultural issues in clinical practice and research (APA, 2003; D. W. Sue & D. Sue, 1990). Many scholars have argued that multicultural competence is equivalent to clinical competence, due to the diversity present in society (H. L. Coleman, 1998; Fuertes & Brobst, 2002; Goh, 2005; Pederson, 1991). According to D. W. Sue (2004), "a psychology that does not recognize and practice diversity is a psychology that is truly bankrupt in understanding the totality of the human condition"

(p. 766-767). If psychological knowledge is to be useful, it must explore, acknowledge, and appreciate the vast range of human experience.

Increased consideration of multicultural issues in psychology was initiated by the Civil Rights Act of 1964 and numerous publications published throughout the 1970s that highlighted and challenged the ethnocentrism of the field of psychology (Arredondo & Perez, 2006). The American Psychological Association (APA) first acknowledged this growing concern in 1981 when they commissioned a report on cross-cultural competencies (D. W. Sue et al., 1998). D. W. Sue et al.'s (1982) cross-cultural competencies began the APA's involvement in the development of multicultural treatment guidelines, task forces on diversity issues, and professional organizations centered on the practice and study of multicultural diversity (Arredondo & Perez, 2006). Multicultural psychology has been declared psychology's "fourth force" (Pedersen, 1988, 1989, 1990) and is now considered by the APA and many clinicians to be a requirement for ethical practice (APA, 2003; Arredondo, 1998; Goh, 2005; Watson, Herlihy, & Pierce, 2006).

Until this shift in awareness began, late in the 20th century, culture had been either ignored or pathologized in counseling methods (Arredondo, 1998). Additionally, the clinical implications of stigma and societal oppression had not been considered or discussed (Arredondo, 1998). This absence is not surprising, given that "the group who "owns" history also controls the gateway to knowledge construction, truth and falsity, problem definition, what constitutes normality and abnormality, and ultimately, the nature of reality" (D. W. Sue, 2004). Historically, counseling models have been founded on Eurocentric assumptions (APA, 2003), tested on white, educated, middle class

populations (S. Sue, 1999), and based on White Americans as the reference group for what is normal (M. J. Miller & Sheu, 2008). Furthermore, in research, ethnicity has been considered a nuisance variable (APA, 2003; Arredondo & Perez, 2006; Morrow, Rakhsa, & Castañeda, 2001; Quintana, Troyano, & Taylor, 2001; Phinney, 1996; S. Sue, 1999) and consistently viewed in a negative manner (D. W. Sue, Ivey, & Pedersen, 1996). It is not surprising, then, that traditional approaches to counseling have been found to be less effective with ethnic minority clients (Casas, Ponterotto, & Gutierrez, 1986; Ibrahim & Arredondo, 1986; D. W. Sue, 1990; D. W. Sue & D. Sue, 1990; D. W. Sue et al., 1982).

Contemporary understanding of multicultural issues necessitates respect and interest in cultural groups, recognition of the defining role of cultural context, and the influence of historical, social, political, and economic factors (APA, 2003). Far from being a nuisance variable, ethnicity and culture are central to processes of identity, relationship, community, illness, and health (D. W. Sue & D. Sue, 2012). They are an integral part of the worldviews of both client and clinician, and as such these differences influence alliance development, assessment, diagnosis, and therapeutic effectiveness (S. Sue, 1998). Therefore, exploring the influence of these differences and similarities on individuals and their relationships is essential for culturally competent clinical work.

Defining multicultural. Multiculturalism can be defined a number of ways, and multicultural research has suffered from a lack of clarity around its terms (Helms, 1994). The APA Guidelines on multicultural education, training, research, practice, and organizational change for psychologists note that, "multiculturalism, in an absolute sense, recognizes the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other

cultural dimensions" (APA, 2003, p. 380). When defined inclusively, multiculturalism refers to a wide variety of cultural identifications, and includes the dimensions of sexual orientation (Arredondo & Perez, 2006). Alternatively, the APA applies their guidelines to a more narrow definition of multiculturalism, referring "to interactions between individuals from minority ethnic and racial groups in the United States and the dominant European–American culture" (APA, 2003, p. 378). The arguments for utilizing this more limited definition of multiculturalism relate to concerns about diluting the meaningfulness of the concept and permitting individuals to further avoid issues of race and racism (Helms & Richardson, 1997; M. J. Miller & Sheu, 2008; D. W. Sue, Arredondo, & McDavis, 1992).

It is important to clarify what is meant by the terms of race, ethnicity, and culture, as these terms are often used interchangeably (Helms & Talleyrand, 1997; Phinney, 1996). While race originally referred to biological phenotypes (Phinney, 1996), these biological categorizations do not exist in reality and instead there exists significant within-group differences in these presumed categorizations (APA, 2003; Zuckerman, 1990, as cited in Phinney, 1996). According to Helms and Talleyrand (1997) and Day-Vines et al. (2007), race is a socially constructed concept that shapes individual, communal, and institutional interactions. "Race, then, is the category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result" (Helms & Talleyrand, 1997, p. 1247). They argue that race is a useful concept in research and scholarship because it has a salient influence on individual's lives across societies, because "advantageous or disadvantageous treatment occurs according to phenotypic characteristics, regardless of

the culture in which one is socialized" (p. 1247).

Ethnicity refers to members of groups sharing a heritage of cultural values (Day-Vines et al., 2007). Whereas culture is intrinsic to ethnic identifications, there are cultural groups that are not related to ethnic identities, such as those defined by their spiritual perspective or sexual orientation. Referencing Leighton (1982), Day-Vines et al. (2007) define culture as an "integrated pattern of human behavior that includes thoughts, communication, action, customs, beliefs, values, and instructions of a racial, ethnic, religious, or social group" (p. 403). Ethnic minorities and other types of cultural minorities share the experience and implications of systemic discrimination (Lowe & Mascher, 2001), though *minority* is and will continue to be a misleading term as European Americans cease to be the numerical majority (Phinney, 1997).

Prejudice and ameliorating prejudice. The psychological implications of these categorizations are significant (APA, 2003). Allport's (1954) social categorization theory posits that individuals make sense of their world by categorizing others into in- and out-groups. According to Fiske (1998), social categorization protects cognitive resources by enabling people to process information automatically and unconsciously. This process tends to exaggerate differences between groups, and encourages a tendency towards cooperation with members of a person's group and competition with members of other groups (Fiske, 1998). In cross-cultural encounters, assumptions can also lead to miscommunications due to differing values and worldviews (APA, 2003; S. Sue, 1998). This classification may have been especially useful for early survival when people lived in small homogenous groups because it provided rapid recognition of allies and enemies

(Ponterotto, Utsey & Pedersen, 2006). However, in a contemporary world that is multicultural, these processes can get in the way of cross-cultural collaboration.

These social categorization processes occur across cultures, leading to attitudinal bias and, at times, this unconscious process results in discriminatory actions (Utessey, Ponterotto, & Porter, 2008). According to Utessey, Ponterotto, and Porter (2008), negative bias towards groups of people is called prejudice and racial, ethnic, and cultural prejudices exert powerful influences in contemporary society. Further, these scholars note that racism, sexism, and heterosexism occur when the presence of negative bias includes action or the presence of power to subjugate the group in question. Prejudice can occur on individual, institutional, or cultural levels and while more traditional forms of overt racism have diminished, more covert, subtle, and psychologically destructive forms of racism are quite common (Dovidio, Gaertner, Kawakami & Hodson, 2002; Utessey, Ponterotto, & Porter, 2008).

Cultural dynamics exist within and are influenced by the context of race relations and oppression in the United States (D. W. Sue et al., 1992). All people hold some level of attitudinal bias concerning dimensions of difference, due to the realities of socialization and cognitive processing strategies (Ancis & Szymanski, 2001; APA, 2003; Dovidio & Gaertner, 2000). According to D. W. Sue and D. Sue (2012) "research suggests that the socialization process culturally conditions racist, sexist, and heterosexist attitudes and behaviors in well-intentioned individuals and that these biases are often automatically enacted without conscious awareness, particularly for those who endorse egalitarian values" (p. 154). These inherent biases become particularly problematic in the counseling setting, where implicit attitudes have been shown to influence counselors'

case conceptualization, diagnosis, and treatment (E. E. Jones, 1982; Tomilson-Clarke & Camili, 1995).

Greenwald and Banaji (1995) emphasize that social cognition is largely implicit and outside of conscious awareness, making these attitudes difficult to measure, identify, or acknowledge to oneself. Even those with consciously egalitarian attitudes can also hold biased attitudes (Boysen & Vogel, 2008; Dovidio & Gaertner, 2000; Utessey, Ponterotto, & Porter, 2008). This finding highlights the importance of people exploring their biases and assumptions about their own and other cultures (APA, 2003; Richardson & Molinaro, 1996; Ridley, 2005). D. W. Sue and D. Sue (2012) have stated that:

> No person or group is free from inheriting the biases of this society. It does not matter whether you are gay or straight, white or a person of color, or male or female. All of us have inherited biases. Rather than deny them and allow them to unintentionally control our lives and actions, we should openly acknowledge them so that their detrimental effects can be minimized. (p. 30)

This self-reflection process is particularly important for white clinicians, who usually have not spent as much time considering the role of their ethnicity and culture because they identify with what is considered in America to be the cultural norm (D. W. Sue & D. Sue, 2012). One of the most effective ways to minimize prejudice is through personal contact with individuals belonging to differing cultures (Pettigrew & Tropp, 2000, 2008). Pettigrew and Tropp noted that having personal experiences with members of an out-group increases empathy, enables perspective taking, decreasing anxiety about contact, and increases knowledge that may disconfirm assumptions and stereotypes. Finally, research indicates that multicultural training involving increased knowledge about other

cultures and the role of culture also reduces prejudice (T. B. Smith, Constantine, Dunn, Dinehart, & Montoya, 2006).

Cultural competence. The literature from multicultural psychology has a great deal to offer clinicians concerning the treatment and experiences of LGB clients (Greene, 1994) because multicultural psychology has a rich history of research and theoretical literature on the roles of difference and similarity in clinical work (Israel & Selvidge, 2003). S. Sue has stated that in its basic form, "cultural competence (along with the broader concept of multiculturalism) is the belief that people should not only appreciate and recognize other cultural groups but also be able to effectively work with them" (1998). In a manner, this subfield began with the concept of Multicultural Competence (MCC) when D. W. Sue et al. (1982) provided a model of cross-cultural competence that included competencies on three dimensions: attitudes, knowledge, and skills (Arredondo & Perez, 2006). In addition to encouraging the development of specific knowledge and skills to work with multicultural populations, this model encourages an active and ongoing process of reflection, which recognizes "the complexity and diversity of the client and client populations, and acknowledge[s]… our own personal limitations and the need to always improve" (D. W. Sue & D. Sue, 1990; p. 146).

A substantial amount of research has been done on this model, which has been updated periodically (American Psychological Association, 2003; Arredond et al., 1996; D. W. Sue et al., 1992; D. W. Sue et al., 1998) and remains the prevailing standard, though others have been developed (e.g. Cultural Intelligence, Ang & Van Dyne, 2008; Universal Diverse Orientation, Millville et al., 1999). MCC has been highly correlated with client satisfaction (Constantine, 2002), particularly with clients who hold ethnic

identities (Fuertes & Brobst, 2002; Fuertes et al., 2006). Additionally, MCC has been shown to reduce attrition with ethnically identified clients (Wade & Bernstein, 1991). Largely, MCC has been measured by self-report scales, which is problematic due to the influence of social desirability (Constantine & Ladany, 2000; Worthington, Mobley, Franks, & Tan, 2000). Furthermore, studies show minimal associations between self-reported MCCs and MCC ratings by others (Sehgal et al., 2011). These and other measurement issues underscore the importance of studying client experiences and perceptions (Constantine et al., 2002; Pope-Davis et al., 2002).

A primary tension in multicultural counseling is between universal and culturally specific aspects of human experience (A. R. Fischer, Jome, & Atkinson, 1998). Some scholars propose that universal healing conditions should be emphasized (A. R. Fischer et al., 1998; C. H. Patterson, 1996). Others argue that particularities of culture need to be acknowledged and valued and that focusing on universals denies vital aspects of individual's identities (McFadden, 1996; Pederson, 1996). There have been concerns that focusing on cultural differences would eventuate stereotypes and that instead "colorblindness" would provide the most fair treatment. On the contrary, colorblind attitudes tend to minimize and ignore important identities and often lead to implementing racist practices (Brewer & Brown, 1998; Wolsko, Park, Judd, & Wittenbrink, 2000).

> Whether knowingly or not, color blindness allows Whites to deny the experiential reality of minorities by minimizing the effects of racism and discrimination in their day-to-day lives. It further allows many Whites to deny how they benefit from their own Whiteness and how their Whiteness intrudes upon persons of color. (D.W. Sue 2004, p. 763)

Culturally adapted treatments have been found to be significantly more effective than universal approaches (Griner & Smith, 2006; T. B. Smith, Rodriguez, & Bernal, 2011; Thompson, Worthington, & Atkinson, 1994). Additionally, acknowledging and discussing the cultural differences present in counseling relationships, called "broaching race," increases counseling outcome measures in multicultural practice settings (Aitken & Burman, 1999; Asnaani & Hofmann, 2012; D. R. Atkinson, Casas, & Abreu, 1992; Day-Vines et al., 2007, Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Thompson, Worthington, & Atkinson, 1994; Zhang & Burkard, 2008). Clients see counselors who do so as more culturally competent and when broaching does not occur, clients appear to strategically manage the involvement of culture in sessions (Pope-Davis et al., 2002).

Similarly, integrating the empirically supported treatment (EST) movement and multicultural paradigms raises theoretical complications (H. L. Coleman & Wampold, 2003). ESTs are technique oriented, intending to determine what therapeutic approach is the most effective across the population. According to H. L Coleman and Wampold, this approach to research obscures the client and clinicians personal characteristics that play a role in the therapeutic process. However, these researchers also note concerns that culture-specific treatments assume that differences between cultures are more significant than differences between individuals. Additionally, ESTs are established by particular research methods such as controlled clinical trials. Due to the complexities of accounting for ethnicity in research, this type of research often cannot be generalized across ethnicities, continuing the dearth of research on working with multicultural populations (S. Sue, 1999). Many multicultural researchers have encouraged the use of diverse research methods, including qualitative methods, to develop a more comprehensive

knowledge base (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Pope-Davis et al., 2002; S. Sue, 1999).

Ethnic identification and therapist preference. The literature on matching clients and clinicians based on various variables is particularly important to this research. In addition to commenting on the role of similarity and difference on the therapeutic relationship, this body of literature also informs practice with LGB people of color, with whom clinicians must consider the influence multiple intersecting identities (Fukyama & Fergason, 2000). There are significant disparities in treatment utilization between white clients and clients of color (Whaley & Davis, 2007). Moreover, a significant proportion of clients of color terminate without discussing this choice with their therapist (J. Owen, Imel, Adelson, Rodolfa, 2012). Ethnic matching has been one avenue for exploring what treatment features are effective with clients of color, and future research must continue to identify what constitutes ethical practice with multicultural populations.

Originally, the theoretical assumption behind the practice of matching was that stronger therapeutic alliances would result from ethnically matched therapeutic relationships (S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991; D. W. Sue & D. Sue, 1977). It is assumed that individuals from a similar ethnic background will also share worldviews or other psychological constructs (Quintana, 2007; Zane et al. 2005). This theory has been verified by social psychology research on "the similarity effect" (Simons, Berkowitz, & Moyer, 1970), which is the tendency for people to see similar others as more attractive and credible than dissimilar others (Holland, Atkinson, & Johnson, 1987).

Conclusions from research about the effects of similar ethnic dyads vary significantly, leading many to declare this research inconclusive (Cabral & Smith, 2011;

Karlsson, 2005; Maramba & Nagayama Hall, 2002). Differences in matching preferences have been recognized across ethnic groups and research designs (H. L. Coleman, Wampold, & Casali, 1995; Karlsson, 2005). Matching clients and counselors on the dimension of ethnicity appears to be particularly important for African American clients, which may be due to mistrust resulting from historical discrimination and mistreatment (Awosan, Sandberg, & Hall, 2011; H. L. Coleman et al., 1995). Differences in matching preferences are also associated with the types of problems with which clients present (Pope-Davis et al., 2002). Pope-Davis et al. (2002) found that clients who define their problem as relating to their ethnicity indicate a stronger preference for ethnically similar therapists than those who define their issue more generally. Finally, differences in preference appear to vary with respect to the client's level of identity development (Parham & Helms, 1981).

Some research has demonstrated increased effectiveness and treatment retention when clients and counselors share ethnic identifications (D. R. Atkinson, 1983, 1985; Grantham, 1973; Harrison, 1975; Lam & Sue, 2001; Parham & Helms, 1981). Alternatively, many studies have shown no influence of ethnic matching on treatment outcomes (Bryan, Dersch, Shumway, & Arredondo, 2004; Johnson & Caldwell, 2011; Sterling, Gottheil, Seinstein, Serota, 1998). In a review of the literature, Cabral and Smith (2011) indicated that clients may prefer a matched therapist, but that matching does not have a significant effect on therapeutic outcome (Cabral & Smith, 2011). Similarly, a meta-analysis by Maramba and Nagayama Hall (2002) found that matching had a small effect on utilization and premature termination, though they contend that the effects were insignificant and unlikely to effect treatment outcome. Conversely, Gray-

Little and Kaplan (2000) and Lam and Sue (2001) have argued that outcome is related to retention, proposing matching improves outcome indirectly by increasing sessions. S. Sue (1998) interprets this variance by noting that while it could be important for some clients, it is not central or decisive in therapeutic healing.

In a recent qualitative study exploring the significance of race for ethnic minorities, Chang and Yoon (2011) found that many ethnic minorities avoided cultural topics in therapy because they believed that a white therapist would not be able to understand their experience. These researchers also found, however, that racial differences can be moderated by the experience of a therapist who is comfortable discussing cultural issues, as well as accepting and compassionate. Chang and Yoon also recognized a subgroup of people who preferred racial mismatch and saw matching as disadvantageous. This work highlights the fact that client preferences are not universal, while also reinforcing the value of acknowledging and discussing culture with clients.

Karlsson (2005) has argued that methodological inconsistencies make it difficult to developing conclusions based on the literature, though he proposed that differences in findings over time may be the result of an increase in awareness and ethical cross-cultural counseling practice. A meta-analysis by H. L. Coleman, Wampold, and Casali (1995) suggested that studies researching ethnic matching provide different findings depending on how the issue is tested. Matching research often tests clients' preferences through analogue studies. H. L. Coleman et al. (1995) found that there was a substantially larger preference for counselors of the same ethnicity in those studies that used a two choice model, as opposed to those that offered more options. Lastly, findings from matching

studies are also limited by their use of "pseudo-clients," indicating the usefulness of studying real clients (Worthington, Soth-McNett, & Moreno, 2007).

Maramba and Nagayama Hall (2002) have suggested that the inconsistency of matching outcomes may be due to the fact that ethnic match approximates but does not adequately measure broader attitudinal similarity resulting from shared culture. This view is supported by literature focusing on cognitive match and other variables meant to reflect personality similarity (D. R. Atkinson, Wampold, Lowe, Matthews, & Ahn, 1998; Kim, Ng, & Ahn, 2005; Zane et al., 2005). S. Sue (1998) has proposed that it may not be useful to explore the benefits of cultural match empirically, but instead that researchers should explore the experiential results of therapeutic dyads that are culturally matched or mismatched. This research project aims to take this approach to the issue of sexual orientation difference on the therapeutic relationship. Cabral and Smith (2011) have argued that while similarity may encourage connection, differences encourage insight and open up the opportunity for clarifying and reframing. Complete similarity between a therapist and client, therefore, may not be clinically desirable. According to Pederson (1996), researchers and clinicians make three significant errors when discussing difference: emphasizing similarities, emphasizing differences, and assuming that one must emphasize one or the other. The research on ethnic matching suggests that there are benefits and drawbacks to matching counselors to clients on such demographic variables, and this research will likely demonstrate similar complexity.

The Role of Gender in the Therapeutic Relationship

Gender influence. Differentiating people based on their gender or sex is the first social categorization that children learn (Diamond, 2000). According to Fassinger and

Richie (1997), "sex—what sex one is as well as the sex of one's intimate partners—constitutes a primary organizing principle used by people in their interpretation of daily experiences and in their construction of attitudes and worldviews" (p. 84). Whereas sex concerns biological phenotypes historically classified in the binary of Male or Female, gender relates to roles and identities that are personally and socially constructed (Mintz & O'Neil, 1990). According to Mintz and O'Neil, expectations around behavior are taught to individuals through a process of socialization that results in a gender identity. Roles and expectations on the basis of gender operate differently in various societies, though they are highly influential determinants across cultures (Diamond, 2000). In contemporary US society, "men tend to define themselves and their lives primarily through independent, goal-directed, assertive activity, and women through interdependent, nurturing relationships with others" (Cook, 1993, p. 229, as cited in Fassinger & Richie, 1997). Because of its pervasive influence, gender impacts the therapeutic relationship in a number of important ways (Kaplan, 1979). In order to highlight existing research on the influence of gender in the therapeutic setting, I will refer to findings from research about women and men, as these are the categorizations that have been used in the reported research. However, the author recognizes evidence that there exists more variation than this categorization would suggest (Fausto-Sterling, 1993, as cited in Moradi et al., 2009) and would like to acknowledge the complexity and variance of gender identities.

Research on counselor bias has consistently indicated that counselors view clients differently depending on the client's gender (A. V. Bowers & Bieschke, 2005; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; E. E. Jones & Zoppel,

1982; Tomlinson-Clarke & Camilli, 1995). Both male clinicians (Aslin, 1977) and female clinicians have been found to perceive female clients more negatively (Neulinger, Schllinger, Stein, & Welkowitz, 1970, as cited in Brooks, 1981), particularly in countertransference reactions to sexual abuse (Adams & Betz, 1993; Latts & Gelso, 1995). A foundational study by Broverman et al. (1970) asked clinicians to describe characteristics of healthy and unhealthy men and women. The researchers found that traditionally masculine traits were described as healthier, whereas females were described as healthy when they conformed to socialized gender roles of being more submissive, dependent, and emotional. This discrepancy places women into a double bind in which they have two choices: to be seen as a healthy adult or a normal woman (Fassinger & Richie, 1997). This finding is consistent with the views of other scholars who report that individuals are pathologized when they do not conform to societal gender roles (Betz & Fitzgerald, 1993 Gilbert, 1992; Morrow, 2000). According to Betz and Fitzgerald (1986) this stigma is the result of sex role bias, which is defined as "any set of attitudes or behavior which favors sex role congruent behavior and negatively evaluates sex role incongruent behavior" (p. 83).

There is also empirical evidence that female and male clinicians demonstrate significant differences in their perception of clients and therapeutic work. Female therapists have been found to demonstrate increased empathy (Abramowitz, 1976; Stein, 1997) and elicit increased self-disclosure (Grantham, 1973). Many researchers also suggest that female therapists form stronger therapeutic alliances (Bryan, Dersh, Shumway, & Arredondo, 2004; Dolinsky, Vaughn, Luber, Mellman, & Roose, 1998; E. E. Jones & Zoppel, 1982; Zlotnick, Elkin, & Shea, 1998; Werner-Wilson, Michaels,

Thomas, & Theisen, 2003). E. E. Jones and Zoppel (1982) and Tomlinson-Clarke and Camilli (1995) have both found that female clinicians rate their clients' problems as more severe, which may be due to increased empathic engagement. Furthermore, according to a study by A. V. Bowers and Bieschke (2005), female clinicians rate their clients as being stronger, more active, and less responsible for their problems than their male counterparts. In clinical evaluations, female clinicians expected greater improvement, while male clinicians expected greater treatment difficulties. Additionally, A. V. Bowers and Bieschke found that whereas male clinicians reported more comfort working with clients, females reported increased interest in working with clients. The researchers theorized that these differences are likely to be a result of female gender roles emphasizing the importance of nurturing and emotional support (A. V. Bowers & Bieschke, 2005; Hyde, 1991).

Gender and therapist preference. Clients have reported preferences for both male (Simon, 1973) and female therapists (E. E. Jones & Zoppel, 1982; Simons & Helms, 1976). Preferences for a gender-matched therapist have also been demonstrated (Johnson & Caldwell, 2011; Simons & Helms, 1976), particularly for female clients (E. E. Jones, Krupnick, & Kerig, 1987). In a sample of 233 clients, B. L. Bernstein, Hofmann, and Wade (1987) found that more than half of the clients had a preference for a clinician of a particular gender. These researchers found that some preferences related to the type of therapeutic concern being discussed, with vocational and academic concerns, rather than relational concerns, more often associated with a preference for a male counselor. Likewise, Blier, Atkinson, and Geer (1987) found that female counselors were preferred for relational and sexual issues, whereas male counselors were

preferred when presenting problems concerned assertiveness. These results indicate that gender role expectations have a considerable influence on therapist gender preferences.

Following a similar pattern to ethnic matching, research on gender preferences are not consistent with research concerning treatment outcome resulting from gender match or mismatch. For example, according to a study by Zlotnick et al. (1998), when clients had gender preferences but were not matched accordingly, this change did not have a significant affect on the outcome of the therapeutic encounter. This research suggests that even though gender is an influential construct and clients have ideas about how gender will influence their work, these beliefs do not necessarily influence treatment outcome. In fact, numerous researchers have argued that gender matching does not have a significant impact on treatment outcomes or attendance (Beutler, Crago, & Arizmendi, 1986; Bowman, Scogin, Floyd, & McKendree-Smith, 2001; Cottone, Drucker, & Javier, 2002; E. E. Jones & Zoppel, 1982; Sterling et al., 1998; Zlotnick et al., 1998). According to Nelson (1993, as cited in Speight & Vera, 1997), the inconsistency of results from gender matching research is likely due to the absence of an exploration of the meaning that individuals ascribe to the construct of gender.

Sterling et al. (1998) conducted an interesting study concerning the effects of gender matching on retention and follow-up outcomes in addiction counseling. The researchers found that while there were minimal improvements for matched female dyads, those who were in mismatched pairs sought increased support outside of the counseling program. This study indicates that clients may be resourceful about getting the support they need outside of the counseling relationship. This finding raises the important point that there are many routes to effective psychological change, and

demographic characteristics may not play the most significant role in psychotherapy. Several authors question the usefulness of studying particular attributes of the therapist over more general factors of effective therapy (Luborsky et al., 1999; Messer & Wampold, 2002). Additionally, some research on the influence of gender matching has found that other characteristics were more influential to therapeutic outcome, such as expertness (Angle & Goodyear, 1984), having a lower caseload, focusing on the therapeutic relationship, and holding a psychodynamic theoretical orientation (Vocisano et al., 2004).

According to Mintz and O'Neil (1990), existing research on the role of gender in therapy has been flawed by the basic assumption that biological sex is equivalent to gender. These scholars recommend, instead, that researchers turn their attention to the influence of gender role socialization on the therapy process. Mintz and O'Neil highlight the error in assuming that the differences between the experiences and biases expressed by men and women are the result of biological differences. Moreover, it would be erroneous to assume that this research communicates something about men and women internationally, as gender role expectations differ cross-culturally (Gilbert, 1992) and the reported research has been conducted with a western cultural context. According to Gilbert (1992), findings are limited by a number of western assumptions; first, context stripping, the idea that meaning can be understood without sociocultural identifications, prevents comprehension of such interactions. Furthermore, Gilbert notes that research tends to focus on individual variables and emphasize differences between the genders rather than similarities. Lastly, more research is needed to understand the experiences of those who do not identify as either male or female.

Gender and sexual prejudice. When it comes to working with diverse clients, female therapists have been found to stereotype clients less than their male counterparts (Unger & Crawford, 1992). Female clinicians have also been found to demonstrate increased multicultural competence (Constantine, 2002; Singley & Sedlacek, 2009). Constantine has argued that this difference is due to women having their own experiences of oppression and negotiating their identity in relation to the dominant group. These findings contrast with studies of younger children, in which males are generally less hostile than females toward other children (Miville et al., 1999). Hamilton and Trolier (1986, as cited in Miville et al., 1999) have proposed that this decreased tolerance comes with adopting more traditional masculine gender roles emphasizing competition.

These differences in acceptance of diverse others also applies to LGB clients, with research consistently suggesting that female counselors hold less negative attitudes towards gay men and lesbian women (Balsam & Mohr, 2007; A. V. Bowers & Bieschke, 2005; Gilliland & Crisp, 1995; Herek & Capitano, 1999; Kite & Whitley, 1996; Mohr & Fassinger, 2000; Mohr & Rochlen, 1999), though there is significantly less research on attitudes regarding bisexual individuals (A. V. Bowers & Bieschke, 2005). Furthermore, women have been found to be more aware of heterosexual privilege and resistant to heteronormativity (Montgomery & Stewart, 2012). However, this finding may be complicated by a recent study that indicates women are more motivated to "respond without prejudice", and may demonstrate more affirmative attitudes as a result (Ratcliff, Lassiter, Markman, & Snyder, 2006). Herek (2002) has proposed that men hold more sexually prejudiced perspectives due to higher societal pressures to conform to masculine gender roles that attach importance to heterosexuality. This argument is supported by

empirical evidence that men who exhibit rigid adherence to gender roles tend to express less comfort and offer a less positive prognosis to gender role nonconforming clients (Wisch & Mahalik, 1999).

According to Fukuyama and Ferguson (2000), stigma around sexual orientation serves to maintain traditional gender roles. In numerous studies, traditional gender roles have been correlated with sexual prejudice, particularly in men (Falomir-Pichastor & Mugny, 2009; Goodman & Moradi, 2008). According to Falomir-Pichastor and Mugny (2009), "sexual prejudice is an inner organizing principle of our cultural meaning of manhood" (p. 1234). Sexual orientation and gender roles are separate categorizations (Fassinger & Richie, 1997) and heterosexual individuals do violate gender role norms. However, predominant stereotypes suggest that lesbian women are "masculine," whereas gay men are "feminine" (Herek, 1993). In a culture that values the masculine, feminine men are shamed and devalued (Morrow, 2000). According to Betz and Fitzgerald (1986) this stigma is an example of sex role bias, which is defined as "any set of attitudes or behavior which favors sex role congruent behavior and negatively evaluates sex role incongruent behavior" (p. 83). Sex role bias has been demonstrated in research in which clients who violated gender role expectations were viewed as more pathological (Robertson & Fitzgerald, 1990).

The results of these biases may account for research conducted with LGB clients in which gender played a significant role in therapist preferences. In 1996, Liddle found that female therapists, regardless of sexual orientation, where rated as more helpful than male therapists. This finding is consistent with other studies by Brooks (1981) and Saulnier (1999) in which samples of lesbians preferred heterosexual and lesbian female

therapists to male therapists. Lesbian women appear to be more concerned with the gender of the therapist than gay men (Kaufman et al., 1997; Liddle, 1996), which can be understood in light of the overarching influence of sexism in western culture. As Morrow (2000) has noted, "the outcome of a culture that privileges and values men and masculinity is misogyny, the hatred of women and the feminine" (p. 141). Women may be particularly sensitive to and avoidant of this devaluation due to personal experiences with misogyny. Gender and sexuality influence the therapeutic relationship in complex ways and competent practice with sexual minority clients requires an appreciation and sensitivity to the influence of societal expectations and stigma on psychological health (Fassinger & Richie, 1997).

The Influence of Sexual Orientation on the Therapeutic Relationship

Sexual orientation and therapist preference. Following the reasoning behind matching on other variables, sexual orientation matching has been theorized to increase the client's capacity for trust and identification with the therapist (Gelso & Mohr, 2001; Rochlin, 1982). Research on LGB clients' preferences for therapists has changed over time, with matching appearing more significant in research conducted previous to the mid-90s. This shift may be due to changes in social climate, therapist education, and increased methodological complexity. Matching research has always demonstrated some inconsistency, indicating personal differences in clients' needs. Liddle (1999) argues that it may have taken several decades for the 1975 APA resolution to effect practice. The scholar posits that substantial time was required for educational programs to integrate research into their training programs and for older therapists, who were educated to see sexual minority status as pathological, to retire. Liddle also notes that improved

awareness likely resulted from the gay rights movement and AIDS epidemic contributing to increasingly affirmative practice over time.

The first study to explore sexual orientation matching was conducted by Liljestrand, Gerling, and Saliba in 1978. The researchers interviewed 16 therapists and 24 clients about the influence of gender and sexual orientation similarity on their therapy and found sexual orientation matching to be significantly related to positive outcomes. This research did not indicate a strong influence of gender, which contrasts with subsequent research indicating preferences for heterosexual female therapists along with sexual minority therapists (Brooks, 1981; Liddle, 1997; Saulnier, 1999). In these studies, lesbians and gay men were more likely to choose therapists of their own gender and orientation, with the least preference indicated for heterosexual male therapists. This preference for a therapist of the same gender appears to be more significant for lesbians than gay men (Liddle, 1997). Furthermore, a survey completed by Saulnier (1999) indicated gender matching was a more important preference (64.4%) than that of sexual orientation (38.5%). This body of literature reflects gender role influences discussed previously and reminds researchers that client preferences are complex and multidimensional.

In 1981, using an analogue design, D. R. Atkinson et al. found that sexual minority counselors were rated more favorably than heterosexual counselors or counselors of unknown orientation. Nevertheless, counselors who demonstrated affirmation and similarity in attitudes concerning gay rights were rated almost as favorably as sexual minority therapists. Similarly, in 1989, McDermott, Tyndall, and Lichtenberg conducted a survey that found LGB clients preferred therapists of the same

sexual orientation, while also discovering that 39% believed that therapist sexual orientation did not make a significant difference. Those who were less comfortable speaking with a heterosexual or nondisclosing therapist tended to demonstrate higher levels of internalized heterosexism, indicating the importance of client factors on counselor preferences. Moreover, the client's presenting problem influenced their preferences, such that clients who were seeking therapy for a problem related to their sexuality demonstrated an increased preference for a sexual minority therapist. This finding was corroborated by a later survey by Kaufman et al. (1997), suggesting that the nature of the presenting problem influences therapist choice.

In 1992, an analogue study by M. R. Moran modified variables of counselor experience and sexual orientation and found that, for lesbians, sexual orientation was less significant than counselor experience. This study is notable for the inclusion of therapist variables that are modifiable as opposed to demographic characteristics such as gender and sexual orientation. Liddle (1996) has criticized the focus of matching research due to the fact that these studies tend to emphasize the influence of factors that are immutable instead of exploring aspects of therapist competence that can be changed or developed. Many of these studies also suffer from unrepresentative samples that are primarily highly educated and white, limiting the usefulness of their findings (Bieschke et al., 2007). Research conducted after the midnineties tended to approach this issue with more complexity, exploring therapist preferences along with other aspects of treatment. However, qualitative methods such as surveys and convenience samples have still been relied upon heavily.

In 1999, M. A. Jones and Gabriel conducted a national survey of 600 sexual minority people that explored therapist preferences in addition to therapy utilization patterns over time. Their findings suggested a preference for therapists of the same sexual orientation, though a majority of clients indicated believing that heterosexual therapists could be equally effective. In fact, only 26% indicated that a sexual minority therapist was necessary for beneficial therapy. Another hopeful finding was that 86% felt that therapy has influenced their lives in a positive manner. At the same time, preferences towards a sexual minority therapist increased with each treatment episode, indicating that sexual orientation matching may become more important to clients over time.

Subsequently, M. A. Jones et al. (2003) conducted a study of indicators of therapeutic benefit using questionnaires and a sample of 600 LGB individuals. M. A. M. A. Jones et al. found that gender and sexual orientation matching did predict beneficial treatment. However, the researchers were hesitant to make the assumption that it was a causal relationship and theorized that the results may be due to differences in the competence of the therapists. They also posited that preference for matching could be different for clients at varying stages of identity development. Similar to previous studies, M. A. Jones et al. found that female and sexual minority therapists were deemed the most attractive to clients. Further, these researchers noted that their survey respondents reported more beneficial experiences with social workers and psychologists than analysts. Likewise, Liddle (2000) explored the usefulness of various types of providers and discovered that among social workers, counselors, psychologists, and psychiatrists; psychiatrists were the most likely to demonstrate a lack of acceptance for

the client's sexual orientation. Liddle interpreted these findings to be a result of psychiatric training programs lagging behind others in including more contemporary affirmative curricula.

Additionally, M. A. Jones et al. (2003) found that the year that treatment was received was an important predictor of therapeutic benefit, indicating that positive therapy experiences are increasing for sexual minority people. A study by Liddle (1999) also corroborates this perspective, finding in a survey of 392 LGB adults that the helpfulness of therapy has been increasing steadily in recent years. Liddle has noted that, while this finding may demonstrate the provision of increasingly effective treatment, it may also indicate that sexual minority clients are becoming more educated consumers of therapy, seeking out affirmative experiences deliberately. Indeed, many clients prescreen their therapists to check for gay-affirmative stances (Liddle, 1997). This practice reiterates the importance of therapists explicitly affirming LGB lifestyles, which is an integral part of competent practice with sexual minority clients. As clients are testing the safety of the relationship when they disclose their orientation, it is the counselor's responsibility to demonstrate affirmation and initiate discussions about sexuality (Mair & Izzard, 2001). Affirmation can be communicated by allowing clients to explore their relationships and sexuality, normalizing same-gender sexual attraction, asking about partners without using opposite gendered language, and disclosing experience with this population (Lebolt, 1999).

In order to ascertain how therapist practices influence the helpfulness of treatment, Liddle (1996) conducted a survey utilizing themes of inadequate and appropriate treatment identified by Garnets et al.'s 1991 seminal study. Clients who saw

therapists who used practices classified as inappropriate (e.g. assuming heterosexuality, regarding LGB identities as pathological, blaming problems on sexual orientation, lacking basic knowledge, or pressuring clients to come out to unsafe others) were five times more likely to discontinue treatment after one session. Conversely, therapists engaged in exemplary and affirmative practices were rated as six to twelve times more helpful. Liddle concluded that therapist techniques accounted for more variance on client experiences than demographic variables. Therefore, there are practices that therapists can adopt in order to provide helpful treatment regardless of provider sexual orientation or gender.

A notable exception to the reliance on quantitative methods to explore this topic is a qualitative study conducted by Lebolt (1999). In this phenomenological study, gay men's experiences of affirmative therapy were explored in order to identify what therapist qualities led to a useful and affirmative experience. This study demonstrated that while some individuals appreciated the role modeling offered by a gay therapist, heterosexual therapists who had appropriate knowledge about and respect for LGB identities were capable of providing affirmative experiences. The use of a small and all male sample is a notable limitation to these findings. However, the incidence of these experiences is promising for those heterosexual therapists wishing to provide effective treatment to LGB clients.

In 2006, Burckell and Goldfried conducted a study in which 42 sexual minority individuals rated therapist characteristics using a Q-sort methodology in order to ascertain what therapist qualities were preferred by LGB clients. The researchers found that LGB clients generally believed that heterosexual therapists could be competent and

that there are numerous factors to consider in therapist choice along with sexual orientation. Counselor awareness of sexual minority issues, an affirmative stance, and the development of a strong therapeutic alliance were all deemed important aspects to effective treatment, regardless of the nature of the presenting problem. A survey by Saulnier (2002) echoes this emphasis on therapist competence over provider sexual orientation, which is consistent with early research by Spiegel (1976) in which expertness proved to be more influential than similarity in college counseling dyads. Furthermore, a 2011 study of counselor orientation to diversity (UDO) reported that a counselor's openness and interest in diversity, a cornerstone of multicultural competence, influences effective treatment more than sexual orientation matching (Stracuzzi, Mohr, & Fuertes, 2011).

Speight and Vera (1997) have raised an important criticism of the complete body of matching literature and its tendency to utilize one demographic characteristic to demonstrate the influence of similarity or difference more generally. They note:

> In an attempt to understand the importance of specific individual demographic variables, such as ethnicity, gender, or race, researchers have yet to address the more fundamental question of how similarities and differences, in general, affect the development of a therapeutic relationship. (p. 285)

Though a useful body of literature exists on the preferences of LGB clients in therapy practice, virtually all of it has been quantitative in nature. A quantitative approach is an important way to get information about what is generally important for effective treatment with LGB clients. However, at this time, researchers and practitioners need to gain more understanding of how clients experience difference, what has helped them

therapeutically, and how clinicians can meet their needs in more subtle and personal ways.

This survey of the literature suggests that competent practice with LGB clients is possible with clinicians who are not sexual minorities. Recent reviewers of this literature have declared that LGB clients are more concerned with competent treatment than demographic characteristics (Bieschke et al., 2007). There are multiple factors that make a positive therapeutic alliance with this population, which can be sought out in training throughout a provider's career in order to work effectively with this population. Understanding clients does not require that the clinician has had the same experience; understanding can be expressed through shared life-experience or through empathic open-ended exploration. While a preference for therapists of the same orientation is indicated for some clients, therapeutic benefit is clearly a more complicated matter involving other factors such as competence, gender, and gay-affirmative practice.

Benefits and challenges of sexual orientation matched therapeutic relationships. Demonstrating the capacity for heterosexual therapists to effectively treat LGB clients is not meant to suggest that all LGB clients should see heterosexual therapists. There are important reasons that clients may prefer a therapist of one orientation or another, and clients are entitled to have preferences and seek therapists of their choosing. There are multiple reasons why a client may prefer a therapist who shares their sexual orientation. A primary reason that an LGB client may want to see an LGB therapist is a hope that this similarity will facilitate acceptance and understanding (Cabaj, 1996; Isay, 1991; Guthrie, 2006; Rochlin, 1982). According to Rochlin (1982), this experience may be particularly important for sexual minority individuals because, unlike

other oppressed groups, their experience of difference was also likely present in their family of origin. Additionally, an LGB client may seek a similarly oriented therapist in order to avoid feeling the need to educate their therapists about common aspects of LGB experience (A. C. Bernstein, 2000; Rochlin, 1982). Conversely, Cabaj (1996) has noted that seeking a sexual minority therapist may be a way to avoid acknowledging and exploring difficult material, such as internalized heterosexism.

Holding a similar sexual orientation does not necessitate mutual understanding or similarity of experience, however, and identification with the LGB community does not automatically lead to competence in working with LGB clients (Burckell & Goldfried, 2006; Dworkin, 2000). One danger is in this dyad is that the therapist could overly identify with their client, which could prevent the provider from recognizing their client's responsibility in situations (Greene, 1997; Morrow, 2000). It may also be more difficult for clinicians to hold boundaries and detect countertransference in this dyad (Ritter & Terndrup, 2002). Furthermore, Gelso and Mohr (2001) warned that similarity can lead to a superficial, and thus tenuous, therapeutic alliance. These researchers recommend consistent monitoring of countertransference and transference, as that is likely where the influences of these dynamics will arise. Similarity in sexual orientation may offer clients certain advantages, but also poses the potential for assumptions and overidentification.

Benefits and challenges of cross-orientation therapeutic relationships. It is essential to understand the dynamics of therapeutic relationships between heterosexual therapists and lesbian, gay, and bisexual clients because there are many reasons LGB clients could be in such treatment relationships (A. C. Bernstein, 2000; McWilliams, 1996). According to A. C. Bernstein (2000) practical reasons are that there may not be

self-disclosing sexual minority therapists available in their community or within the treatment specialty for which they are seeking treatment. Psychological reasons may be to have a boundary between their therapeutic experience and personal life, a concern about the therapist overidentifying with their experience, or to avoid erotic transference or their own internalized heterosexism. Moreover, scholars (A. C. Bernstein, 2000; Iguarta & Des Rosiers, 2004; Marmor, 1996; McWilliams, 1996; Stracuzzi et al., 2011) consistently note the healing potential of a heterosexual therapist providing a "corrective emotional experience" (Marmor, 1996, p. 543) in comparison to previous and repeated rejections from members of the dominant culture. According to Iguarta and Des Rosiers (2004), it is particularly beneficial for LGB clients, who may have been parentified by the process of educating their own parents about their sexual orientation, to experience a parent figure that demonstrates appropriate knowledge and understanding. Additionally, the perspective of a heterosexual counselor may be considered legitimate due to their social privilege (Stracuzzi et al., 2011).

McWilliams (1996), working from a contemporary psychoanalytic perspective, provided a thoughtful reflection on the tensions she experiences when working with sexual minority clients. One of the primary tensions she notes is balancing the client's wish to be seen as both unique and normal. This clinician posits that a client's reluctance to discuss sexual material may stem from conflict related to the client's wish for the clinician to identify with their experience, while respectfully acknowledging the inherent differences between their experiences. This issue reflects the delicate balance that therapists must negotiate between acknowledging and normalizing sexual orientation differences (A. C. Bernstein, 2000; Garnets et al., 1991; Israel et al., 2008).

McWilliams (1996) also noted the challenge of being open to all of the client's potential feelings about their sexuality. While supporting clients in developing pride in their sexual orientation, this clinician recommends that therapists also hold space for grief and unconscious wishes to be heterosexual. Often therapists who are trying to be or seem affirmative do so at the expense of exploring important aspects of their client's experience. According to McWilliams:

> By communicating an attitude of aggressive political correctness, a therapist can inadvertently discourage a client from talking about the pervasive pain that goes with being in a minority that is ignored, ridiculed, despised, and persecuted. A defensively gay-affirmative, counterhomophobic therapist also sends the message that the patient is not to bring up troublesome topics. (para. 9-10)

Furthermore, the therapists wish to be seen as an ally can also prevent them from communicating challenging, and therapeutically important, feedback (Greene, 1997; Holahan & Gibson, 1994, as cited by Morrow, 2000; Iguarta & Des Rosiers, 2004). As heterosexual marriage and family therapist (MFT) A. C. Bernstein (2000) has noted:

> To be effective as therapists working with gays and lesbians, straight MFTs must strike a balance between presuming to know what they do not and cannot know and bringing their clinical knowledge to bear, thus raising questions or challenging assumptions that may not always be well-received. (p. 452)

Overly affirmative heterosexual therapists may overemphasize societal stressors and overlook situations in which their clients hold more responsibility for their distress. Therefore, Morrow (2000) encourages heterosexual therapists to be aware of their own identity development process in order to consider ways that their identification as allies

may influence the therapy. It is important that heterosexual therapists have the capacity to witness their client's anger at the treatment they have received from heterosexual culture without responding based on their own defensiveness (A. C. Bernstein, 2000).

Morrow (2000) also cautions heterosexual female therapists not to idealize lesbian relationships as perfectly egalitarian. Power struggles arise in all relationships, and clients need therapists' help in recognizing and coping with relational dynamics of all types. Iguarta and Des Rosiers (2004) categorize this idealization as countertransferential envy in the therapist, which can create a distorted perspective and can blind therapists to very real problems that occur in these relationships. A. C. Bernstein (2000) notes that this tendency toward idealization can also occur for heterosexual male therapists, who may envy openness in the sexual expression gay men. The clinicians cautions heterosexual therapists not to let personal relational disappointments prevent them from appropriately treating their client's relational needs.

Additionally, heterosexual therapists who have not acknowledged and explored their own sexuality may be uncomfortable and unable to respond to the presence of erotic transference in therapy with sexual minority clients (Greene, 1997). Denial of a clinician's potential for same-gender attraction can lead to inadvertent seductive behavior toward the client or an avoidance of the client's sexual material (Iguarta & Des Rosiers, 2004; McWilliams, 1996). According to McWilliams, (1996) the exploration of a client's needs and wishes for the therapist can constitute a deeply influential and transformative experience when a therapist is able to validate, respect, and understand it.

These and other dynamics that arise in cross-orientation therapeutic dyads emphasize the importance for considerable and unending personal reflection on the part

of the therapist (A. C. Bernstein, 2000; Iguarta & Des Rosiers, 2004; McWilliams, 1996; Morrow, 2000). A. C. Bernstein emphasizes the role of trust in therapeutic relationships with sexual minority clients, noting that continual self-monitoring for heterosexism is a part of developing that trust. The clinician notes that this process includes developing personal relationships with LGB individuals. Seeking training beyond graduate and licensure requirements is also highly recommended if therapists wish to provide affirmative and competent care to sexual minorities (Morrow, 2000). Working cross-culturally requires consistent education, exploration, and awareness of assumptions. However, when this work is done competently, it has the potential to offer a deeply gratifying experience to all who are involved (McWilliams, 1996).

Heterosexual Allies: Development, Challenges, and Roles.

There is a growing body of literature about the development, experiences, and roles of heterosexual allies. In this literature, allies are often defined as "a person who is a member of the 'dominant' or majority group who works to end oppression in his or her personal and professional life through support of, and as an advocate with and for, the oppressed" (Washington & Evans, 1991, p. 195). Alternately, some authors define allies in a manner that emphasizes their engagement with activism (Fingerhut, 2011; Russell, 2011) or their acknowledgement of heterosexual privilege (Broido, 2000). The primary threads of this research explore the development of allies and the roles that they can serve for members of the LGB community (Russell, 2011). Because this literature is early in its development, a majority of the research has been qualitative explorations or quantitative studies utilizing college and school samples (Brooks & Edwards, 2009; Duhigg, Rostosky, Gray, & Wimsatt, 2010; Russell, 2011). Still, the literature that exists

indicates some initial understandings of what motivates individuals to become allies, what challenges allies face in this process, and how they can offer support.

Motivations and challenges. While the specific results of ally investigations vary, there are two primary motivations for becoming an ally to the sexual minority community that have been repeatedly noted in the literature: social justice values and personal experiences with LGB people. The presence of core social justice beliefs have been cited as a primary motivator for ally behavior my numerous scholars (Duhigg et al., 2010; Goldstein & Davis, 2010; Russell, 2011; Stotzer, 2009). In a substantial grounded theory project, Russell (2011) found that ally behavior was often founded in deeply seated moral, patriotic, and civil rights values, and at times did not involve any personal connection to the LGB community. Russell argued that the passionate personal investment this researcher witnessed in participants suggests the need for a more complex conceptualization of allies from the common perception of allies as helpful friends and family members. While egalitarian values can be influenced by religious beliefs (Roades & Mio, 2000), a study focusing on the experiences of Christian identified allies indicates that, for those with religious identities, considerable conflict and a redefining of religious ideals is likely part of the ally development process (Borgman, 2009). Duhigg et al. (2010) similarly described the values motivation as dissonance between egalitarian values and an awareness of the prejudice and privilege that exists around heterosexuality. They stated, "ultimately, each of these participants resolved this conflict between their core values and sexual identity-based social stigma by using their privilege to promote social justice for sexual minorities" (p. 10).

While personal relationships with LGB community members is not required for ally behavior, many studied have indicated that becoming an ally is often motivated by personal experiences witnessing oppression against sexual minorities (Broido, 2000; Duhigg et al., 2010; Distefano, Croteau, Anderson, Kampa-Kokesh, & Bullard, 2000; Goldstein & Davis, 2010; Stotzer, 2009). Commonly, parents of LGB people become allies as part of the process of accepting and supporting an LGB child (Vernaglia, 2000, as cited in Russell, 2011). Other allies describe close friendships with LGB individuals with whom they witnessed the experiential results of prejudice and discrimination (Duhigg et al., 2010; Stotzer, 2009). While interpersonal motivations often took the form of close relationships with LGB people, the experiences that led heterosexuals to feel outrage at injustice did not have to occur on a personal level (Russell, 2011; Stotzer, 2009). Additionally, family modeling influenced many allies, both positively and negatively, with family members either teaching values around normal sexuality variance or demonstrating prejudicial ideals that the allies then fought against (Stotzer, 2009). The key influence of role models and personal experiences is likely connected to the prejudice ameliorating qualities of interpersonal contact, which, according to Pettigrew and Tropp (2000, 2008) is particularly influential against sexual prejudice.

According to a study by Goldstein and Davis (2010), a majority of college-age allies are "white, female, politically liberal, and religiously inactive, social science and humanities majors" (p. 489). These researchers further noted that these demographics tend to correspond with low levels of sexual prejudice. Fingerhut (2011) has also demonstrated that self-identified allies are often highly educated women. This finding stresses the importance of establishing ways of recruiting and encouraging ally behavior

in those who do not fall within this demographic (Goldstein & Davis, 2010). Moreover, the overrepresentation of women as allies relates to a barrier to ally behavior that has been noted by many studies: the fear of being seen as a sexual minority (Dillon et al., 2004; Goldstein & Davis, 2010; R. R. Hubbard, Snipes, Perrin, Morgan, DeJesus, & Bhattacharyya, 2013). Becoming an ally requires acknowledging this concern, which Dillon et al. (2004) refer to as "homophobic self-consciousness." It may be that men, who experience particularly rigid masculine role expectations prohibiting sexual and nonsexual male intimacy, are especially discouraged by this fear (Duhigg et al., 2010). Regardless, being an ally means exposing oneself to the discrimination that LGB people face (Ji, DuBois, & Finessey, 2009).

Another barrier that allies have noted in studies concerns fears about how they will be received by the LGB community. Many respondents in studies of allies note insecurities and lack of confidence about being an ally (Asta & Vacha-Haase, 2013; Distefano et al., 2000; Ji, 2007). Additionally, many allies worry they may inadvertently use heterosexist language or expose themselves as misinformed (R. R. Hubbard et al., 2013; Ji, 2007). Heterosexual people who are low in prejudice are often concerned about behaving in heterosexist ways and feel guilt when they inadvertently do so (Devine, Monteith, Zuwerink, & Elliot, 1991). In a study concerning mistakes that well-meaning heterosexuals make, Conley, Calhoun, Evett, and Devine (2002) noted that, while there are some mistakes that can be avoided through knowledge acquisition, some expectations of heterosexuals are contradictory, such as the wish for allies to alternately emphasize and ignore gay issues. Expectations of prejudice due to past experiences may make expectations of ally behavior difficult to meet (Conley et al., 2003). However, some

allies note that after an initial period of mistrust, their continued ally behavior is generally well received by the people they are supporting (Roades & Mio, 2000). This initial insecurity may be why many allies interviewed by Asta and Vasha-Hasse (2013) were hesitant to identify themselves as allies, though the respondents also noted believing that the right to designate allies belonged to members of the disenfranchised group.

Lastly, acknowledging heterosexual privilege is part of developing an identity as an ally, according to Dillon et al. (2000), Duhigg et al. (2010), Montgomery and Stewart (2012), and Russell (2011). This process may present a barrier to some people becoming allies, because acknowledging privilege is a challenging process that tends to generate feelings of guilt (Asta & Vasha-Haase, 2013; Case, 2007; Ji, 2007) and helplessness (Sontag, 2003, as cited in Stewart, Latu, Branscombe, Phillips, & Ted Denney, 2012) in members of the dominant group. Montgomery and Stewart (2012) define privilege as "socially conferred benefits or advantages that result from mere membership in a particular social group" (p. 162). Acknowledging privilege challenges the cultural "myth of meritocracy" (McIntosh, 1998, p. 190), in which individuals holding privileged statuses are taught to see their resources and accomplishments as the result of personal merits, as opposed to the result of unequal opportunities and unearned advantages (Stewart et al., 2012). Further, one of the advantages of belonging to the dominant group is avoiding considering the role of the dominant identity, and instead being considered the norm (Case, Iuzzini, & Hopkins, 2012; Pratto & Stewart, 2012). Many people hold multiple intersecting identities in which they experience both privileged and advantaged statuses (E. R. Cole, 2008). While these multiple identifications can prevent people from acknowledging their privilege, individuals can also draw upon their subordinated statuses

to understand and acknowledge the privilege they hold (Montgomery & Stewart, 2012). Montgomery and Stewart (2012) have argued that this intersectionality may account for the increased awareness of heterosexual privilege and ally behavior they found in women. Because facing oppression and privilege are processes that go against deeply ingrained socialization, Case (2012) recommends that members of dominant groups expect themselves to struggle and make mistakes in this process. Moreover, Case argued that acknowledging privilege is a life long process that is best done with support. At the same time, privilege is one of the tools that allies can use to support their sexual minority colleagues (Roades & Mio, 2000)

Given these challenges, it is not surprising that Broido (2000) has declared developing confidence as an essential step for ally development. Furthermore, Dillon et al. (2004) have emphasized the importance of having a safe and trusting space in which to explore the researchers sexual orientation and beliefs about sexuality to facilitate ally development. These researchers stress that this process of confronting internalized biases, changing language, exploring personal sexuality, and acknowledging heterosexual privilege is not a simple or straightforward task. Several models of identity development have been developed, though many of these models emphasize that the process of becoming an ally is not a linear process passing through defined stages.

Ally development models. While there are several same-gender orientation identity models (see Cass, 1979; E. Coleman, 1982; Potoczniak, 2007; Sophie, 1986; Troiden, 1989), there have been few comparable models exploring heterosexual identity development. In 2002, Mohr and Worthington, Savoy, Dillon, and Vernaglia proposed two significant heterosexual identity development models. Mohr's (2002) model

highlights the intersection of motivations, exposure to information, and mental models of sexuality. Mohr emphasizes that these identity states are not stable and shift according to context and the nature of external stimuli to which one is exposed. Thus, this model highlights the importance of ally development being a continuous process, wherein one explores and processes ones biases and perceptions across time and in response to different contextual information. Worthington et al.'s model also highlights the nonlinear and multidimensional process of sexual identity development, though it focuses on biopsychosocial influences. Both models represent an important step in acknowledging and considering the development of heterosexuality as one of many sexual orientations, instead of unconsciously accepting heterosexuality as the norm. Additionally, both models note transferential and countertransferential issues that may arise given various identity development stages and emphasize the importance of clinicians consciously exploring their sexual orientation.

According to Asta and Vacha-Haase (2013), the first heterosexual ally development model was created by Washington and Evans (1991) and included the stages of developing awareness, pursuing knowledge, developing skills, and engaging in action. Asta and Vacha-Haase also note a model by the Rainbow Visibility Project (Getz & Kirkley, 2003), in which five stages were noted: "entry, fear of the unknown, acknowledgement of privilege, engagement, and conscious self identification as allies/advocates" (p. 496). Furthermore, Chojnacki and Gelberg (1995), reflecting upon an LGB group led by heterosexual counselors, proposed that allies follow a similar developmental process to LGB individuals, moving through confusion, comparison, tolerance, acceptance, pride, and finally integration, the authors citing anxieties and

concerns along the way. Many allies feel their development does not follow such lines and instead experienced their process as evolving quite fluidly (Asta & Vacha-Haase, 2013; Ji, 2007).

Roles allies serve. In contrast to the body of descriptive literature on ally development, less information is available on how allies demonstrate their alliance with the LGB community. A recent study by R. R. Hubbard et al. (2013) indicated that the most commonly cited ally behaviors were educating others about heterosexism and sexual prejudice and expressing the values that underlie their alliance. In addition to confronting heterosexism and prejudice when it occurs, allies can become involved in political campaigns for equal rights (Duhigg et al., 2010; Swank, Woodford, & Lim, 2013). Similarly, Ji (2007) describes ally behaviors as involving support and advocacy. This researcher particularly emphasizes the way in which an ally's acceptance of a lesbian or gay individual can help to foster internal acceptance in a society replete with discriminatory messages. This acceptance is an important function generally, but one that may be particularly helpful during the coming out process. Finally, Ji encourages allies to dispel myths about LGB individuals, helping others to acknowledge their biases and become allies themselves. At their best, allies "reframe the status quo and encourage all of us to consider active change" (Roades & Mio, 2000).

The largest body of empirical evidence on the impact of allies involves the influence of Gay-Straight Alliances (GSAs) in schools. GSAs are extracurricular youth activities that first began in 1988 (H. E. Murphy, 2012). The presence of GSAs raises awareness about LGB issues and influences support of LGB students (Evans, 2002, as cited in Goldstein & Davis, 2010). Schools that have GSAs or similar youth

organizations report lower levels of student victimization and suicide (Goodenow, Szalacha, & Westheimer, 2006, as cited in H. E. Murphy, 2012), and increased levels of student safety (Walls, Kane, & Wisneski, 2010, as cited in Toomey, Ryan, Diaz, & Russell, 2011), well being, and educational attainment (Toomey et al., 2011). Furthermore, a recent study by Poteat, Sinclair, DiGiovanni, Doenig, & Russell (2012) indicates that students in schools with GSAs reported decreased levels of high-risk behaviors such as substance use and casual sexual behavior. This organizational representation of alliance clearly impacts LGB youth in meaningful ways.

Comparatively little research has been done with LGB people exploring what they would like from allies. In a notable exception, Brooks and Edwards (2009) conducted a qualitative investigation of how LGB individuals would like to be treated in work environments. Brooks and Edwards found that participants reported wishes to be included, feel that their jobs are safe, and be treated equally. While the importance of allies on a personal scale is represented in the literature, the role and impact of the ally therapist has also not been explicitly explored. However, it is clear that allies can play a powerful role of acceptance, advocacy, education, and support for their LGB counterparts. Therefore, this research sought to explore what form this role may take, what pitfalls need to be avoided, and what challenges are stimulated by such a therapeutic dyad.

The Therapeutic Relationship

Psychotherapeutic efficacy. Psychotherapy has an average effect size of .80 (Wampold, 2001), suggesting that it is significantly effective for many, but not all, clients (Campbell, Norcross, Vasquez, Kaslow, 2013). This efficacy discrepancy highlights the

importance of determining which aspects of psychotherapy are most useful. Some propose that specific techniques and interventions are the most efficacious components (DeRubeis, Brotman, & Gibbons, 2005), while others argue that the effective aspects of therapy are factors that are common to all therapeutic approaches (Frank & Frank, 1991; Wampold, 2001, Wampold et al., 1997). This body of literature stands in contrast with matching literature, which focuses on variables specific to the client and therapist. DeRubeis et al. (2005) have argued that there are therapeutic techniques that are most effective for specific diagnoses, which they report having been demonstrated with respect to the treatment of posttraumatic stress disorder (exposure therapy), obsessive-compulsive disorder (exposure and response prevention), and social phobia (cognitive behavioral group therapy). However, when Luborsky et al. (1999) evaluated meta-analyses and comparison studies, the scientists found that the researcher's allegiance to a particular therapeutic approach accounted for a significant portion of the outcome variance. When effect sizes were corrected for researcher allegiance, the differences in the outcomes for various treatments were negligible (Luborsky et al., 1999). Furthermore, many meta-analyses indicate that the outcomes of various treatments are comparable when assessing treatments that follow a protocol (Messer & Wampold, 2002; Wampold, 2001; Wampold et al., 1997). This finding has led some researchers to underscore factors that are common to all therapeutic dyads, such as the quality of relationship between therapist and client (Luborsky et al., 1999; Messer & Wampold, 2002; Wampold, 2001, Wampold et al., 1997).

Defining and measuring the relationship. Conceptualizations of the therapeutic relationship vary over time and theoretical perspective. Early on in the development of

psychotherapy, Freud emphasized the importance of the patient as a collaborative partner in the therapeutic work, (Hatcher, 2010). While this conceptualization laid the foundation for the concept of the "therapeutic alliance," Freud generally emphasized the powerful role that the patient's transference has on the relationship and at times viewed instances of client disagreements to be indicative of resistance to the therapeutic process (Arnd-Caddigan, 2012). Transference has been described as "the client's experience of the therapist that is shaped by the client's own psychological structures and past…that involves displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully in early significant relationships" (Gelso & Hayes, 1998, p. 51). In 1934, Sterba proposed that, despite transference influences, the therapist could forge an alliance with the patient's rational observing ego against these transferential forces (Gaston, 1990). Subsequently, Zetzel (1956) used the term "therapeutic alliance" to designate the collaborative relationship that is based on identification with and attachment to the therapist, though the scholar theorized that this relationship represented a repetition of positive transferential feelings based on the mother-child relationship (Gaston, 1990). Later theorists, such as Greenson (1965) and Gelso and Carter (1994) have differentiated between the transference relationship and the more "realistic" alliance, theorizing that the therapeutic relationship is composed of three interrelated parts: the working alliance, the transference, and the real relationship between the therapist and client (Horvath & Luborsky, 1993).

Early critiques of the concept of the alliance came from psychoanalytic theorists, such as Brenner (1979), who argued that all aspects of the relationship should be considered aspects of transference and resistance. According to Gaston (1990), there

were also disagreements between theorists who defined the alliance according to the task oriented collaboration, such as Frieswyk et al. (1986), and theorists who defined it according to the bond shared, such as Luborsky (1976). Nevertheless, the most often cited perspective on the alliance is that of Bordin (1979), who combined these perspectives stating that the working alliance "includ[es] three features: an agreement on goals, an assignment of task or a series of tasks, and the development of bonds" (p. 253). This pan-theoretical fusion of previous definitions has been used consistently in the alliance research literature (Ackerman & Hilsenroth, 2003). However, Cornelius-White (2002) argues that this common conception ignores the invaluable contribution of Rogers' (1957) theory that effective relationships involve empathy, authenticity, and unconditional positive regard. Further, Horvath and Luborsky (1993) emphasize the influence of social theories by LaCrosse (1980) and Strong (1968), who propose that the influence of the therapist depends, in part, on the client's view of the therapist as expert, attractive, and trustworthy.

According to Horvath, Del Re, Flückiger, and Symonds (2011), there are over 30 scales that have been developed to measure the working alliance. While four of these measures demonstrate sufficient internal consistency, these researchers go on to note that these scales define and measure alliance inconsistently. Having an imprecise definition of the alliance has enabled this concept to be embraced and researched by diverse theoretical orientations; at the same time, it leads to a lack of clarity in the research about what exactly is being measured (Horvath et al., 2011). Some researchers recommend using aggregates to obtain more accurate measurements (Crits-Christoph, Gibbons, Hamilton, Ring-Jurtz, & Gallop, 2011), while others note that aggregates may conceal or

minimize important differences (Davis & Ancis, 2012). Measurements are also not consistent between client and therapist ratings of the alliance (Bachelor & Horvath, 1999; Fuertes et al., 2006; Fitzpatrick, Iwakabe, & Stalikas, 2005; Horvath, 2000; Horvath & Symonds, 1991; Muran et al., 2009). These differences may be related to what relational models are being used for comparison. Horvath (2000) has argued that clients generally rate the alliance higher because they are comparing the relationship to their other experiences of relationship, which may not be very supportive, whereas clinicians are comparing their experience to theoretical models of ideal relationships. Divergence in perceptions appears to be common in the literature, with client assessments more consistently predicting therapy outcome (Fitzpatrick et al., 2005).

Alliance and outcome. Therapeutic alliance has been consistently associated with therapeutic outcome in multiple meta-analytic studies (Horvath et al., 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Horvath et al. (2011) argue that this correlation is substantial regardless of whose perspective of the alliance is considered, how measurement of the alliance occurs, at what point during treatment the assessment occurs, what type of therapy is being discussed, and how researchers assess outcome. This robust association is modest however, accounting for roughly 7.5% of outcome variance (Horvath et al., 2011). While some authors argue that the alliance-outcome relation insufficient and overstated (DeRubeis et al., 2005), it does account for more variance in the outcome of therapy than variables such as clinician competence or adherence to treatment protocols (Flückiger, Horvath, Ackert, Del Re, Symonds, & Wampold, 2013, citing a study by Webb, DeRubeis, & Barber, 2010). Furthermore, weaker therapeutic alliances are associated with client termination generally (Sharf,

Primavera, & Diener, 2010), and terminations that are not discussed with the clinician in particular (Tryone & Kane, 1990). These findings have led an APA task force to assert that the alliance is an empirically supported and demonstrably effective variable in the relationship (Ackerman et al. 2001; Norcross, 2001; Sharf et al., 2010).

The working alliance is theorized to support treatment in a number of ways. According to Horvath and Luborsky (1993) and Gaston (1990), a strong alliance can encourage a client's engagement in treatment and instill hope that the therapeutic process will be useful. Bloomgarden and Mennuti (2009) argued that a positive alliance motivates clients to do the hard work of therapy, leading to more effective technique. Other scholars also share this idea that the relationship is a facilitative context in which technique occurs (Lambert & Barley, 2001; Norcross & Lambert, 2011). Alternately, Mallinckrodt (1996) has proposed that the alliance leads to increased outcome through the provision of increased social support. At the same time, some contend that it is incorrect to interpret alliance as preceding outcome and argue instead that increased alliance ratings may occur subsequent to improvement (Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005; DeRubeis et al., 2005). These theorists maintain that benefits from therapy lead to increased hope and engagement, encouraging further gains. These benefits may account for a portion of the impact of alliance over time, though a recent study by Zilcha-Mano, Dinger, McCarthy, and Barber (2013) suggests that increases in alliance do precede gains.

Given the consistent evidence that alliance does have an influence on outcome, researchers have begun to explore what supports and hinders alliance development. Though both client and clinician contribute to the quality of the relationship (Bachelor,

1995), a recent meta-analysis by Del Re, Horvath, Flückiger, Symonds, & Wampold (2012) indicates that therapist variables make a larger contribution than client variables. Alliance ratings increase with therapist who clients perceive as flexible (Kivlighan, Clements, Blake, Arnez, & Brady, 1993), trustworthy (Horvath & Greenberg, 1989), warm (Dunkle & Freidlander, 1996; Hersoug, Høglend, Monsen, & Havik, 2001), confident (Hersoug et al., 2001), and respectful (Bachelor, 1995). Therapist judicious disclosure of information about their own experiences has also been connected to increases in strength of the therapeutic relationship (Barrett & Berman, 2001; Zur, 2011), though in negatively rated relationships, such disclosures can be experienced as unhelpful (Meyers & Hayes, 2006). According to a study by Duff and Bedi (2010) 62% of the variability in alliance ratings was attributable to three therapist behaviors: reflecting encouragement, welcoming the client smiling, and making positive comments about the client. These findings are consistent with other efficacy studies in which positive behaviors such as warmth lead to increased efficacy and attacking, blaming, and criticism appear to decrease such effectiveness (Najavits & Strupp, 1994). Finally, in discussing what makes a therapeutic relationship effective, Norcross and Wampold (2011) argued that empathy, collaboration, consensus and positive regard are essential features of effective therapeutic alliances, whereas resistance to feedback and lack of the above features predict premature termination and decreased outcome measures.

Other variables have found less consistent empirical support. The influence of therapist experience on working alliance ratings is not reliable, with some studies indicating increased experience is associated with increased alliance scores (Mallinckrodt, & Nelson, 1991) and others indicating that experience does not

significantly impact alliance (Dunkle & Freidlander, 1996; Hersoug et al., 2001). Theoretical orientation does not appear to contribute to any variance on alliance measures (Ackerman & Hisenroth, 2003). It has been argued that similarity would lead to strong working alliances (D. W. Sue & D. Sue, 1977; Gelso & Mohr, 2001) and there is some support for this argument. Founding their research on Bordin's definition of alliance, Taber, Leibert, & Agaskar (2011) found that personality congruence between the therapist and client was associated with having a strong bond, which led to a collective task and goal, which was then correlated with positive therapeutic outcome. Hersoug et al (2001) also found minimal support for this hypothesis; however, these researchers also theorized that there may be an optimal balance between similarity and difference in the treatment relationship.

The establishment of a strong therapeutic alliance is particularly important with clients who come from historically marginalized cultures (Asnaani & Hofmann, 2012; Constantine, 2007; Davis & Ancis, 2012; Lee, 2012; T. B. Smith et al., 2011; Vasquez, 2007). The importance of the alliance with multicultural populations is particularly salient when the influence of alliance on termination and the increased rates of termination with racial and ethnic minority clients are considered (J. Owen et al., 2012). Client perceptions of therapist multicultural competence have been associated with strengthened working alliances (Li & Kim, 2004; J. Owen, Tao, Leach, Rodolfa, 2011), and working alliance measures increase when therapists appear sensitive to and able to discuss cultural differences (Asnaani & Hofmann, 2012; Zhang & Burkard, 2008). An interesting study by Fuertes et al. (2006) found that while expertness, trustworthiness, attractiveness, working alliance, and therapist multicultural competence were all

associated with increased outcome, different clients and clinicians ratings were associated with outcome effects. For clients, the influence of multicultural competence and empathy was more significant, whereas working alliance was found to be more influential for therapists.

The development of a strong therapeutic alliance can be impeded by mistrust due to prior discrimination or the experience of microagressions in treatment (Constantine, 2007; Walling, Suvak, Howard, Taft, & Murphy, 2012). According to a study by Constantine (2007) the experience of microagressions in counseling was correlated to decreased working alliance and lower client perceptions of therapist multicultural competence. In Constantine's study the experience of microagressions was not mediated adequately by strength of working alliance. However, J. Owen, Imel, Tao, Wampold, Smith, and Rodolfa (2011) recently conducted a similar study in which experiences of microagressions were consistently mediated by the client's perceptions of a strong working alliance. It may be unclear to what extent the alliance can overcome difficult experiences in the relationship, but the finding that it can mediate these experiences to any extent is significant. Additionally, microagressions have been found to occur in therapeutic relationships regardless of the racial or ethnic identifications of the client and therapist (J. Owen, Imel et al., 2011). Therefore, J. Owen, Imel et al. (2011) recommend that therapists increase their awareness around the cultural messages they are conveying to all clients and develop the capacity to manage and discuss such occurrences.

These findings indicate that therapist sensitivity to client experiences has a significant influence on clinical outcome. Asnaani and Hofmann (2012) highlight the importance to tailoring the quality of relationship to client needs when they note that

although collaboration is often a positive aspect of alliance, collaboration may not be the most effective type of relationship for clients from cultural backgrounds that are more hierarchical. A recent study by Hook, Davis, Owen, Worthington, and Utesey (2013) explored the construct of "cultural humility" and found that it was significantly correlated with increased outcome and alliance. They stated that:

> For a therapist to develop a strong working relationship and conduct effective counseling with a client who is culturally different, the therapist must be able to overcome the natural tendency to view one's own beliefs, values, and worldview as superior, and instead be open to the beliefs, values, and worldview of the diverse client. (Hook et al., 2013, p. 354)

Thus, being sensitive to another person's culture requires an awareness of and respect for the ways in which they may see things differently, which is an integral aspect of multicultural competence (D. W. Sue & D. Sue, 2012). These perspectives emphasize the importance of the therapeutic alliance in cross-cultural therapy, but more research is needed to understand the subtle impacts of difference on alliance (Williams & Hill, 2001).

Rupture and repair. Early alliance theorists stressed the importance of developing a strong alliance in the beginning treatment (Eaton, Abeles, & Gutfreund, 1988; Horvath & Symonds, 1991) and it has been reported that steady increases over time are associated with effective therapy outcomes (Kramer, De Roten, Beretta, Michel, & Despland, 2009). However, there is increasing interest in the influence of variability in working alliance development on treatment relationships (Gelso & Carter, 1994; Safran & Muran, 2000, 2006). Bordin (1979) originally theorized that in the process of therapy,

the client'd relational problems would inevitably create conflicts in the therapeutic relationship. Further, Bordin argued that the subsequent relationship repair process provides a vital aspect of therapeutic growth.

These occurrences are referred to as misunderstandings, impasses, or ruptures in the therapeutic relationship (Williams & Hill, 2001). Safran and Muran (2006) define ruptures in the alliance as "breakdowns in collaboration" and "poor qualities of relatedness" (p. 289). Several studies have now supported the proposition that there are distinct patterns of alliance development (e.g. steady, increasing, high-low-high/quadratic). Alliance developmental patterns that demonstrate episodes of misunderstanding followed by increases in the therapeutic relationship are associated with the best outcomes (Kvlighan & Shaughnessy, 2000; Stiles et al., 2004; Strauss et al. 2006). According to Strauss et al. (2006), "working through and repairing ruptures can provide a potent opportunity to disconfirm maladaptive schemata and provide 'corrective experiences' that can facilitate change. In contrast, ruptures that are not addressed adequately can increase avoidance and inhibit change" (p. 338). Many scholars see this process as an integral aspect of the therapeutic process (Ackerman & Hisenroth, 2003; Lee, 2012; Safran & Muran, 2000, 2006; Williams & Hill, 2001)

In a study of client experiences of misunderstandings, Rhodes et al. (1994) found that unresolved misunderstandings resulted from the therapist providing an unwanted intervention such as advice or the absence of providing a wanted intervention. Clients either did not bring up the rupture, or experienced defensiveness and criticism when they did. In both situations, the rupture influenced the termination of the treatment. Clients who experienced resolved misunderstandings, alternatively, tended to bring up the

concern themselves and reported the therapist responding with flexibility, acceptance, and attempts to repair the relationship. This study suggests that clients are able to hide their dissatisfaction from their therapists, and that when these issues were are not discussed terminations often result. Clients regularly hold secrets from their therapists, likely as a result of insecurity and shame (Hill, Thompson, Cogar, & Denman, 1993). Additionally, there is evidence that they attempt to protect the relationship with the therapist from negative affects (Rennie, 1994).

Therefore, it is absolutely imperative that therapists monitor, assess, and discuss the quality of the relationship in order to provide effective psychotherapy. A study establishing therapist variables that predict change in symptoms found that the behavior most predictive of symptom change was therapists' emphasis on the therapeutic relationship (Vocisano et al., 2004). In Safran and Muran's (2000, 2006) extensive work with relational repair techniques, they note that repair begins with the therapist acknowledging the rupture and their contribution to it. They recommend that the therapist maintain a stance of affirmation, nurturance, understanding, and validation of the client's experience. The importance of this process is heightened in cross-cultural therapeutic encounters, where misunderstandings are likely to occur (Keenan, Tsang, Bogo, & George, 2005). Furthermore, the regular experience of microagressions for people of color often leads to an automatic tendency to conceal authentic responses (Vasquez, 2007). As a result, it is imperative that therapist develop an increased capacity to detect signs of rupture, discuss these difficult experiences, and respond nondefensively if a client reports misunderstandings of which therapists were unaware (Safran, Muran, & Eubanks-Carter, 2011). At times, repairing rupture events requires the therapist to

disclose aspects of their own experience, a practice that is vulnerable and precarious, though also potentially productive therapeutically (Hill & Knox, 2002; Knox & Hill, 2003).

Therapist self-disclosures and the relationship. Therapists disclose information about themselves in a number of ways. There are unavoidable self-disclosures concerning visible demographic characteristics such as age, gender, pregnancy, and sometimes ethnicity or disabilities status, as well as personality and style preferences that are expressed through the décor an office or a therapist's style of dress (Tillman, 1998; Zur, 2011). Accidental disclosures occur when therapists encounter clients outside of the therapy setting (Zur, 2011). It is also a relatively common practice for therapists to verbally share personal information, which is the act that the term "self-disclosure" generally designates (Henretty & Levitt, 2010; Hill & Knox, 2002; Knox & Hill, 2003). These verbal expressions can involve feelings, insight, reassurance, challenges, and information (Knox & Hill, 2003). Disclosures can also be separated between those statements that are self-revealing and self-involving (Zur, 2011), a distinction first made by McCarthy and Betz in 1978 (Henretty & Levitt, 2010). According to Zur (2011), while self-revealing disclosures reveal information about the therapist, self-involving disclosures divulge the personal emotional reactions that a therapist has to a client and their interactions. There is some evidence to suggest that clients experience the latter type of disclosure more positively (Henretty & Levitt, 2010; Knox & Hill, 2003).

According to a 2010 meta-analysis by Henretty and Levitt, a vast majority of therapists use self-disclosure periodically with clients. Unfortunately, these researchers

go on to note that the research on this intervention is limited, inconsistent, and methodologically problematic. Arguments against self-disclosure began with Freud's belief that analytic neutrality would most effectively allow for the projection, and subsequent analysis, of transferential material (Gibson, 2012; Bloomgarden & Menuti, 2009; Farber, 2006). Later theories, such as humanist, feminist, and multicultural theories, on the other hand, encouraged disclosure in order to model openness and increase trust (Henretty & Levitt, 2010; Knox, Hess, Petersen, & Hill, 1997; Williams & Hill, 2001). In addition to differences in use of self-disclosure across theoretical orientations, more experienced therapists seem to use disclosure more often, perhaps due to increased comfort with the role (Henretty & Levitt, 2010).

Disclosure of personal information by the therapist can profoundly affect the therapeutic relationship; however, whether its influence is beneficial or destructive depends largely on the context (Farber, 2006; Gutheil & Gabbard, 1998; Peterson, 2002; Zur, 2009, 2011). As Bloomgarden and Mennuti (2009) stated:

> Every therapeutic relationship is so unique that therapists have to stay alert, constantly monitoring this aspect of the therapy. The very same disclosure that may be powerfully healing for one client will be unpleasantly experienced as "too much information" by another. Clients need vastly different amounts of connection, realness, and disclosure from their therapists, depending on so many variables that it is not possible to get it right every time. But, when the therapist finds that balance, there is good chemistry between client and therapist, and the client benefits enormously. (p. 12)

In addition to personal differences around comfort with disclosure, different cultures hold varying values around disclosure (Pederson, 1996). Discomfort with disclosing may also be a reason for people not to attend psychotherapy (Vogel & Wester, 2003). Since the impact of disclosures varies so widely, it is worth stating the benefits and potential costs of using this intervention with clients.

One often cited reason for therapist disclosure is to promote an egalitarian relationship (L. S. Brown, 1994; Hansen, 2005). The therapeutic process requires self-disclosure from clients and some therapists find that sharing some of themselves welcomes the client to do so in a nonshaming manner (Jourard, 1971; Zur, 2011) or demonstrates the therapists willingness and engagement (Goldstein, 1997). Similarly, Fosha (2000) has stated "the patient cannot be expected to rapidly open up to a therapist who remains hidden and shielded…The patient's sense of safety within the therapeutic relationship is enhanced in part by the therapist's risk taking" (p. 213, as cited in Prenn, 2009). Thus, appropriate disclosure may facilitate an environment of trust, openness, and authenticity (Knox et al., 1997) and express empathic attunement (Goldstein, 1997). Some also argue that self-disclosure leads to the therapist being experienced as "more real and human", which can reduce shame surrounding vulnerable experiences (Burkard, Knox, Groen, Perez, & Hess, 2006, p. 16).

Disclosing information in the context of a safe relationship is also associated with various benefits for the discloser, emphasizing the therapeutic importance of encouraging client disclosures. Farber (2006) has noted six primary benefits: it can support the experience of intimacy, offer validation, lead to insight, help the client differentiate themselves in relation to the therapist, increase authenticity in the relationship, and offer

catharsis. Some theorists appeal to attachment and neuroscience literature emphasizing that therapeutic gains occur through emotional "right brain to right brain" communication (Schore, 2003, Siegel, 1999). Quillman (2012) similarly argues that therapist disclosure can help patients to connect to the therapist and their own experience through that connection. Prenn (2009) built on this theory noting that disclosure events offer an opportunity for metaprocessing, in which the client and clinician discuss their moment-to-moment engagement. The psychotherapist notes that "self disclosure is neither good no bad; it is the quickest way to have an experience between two people."

Nonetheless, there are potentially significant pitfalls to this practice (Peterson, 2002). If a therapist discloses about personal problems, clients could feel burdened or like they need to take care of their therapist, which could decrease client safety (Gutheil & Gabbard, 1993). Further, any situation in which therapists are getting their needs met by clients is exploitative (Gutheil & Gabbard, 1995). Henretty and Levitt (2010) especially caution about sharing that a therapist is in a precarious situation like drug and alcohol recovery, which could keep clients from disclosing negative feelings towards the therapist. Clients who do not wish to know things about their therapists may feel that their therapeutic space has been invaded (Geller, 2003). Some go so far as to say that self-disclosures by the therapist can lead to client suicide or sexual exploitation of the client (Epstein, 1994). This argument that supposes that disclosure leads inevitably down a "slippery slope" to the most egregious ethical violation of sleeping with clients is common, though the two behaviors are not correlated with one another (Zur, 2009). In fact, according to Zur (2009), often restricting authentic behavior due to fear of litigation

undermines clinical judgment and paradoxically leads to increased ethical issues and complaints.

Given the variation in responses to disclosure, it is not surprising that therapists often feel unprepared and inadequately trained for managing this experience (Burkard et al., 2006). Most guidelines emphasize the importance of therapists disclosing information after careful thinking about their intentions and the potential consequences (Bloomgarden & Mennuti, 2009; Zur, 2011). It is important that disclosure is used infrequently and only when it is deemed to be beneficial for the client (Knox & Hill, 2003; Zur, 2007). When considering client preferences, self-disclosure is not recommended with clients with whom the therapist does not have a strong alliance or with clients who have poor boundaries (Henretty & Levitt, 2010). It is generally preferable to disclose information about the client and relationship, as opposed to personal issues and should be followed by checking in with the client about the disclosures impact (Knox & Hill, 2003). It is recommended that therapists pay considerable attention to their client's reactions before, during, and subsequent to the disclosure and return the focus immediately to the client (Henretty & Levitt, 2010). In sum, thorough exploration on the part of the therapist is necessary to discern whether there is a clinical value to the disclosure and how the information may impact the client, therapeutic relationship, and treatment.

Despite a common encouragement to use self-disclosure with clients of stigmatized identities, there is a paucity of research involving diverse samples (Burkard et al., 2006). Therefore, this blanket recommendation is problematic because there are significant cultural differences concerning values around self-disclosure (Pederson,

1993). In Western Anglo-American culture, verbal expression is highly valued and most models of psychotherapy reveal this bias (Farber, 2006). D. W. Sue and D. Sue (1990) note that therapist use of disclosure could be useful for multicultural clients to model expected openness, demonstrate awareness of cultural issues, and facilitate trust. One notable study by Burkard et al. (2006) explored the use of disclosure by European American therapists about experiences of oppression with ethnic minority clients and found that the therapists perceived these disclosures to deepen their clinical work. However, the usefulness of this finding is limited by the lack of information about the client's experience.

There have only been a few studies that have explored how LGB clients respond to therapist disclosure. A recently qualitative study by Israel et al. (2008) indicated that self-disclosure could be experienced as both a helpful and an unhelpful therapeutic practice. Still, more clients rated the practice as useful, and those that found it unhelpful described it as excessive, indicating that it may be most useful when used discriminately. Another study indicated that therapists who disclosed information about their personal as well as professional background were seen as more trustworthy, attractive, and effective by LGB clients than those who disclosed about their background alone (Borden et al., 2010). While this study used a sample of college students, limiting generalizability to individuals with socioeconomic, cultural, and other kinds of diversity, the findings lend support to the idea that disclosing personal information with LGB clients is a useful practice. While their findings are consistent with comparable studies with non-LGB samples, it may be particularly important to utilize techniques that cultivate trust when working with clients with stigmatized identities.

Disclosure of sexual orientation. Self-disclosure gains complexity and importance in working with LGB clients because it is related to the issue of "outness" in their own lives. An LGB identity is one of few stigmatized identities that can be invisible to others (Buck & Plant, 2011), permeating LGB people's lives with disclosure decisions (Flores, 2011). Further, due to the stigmatized status of LGB people, disclosure is always somewhat dangerous (Reynolds, 2003). Several theorists recommend that therapists disclose their sexual orientation when working with these clients (L. S. Brown & Walker, 1990; Cabaj, 1996; G. W. Cole & Drescher, 2006; Guthrie, 2006; Isay, 1996; Mahalik, Van Ormer, & Simi, 2000; Rochlin, 1982; Russell, 2006; Satterly, 2006). In fact, Zur (2009) states that working with LGB clients "present[s] one of the most…convincing arguments for self-disclosure" (p. 44).

A significant reason therapists working with LGB clients are recommended to disclose their orientation is that they have a right to know about therapist identities or values that could influence their treatment. Feminist scholars such as L. S. Brown and Walker (1990) and Mahalik et al. (2000) have argued that informed consent should include this information because similarity on variables such as sexual orientation may influence the therapist's ability to provide role modeling for the client. However, Cabaj (1996) and Rochlin (1982) both argue that therapists of all sexual orientations can be effective role models. An additional argument in favor of self-disclosure is that, given their stigmatized status, LGB clients have a right choose therapists who they feel are supportive and to rule out therapists who do not respect their sexual orientation (A. C. Bernstein, 2000; Zur, 2011). In actuality, many LGB clients do prescreen for affirmative attitudes (Flores, 2011). Particularly if the therapist is also LGB, disclosing this

information could facilitate empathy and openness (Liljestrand et al., 1978), provide a sense of safety and freedom from judgment (Hanson, 2005), help the client to see this orientation as acceptable (Perlman, 1991), and to provide role modeling that may otherwise be unavailable (Cabaj, 1996; Kooden, 1991).

According to Hanson (2005), it is likely detrimental not to disclose such information with LGB clients because this openness can minimize power differentials. Furthermore, Isay (1991) has noted that a counselor hiding or denying their sexual orientation could trigger shame for clients who have high levels of internalized heterosexism. Thus, Isay has argued that a therapist's comfort with his or her own sexual orientation may be more impactful than the disclosure in particular. Moreover, a therapist's choice not to disclose can reinforce the social perspective that sexual orientation is shameful and not to be expressed (Guthrie, 2006). Silence around this issue could be experienced as indifference or disapproval (Farber, 2006). Despite the substantial theoretical discussion and case studies on the matter, I am aware of only one empirical study has explored this issue. Using an analogue design, D. R. Atkinson et al. (1981) found that in a sample of gay men, male therapists who disclosed a gay orientation were perceived as more attractive, trustworthy, and expert than those who disclosed a heterosexual orientation or did not disclose an orientation. This study is often cited to support the disclosure of the therapist's sexual orientation, though due to the exclusion of women from its design, it reveals more about gay male therapist preferences than disclosure preferences more generally.

Like all disclosures, how a disclosure of orientation is experienced will depend on complex client and counselor characteristics. Guthrie (2006) emphasizes the multiple

meanings that disclosure can have when working with LGB clients and recommends exploring what this question means to the client and considering this issue thoughtfully before responding. The psychotherapist further notes that the question may not be posed directly and there are some clients who will not wish to know. Disclosure with LGB clients may make good clinical sense, but it is still important for therapists to examine their own intentions, if a disclosure is occurring due to a clinicians need be seen as compassionate, it is ethically questionable (Perlman, 1991). The impact of disclosures, like all therapeutic techniques, depends on a wide range of client, clinician, and situational factors that clinicians need to thoughtfully consider.

Need for Research on this Topic

Continued research on the treatment needs of sexual minority clients is needed to provide competent services to this important population (Bieschke et al., 2007; Burckell & Goldfried, 2005). Research on the role of various demographic variables in therapeutic relationships has suffered from simplistic designs (Speight & Vera, 1997), methodological inconsistencies (Karlsson, 2005), and inadequate sampling strategies (S. Sue, 1999). According to Karlsson (2005) the lack of complex research designs that consider within-group and therapist variables has led to the topic remaining "essentially unexplored" (p. 125). I disagree somewhat with this perspective, noting the diverse range of findings that have been acknowledged and surveyed in this review. Nonetheless, there are many questions that are left unanswered, which require complex approaches and continued attention to these issues, particularly concerning affirmative treatment with sexual minority clients. Certain therapist practices have been recognized as particularly useful or destructive, and the importance of establishing a positive therapeutic alliance is

clear (Burckell & Goldfried, 2005). However, according to Burckell and Goldfried (2005), what needs to be clarified is how positive therapeutic alliances are formed with LGB clients. Additionally, Bieschke et al. (2007), in their review of the literature on treatment with LGB clients, note the need for continued studies on what contributes to affirmative experiences in therapy with sexual minority clients. Thus, this research represents a step in the direction of developing nuanced, client-based findings that will hopefully be built upon by future research focusing on the experience of bisexual clients working with heterosexual and sexual minority therapists.

Multiple theorists note that, rather than exploring demographic variables, exploration of psychological phenomena and the experiential impact of cultural match and mismatch could provide nuanced and useful findings (Speight & Vera, 1997; S. Sue, 1999, 2003; Williams & Hill, 2001). Research that involves real clients' perceptions, values, and experiences is needed to provide increased understanding of these psychological processes (Constantine et al., 2002; Pope-Davis et al., 2002; Speight & Vera, 1997; Worthington, Soth-McNett, & Moreno, 2007). According to Speight and Vera (1997), exploring the meaning that clients have made of similarities and differences could help clinicians to understand the roles of these complex constructs. Such inquiries would provide the field with much needed information, as "the task before all counseling participants is to develop an effective therapeutic relationship in the face of these similarities and differences" (p. 291).

In order to determine what is important to clients without imposing researcher ideas and models, the use of open-ended methodologies is also needed (Ponterotto et al., 2002; Pope-Davis et al., 2002; Speight & Vera, 1997). According to D. R. Atkinson and

Wampold (1993), empirical research often entails testing a predetermined theory, which limits research outcomes to either the support or refutation of that theory. This approach does not allow the discovery of any new information, which is particularly problematic in research with multicultural populations (Pope-Davis et al., 2002). Qualitative methods are focused on providing an "experience near" (Blustein, 2006, as cited in Crouteau, 2008) perspective by giving research participants the opportunity to include material in the research that is relevant to their experience.

Another benefit to the use of qualitative methods is their acknowledgment and inclusion of multiple contextual influences (Nagata, Kohn-Woods, & Suzuki, 2012; S. Sue, 1999). Qualitative methods allow for the inclusion of contextual factors that organize experience in real world settings (Leach & Carlton, 1997, as cited in Pope-Davis et al., 2002), providing much needed external validity to findings (S. Sue, 1999). Qualitative methods provide rich accounts of the multiple facets of identity and collect data through respectful and ethical strategies (Lyons & Bike, 2010). When researchers consciously reflect on the influence of power, privilege, and bias, this research approach is "essential to understanding the contextually complex lived experiences that exist within diverse communities" (Nagata et al., 2012, p. 257).

Qualitative methods are well suited to gaining knowledge about understudied populations, such as LGB people of color (Morrow, 2003). The fact that the majority of research on treatment issues with the LGB population represents the experience of white and highly educated participants substantially limits clinical knowledge (Bieschke et al., 2000, 2007). There are significant barriers to sampling LGB people of color (Croom, 2000; Deblaere, Brewster, Sarkees, & Moradi, 2010). However, more creative strategies

must be utilized in order to provide information that applies more broadly to the members of the LGB community. Furthermore, the absence of inclusion of LGB people of color continues an implicit historical assumption that LGB people either do not exist or do not matter, neither of which is the case (E. R. Cole, 2008). According to Croom (2000), "the omission of LGBT ethnic groups from the psychological literature may not be intentional but certainly reflects the historically difficult relationships and the dynamics of power between the dominant community of white Americans and people of color" (p. 266). This research does not explicitly focus on the experience of LGB people of color, but will attempt to include these experiences as much as possible.

Unfortunately, a majority of the research on the treatment preferences of LGB individuals has been quantitative in nature. This body of literature has recognized general themes and began to direct the development of more affirmative practice and training. However, a nuanced and multifaceted exploration of sexual minority clients' experiences in therapy with sexual majority therapists is needed. Providing such an account could determine therapist practices that increase as well as decrease the strength of the therapeutic alliance, as well as distinguish areas that need further research. Qualitative inquiry aims to represent the complex social, interpersonal, and intrapsychic issues present in any phenomena and this perspective is currently lacking in our understanding of cross-orientation therapeutic relationships. Furthermore, accounts of therapeutic alliances between sexual minority clients and sexual majority therapists have been focused primarily on the therapist's experience. While these accounts have provided useful preliminary understandings of benefits and challenges inherent in this

cross-orientation therapeutic alliance, the perspective of the client is noticeably absent. This study aims to fill this gap in the research.

Method

Approach

This research project was conducted from a qualitative approach, wherein the data collected and analyzed were personal accounts of experiences, rather than numerical or experimental in nature (Denzin & Lincoln, 2003; Seale, Gobo, Gubrium, & Silverman, 2004). On a general level, qualitative research "involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data" (Creswell, 2009, p. 4). However, knowledge acquisition is a complex process. Qualitative research encompasses methodologies founded in differing philosophical paradigms, seeking to answer diverse questions, which use a variety of tools for collecting and analyzing data. Therefore, I begin by surveying definitions of qualitative research, explicating underlying foundations in continental philosophy of science, and situating these methods historically. Finally, I discuss issues concerning objectivity and rigor in qualitative inquiry.

Defining qualitative. Qualitative research is often defined by its differences in relation to quantitative research (Guba & Lincoln, 1994; Yardley, 2000). While I highlight several common differences between qualitative and quantitative studies, considerable nuances exist in these approaches, and there are exceptions to the distinctions made. Quantitative studies test theories through quantification procedures, such as measurement, statistical probability, and random sampling (Camic, Rhodes, & Yardley, 2003). Qualitative studies, on the other hand, reflect an emphasis on the qualities of experience (Denzin & Lincoln, 2003). Philosophers debating the nature of

the human subjectivity often appeal to the concept of "qualia", which refers to private subjective experience; "the introspectively accessible, phenomenal aspects of our mental lives" (Tye, 2013, para. 1). Qualitative projects are designed with an interest in individuals' internal experiences, as well as their perspective on their external world (Polkinghorne, 2005). Schwandt (2001) defines it similarly; "qualitative inquiry deals with human lived experience. It is the *life-world* as it is lived, felt, undergone, made sense of, and accomplished by human beings that is the object of study" (p. 84). This approach is interested in exploring what individuals believe is important in regards to a topic (Rubin & Rubin, 2005). Therefore, a qualitative stance is appropriate for this research project because I sought to understand the phenomena of cross-orientation therapeutic alliances through the participants' experience.

Qualitative approaches have been differentiated from quantitative approaches by their analysis of language, as opposed to numeric, data (Biggerstaff, 2012; Denzin & Lincoln, 2003; Seale et al., 2004; J. A. Smith, 2003). Although, it may be more appropriate to say that these methods involve communicated data, which comes through language as well as nonverbal interaction (Yeh & Inman, 2007). Hill (2006) described qualitative data as open-ended, with responses generated by participants instead of chosen from presumed responses. Because the data are derived in these forms, complex and intricate findings may be gathered (Denzin & Lincoln, 2003). However, language data requires interpretation, which is a complex process conducted differently depending on the methodology chosen (Polkinghorne, 2005). Nevertheless, similarities between qualitative and quantitative methods exist in the demanding nature of each project, the imagination required in designing the study and conceptualizing resulting implications,

the efforts to respond to researcher bias, and the importance of offering rigorous and transparent research to consumers (Fisher, 2006).

Qualitative and quantitative approaches are suited for different types of investigations (Camic et al., 2003; Creswell, 1998). Qualitative methodologies are particularly useful for exploring topics about which little is known and for developing in-depth analyses of phenomena (Morrow, 2007). Questions concerning the how of existence lend themselves to qualitative investigation, whereas quantitative approaches often answer questions of why (Creswell, 1998). According to Maracek (2003) the field of psychology has been focused on discovering underlying causes of human experience (why) and qualitative methods offer a useful exposition of how life is experienced by individuals. Moreover, the focus of inquiry for qualitative and quantitative approaches is often at a different level of specificity. In a 2005 article in an issue of the *Journal of Counseling Psychology* dedicated to qualitative inquiry, Morrow stated that qualitative methods are primarily interested in the emic or idiographic level of analysis, which focuses on individuals. In contrast, the scholar noted a quantitative stance investigates the etic or nomothetic level, seeking standardized categories and findings that apply across populations.

Qualitative research is difficult to define because the term encompasses a multitude of research methods utilized by several disciplines (Denzin & Lincoln, 2000). Qualitative methods have a long and varied history in the fields of sociology, education, anthropology, history, and psychology. This multifaceted methodological history has led to some qualitative researchers to adopt the metaphor of the researcher as a "bricoleur" (Denzin & Lincoln, 1994; Henwood & Pidgeon, 2003; Josselson, Leiblich, & McAdams,

2007; Macleod, 1996; Morrow, Castañeda-Sound, & Abrams, 2012; Ponterotto, 2005b): a craftsperson, who can skillfully utilize different methods, tools, and experiences to weave together a complex and multiply informed research product. In their definition of qualitative work, Camic et al. (2003) described qualities as "emergent properties arising from the configuration of elements in a whole" (p. 9). Thus, a qualitative approach is holistic, exploring interactions between people and their environments (Denzin & Lincoln, 2011).

Consequently, context is important to qualitative research (Creswell, 2009; Mishler, 1979). Mishler (1979) has argued that seeking universal laws has led psychology to use methods that strip the contextual information key to understanding human meaning. Whereas laboratory research settings are controlled so as to limit the number of variables, qualitative inquiry is interested in how things are in the world, including resulting complexity (Denzin & Lincoln, 2003). Therefore, researchers working from a qualitative stance often engage with participants in settings that approximate their natural occurrence (Creswell, 2006; Denzin & Lincoln, 2000). While some information may need to be omitted to protect the confidentiality of participants, qualitative researchers report data in a manner that acknowledges the contextual location of individuals (Elliott, Fischer, & Rennie, 1999; Macarek, 2003; Mishler, 1979; Morrow, 2005; Stiles, 1993).

An interest in the practicalities of the world also means that qualitative researchers value flexibility in the research process (Creswell, 2009; Patton, 1990). The arenas they investigate are not static and controlled but changing and evolving, as are their understandings about topics of investigation (Creswell, 2006). Therefore, they use

emergent designs that can be modified as necessary or appropriate, in ways that are intended to enhance the quality of their research project (Morrow, 2007). The research process is not planned ahead of time and executed regardless of subsequent events in a linear fashion. Instead the process is iterative, wherein discoveries lead to looking at previous data in new ways and the researcher is open to these unexpected occurrences leading to novel considerations (Haverkamp, 2005).

Analytic procedures utilized in a qualitative approach are also somewhat nonlinear (Barbour & Barbour, 2003). Qualitative researchers are often described as using inductive logic, building theories from integrated data (Creswell, 2009; Flick, 2002; Morse, 1992). However, analytic approaches can also be recursive or iterative, cycling from induction to deduction, developing theories from data which are then tested and refined through the accumulation of further data (Hill, 2006; Polkinghorne, 2005). Thus, the analytic enterprise is more sensitive to researcher bias in qualitative research because the analytic instrument is the researcher (Kvale, 2003). Though Eisner (2003) has argued that the results of research are always influenced by the research act, regardless of what analytic approach is used. Many current researchers acknowledge that the position of the researcher is never fully objective, and instead researchers must acknowledge and engage with their subjective experience in order to offer valid results (Breakwell & Rose, 2006; Brinkman & Kvale, 2005; Finlay, 2002a, 2008; Rennie, 2004, 2012). Many qualitative researchers engage explicitly with their subjectivities, though the way this practice is conducted differs between paradigms and methods (Morrow, 2007).

In the same way that the presence of the researcher is emphasized and highlighted, the relationship with the research participant is at the heart of the qualitative

research approach (Yeh & Inman, 2007). As a result, qualitative approaches often appeal to psychologists who practice psychotherapy. Yeh and Inman (2007) stated that:

> In counseling psychology, making a human connection is certainly underscored in practice, but this idea of entry as a person is also central to qualitative research. Such relational interconnectedness between researcher and participant can contribute to shared understandings and perspectives that foster accurate interpretations and meaningful theory building. (p. 381)

Many methods using a qualitative approach emphasize a collaborative relationship between researcher and research participant, recommending that researchers be aware of and neutralize hierarchical relationships where possible (Sciarra, 1999). Using the term *participant* in lieu of *subject* is one way of honoring their participation in the research enterprise (APA, 2009; Corrigan & Tutton, 2006). Some methodologies also seek to include research participants in the analysis phase (Elliott et al., 1999; Fade, 2003) or create programs that give back to communities of research (e.g., Kidd & Kral, 2005).

Fundamentally, qualitative research "regards those whom we study as reflexive, meaning-making, intentional actors" (Macarek, 2003, p. 54) who have an authoritative perspective that is worth understanding and sharing. This practice of valuing the individual's perspective is one reason that qualitative methods are recommended when working with people who have historically been marginalized or silenced (Morrow, 2003; Morrow, 2007; Ponterotto, 2005a, 2010). Within the qualitative approach, there are methodologies that have a strong social justice components and an acknowledgement of the inherent political and personal values advanced by research (Denzin & Lincoln, 2000; Stiles, 1993). Due to the close engagement with participants, this stance constructs

particular ethical responsibilities on the part of the researcher, which require their own section to be discussed adequately.

Paradigms and historical influences. It useful to begin with questions of philosophy of science, because assumptions scientists have about the world informs their approach to understanding it (Madill & Gough, 2008). Consequently, Elliot et al. (1999) and Haverkamp and Young (2007) have noted that understanding the philosophical underpinnings of research is key to designing a rigorous research project. Research approaches involve issues of ontology, epistemology, and methodology, which together make up a paradigm, or "worldview" (Guba & Lincoln, 1994). Ontology denotes a system of ideas about the state of the world and beings within it; epistemology concerns how people can know or apprehend things about the world; and methodology determines how, given the above propositions, a person could proceed in discovering phenomena in their world (Denzin & Lincoln, 2003; Morrow, 2007; Ponterotto, 2005b). Thus, a paradigm describes what a person believes about existence, humanity, and truth.

Kuhn (1962) proposed that science, along with other social institutions, is impacted by historical and cultural influences. Kuhn argued that paradigms are directly related to the social world and they guide the ways scientists approach and think about their work. Over time, and due to shifts in cultural dynamics, an existing paradigm may not be able to account for aspects of experience that become important, and if there is an alternative perspective that can respond more effectively to these issues, there will be a shift to a new paradigm. Often, Kuhn noted, shifts occur when the rigidity of a theory renders it too limiting (Sciarra, 1999). Paradigms do not change completely or

consistently, however, and tensions between these paradigms are present in methodological discussions today (Dennett & Ghaemi, unpublished manuscript).

Paradigms are categorized in many different ways, some highlighting intricate nuances and others offering broad categorizations to emphasize the compatibility of certain worldviews. I follow Guba and Lincoln (1994), Haverkamp and Young (2007), and Ponterotto (2005b) in discussing four main paradigms: positivism, postpositivism, interpretive-constructivist and critical ideological. I find this model to be useful, though it simplifies a complex history of evolving theories. According to Williams and Morrow (2009), qualitative methods often use combinations of paradigms and therefore it is appropriate to consider paradigms as existing on a continuum ranging from worldviews that emphasize objectivity to those that are more participatory in nature. A complete exploration of philosophy of science is outside of the scope of this project, and notable scholars in the field of psychology have provided thorough explorations of scientific paradigms (e.g., Haverkamp & Young, 2007; Denzin & Lincoln, 2011; Ponterotto 2005b). This discussion is limited to the philosophical and scientific history of "western" cultures and does not intend to imply that these ways of seeing the world are universal to all people or represent all approaches to inquiry. Scheurich and Young (1997) have encouraged researchers to be aware of the ways that contemporary epistemologies are rooted in the social history of the dominant culture, reinforcing and reflecting a particular perspective, often excluding or marginalizing the history and approaches of other cultures.

The history of philosophy highlights the impact of humanity's cultural evolution on the ways that people understand their existence. After the dark ages, the

Enlightenment period moved Western societies from worldviews ruled by god and faith to a new world that could be mastered and measured by reason and scientific technology (Gergen, 2001). According to Gergen (2001), ideas about the world that were developed during the Enlightenment continue to pervade Western culture. Gergen acknowledged reverberations of this era in the widely held beliefs that mental events can be studied objectively, mental and physical events are causally related, and the experimental method is the superior method of knowledge acquisition.

According to Polkinghorne (1983), Bacon, Galileo, and Newton exemplify enlightenment thinking. In 1620, Bacon maintained that theories could be generated, and then tested through sense-based evidence allowing for future prediction (J. Klein, 2012). Shortly thereafter, Galileo argued that nature is systematic and that its patterns can be discovered through the use of mathematical formulas (Polkinghorne, 1983). Newton built upon these ideas, arguing that mathematical methods offer the promise of understanding the physical world and making predictions, which has been a significant goal of the psychological sciences throughout the twentieth century (Gergen, 2001). This period of scientific progress laid the foundations for the positivist paradigm and significantly influenced the field of psychology (Hoshmand & Polkinghorne, 1992).

According to Packer and Addison (1989), enlightenment thinking resulted in two key scientific perspectives that later influenced positivism: empiricism and rationalism. The scholars noted that both empiricism and rationalism support dualistic perspectives of the world as broken into mind and body. In the 17th century, Descartes, seeking a way to assert statements of truth about the nature of existence, split the world into a physical realm of objects and the mental world from which people can relate to and consider the

material world (Polkinghorne, 1983). This separation concretized the idea that there are physical things that operate under certain properties, and then there are other sorts of things (i.e., ideas, beliefs) that have entirely different properties, leaving many subsequent scholars to debate how the two realms interact (Michell, 2003).

According to Descartes (1641/1951), perceiving the world through his senses meant relying on an imperfect system that had the potential to deceive him. Because senses could not be trusted, Descartes and subsequent rationalist philosophers "held that the things known by the intellect have a higher reality than the objects of the senses" (Hatfield, 2011, para. 46). This perspective provided an argument for the existence of reality separate from human's experience of it and posited that clear understanding results from a detached perspective (Angen, 2000). The Cartesian process is one of "methodic doubting [in which] the subjectivity of the researcher is seen as a bias which obscures the accurate view of reality" (Mottier, 2005, para. 4). Formal abstraction was considered more valuable than experience, and was meant to reveal the underlying structure of experience (Packer & Addison, 1989). Packer and Addison (1989) noted that this focus on structural foundations has influenced the contemporary scientific practice of stripping relational and cultural context from objects, a practice that is criticized by interpretive traditions.

Empiricism is a different response to the dualistic worldview: whereas rationalism privileges abstract thought, empiricism privileges physical phenomena (Packer & Addison, 1989). According to J. A. Smith (1989), Locke built a complete theory of science, referred to as empiricism, from the elemental ideas of Bacon, Galileo, and Newton. J. A. Smith further explicates Locke's conception of knowledge: people are

"blank slates" upon which experience and knowledge are inscribed. Locke proposed that because knowledge is always the result of sense-based information, knowing cannot occur outside of sense experience (J. A. Smith, 1989). Moreover, Packer (1985) noted that Locke proposed a "correspondence theory of truth," in which theories could be checked by their corresponding physical "empirical" data. Therefore, empiricism emphasizes the verification of claims: the premise that ideas, once verified by sense data, can be considered true (S. Koch, 1981). If scientists are interested in a nonphysical phenomenon, they need only to find the measurable behavioral correlate to study (Packer & Addison, 1989). Privileging the physical offered a sense of certainty about "the real," which was an appreciated departure from the religiosity and faith based information of the medieval period (Angen, 2000).

According to Packer and Addison, while rationalism and empiricism view the portal to valid truth differently, they both claim to have discovered "truth" about the world. Both perspectives espouse a realist ontology, in which there is a single real world, one that follows causal laws between physical objects and which can be discovered by humans through the use of various techniques. Packer and Addison further noted that both ways of approaching a dual world, valuing the cognitive and valuing the physical, have driven psychological research, knowledge, and treatment.

A realist ontology, combined with an empirical epistemology, and a high regard for rationalist objectivity, designates a positivistic paradigm (Lincoln & Guba, 2000). Comte is credited with coining the term *positivism* to designate the belief that the progression of scientific knowledge can lead to positive societal advancement (Danziger, 1990). Habermas (1968/1971, as cited in E. A. St. Pierre & Roulston, 2006) has noted

that Comte used both rationalism and empiricism to demonstrate the validity of science. Moreover, Angen (2000) has argued that positivism resulted from the marriage of Bacon's goals of control and prediction and Cartesian dualism. While both rationalist and empiricist perspectives influence positivism, this paradigm is generally considered a version of empiricism due to its reliance on "empirical," or sense-based, data (Packer & Addison, 1989; J. A. Smith, 1989). According to Polkinghorne (1984), "positivism is based upon the principle that the only reliable knowledge of any field or phenomena is knowledge that can be reduced to knowledge of particular instances of simple sensations" (p. 15).

Mill extended positivism (J. A. Smith, 1989) and his text *A System of Logic* (1843) is credited as foundational to this perspective (Polkinghorne, 1983). Mill asserted that the goal of science should be the development of a canon of laws that have been established through developing hypotheses and testing observable phenomena using large data sets (Polkinghorne, 1984; Ponterotto, 2005b). Being able to explain the world in this direct manner creates the potential for prediction; solidifying the idea that science is concerned with the business of prediction and, thus, control (S. Koch, 1981; Ponterotto, 2005b). Additionally, Mill recommended that social sciences and natural sciences should use the same empirical methods (Polkinghorne, 1984; Ponterotto, 2005b). According to Polkinghorne (1983), Hobbes was the first of many to argue that the methods of science could also be used to understand humans. This doctrine of universal methods for all types of inquiry is often credited to positivism, though Comte did not himself belief that quantification was appropriate for all types of inquiry (Kvale, 2008; Michell, 2003). Positivism went on to be developed by other scientists, such as Mach, Carnap, and

Russell (Polkinghorne, 1983), leading to varying conceptions of what the paradigm designates.

Regardless of attribution disagreements, positivism created the foundations of science, and psychology adopted this paradigm early on in an attempt to establish itself as a credible science (Hoshmand & Polkinghorne, 1992; McLeod, 2001). Madill and Gough (2008) have expressed concern that positivism has become a derogatory term to designate individuals who oppose an interpretive stance. Further, Michell (2003) has noted that the term is sometimes used to imply outdated and preposterous scientific perspectives. According to Michell (2003), many scientists misunderstand positivism to equate the quantitative imperative, which is the idea that "studying something scientifically means measuring it" (p. 6). Michell has argued that positivism did not originally, and does not necessarily, condone this proposition. In fact, Comte is quoted noting that "our business is to study phenomena, in the characters and relations in which they present themselves to us, abstaining from introducing considerations of quantities, and mathematical laws, which is beyond our power to apply" (1975, p. 112; as cited in Michell, 2003). From this scholar's perspective, positivism was primarily a romantic belief that science would lead to social progress, and not originally the absolutist position it has become. The focus on quantification, Michell proposed, goes back to Pythagoreas, more than a century before Aristotle. Additionally, Michell argued that a thorough reading of positivism proves they anticipated the critiques of postpositivists.

According to Polkinghorne (1983), critiques of positivism came from German idealist philosophers, as well as from an influential American psychologist, William James. J. A. Smith (1989) described German idealism as a neo-Kantian philosophy

influenced by Kant's critique of empiricism. As opposed to Locke's conception of direct knowledge transfer, Kant believed that what humans experience through their senses are appearances of phenomena influenced by the intuitive processes of humans (Rohlf, 2010). Arguments based on this mediated model of experience challenged positivism and eventually led to a more modest form of the theory (Lather, 1986). The opposition was not united, though each argued that human existence was somehow particular and separate from the natural sciences.

Polkinghorne (1984) has noted that the challenge to universal scientific methodologies was first posited by Droysen, a German historian who differentiated between the goal of explanation (*erklären*) in the physical sciences from the goal of understanding (*verstehen*) in the human sciences. Sciarra (1999) has suggested the philosopher Dilthey furthered the erklären-verstehen distinction by arguing that life was an experiential and reflective process informed more by personal histories than causal laws. Dilthey differentiated between *Geisteswissenschaften* (the human sciences) and *Naturwissenschaft* (the natural sciences) and believed that though the scientific method makes sense in relation to the physical world, knowledge about the social world required a different goal altogether, Droysen's verstehen (understanding) (Wertz, 2011). According to Sciarra (1999), Dilthey viewed humans as social beings and proposed that to make sense of humans they would need to be understood from their own perspective, utilizing a similar technology to a therapists empathy (Sciarra, 1999).

Danziger (1990) and Wertz (2011) have highlighted that Wundt and Brentano, members of the German idealist school, recommended different methods for the study of human beings (Danziger, 1990; Wertz, 2011). Danziger credits Wundt with being a

founder of psychology because the scientist was the first to create a laboratory for the study of psychological phenomena. Wundt valued and borrowed some experimental approaches from the natural sciences, which informed his particular approach to introspection, but the researcher also thought that subjective data was needed to develop a full understanding of humans (Polkinghorne, 1983). James is also considered a founder of the discipline (Snarey & Bridgers, 2006). James encouraged an empirical approach to psychology, though this scientist too argued that the exclusion of any kind of experience limited the field, including that of spiritual or emotional experience (Polkinghorne, 1983).

Similarly, idealist philosopher Brentano shared an appreciation of positivistic ideas, but believed that without including subjective description, the empirical method was limited (Polkinghorne, 1983). Further, Polkinghorne noted that Brentano encouraged psychology to have an empirical causal approach only after the experiential realm was fully explored and described. Brentano also postulated important ideas about the intentionality of humans, which would be built upon by phenomenological philosophers such as Husserl and Heidegger (Cohen, 1987). Intentionality conveys the object-oriented nature of consciousness, linking internal and external experience and thus emphasizing the importance of context to understanding individuals (Cohen & Omery, 1994).

The postpositivist paradigm grew out of positivism, softening its claims that reality can be apprehended flawlessly (Haverkamp & Young, 2007). Postpositivists still assert there is a singular real world and that scholars should go about exploring it empirically and objectively (Denzin & Lincoln, 2011). However, this paradigm adopts a critical realist ontology, which posits that there is a real world, though it cannot be

experienced directly (Morrow, 2007). Methodologically, postpositivism changes the focus from theory verification to theory falsification (Ponterotto, 2002). Scientist Popper believed that false theories could still be supported by data and recommended that a more appropriate way to verify a theory would be the inability to disprove it, leading to the empirical procedures many scientists use today (Lincoln & Guba, 1994). Conversely, an alternate claim has been made that refutation does not prove to us what is true as much as which theories are not (Dennett & Ghaemi, unpublished manuscript). Similar to its softening of the realist ontology, postpositivism acknowledges the epistemological difficulty of objectivity, while still maintaining it as an ideal (Lincoln & Guba, 2000).

Postpositivism is the foundation for most quantitative research approaches, as well as some qualitative approaches that emphasize consensual agreement and the pursuit of objectivity (Morrow, 2007). While postpositivism is not the paradigm to which I adhere, postpositivist ideas, and the rationalism and empiricism that inspire it, have provided much to the sciences and the general understanding of the material world in the west. Guba and Lincoln (1994) call postpositivism "the received view," as it pervades the dominant discourse and is often accepted uncritically by society and scientists. Theorists highlight the tendency for psychology as a field to align with this paradigm (Camic et al., 2003; C. T. Fischer, 2006; McLeod, 2001), citing modernist ideas about certainty, progress, and credibility as likely reasons.

The pursuit of science can be approached in different ways, however. In the 20th and 21st century, constructivist-interpretivist and critical-ideological approaches have challenged the received view (Denzin & Lincoln, 2003). As Kuhn's (1963) theory indicates, shifts in paradigms occur when new social configurations create

inconsistencies with the existing view. In the middle of the 20th century there was an "interpretive turn" (Rabinow & Sullivan, 1987, as cited in Mottier, 2005, para. 5) in the methodological debate. During this time, new theories built upon earlier philosophies that focused on meaning and understanding in inquiry, such as hermeneutics (Schwandt, 2003), pragmatism (Denzin, 1995), and cultural romanticism (Denzin, 1992). There are many versions of constructivist thought, however, and I focus my discussion on symbolic interactionism and social constructivism. Though they did so in different ways, these theories each proposed that mental processes construct people's experience, therefore arguing that understanding social phenomena requires interpretation (Ponterotto, 2005b).

Symbolic interactionism was an early constructivist theory developed in the work of philosopher Mead and expanded by his student Blumer (Given, 2008). This theory posited "that we know things by their meanings, that meanings are created through social interaction, and that meanings change through interaction" (G. A. Fine, 1993, p. 64). This theory is rooted in pragmatism: a theory that conceptualizes knowledge as a process and reality as a meaningful product of that process, which was supported by Dewey, James, and Peirce (Given, 2008). According to Denzin (1995), symbolic interactionists conceptualize the self as multilayered with various identities dependent on both external processes and internal consciousness, which are most appropriately studied in natural contexts (Denzin, 1995). The rationalist idea that stripping context from an event allows clearer vision of it is highly questionable from this stance (Lincoln & Guba, 2000). The process of abstracting and reducing removes historical and symbolic factors that are needed to properly understand the phenomena (Denzin, 1995). Qualitative methods working from this theory embrace a critical realist ontology in which reality is the result

of symbolic processes interacting with external empirical realities (Eatough & Smith, 2008).

According to G. A. Fine (1993), interpretive approaches have been influenced and exemplified by postmodernist theory, though feminist thought on the construction of gender has been an equally important influence. Symbolic interactionism has much in common with postmodernism, and many theorists combine interactionism with other postmodern theories (G. A. Fine, 1993). G. A. Fine (1993) further noted that many symbolic interactionist ideas have become mainstream due to the success of postmodernism, though as a result the original theory is often obscured by contemporary strands of constructivism. According to Gergen (2001), three primary modernist themes became problematic in the postmodern world: the idea that there is an objective reality people can know things about, individual reason as the primary route to knowledge, and the assumed truth status of language. The postmodern world initiated a growing awareness that existence and language can be experienced, interpreted, and perceived in multiple ways (Gergen, 2001).

Postmodern theory is also associated with social constructivism (Given, 2008). Gergen (1985) described social constructivism as the perspective that people's experiences are constructed socially through language, culture, and sociohistorical influences. A constructivist research orientation, thus, is interested in the processes by which individuals understand, relate to, and make meaning of their world (Haverkamp & Young, 2007). Since individuals' experience of the world is mediated and influenced by personal, social, and historical factors, there are as many realities as people (Morrow, 2007). If there exists as many realities as there are people, then it is useful to seek

knowledge about people's perspectives on the world, regardless of whether their perspective is testable or shared by an entire population. Social constructivism is relativist, viewing the world as made up of multiple realities that change relative to people's social position (Gergen, 1985, 1989).

The constructivist epistemological approach is distinct from positivist and postpositivist paradigms. Gergen (1985) distinguishes between endogenic epistemologies, such as can be found in Kant, as well as Husserl, from exogenic epistemologies, displayed by Locke and Mills. From an exogenic perspective, knowledge comes from external events, whereas from the endogenic perspective, knowledge depends on processes within the organism that categorize and interpret information obtained by the senses. Ponterotto (2005b) noted Kant's *The Critique of Pure Reason* (1998) was an important influence to constructivists and other interpretive traditions. Kant challenged the idea that a person could perceive something objectively and thought instead that the mental apparatus with which humans perceive has a significant influence on what is observed. Thus, humans cannot step outside of themselves in order to attain an unbiased perspective. Qualitative methods working from a constructivist-interpretivist paradigm view subjectivity as inescapable and consider engaging with their perspective to be central to the research process (Patton, 2002).

Critiques to the constructivist paradigm highlight the relativism that it suggests, arguing that it leads to an "anything goes" mentality around what constitutes good or valuable research (J. K. Smith & Hodkinson, 2011). While constructivism does allow for multiple interpretations to exist, these interpretations are not considered "value-free" and are often assessed in terms of moral choices (J. K. Smith & Hodkinson, 2011) and social

consensus (Gergen, 1985). Additionally, constructivist theories lie on an ontological spectrum from strong relativism to critical realism (G. A. Fine, 1993). Qualitative methods that work from the constructivist-interpretive paradigm include forms of grounded theory and phenomenology, among others (Morrow, 2007).

The fourth paradigm I would like to introduce comprises various critical ideologies. The critical-ideological paradigm emphasizes the social justice goals of qualitative research and uses critical theories to critique, analyze, challenge, and hopefully change, the dominant discourse (Kincheloe & McLaren, 2000). Critical theories such as Feminism, Marxism, and Queer theory are all lenses through which scholars can perform critical interpretations. This paradigm generally holds an ontological stance of critical realism, called "subtle realism" by some (Hammersley, 1995; Silverman, 1993), proposing "that a discernible reality exists, but that this reality reflects the oppressive influence of social, political, and historical factors" (Haverkamp & Young, 2007, p. 268). These theories also emphasize a very real world of marginalization and oppression within which people exist (Morrow, 2007). Consequently, methodologies working within the critical-ideological paradigm often encourage participatory methods, aimed at balancing social hierarchies and empowering participants. Many of the research methods utilized by interpretive-constructivist researchers can also be used from critical perspectives.

Morrow et al. (2001) categorized critical ideologies as two distinct paradigms: ideological-emancipatory and ethnic and liberatory paradigms, which includ perspectives such as African-American and Chicana feminist-womanist epistemologies. Alternately, Lincoln and Guba (2003) separate this paradigm into those that use critical theory and

those that use participatory methods. Participatory Action Research (PAR; Kidd & Kral, 2005) argues the researcher has an obligation to effect change in the world in a manner that furthers social justice (Kincheloe & McLaren, 2000). PAR is an exemplary approach to research in which the research implements programs with real world effects for the individuals and communities involved. While I deeply respect this method, I do not feel that this research question, as researched by myself, is well suited to PAR. I do not currently have enough information about cross-orientation therapeutic relationships to make recommendations about what should be done, though I has been my hope this research could provide direction on the matter.

Paradigm debates have been occurring with such intensity that some refer to them as "paradigm wars" (Lincoln & Guba, 1985). The reason for this strong language, and the arguments behind them, is that paradigms are a core feature of how each of us interacts with the world. People are defending their own reality. Some researchers encourage paradigmatic pluralism, arguing that they can usefully supplement each other (Creswell, 2003; Tashakkori & Teddlie, 2003), while others argue they are incommensurate and any attempt to combine differing paradigms compromises the quality of the resulting research (Lincoln & Guba, 1994, 2000; Tashakkori & Teddlie, 2003). Regardless of scholar's views on the commensurability of paradigms, each of these paradigms offers a way of looking at the world that determines what research focuses on, how it is obtained, and what sense is made of it. Each has considerable strengths as well as challenges. Finally, each is a product of the historical and cultural revolutions of their time, and they can be easily misunderstood without this context.

Historical context and contemporary trends. Qualitative methods, as stated previously, have a long and sorted history. For an overview of the history of qualitative methods generally, and in the fields of anthropology and sociology specifically, see Denzin and Lincoln (2003) and Vidich and Lyman (2000). I will focus this historical situating on the field of psychology, though it is important to say something about where qualitative methods began, in anthropology and colonialism. Qualitative research was born from interest in the other, Denzin and Lincoln (2003) noted, referencing Vidich and Lyman (2000). These methods developed to make sense of the "primitive" societies being discovered through colonial conquests (Vidich & Lyman, 2003). Early anthropologists saw these new specimens of human beings as undeveloped in comparison to European individuals whose social and scientific knowledge was considered far more advanced (M. Fine, 1994). Therefore, "from the very beginning qualitative research was implicated in a racist project" (Denzin & Lincoln, 2003, p. 2).

Between the 1970s and into the 1990s, calls for reform swept across anthropology and sociology, including a growing criticism of the imperial approach to research (Denzin & Lincoln, 2011). "The political demand to honor multiple traditions and various indigenous points of view has animated the development of the methodological pluralism that now prevails" (Wertz, 2011, p. 83). Denzin and Lincoln (2011) called this period "blurred genres" (p. 3); it was a period interdisciplinary exploration, a time of significant collaboration between the humanities and social sciences. With all these distinctive perspectives being put forth, a crisis of representation occurred in which researchers began to question whose reality they were portraying. Following the crisis of representation, there were crises around legitimizing qualitative methods and around the

role of politics and values in research (Denzin & Lincoln, 2011). Morrow (2007) joins others (Gergen, 2001; Haverkamp, Morrow, & Ponterotto, 2005; Haverkamp & Young, 2007) in noting that questions about representation and credibility may have prevented the field of psychology from embracing methodological and epistemological diversity at this time, given the field's concerns about authority. This period was "[c]haracterized by concerns with social justice and a politics of liberation, action and activist research guided by cultural studies, critical race theory, feminist theory, and social constructionism" (Morrow, 2007, p. 243). In addition to expanding critical inquiry, significant methodological experimentation occurred, such as the incorporation of performance and novel ways of analyzing narrative.

Denzin and Lincoln (2011) called the period between 2000 and 2010 "the methodologically contested period" (p. 3). Political conservatism in the United States ushered in a "reemergent scientism" (Maxwell, 2004, p. 35). In the beginning of the 21st century, the National Research Council declared what sorts of evidence would be considered valid, emphasizing quantitative procedures such as randomized controlled trials, which allow for replication and generalization (Ryan & Hood, 2004). According to Denzin and Lincoln (2011), the current phase is responding to this conflict "ask[ing] that the social sciences and the humanities become sites for critical conversations about democracy, race, gender, class, nation states, globalization, freedom, and community" (p. 3).

The place of qualitative methods in psychology is much more tentative than in other social sciences (Denzin & Lincoln, 2000; McLeod, 2001), though it has not always been this way and appears to be is changing (O'Neill, 2002). Many researchers have

noted the irony in psychology being a somewhat hostile field to qualitative methods given the field's origins (Biggerstaff, 2012; McLeod, 2003). Developmental psychologists such as Piaget, as well key theorists of psychotherapy, Freud, Horney, Maslow, and Rogers (Morrow, 2007; Ponterotto, Kuriakose, & Granovskaya, 2008) all used qualitative methods such as case studies and language data to develop their theories. Kvale (1996), among others, has emphasized that the majority of psychology's clinical knowledge has come from qualitative methods.

Psychology has aligned itself with the natural sciences not only in order to establish itself as a credible discipline, but also due to funding and political pressures, especially in the US (Macarek, 2003). According to Kvale (2008), Psychology has been slow to utilize qualitative methods (also noted by Macarek, 2003; Rennie, Watson, & Monteiro, 2002), which the scholar finds particularly odd alongside the impressive use of qualitative methods in marketing research. Biggerstaff (2012) proposed that the limited use of these methods might be due to misunderstandings about them. The diversity of qualitative methods may contribute to this confusion as well (Rennie, 2012), since a multiplicity of methods exists with varying approaches to design and rigor. Madill and Gough (2008) explained, "standoffs between specialists will tend to serve the dominant, and relatively unified, quantitative methodologies" (p. 267). While some scholars worry about fragmentation (P. Atkinson, 2005), others see it as an indication of the fertile growth of the field (Gergen, 2001) broadening potential foundations of evidence (Barbour, 2000). Additionally, any effective approach to understanding the diversity human beings is going to have to represent and have space for multiple perspectives (S.

Koch, 1981). Due to methodological pluralism, Holloway and Todres (2003) encourage researchers to find a balance between flexibility and coherence in method use.

As a result of these social trends, qualitative research composes a minority of psychological research, both in doctorate and professional levels (Rennie et al., 2002). The qualitative approach is also underrepresented in educational programs in psychology, with only 10% of doctorate level psychology programs requiring its students to take a course qualitative research methods (Ponterotto, 2005c). Gergen (2001) fears "that the conception of psychological science commonly shared within the discipline is historically frozen and is endangered by its isolation from the major intellectual and global transformations of the past half century" (p. 803). Gergen and others (Barbour, 2000; Denzin, Lincoln, & Giardina, 2006) argue that a reliance on quantitative approaches is limiting psychology's potential development as a field and body of knowledge.

However, the use of qualitative methods is growing (Neimeyer & Daimond, 2001; Madill & Gough, 2008; Morrow et al., 2012; O'Neill, 2002; Wertz, 2011; Yeh & Inman, 2007) in response to calls for diversity in research methods (Haverkamp et al., 2005; Haverkamp & Young, 2007; Hoshmand, 1989; Kopala & Suzuki, 1999; Polkinghorne, 1984). This increase is particularly evident in counseling research methods (Hoyt & Bhati, 2007; Morrow, 2007; Ponterotto, 2005a). Qualitative methods and counseling share an interest in emotional and cognitive experience and use empathy to understand the individual within their context (Hill, 2005; McLeod, 2001; Ponterotto et al., 2008; Sciarra, 1999). Due to this affinity, many researchers emphasize the importance of methodological pluralism in bridging the research-practice gap (Blatt, Corveleyn, & Luyten, 2006; Talley, Strupp & Butler, 1994).

Another important role that qualitative methods can play is in multicultural research (Morrow, 2007; Ponterotto, 2005a, 2010). Ponterotto (2010) quotes the APA's (2003) Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists, which encourages researchers "to recognize and incorporate research methods that most effectively complement the worldview and lifestyles of persons who come from a specific cultural and linguistic population, for example quantitative and qualitative research strategies" (p. 389). Ponterotto (2010) emphasizes four main ways that qualitative methods help psychologists to meet the unique needs of multicultural populations. Through the use of qualitative methods, researchers display respectful interest in participants' perspectives, level power dynamics by being more cooperatively oriented, empower individuals in the face of oppressive systems, and avoid forcing people to separate elements of experience that indigenous societies understand more holistically.

Subjectivity and reflexivity. Objectivity has been a hallmark of the positivistic approach to science. The Oxford English Dictionary (2013) defines objectivity as "the ability to consider or represent facts, information, etc., without being influenced by personal feelings or opinions; impartiality; detachment." The subject-object dichotomy is tied to Descartes and his process of reflecting on his own subjective experience, as was explicated previously. In his famous dictum "I think, therefore I am," (1637/1951, 1:7) Descartes declared himself a thinking thing; a subject thinking about objects (Polkinghorne, 1989). Descartes and many subsequent philosophers, such as Kant (1998) and Nagel (1989), struggled with making sense of the ways in which subjectivity influences perception. Most researchers now acknowledge that there is something about

their own positioning that affects the research, though they vary in how they respond to subjective influence (Kvale, 1996; Rennie, 2004, 2012). Finlay (2002a) has stated, "researchers no longer question the need for reflexivity: the question is how to do it" (p. 212).

While positivists saw scientific methodologies as a solution to subjectivity, outside of the positivist and postpositivist paradigms, the value of objectivity is debatable. Ratner (2002) stated that "objectivity presupposes an independent reality that can be grasped. If there is no independent reality, or if reality cannot be apprehended, or if reality is merely the concoction of the observer, then the notion of objectivity is moot" (para. 10). If people's experience of the world is filtered through "the lens of language, gender, social class, race, and ethnicity" (Denzin & Lincoln, 1998, p. 12, cited in Polkinghorne, 2005, p. 139), then taking an objective position is more like taking a "god's eye view" (M. Fine, 1994; Putnam, 1981) or a "view from nowhere" (Nagel, 1989). A god's eye view is a theoretical viewpoint outside of human perspectives, which is impossible (Breakwell & Rose, 2006) and, from my perspective, unscientific. Knowledge can only come to a knower, an "epistemic subject", who tends to discover what they seek (Breuer & Roth, 2003, para.1).

Even if it were possible to attain such a perspective, it is not clear that it would bring researchers closer to understanding. Aluwihare-Samaranayake (2012) referenced Lerum (2001), noting that in practice, objectivity often turns out to be a sort of emotional detachment from experience and participants. Relating to people in a detached manner undoubtedly influences the information gathered; this approach could make participants feel uncomfortable sharing personal information or lead them to believe only a particular

type of information is being sought, thus skewing the data (Kvale, 1996). Nagel (1989) noted that:

> What really happens in the pursuit of objectivity is that a certain element of oneself, the impersonal or objective self, which can escape from the specific contingencies of one's creaturely point of view, is allowed to predominate. Withdrawing into the element one detaches from the rest and develops an impersonal conception of the world and, so far as possible, of the elements of self from which one has detached. That creates the new problem of reintegration, the problem of how to incorporate these results into the life and self-knowledge of an ordinary human being. (p. 9)

From Nagel's perspective, attaining objectivity is an act of splitting up the subject, separating it from its naturally embodied position. If researchers are seeking information about human existence and the societies in which people live, then this practice strikes me as both odd and inefficient. Additionally, Packer and Addison (1989) remind researchers that a distanced perspective is still a particular position in relation to the research, and so it cannot be considered objective by Oxford's definition.

Moreover, some scholars point to the presence of researcher influence in objectivist forms of inquiry. Haraway (1991, as cited in Malterud, 2001) argued that knowledge created in laboratories is incomplete and conditional. Suzuki and Quizon (2011) further highlighted this view that both quantitative and qualitative research designs are influenced by "subjective aspects…that determine not only the who, what, where, when, and how of what is to be studied but also how data are gathered, analyzed,

and interpreted" (p. 24). From these perspectives, subjectivity is a challenge for research undergone from any paradigm.

I do not believe that humans attain knowledge through a direct information transfer, like computers, but learn through experience. G. Hubbard, Backett-Milburn, and Kemmer (2001) highlight the role of participation and emotions in human's attainment of knowledge. They have noted that people cannot learn without having an experience through which learning occurs, and emotions are one of the ways that people process information. If researchers take emotions out of the equation, then access to knowledge is limited. In order to maximize understanding, Heshusius (1994) has encouraged a "participatory mode of consciousness." Instead of seeing reality as thing to be discovered, Heshusius has highlighted the ways knowledge evolves mutually through the relating of people. The researcher works with the participant as a subject, as opposed to observing them as if they were an object. Heshusius stated that taking a detached perspective on a person, separates people not just from community, but also from socially informed knowledge. Additionally, participating in social engagement is considered by Kvale (1996) to be more ethical because the value of distance is wrapped up in ideas about hierarchy, professionalism, power, and authority. Finally, distance is a particularly masculine and western value (Pederson, 1997), which may feel quite foreign and uncomfortable for people from other cultural backgrounds.

Due to the inherent inconsistencies between objectivity and the world in which researchers are seeking understanding, qualitative scholars have reconceptualized objectivity a number of ways. Ratner (2002) offered "objectivism" as an intermediary between objectivity and subjectivity, arguing, "objective knowledge requires active,

sophisticated subjective processes" (para. 8). Further, the researcher stated this concept facilitates the "highest form of respect for the participants. It respects their psychological reality as something meaningful and important which must be accurately comprehended" (para. 14). Haraway (1991, as cited in Malterud, 2001) defined objectivity as the recognition of the partial and situated state of knowledge, and the subsequent acknowledging and accounting for researcher effects. Similarly, Brinkman and Kvale (2005) quoted MacIntyre (1978, as cited in Brinkman & Kvale, 2005) in a conception of objectivity as scientists recognizing their place in community and the work's place in history.

Moreover, Kvale (2003) argued that there are different kinds of objectivity. One conception, cited from Latour (2000) is that to be truly objective a method must "allow the object to object" (Kvale, 2003, p. 291), to defend itself and disagree. According to this definition, interviews would be the most objective form of gathering data, because this procedure gives the object of study a forum for disagreeing with the researcher. Additionally, MacIntyre (1978, as cited in Brinkman & Kvale, 2005) has framed objectivity as an ethical concept, as opposed to a methodological one. Brinkman and Kvale explicated this perspective: "being ethical means being open to other people, acting for the sake of their good, trying to see others as they are, rather than imposing one's own ideas and biases on them" (p. 161). One of the things that objectivity is meant to guard against is bias, which is defined as "an inclination, leaning, tendency, bent; predisposition *towards*; predilection; prejudice" (Oxford English Dictionary, 2013). Alternatively, Stiles (1993) defined bias as "impermeability to new ideas" (p. 613), which can be balanced with permeability: flexibility and openness to differing perspectives. To

be open to new perspectives, however, a person must first be aware of the perspectives they hold, which introduces reflexivity into the dialogue.

In 1992, Rennie defined reflexivity as self-awareness that leads to action. Similarly, Finlay (2002a, 2008) has emphasized the embodied aspects of reflexivity, concerned that keeping reflection a mental event retains the distance researchers are trying to collapse through the introspective process. Finlay (2002b) underscores the complexity of reflexivity, "the researcher is aware of experiencing a world and moves back and forth in a kind of dialectic between experience and awareness" (p. 533). Further, Finlay (2002a) encourages researchers to use multiple layers of reflection: to consider personal beliefs, relational dynamics, and methodological concerns. Finally, the researcher notes that collaboration and social critique are useful avenues to revelation.

Often researchers look back on their research project once it is complete and offer perspectives in sections concerning limitations and future research. However, hindsight is not enough if the implications of subjectivity are taken seriously (Peshkin, 1988). On the contrary, Peshkin (1988) has argued researchers "should systematically seek out their subjectivity throughout the course of their research" (p. 17). For many researchers, the process of reflexivity is paramount to producing good quality research (Breuer & Roth, 2003; Finlay, 2002a, 2008; Morrow, 2005; Rennie, 2004, 2012). I agree with this perspective, which may already be clear by the periodic exploration of my subjective engagement.

Reflexivity is by no means simple, and one reason is that introspection is impacted by the unconscious (Walsh, 1996). I hold personal and cultural beliefs of which I am unconscious, which still influence my behavior and thoughts (Ellenberger, 2008;

Kihlstrom, 1987). Furthermore, The APA's most recent recommendations for reporting scientific research highlighted the powerful influence of society in stating, "long-standing cultural practice can exert a powerful influence over even the most conscientious author" (APA, 2013, p. 71). In my opinion, the issue of influence provides an argument for reflexivity, not against it. I take it as given that there are things that occur outside of human's conscious awareness, but I believe that it is possible to gain some access to previously unconscious beliefs, which is accomplished through active introspection.

The presuppositions individuals bring to research projects are very similar to countertransference in psychotherapy (Gemignani, 2011). In psychotherapy, countertransference can be the source of useful information that aids the clinician in understanding and relating to the client (Gelso & Carter, 1994). Gemignani defined countertransference as "the influence of the patient on the therapist in the here and now of the clinical relationship" (p. 705), further noting these feelings and thoughts derive from the latent expectations and interpretations of each person. In research, reflecting on these experiences is important because researchers develop meaningful and personal responses to research as it develops, and these responses influence the interpretive process and the positioning of the researcher. Gemignani notes that benefits of this process include increased self-awareness, engagement with the research and increased rapport with participants. In scientific research, as in counseling, reflecting on subjective influence provides useful and practical information (Gemignani, 2011; Rennie, 2004).

Critics of reflexivity see the practice as no more than navel-gazing or a "comfortable neurosis that will resist change at all costs" (Macmillan, 1996, p. 22, as cited in Finlay, 2002b). They argued it takes the focus away from the topic, which

should be central (P. Atkinson, Coffey, & Delamont, 2003). Finlay (2002a) is a proponent of reflexivity, while openly acknowledging the risks involved. Finlay has noted researchers much reach a delicate balance between focusing on external aspects of the research and becoming caught up in their own reflexivity in a way that prevents clear engagement with their topic. Introspection can also be a painful process in which researchers discover beliefs that are uncomfortable or shameful. Finally, the scientist indicated that it is extremely vulnerable to put the products of researcher's reflexivity in a paper for their colleagues, professors, and clients, to see. Despite the perils implicated in this process, reflexivity is an important part of conscious research (Finlay, 2002a; Rennie, 2004).

Determining rigor. Researchers often make claims, and the ability to judge the trustworthiness of these claims is important, especially when these claims impact people's lives. While determining the quality of interpretive research can be more complex than other forms of research, it is not impossible (Barbour & Barbour, 2003). Madill and Gough (2008) noted that most criticism concerning rigor in qualitative methods comes from judging them based on quantitative criteria. Interpretations are made in all types of research (Gergen, 1989). Therefore, ways of assessing whether research is credible, trustworthy, and useful are necessary for scientific inquiry to be adequately understood and taken seriously.

In the postpositivist paradigm, the "holy trinity" of validity, reliability, and generalizability are used to verify the quality of research (Kvale, 1996). Reliability is concerned with the consistency of results (Pope, Ziebland, & Mayes, 2000). A test is considered reliable if it provides the same result under different conditions, or when

administered by different researchers (Golafshani, 2003). The latter specification refers to interrater reliability and is meant to demonstrate the absence of researcher subjectivity (Golafshani, 2003). In a research pursuit that admits subjective influence, verifying the reliability of claims becomes more complicated (Angen, 2000). Researchers who work from a postpositivist paradigm respond to this concern by utilizing research teams and coding protocols in order to increase interrater reliability (Mays & Pope, 1995). However, if research is admittedly offering one of many perspectives, as it is from a constructivist-interpretivist paradigm, then replicating results is not relevant (Golafshani, 2003; Yardley, 2000). Though I agree with the constructivist response to reliability, there is research suggesting that qualitative interpretations can demonstrate a high level of agreement among coders. In 1997, Armstrong, Gosling, Weinman, and Marteau conducted a study in which they gave six separate researchers a transcript to perform thematic analysis of the data. They found that, though the themes were organized in different ways, there was significant consistency among the raters.

According to Merrick (1999), validity concerns whether the study is exploring what it is meant to explore, and the concept is broken into different components. Construct validity asks whether the constructs being used in a study relate to their represented entities. Approximating research phenomenon is a concern in all forms of research, though Kvale (1996) has argued that exploring participant meaning could provide more "valid" constructs. Furthermore, research participants have noted language offers more precision than quantitative procedures (Marecek, 2011). Marecek (2003) discussed two primary types of validity: internal and external validity. Internal validity concerns whether a study's outcome can be interpreted as the result of the intended

variables, hence the value placed on laboratory studies that control and isolate dynamic influences. External validity, on the other hand, speaks to whether or not the study's findings can usefully be applied to situations external to the experiment. Marecek (2003) stated that quantitative approaches emphasize internal validity at the expense of external validity, highlighting the unique manner in which qualitative methods attend to external validity. Participants are studied in a real life context, whereas "the laboratory setting bears little resemblance to the real world in which multiple and dynamic factors operate" (Marecek, 2003, p. 64).

Internal and external validity are tied to the idea of the generalizability of findings, which is not a primary goal for qualitative projects (Whittemore, Chase & Mandle, 2001). According to Morrow, Rakhsha, and Castañeda (2001), generalizability is a useful research purpose, but it is one of many useful purposes for research. In quantitative projects, generalizability is built on large sample sizes and statistical formulas (Fairweather & Rinne, 2012). However, given the abstracted environment of quantitative projects, Maracek (2003) argued that both types of research struggle with the generalizability of findings. Some scholars differentiate between "analytic" and "statistical" generalization in which transferability is determined by theory built by multiple cases as opposed to statistical sampling of a population (Yin, 1994). Furthermore, Stake (1995) supplements these forms of generalizability with "naturalistic" generalizability, in which personal experience is applied to future possibilities. McLeod (2003) stated that qualitative projects supplement the knowledge base through the use of replication, in which consensus is provided by multiple studies, as opposed to multiple participants. Generalizability becomes particularly problematic when discussing

multicultural issues, though generalizing is equally suspect with "white" research in a multicultural society (S. Sue, 1999). Quintana et al. (2001) argue that the transferability of research findings is more appropriate to individuals who share psychological characteristics than demographic identifications. Moreover, according to H. L. Coleman and Wampold (2003), if cultural differences are taken seriously, "examining generalizability across groups is intuitively appealing but theoretically impoverished and pragmatically impossible" (p. 231).

Scholars debate whether quantitative criterion can, or should, be used for qualitative research (Mays & Pope, 1995; Merrick, 1999; Hoyt & Bhati, 2007). Some feel that validity and reliability need to be engaged with no matter what kind of research is being done (Malterud, 2001; Mays & Pope, 1995). Guba's (1981) initial quality criteria mirrored those of the postposivist paradigm. These were credibility (internal validity), transferability (external validity/ generalizability), dependability (reliability), and confirmability (objectivity). While building connections and clarifying communication between these approaches is needed, standardized criteria are not adequate because researchers work from differing underlying paradigms (Morrow, 2005). Validity and reliability, as conventionally defined, only make sense from a realist ontology (Golafshani, 2003; Madill, Jordan, & Shirley, 2000) in which a particular world is being approximated. Thus, more appropriate criteria are needed to judge the rigor of qualitative work (Morrow, 2005; Williams & Morrow, 2009; Yardley, 2000). Trying to fit qualitative work into a quantitative approach leads to inconsistent, and subsequently unsatisfactory, research (Hoyt & Bhati, 2007; Stenbacka, 2001). Researchers often try to appeal to quantitative axioms in order to demonstrate the credibility of their work, though

commitment to the underlying paradigm and method are more likely to produce rigorous research (Caelli, Ray, & Mill, 2003; Dixon-Woods, Shaw, Agarwal, & Smith, 2004; Leninger, 1994; Mishler, 1990; Sandelowski, 1993). Yeh and Inman (2007) have encouraged researchers not to justify their research through the use of quantitative standards, as qualitative approaches constitute legitimate modes of inquiry.

Numerous models exist for assessing the quality of research. Checklists have been offered, such as those proposed by Mays and Pope (1995), to provide a clear format for researchers and readers of research. However, Barbour and Barbour (2002) argued that such a formulaic approach to rigor does not work if techniques are not applied conscientiously throughout the research process, as they see rigor as a theoretical, not methodological, issue. Additionally, the checklist and technique approach mirrors traditional approaches to credibility. Nevertheless, Mays and Pope (1995) highlighted several valuable strategies, such as including contextual information and being transparent in what techniques were used at each stage of the research. Despite much variation in quality criteria, Meyrick (2006) noted that qualitative researchers generally agree on the importance of transparency and the systematic use of method. When researchers are transparent about their work, they leave an "audit trail" (Halpern 1983, cited in Lincoln & Guba 1985), which allows for thoughtful critique by readers (Morse, 1994; Altheide & Johnson, 1994). Similarly, reflexivity is an important aspect of credible, trustworthy research through the provision of another level of transparency (Elliott et al., 1999; Lather, 1986; Merrick, 1999; Patton 2002).

A key task in qualitative work is ensuring that research claims are grounded in adequate data sources (Yeh & Inman, 2007). Morrow (2005) referenced Erikson (1986),

who proposed ways of ensuring "adequacy of data" (Morrow, 2005, p. 255). Erikson suggests that evidence attains a higher interpretive status when significant amounts of evidence are gathered from different sources. This scientist also encourages the explication of disconfirming evidence and the analysis of cases that offer divergent perspectives in order to provide a multifaceted account. These strategies employ the logic of triangulation: the use of multiple theories, data sources, or methods of analysis to increase the accuracy of perspectives, and thus credibility, of results (Biggerstaff, 2012; Patton, 2002). A similar argument can be made for including qualitative and mixed methods in the larger research conversation. Eisner (1981), in discussing the artistic and scientific aspects of research, emphasizes the importance of using both perspectives, as multiple methods allow for "binocular vision" (p. 9).

The truth-value of interpretations can also be increased through the use of "thick descriptions," which was a concept applied to qualitative methods by Geertz (1973), though according to Ponterotto and Greiger (2007) it originally came from Ryle (1971). The interpretive value of a research project is enhanced by the use of rich descriptions and examples from the data (Denzin & Lincoln, 2003; Morrow, 2005; Patton, 1990; Whittemore et al., 2001). "The aim is…to support broad assertions about the role of culture in the construction of daily life by engaging themes exactly with complex specifics" (Geertz, 1973, p. 28). When interpretations are linked with the accounts from which they arose, the reader has the opportunity to assess the interpretations. Similarly, Guba and Lincoln's (1985) "authenticity criteria" designates the degree to which the interpreted account approximates the original participant's experience.

In qualitative methods, the results of research are also a component of rigor, as the value of a study is intricately tied to its social impact (Angen, 2000; Elliott et al., 1999; Stiles, 1993; Yardley, 2000). Morrow (2005) has emphasized the importance of "social validity" (p. 253), proposed by Wolf in 1978, which refers to the extent to which the research supports societies goals, using appropriate techniques, and leads to significant social effects. This concept is similarly referred to as "catalytic authenticity" by Guba & Lincoln (1989, pp. 245-251, as cited in Lincoln & Guba, 2000), "consequential validity" by Patton (2002), "transgressive validity" by Lather (1994, p. 39), and "psychopolitical validity" by Prilleltensky (2008). This emphasis on emancipatory practice brings ethics into the center of rigorous research (Davies & Dodd, 2002; Haverkamp, 2005). While keeping these values and criteria in mind is essential to performing a credible and significant research project, Merrick (1999) reminds scientists that they "must acknowledge that these efforts neither eliminate the researcher's position of power nor obviate the fact that researchers have set up a relationship for their purposes" (p. 33). For Merrick, ethical practice requires attending to each of these factors of quality, while also acknowledging their imperfection.

Research into human life is an intricate process that is bound to produce complex results. Some find this lack of clarity to be problematic for validity, but I feel this ambiguity makes research all the more representative of real life. S. Koch (1981) quotes philosopher Russell stating:

> Almost all the questions of most interest to speculative minds are such as science cannot answer… It is not good either to forget the questions that philosophy asks, or to persuade ourselves that we have found indubitable answers to them. To

> teach how to live without certainty, and yet without being paralyzed by hesitation, is perhaps the chief thing that philosophy, in our age, can still do for those who study it (Russell, 1945, pp. xiii-xiv, as cited in S. Koch, p. 262-263).

Nagel echoes the importance of allowing complexity in existential concerns despite the experience of discomfort when the philosopher states: "there is a persistent temptation to turn philosophy into something less difficult and more shallow than it is" (1989, p. 12). I believe that most worthy endeavors are extraordinarily complex. When scientists' work involves people they must resist the urge to make their work easier or their explanations neater, and expend considerable energy honoring people's realities.

Methodology

This research was implemented using Interpretive Phenomenological Analysis (J. A. Smith, Flowers, & Larkin, 2009; J. A. Smith & Eatough, 2006; J. A. Smith & Osborn, 2003). This method has philosophical underpinnings in phenomenology, hermeneutics, and idiography (J. A. Smith et al., 2009). Interpretive Phenomenological Analysis (IPA) was developed in the UK specifically for psychological inquiry (Biggerstaff, 2012), and has been increasingly used in the fields of mental and physical health (Madill & Gough, 2008, J. A. Smith, 1996). IPA aims to explicate the meaning individuals make of their experience, and is "thus especially suited to behavioral and psychological studies that relate findings to the bio-psycho-social theories informing discourse among healthcare professions" (Biggerstaff, 2012, p. 192).

IPA is consistent with the constructivist-interpretive paradigm, offering an account of phenomena as filtered through the lenses of both participants and researcher (Fade, 2004). Biggerstaff and Thompson (2008) noted that IPA's interpretive perspective

is informed by symbolic interactionism, which sees meaning as central, though inaccessible without interpretation. Consistent with this version of constructivism, Eatough and Smith (2008) place IPA on "the light end of the social constructionist continuum" (p. 184) because the construction of experience through social engagement and language is considered alongside the powerful empirical realities of individuals. IPA's critical realist ontology supplements a constructivist sensibility with the acknowledgement that some differing constructions are a result of real external conditions such as geographical positioning, socioeconomics, race, gender, etc. (Fade, 2004). J. A. Smith (1996) has argued that IPA is especially useful in fields exploring the interaction between external entities and individuals' meaningful interpretations of these entities. Therefore, IPA can provide a useful perspective into individuals' experiences concerning social interactions with clinicians and social dynamics at large. By combining the theories of phenomenology, hermeneutics, and idiography; rich, personal, and meaningful data can be analyzed thoughtfully and thoroughly.

Idiography. According to J. A. Smith et al. (2009), the idiographic (emic) perspective focuses on particulars over generalities. Much of modern science is nomothetic (etic), focused on generalizing understanding to the level of a population or group. IPA is focused on deeply understanding and representing particular individual's experiences, and not on generalizing and abstracting individual data to a larger scale. An idiographic perspective pursues "detail…understood from the perspective of particular people, in a particular context" (J. A. Smith et al., 2009, p. 29). Idiographic understanding is often gained through case-study analysis (Stake, 1995; Yin, 1994, 2012), which was an important form of inquiry for 20th century psychologists such as

Allport and Murray (Polkinghorne, 1988; Ponterotto et al., 2008; J. A. Smith, Harre, & Van Langenhove, 1995). Allport argued for a return to psychology's founding practices of investigating on an idiographic level in order to account for the variation of human characteristics, as well as correct psychology's preoccupation with prediction (Eatough & Smith, 2008).

Case studies can provide "analytic induction" (Robson, 1993), wherein theoretical hypothesis are made based on data coming from a small number of cases. Schwandt (1997) calls this analytic generalization, which occurs when the presence of a phenomenon in a case offers evidence for the support, elaboration, or refinement, of a theory. Case studies provide indications of instance, as opposed to prevalence (Yin, 1989). These types of studies do not provide information about how likely it is that a characteristic will be present in an individual, but displays a picture of a phenomenon that exists within the larger context of the individual's experience. While a holistic view of the phenomenon is developed, the study begins from, refers to, and privileges the individual cases.

Stake (1995) differentiated between intrinsic and instrumental case studies. Intrinsic case studies focus on an individual of interest, whereas an instrumental case study uses cases to highlight an aspect of experience. Both, Stake stated, can provide a modest generalization (Flyvberg, 2006), though generalization need not be the only focus of psychological inquiry (Feagin, Orum, & Sjoberg, 1991). This study is an example of an instrumental case study method. APA (2013) noted that "case studies illustrate a problem; indicate a means for solving a problem; and/or shed light on needed research, clinical applications, or theoretical matters (p. 11). Consequently, the case study is an

appropriate method for investigating a phenomena and detecting potential resolutions to problems.

Allport (1942) hoped that a holistic case study approach would provide psychology with a "touchstone of reality" (p. 184, Quoted, in Wertz 2011). Using multiple real world examples of a phenomenon provides a type of triangulation of accounts, in which multiple viewpoints on the same phenomenon provide a nuanced and multifaceted perspective (Polkinghorne, 2005). Finally, employing case studies provides an opportunity to focus deeply on personal experiences while having the potential for hearing very different accounts, thus allowing for research that conveys both depth and breadth (Todres & Galvin, 2005).

Phenomenology. What makes IPA particularly phenomenological is its position that there is "nothing more fundamental than experience…[IPA's] primary concern is uncovering/expressing/illuminating individual subjective experience" (Eatough & Smith, 2008, p. 181). Phenomenology is the study of the lived experience of individuals and phenomena (Langdridge, 2007). Beginning with Husserl, and continuing through Heidegger, Gadamer, Merleu-Ponty, and Sartre, phenomenology has focused on what it is like to have certain experiences (Langdridge, 2007). Husserl saw an individual's experience and "life-world," or *Lebenswelt* (Husserl, 1954/1979), as the foundation of knowledge, from which scientific knowledge abstracts and builds.

Instead of abstractions being considered the most accurate, as rationalist posit, Husserl encouraged a return to things themselves, *zu den sachen selbst* (Earle, 2010). For example, for phenomenologists, the experience of sitting in a chair is more "real" than the idea of a chair. This marked a significant shift towards priviledging conscious

experience. Husserl followed his teacher Brentano in positing an intentional perspective of consciousness, in which consciousness, by its nature, relates to objects. "Consciousness is always a consciousness of something" (Finlay, 2008). This perspective closes the divide somewhat between subjects and their external worlds (Laverty, 2003; Osborn, 1990). Husserl considered meaning and subjectivity (Bradfield, 2007) to occupy an intermediary space "between an act of consciousness and its object" (Giorgi, 2005, p. 36).

Building from his theory, Husserl developed a method of inquiry that emphasizes description of phenomena, which has inspired several methods of phenomenological investigation (Giorgi, 2005, 2008, 2010; 2012; Giorgi & Giorgi, 2003; Moustakas; 1994; van Manen, 1990). Husserl also emphasized a particular approach to subjectivity, called "bracketing," in which after reflection, a researcher sets aside their presuppositions about the area of focus (Cohen, 1987; Giorgi & Giorgi, 2003; Osborne, 1990; Polkinghorne, 1983). The process of bracketing presuppositions is called "epoché" (Husserl, 1954/1979; Tarozzi & Mortarri, 1997). Once a researcher sets aside their particular relationship to a phenomenon and explores examples of it, essences can be perceived (Cohen & Omery, 1994; Hain & Austin, 2001). Husserl objected to the positivistic paradigm of his time and sought an alternative approach to inquiry that was more experiential (Cohen, 1987). Yet, Laverty (2003) noted a yearning towards certainty and objective truth in his approach to method. Husserl's method is a systematic process of intuiting essences of phenomena (Overgaard, 2003), which is referred to as "descriptive" or "empirical" phenomenology (Hein & Austin, 2001, p. 3).

Heidegger (1927/1962) was a student and, subsequently, a critic of Husserl's who furthered and modified phenomenological inquiry. According to Overgaard (2003), Husserl was committed to the investigation of intentional experience to such an extent that the philosopher tended to ignore the objects to which consciousness was relating. Heidegger (1927/1962), on the other hand, argued that phenomenological experience could not be understood without equally considering the object towards which consciousness is directed. The philosopher emphasized the way in which understanding lived experience requires its cultural, historical, and relational context (McDonald & Wearing, 2013). From this philosopher's perspective, a self or sense of consciousness is "being-in-the-world," *in-der-welt-sein,* (1927/1962), and not a separate thing from the world as Descartes had supposed (Laverty, 2003). Heidegger used *Dasein*, a German term meaning "being there" to highlight the context-specific nature of existence (McDonald & Wearing, 2013). This philosopher's focus on existence has led him to be considered an "existential-phenomenologist" along with subsequent French phenomenologists Sartre and Merleau-Ponty (Hein & Austin, 2001).

Sartre (1963) was the first French phenomenological philosopher (Cohen, 1987; Earle, 2010), though the philosopher expressed other philosophical perspectives at different parts of his career. Like other phenomenologists, Sartre denied the split between subject and object and responded to Cartesian dualism with the intentionality of consciousness (Osborne, 1990). If consciousness is always in relationship to experience, there is no mind-body problem (Sartre, 1963). Sartre criticized the positivistic paradigm for approaching the study of humans in what the scholar believed was a preposterous manner. Sartre stated:

> It was legitimate for the natural sciences to free themselves from the anthropomorphism, which consists in bestowing human properties on inanimate objects. But it is perfectly absurd to assume by analogy the same scorn for anthropomorphism where anthropology is concerned. When one is studying man, what can be more exact or rigorous than to recognize human properties in him? (1963, p. 157, as cited in Cohen, 1987)

Sartre also brought narrative, and by extension the seeds of constructivism, into the phenomenological process (I. R. Owen, 2008). The philosopher proposed that humans determine their existence through the telling of stories, linking this tradition to symbolic interactionism (Bruner, 1987). In fact, one of the main freedoms people have is to define their character through this reflexive process (P. Klein & Westcott, 1994; Rennie, 2004). Sartre believed selves and meaning are developed through this narration (Lopez & Willis, 2004), though this process can be painful and burdensome (Langdrige, 2007).

Merleau-Ponty extended phenomenology's focus on the contextual nature of understanding (Dahlberg, 2006); "man is in the world, and only in the world does he know himself" (1945/2004, xii, as cited in Eatough & Smith, 2008). Merleau-Ponty also emphasized the embodied aspects of experience (Caelli, 2000; Dalhberg, 2006; Langdrige, 2007; Larkin, Eatough, & Osborne, 2011) seeing people's embodiment as an essential part of their knowing and meaning making. Humans understand others through empathy, which is a bodily experiencing of the other (Finlay, 2005). While Merleau-Ponty's exploration of physical experience and perception could suggest a sort of "empiricism," the scholar rejected empiricism because of the belief that it distorted experience (Earle, 2010). Merleau-Ponty conceptualized existence as dialogic in nature,

with subjects and objects in an irreducible relationship described as an "embrace" (Merleau-Ponty, 1960/1964, p. 271, as cited in Finlay, 2013). There is no internal or external experience, but only experience (Giorgi, 2008, 2010; P. Klein & Westcott, 1994; Kvale, 1999). The philosopher encouraged a descriptive approach to phenomenology, following Husserl, and thought that this method could return people to "prereflective understanding" (Westerman, 2011, p. 170), a childlike state previous to scientific misrepresentations (Earle, 2010; D. Moran, 2000). Merleau-Ponty, however, did not believe that the reductive process was fully possible and noted famously that "[t]he most important lesson which the reduction teaches us is the impossibility of a complete reduction" (1945/1962, p. xiv, as cited in I. R. Owen, 2008).

Existential phenomenology has also been called "hermeneutic" or "interpretive" phenomenology because it acknowledges the potential for multiple interpretations of data (Hein & Austin, 2001). According to Hein and Austin (2001), this type of phenomenology emphasizes acknowledging preunderstandings over bracketing them. Heidegger argued that humans experience things from within their own preunderstanding (T. Koch, 1995), and thus people cannot make sense of anything without that understanding being influenced by their historicity and culture (Laverty, 2003). Heidegger and Gadamer, who was Heidegger's student and a central hermeneutic philosopher, both believed that people's use of language led to the complication, and even impossibility, of bracketing (Annells, 1996). Subjective interpretation is unavoidable. Heidegger's view is consistent with the symbolic interactionist aspects of IPA in understanding meaning as coconstructed from experience and prior understanding (Biggerstaff & Thompson, 2008; Eatough & Smith, 2008).

Considerable variation exists in research approaches to phenomenology (P. Klein & Wescott, 1994), and there is some concern that researchers using this approach are not coming from adequate philosophical positioning (Giorgi, 2000, 2010; Jennings, 1986). Unfortunately, reports of phenomenological investigations are often not clear about what type of phenomenology they are using (Norlyk & Harder, 2010). At the same time, others believe that phenomenological investigation can be approached without being grounded in an in depth understanding of its philosophical origins (Wertz, 2005). Phenomenology has become particularly common in the field of nursing scholarship (Annells, 1995; Caelli, 2000; Cohen, 1987; Earle, 2010; T. Koch, 1995), and despite arguments that the term phenomenology is being diluted (Giorgi, 2000, 2010), other researchers have argued that contemporary developments in phenomenology are extending its scope in useful and meaningful ways (Caelli, 2000). Having studied philosophy throughout my life, this approach appeals to me and gratifies my analytic nature. I am pleased that phenomenology is becoming more accessible to people because I believe this perspective offers an extremely important counterbalance to the common emphasis on abstracted experience in the mainstream scientific discourse.

Hermeneutics. The interpretive aspect of IPA alludes to the philosophical foundation of Hermeneutics, which is "the art of the technique of reading" (Van Langenhove, 1995, p. 11). This method began with Biblical interpretation, though it grew to incorporate more general questions of how to make interpretations that illuminate deeper meanings and contextual understandings (Kisiel, 1985). The focus of IPA is on the phenomenological experience of the participants, but the results of IPA are always an interpretation (J. A. Smith et al., 2009). According to J. A. Smith and Osborn (2003), the

products of IPA come in the form of a double hermeneutic, "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (p. 51). The bridging of phenomenology and hermeneutics is meant to offer rich analysis and a thorough exploration of the "totality of the person's lifeworld" (J. A. Smith & Eatough, 2006, p. 325).

The word *hermeneutic* comes from the Greek mythological tradition involving Hermes, the messenger to the gods, who was able to translate and interpret both godly and terrestrial concerns (Caputo, 1987; Moules, 2002; Vandermause & Flemming, 2011). Anytime language is involved, interpretation is required (Polkinghorne, 2005). Hermes is considered a trickster, and Freeman (2011) argued this metaphor is appropriate because language interpretation is tricky; it always has the potential to bring people further from the truth as well as closer to it. Hermeneutics can be considered a relativist (Rorty, 1985) or postmodern (Freeman, 2011) theory, as language is not believed to be a direct expression of subjectivities. Instead, Freeman emphasized, language is a medium through which sharing and construction of understanding occurs. The focus of a hermeneutic inquiry is also in this intermediary space, in the interplay between a subject and their situation (Kisel, 1985). A hermeneutic perspective often incorporates an awareness of how language is being used in the reporting or application of such inquiry (Freeman, 2011; Packer & Addison, 1989). For example, Steele (1989) encourages hermeneutic researchers to maintain awareness around the ways that language is being used to shape or frame results, as well as the manner in which words designate relationships between participants, researcher, phenomena, and audience.

A primary tenant of hermeneutics is that understanding and interpretation are circular (Addison, 1989). Humans understand through interpretations and they come to interpretations as a result of their previous understanding. An individual's personal and social history designates their "interpretive horizon" (Gadamer, 1960/1989), which represents both what humans have access to understand as well as the limits of that understanding. Packer and Addison (1989) illustrated this concept with the metaphor of a clearing in a forest in which, where a person stands determines what is seen and hidden, though people have some control over their point of reference (Packer, 1985).

The "hermeneutic circle", which was first conceptualized by Ast (I. R. Owen, 2008) and later picked up by Schleiermacher and Heidegger (D. Moran, 2000), refers to the process of moving back and forth between the particulars to the whole (L. M. Brown, Tappin, Gilligan, Miller, & Argyris, 1989; I. R. Owen, 2008; T. B. Smith, 2009). The researcher projects themself forward into an experience to establish a perspective and the reverse arc signifies the process of reevaluation and assessment (Packer & Addison, 1989). Some researchers (Conroy, 2003; Kvale, 1996) have reframed the hermeneutic circle as a spiral, including the part-to-whole movement while emphasizing the continual deepening into the subject matter.

As noted previously, Gadamer believed in critically engaging with prejudices over bracketing them (I. R. Owen, 2008). The philosopher meant to rescue the word prejudice from its negative connotation (R. J. Bernstein, 1985; Dobrosavljev, 2002) and used the word to express the way in which people are initially directed towards experience (Gadamer, 1960/1989). Gadamer thought that "[t]o try to eliminate one's own concepts in interpretation is not only impossible, but manifestly absurd" (1960/1989,

p. 397). According to Gadamer, prejudice allows humans to understand and "understanding cannot be separated from self-understanding" (Misgeld & Jardine, 1989). Therefore, hermeneutics endorses a subjectivist empiricism in which individuals learn about the world through their subjectivity. Gadamer emphasized the historicity of human's understanding and the importance of tradition in this process (B. H. Clarke, 1997). According to Smyth and Spence (2012), the literature review process can be an important part of hermeneutic positioning, in which contemporary knowledge builds from historical perspectives.

In highlighting the temporal nature of understanding, Gadamer took knowledge out of an eternal fixed state and made it more practical and human (Dubrosavljev, 2002). Interest is paid to everyday aspects of existence, with an awareness of the researcher's socio-historical positioning (Moules, 2002). Hermeneutics is highly contextual and relativist; regarding each person's existence as framed by their own particular horizon of understanding (L. M. Brown et al., 1989; Elliott, 1989). A hermeneutic researcher is not interpreting an object, but "the relationship between what is mine and what is other, between the present and the past, which initially bring each other into relief through contrast, and ultimately blend into each other in a meditation that expands one's horizons" (Kisiel, 1985, p. 9). For Gadamer, the interpretive process entails a "fusion of horizons," in which multiple perspectives offer many vantage points (T. Koch, 1996). At the same time, Weiner-Levy and Popper-Giveon (2012) highlighted the ways in which research does not always result in merging horizons, and recommends holding an open and curious approach to the situations in which this merging is more difficult.

Understanding, from a hermeneutic perspective, is relational (Schwandt, 1999). The conversation in which understanding takes place is an important part of the construction of understanding itself (Freeman, 2011; Hollinger, 1995). According to R. J. Bernstein (1985), Gadamer emphasized the dialogic nature of knowledge when the scholar clarified the conditions under which understanding most usefully takes place. Further, R. J. Bernstein noted, the relationship is what allows for the development of new and surprising ideas, since conversation is not predetermined. Empathy is needed both to elicit information and to engage with differing perspectives (Freeman, 2011). This relational approach encourages a holistic approach to the person, supporting a complex perspective on human phenomena through attending to the variability of subjective experiences (I. R. Owen, 2008).

Critiques of hermeneutics focus on the difficulty of determining the validity of an interpretation, echoing a positivistic striving towards objective measures (B. H. Clarke, 1997). For example, Spence (1989) expresses a concern that hermeneutics uses metaphors and insinuates causal laws from symbolic, and thus not testable, relationships. However, these critiques may not be a concern if researchers are not making causal claims or putting forward universal truth. From a hermeneutic perspective, a true interpretive account is one that helps us, and the people researchers study, to further relevant concerns (Packer & Addison, 1989; Polkinghorne, 1984). Some hermeneutic researchers direct this practical engagement with the world towards social justice (Steele, 1989). "[E]mancipatory knowledge increases awareness of the contradictions hidden or distorted by everyday understandings, and in doing so it directs attention to the possibilities for social transformation inherent in the present configuration of social

processes" (Lather, 1986, p. 259). In acknowledging historical traditions, Gadamer is not requiring their continuation but encouraging us to bring awareness to aspects of life usually taken for granted (Packer & Addison, 1989).

Gadamer was uninterested in creating a hermeneutic method, as earlier interpretive theorists Schleiermacher and Dilthey had worked towards (Moules, 2002). Gadamer argued that there is no method that leads easily to objective truth (1960/1989), though the scholar proposed that the hermeneutic perspective allowed for the pursuit of knowledge and progress (Ingram, 1985). Various contemporary scholars have made attempts to create methods based on hermeneutic ideas (Addison, 1985; Conroy, 2003; Packer & Addison, 1989; T. B. Smith, 2009). Common to all of these models is part-to-whole synthesis, immersion in the participant's experience, and an acknowledgement of the contextual positioning of both researcher and researched. IPA emphasizes these tenants, believing that there is something of value in any experiential phenomena that can appear through adequate facilitation and interpretation (J. A. Smith et al., 2009).

Participants

Interpretive Phenomenological Analysis encourages researchers to work with a small and homogenous sample in order to fully explore the specific phenomena in question (J. A. Smith et al., 2009; J. A. Smith & Eatough, 2006; J. A. Smith & Osborn, 2003). Due to the idiographic nature of IPA, the focus is on in-depth understanding of individuals' experiences and not on providing a statistical sample of populations. Therefore, participants were selected purposefully (Morrow, 2005; Patton, 2002; Polkinghorne, 2005) with criteria designed to fully investigate the experience of lesbian women and gay men in therapy with heterosexual clinicians. Due to the study's focus on

the particulars of human experience, small sample sizes are best suited for this enterprise (Eatough & Smith, 2008). J. A. Smith et al. (2009) recommend three to six participants, with an understanding that including a larger sample size of eight can be done as long as attention continues to focus on quality over quantity.

In this study, seven participants were selected purposefully with the inclusion criteria of identifying as gay, lesbian or bisexual, having been in therapy for at least two months with a heterosexual clinician, and having done therapy with at least one other clinician. Requiring participants to have worked with another clinician is intended to enhance the data by providing material for participants to compare and contrast. Similarly, the criterion of having been in therapy for a minimum of two months is designed to increase the likelihood that clients have had adequate involvement with this therapist to provide rich descriptions of their experience. I would like to acknowledge that having any time requirement could skew the results, excluding the experiences of individuals who left treatment quickly due to discriminatory experiences. However, this did not seem to be the case, with many participants discussing additional therapy experiences that were brief due to inadequate cultural knowledge and understanding. Influences of this and other sampling choices will be revisited in the discussion chapter.

The criteria of having worked with a heterosexual therapist was determined by the client's perception of the therapist's sexual orientation, as opposed to choosing clients whose therapists have disclosed their sexual orientation directly. Because the focus of this study is on the client's experience, I feel that the client's perception of the clinician's orientation is most important. This choice has currently unknown implications for the

information gathered, as does every choice in research design. To enter into an inductive study, however, it is essential to try not to impose assumptions of meaning as much as is possible and to focus on the participants lived-experience (Kral, Burkhardt, & Kidd, 2002). Using minimal exclusion criteria is consistent with this intention.

In quantitative research, a sample is meant to represent the larger population so as to allow for generalization, though in qualitative work, generalization is not the goal (Fade, 2003). Nonetheless, assumptions are still made based on the data, so it is important create samples that can represent the researcher's intended phenomena (J. A. Smith et al., 2009). It is important to acknowledge that this study concerns consumers of psychotherapy and thus may not be applicable to other LGB individuals. I am purposefully sampling a clinical population, individuals who have sought therapeutic services. Early research made assumptions about the larger LGB population based on findings from clinical populations, leading to a pathological impression of this identity (Morin, 1977). While it is not my belief that engaging in psychotherapy precludes health, research findings are best considered within the context of their sampling context.

Significant sampling issues have characterized research with the LGBT population, contributing to biased results and discriminatory practices (Meyer & Wilson, 2009; Moradi et al., 2009). Early research studied prison and clinical populations, providing findings that emphasized the pathological nature of "homosexuality" (Morin, 1977). In contemporary research, limited and unrepresentative samples continue to distort scientists understanding (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000).

Having a clear sense of a population facilitates appropriate sampling, which is particularly complicated with LGB individuals because accurate demographic information about a continuum of orientations is difficult to access (Meyer & Wilson, 2009). Frequently in studies, descriptive categories are offered to indicate the presence of diversity, though these identities are implicitly assumed to designate psychological similarity (Phinney, 1996). In practice, there is tremendous variability within sexual orientation identification (Moradi et al., 2009). Using the terms *lesbian*, *gay,* and *bisexual* suggests much clearer sexual orientation distinctions than there are in reality. Many scholars note that defining sexuality is very complicated (Binson, Blair, Huebner, & Woods, 2007; Dowsett, 2007; Meyer & Wilson, 2009, Moradi et al., 2009). According to Meyer and Wilson (2009), definitions can be based on behavior or thoughts, and are periodically qualified by time periods during which a particular fantasy or act occurred. Identity labels vary across geographical location, cultural association, and generations (Meyer & Wilson, 2009), in addition to not being stable over time in the same individual (Lowe & Mascher, 2001). Furthermore, sexual orientation relates to intersecting dimensions of identity such as gender, sex roles, and gender expression (Moradi et al., 2009). I do not feel it is my place to define another person's sexuality for them. As such, I will be working with the participant's identifications.

Bieschke et al. (2000) and Dowsett (2007) encourage researchers to seek out more inclusive samples, including bisexual and transgendered individuals. Bisexual participants were included in this study, and these participants described a complex experience of being sexual minorities who have, at times, experienced prejudice from other sexual minorities. Individuals who identify as transgendered were not included in

this study. While these individuals are included within the larger community of sexual and gender minorities (LGBT), I do not feel I could do justice to the intricate gender dynamics with a small sample size. Furthermore, while gender will invariably influence participants' experiences, I feel it is most appropriate for this study to focus on orientation dynamics in therapeutic relationships. Nonetheless, two participants of this study were in relationships with transgendered individuals who transitioned in the context of their relationship, which provided interesting reflections on the role of gender and visibility on queer relationships as influenced by gender transitioning.

In addition to these groups, Bieschke et al. (2000) and Dowsett (2007) encourage researchers to create samples representing cultural, socioeconomic, and experiential diversity. This recommendation is in response to a tendency in research for samples to consist primarily of white and highly educated individuals. Using samples that are biased in such a manner skews research about and understanding of the LGB community and perpetuates an unfortunate separation between white LGB individuals and LGB people of color (Lowe & Mascher, 2001; Phillips, Ingram, Smith, & Mindes, 2003). Lowe and Mascher (2001) stated that this division relates to a tendency for people who are oppressed on a particular dimension to identify with coexisting dimensions of privilege. This results in communities of color tending towards heterosexism and LGB communities being less welcoming towards LGB people of color. While I strove for a culturally and experientially diverse sample, a small sample cannot represent the diversity that exists in the world or in the LGB community and this sample was limited by its reliance on collegial networks.

Meyer and Wilson (2009) argued that sampling LGB people involves particular challenges. Thompson and Phillips (2007) noted that it is difficult to sample groups with nonassociative members due to practical issues around how to make contact with them, as well as psychological challenges concerning their level of comfort seeking out engagement. "Volunteer bias" describes the phenomenon that research tends to interview individuals who are willing or interested in being interviewed, thus skewing the data to reflect a particular perspective (Meyer & Wilson, 2009, p. 26). The reasons for an interest in being interviewed can be multiple and depend on the study, though it is suggested that individuals who are extroverted or open to new experiences are most likely to respond (Dollinger & Leong, 93; Rosenthal & Rosnow, 1975). Enrolling individuals in this study requires people to identify themselves as lesbian or gay. As a result, willingness to participate could relate to participants' level of comfort being open with others about their sexual orientation. While outness is still considered a milestone in identity development for LGB individuals, individuals who declare a public LGB identity only comprise a subset of the population of LGB individuals (Diamond, 2005). Furthermore, the history of discriminatory practices in scientific research towards the LGB population may influence individuals' comfort and trust discussing their identities (Dowsett, 2007).

I advertised this study at a local LGBT community center message board and through a network of colleagues. Unfortunately, I did not receive any interest in the study through the community center. This may be due to aforementioned suspicions about involvement in research, have something to do with who has access to the services offered there, or individuals' comfort with discussing personal experience. There was,

however, considerable interest in involvement through collegial networks. Participants discussed feeling excited about this research and wishing to contribute their experiences to inform competent practice with this population. This resulted in a distinctive sample, in so far as it includes four professional therapists and consists of highly educated adults in their 30s and 40s. Limitations and benefits to this will be discussed in the discussion section.

In order to protect the confidentiality of my participants, their accounts will be presented under pseudonyms. I will also modify aspects of their identifying characteristics that are not essential to expressing their experiences to further disguise their identities. I will provide a general introduction of the participants here and in the results section their quotes will be contextualized with relevant aspects of their identifying information. This sample included two gay men, two lesbian woman, and three women who identified as queer, with ages ranging between 30 and 48. Four participants identified as Caucasian, two as biethnic, and one as Latina. Geographically, participants lived on the east and west coast, with a few participants growing up in the Midwestern and Southern regions of the US. Participants discussed between two and five therapeutic experiences, with five of the participants discussing experiences with both heterosexual and sexual minority therapists and two participants discussing experiences with multiple heterosexual therapists. Participants hold graduate degrees, and are employed in middle class occupations such as academia, psychotherapy, and personal fitness. While this contributed to articulate interviews, it raises the importance of conducting future research on a more experientially and culturally diverse sample.

Many sampling issues concern whether researchers can make statements concerning the larger population based on a study. However, the research design I am following is not intended to make claims about the entire population of LGB men and women. Modest implications will be put forward, and great care will be taken to specify under what conditions application of findings could be useful. Sampling strategies also concern increasing ethical and respectful treatment of individuals and bringing awareness to how information may be used by readers. I will take into consideration how each choice I made will affect the process and product of the research.

Account Collection Procedures

Semistructured interviewing is the primary mode of gathering data for IPA specifically (Brocki & Wearden, 2006; J. A. Smith & Eatough, 2006; J. A. Smith & Osborn, 2003), and qualitative methods generally (Madill & Gough, 2008; Polkinghorne, 2005). Interviewing offers rich descriptions from the participant's perspective, and semistructured interviews allow the researcher to follow lines of thought that the participant deems important, as opposed to imposing the researchers predetermined theory (Rubin & Rubin, 2005). This procedure is in line with IPA's focus on the participants lived-experience and promotes a collaborative approach to the material (J. A. Smith et al., 2009). Furthermore, semistructured interviewing enables participants to be "conversational partners" (Rubin & Rubin, 2005), active and guiding influences in the interview.

Interviewing has been an important form of data collection since World War II when surveys began exploring popular opinion and, suddenly, regular people's ideas and opinions were considered valuable (Kvale, 1996). According to Mishler (1984),

definitions of interviewing from the 1950s into the 1980s often emphasize obtaining knowledge from another person through verbal communication. Interviews were then used by behavioral psychologist and were often framed as sequences of stimuli and response (Mishler, 1984). With constructivist and postmodern shifts in the second half of the 20th century, interviews began to be seen as a coconstructed experience, with more emphasis being put on the dyadic nature in which this exchange occured. Mishler (1984) describes interviews in the following way: "interviewers and respondents, through repeated reformulations of questions and responses, strive to arrive together at meanings that both can understand" (p. 64). This perspective highlights the agency and importance of interview participants in the attainment of knowledge. Following this shift, Polkinghorne (2005) and others (McLeod, 2001; Van Manen, 1990) use the word *accounts* instead of *data* to step away from language that has connotations of sterile or neutral research. I will henceforth be following this practice.

According to P. Atkinson and Silverman (1997), an "interview society" (p. 309-315) has been created through media. They have argued interviews have become romanticized in promising a pure, unmediated, and authentic perspective. With the abundance of reality television and talk shows, interviewing has also become a pathway to some degree of immortality for the interviewee. P. Atkinson and Silverman encouraged researchers to remember the way in which interviews are technologies for constructing and performing selves. They note a tendency for researchers to equate the selves that are revealed to unobstructed truth. This fantasy of privileged access to meaning is as powerful as positivist fantasies about objectivity. Nonetheless, as this

research is exploring individuals' constructions of meaning, I feel this account collection procedure is consistent with the research goals.

Interviews are often considered a collaborative approach to gaining information (Kvale, 1996; Gubrium & Holstein, 1995). While Kvale (2006) agreed that they could be progressive and egalitarian, the scholar reminds us that the interview situation can still be a tool of dominance, both explicitly and implicitly. Explicitly, interviews can be used for the purpose of interrogation or for the purpose of collecting information about people's consumer practices. Interviews are widely used by market research where the accounts collected are used to manipulate and control people's purchasing habits (Kvale, 2006). Implicitly interviews can be used to obtain highly personal information from people, with the potential of leaving them feeling exposed or manipulated.

The idea that interviewing is automatically collaborative can lead qualitative researchers to use strategies to obtain more information than individuals may otherwise feel comfortable revealing (Brinkman & Kvale, 2005). T. Miller, Birch, Mauthner, and Jessop (2012) raise concerns about the manipulative process of "faking friendship" (p. 108), in which researchers can use their empathic skills in a manipulative manner. Many researchers thus emphasize the importance of acknowledging the implicit power dynamics at play in this work (A. Clarke, 2006; Gubrium & Holstein, 2002; Kvale, 2005). Interviewers get to choose the time, place, purpose, and beginning tone of the interview, as well as control how the accounts are organized and shared with a wider audience (Briggs, 2002). Interviewing can provide complex and personal accounts, but this procedure also can create complex ethical issues (Allmark et al. 2009). These will be explored at length in the section concerning ethics.

Researching can also pose risks for the researcher, especially when working with vulnerable populations or researching sensitive matters. Bahn and Weatherill (2012) notes that risks to researchers involve emotional distress as well as potential physical harm when interviewing individuals in unfamiliar locations. The tendency for qualitative research to give voice to emotional concerns has led some researchers to call this type of research "emotion work" (Dickson-Swift, James, Kippen, & Liamputtong, 2009). In particular, the affective intensity of qualitative inquiry can lead to role confusion for researchers with experience working as therapists (Kvale, 1999, 2003; Haverkamp, 2005; McLeod, 2001). While many therapeutic skills are useful in research interviewing, Polkinghorne, (2005) has recommended researchers keep in mind the different goals and role expectations. Clarifying these boundaries with participants is important because they may be coming to the interview with expectations about receiving advice or therapeutic support (Haverkamp, 2005).

The semistructured interview approach offers flexibility wherein the researcher can use follow-up probes to explore the participant's perspective (J. A. Smith & Osborn, 2003). IPA acknowledges that the most important material is often unexpected to the researcher (J. A. Smith et al., 2009). Therefore, structured interviews would be ill suited for the exploration of participant meaning. J. A. Smith and Osborn (2003) have found that semistructured interviewing tends to facilitate strong rapport with participants, which may lead to further disclosure on their part. An interview schedule was created in order to designate the main areas to begin exploration, and was composed of 10 questions. Few questions were prepared in order to allow agency and space for the participant to direct

the interview. While participants and I discussed the topics reflected in the interview schedule, I followed the participant's process, which led to variant interviews.

Quality criteria for interviewing include preparing short questions that lead to long responses from participants and spending time in the interview verifying and clarifying interpretations (Kvale, 1996). Clarifying the researcher's interpretation and impression during the interview is an important way to check the accounts with the participant. Morrow (2005) recommends deepening engagement with participant accounts by taking the stance of a "naïve inquirer" (p. 254). This clarification process can also be a way to actively seek out disconfirming evidence, which is fundamental to rigorous research (Denzin, 2009; Morrow, 2005; Morrow et al., 2001; Ponterotto & Greiger, 2007; Pope et al., 2000).

J. A. Smith et al. (2009) recommend preparing for potential challenges in the interview process. Establishing trust and rapport may be difficult with some clients given the history of abuses the field of psychiatry has perpetrated towards the LGB population and my status as an outsider. I felt that being open about my sexual orientation and interest in the treatment of LGB individuals was important in order help participants feel safer sharing with me, and several of the participants had knowledge of my sexual orientation. Asher and Asher (1999), heterosexual researchers working with lesbian women, found that being transparent about their identities and goals assuaged participant concerns about their intent. Their perspective was that being open demonstrated willingness to share vulnerability with participants, which led to increased openness on the part of participants. Attempts were made to utilize open and unbiased language, including using the participant's words and chosen identifiers during the interview. This

research concerns personal topics relating to individuals identities, relationships, and sexual practices. Working with sensitive topics, it is crucial to operate from a perspective that recognizes the participants' contribution as valuable and offers them space to explain their experience (Ponterotto, 2010).

Developing rapport and comfort is an important step to obtaining quality information in interviewing, especially when exploring personal topics (Kvale, 1996; Seidman, 1998). While limitations to interviewing colleagues will be discussed in the discussion section, having previous rapport with some participants appeared to facilitate expressive and thorough interviews. Seidman (1998) recommends that to obtain deep meaningful accounts, three interviews are best: one to introduce the researcher and gain background on the participant, one to gain insight on the topic, and one to debrief and check the researcher's preliminary interpretations. Scheduling multiple interviews appears to be an ideal approach. However, I was concerned about the burden multiple interviews places on the participant (Barbour, 2001; Bloor, 1997). Therefore, I followed Seidman's recommendations in a modified manner. Participants and I had an introductory conversation over the phone in which we discussed informed consent, roles, boundaries, and expectations. In this conversation, I addressed any questions that participants had and attempted to begin building rapport. While some participants did not have questions at this point, I tried to convey openness to subsequent inquiry, in case questions arose during the research. Participants and I then scheduled and conducted the semistructured interview, which lasted between 60 and 90 minutes. Finally, I checked in with participants a week after the interview, in order to debrief and follow up on the experience.

Most of the interviews were conducted in person, although three occurred over Skype due to geographic distance. While I prefer to interview people in person, as in person interviewing provides more in the moment contextual cues for both parties (Irvine, Drew, & Sainsbury, 2013), I felt that Skype interviews provided visual cues while increasing access to a wider range of participants. In one instance, connectivity issues influenced communication facility in one part of an interview, but generally I found that interviewing with a webcam approximated in-person interview experiences. Taking all the aforementioned issues into consideration, I believe semistructured interviewing was an effective way to collect rich, personal, and participant-centered information on this topic.

Recording and Analysis

After interviews were completed, they were transcribed. Transcription is generally considered a mundane and straightforward process of copying of accounts from one form to another, and is often mentioned briefly in research reports (Bird, 2005; Tilly, 2003). This approach to transcription makes sense from a realist ontology in which scientists are recording external, universally observable events. However, transcribing can also be considered an interpretive act (Bird, 2005; Lapadat & Lindsay, 1999; Kvale, 1996; Tilly, 2003). From a constructivist lens, the transcription process is the creation of a text, meant to represent a conversation in a decontextualized form (Mergendoller, 1989). The recording process is impacted by theories held by the researcher and is framed by the researcher's choices about when the recording begins and ends (Kvale, 1996) and how to communicate silence, sounds, and other nonverbal communications (Hammersley, 2010). I transcribed all audible aspects of the interview, taking notes in

the margins about emotional cues that I witnessed or heard upon reviewing the recording, such as pauses and tone of voice. However, in the quotes I will present in the results section, I have omitted words such as *um* and *like* because I felt that they detracted from the meaning of my participants.

The act of recording also influences the interview experience (Kvale, 1996; Mishler, 1991). Recording changes the quality of performance for both participant and researcher (P. Atkinson & Silverman, 1997; Gubrium & Holstein, 2012) and symbolizes the presence of an onlooker, foreshadowing the presence of an audience. Researchers often assume that once transcription has occurred, analysis begins. On the contrary, Lapadat and Linday (1999) argued that the transcription process provides the first level of analysis. They experienced the transcription process as a phase during which understandings arise and preliminary interpretations take place. The danger in seeing transcripts as a direct copy of an event is that these interpretations could be made unconsciously.

IPA recognizes that phenomenological research is always a double hermeneutic; products of research are the researcher's interpretation of the participants experience, which is itself interpreted (J. A. Smith & Eatough, 2006). While IPA emphasizes that their analytical procedure can be done a number of ways, J. A. Smith et al. (2009) have offered a protocol for researchers to follow. They remind the researcher, however, to use these as guidelines and make sure to modify them in any manner that furthers the primary goal of analysis, which is deep immersion in the case. IPA utilizes a form of thematic analysis, in which patterns of meaning are recognized and then organized based on their interrelationships (Braun & Clarke, 2006; Madill & Gough, 2008; Miles & Huberman,

1994; J. A. Smith & Eatough, 2003). I followed the guidelines of IPA as illustrated in J. A. Smith et al. (2009) and attended to recommendations from the literature on increasing interpretive rigor.

In accordance with the idiographic focus of IPA, analysis began with thoroughly reading and identifying themes in one case. Subsequently this process was repeated for each interview, in the order in which they occurred. After a close reading of each account, I recorded initial notations on the descriptive, linguistic process, and conceptual aspects of the interview during separate readings (Fade, 2004). Careful attention was given to the coding closely representing the participants' account. Themes were identified using the participant's language and then organized in terms of their relationship to other themes expressed in the interview. These steps were executed with each case, followed by an exploration of patterns across cases (J. A. Smith et al., 2009). Procedures and steps taken with the accounts were documented in order to demonstrate rigor and transparency (Yin, 2003). Additionally, attempts were made to maintain consistency in coding throughout different cases to increase the value of the constructed results (Gibbs, 2007). However, this aim was balanced with an attention to the nuances between cases and a continual process of refining language to more accurately reflect participant meaning.

While these steps appear to be linear, the process of analysis of qualitative data is quite iterative (Barbour & Barbour, 2002; Biggerstaff & Thompson, 2008, 2012; Lyons & Bike, 2010; W. L. Miller & Crabtree, 2008; Reid, Flowers, & Larkin, 2005). The processes of observing, clarifying, interpreting, rephrasing, reinterpreting, and stepping back to assess interpretations occurs cyclically. Grounded Theory (see Glaser & Strauss,

1967) is the most commonly used qualitative analysis strategy, in which a structured process of induction and deduction provides the foundation for theory development (Morrow et al., 2012). However, this research project is not aiming at developing a theory, but on exploring experience. Therefore, analysis will be done using an inductive approach, in which findings are made based on collected accounts (Creswell, 2009). This process is still quite complex, because inductive analysis requires a simultaneous attention to generalities as well as particulars, and a balance between theories, experiences, and novel perspectives (Packer & Addison, 1989).

In addition to the capacity to analyze from varying levels of specificity, "empathic immersion" in the participants experience is key to analysis (Wertz, 1986). Wertz also recommends the processes of magnification, comparison, distinguishing components and suspending belief as ways of deepening analysis. J. A. Smith et al. (2009) recommend that empathic engagement be balanced with critical questioning. In analysis, a researcher seeks an empathic understanding of the participant's experience, while remaining curious about the participant's constructed meaning. Packer and Addison (1989) have emphasized that keeping an open analytic attitude involves the capacity for tolerating ambiguity in order to avoid premature interpretations. A wish for certainty and explanation can lead researchers to grasp at assumptions that are more likely to express their own perspective than the participant's. Developing a capacity for uncertainty has been a significant part of my clinical training as well. It prevents the imposition of theory onto other people's experiences and, therefore, increases the client's agency on insight that is developed in the context of the therapeutic relationship.

Knowing when to begin actively interpreting is a similar issue to knowing when to declare the interpretive process complete. Many scholars note the standard of "saturation," originally put forth by Glaser and Strauss (1967), as the indication that the interpretive process is complete (Elliott et al., 1999; Henwood & Pidgeon, 1992). Saturation occurs when no new information is found that has not already been accounted for in the analysis. Hein and Austin (2001) questioned whether this level of redundancy is possible in phenomenological analysis. Saturation is difficult due to the unique nature of individuals (Morrow, 2007). In this research, I sought a balance between interviewing enough individuals to develop thematic saturation, while remaining faithful to the in-depth idiographic perspective.

As discussed previously, rigor in qualitative analysis is assessed differently than in quantitative research, due to its particular paradigm and the nature of the content being analyzed. IPA acknowledges that the product of research is one researchers interpretation and not an absolute or universal truth. J. A. Smith et al. (2009) have noted that the goal is to provide a credible interpretation, not to provide the only true interpretation. However, in order to ensure that the interpretation comes out of and relates to the participant's phenomenological experience, I will use participant checks. This procedure, which is somewhat controversial, involves sharing an account of the analyzed interview with the participants to assess the accuracy of representation (Finlay, 2008). Many researchers use this practice in order to increase the likelihood that what is reported reflects the participant's perspectives (Elliott et al., 1999; Yeh & Inman, 2007). Conversely, some scholars worry that this task places unnecessary demands on participants, which could be experienced as a burden (Barbour, 2001; Bloor, 1997). I

plan to make this verification optional, giving the participants the choice whether or not to respond. Four of the seven participants participated in the review process, with all approving of the initial thematic structured and expressing interest in the product of the research.

Researchers can validate their results with participants in a number of ways: verifying the transcription, sharing interview accounts that have undergone some analysis to make sure the research is on the right track, or corroborating the final analysis. As is the case with all aspects of research, each choice has strengths and challenges. I shared the preliminary thematic structure that was drawn from the accounts along with the participant's quotes that reflected each theme. I gave the participants context for this process, explaining that the themes are conclusions drawn across participants, and as a result, some themes may not directly apply to their interview. However, I let participants know that for those themes that were reflected their interview, I encouraged them to inform me if they felt their theme, or the organization of it, misrepresented their experience.

While I worked to ensure that I reflected their experience as faithfully as possible, the product of the research reflects my interpretation of the accounts. A researcher will invariably construct a different interpretation of an account from a participant. Court and Abbas (2013) have indicated that a balance should be sought between trying to represent the participant's experience and taking responsibility for the interpretation a researcher has provided. IPA theorists Eatough and Smith (2008) note that the different perspectives can be conceptualized as two levels of interpretation. At times, researchers take an empathic approach to representing the participant's perspective, while at others, a

"critical hermeneutics" occurs, in which the researcher makes interpretations beyond those of the participant.

In order to provide a balanced view of the information, discrepant accounts have been included (Creswell, 2006). Because humans have an innate tendency to seek out information that confirms their perceptions (Nickerson, 1998), rigorous researchers actively seek out perspectives that provide alternate accounts (Morrow, 2005). I find working from a constructivist-interpretivist paradigm makes it is easier to be transparent about conflicting accounts, because successful research does not require that all of the respondents respond in the same way for the results to be useful. I believe that a useful finding of this research is the considerable diversity around what participants appreciated and looked for in a therapeutic relationship, which will be reflected upon in the discussion chapter.

Reflection on my involvement in the accounts created is also a crucial aspect of rigor (Yeh & Inman, 2007). From the perspective of IPA, everything is contextually situated, and thus subjectivity is unavoidable (J. A. Smith et al., 2009). I believe it is essential that researchers maintain awareness of the ways in which they are bringing their assumptions and beliefs into a research project. As a result, I will be documenting my experience and reactions with memos throughout the research process so as to consciously assess my subjective engagement with the topic. The results of this reflexivity will be discussed when relevant, as I have already done with respect to my interest in this research topic. The research presented will be my interpretation of the accounts provided, though a thoughtful and rigorous interpretation.

Finally, I will be following Herek, Kimmel, Amaro, and Melton's (1991) guidelines for avoiding heterosexist assumptions in psychological research, which includes directives on defining constructs, language use, literature reviewing, and participant treatment. Their primary recommendation is for researchers to demonstrate and acknowledge that experiencing sexual attraction towards those of the same gender, or multiple genders, is as healthy and normal as different-gender attractions. Finally, Herek et al. recommended securing a diverse sample, framing questions in unassuming ways, and disseminating the results in a manner that are not likely to be interpreted as pathologizing nondominant expressions of sexuality.

Clinical Application

Qualitative research has much in common with counseling, which makes it a useful approach to questions about clinical work. Qualitative methods tend to come from paradigms that acknowledge the presence of significant human variance and the importance of symbolic meaning, both important values in clinical work (Hoshmand, 1989; Ponterotto, 2005b). Researchers who are practicing clinicians may feel congruence with the value placed on the research relationship, close attention to resulting ethical concerns, and sensitivity to the role of language (Heppner, Kivlighan, & Wampold, 1999; Yardley, 2000). Rennie (1989) notes that clinically relevant research is likely to come from approaches that mirror aspects of clinical engagement such as attention to intersubjective dynamics and theories integrating multiple dimensions of experience. M Smith (2001) echoes this sentiment recommending researchers to investigate "humanly significant problems with methods chosen or devised with intelligent flexibility to fit the problems being pursued" (p. 443). Additionally, qualitative methods are argued to be

useful exploring process-oriented phenomena, such as psychotherapy (Hill, 2005; Hill, Thompson, & Williams, 1997). At the same time, qualitative approaches may have skills and concepts to offer to counseling practice, such as expanded ways of listening (Bradfield, 2007) and an increased awareness of the implicit power dynamics at play (M. Fine, 1994).

Phenomenology is particularly usefully in exploring clinical issues because small samples provide rich descriptions of the individual's experience (Hoyt & Bhati, 2007; Hoshmand & Polkinghorne, 1992; Osborn, 1990). The empathic engagement required by phenomenological investigation is a fundamental skill in psychotherapy, implicitly acknowledging both the interconnected and separate aspects of experience (Bradfield, 2007). Further, psychotherapists and phenomenological researchers share a keen interest in the experience of subjectivity and identity (Wertz, 2005).

Qualitative approaches are particularly appropriate for studying multicultural issues (Hoyt & Bhati, 2007; Morrow et al., 2001; Morrow, 2007; Ponterotto, 2002; S. Sue, 1999). This affinity is because these methods work from a paradigm that includes and appreciates multiple ways of knowing (Ponterotto, 2005a). Qualitative methods are particularly useful in exploring populations about which much is unknown (Camic et al., 2003). Because these methods aim to explicate the participant's perspective and seek to impose as few theoretical assumptions as possible, they are useful for exploring unfamiliar phenomena (Hoyt & Bhati, 2007; Morrow, 2007). According to Kral et al. (2002), qualitative approaches are especially useful with cultural populations who have been previously mistreated by researchers because of their collaborative stance. Lastly,

the tool of reflexivity is an asset when working with marginalized or sensitive populations (Dowsett, 2007).

Ethical Concerns

Research ethics. American Psychological Association and Pacifica Graduate Institutes Internal Review Board ethical guidelines were followed. Ethical guidelines are useful for offering general directions and avoiding obvious unethical treatment (Small, 2001). However, ethical treatment of participants requires more than the following of guidelines (Denzin & Giardina, 2007; Ellis, 2007; Mabe & Roland, 1986; Small, 2001). Many ethical issues are too complex to approach procedurally (Aluwihare-Samaranayake, 2012; Guelemin & Gillem, 2004). Instead, many contemporary researchers call for extended engagement with conflicts and choices (Aluwihare-Samaranayake, 2012; Guelemin & Gillem, 2004; Haverkamp, 2005; Maracek, 2003), coupled with an acknowledgement that "each choice has consequences, but choose we must" (Denzin & Giardina, 2007, p. 212).

Contemporary codes of ethics are developed based on a utilitarian model in which beneficial ends can justify unethical means (Brinkman & Kvale, 2005; Christian, 2007; Thompson & Russo, 2012). Haverkamp (2005) further stated western codes of ethics are built on positivist ideas of autonomous individuals and value-free science. Unfortunately, this approach to ethics has led to deceptive and destructive research in the name of social progress, especially in relation to multicultural populations (Ponterotto & Grieger, 2008; Trimble & Fisher, 2006). A virtue approach to ethics is also present in the APA code of ethics (2010), following Aristotle, in which certain virtues are encouraged, such as beneficence, justice, and nonmaleficence (Brinkman & Kvale, 2005, 2008).

These are useful, but Brinkman and Kvale (2005, 2008) have argued they are quite abstract and difficult to use in practice. Thompson and Russo (2012) recommended a deontological relation to ethics, in which the impact of the act is considered most important. Brinkman and Kvale (2005, 2008) have called this duty ethics (Brinkman & Kvale, 2005, 2008), which they note originated from Kant's moral imperative to treat human as ends in themselves. Social justice theorists expand on this approach, urging researchers to think deeply about the treatment of participants as well as the ways that findings could be used or interpreted (Vera & Speight, 2008).

Internal Review Boards tend to privilege certain types of research (Denzin & Giardina, 2007), and are modeled after patriarchal values such as objectivity and individuality (Christian, 2007). Additionally, ethical codes often require researchers to simplify situations, which can lead to unintentional racism (Ridley, 1995). Furthermore, they are difficult to enforce (Mabe & Roland, 1986) and it is not always clear whether they are meant to protect participants, researchers, or institutions (Cieurzo & Keitel, 1999). Finally, they do not always lead to appropriate action (Blasi, 1980, as cited in Ridley, Liddle, Hill, & Li, 2001). Childers (2012) argued that pure ethical behavior is actually impossible, and that protocols are there to help researchers feel less out of control than they, in fact, are.

The aforementioned issues with ethics codes have led many researchers to recommend a participatory or relational form of ethics (Aluwihare-Samaranayake, 2012; Christian, 2007; Ellis, 2007; Rossiter, Walsh-Bowers, & Prilleltensky, 1996) modeled after a feminist "ethics of care" (Gilligan, 1982; Noddings, 1984). This model emphasizes the relationships developed between researchers and participants

(Gunzenhauser, 2006), and encourages researchers to approach participants with the same ethical obligations they would have towards friends (Tillmann-Healy, 2003). Empathy is often an important tool in this form of engagement, though researchers have warned of its potential to be used in inauthentic or manipulative ways (Duncombe & Jessop, 2002; Watson, 2009).

The model of privileging relationships over the outcomes of research is an extension of the social justice values many approaches to qualitative inquiry promote (Denzin & Giardina, 2007). M. Fine's (1994) recommendations of relational approaches to social justice work are relevant to this approach:

> When we opt, instead, to engage in social struggles *with* those who have been exploited and subjugated, we work the hyphen, reveling far more about ourselves, and far more about the structures of othering. Eroding the fixedness of categories, we and they enter and play with the blurred boundaries that proliferate. By *working the hypens*, I mean to suggest that researchers probe how we are in relation with the context we study and with out informants, understanding that we are all multiple in those relations . . . . working the hyphen means creating occasions for researchers and informants to discuss what is, and is not, "happening between", within the negotiated relations of whose story is being told, why, to whom, with what interpretation, and whose story is being shadowed, why, for whom, and with what consequence. (p. 72)

I join others (Denzin & Giardina, 2007; Haverkamp, 2005; Kvale, 1996) in believing this authentic engagement with individuals is the foundation for quality research, particularly with populations who have been marginalized or silenced.

Current models of ethics put a high premium on value-neutrality (Christians, 2007) and there are some researchers who express concern about placing too much emphasis on social justice ideals (Hammersley & Traianou, 2011). However, I hold the perspective that value neutrality is an impossible and undesirable goal, as research is always political (Lumsden, 2012). Brinkman and Kvale (2008) argued the research with humans could never separate values from facts because scientific facts have a powerful influence on individuals. In fact, numerous scientific studies done from a supposedly "neutral" place have been recognized as destructive and unethical (M. Fine, 1994; Mertens, 2012; Ponterotto & Greiger, 2008; Trimble & Fisher, 2006). While it is important to remember that not all qualitative research approaches promote social justice goals (Creswell, 2006), a qualitative approach does lend itself to supporting multicultural and social justice goals (Morrow et al., 2001; Ponterotto, 2010, Suzuki, Prendes-Lintel, Wertlieb, & Stallings, 1999).

Nonetheless, Brinkman and Kvale (2005) have argued that qualitative methods are not automatically ethical, as any research method can be used for progress or domination (Marecek, 2003). Interviews, which are often discussed with the language of participation and collaboration can be used as instruments of dominance and are often saturated with more concealed forms of power (Kvale, 2005). Thus, despite steps taken to increase collaboration, researchers must acknowledge the inherent power dynamics in the research act (Allmark et al., 2009; Aluwihare-Samaranayake, 2012; Banister, 2007; Hoshmand, 2005; Polkinghorne, 2005). Prilleltensky (2008) defined power as "a combination of ability and opportunity to influence a course of events" (p. 119), which scientists clearly possess. The researcher makes choices about what is researched, how,

and what version of the narrative is published (Josselson et al., 2007). The social position of the scientist is inherently privileged by their ability to publish and declare truth. This power hierarchy requires a "fiduciary responsibility" (Fisher, 2000, p. 130) to the individuals scientists interact with, as researchers have a significant impact on participants lives (Hadjistavropoulos & Smythe, 2001). At the same time Hegeland (2005) encourages researchers to treat participants as capable and to avoid relating to them in a patronizing fashion.

As opposed to seeing qualitative methods as inherently ethical, I believe there are unique and complex ethical concerns in the use of this type of inquiry. Participants in this study will consent to be involved after being informed of the intent, procedure, and potential implications of the research, a procedure referred to as "informed consent" (Creswell, 2009). However, it is difficult to inform someone of what will occur in an interview that is open-ended (Allmark et al., 2009; A. Clarke, 2006; Cieurzo & Keitel, 1999). For this reason, some researchers recommend a process approach to informed consent, in which consent can be rescinded at any time (Ellis, 2007; Smyth & Murray, 2000). Participants in this study were given the right to withdraw their involvement in the study at any time. Wertz et al. (2011) have noted that individuals do not always listen clearly to the information they are consenting to, wishing to begin the interview process. Therefore, details about the study were given in writing in order for participants to have access to them outside of the interview situation.

The American Psychological Association Code of Ethics (2002) has stated that researchers are obliged not to cause harm. Nevertheless, discussing sensitive topics with participants can lead to distress (Aluwihare-Samaranayake, 2012). I recognize that

speaking about any meaningful experience can bring up emotional reactions, especially when interviews concern marginalized identities. Therefore, appropriate referrals to affirmative therapists will be offered to individuals to mitigate any emotional activation caused by the interviewing process. It was my hope that discussing these topics would be useful, even if it was difficult, as studies indicate (Cook & Bosley, 1995; Elliott, 1989; Scott, Valery, Boyle, & Bain, 2002). Evidence suggests that individuals experience benefits from being involved in research such as telling their stories, gaining different perspectives, feeling empowered, and experiencing agency through donating energy to a project (Cook & Bosley, 1995; Clark, 2010). In fact, participants often noted feeling excited about being a part of this research and finding it meaningful to reflect on and create a narrative around their experiences in therapy. Additionally, one participant noted this experience demonstrated to them ways in which they have grown out of emotional challenges.

Cieurzo and Keitel (1999) have shared concerns that individuals could expose more of themselves than they anticipate, to the interviewer as well as themselves. Duncome and Jessop (2002) noted, "interviewers run the risk of breaching the interviewees' right *not* to know their own innermost thoughts" (p. 112). This statement speaks to the difference between interviewing in research and therapy. In research, the contract does not include changing the person's relationship to topics discussed, though a transformation may occur nonetheless (Kvale, 1996). Two participants noted that the interview process led them to consider experiences from novel perspectives.

Dual relationships are a related ethical issue that raises questions about conflicts of interest and the existence of preexisting relational dynamics that could influence

findings (Thompson & Russo, 2012). A particular concern in therapy research is the ethicality of interviewing former clients (Pacifica Graduate Institute, 2013). Such participants could feel obliged to participate or to offer a particular perspective on the therapeutic work. Participants will be chosen that have no therapeutic connection to the researcher in order to avoid undue conflicts of interest, influence, and role confusion.

Confidentiality is meant to protect the privacy of participants (Wiles, Crow, Heath, & Charles, 2008). Nevertheless, some researchers worry that without using people's real identities, researchers are not held accountable to what say about participants (Guenther, 2009). Without this culpability, researchers may be tempted to use the most sensational aspects or create a voyeuristic portrayal of participants (Allmark et al., 2009). The common practice of naming people through the use of pseudonyms is an authoritative act (Guenther, 2009). Further, the researchers have the ability to de- and re-contextualize information as they choose (Briggs, 2002). According to Watkins and Shulman (2008), "for some, the offer of anonymity re-inscribes the asymmetry of power in the research relationship, where authorship goes to the researcher and anonymity goes to the participants" (p. 306). There is a great deal of power enacted in narrating the story told (Smyth & Murray, 2000). Smyth and Murray (2000) have recommended that researchers "own their narrative," while also acknowledging the inherent power in their ability to do so.

Confidentiality can be difficult to keep in qualitative research projects where a few participants' stories are told in depth (A. Clarke, 2006; Kvale, 2005). If significant quotations are used in order to offer "thick description," the potential exists for participants' identities to be revealed. These scholars are not necessarily advocating

against confidentiality, but for researchers to make conscious and informed choices about ethical matters. In this study, all efforts were made to protect the confidentiality of participants identifying information, transcripts, and audiotapes. Furthermore, the results are presented under pseudonyms and some identifying information was modified, in order to further disguise the identity of the participants. It is my view that confidentiality is important because this research concerns identifications that are discriminated against. I feel strongly that it is not my place to disclose the sexual orientations of others.

Outsider research. The history of research with the LGBT population has been particularly destructive and repressive, as noted previously (Meyer & Wilson, 2009; Moradi et al., 2009). These issues influence the historical background of this project, and I can contribute to mistrust or hostility as a result. My identity as a heterosexual white woman will undoubtedly have implications for this study, which requires particular sensitivity and appropriate supervision (Ponterotto, 2010). In the research of cultural topics, there is an enduring debate around whether a researcher who identifies as an "insider" or "outsider" is more effective or ethical (Allen, 2010; Bridges, 2001; Pitman, 2002). The benefits of researchers working with cultures with whom they share identifications include shared knowledge (Bridges, 2001), increased rapport due to assumed similarity (Pitman, 2002), and increased potential for representing the culture accurately (Quintana, Troyano, & Taylor, 2001). According to Pitman, (2002) individuals may feel safer and feel the potential for acceptance and understanding more easily with those who share community affiliation.

Alternatively, there can be benefits to approaching research as an outsider. Outsider researchers have the potential to be faithful to their participant accounts

precisely because they are not filtering them through their own experiences (Bridges, 2001). They may be more likely to ask clarification questions, rather than to assume they understand what the individual is expressing (Asher & Asher, 1999). Pitman (2002) reported that when conducting research as an insider, the "illusion of sameness" (p. 285) that facilitated rapport also led to a tendency towards complacence and agreement. According to Pitman, it is possible that the presence of an outsider perspective could encourage both individuals present to take more responsibility for their own perspectives. Moreover, individuals may feel more comfortable sharing information with outsiders. Allen (2010) proposed that, particularly in research on sexuality, participants would not need to manage an ongoing relationship or reputation with outsider researchers in the same manner they would with community members (Allen, 2010).

Doing researcher as an insider could lead to less flexibility in theoretical assumptions due to the fact that the researcher is personally implicated in the results. While discussing the benefits and costs of insider and outsider research with lesbian women, Krieger (1982) stated that heterosexual women offer a valuable perspective because of their privilege and external perspective.

> As an insider, the lesbian has an important sensitivity to offer, yet she is also more vulnerable than the non-lesbian researcher, both to the pressure from the heterosexual world—that her studies conform to previous works and describe lesbian reality in terms of its relationship with the outside—and to pressure from the inside, from within the lesbian community itself—that her studies mirror not the reality of that community but its self-protective ideology. (p. 108, as cited in Bridges, 2001)

Krieger differentiates heterosexual women from heterosexual men because the scholar reported heterosexual men have perpetrated a majority of the discriminatory and conducted destructive research. This argument raises the point that there are real effects of gender implicated in research as well, which need to be taken into consideration. Rasmussen (2006) also encouraged researchers to be aware of the multiple intersecting identities involved with research, in addition to sexual orientation.

Allen (2010) provided a skillful deconstruction of the arguments around insider/outsider research in regards to sexuality. Allen furthered the arguments of queer theorists by questioning the underlying assumptions of the argument that identity predicates knowledge. The primary hypothesis Allen questioned is that heterosexuality implies heteronormativity: the idea that individuals who are heterosexual cannot provide anything but heteronormative knowledge. The instability of identities over time and the ubiquity of heteronormativity challenge the veracity of this claim. People with LGB identities are not free of the social messages condoning heterosexuality as the socially privileged orientation, as indicated by research on internalized heterosexism (DiPlacido, 1998; Herek et al., 1991; Syzmanski & Chung, 2003). Allen's argument is not that identities are of no concern or that they do not have real world implications, but that identity by itself does not allow or prohibit certain perspectives. The responsibility for providing antinormative approaches to and interpretations of knowledge is more personal. Taking this perspective into consideration, the ethical disposition and reflexive process of the researcher may impact the quality of research as much as their demographic characteristics.

Morrow (2005) and Ponterotto (2010) have recommended that researchers working outside of their culture prepare for their work by exposing themselves to the culture of interest in multiple ways. This practice supports the researcher in developing adequate context, appropriate language use, and other tools needed for sensitive interpretation (Morrow, 2005; Ponterotto, 2010). Regardless of preparation, competence working with cultures to which the researcher does not belong requires acknowledging limitations and seeking the support of colleagues and supervisors (Thompson & Russo, 2012). Being a respectful outsider researcher requires "sensitive and reflexive understanding of the experience of others; respect for others as persons; listening to others in conditions of respect and care; mutuality of benefit and gratefulness for giving relationships; openness to criticism and the exposure of prejudice" (Bridges, 2001, p. 384). I worked closely with the dissertation committee to ensure I was attending to these criteria adequately, as well as to exploring ways that I could increase my cultural competence as a researcher, psychotherapist, and person.

Interestingly, the question of whether outsiders can engage effectively in a research project is quite similar to the underlying questions of this research project. Of course, this statement frames the issue in a simplified manner. It is more appropriate to say that both are exploring the challenges and benefits inherent to cross-cultural relationships. Likely, relational dynamics in research, like those in therapy, are experienced differently for different people based on expectations, prior experiences, and beliefs. Nevertheless, I believe that if outsiders are able engage ethically, the same potential for positive experiences with a representative of the dominant culture exists that is occurs in the cross-orientation therapeutic dyad. I have outlined some of the

challenges discussed in the literature and attended to them as suggested. To the best of my ability, all considerations were made to avoid harm and treat participants with respect, care, and dignity.

Results

This study provided rich data regarding the experiences of LGB clients with sexual majority and minority therapists. While I asked the seven participants the same questions, their responses reflected diverse experiences filtered through divergent perspectives on their lives and LGB issues at large. I set out to explore individuals' experiences with cross-orientation therapeutic dyads. However, these experiences were contextualized within an exploration of various aspects of their sexual orientation and therapeutic experiences. Therefore, my results represent a more complex picture than ideas about one kind of therapeutic dyad. Qualitative inquiry creates the conditions for discovering of the unexpected in this way. Open-ended questions generate possibilities, and what participants' share is out of the researchers' control.

What I found was seven individuals' reflections on identity, experiences of heterosexism inside and outside of therapy rooms, and qualities they look for and appreciate in therapeutic practitioners. I was struck by the ways in which historical experiences around identification and heterosexism outside of therapy influenced expectations and concerns about therapeutic experiences. Therefore, my results include aspects of LGB individuals' experiences outside of therapy that I feel clinicians would benefit from considering. This is particularly the case for heterosexual clinicians who may not be aware of these aspects of sexual minority experience. However, the diversity between different LGB people's experiences suggests that practitioners who identify as sexual minorities would also benefit from reflecting on the variations in these participants experience.

I will be presenting quotes from the original data in order to provide transparency around my interpretations and an opportunity for the reader to reflect upon what participants discussed. Explicit interpretation about the impact of these results on the field of psychology will be withheld until the next chapter. Nonetheless, interpretive phenomenological analysis considers the interpretation to be involved throughout the research process, from the conception of the study to the way that the researcher groups the data. Though the following thematic structure reflects my perspective on the body of data, reflection on this involvement and presentation of original data aims to facilitate rigor within this interpretive study.

The results of this study are presented within five main themes: Categorizing Selves, Identifying Others/Identifying Allies, Navigating Heterosexism, Preferring Therapist's Identities, and Understanding Therapeutic Practices. Categorizing Selves contextualizes the larger exploration of cross- and shared-orientation therapeutic relationships by discussing participants' chosen identifiers and ways in which the visibility and invisibility of sexual diversity influences identification and society's view of LGB culture. Identifying Others/Identifying Allies discusses the cues that participants used to discern the sexual orientations of their therapists, as well as highlighting cues of allyship, which indicated support regardless of the therapist's sexual orientation. Navigating Heterosexism features reflections on the stigma that participants have experienced and how this pervasive occurrence influences their experience of, and relationship to, therapy. This theme also includes a discussion of experiences of stigma that have occurred within the therapeutic relationship and considers how the therapist's responses have impacted participants and their therapeutic experience. Preferring

Therapist's Identities provides a space for participants' reflections on the identities of their therapists and their preferences about working with particular identities. Finally, Understanding Therapeutic Practices discusses ways that therapists related to clients that participants found useful, regardless of their sexual orientation, and thoughts about qualities they would want in future therapeutic relationships. Detailed descriptions of each of these themes are included below.

Categorizing Selves

A prerequisite to exploring experiences tied to identity is to discuss the identities themselves. Self-categorization is a complex process; identities can change over time, and are defined by individuals based on their own experiences and vocabularies. It is important to recognize that this study was not focused on how individuals come to identify as LGB and, thus, it does not aim provide a thorough picture of how individuals come to sexual minority identifications. Instead, I asked participants about their chosen identifiers in order to contextualize their perspectives. Similarly, I am first presenting participant reflections on the process of self-categorization and the influence of invisibility in order to contextualize subsequent findings. While there is a wide variation in terminology that sexual minorities use to identify themselves, this subset of the population used the terms *lesbian*, *gay*, and *queer* to describe their sexual orientations.

Sexual orientation is not always a visible to others, which creates distinct challenges in terms of self-identification and representation. Some identities seem more obvious than others, such as gender and ethnic identities, which theoretically provide visible markers. However, an increasing awareness of the diversity of gender expression and the existence of numerous multiethnic individuals makes both of these identities

more complicated and less obvious than they at first appear. Even if a person presents a certain way, that does not guarantee anything about how they identify, because humans cannot see or measure internal experience. Sexual orientation is similarly visible and invisible because it involves internal experiences of self and attraction, and private experiences of sexuality and romance. There may be some external cues, but people's presentations do not necessarily reflect internal identifications. Therefore, the visibility or invisibility of a person's sexual orientation can vary significantly.

A primary tension in discussing sexual orientation is that identity terminology suggests a categorical conception of identity, though there is increasing support for considering sexual identities as occurring across a spectrum. Labels and Spectrums discusses the terms participants used to describe their sexual orientation while recognizing that there exists more diversity than these words would suggest and notes why it may be important to consider identities as occurring on a spectrum. Visibility and Identification considers how limited or particular visibility of representatives of LGB culture has influenced some participants' comfort in identifying as LGB. Additionally, some participants discussed their experience of having their identity be largely invisible to others, while acknowledging the privilege that goes along with "passing" in dominant culture, which is explored in Invisibility and Experience. Visible identities navigate experiences with others, and how society views LGB culture impacts ideas about sexual minorities and sexual minorities ideas about themselves. While the process of self-identification occurred outside of therapy for these participants, it is important for practitioners to understand common identity terminology, how sexual identities can be

conceptualized, and the influence of variations on visibility and invisibility on sexual minority clients.

Labels and spectrums. This subtheme includes various responses to the question of how participants identified in terms of their sexual orientation. For some participants, this question elicited a simple response of gay or lesbian. Despite an apparent clarity with their own identifications, a couple of these participants still noted a broader view of these categorizations later in their interview. For example, Anne, a Caucasian, female-identified, professor in her thirties, answered the self-identification question with "lesbian, but also with the kind of fundamental belief that things are not strict categories," holding the tension between categorical and continuous identities. Similarly, Michael, a Caucasian personal trainer in his late thirties, after identifying himself as a gay male, emphasized the diversity that exists within these categories. These participants appeared to feel comfortable with the absolute sexual identity terms for themselves, though they were still aware of the complication of seeing identities as discrete categories.

Nina, a Latina-identified female sociologist in her early thirties, spoke directly to why she felt it was important to understand sexual orientations as occurring along a spectrum. Reflecting on the impact of categorization she noted:

> Society leads us to see sexuality and gender as a binary and I think that's an incredibly limiting and, at times, downright dangerous way of looking at sexuality and gender. When you position only two ways of being, that's really the core of homophobia . . . I think it leads to unhappiness and uncertainty and bad self esteem for people who do not fit into this structure but are continually forced to conform or be seen in response to that.

While many participants noted the idea of the spectrum as important in terms of heterosexual individuals recognizing the diversity within the LGB community, Nina highlighted the impact that categorical identities can have on the self-esteem and mental health of those who do not fit within these boxes. She also suspected that the idea of humans as falling into clear categorization is a foundation of homophobia, because if humans can be categorized so simply, then those that fall outside of this structure are considered deviant or unnatural. From Nina's perspective, how society conceptualizes identities has a significant impact on how individuals treat themselves and each other.

For a few participants, the word 'queer' was used to label themselves as sexual minorities while encompassing different aspects of their experience that the absolute categories of lesbian and gay do not adequately incorporate. Alisha, a biethnic female therapist in her thirties, used the word 'queer' to include earlier experiences in her life:

> I identify as queer even though I am in a lesbian relationship because I want to make room for the fact that I have been with men and that is part of my story, that I don't want to get rid of. So queer for me is just encompassing of the experiences I've had, and the current one that I am having.

For Alisha, this identity category allows space for multiple aspects of her historical and current experience. Later in the interview, Alisha also used percentages to describe her fantasy that her therapist has a complex sexual identity including same- and different-gender attraction. For individuals who do not see themselves as exclusively attracted to one gender, or who have had varying sexual encounters and attractions, queer can provide a more complex representation of their experience.

Additionally, there were two participants who used the word queer to include a more complex conception of gender, which felt important both for themselves and for their partners. Both Nina and Bethany are in relationships that began as same-gendered and changed into an different-gendered pairing due to the gender transition of their partners. While reflecting on what queer means to her, Nina stated,

> That term is probably the bane of a lot of people's existence because it's so ambiguous. For me, it means to me existing outside of a heteronormative binary gender paradigm. Some see it explicitly as a sexuality term, some as gender, but the gender dynamics that are emerging from my relationship make describing that aspect important to me.

Perhaps it is because of the term's ambiguity that it is attractive to individuals whose sexuality does not fit within a clear binary view of same- and different-gendered attraction. Similarly, Bethany, a Jewish-American female therapist in her late thirties, described queer as "a movement away from the term bisexual because I believe that there is more than two genders. And so, I understand my sexuality as fluid, I find attraction in gendered beings." Queer is a term that is increasingly being used by the LGB community, despite its historical derogatory use. This term holds different meanings for different people, though it appears to provide way of identifying outside of the sexual majority in a manner that maintains personal complexity.

There are various terms that clients can use about their sexual orientation and the identifications that individuals choose can change over time. Furthermore, the terminology available for describing different sexual orientations is likely to continue to evolve. Thus, attending to individual preferences around labels and understanding

reasons people choose labels is one way that clinicians could demonstrate support for their clients' sexual identities. Additionally, familiarity with sexual orientation terminology may ideally be balanced with an understanding of the spectrum of sexual identifications. The spectrum allows for agency in individuals' identifying their particular orientation and communicates normalcy for a diversity of sexual expressions. These participant quotes suggest that although labels are useful for discussing identities, it is important not to consider identity labels as static.

Visibility and identification. In the process of identity development, sexual minorities usually go through an internal process of recognizing their sexuality before they take on a sexual minority identity and then share this identity with others. In between becoming aware that of sexual attractions towards same-gendered people and coming out, there is a period of processing feelings about this identity. During this time, individuals are influenced by, and sensitive to, the social messages around them. In particular, three participants discussed how visible representatives of gay culture, or the lack of visible representatives, influenced their feelings about their burgeoning sense of sexual attraction.

The visibility of only select individuals within the queer community can lead to discomfort or hesitance around being seen as part of a community associated with stereotypes. For example, Gwen noted that she felt reluctant to take on the label of 'lesbian' partly out of discomfort being seen alongside the stereotypical images that accompany this identification.

> What I have also experienced in terms of internalized homophobia is, this difficult positioning relating to people who share a label, whether societally imposed or

> individual identity label, in the sense that, there are alike people. And at that point in time, I also, it took me a while to take on or be comfortable with, choose, a lesbian identity because, and I actually did so mostly as a kind of political reaction to my own internalized homophobia of rejecting that label . . . I do think that I was hiding behind this idea of the spectrum and all this stuff, actually not only for those reasons, although I do also believe them, but because of this internalized homophobia of, I am not that. I am not, the stereotypical box.

Gwen expressed discomfort with how lesbians are perceived by others, and a reluctance to take on a label that may lead to others seeing her as fitting within that "stereotypical box." This reflection occurred after Gwen recounted an experience where her therapist demonstrated her approval of sexual minorities by noting her affection for her lesbian-identified sister. Along with recognizing the therapist's intention to demonstrate acceptance and hope that her own sister would be similarly accepting, Gwen noted discomfort with being grouped with someone identifying as a lesbian before she felt ready to self-identify. She expressed concern that her therapist would then be seeing her through that lens, and project ideas about lesbian women onto her based on this shared label. This also raises the importance of avoiding identity labels before clients have identified themselves.

Michael noted a similar concern, communicated with humor around the visible representative of gay culture that he was exposed to at period of nascent identity development.

Michael: [The therapist] encouraged me or us to go to, a gay youth group, and I went to one meeting, [which] was led by this openly gay, very, very, very gay, very, very, very gaaaay.

Rebecca: What do you mean when you say.

Michael: I'm being silly.

Rebecca: I know, but there's something there.

Michael: He had a pink polo shirt on with peroxide blond hair with two earrings and I think it was very intimidating for my mother and myself, who had sort of my own internalized homophobic issues and I felt that that was a little like, uh [pause]

Rebecca: Too much?

Michael: Oh my god, yeah, I thought like, this is what it means? Is this really what's in store for me? Is this really who I wanted as a role model? . . . It ended up being too much for my mother. She was just, she kind of freaked out, she pulled the car in right as, the lights shone as everyone was doing a big group hug and it was almost like, ok ok, that's enough.

Michael described being exposed to a stereotypical, and thus highly visible, representative of gay culture, which had a significant impact on him. Because he had experienced limited visible representations of what it means to be gay, he got the impression that to be openly gay means presenting in a manner that was overwhelming to himself and his mother. This quote also illustrates Michael's sensitivity to and awareness of his mother's reaction to the situation. During the interview, he wondered how it would have impacted him to stay in the group and develop additional comfort with his identity

at that time. He thought that he may have experienced less internalized homophobia and developed a more supportive community. At the same time he expressed concern that increased comfort with his sexuality at an early age may also have exposed him to increased prejudice from peers. Regardless, he discontinued his attendance, and after trying to be "above sexuality," he came out to himself and others in his mid twenties, which he reported relieved significant interpersonal and intrapsychic discomfort.

Scott, a Caucasian gay male therapist in his forties, discussed the influence of invisibility on his developing awareness of same-gender attraction. Growing up in a rural northwestern town, Scott described experiencing anxiety about the man he was becoming because there was no external support for his internal experience.

> Scott: What I realize is that my experience was very normative for sexual minorities growing up and feeling different and feeling suicidal because they're so different and they don't understand how they can possibly understand, how they can possibly become an adult, like this, and live in society.
>
> Rebecca: How you can fit?
>
> Scott: Right, right, how am I going to have peers, if I'm attracted to John. Nobody's going to like me. I'm not going to be anything. You know, I wanted to, I remember I wanted to be a rock star and I thought, how could I be a gay rock star. Nobody is going to listen to a gay rock star. Because you know, back then, there all the MTV videos . . . they were all opposite sex there was nothing about same sex. Nothing. And I thought, no one will like me, I'll fail . . . No visibility whatsoever. And I thought, I will, I'm doomed. I want to be a rock star and I can't be a rock star because no one will like me, just like no one likes me in

> society. So even if I become this big star with this great voice and I'm great at entertaining, no one will care. I'm doomed for failure. Because of how I was born, or "the choice" I made, which was what messages I was receiving.

In a small town, Scott noted that being different felt dangerous, and his increasing awareness of sexual orientation divergence from his peers felt acutely threatening. Moreover, without any visible examples of sexual minorities, he struggled to imagine life as an adult including the attractions and feelings of which he was becoming aware.

Describing the opposite experience, Shay, a lesbian-identified female therapist in her late thirties, discussed the impact of changing marriage laws that have acknowledged sexual minorities in her state. She notes,

> Whenever the greater society carves out room within the rigid structure of how we think about nondominant identified people, then I think people can breath into the space that was created and it, it normalizes it a bit more. The visibility piece becomes safer, and it just becomes, becomes more normal when society takes that step as a whole to protect the rights of a people and individuals, who maybe it wasn't on their radar, can expand into that place and I think everyone benefits from that.

In Shay's experience, increasing LGB rights has allowed for increased safety and visibility for LGB individuals. This visibility, from her perspective, communicates normalcy and welcomes sexual minorities into the larger society.

When there is limited visibility of sexual minority individuals in society, only those who are highly stereotypical are seen by youth. Alongside other messages about divergent sexual identities, lack of visibility or limited visibility limits perspectives of

possible developmental trajectories. How individuals are seen and treated, along with the messages that people are exposed to about those individuals, seems to have an impact on how people then see themselves in relation to these identities. The process of accepting same-gender attractions and identifying as a sexual minority is influenced by covert and overt societal messages about sexual minorities, which will be further explored in the Navigating Heterosexism. However, Visibility and Identification highlights a compelling relationship between visibility of sexual minorities in the culture, and internal processes of self-acceptance and self-identification. The significant influence of societal messages on individual experience that was described by these participants underlines the value of practitioners understanding and acknowledging the unique challenges that LGB clients face with these processes of identification and acceptance.

Invisibility and experience. Four of the seven participants discussed their experience of feeling like their sexual orientation was invisible to others. These participants were all female-identified and they noted that their status as sexual minorities was often unrecognized because of their more traditionally feminine presentation. Alisha reported finding it frustrating not to have her identity seen because her membership to her community is unrecognized. She notes that this invisibility mirrors her experience of being biethnic.

> First, it was with my cultural identity, that I'm ambiguous unfortunately in all ways and so, I was, it was always I wasn't really white enough for the white people but I definitely wasn't Indian enough for the Indian people, and to just not be recognized by any community, without explicitly saying I'm a member of this community feels very difficult and very invisible, until finally, learning about

> biracial communities and multiethnic people, that then I was able to identify, ok, that community sees me, they know, they can look at me and say you're mixed, with something. So the same thing comes up in the gay community is that, no one, unfortunately, really sees me as one of them, which feels very invisible.

She further described the experience of not being recognized by others who share her identification, which feels isolating, unless she is accompanied by her more stereotypically presenting partner, which feels like cheating. She went on to note that having her sexual identity invisible also opens her up to unwanted male attention, because others read her as heterosexual.

Shay discussed another kind of unwanted attention due to the invisibility of her sexual orientation.

> I'd never been visible in that way and hence when you're of a certain age and you appear in a certain category, people are like, are you going to get married? Are you going to have kids? And it's well no, sorry, but at the time I don't have the right to get married and no, it wouldn't be to this awesome person, awesome guy that you have to recommend . . . I think when someone treads the line of privilege and a less dominant identity, it's complicated. I have these identities, but in some ways it only matters what people see.

Shay noted that despite her internal identity, people relate to their view of her and treated her as heterosexual as a result. She described particular discomfort navigating other people's interest in her romantic life. Shay also discussed the way in which she, at times, feels judged by other lesbians for her feminine style and appreciation of make-up. Other participants also noted fears of judgment from other sexual minorities about not being, or

not being seen as, gay enough. However, Shay added that if people do what is right for them, there would always be judgment from someone, and therefore people need to follow their own sense of integrity and self-expression.

Another participant discussed the influence of her invisible sexual orientation on social interactions. Bethany reviewed an instance in which she made a comment that disclosed her queer identity in the presence of a supervisor, who was awkwardly surprised by this information. It took her a few moments to determine what created the awkwardness before she realized that he had been holding an idea of her as heterosexual. She noted that, at times, she approaches relationships in such a way so as to avoid such instances.

> Sometimes I try to say things that complicate my identity right away when I'm with new people just because I want them to put that into the container with me, right away, but it doesn't always happen, there's not always opportunity.

In this way, Bethany tries to manage other people's awareness of her identity in order to prevent such awkwardness. The way she told this story reflected an annoyed acceptance of this dilemma of weighing awkwardness and managing her identity with others.

Both Bethany and Nina discussed the way that the visibility of their sexual orientation changed due to their partners' transitions from female to male, though they discussed different reactions to this experience. During the transition, Bethany started a new job where she chose not to be out. Discussing her experience of this change of visibility, she noted,

> I didn't know how to represent my own queer identity without calling out [my partner] . . . so then all of a sudden I was a straight person, which was so different

> for me, because I had worked so hard to establish this other part of my identity. So then people are treating me like a straight person, in the sense that asking me about marriage and babies all the time and, 'you know how men are!' And just these things that are, it was hilarious, but it was also very, uncomfortable . . . There was this huge part of me that was never seen.

For Bethany, it was disorienting to go from being very public about her queer identity, to be seen as being in a straight relationship. Nina described a different experience, which may also reflect differences in her relationship, going through the process within the same geographical community, the recent nature of her partner's transition, or differing ideas about identity. She noted with surprise how often others ask her what her partner's transition will mean about her identity. For Nina, the visibility of her queer identity is not as salient as her concern for traversing this shift in her relationship.

While these narratives demonstrate some frustrations that go along with holding a minority sexual identity that is unrecognized by others, there are privileges to 'passing' as heterosexual. Nina noted that her privilege of being a feminine female-bodied person is that of feeling comfortable in most spaces. Her comfort in many situations also highlights the way in which those who are visible sexual minorities can be exposed to more overt prejudice or scrutiny. In some instances, passing as heterosexual is an essential way to avoid discrimination. At one point, Shay worked at a religious agency in which knowledge of her sexual orientation would have led to losing her job. In this and other situations, passing can be advantageous for avoiding overt discrimination and threats to safety.

Participants described both benefits and costs to the invisibility of their sexual orientation. In a heterosexist society, hiding sexual orientation can provide safety from overt and covert discrimination. At the same time, participants described feeling unseen and unrecognized, or like they had to acquiesce to other people's inaccurate projections. At times, the invisibility of their identity required them to manage other people's expectations of them or repeatedly come out to others, a risky and uncertain act. Variations in the visibility of sexual orientations adds to the complexity of different sexual minority's experiences, and is another dimension for clinicians to consider in regards to the diverse experiences of sexual minority clients. Individuals whose sexual identity is read more easily by others would likely describe a different constellation of benefits and costs, though participants in this sample did not reflect this experience. Despite human's attempts to identify others based on visual cues, which will be discussed further in the next theme, sexual orientation identification is a personal process, which gives individuals the authority on their identity.

Identifying Others, Identifying Allies

In order to explore individuals' experiences in shared- and cross-orientation therapeutic dyads, participants discussed what they suspected their therapist's orientation to be and how they came to this belief. While it is impossible to verify this information, I chose to base this study on individuals' perceptions of their therapist's sexual orientations because this study is focused on the LGB clients' experience. I believe that how participants saw and related to their therapist's sexual orientation has a more significant impact on the therapeutic experience than the therapist's actual orientation. Despite the complexity, or inaccuracy, of the identification process, individuals consistently make

assumptions about other people's identities. As such, it is worth exploring what cues participants use to assess the identities of their therapeutic practitioners. Furthermore, many of the cues that participants' discussed as revealing sexual orientation also conveyed alliance and understanding of LGB culture in therapists whose orientations appeared heterosexual or ambiguous.

While most of identity assumptions are made based on the visual cues and behavior of others, aspects of the people's making these discernments also influence assumptions. For example, two participants noted that when they were earlier in their identity development, they were less likely to suspect that others had minority sexual identities. These statements highlight the position that young sexual minorities hold before they become more connected to the larger LGB community and aware of the diversity of sexual expression. Their sexual orientation was divergent from the mainstream, and this difference lead to them to assume that same gender attraction is rare and unlikely to be encountered. This perspective mirrors the common "heteronormative assumption" in which the absence of obvious cues leads individuals to assume the heterosexuality of others.

The conviction with which participants presented the orientations of their therapists varied, as did their comfort with explaining how they got to those conclusions. At times, participants had a hard time declaring how they knew their therapist's orientation. For example, Nina notes, "this is what I feel like is a little bit challenging about this part of the conversation, I don't know if I've ever had anyone say 'I'm queer' but there are markers and signs that are so entirely clear." Many participants expressed the difficulty involved with explicitly stating cues, and yet, when asked further, a wide

array of cues were revealed that participants used to discern orientations. The most often cited cues concerned the gender of the therapist's current partner and their mode of dress.

Participants' confidence in their therapist's sexual orientation was greatest when they had knowledge about the gender of the therapist's romantic partner, which resulted from verbal disclosure, nonverbal disclosure, or outside knowledge of their relationship. Verbal disclosures occurred when therapists would talk about their wives, husbands, or partners, and seldom took the form of therapists naming their identity separate from describing their partner. Alternatively, nonverbal disclosure often resulted from pictures of family and couples displayed in the therapist's office. At other times, participants had outside knowledge of their therapist's partners. Examples of such situational disclosures were a therapist whose therapy office was adjacent to the office of her husband and a campus counselor who was married to a professor who taught at the same school. Though two participants admitted that the gender of their therapist's partner might have been transgender, thus questioning their assumption, more often, knowledge of current relationships gave participants a sense that they knew their therapist's sexual orientation or confirmed initial suspicions. Participant accounts indicate that the gender of therapist's partner is considered a clear indicator of sexual orientation, despite the fact that sexual identity can involve different historical behavior and current attractions.

Participants also cited visible cues that indicated sexual orientation, such as the therapist's style of dress. Several participants noted embarrassment at using stereotypical conceptions of style to discern orientations, though this method was commonly cited. The aesthetic that clients mentioned related to how much therapists followed or transgressed traditional gender expectations. For example, after some hesitance to define

her perspective, Shay noted that her female therapist dressed in ways that conformed to feminine gender expectations.

> She just appeared so very, so very heterosexual and that was substantiated along the way but not in a threatening way, and not in an in your face, kind of way, it just was. In the same way that, she very much accepted who I was. I mean, her pattern of dress was very, Anthropologie, Old Navy. She, I, this is just terribly stereotypical, but she just appeared like a feminine person, and, she sort of embraced her femininity in a way that hadn't been very congruent with my experience of lesbian people to that point . . . I'm trying to do my best to quantify these things but it is hard.

Other participants echoed this equation of conventional dress to conventional relationship. In the same way that conventional dress was tied to conventional sexuality, alternative dress and tattoos were mentioned to be potential indicators of alternative sexual practices. Many participants also cited the "butch" look, a more masculine presentation, as a clear indicator of alternative sexual preference. Similarly, participants described female therapists with low-maintenance hairstyles paired with loosely fitting clothing, minimal make-up and gender-neutral footwear. Male therapists were described less, though when they were, cues from style were noted as well. Gay male therapists were noted to be stylish, and more expressive and colorful with their clothing, whereas male therapists were assumed to be heterosexual when they dressed in a less refined manner.

While participants frequently noted cues related to partner's gender and mode of dress, I would like to focus on another set of cues that participants discussed. These cues

provided less consistent information on sexual orientation, but often carried a different significance. They offered an indication of allyship, representing support regardless of sexual orientation. These cues also communicated to clients how competent and comfortable therapists were with LGB issues and cultural knowledge, facilitating clients' choices around treatment. These themes that were associated with orientation and allyship involve Professional Identifiers, Language Cues, and Subjective Senses. This theme, thus, reflects ways in which therapists of all sexual orientations can convey appreciation for, acceptance of, and competence with sexual diversity.

Professional identifiers. Professional identifiers refers to orientation and alliance cues found on websites and in offices, which indicated therapists were sexual minorities or had competence in working with sexual minorities. One indication of competence, and potentially orientation, took the form of therapists noting expertise in LGBT issues. Two participants noted that, historically, noting such expertise was a subtle indication that therapists were queer themselves. They noted that expertise is currently a less reliable indicator, though it still raises the possibility that the therapist may identify as LGB. Shay stated,

> When a therapist has identified some sort of experience in those areas, it's almost like they're outing themselves in a way, because there aren't really any programs that I've ever encountered that teach issues specific to LGBT, and so, it's typically a subtle indicator that you're amongst family, as it were.

She highlighted that part of the reason mentioning expertise may disclose the therapist's orientation is due to the fact that few therapy programs provide substantial information about competence with LGBT clients. Therapist who identify as LGB may, therefore, be

more inclined to seek further proficiency about sexual minorities or be denoting their personal knowledge.

At other times, expertise was demonstrated by affiliation with certain programs or referral bases. Nina described seeking a couple's therapist who had knowledge and comfort with transgender issues through a program that focuses on providing services to the LGBT community. She stated that this affiliation communicated to her that this therapist went "through a very deliberate process of being available for queer couples," thus reflecting experience and knowledge. Alisha also discussed seeking a culturally competent therapist through a website called Gaylesta, which advertises therapists who have expertise with the LGB population practicing in Northern California. Because Gaylesta is not a commonly known website, she noted that providers listed there are likely to identify as LGB or have significant knowledge and experience of the LGB community. When practitioners were affiliated with LGB organizations, it indicated to participants that they are either LGB themselves or involved in the LGB community.

Visual cues in the office can also be used as data to discern a therapist's experience working with sexual minorities. Two participants mentioned that the presence of a rainbow in a therapist's office acted as a subtle cue of LGB acceptance. Shay described an arrangement of pictures on the wall of her therapist's office that formed a subtle rainbow, and Michael noticed a rainbow keychain on the keys of his therapist. The image of a rainbow, even when it took the form of an arrangement of differently colored pictures, communicated to these clients acceptance and understanding of the spectrum.

What is exhibited in offices communicates a great deal to clients. After describing therapy offices with pictures of heterosexual couples, Scott described the way

in which the pictures displayed communicate to him the inclusiveness and safety of a new space.

> The environment. Inclusiveness. I think that's first and foremost . . . that's what I have a history of noticing, whenever I walk into a new area, regardless of what it is. Grocery store. Dentist office. I'm looking for safety. Am I only going to see white people? On the walls, displayed. Am I only going to see white [heterosexual] couples? What does that mean? That tells me that we serve or we celebrate a certain type of demographic. When I see that, that's my thoughts. They don't celebrate me. I want to be celebrated. I want to feel included. I want to feel safe in an environment, which I often don't see.

Scott's narrative demonstrated the way in which seemingly innocuous images can send powerful messages to clients who may not expect to receive acceptance from others due to previous experiences.

Another significant professional cue that was noted by both Scott and Alisha involved the books that therapists have on their office shelves. Alisha stated,

> One thing I always do, wherever I go, is I always look at the books that people have because I think it tells a lot about the person, especially when I go to see a therapist . . . And [my therapist] has a lot of books that are about queer theory and the kink community and lesbian sex and so I think it's seeing those let's me know that, ok, one, she's educated about this stuff, two, she believes in it, because it's here. So, it's an extension of her. I feel like books are like that, books are an extension of people, so her extension works very well for me.

Therapist bookshelves display information about which topics therapists are knowledgeable and interested. Scott also discussed the way that seeing books about LGB people's experiences has facilitated his sense of safety. His current therapist displays books about numerous minority experiences, including books on African American women, individuals in the Jewish community, and people from the Middle East. In their first session, he asked his therapist about these books and she noted that whenever she has a new client, she educates herself on aspects of their cultural experience to see how that related to her new client's experience. Scott noted that, in addition to following this model in his own therapy office, it helped him to feel included and safe. He states: "it feels good to be with somebody who is interested in others." The therapist's interest in people with diverse backgrounds indicated to Scott that she could be open, accepting, and interested in his experience, despite their differences.

These contextual cues indicated to participants that the therapist had an interest in the experiences of minorities, which may or may not be connected to their own identity. They also communicated experience and expertise in working with sexual minorities, which was important to several of the participants in this study. Furthermore, participants described a marked increase in their safety and comfort in the therapy relationship when such markers were present, which likely facilitates productive and supportive therapeutic relationships.

Language cues. A Therapist's comfort, or discomfort, with the use of terminology was often used as a cue of sexual orientation. As Gwen stated "I really believe that speech is meaningful, and has consequences in terms of shaping how the other person will react." When therapists appeared awkward using terms that were

common to sexual minority subculture, they were often assumed to be straight. Moreover, they conveyed a lack of comfort with LGB issues, which had a direct impact on the client's experience of comfort in the therapy. Nina described a couple's therapist who did not seem comfortable with the word queer and noted that it made both her and her partner feel like they could not talk about sex with her as a result. Bethany described it this way:

> I think the questions that she would ask or ways that she kind of fumbled through language, or naming experiences, when she tried to reflect back to me what she heard, it felt really, disjointed and clunky. Like she was saying words she wasn't used to saying. It felt awkward, I felt awkward, I felt really, like a spectacle kind of, like a curious spectacle.

The awkwardness that Bethany felt in her therapist's words transferred into a lack of ease in her presence. She further described how this awkwardness made her feel like compartmentalizing and hiding aspects of her experience in order to protect herself from the therapist. Bethany noted feeling like the therapist was more interested in making sense of her than helping Bethany make sense of herself and she decided not to continue with this therapist due to the resulting discomfort.

Similarly, Shay described an experience with a therapist whose discomfort was conveyed by the way the therapist stressed female gender pronouns when talking about her partner. Shay described the therapist's emphasis as overwhelming and uncomfortable. She noted, "I want to feel more congruent, more able to express who I am, I don't want it to be thrown in my face that there's something going on requires the use of stressed vocalization." Shay also decided not to continue with this therapist.

When I asked how this behavior landed for her, she noted, "it didn't land. It bounced, and I bounced with it." She noted recognizing the therapist was trying to say the right thing, but the lack of ease that was created by her emphasis did not facilitate her comfort in the therapy. For each of these clients, the therapist's discomfort, as conveyed by their language, indicated to them two things: that the therapist was heterosexual, and that the therapist was not comfortable working with LGB issues.

Alternately, comfort with language or appropriate use of language indicated to clients that therapists were either allies or sexual minorities. Nina described her therapist as giving her "cues of ally-ship, it's clear that she's been in community with queer people, that she's somewhat familiar with the terminology that perhaps she's had some therapeutic experience working with queer people, but whether or not she identifies was unclear." These cues of allyship do not directly answer the question of the therapist's sexual orientation, though when paired with a suspicion that the therapist is heterosexual, they seem to have a meaningful impact. Shay described how she

> noticed right off the bat that [the therapist] didn't use any of the automatic assumptions some people tend to use. When you say that you're breaking up with my partner and you're a female-bodied person they inevitably will go, well 'what's going on with him' and [the therapist] didn't make any assumptions about it at all, she was just amazingly supportive so it was, it kind of blew my mind.

The simple act of not assuming that all clients were heterosexual suggested to Shay that this therapist recognized and supported diverse sexual orientations. While Shay had already determined that her therapist was heterosexual, this language cue communicated to her that her experience could be recognized and welcomed nonetheless.

Scott described appropriate use of language as an essential ingredient to his comfort in a therapeutic space. He noted that he appreciated the way his current therapist originally referred to him as a "gay male," using gay as an adjective denoting an aspect of his experience, as opposed to a noun defining him by that label. He described feeling that he is more than his sexual orientation and to refer to him solely by that label is offensive. He feels that labels, both diagnostic and identity labels, are often used to create hierarchies and differentiate people, instead of recognizing common human experience. He noted that he frequently corrects people in his internship about language use with minorities, as well as the problems with labeling patients by their diagnoses. "I want people to understand that we are humans first and then we all have symptoms of or all identify as, but remember we're all human first and it comes back to let's love and respect each other, without labeling." The words people choose, and the ways in which they communicate them, carry significant meaning.

The comfort, or discomfort, that therapists demonstrated with sexual minority terminology influenced how much personal comfort participants experienced with these therapists. Whether or not external discomfort was truly reflective of therapists' internal discomfort with diverse sexual orientations is less relevant than the potential danger that this behavior implied to these participants. Participants described being sensitive to cues of competence, particularly in initial sessions, and these cues were used to attempt to avoid unsupportive clinicians and identify supportive clinicians. For these participants, verbal signals of comfort and ease around LGB issues facilitated ease in the therapy and confidence in the therapist.

Subjective senses. Orientations and allyship were also communicated by nonverbal means. Some participants emphasized the energetic sense that they get from others who share their orientation. Shay described it as being "'gaydar' if you will, . . . its like when you have been traveling and you come across someone else from your home land, you know your people." Similarly, Alisha described the presence of invisible cues, noting an energy that she could at times pick up on to help her assess other's sexual orientation. While participants often had a hard time defining how orientation was communicated, subtle nonverbal cues were used to identify other sexual minorities.

Participants also described having a subjective sense of acceptance with certain therapists, indicating the presence of allies. Scott described his therapist as conveying "an energy of warmth and compassion and understanding and curiosity." Similarly, Bethany described the quality of attention and questions that her therapist has with her:

> She's just paid attention since the beginning, and I've never like asked for her qualifications in terms of what she studied or how she knows what she knows, but her curiosity and the kinds of questions that she asks, even from the very first session, reflected to me, not only that she had a level of comfort with what I was saying and familiarity, but that she was really thinking about who I was within what I was saying as well. She could hold these multiple layers and intersections to the socio-political overview, maybe her own life experiences and, therapeutic experiences with people but then also, me. And what my particular . . . how I'm relating to all of that . . . it felt like she was able to be ok with things that were unknown or still felt raw, or the intersecting parts of me. Yeah, and she asked a lot of questions but none of them felt intrusive or, voyeuristic or for her own

> curiosity or her own learning. They felt like they were questions that were helping me further clarify me, in the room, in my own experiences.

Bethany feels like her therapist is interested in helping her to understand herself, more than she is interested in having a clear understanding of Bethany for her own purposes. Moreover, Bethany described feeling like she is seen both in terms of her particular experience as well as her cultural context.

Nina spoke explicitly to the impact of ally cues on her experience in therapy with some therapists.

> I think that having this feeling about her, this person, whether or not this person is queer, is an ally, made me feel really safe . . . similarly my second therapist who was from San Francisco . . . she just felt like an ally, I knew she wasn't queer, but I felt somewhere in my mind . . . she was from San Francisco, she must know all the gay people, you know? And those cues I think were important to me in feeling safe, I guess. I mean I keep using that word because I think at the time was what was really important to me, was that I feel not just that I felt heard and supported to but that I was in a space that was free of any residual judgment or expectation from providers.

The cues of allyship, as Nina described them, seem to circumvent the importance of the identity of her therapist. Whereas in other situations being with a provider who she felt was queer would provide safety, the cues of allyship were able to offer a similar relief. She described safety as freedom from expectation and judgment, which all therapists could provide, regardless of their sexual orientation.

Subjective senses are not something that clinicians can create in their clients. However, practitioners can convey acceptance through their quality of presence, which results from the internal feelings and beliefs they have about sexual identity and expression. Quality of presence is also tied to the personal work that I will be discussing under the final theme, Understanding Therapeutic Practices. Generally, participants did not feel that faking acceptance was possible, but recommended that clinicians take the time to explore their own ideas, biases, and issues around sexuality and gender in order to come to a place of acceptance and respect for other people's choices. Those who do not feel genuine acceptance towards sexual minorities may not be able to provide culturally competent care for these clients. Therefore, participants' sensitivity to practitioners' openness appears to be an adaptive strategy for assessing and choosing competent clinicians.

Navigating Heterosexism

Listening to participants, it became apparent that they navigated minor and major experiences of stigma both outside and inside of the therapy room. They often arrived to therapy holding particular concerns and sensitivities about how therapists would respond to their orientation. At times these expectations were due to historical experiences in therapy, and other times the expectations resulted from experiences of social and familial stigma. Participants discussed experiences with therapists with whom they navigated a general lack of knowledge, as well as judgments and invalidations, about their experiences as sexual minorities. This theme highlights the ways that experiences of heterosexism in society influence clients' experiences of and approaches to

psychotherapy. As a result, competent care likely requires understanding and acknowledging the influence of heterosexism on the lives of sexual minority clients.

Learning Heterosexism describes participants' experiences of prejudice. I will then introduce reflections on Internalizing Heterosexism, which is the process by which prejudicial messages are internalized by individuals. Both internal and external heterosexism influences the expectations that LGB individuals come into therapy with, which will be discussed in Expecting Heterosexism. This theme also includes the various ways in which participants actively assessed the competence and comfort of therapists with LGB issues due to these expectations. Furthermore, those who reported positive experiences with therapists often described the experience as a pleasant surprise, indicating that safety is not an expected experience. Navigating Knowledge explores the experiential associations participants hold with educating and informing people about their experience as sexual minorities. This subtheme also discusses how therapists' responses to education and corrections to their language have influenced the participant's experience of therapy. While Navigating Knowledge relates to how clients navigate cultural knowledge, Navigating Judgment notes situations in which a therapist's personal judgment negatively impacts the client's comfort in the therapy space. These experiences are discussed in terms of their impact on the individual and the therapeutic relationship, providing indications of how important it is for clinicians to attend to their clients' experiences of cultural prejudice and judgment in the therapy.

Learning heterosexism. Participants noted that they frequently received negative messages about sexual minorities from their families and society. Two participants discussed their awareness of their parents' homophobia as preceding their

awareness of their own sexual identity. Gwen noted that despite having a supportive and progressive family in other contexts, she consistently heard negative statements from her mother about gay men. Nina similarly described her experience as "growing up with very religious heterosexual Latino parents, growing up in community with Latino people who said homophobic things at every turn . . . I was raised to hate gay people." She felt it was important for people and clinicians to know that, despite increased visibility around LGB issues and some legislative shifts, discrimination against individuals in the LGB community is disturbingly common. At the same time, Nina compared her childhood experience to contemporary metropolitan youth who she noted are much more accepting and knowledgeable about sexual diversity, indicating the potential for shifting societal perspectives.

While some participants noted having positive experiences coming out to their families, frequently challenges were noted in this area. Scott noted that his experience of coming out was quite negative, and he described how his therapist has helped him to understand the impact his family's reaction had on his experience of safety. He stated, "that formed a different type of lens of not feeling safe within my family environment, and then compounding that into society; because if my family couldn't accept me, then society certainly couldn't accept me." Scott's narrative demonstrates how experiences in the family can impact people's expectations of treatment in society and therapy.

Furthermore, Scott discussed the foundation of common experience that he has experienced with other sexual minorities:

> Often what I find is there's a common denominator for sexual minorities in terms of growing up and having to live in the closet, hiding their sexuality for fear of

> safety, fear of discrimination, fear of oppression. And hearing societal messages that continually discriminate against minorities in the classroom, on the football field, the basketball, in the locker room, at the grocery store, etc.

The common experience that Scott described is that of pervasive discrimination. While that experience occurs at different levels and with different specifics, he noted a shared understanding of what it is like to live in a heterosexist world. Likewise, Shay explained a very tangible example of discrimination in the professional sphere when she described her experience working at a catholic agency.

> I was always under the threat of being fired because they make you sign this document when you come to work for them that says that you will abide by catholic morals and values in your life. And so I wasn't able to be out at work, and my office, I kid you not, was a converted janitorial closet, so I was in the closet, while being in the closet [both laugh].

While Shay finds humor in this ironic situation looking back, the threat of her identity being discovered by others, and the impact of living in this disguised manner, were significant stressors in her life. Participants consistently described experiences of discrimination, which occurred from childhood to adulthood, and this provided a backdrop to their experiences of new individuals in a variety of contexts. Understanding heterosexism, thus, appears to be foundational to understanding LGB clients' experiences. Furthermore, these experiences had a significant influence on their feelings about themselves, which many participants discussed working with in psychotherapy. The impact of societal and familial messages occurs primarily through a process of internalization, which I will now discuss.

Internalizing heterosexism. Participants discussed ways that negative societal messages were internalized and influenced self-esteem and mental health. Nina highlighted this important connection when she stated that there is increasing social awareness concerning "the degree to which having a different sexual or gender identity from heterosexual and cys-gendered is an incredible factor in people's drugs abuse and depression and suicide rates and all kinds of things that are all about mental health." Hearing stigmatizing messages about LGB people can add to feeling of shame in those who identify as LGB, exacerbating or creating mental distress.

Highlighting the influence of societal messages, Scott discussed his process freeing himself from shame about his sexuality, which related to messages that his sexual identity was a choice:

> When we're younger, we're absorbing societal messages many times throughout the day . . . Coming to the realization that I can't change, and it's not a choice and it's how I was born, that relieves me of trying to prove anything to society and it also, it also helps with self shame. I don't have to shame myself for being [tall]. I don't have to shame myself for . . . having lighter skin. I don't have to shame myself for having ten fingers. I don't have to shame myself for being gay. I don't have to shame myself for having a tongue. So the impact is strong and it's a lot of self-talk, of positive self talk of telling myself I'm ok, this is how I am and realizing that society doesn't necessarily adhere to my ideas, but then it's ok for me not to have the same ideas as society, because I have to honor who I am. But it takes so, for me it took a long time, and as much as I tried to tell myself I was ok, I would go out in society and hear I wasn't ok, and retreat back into my safe

> place and say I was ok, and then go out and hear I wasn't ok. And so it was a lot of back and forth, and it took a long time to say I was ok, when I was hearing everywhere I wasn't ok, without wanting to retreat and isolate.

Scott described a long process in which he would repeatedly build up confidence in his own perspective and then experience negative societal messages that challenged his self-acceptance until the impact of these messages decreased. Similarly, Bethany talked about working with a therapist who was able to reflect to her how challenging it can be to "live in a homophobic culture" and explored the ways the culture has impacted her experience.

> For me, in that bitter context and her talking about how people take that up or how I took that up and took it in in a way that might be affecting my worldview, my sense of self, was really powerful and really helpful, and really soothing. It helped me kind of calm down about a lot of things, because I have a tendency, I don't know, there's all kinds of reasons why, but I like to blame myself [laughs] for a lot of things. And so it was really good to have someone say 'not so fast, well, you're, you know, the uphill battle! Everyone's telling you you're wrong or not ok, of course you're taking that in!' Yeah, so that felt really good, that was a really helpful intervention . . . it felt good that she felt so confident and so comfortable occupying that space of holding society accountable and holding people accountable and just having a large frame for understanding and helping me do that.

For Bethany, it also took a long time to appreciate the impact the larger culture had on her intrapsychic experience. She noted having to hear this reminder repeatedly, in order to combat the pervasive exposure to heterosexist society. It was helpful for her to have

her therapist hold this larger perspective and remind her of the internal impact of persistent social messages.

These descriptions underline the significant impact that repeated exposure to heterosexist messages can have on sexual minorities. While the specific examples will be different and the extent to which these experiences are internalized will differ, it is unlikely that a sexual minority will avoid some degree of internalized heterosexism. For those participants who discussed positive therapeutic experiences, many noted that a significant aspect of the therapy was assistance with self-acceptance and understanding the influence of societal norms. It seems, therefore, that one useful role of psychotherapy is the identification of this process, which can then ameliorate the power of the prejudicial messages.

Expecting heterosexism. This subtheme explores the way in which experiences of stigma influence expectations of, and comfort with, psychotherapy. Several participants discussed their expectations of psychotherapy. Their expectations of limited competence led to various ways of navigating new therapy experiences and determining the therapist's competence with LGB issues. Furthermore, while a few participants described finding safety with therapists, these accounts were described as unexpected and divergent from other experiences, indicating that LGB clients often anticipate encountering heterosexism in therapy.

Scott noted that many of his friends do not seek treatment due to "fear[s] that they'll be judged or stigmatized in therapy, which is a very sensitive place to be and vulnerable place to be." Therapy is already a vulnerable experience, which can be difficult to enter. When individuals expect to be misunderstood or stigmatized due to

experiences in society or previous therapy, then going to therapy can become an even more distressing endeavor. Bethany also discussed going into therapy with "fears about . . . what [the therapist] would think, feel, judge," as well as misgivings about having to teach her therapist about her experience as a sexual minority. While going to therapy can be a vulnerable experience, these participants described additional concerns about experiencing judgment and prejudice due to their sexual orientations.

Due to these fears, participants often entered psychotherapy with a heightened awareness of their therapist's cultural competence, implementing various tools for assessing the competence of therapists with LGB issues. At times they sought queer therapists through LGB referral bases in order to avoid educating and levels of stigma. At other times they reported asking therapists before meeting or in the first session about their experience and comfort with LGB topics. Bethany recounted different ways that her question about therapist experience has been responded to, such as with a forced-sounding yes. Conversely, she appreciated the way that her current heterosexual therapist responded: "She paused and she thought about it she was like 'you know, I feel really, really comfortable' and it just felt like she really thought about what I was asking and heard what I was asking." Her therapist's thoughtful response helped her to feel safe, and indicated that the therapist understood the importance of this question and the concerns that were behind her inquiry.

Other participants discussed a general awareness of cultural competence that they use in all new environments. Scott discussed the way in which he assesses safety in novel situations, he noted "I've done this for a very, from a very small age, I just learned how to do it." He also discussed being aware of his vulnerability and managing his

vulnerability in situations with others, in so far as he only opens up once he has determined the safety of the environment and other person. Michael also noted a general awareness of therapist cultural competence when he is seeking a provider. "I know what to look for and things, like oh, you're not competent in this area, oh, you're not familiar with HIV culture . . . It just makes me feel like I'm in the wrong place, or you need to inform people otherwise." He discussed this decision pragmatically, he either needs to exit the relationship or educate the other person, a process that will be discussed in the subsequent theme.

Stigma and judgment appear to be such strong expectations of new experiences that those participants who did find themselves in therapeutic environments that felt safe described this experience as unexpected. As Shay describes:

> I was hopeful for having someone that would have that openness and some kind of experience, which is why I had sought that out before, but still, not really having any, not really having any hopes really that that was going to happen. But she just blew my mind really, in terms of how accepting a straight person could be . . . I didn't expect it at all, and didn't even think it was possible, and when it happened it was quite nice.

Safety and acceptance were so unexpected by a heterosexual therapist that she noted it "blew her mind." Additionally Nina described her therapist, who was "so incredibly open and nonjudgmental . . . and for whatever reason, I didn't expect that. I think that I expected her to want me to make a decision one way or another [but] that wasn't what she was trying to do." This anticipation mirrors Nina's earlier definition of safety as "freedom from expectation and judgment" from the therapist.

Describing his current therapy experience, Scott stated, "I know that when I sit down on her chair [pause] I'm safe. I'm safe for 50 minutes." While Scott did not state directly that safety felt unexpected, the relief he conveyed when he described his experience with his current therapist indicated that such security with practitioners is not a feeling on which he can depend. No matter what the rest of his day in society brings, he knows that he will be safe for the 50 minutes he has in his therapist's office, and he described this therapy experience as deeply meaningful.

What participants experience in society appears to shape their expectations from therapists and therapy. When people have experienced a significant heterosexist messages, new encounters always have the potential to be destructive. Participants' descriptions of their approaches to psychotherapy indicate that while they are seeking help, they are also very aware of the potential for not receiving the help they desire. In order to provide competent care with this population, it is important practitioners understand the powerful influence of growing up in a heterosexist society and how this may play out in their relationship with sexual minority clients.

Navigating knowledge. Individuals holding minority identities often have to educate others about their experience, both in social and therapy spaces. Participants consistently noted frustration that educating the therapist took limited therapy time and changed the dynamic from the therapist providing to receiving support. For example, Shay described her perspective on educating others:

> Inevitably the responsibility for educating the other person falls on the person who has the less commonly recognized experience. And sometimes that can feel like a waste of time a little bit, or frustrating a little bit, or angering because

> you're trying to get a person up to speed on some basic life shit that you're going through and that can be frustrating . . . it's like, ok, now I'm supposed to be trying to heal here, and then I'm trying to justify my existence.

Shay noted that it has at times felt counterproductive in a therapy space to justify her experiences when she is trying to seek support for her experience. However, she was careful to state that she does not always feel this way, and noted that her relationship to educating often depends on other aspects of the therapy. Similarly, Scott noted that his frustration varies based on how much educating is needed. He noted,

> I think there's a desire for my therapist to, maybe, be quicker and have less of an education process, and almost an expectation that he or she has been schooled on LGBT topics, which I find, is not the case. So there's a frustration that I have to, not only school society, but school somebody I'm seeking help, a helping professional. I have to be in that role quite often . . . But, the older I get the more I realize that even someone whose been schooled in LGBT topics and maybe even identifies as a sexual minority, my experiences are going to be different than his or hers, so there's always that learning curve, there's always that educational component . . . What I would like is for it to be minimal in terms of therapy, because I don't want to waste a lot of time on that.

Scott recognized that educating the therapist on his experience is going to be a part of therapy, but the frequency with which he is in the role of educator makes is frustrating. Additionally, the lack of consistent education of LGBT issues in graduate programs means that, at times, clients may have to educate their therapists a great deal.

Scott went on to discuss another aspect of educating others, correcting them when they use inappropriate or offensive language. He reports correcting others both in order to help people become aware of the impact of their language and to help him feel comfortable in his environment. However, he reported hearing offensive language so frequently that he does not always speak to his concern. He described the process of deciding whether to respond to offensive speech as relating to how much energy and time he has available, as well as how receptive he perceives the other people to be. At times, he noted removing himself from the environment when it does not feel useful to correct others. Moreover, Scott noted that when he does decide to take on the role of educator, his affective engagement is variable. Sometimes he reports responding in a cognitive way, and sometimes his frustration will come through because of how regularly he encounters insensitivity and lack of understanding. He reported that the need for education feels constant and speaking up for his and other margalized experiences can be emotionally challenging.

Scott reviewed a time when he saw a therapist who used terminology that felt offensive, and he brought this language to her attention. He reported that the therapist became defensive, noting that her terminology reflected how she was educated. Furthermore, she continued to use language that he had noted was offensive to him, which felt malicious after he had shared his reaction with her.

> When you're in a vulnerable state, the last thing you want to do is decide if someone is being malicious or not. And I didn't think it was a good fit, because she was unable to catch on to simple cues that made me uncomfortable. Or chose not to . . . There's just terms that you don't want to use, especially if someone

> tells you they're uncomfortable with a certain term, you want to stay away from that term, unless you're trying to oppress or demean or create a hierarchical imbalance. I think we need to be sensitive with language, that's what I'd like, when I don't feel that sensitivity with language, then I'm not interested in participating.

Scott felt that her defensiveness reflected a lack of receptivity to his perspective, and this insensitivity led him to discontinue the therapy.

Defensive reactions can occur from therapists who are deeply invested in being allies to the queer community. For example, Gwen recounted a story in which her partner was in a workshop where Anne's therapist led the group in an exercise imagining what it would be like to go through the world as a sexual minority experiencing heterosexism, without acknowledging that some of the participants may, in fact, know what that feels like. When Anne's partner let the therapist know that the exercise made a heteronormative assumption, the therapist was quite defensive. Gwen noted that it was likely the therapist identity as an ally that made her unreceptive to the feedback, indicating that a therapist's attachment to being an ally may, in some instances, prevent them from being sensitive allies.

In contrast, Scott spoke about a time in which his therapist responded to educational information in a manner that added to his comfort in the therapy. Scott reflected on a moment with his current therapist in which he corrected her and she received that correction with an apology and further curiosity about his experience. He stated that her openness and interest in learning about how her words impacted him contributed to his feeling of safety and appreciation of their therapeutic work. In fact, he

noted getting tearful because he felt so safe and heard in her presence. Moreover, an indication of the safety in the relationship is the comfort he feels discussing occurrences in their relationship. He reports that if he ever felt stigmatized he would promptly bring it with her, knowing she would be receptive and interested in increasingly understanding his experience.

Similarly, Nina described an interaction with her therapist in which her therapist asked her about the meaning behind a term she used. While the therapist's confusion about the term "femme" indicated to Nina that her therapist was heterosexual, Nina appreciated the way her therapist admitted not knowing and asked about the word's meaning and how Nina related to the term. She noted that people are often afraid to ask questions due to fears of being wrong, but she appreciated that someone who was in the position of authority asked her what she thought and admitted they did not know something in order to learn more about it. Nina respected the way in which her therapist responded to the situation and recognized that it is not reasonable to expect her therapist to know everything about her culture due to the diversity present within the spectrum of sexual identities.

At the same time, Nina encouraged therapists to seek information for themselves and engage thoughtfully with it. She stated, "the people who are the one's being oppressed, cannot also subsequently be the one's educating about every little detail. You can do some research and come back and have a conversation about the complexity," thus encouraging those who hold privileged identities to take responsibility for educating themselves. Further, Nina mentioned that she was aware that her current therapist was doing research about gender identity, which was indicated by increased comfort with

certain vocabulary and asking questions that related to current ideas about gender identity. She stated:

> What I see in her attitude and desire to know more, what I read from that is a real desire to do justice to the work she's doing with me, it signals she knows she has things to learn, that there are challenges in providing services to me, and then it's her job to go a little further to make sure that she gets the subtleties of my experience.

Nina noted that her therapist's increasing knowledge helps her to feel heard and supported by her therapist, as well as indicating they are doing good collaborative work together.

Participant accounts indicate that sexual minorities are in the position of educating others about their experience in multiple venues, including the therapeutic relationship. These quotes suggest that this can be a frustrating experience, but this frustration can be minimized in a number of ways. Clinicians can seek knowledge about their clients' experiences on their own, and this may be necessary if educational programs are not offering adequate information about diverse experiences around sexuality. Furthermore, practitioners can be receptive to clients' corrections and feedback, recognizing that clients hold knowledge that will help therapists to understand and support the clinical work. Finally, these accounts can facilitate clinicians' empathy for the persistent pressure involved in explaining their experience to family, professional colleagues, practitioners, and friends.

Navigating judgment. Participants also described experiences of judgment occurring within the therapeutic relationship, primarily with sexual majority, but also

with sexual minority, therapists. These experiences of judgment and invalidation influenced the clients' use of and comfort in the therapy, and led to termination, either directly or indirectly. It is important to note that I do not have information about the therapists' perspectives, and cannot speak to their intentions. Therefore, I will share my participants' accounts and further reflect upon the complexities of these situations in the Discussion section.

Two participants discussed experiences in which their identities as sexual minorities were invalidated by therapists, one in which the impact of being a sexual minority was minimized and another in which the orientation was considered transitional. Scott described invalidation as an undercurrent of several brief therapy experiences. He notes,

> I didn't feel an energy of inclusion, I felt an energy of . . . 'you're a sexual minority, get over it'. It wasn't, tell me about . . . experiencing discrimination and oppression throughout your entire life, but, look at you now, you're in grad school, you're ok, it's not that big of a deal. Minimizing, minimizing my experience, and not acknowledging how my experiences have provided a template for how I view life.

This dismissive outlook reflects a judgment that a person's sexual orientation is not a significant aspect of their identity or experience. Scott terminated with both therapists who gave him this impression, because he did not feel comfortable working with therapists who appeared uninterested in learning about his experience.

Alisha discussed working with a heterosexual male therapist who suggested that her sexual orientation was a phase that would eventually result in a more preferable

heterosexual orientation. This perspective reflected a judgment that same-gender attraction and relationships are inadequate, abnormal, or illegitimate. She describes the therapist's bias for heterosexual relationships as a subtle message that she did not recognize at first. She reports being less conscious of stigmatizing statements at the time because she was newly identified as queer. However, throughout the therapy she became increasingly aware of her discomfort with the therapist's treatment of her relationship. She noted being grateful to the fact that she was in graduate school learning about different theoretical approaches to therapy because she saw his preference as a result of his theory. She noted that this knowledge helped her not to take his judgment personally. Nevertheless, she stopped speaking about her relationship with him and reported that the therapist's view limited the length of their treatment. She indicated that while he was genuinely helpful in one aspect of their work, his shortcomings limited how much they could work with together. Additionally, Alisha remarked that without having this knowledge of various theoretical orientations, the influence of his perspective might have been more destructive.

An interesting positive outcome of the experience that Alisha reported was that she learned to use her intuition and personal discomfort as valuable relational information. This highlights the resilience of clients taking challenging experiences and learning valuable lessons from them. Similarly, while Alisha's therapist noted believing that her healing would occur through eventually being in a relationship with an assertive male other, it seems that significant therapeutic growth occurred through developing and acting on her own assertiveness around her right to comfort in the therapy space.

Furthermore, the experience raised her awareness around how therapists' personal beliefs can get in the way of therapeutic work.

Other participants noted situations in which therapist judgments were more obvious. Michael recounted a situation early in his relationship with his current partner, in which he was discussing his new relationship with his female therapist of unknown orientation. He reported discussing his new partner's interest in having a nonmonogamous relationship and periodic use of ecstasy, when the therapist suggested that his new partner was a sex and drug addict. Michael emphasized the importance of cultural context in understanding behavior and felt that the therapist did not understand gay culture, particularly in the metropolitan area in which he lived, where using ecstasy on a semiregular basis and having nonmonogamous relationships was widely practiced. He acknowledged that some individuals have personal challenges with addiction, but given the cultural support he felt he had for these behaviors, the therapist's response led him to question her ability to help him navigate his social world.

> Regardless as to what her sexual orientation was or her gender was I didn't feel she was culturally competent at that point and able to guide me, because she didn't have an understanding, she had a judgment. And she wasn't asking me questions, and I started lying to her. So as soon as you start lying to your therapist, you're not feeling comfortable, and you're not getting anything out of it, so I terminated.

Michael described relying on cultural norms within his community to defend himself from the therapist's judgment. However, the therapist's concern about his new partner's

behavior prevented the therapy from being a place where he could explore his opinions about drug use and nonconventional forms of relationship.

Nina discussed an experience in which she experienced judgment from a therapist who, as far as she could tell, shared her sexual orientation. She went to this therapist to process fears and other associated feelings that she had about her partner's upcoming gender transition. She felt that the therapist was pushing her to be more supportive about the transition than she was ready for, at that time. Nina noted generally not feeling like the therapist was on her side and, after a summer break, she chose not to resume treatment. While she was unsure of the therapist's gender identity, she felt that her therapist was likely transgendered. In their first meeting, the therapist had reacted strongly to Nina calling the therapist by their first name, which was listed on their business card and e-mail address. She admitted that she could have been projecting her fear onto the therapist, but she noted that this experience highlighted to her the potential for therapists who have a similar orientation to project their own experiences onto their client. For Nina, this issue reminds her of her own sociological work, in which studying personal topics is discouraged,

> because you lose that objectivity of seeing things and on top of that you map your own experiences onto them and that's just going to happen, but I think that, to me, seems like something that could happen in this space, where on the one hand your level of connectivity with individuals, with communities can be helpful, but on the other hand if you're not aware of your own, what you're mapping onto this person, it can be harmful, like I felt like my relationship with [this therapist] was.

Nina's experience highlighted that judgment does not only result from difference. At times, therapists' may struggle to separate their own experiences or ideas from the experiences and needs of their clients when they share an identity or experience.

Nina noted that because the therapy experience is "two humans in a room by themselves and . . . that relationship can be so intimate and so detached simultaneously," it is particularly important for the therapist and client to be able to discuss moments where they might not understand each other. She recounted an experience with her current heterosexual therapist, wherein her therapist recommended increasing the frequency of their visits towards the end of a session, without leaving adequate time to discuss this topic. Nina left the session feeling upset and mentioned it in the next session. The therapist immediately apologized to her and took responsibility for not bringing the topic up in a more thoughtful manner. In addition to being surprised by the therapist's apology, Nina noted feeling empowered in the relationship and validated in her experience of the interaction. She stated, further, "I feel like I can trust her even more. I can trust her to even be self-reflective and know when she's being a good counselor." After the previous therapeutic relationship in which she felt judged, Nina appreciates her therapist's ability to take responsibility for her part in their interaction.

Countless dynamics can arise in the therapy, and the ways that therapists' relate and respond to their clients appears to have a significant impact on the therapy experience. While considerations about the role of therapist judgment in therapy will be discussed in the Discussion chapter, these narratives provide a model of how judgment can create ruptures in the therapeutic alliance. Moreover, all of these situations of judgment resulted, either directly or indirectly, in termination. The presence of judgment

negatively influenced participants' comfort in the therapy and eventually led to them discontinuing the treatment. It is unclear whether discussing the above situations would have prevented this, but Nina's experience of a therapist apologizing to her suggests that discussing interactions that occur between the client and clinician may facilitate working through such rifts in the therapeutic relationship.

Preferring Therapist Identities

Interviewing seven people, I was struck by the variance in therapeutic preferences, which result from differences in personality and historic experiences. As a result, participants had varied ideas about the importance of the therapist's sexual orientation on their therapy experiences. Preferences, for particular therapist identities or therapeutic styles, are a uniquely personal thing, because what makes each person feel comfortable is unique. This theme notes benefits, and briefly notes challenges, to both cross- and shared-orientation therapeutic relationships and highlights the diversity and legitimacy of diverse client preferences. Identity preferences and reasons for these preferences will be discussed under the subthemes: Shared-Orientation Beneficial, Cross-Orientation Beneficial, and Sexual Orientation Secondary.

While there was incredible diversity between the participants' desires for therapy, there were also differences in what participants wanted from therapy at varying life stages. Participants periodically discussed dissimilar therapists, who they felt responded to different needs that they had at different times. Three participants discussed benefiting from increasing depth in their therapeutic relationships as their health and self-awareness increased due to previous therapy experiences. For example, Bethany noted,

> It's amazing, what therapy can do. I mean all of these experiences I've talked about, they've all been important, but I think, just that the age I'm at, the place I'm at in my life, the fact that there's no fires right now. I have hard things, stress, but my life is really solid and therefore I can really dive into these deeper layers that, and look at how I was put together in this world and how those experiences were informed by the people around me and it's so great.

Bethany highlights that as she grew in her life and in therapy, she wanted something different from her therapist. In a similar fashion, the importance of the therapist's identity can change depending on the nature of the client's presenting problem at that particular time. When participants' sexual identities or relationships with same-gendered others were the focus of their therapeutic work, the therapist's identity often seemed more important. At other times, clients' prioritized their presenting problem or other therapist qualities. Therefore, changing needs can make preferences quite complex.

Three participants discussed an identity preference independent from sexual orientation, which was a preference for female therapists. Because the focus of this study is not on gender, but is influenced by gender, I would like to briefly note this preference. For two of the three participants who discussed preferring a female therapist, this preference was related to their experience of sexual abuse perpetrated by men. One participant noted that, after purposefully seeing a male therapist to discuss her abuse history, she would now only see women because "I don't think that [men] can really identify with what it means to be in such a powerless situation." Another survivor of sexual abuse stated that her preference for females relates to those with whom she feels most safe. The other participant who prefers working with female therapists specified

that her gender preference is the result of challenging experiences with men and authority, which reflected sexism in her family of origin, as well as in society. Some of these participants wondered whether in the future they might benefit from working with men, whereas others felt that their increased comfort with women guided their therapy choices in unproblematic ways. This gender preference highlights the way that personal experience influences the therapist qualities that are associated with comfort, which aid in developing a therapeutic alliance.

Given concerns about experiencing heterosexism and misunderstanding in therapy with heterosexual therapists, preferences toward same-orientation therapeutic relationships are understandable. At the same time, those participants who ended up in supportive therapeutic relationships with sexual majority therapists discussed significant benefits. Clients are entitled to their own particular preferences when setting up a relationship that can be vulnerable and complicated. Therefore, it is worth understanding why some clients would seek one type of relationship over another. However, as clinicians cannot control or change their personal identities, Therapeutic Practices are discussed in a subsequent theme in order to provide tools for therapists who wish to provide competent care for LGB individuals.

Shared-orientation beneficial. Several participants indicated having a future or historic preference for therapists who are LGB. One of the reasons cited for this preference was a reduction in explaining their experience due to shared cultural knowledge. Shay described seeing a lesbian-identified therapist and noted that the shared cultural background relieved her of the responsibility of explaining her rights and the nuances of coming out to others and created an increased sense of ease and

understanding around the influence of her sexual orientation on her experience. Likewise, Michael stated,

> It just minimizes the risk to me that I have to explain stuff. I know intellectually that it may not matter, depending on the therapist experience, but it's almost like, why would I even take that gamble? . . . Why would I take that risk of cultural competency and relatability?

Michael described seeking a heterosexual therapist as a gamble and a risk, which was minimized with a therapist who shares his cultural context. Michael went on to note that because he lives in a metropolitan area where gay male therapists are common, taking the risk of lack of cultural knowledge with a heterosexual therapist does not make sense. However, LGB therapists are not readily available in all geographic locations.

Bethany described seeking a sexual minority therapist in order to maximize safety in the therapy around vulnerable aspects of her identity. When her partner was transitioning genders, she felt that it was particularly important to see a therapist who had understanding and expertise about the transitioning process and associated transgender issues.

> I felt so raw, and so fragile that I really needed to know that there wouldn't be big mistakes that would hurt me. That, in the sense that you can't always guarantee that that wouldn't happen, but, I felt like I was taking reasonable measures to reduce that risk . . . and feeling reasonably certain that I wasn't going to be judged or viewed as weird, because I felt really like, a lot of inner persecution and turmoil and I felt that from the outside and I felt very protective of [my partner]

too, that he wasn't there in the room but he was, you know, emotionally, and I felt very protective of his process because he was so fragile at that time too.

Bethany sought a therapist with a common identity in order to protect herself and her partner during a complicated and challenging time. She also spoke about the value of working with a therapist who had positive feelings about the LGB community in order to allow her to fully process her feelings about her partner's transition. She reported feeling that her therapist could hold the diverse array of feelings she was having without feeling like she needed to protect or manage her therapist's perception of the queer community.

Many participants shared the expectation that having a shared orientation would lead to shared experiences. However, other participants noted that this assumption is not always the case. Alisha, while discussing the way her LGB clients ask about her sexual orientation, noted "there is a level of safety that comes with knowing that this person shares in your identity . . . they're seeking safety in an identity, even though, even if we share the same identity that doesn't mean we share the same experience." Scott recognized that education would be minimized if the client and therapist shared a common foundation of experience around growing up in a heterosexism society, because "even though there are differences there are a lot of similarities and an understanding that's deeper than somebody who hasn't experienced that." At the same time, while discussing his friends' preference for gay male therapists, he noted that they are seeking "that common denominator so they don't feel like they have to educate the therapist perhaps on their experience, where there would be more similarities, or the idea of more similarities." He added that he respects their wish for understanding and avoidance of

heterosexism, though he was unsure whether having the same orientation would offer the safety they sought.

According to many participants, shared-orientation therapeutic relationships feel safer than cross-orientation relationships. This is because it feels likely that a sexual minority therapist will understand the impact of internal and external heterosexism on LGB individuals' lives and share common linguistic and cultural references. Nonetheless, the experiences of sexual minorities vary greatly, and the expectation of similar experience is not always delivered. Furthermore, there may be many other aspects of clinician that influence treatment outcome.

Cross-orientation beneficial. While having a shared-orientation can relieve clients of having to explain themselves, Michael noted that sometimes it could be beneficial to explain aspects of experience in order to reflect on why and how things are. He noted that is one of the "good things about having cross-cultural mismatch." As an example, he discussed how describing how things are in a person's family allows the client to actively reflect on things that may be automatically accepted as normal within that family system. Exploring behavioral patterns that one has grown up with can allow for insight and questioning about whether those patterns work for the client in present contexts. Moreover, all clients come from unique familial and social cultures and, therefore, understanding clients requires much more than knowledge about cultural norms.

Although potential challenges working with heterosexual therapists includes coping with misunderstanding and judgment, there are potential benefits to cross-orientation therapeutic dyads. Two clients shared that they received significant benefit

from experiencing acceptance from a heterosexual person. Shay discussed working with a heterosexual therapist at a particularly challenging time in her life after three therapists did not agree to work with her. She noted that the therapist's acceptance provided needed support and helped her to return to therapy later in her life after discouraging initial experiences.

> To be accepted by a therapist and you know, to have that be the root that allowed me to then return to therapy later with less fear, anxiety, so she kind of inoculated me against my current, then current state, of being terrified of being dumped by a therapeutic professional. Just the incredible welcoming and accepting aura in her office and from her, which was one of the only places that was accepting of my lesbian status at that time. I wasn't even out to some of my family members at that point in time and so, and everything was, I felt that everything in my life was pressuring me to continue to conform to heteronormative standards and, that was reinforced at work, and it just, that was literally the only place where it was fully accepted. So…I don't think I could really overstate her impact on my life.

Her relationship with this therapist provided the only space in her life where she could be honest about her identity as a sexual minority. Similarly, Bethany discussed the value of having a heterosexual person treat her with respect and care.

> Bethany: But there's been something really, really healing about, me being able to be fully seen, respected, validated, understood, all of those layers of my identity by her, with my understanding that she has this kind of traditional arrangement, and, I think it's been, because my biggest fear was a straight therapist couldn't understand me and I feel more understood by her than I ever have by anyone and

> that feels amazing, even though I went in thinking this is one complicated ball of mess . . . To have the fantasy or the idea that she very may well have no idea what I'm talking about, or have never come across it until meeting me, and yet, I am still understandable and relatable and not confusing, or pathologizing, or weird, or . . . she's not going to judge my relationship or, yeah, that, all of that. It's good. I'm fine. That I'm more than fine.
>
> Rebecca: You're more than fine.
>
> Bethany: Yeah, yeah. That's been really, really, really healing, and good. Yeah, to be understood by a straight person feels really good. And . . . I'm not ever going to get that kind of approval and understanding and support and celebration and admiration and, I'm not going to get that from my mom and, and even if she finally got there. It's kind of like, she can't take back what's already happened either. And so to have, this older wiser person than me doing that for me is such a gift and, it feels amazing all the time.

The support Bethany feels from her therapist provides a supportive compensation for her mother's lack of acceptance. Furthermore, there is a way in which having understanding from a person who does not share her culture makes her feel comprehendible.

Both of these clients noted that they did not necessarily seek out a heterosexual therapist, although the experiences they shared were deeply healing for them. It is understandable that none of the participants discussed having an explicit preference for sexual majority therapists, given their expectations of heterosexism from those who are not sexual minorities. Nonetheless, if a sexual majority therapist is compassionate and

educated about sexual minority experiences, meaningful experiences of acceptance by representatives of the dominant culture are possible.

Sexual orientation secondary. Some participants where uninterested in the sexual orientation of their historical and current therapists, or felt that sexual orientation was less important than other aspects of the therapy such as skill, presenting problem, and theoretical approach. For example, Scott noted "it didn't matter how she identified, what mattered was her energy towards me. And I wasn't necessarily looking for a gay therapist or a lesbian therapist, I was just looking for a good therapist." For Scott, the therapist's skill, acceptance of the client, and the fit between the client and therapist are the most important factors. He went on to note:

> I'm looking for somebody who is willing to understand me . . . regardless of their sexual orientation . . . And actually, through the course of my work with my therapist, I've told my gay friends the importance of finding a good fit, more than finding a gay therapist because the gay therapist might not be a good fit, so I, though I understand their positioning, be open to somebody who is more of a good fit than more of the same sexual orientation.

Scott explained "a good fit with another allows the person to feel safe and vulnerable." He noted that he can tell that there is a good fit between himself and his therapist when he feels safe and comfortable to explore his experience. He reported experiencing this feeling when he is with someone who is welcoming, nonjudgmental, and interested in helping and learning.

Alisha highlighted therapist skill and confidence as more important to her than therapist identity. She recounted a therapy wherein she chose a therapist based on their location and cost, and then found out they identified as lesbian. She stated:

> I loved that she was in the queer community, but that was so not enough [laughs]. She was just, she was very intimidated by the fact that I'm a psychologist, and she's an LCSW, and so she would kind of negate her own work, by saying, 'oh you probably already know about this,' or 'I'm sure that you've already done this before, you already know all of this.' And so, I just didn't feel like. I mean, she didn't have confidence in herself.

The therapist's lack of confidence led Alisha to feel apprehensive about the therapist's ability to help her. She reported needing a therapist who could handle the things that felt unmanageable to her. In this therapeutic experience, Alisha discussed feeling the need to take care of the therapist and, as a result, did not feel like she could express her more primal emotions.

At times, participants discussed prioritizing therapists' specialties over their sexual orientation. The degree to which presenting problems related to their sexual orientation often determined the importance of the therapist's sexual orientation. For example, two participants noted choosing heterosexual therapists due to the therapist's specialization in trauma work. One of these participants noted that earlier in her identity development, that may have been difficult for her, but due to her comfort with her sexuality, she felt like what she needed was a therapist who was experienced with what she identified as her primary issue. She notes "that ended up being more important to me, because that feels like, in so many ways, the core mental health challenge is coping

with that trauma." She added that she had other spaces to explore and support her queerness with her partner and community, so identity did not need to be a focus in her therapeutic space. While this participant felt that earlier in her identity development she would have preferred a sexual minority therapist, Michael's preference for sexual minority therapists has increased over time. He reported that earlier "it didn't occur to me that it was an issue." Developmental trajectories and therapist preferences are individual and variable.

These quotes indicate that therapist identities are not the only thing that is important to sexual minority clients. While some participants discussed preferences for certain identities, the aforementioned participants emphasized other therapist qualities as more important, such as fit, experience, and expertise. This finding suggests that there are multiple aspects of the therapist that facilitate a client's comfort and investment in the therapy, with sexual orientation representing only one piece. Furthermore, there are numerous aspects of client and clinician that lead to a "good fit" between the two individuals. While identity is not necessarily something that clinicians can change about themselves, I will now discuss therapeutic practices that participants appreciated in their therapeutic experiences, which all clinicians can work towards.

Understanding Therapeutic Practices

Participants frequently highlighted the way that therapists' behavior and quality of presence influenced their experience of therapy. This theme includes participant's experiences of their therapists that are unrelated to their identity. Participants discussed the influence of therapist's qualities of presence, techniques, and approaches, reflecting on what worked and did not work for them. As with identity preferences, preferences

around therapeutic practices are variable, with participants experiencing the same behaviors in divergent ways. As Scott noted "one-size fits all is just not applicable to anybody." Therefore, none of these findings can be assumed to be useful for all clients.

Firstly, I will discuss participants' reactions to various levels of therapist Disclosure, both about their sexual orientation and general personal information, which were rather ambivalent. Secondly, I will discuss a quality of presence that many participants described in their positive therapeutic encounters: Nonjudgmental Interest. I will then consider quotes that reflect the importance of therapists working on their own awareness and comfort with sexuality under the heading Personal Work. Relatedly, participants discussed the value and influence of therapists' Comfort with Sexuality, which helped clients to speak about a difficult and taboo subject. Finally, Commonality and Culture includes quotes in which participants reflect on the importance of therapists acknowledging both the common human aspect of their experience and the particularity of their lives as sexual minorities. This theme is built out of participants' experiences with a variety of therapists and, therefore, may provide recommendations for competent practice with sexual minorities for therapists of multiple identifications.

Disclosure. Therapist disclosure was noted by many of the participants. Often disclosure was noted in relation to therapists disclosing their sexual orientation, while other times, it was noted in a general manner. Participants had different levels of comfort with therapist disclosure and two participants discussed an ambivalent relationship to therapist disclosure. For example, Bethany reported having very distinct reactions to therapist disclosure during two therapeutic experiences. When discussing the therapist she saw after college, she noted feeling "comforted by knowing about her life," and

admitted she asked the therapist personal questions in order to ease her discomfort in the therapy space. Alternatively, she noted seeing a therapist a few years ago for one session during which the therapist's use of self-disclosure was disconcerting. She reported the therapist immediately "started talking about her own life . . . it felt like too much of her was in the container right away, and I didn't feel like she truly got me or even had a curiosity about the parts that she might not get." Earlier in her experience, information about the therapist helped her to feel welcomed into the therapy space, whereas in her later therapy experience, the therapist did not leave adequate room for her. This different reaction further emphasizes the way that clients' needs and desires in therapy change over time.

Shay discussed feeling conflicted about disclosure around the therapist's sexual identity. She noted that she would like to see a sexual minority therapist in the future, but questions the choice of therapists disclosing their sexual orientation. She states,

> It's such a fine line, you want to know that someone has a competency in a particular area but it's not really reasonable to expect that they're going to self-disclose, particularly right off the bat. Probably not in a profile online and then, this is my own bias coming out again and then I get kind of worried about someone who would disclose something like that right off the bat, because I seem to be a magnet for people telling me their life stories, and I guess my own judgment about that is, it is something that still is private, it has a facet of invisibility and I'm not out to my own therapy clients. I guess I'm, I follow a similar model as my second therapist, in having cues around and trying to use language and points of reference indicating common experience, but I just, I

> would be very wary of someone who shared that and I think that leeriness comes from the fear that at some point it's going to become more about them than my own feelings.

Shay echoed the concern that a self-disclosing therapist may share too much of themselves in the therapy space and that this insertion may prevent the therapist from properly tending to the client's needs. Additionally, she expressed the opinion that sexual orientation is private, and not something she would feel comfortable sharing with her own clients. As a result, in her own work, she tries to strike a balance and follows the model of one of her therapists who did not disclose overtly but did offer cues of allyship.

Alisha expressed immense appreciation at her current therapist's lack of disclosure. Firstly, she appreciates this aspect of her therapist because her previous therapist disclosed in a manner that felt inappropriate to her. She discussed him discussing the nature of his divorce and feelings about his ex-wife. Furthermore, Alisha ended the therapeutic relationship when he had surgery and requested she visit him due to his lack of family support. In this situation, Alisha recounted, his disclosures conveyed expectations that she take care of him, which felt uncomfortable. Her new therapist's boundaries around disclosure feel relieving and also allow her space for fantasy, which she is discovering she finds very helpful. Alisha described this discovery,

> I would say that that has been so interesting for me to understand as a therapist myself. Because I do feel like, it just helps me to understand that it just so totally depends on the client. I myself had a client where my personal disclosure has so immensely helped the therapy, and has helped her, the client. And so, I've seen how well it can go with the proper disclosure, but now I've also seen that

> absolutely no disclosure at all can be so beneficial. Because it does leave open that space for fantasy, and I don't think that I've really recognized until recently how important it is to have that element of fantasy in the therapy, because then, as the client, I am free to bring up so much more stuff because I have fantasized that she understands that, or she's open to it, or maybe she's had this experience, so just allows for play in the relationship that disclosure could shut down.

While she appreciates the room for creative fantasy in therapy generally, the fantasy that she is specifically referring to is the fantasy that her therapist is bisexual. She noted that this belief allows her to feel understood concerning her lesbian relationship and queer identity, and relieves her of having to explain mundane aspects of LGB experience. At the same time, she reported feeling comfortable discussing past experiences with men and any opposite-attractions she might experience without fear of judgment about being a "bad lesbian." Seeing her therapist as bisexual allows Alisha to bring multiple aspects of herself and her sexuality to the therapy. Thus, disclosure influences safety in interesting and varying ways. However, the diversity with which different clients' experience disclosure indicates that clinicians may wish to use this practice with caution and closely monitor clients' responses.

Nonjudgmental interest. Participants often discussed the therapist's quality of presence. They noted their subjective experience with therapists and described their practitioners as closed, open, awkward, comfortable, warm, cold, etc. Among the various descriptions, however, a general theme emerged among the therapists from which participants felt most helped. The quality that emerged was a general interest in their experience, which was neither judgmental nor overwhelmed. Participants described

being surprised and calmed by their therapists ability to hear and understand their experience. Shay described it this way:

> I guess just like my subjective experience that she could just hold whatever I was going through. She was very calm, nothing seemed to faze her, she didn't seem to get worked up about anything, just incredibly accepting . . . she just, didn't bat an eye. Whatever I brought up was completely fine, and safe, and welcomed.

After having unsuccessful beginnings with three therapists who referred her elsewhere, she was amazed by the therapist's capacity to hold her distressed experience. This subjective experience helped Shay to believe that she may be able to manage the things with which she was struggling. Furthermore, she describes the therapist's calm openness as being very healing to her. Nina described a similar experience, "she wasn't surprised or shocked or, I don't know, I didn't get any sense from her than any of the things that I had laid out kind of manically was anything that she was concerned about." While Nina noted the therapist sharing concern when appropriate, the therapist conveyed comfort with the information and genuine compassion through her presence and lack of reactivity.

In the same manner, Scott described his current therapist who he experiences as inviting, curious, and compassionate. He noted that his therapist demonstrates genuine interest in continually deepening her understanding of Scott's experience. Scott noted that this quality of presence creates an environment that is conducive to significant therapeutic work because "if the client can't feel safe or is guarded in some way and is not able to express that, I think that becomes a road block in therapy." Additionally, Scott noted that his therapist has provided a good model for how he would like to be in his own work as a therapist.

> What it's really done for me is made me such a better therapist, because not only am I on a 'tell me more about that' level, but I'm more of a regardless of your skin color, regardless of how many limbs you have, or how short your hair is, or what color your eyes, regardless. I want to know more about your experience. From a place of 'how can I be better for you,' 'how can I help to understand you more,' which she has done for me. And I think, sometimes I think you can fake it, but it will be revealed later if it's not coming from an authentic place, and, she's taught me the value of learning from others and how if you are willing to go into the depths with them, you will understand them so much more, because they're waiting for somebody to go there and to understand them and not be judgmental.

He has experienced the benefits of his therapist's approach and now works to provide his clients with similar experiences. His quote also highlights the importance of therapists working from authentic interest, because he feels that fabricated interest will not have the same impact on clients. Those participants who had experienced transformative positive therapy experiences all described therapists who conveyed authentic and unprejudiced interest in their experience.

Personal work. The importance of authenticity was also raised by participants who felt that it was important for therapists to work on and be aware of their personal beliefs around sexuality and gender. Some of these participants were therapists themselves, and they discussed the ways in which, put bluntly by Alisha, "your own shit can really get in the way if it's not checked." Just as Scott discussed the way that faked and genuine interest are not experienced in the same way, Bethany noted believing clients

have a sense of their therapist's comfort and acceptance around the issues of sexuality and gender. While highlighting the importance of therapists' personal work in addition to cultural knowledge, she stated,

> There's just such a difference between having a few clients that identify anywhere along that spectrum or those experiences, going to some trainings and feeling, competent, which is a hard word in itself, versus really doing your own work around our own homophobia and our own, everyone: gay, not gay; I think we all live in this homophobic culture, and, doing our own work. Looking at our dark places around sexuality and sexual orientation and gender identity . . . I think that just, no matter who you are, if you've done that work, you can feel it. And, I can feel it, but I think anybody can feel it. That even if, you know, you're the most [conventional] person, you know, missionary style only with opposite gender, you waited until marriage, you're Christian, I don't know, you're the most traditional, in that sense, kind of person. That's what works for you and that's what's hot and feels good and that's your choice, it still is important to understand why that's your choice and why that's hot for you. And I still run into those places in myself, you know, I feel like I have to work with all the time.

Bethany admits that her personal work being a sexual minority concerns acknowledging the differences in her and her clients' experiences, whereas other therapists may struggle with understanding and accepting sexual and gender expressions that deviate from mainstream cultural standards. She emphasized that we all grow up in a culture that assumes heterosexual normativity. Both sexual majority and minority individuals are impacted by culture and culture influences people's beliefs about sexuality and gender.

Additionally, she noted that her therapist's acceptance of her own challenges and mistakes has been instrumental in helping her with self-acceptance. She stated, "I can feel her own acceptance of her humanness. And she can, therefore, help me accept all of my humanness." Thus, therapists' personal work on general acceptance can be helpful to clients.

Nina further underlined the importance of therapists' personal work with respect to her experience with a sexual minority therapist whose personal relationship to gender appeared to influence the therapy. Nina noted that the experience was

> really eye opening to me to see the degree to which, having some familiarity with the queer community is, one, probably not enough, but two, may not actually give you anything more if you don't, if you're not, one, ready to recognize your own pitfalls, and two, aware of the differences between different queer people's experiences and gender identity and all of the above.

From Nina's perspective, therapists need to be aware of their own challenges in order for them to see the ways that their clients' experiences may be different. She felt that her therapist was not able to separate their own relationship to gender transitioning enough to help her move through her own process concerning her partner's transition.

Another critical aspect of personal work that one participant mentioned was therapists acknowledging their particular limitations. Michael discussed the importance of acknowledging that no therapist is perfect for everyone, and all therapists have cultural limitations. While culturally different therapists can offer other benefits to clients, therapists can get caught up in wanting to be so accepting that they try to help every kind of client. On the contrary, Michael noted that it is valuable to recognize and respect

personal limitations. If a therapist does not feel accepting about different expressions of sexuality and gender, it may be best not to work with sexual minority clients.

Comfort with sexuality. Five of the participants discussed the importance of therapists' comfort discussing sex and sexuality. Four noted appreciating therapists who demonstrated comfort with the topic of sex, whereas, one reported that she and her partner avoided discussing sex in their couple's therapy due to a therapist's discomfort. Two participants reported that their therapists' comfort with sex helped them with discomfort with their own sexual nature. Gwen noted appreciating her therapist's openness and positivity around female sexuality, which was a corrective divergence from the catholic perspective with which she was raised. Additionally, Michael discussed seeing a psychiatrist who discussed sexuality openly during the time when he was becoming aware of his nonnormative sexuality. He noted assuming the practitioner was a heterosexual male, though he admits not being sure if that was the case. Michael reported talking to him about having fantasies about kissing and holding hands with men, but wanted the psychiatrist to know he was not thinking about other sexual acts when the psychiatrist responded, "'actually touching another persons anus can be a sign of affection.' So that was like oh ok . . . But it was really validating from straight guy is telling me to finger anuses. Just noting examples of things that were perfectly normal." Michael added that the practitioner's openness was validating because, in movies, psychiatrists are often the authority on what is normal.

Bethany reported that her therapist's comfort with sex was helpful to her, despite the fact that it initially made her quite uncomfortable. She stated that,

> what it did was show me that I can be ok with it, because she's ok with it, and that is something to work towards. And it showed me my own discomfort, which was important. And pointed to some tension that was happening and so, yeah, it's so funny, just going to this career in general. I take these memories and on so many levels, you know, that I really go for it when I talk about sex too, now with my clients and they look at me with those same wide eyes, and sometimes not, and they're like 'yeah!' Whether it's queer sex or any kind of sex . . . so it did something for me . . . Sex is important and I think that's what she was really holding for me: that it's important and a legitimate need and that when there's hard things happening, how to work through that and how to name what's happening and talk about it . . . And that it's not taboo, you don't have to just feel like something is not right and not address it.

Bethany felt it was helpful for her to see her discomfort with sex and experience another way that she could be in relation to her sexuality. It also allowed her to improve the quality of sex she was having in her relationship by having permission to discuss her preferences. Moreover, she found explicit discussion of sex to be so important that she has implemented the practice in her own therapy work with clients.

Relatedly, Alisha noted the importance of therapists' discussing sex because it is a taboo subject that is seldom discussed. She stated, "I think it's important to talk about sex generally. But it's hard to talk about sex and so it's especially important to be able to talk about sex in therapy. And to be able to talk about uncomfortable sex in therapy, because if you can't talk about it there, then where are you talking about it?" Sex is a complex topic that all humans negotiate in different ways. Therapy is, theoretically, a

place where challenging topics can be faced. However, in order for this open discussion to occur, therapists need to express openness to this topic by being comfortable discussing sex directly.

While reflecting on LGB issues in the larger society, Nina argued that acceptance around sexual minorities is more complicated than some other human rights issues because these identities directly involve sexuality, which an extremely taboo subject in US culture. She sees this as one of the main barriers to wider cultural acceptance and noted that, in terms of cultural change, "the work is about overarching acceptance of sexuality." The presence of pervasive sexual prejudice in the culture indicates that therapists' ability to speak about different sexual practices with ease requires personal work on their part. Nonetheless, this social climate underlies the value of demonstrating explicit acceptance of alternative sexual practices with clients. These participants' quotes highlight the way in which engaging explicitly and comfortably with this topic with sexual minority clients demonstrates acceptance of and comfort with nondominant sexual practices. Furthermore, demonstrating acceptance can help clients with self-acceptance and help them to navigate this, at times, complicated part of being human.

Culture and commonality. As my participants discussed the ways that therapists related to their cultural context, I witnessed a tension between appreciating times when therapists related to their common experiences, as well as times when therapists explicitly highlighted the influence of their sexual orientation. Both Gwen and Bethany noted appreciating the way that their therapists seemed to treat their relationships as normal. Gwen stated "I never felt, actually like the lens was colored, in the sense that, I think that she would have been approaching it the same way based on me as an individual

regardless of who I was with." Similarly, Bethany's reported that her therapist's normalization was extremely beneficial. She stated,

> I think it made my relationship possible too. I needed someone to be interested in my relationship and support my relationship and treat it like any other relationship and, not think it was weird. And she didn't. You know, it was very, it was very normalized. It wasn't, we never really talked about identity or coming out or queerness at all, but the things that I would bring in terms of, just, what's it like to move in with someone, what's it like to just have relational issues were just treated as very matter of fact, like any other kind of relationship and that, that was really soothing because I was, I was very estranged from my mom at that time and she was really not very accepting and . . . embarrassed and you know all kinds of horrible reactions, and so to just have it be a nonissue was really helpful. Mostly it was like a non-issue that, it wasn't the core of therapy, it wasn't the thing that I was struggling with and it wasn't weird or taboo it was just, this part of your life and your landscape and love you're looking at right now. Yeah, and that made me feel really good and really safe and really normalized and nice.

Bethany experienced a healing effect from having her relationship recognized as a real and regular relationship.

However, as she continued to reflect on this experience, she started to wonder if she could have benefited from having her therapist acknowledge the unique challenges they confronted as a couple. She noted that she did not know, at that time, how to talk about her experience as a sexual minority, and that it may have been helpful for her therapist to ask questions about her sexual identity and help her narrate the particularities

of her experience as a sexual minority. Bethany also acknowledged she may have been closed to exploring that aspect of her experience, due to the rejection she experienced from her mother. Furthermore, she noted that if she had not had other community spaces to mirror and nurture her queer identity, the normalization might not have been adequate. In the follow up to our interview, she noted being unsure whether she would have liked her therapist to relate differently to her relationship. Regardless, she emphasized the therapist's explicit positive support of her relationship as essential support at a time when her relationship was not acknowledged or supported by important others in her life.

Many participants discussed the importance of cultural knowledge and therapists acknowledging or understanding the unique aspects of their experiences as sexual minorities. For example, Alisha, while discussing what she looks for in therapists, noted the importance of cultural knowledge and acceptance. She stated, "they don't necessarily need to be a part of any of these communities, but has to have a very strong knowledge and acceptance of those communities," referring to her ethnic, geographical, and sexual identities. At the time same, Michael raised a concern about focusing too much on cultural identities. While discussing a job that emphasized multicultural awareness, he noted the tendency for people to make assumptions based on culture, as opposed to recognizing the differences among those who share a cultural identity. These quotes indicate there may be a balance to be struck between recognizing the influence of culture and recognizing the uniqueness of each person's experience.

Bethany discussed her current therapy experience in which she feels a remarkable recognition of both the differences and similarities between her therapist and herself. She

noted appreciating the way her therapist recognizes the common parts of her experience as well as the unique parts.

> It's like we can boil it down to an essentialness that's completely human, that any person would run up against. And that's the normalcy, yet it's also so completely particular . . . I think together we've found a way to hold that, and she's really made that available to me . . . also even like . . . thinking deeply about how my experiences might have been the same but might also have been really different. And, and doing, both, all, directions of that. Which enables a different kind of listening and a different kind of empathy to emerge, that yeah, I and that's what I feel the most strongly from [my therapist], is that, I feel like her listening is to deep because she, she knows despair in her own self, she can recognize that, she knows fear and loss and, isolation and loneliness, which take away the details you know . . . listening to the details but then resonating with the feeling and, if and that's, that's that work, it's like horizontal and vertical, the cultural and then the interpersonal. And that just seems really, that has felt really important when people have held that for me, gay, gay or straight.

Bethany describes this balance as a deep form of empathy, in which her therapist attempts to understand her client's experience through recognizing universal human feelings, while honoring the unique aspects that may be outside of the therapist's experience. While the degree to which both common and distinct experience need to be acknowledged for each participant may be different, there seems to be a meaningful balance between these two aspects of experience.

Summarizing Results

These five themes were identified through the in-depth analysis of the narratives of seven sexual minority individuals. The themes represent aspects of these participants' experiences inside and outside of the therapy room, which influence their preferences concerning therapy. As participants shared these stories, they expressed a wish for therapists of all identities to be aware of the unique challenges they face, while also recognizing their common experience as human beings. Categorizing Selves highlighted the identity terminology they prefer and discusses the way in which considering sexual diversity as occurring on a spectrum benefits those who do not hold heterosexual identities. Further, participants noted influences of holding invisible minority identities, such as having limited role models, experiencing a lack of recognition of their identities, and uncomfortable assumptions by others about their relationships. Identifying Others/Identifying Allies noted the ways that participants attempted to understand the sexual orientations of others, though it also revealed the cues by which they identified allies and competent clinicians. Participants discussed assessing therapist orientations through information on websites, items in offices, clinicians' appearance of comfort with LGB terminology, and practitioners' assumption, or lack of assumption, of heterosexuality, in addition to describing a felt sense of allyship.

Navigating Heterosexism was a common experience that participants described throughout their lives, and their experiences of heterosexism often led to expectations of lack of safety in therapeutic relationships. Furthermore, the internalization of heterosexist messages was noted to be a frequent focus of work in successful therapy experiences. Participants' sensitivity to heterosexism led to increased attention to

cultural competence in their providers, and participants discussed ways in which they identify and assess the safety of their therapeutic relationships. Experiencing heterosexism was noted to be a common denominator of experience for individuals identifying as LGB and participants noted preferring sexual minority therapists, at times, because they comprehended and recognized this influential force. These societal experiences of heterosexism appeared to make participants sensitive to judgment from the therapist, with experiences of judgment often resulting in termination without processing the rupture.

Therapeutic preferences were also discussed, highlighting the diversity of both therapeutic identities and therapeutic practices. Preferring Therapist Identities discussed the benefits and costs to both same- and cross-orientation therapeutic relationships. Shared-orientation relationships provided relief for clients around describing their experiences to others, but ran the risk of assumptions about having had the same experience preventing dialogue and useful questioning. Cross-orientation relationships avoided such assumptions, and supported some clients with self-acceptance through acceptance by a therapist that represented the dominant culture. Nonetheless, the risk cross-orientation therapeutic relationships post is that of exposure to heterosexism and misunderstanding.

Understanding Therapist Practices included participant reflections on experiences in therapy, which may provide insight into practices that therapists of any orientation can work towards. Participants described appreciating therapists who were able to acknowledge their cultural experience as well as their humanity, discuss sexuality with comfort, disclose appropriately, and suggest interest in their clients' experience without

judgment. While recommendations for clinical practice will be made on behalf of these accounts, it is my hope that being exposed to these personal experiences will help practitioners experience compassion for the unnecessary challenges that sexual minorities experience from living in a heterosexist world.

Discussion

A discussion of the findings of this research will be presented after a brief reflection on the foundation of these interpretations and the interpretive process. The implications of participant accounts will then be presented under the headings of the five main themes: Categorizing Selves, Identifying Others/Identifying Allies, Navigating Heterosexism, Preferring Therapist Identities, and Understanding Therapeutic Practices. Interpretations will be proposed along with notes about how participant accounts related to, or diverted from, relevant research concerning clinical practice with LGB clients. Additionally, I will be making clinical recommendations based on the confluence of participant accounts and existing research and summarize these under the heading Recommendations for Clinical Practice. There is an important need for further research on this and related topics, which will be discussed in Methodological Implications. This section will also include reflections on the strengths and limitations embedded within this research project and how methodological choices may have influenced findings.

Foundation of Interpretations

Interpretive Phenomenological Analysis is often described as a "double hermeneutic" (J. A. Smith & Osborn, 2003), in which the researcher attempts to make meaning of the participants' attempt to make meaning about their experience. J. A. Smith et al. (2009) see the interpretive process as the primary way in which humans relate to their environment and their experiences. The centrality of this process emphasizes the importance of interpretation, but also reminds researchers to be modest about their analyses. Another researcher may interpret the same results in a different fashion. Throughout the analysis I was aware of the danger in thinking I got "the whole

truth" in my interviews, of which P. Atkinson and Silverman (1997) warned. I will be exploring possibilities embedded within my participant accounts, but I am in no way declaring these to be absolute truths.

The participants themselves may have described their experience differently in a different setting, relational context, or mood. Thus, it is important to acknowledge the influence of the context of these narratives. As the paradox of Schrödinger's cat demonstrates (Schrodinger, 1935), scientists cannot learn about phenomena without influencing the phenomena studied. I witnessed my participants actively questioning their experiences as they recounted them, indicating that the act of looking at an experience has the potential to modify the person's relationship to the original experience. For example, participants wondered if they would have appreciated different therapeutic approaches and how their stories might have changed if clinicians had approached them differently. I feel it is important to consider ways in which the interview situation could have constructed aspects of their responses. It is possible that modifications in the research relationship, stated purpose of the research, or questions asked could have changed the accounts shared. As I reflected on the results of this study, I recurrently considered how my presence might have influenced the accounts.

The research questions with which I approached this study have also framed the research. I began the research wondering about the experience of sexual minority clients working with sexual majority therapists. However, this qualitative study yielded results that concerned sexual minority clients' experiences inside and outside of therapy that influenced their preferences in therapy with differently identified therapists. In addition to reflecting on these results, I will respond to the research questions posed in the

introduction. I explored the phenomenological experience of my participants in order to identify what they felt was and was not helpful in their therapeutic experiences. Furthermore, I wondered if and how orientation differences were discussed, how orientation difference influenced alliance, and how ruptures in the alliance were navigated. These questions guided the development of questions and may have influenced how I heard participants' accounts.

While taking these influences into consideration, I analyzed the results of this study from multiple viewpoints: the participants' explicit statements, the nonverbal communications of these participants, my clinical perspective, my own visceral and personal reactions, and the imagined perspective of the others involved in my participants stories. Moreover, the review of the literature that began this study created an interpretive horizon through which I understood and related the participants' narratives. It is my hope that presenting developed ideas about these accounts will provide readers with a deepened understanding of the participants' experiences, creating compassion and understanding around sexual minority experience and facilitating clinicians' investment in competent practice with this population.

Categorizing Selves

Self-identification and visibility. Categorizing Selves discussed aspects of self-categorization including participants' chosen terminology and reflections on the impact of visibility and invisibility on social interactions and the process of self-identification. Fassinger (1991) calls the LGB community the "hidden minority," because these identities are related to personal behavior and not to external characteristics. While some external characteristics have been anecdotally associated with sexual minority identities,

it is not possible to accurately assume another person's sexual orientation. Consequently, Matthews (2007) recommends that clinicians ask all clients about their sexual orientation. Matthews advocates for affirmative treatment to be provided to all clients because assuming the heterosexuality of individuals alienates some clients by presuming the normalcy of heterosexuality. Further, making this assumption conveys a lack of acceptance for and awareness of sexual diversity (Matthews, 2007). If clinicians do not ask their clients about their sexual orientation, it also puts pressure on the client to out themselves, which is a precarious act (Bieschke et al, 2007; Herek, 1996).

The invisibility of this identity means that the only accurate identification is self-identification. As I interpreted my results, I was struck with the inherent challenge in interpreting another person's chosen identifier. It would be preposterous and disrespectful for me to question that participants identified in the ways they described. One participant reported terminating immediately with a practitioner who used inaccurate identity terminology after the participant shared their discomfort with the term used. Identities are personal choices, and while clinicians can explore the underlying meaning and options around identities, they do not get to make personal choices for clients. Therefore, clinicians are advised to use and respect the chosen identifiers of their clients.

Additionally, the multiple definitions of the term *queer* provided by participants indicate that it is worth taking this categorization question another step further by asking what these words mean to clients. I noticed in myself the urge to stop at asking the identification question. My impulse was to reflect to the client that I knew what the term meant without asking more, in order to demonstrate my knowledge and competence. However, words and labels are concrete and categorical in a way that sexual orientation

is not. If the idea of a spectrum is to be taken seriously, then each linguistic category will represent individuals who define the word differently. These definitions can, therefore, assist clinicians in understanding the particular experiences and identities of their clients.

Moreover, sexual behavior is not necessarily a reflection of sexual orientation. Dworkin (2000) recommends that clinicians avoid assuming that individuals will identify as Lesbian or Gay based on same-gender sexual experiences. Individuals may choose not to identify with these experiences, may identify as bisexual, or may choose an alternate designation. This recommendation is also important because in various cultural communities self-identification may not utilize terms such as gay or lesbian (Fassinger & Arseneau, 2007). Consistent with this recommendation, one participant described discomfort around being identified as a lesbian before she was ready to identify herself. While she was involved in a same-gendered relationship and eventually chose to identify herself as a lesbian woman, she was startled by and uncomfortable with the therapist's assumption. This account indicates that it is more appropriate for clinicians to wait for clients to self identify, or to be sensitive with the use of identity labels while discussing possible identity options and sexual development trajectories. According to Fassinger (2000) sexual orientation is comprised of multiple dimensions of behavior, attraction, relationship, intimacy, community, and politics. Therefore, helping a client with identity questions ideally involves a nuanced exploration of each of these factors.

Categorical views limit, diverse views encompass. While it is important to respect the identifiers that individuals choose, it also seems that identity categories are not the most ideal way of conceptualizing sexual and romantic identities. Categorical terms may facilitate discussions and classification (Moradi et al., 2009), but the diversity

of sexual orientations indicates that it is more appropriate to consider sexual identities as occurring on a spectrum (Savin-Williams & Vrangalova, 2013). The term *spectrum* evokes the image of a rainbow, which is the symbol for sexual diversity. While this image highlights the fact that there are innumerable dissimilar positions contained in the rainbow, it also communicates something important about the visibility and invisibility of LGB identities. The rainbow is an apt symbol because the rainbow of visible light is only one small part of the larger and more complex electromagnetic spectrum. A sophisticated understanding of the spectrum discloses that there exist more than a rainbow of sexual orientation options. Similarly, those who are visible sexual minorities only represent a part of the diversity that exists in nature.

This inclusion of sexual identities that are invisible is extremely important. In this study, participants shared frustration involved with having their identities be invisible to others. While they also noted that there are privileges to passing as heterosexual in a heterosexist world, they discussed experiences of unwanted attention from others, such as from opposite gendered individuals or from people invested in their relationship status. Additionally, participants reported having to manage other people's understanding of their identity through continual coming out. This invisibility also caused frustrations around the lack of community recognition of their status as sexual minorities.

Results also indicated that there is a complicated relationship between visibility and heterosexism that relates to stereotypes. Often, those sexual minorities who are considered highly visible are presenting in ways that conform to stereotypes. Two participants discussed the way in which being exposed to stereotypical lesbian and gay individuals invoked unrecognized internalized heterosexism and decreased their comfort

with identifying as sexual minorities as youth. The presence of solely stereotypical models led these participants to avoid identifying as sexual minorities because they did not want to be associated with the accompanying stereotypes. At that time, they were not aware that there were many kinds of gay men and lesbian women. These narratives indicate that making the diversity of sexual minorities more visible would assist youth in self-identification. Furthermore, increasing visibility around the diversity of sexual orientations would likely humanize alternative sexual orientations, demonstrating to members of the sexual majority that LGB individuals are not highly dissimilar to their heterosexual counterparts. This finding is consistent with studies that indicate exposure to individuals of different groups reduce prejudice due to this humanizing factor (Pettigrew & Tropp, 2000, 2008). Clinically, it is important that practitioners understand the challenges that sexual minorities face when developing their identities. Likewise, Garnets et al.'s (1991) seminal study identifying inadequate and biased therapeutic practices highlighted the importance of clinicians recognizing the ways that internalized heterosexism can complicate identity development for LGB individuals.

The increased visibility of individuals on the extreme ends of the spectrum also leads to invisibility around bisexuality. For example, one participant related her feelings of invisibility around her sexual orientation to being biethnic and feeling as if she is not accepted by either of the communities to which she is ethnically identified. This participant's experience suggests that bisexual people may feel similarly left out of two communities with which they partially identify. This isolation has important implications for psychological distress, because community membership has been shown to help individuals ameliorate the influence of internalized heterosexism (Szymanski &

Kashubeck-West, 2008c). It is important that clinicians understand the particular challenges associated with bisexual identities. Unfortunately, bisexual identities are significantly under-researched (Bieschke, Paul, & Blasko, 2007; Morrow, 2012).

I myself held an unconscious assumption about bisexual identities before actively reflecting on the complications of this sexual orientation. I originally did not plan to include bisexual individuals in my study, because I thought that the overlapping identification and disidentification with heterosexual therapists would complicate the exploration of cross-orientation therapeutic dyads. While conducting my literature review, I realized that this view reflected an oversimplified idea of bisexual identities as constructed of half sexual majority and half sexual minority. Once I recognized the inaccuracy of my assumption, I felt declining individuals who identify as sexual minorities from participating would represent an imposition of an unnatural and inaccurate conception of sexual orientation. Furthermore, it would have excluded important perspectives that occur along the identity spectrum. This study was not focused on bisexual identities and does not aim to make clinical recommendations about their specific experience as a result. However, results concerning variations in visibility necessitate acknowledging the unique position that bisexual individuals hold.

One participant highlighted the way in which binary views of sexual orientation and gender result in decreased psychological wellbeing for those who do not feel they fit within this structure. Historically, the field of psychology has operated from the heterosexist perspective that there are only certain sexual orientations that are healthy or appropriate. Fortunately, in 1975, the American Psychological Association identified this inaccuracy (Conger, 1975). Empirical studies indicate that there is no significant

difference in sexual minority and sexual majority individuals' mental health (Gonsiorek, 1991). Where differences have been indicated, it has been shown that these are the result of the influence of heterosexism (DiPlacido, 1998). This evidence suggests that minority sexual orientations are not destructive by themselves. Perspectives that devalue nondominant sexual orientations are destructive. In order to provide competent care with this population, the APA (2013) recommends that practitioners recognize sexual diversity as reflecting normal variation. It is imperative that clinicians understand and believe that there are many ways to have healthy relationships, and that the gender of a person's romantic partner has very little to do with the psychological adjustment of the individual. Sexual object choice is not relevant to health and normality, with the exception of the influence of additional stressors due to societal, familial, and personal prejudice.

Identifying Others, Identifying Allies

Categorizing others to assess safety. Participants discussed a wide range of cues that helped them to determine the sexual orientation of their therapists. Many participants established their clinician's sexual orientation based on the gender of their partner or by the extent to which practitioners transgressed gender role expectations of style and presentation. Participants also discussed subtle cues that provided information about their clinician's sexual identity and experience with LGB issues. These cues communicated to participants that practitioners were knowledgeable about sexual diversity, either due to their own identity or due to interest, education, and experience. Given the participants' prior experiences with and resulting sensitivity to heterosexism, participants often entered therapy expecting prejudice and judgment. These cues of competence facilitated comfort and confidence in the therapeutic relationship.

Therapy is a vulnerable experience. Clients are asked to disclose very personal information to professional individuals about whom clients know very little. Attending therapy as a sexual minority compounds this experience with additional questions around the clinician's ability to understand and accept LGB clients. Experiencing additional judgment and stigma in the therapy can be extremely detrimental to clients. According to a qualitative study exploring the influence of homophobic microagressions in treatment, prejudicial experiences in therapy can exacerbate previous trauma due to historic sexual prejudice (R. Bowers et al, 2005). Even subtle experiences of prejudice in therapy are associated with premature termination and increased frustration and anger with therapy (Constantine & Sue, 2007). Therefore, practitioners working with diverse others need to be aware of these supplemental challenges to initial safety and trust. Additional training is also recommended for practitioners to avoid microagressions and learn how to navigate cultural misunderstandings.

Seen within this context, clients' ability to assess the safety and competence of practitioners is an adaptive and advantageous skill. Participants discussed a range of certainty about the sexual orientation of their therapists, and noted the most confidence around extremes of obvious sexual minority and majority members. When participants said their practitioners were "definitely" "obviously" and "clearly" heterosexual, what they meant was that the clinician was so far on the other side of the spectrum that they were suspect; they represented potential risks to be managed. Therapeutically, this identity was assumed to indicate that the clinician would not be able to understand their experience. These quotes indicate that the most important purpose of identifying others may be to identify threats. Practitioners who appear extremely heterosexual were

assumed by participants to hold heterosexist perspectives and minimal knowledge about LGB culture. This finding supports the propositions of Ponterotto et al. (2006), who theorized that prejudicial views are founded in evolutionary needs to identify enemies and allies, which still influences interactions between diverse individuals in contemporary society. Identifying allies and threats, thus, represents an adaptive strategy for these participants navigating a heterosexist world.

These LGB individuals are taking care of themselves by assessing the clinicians' level of acceptance and accommodating it. When someone is identified as so far on the end of the spectrum that they might not know there is a spectrum, clients will not discuss aspects of their relationships with them, such as their sexual fantasies or practices, so as to avoid exposing themselves to judgment. As a way of protecting themselves, the clients may not take the heterosexist-identified therapist's perspective as seriously. Research confirms that clients in cross-cultural therapeutic relationships manage what cultural information they disclose with therapists in this manner. Chang and Yoon (2011) found that many clients avoided discussing culture with white therapists due to a concern that they would not understand or respond empathically. Similarly, Mair and Izzard (2001) conducted a study with gay men who reported avoiding explicit discussion of sexuality with heterosexual therapists. It appears that culturally diverse clients actively utilize strategies in therapy to protect themselves from prejudicial judgment.

On one hand, this strategy is remarkably adaptive. However, there is a downside to this approach because anticipatory protection may also decrease dialogue between individuals identifying with different groups or prevent LGB people from being surprised by other people's acceptance. Using these strategies protects clients, but may also

prevent individuals from learning more about each other, which is important for larger societal shifts around prejudice of sexual difference. I am not recommending that clients withstand prejudice in order to change therapists' minds, but I wish to highlight one disadvantage to this understandably common practice.

Cuing competence, facilitating safety. Participants highlighted three main domains that they attend to while assessing the competence of practitioners: professional identifiers, language cues, and subjective senses. When these cues indicated competence, the participants' level of comfort in the therapy increased, thus facilitating the development of positive therapeutic alliances. This connection is important because positive therapeutic alliances have been associated with increased therapeutic outcome in multiple meta-analyses (Horvath et al., 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Therefore, these cues can help to facilitate client comfort in the therapy, increasing openness and investment in the work, which in turn increases therapeutic outcomes.

Professional identifiers are usually displayed on websites and in offices and signify professional expertise. Clinicians often note experience and affiliation with organizations on their websites, to which participants paid careful attention. Additionally, participants noted seeking therapists who advertised through LGB referral services or organizations that are designed to provide LGB competent care. One participant emphasized that she would not go to a therapist without a website, because it provides initial impressions and information about theoretical approaches and experience. For this participant, websites help to navigate the vulnerability of going to an unknown person's office.

The decorations and contents of an office are another level of information about the practitioner. Participants reported that any decorations reflecting a rainbow indicated that the clinicians were aware and accepting of sexual diversity. In contrast, the presence of only pictures of heterosexual couples indicated a lack of understanding or welcoming of sexual minority clients. Finally, two participants noted that the books displayed on shelves were an important indication of the practitioner's interests and knowledge base. Therefore, practitioners who feel competent to treat LGB clients can facilitate the comfort of their clients by incorporating these cues of competence and safety into their websites and offices.

Participants commonly noted that the use of terminology and the comfort, and discomfort, with which clinicians used terminology were strong indicators of the clinician's competence with LGB issues. When clinicians appeared awkward using common LGB identity terminology, this behavior reflected larger discomfort with LGB identities, which often led participants to discontinue treatment. On the other hand, when clinicians appeared comfortable with and knowledgeable of LGB culture, participants felt increased safety and confidence in the relationship. The impact of these language cues indicates that practitioners wishing to work with this population need to learn about common terminology. Additionally, ongoing exposure to this terminology is needed to be able to comfortably discuss issues that are relevant to this community. Linguistic competence involves using the identity terminology of the clients and avoiding any terms that clients state make them uncomfortable. One participant urged clinicians to avoid using the terms gay and lesbian as nouns, thus labeling people by their sexual orientation. Instead, he recommended that clinicians use these terms as adjectives modifying other

aspects of their identity, such as gay male and lesbian female. This linguistic detail is important to him because it acknowledges that sexual orientation is one aspect of LGB individuals' identities and not their defining characteristic.

Another important linguistic practice is avoiding assumptions of heterosexuality. Studies by Garnets et al. (1991) and Liddle (1996) highlight assumption of sexuality as a feature of inappropriate practice with LGB clients. A couple of participants also noted the importance of clinicians avoiding the common assumption of heterosexuality, which often occurs when clinicians automatically use opposite gendered pronouns to discuss a client's romantic or sexual partners. This assumption immediately indicates a lack of competence around sexual diversity, leading to decreased trust or termination. Correspondingly, a study by Dorland and Fischer (2001) demonstrated that the presence of such language in vignettes led to pseudoclients being less interested in disclosing information or continuing therapy. This finding, coupled with my previous thematic discussion concerning the invisibility of sexual orientation, further indicates that practitioners should, ideally, ask all clients about sexual orientation and avoid assumptions of heterosexuality.

The final way that participants noted identifying other sexual minorities and allies was through their subjective sense of the practitioner. They described being with practitioners who felt like allies, or felt like family members. While this quality of openness and welcoming is an important cue for clients, it is challenging to define or assess in practitioners. It seems to be reflective of comfort with sexual diversity and acceptance of various sexual orientations as healthy approaches to relationship. This cue of competence is the result of personal work in which clinicians reflect on unconscious

assumptions they hold about identity, sexuality, relationship, and gender. While this issue will be further explored within the theme Understanding Therapeutic Practices, the effect of personal work is a quality that participants could detect. Therefore, it is likely that clients can detect it as well.

These cues of competence were an important finding of this study because they represent subtle signals that sexual minorities utilize to help them navigate new therapeutic relationships. At times, these cues indicated to participants that their clinicians were part of the LGB community. When clinicians who appeared to be heterosexual demonstrated these cues, they communicated that the clinician was an ally to the LGB community. While there is minimal research on the roles of therapists as allies, schools with ally programs report increases in sexual minority students' performance and wellbeing (Toomey et al., 2011). This research indicates that engaging with allies has a positive impact on LGB individuals. In conclusion, clinicians who feel competent with this clinical population are encouraged to use these cues to demonstrate their competence and facilitate client comfort.

Navigating Heterosexism

Acknowledging the impact of heterosexism and honoring resilience. The participants in this study discussed numerous ways in which heterosexism impacted their lives. They reported experiencing heterosexism from their families, as well as society, which impacted their sense of self and expectations of others. Experiences of heterosexism have been shown to be associated with decreased psychological wellbeing in samples of Caucasian sexual minority women (Szymanski, 2006), African American sexual minority women (Szymanski & Meyer, 2008), and gay men (Szymanski, 2009).

This relationship is often mediated through the process of internalization and internalized heterosexism is associated with decreased self-esteem, increased psychological distress, and decreased levels of outness and community participation (Szymanski et al., 2008b). Similarly, participants discussed internalizing messages that communicated LGB identities are invalid, unhealthy, or otherwise problematic. These messages influenced their self-esteem, psychological wellbeing, and comfort with identifying as LGB. Due to internalized heterosexism, identifying as a sexual minority is correlated with increased risk for suicide (Meyer, 2013). Echoing this finding, one of my participants discussed feeling suicidal as a youth because he could not imagine growing into an adult successfully with the sexual orientation difference of which he was becoming aware. When youth grow up with messages that alternative sexual orientations are unacceptable, they often feel that they are themselves unacceptable.

Given the high prevalence of reported discrimination and harassment (Herek, 2009), and reports of heterosexuals' attitudes toward sexual minorities (Herek, 2000), the pervasive impact of heterosexism is not new information. In the last several years, I have heard numerous stories of familial rejection, individual harassment, systemic discrimination, and subtle invalidations from my clients. However, I was struck with the weight of perpetual experiences of subtle, and not so subtle, bias that lingered over my participants' accounts. Although it is clear in the literature that sexual minorities experience significant prejudice, there appear to be barriers to heterosexual individuals experiencing the full weight of these stories. It is my view that competent care with this population requires clinicians to understand, recognize, and feel the impact of systemic heterosexism.

I think there are several reasons for my experience of surprise. I am fortunate to live in a part of the U.S. that is fairly open and accepting of sexual minority identifications and I live in a time when rights are, slowly, being conferred to sexual minorities. However, there are also psychological barriers to recognizing the painful reality of heterosexism and its impacts. My surprise was reminiscent of the minimization that one participant reported experiencing from several therapists. This participant noted that they were dismissive of his experience as a sexual minority and encouraged him to "get over it." He described these therapists as ignoring the negative experiences and trying to focus on the positive, which is reflective of either lack of understanding or denial. Although these therapists may not have been knowledgeable about the experiences of sexual minorities, I believe that there are additional psychological barriers to seeing the consequences of heterosexism.

There was something keeping both these therapists and myself from feeling the full effect of this experience. I did know intellectually about this struggle, so I started thinking about denial, and subsequently, guilt. Denial is a psychological defense against knowing something that is painful (Cohen, 2001; A. Freud, 1936/1985), and acknowledging the pervasiveness of this external prejudice that results in self-stigmatization is quite painful. I also noticed that reflecting on the influence of heterosexism raised an experience of guilt in my own experience: guilt about having my privileges and guilt over the potential that I have to harm others in these ways. Analogously, multiple studies concerning ally development noted that acknowledging heterosexual privilege and the challenges implicit in identifying as a sexual minority are common barriers to becoming an ally due to the guilt and sadness that they generate

(Asta & Vasha-Haase, 2013; Case, 2007; Ji, 2007). It seems that one of the privileges of being a member of the sexual majority, is not recognizing the impact of continual discrimination and devaluation by society. It is imperative that clinicians working with individuals in this community acknowledge, recognize, discuss, and experience the reality of heterosexism and the toll it takes to perpetually navigate this experience, despite some increases in social visibility and rights. Suicidality is a part of the story of sexual minority identification, and my surprise indicates that I had fallen into a romanticized view of my participants and their experiences outside of the dominant paradigm.

However, there is a balance that needs to be sought. It is important that the challenges sexual minorities face are held alongside their resilience. A recent qualitative study by Riggle et al. (2008) identified benefits of sexual minority identification. These include increased empathy for self and other, the development of healthy supportive communities, and the ability to create relationships based less on gender roles and more on the needs of the individuals. Furthermore, the experience of discrimination can lead to the development of coping strategies and more flexibility around managing other people's differences (L. S. Brown, 1989; Riggle et al., 2008). An example of this resilience was demonstrated by a participant who discussed learning how to protect herself, trust her instincts, and end an unsupportive relationship through an experience of therapeutic judgment. Through this experience of heterosexism, this participant developed useful strategies for protecting herself and coping with prejudice. Practitioners are thus encouraged to appreciate both the beneficial and challenging aspects of sexual minority experience.

Such strategies are also helpful in managing internalized prejudice. Studies have indicated that the influence of internalized heterosexism can be moderated through community membership (Meyer, 2010; Szymanski & Kashubeck-West, 2008c). In addition, women tend to report lower levels of internalized prejudice, which indicates that experiencing other kinds of societal prejudice may help individuals to manage stigma (Balsam & Mohr, 2007; Mohr & Fassinger, 2003). Feminist values can mediate the impact of internalized heterosexism, because understanding the influence of societally imposed systems of privilege and oppression can help individuals not to take these societal values as personally (Szymanski & Chung, 2003). Consequently, clinicians can play a vital role in helping clients to understand the impact of internal and external heterosexism and to support individuals in developing strategies for coping with this discrimination.

The results of this study also supported the work of previous theorists who have highlighted felt stigma (Herek, 2007), which is the expectation of stigma in different situations. Participants consistently reported expectations that therapists would express or hold sexually prejudiced views, to the point that when participants found themselves in safe therapeutic environments, they reported surprise and shock. Given the prevalence of experiences of heterosexism, these expectations make sense. Nonetheless, these expectations of stigma can have a negative impact on individuals' psychological health. Lewis, Derlega, Griffin, and Krowinski (2003) studied this phenomenon, under the name stigma consciousness, in a sample of 204 sexual minorities and found that it was significantly correlated with increased rates of depression. Moreover, Herek (2007) noted that while stigma threat may lead to the avoidance of some discrimination, it could

also limit social support and significantly disrupt LGB individuals' lives. This strategy may be an adaptive one when navigating heterosexist environments, but may also prevent LGB individuals from experiencing the acceptance of others.

Taking responsibility for knowledge, being open to feedback, and working with judgment. Participants discussed consistently facing treatment situations in which the therapist was inadequately educated about LGB culture and experience, which at times led to microagressions or cultural misunderstanding. These individuals reported frequently spending time educating practitioners about LGB issues, and expressed frustration at having to spend their time in therapy educating the therapist instead of receiving support. Participants noted frustration that therapists do not seem to be sufficiently educated in their training programs and schools about sexual minority issues. Several of the participants noted that some educating of the therapist is manageable and expected. However, when it became constant or the clinician appeared to know nothing about their cultural experience, the lack of knowledge got in the way of their ability to feel supported and comfortable in therapy.

Reflecting this point, several studies have indicated that many counselors feel inadequately prepared by their graduate education to work with sexual minorities (Anhalt, Morris, Scotti, & Cohen, 2003; Dillon et al., 2004; Phillips & Fischer, 1998). Many studies have also demonstrated a lack of sufficient training in most graduate programs (Burke, 1989; Burke & Douce, 1991; J. A. Murphy et al., 2002; Phillips & Fischer, 1998; Sherry, Whilde, & Patton, 2005). Furthermore, a study by Pilkington & Cantor (1996) has indicated that heterosexist bias is present in many graduate level training course materials, classroom interactions, and professional comments. A more

recent study of APA-accredited graduate programs conducted by Sherry, Whilde, and Patton (2005) indicated that education on LGB issues is improving somewhat. However, the quality of education varies according to the institution, indicating that counselors' competence working with this population will continue to be variable if supplemental information is not sought.

A 2002 survey of practicing clinicians by J. A. Murphy et al. indicated that a majority of practitioners' training regarding the treatment of LGB individuals occurred outside of graduate training through continuing education, supervision, and reading books and articles. Because graduate programs are not adequately preparing clinicians for work with this population, therapists are advised to take responsibility for their own competence and seek further education for themselves. When one participant realized that her therapist was supplementing their knowledge outside of the sessions, she noted feeling supported and heard by her therapist and believing they were working well together.

Consequently, clinicians are encouraged to seek additional knowledge and be receptive to education that their clients provide about their cultural experience. Participants reported that therapist defensiveness represented a barrier to navigating knowledge or conducting effective therapeutic work. They noted that it was disappointing when the therapist was defensive or unreceptive to learning more about how their behavior felt for the client or why what they said was offensive. This stance communicated to participants that therapists were not interested in deepening their understanding of the client's experience as individuals or as sexual minorities.

Alternatively, when clinicians acknowledged that they did not know something and asked the client to explain more about their experience, participants did not seem to be as discouraged. For example, one participant reported that a reflection of the quality of his therapeutic relationship was that he could bring any slight misunderstanding up with his therapist with the knowledge that she would recognize the impact, apologize, modify her behavior, and be curious about his experience. For this participant, this ability facilitated the safety he felt with her because he understood that the therapist had no intention of causing him harm. Unfortunately, this experience was not common for participants. More often, the therapist's defensiveness prevented the dyad from navigating cultural assumptions and misunderstanding.

Two instances of defensive reactions stood out among the participants' accounts, which shed light on what prevents therapists from receiving their clients' feedback. In the first, the clinician used language that felt uncomfortable to the client and when it was brought to her attention, she defended her education. In the second, a participant felt that the defensiveness came from the clinician's wish to be seen as an ally. These instances highlight two things that can get in the way of clinicians receiving their clients' feedback: a need to be seen as competent or knowledgeable and a need to be seen as an ally or "good person."

Human beings like to acquire knowledge, and therapists are no exception. Furthermore, people go to therapy to seek expertise. However, clinical work is not a field in which there are clear answers for many problems, due to the diversity and complexity of people. At times, the lack of clarity in this profession may lead therapists to hold on to their knowledge strongly, which may not benefit clients, particularly in this situation. If a

therapist stands by their knowledge in a reference to an identity they do not have, they risk upsetting the client and miss an opportunity to learn about the clients experience.

The other cause of defensiveness has to do with therapists not wanting to admit that they hurt someone, or not wanting to see themselves as someone who could inadvertently hurt someone in a prejudicial way. Therapists have often come into this profession because of their wish to help others. It is threatening, therefore, to realize that, even with the best intentions, therapists can do significant harm. However, to serve clients of diverse experience it is important that clinicians recognize that sexism, heterosexism, racism, classism, ableism, and ageism are systemic problems that unconsciously impact all people. Thus, people who have good intentions can and do communicate these biases unintentionally (Ancis & Szymanski, 2001; APA, 2003; Dovidio & Gaertner, 2000; Shelton & Delgado-Romero, 2011; D. W. Sue & D. Sue, 2012).

Regardless of a clinician's intentions, to deny the impact of an occurrence on a client is invalidating and unsupportive. Furthermore, from a therapeutic perspective, the wound that the clinician has triggered may reflect a previous experience that needs to be processed or a sensitivity that would help the clinician understand their client more deeply. When clinicians defend themselves against the realities of their clients, that conversation is foreclosed upon, those wounds do not get to be explored or understood, and the client re-experiences the marginalization of having their experiences and perspectives denied by the dominant culture. Thereafter, the client has less incentive to initiate a conversation when microagressions occur. Dialogues can build understanding and safety between people, but when therapists reject bids for dialogue, this refusal can

build upon numerous other experiences of disempowerment. Clients may then feel less safe, less open, and less interested in forging cross-cultural contacts in the future.

When clinicians were open and receptive to the participants' experience, repairing cultural ruptures became possible. Research on rupture and repair in therapeutic relationships indicates that the most effective outcomes occur in therapeutic dyads that have had experiences of rupture, which have then been repaired and worked through (Kvlighan & Shaughnessy, 2000; Stiles et al., 2004; Straus et al, 2006). Always responding perfectly to clients is, thus, not necessarily recommended. This body of research indicates that what is healing is for clients to go through conflict with a therapist who is then able to discuss, track, and affirm the client's experience. Safran and Muran (2000, 2006) recommend that repairs begin with the clinician acknowledging the existence of the rupture and their part in it, while validating and expressing nurturing curiosity about the client's experience. This response directly mirrors what one participant reported as exemplary practice from his therapist: acknowledgment of his reality, recognition of their part, and abiding curiosity. According to a study by Chang and Berk (2009), this sensitivity is particularly important in cross-cultural therapeutic encounters, because cultural differences can increase the likelihood of misunderstandings. Therefore, it is important for clinicians to be receptive to clients if they report misunderstandings and increase their sensitivity to ways ruptures could manifest (Safran et al., 2011).

These recommendations are also relevant to situations in which participants encountered a more extreme version of cultural misunderstanding: judgment in the therapy. Participants discussed situations in which they experienced therapists who

related to their sexual orientation in minimizing or pathologizing manners. It is important to note that each of these instances resulted in the client terminating treatment without discussing the matter with the therapist. These results are consistent with research on misunderstandings in the therapy in which rupture resulted in termination if it was either not discussed or the discussion resulted in defensiveness by the therapist (Rhodes et al., 1994). According to these researchers, when clinicians were receptive to client concerns, these situations could be navigated and worked through. The findings of Rhodes et al.'s study, as well as the present study, suggest that a client's dissatisfaction in the therapy, when not discussed, often leads to termination. Because these conversations are challenging and may not be initiated by the client, therapists are encouraged to track changes in the therapeutic alliance and periodically check in about the client's satisfaction and comfort in the therapy process. Additionally, sexual minorities are often responsible for speaking up about prejudice in their daily lives. Having the clinician initiate these conversations makes coping with prejudice in the therapy a new and different experience from facing it in society. This practice is useful in work with all clients, as prejudice and alterations in the working alliance can influence therapeutic relationships regardless of the cultural make-up of the individuals involved (J. Owen, Imel, et al., 2011).

There are many reasons why clients may not discuss difficult relational situations with their clinicians. Rennie (1994) has noted that clients often choose not to discuss issues with therapists in order to protect the therapeutic relationship and avoid negative affect. Secrets are also kept from therapists due to shame and insecurity (Hill, Thompson, Cogar, & Denman, 1993). When a rupture is the result of cultural

misunderstanding, there are further barriers to discussing the incident. Individuals who navigate cultural misunderstanding throughout their lives are not always able to speak up about their experience because such occurrences can happen frequently. For example, one participant noted that it is not possible to respond to all of the injustices because it is emotionally demanding and they occur so regularly. Additionally, speaking up may expose them to further judgment. Clients who often experience cultural bias have learned to conceal their reactions in order to protect their vulnerability (Vasquez, 2007).

When such instances occur in the form of microagressions, they can have an impact without the individual being fully aware of why what was said influenced their level of comfort (Shelton & Delgado-Romero, 2011). Microagressions can be difficult to identify or easy to explain away, particularly when they come from people who are well intentioned, or in a position of support (D. W. Sue et al., 2007). Nonetheless, multiple microagressions can accumulate and create a hostile environment, subtly undermining therapeutic progress (D. W. Sue, 2010). Because microagressions can be difficult to recognize, they are very challenging for therapy dyads to work through (Shelton & Delgado-Romero (2011). Furthermore, even if a microagression does not lead to termination, it could influence therapeutic progress by impeding the development of a strong working alliance (Constantine, 2007; Walling et al., 2012).

Invalidations occur in many ways, although a common manifestation is considering a minority sexual orientation to be a phase. According to a study by Nystrom (1997) 34% of 1,466 gay men and lesbian women reported experiencing a therapist who invalidated their sexual orientation by viewing it as temporary. A qualitative study by Shelton and Delgado-Romero (2011) identified common sexual orientation

microagressions, which included not recognizing a same-gender attraction as a valid sexual orientation. This study also identified assuming sexual orientation is the cause of presenting problems, minimizing or avoiding the discussion of sexual orientation, making stereotypical assumptions, expressing bias towards heterosexual relationships, attempting to overly identify with clients, and warning clients about the dangers connected to LGB identities as common microagressions against LGB people.

In the present study, an example of this invalidation came from a participant who saw a therapist who expressed the opinion that same-gender attraction was a transitory state related to working through a psychological issue, which, once worked through, would result in a more preferable different-gender orientation. This perspective invalidated her sexual orientation by considering it a reaction to psychological pathology and expressed a bias towards heterosexuality. I was struck by the way that this participant managed to receive significant therapeutic benefit from this therapist who expressed negative bias against LGB orientations. For example, she discussed avoiding certain topics related to her sexuality in order to continue to utilize other aspects of the clinician's expertise. She felt that the therapist was skillful at treating her presenting issue, so she worked around their limitation in order to continue to benefit from aspects of the therapy that she appreciated. Although she reported that the clinician's cultural limitations eventually led her to discontinue treatment, she felt that she learned a great deal from this therapy experience nonetheless. Therefore, while some cultural misunderstandings may result in immediate termination, some clients may avoid discussing cultural information and continue to engage in other aspects of the therapy for some period of time. While this participant was able to benefit from her therapy despite

her practitioners cultural shortcomings, this case may be unique. Assessing the probability of this occurrence is not possible in a qualitative study.

While invalidating same-gender attraction may appear to be less severe than overtly pathologizing it, invalidations are considered to be more destructive than more overt prejudicial statements because it is harder for the person to identify the prejudice and defend against it (D. W. Sue, 2010). Similarly, the participant whose sexual orientation was invalidated by her clinician noted that it took time to discern what was making her uncomfortable. With invalidation, individuals are less likely to seek support due to the ambiguity of the assault (Hodson, Dovidio, & Gaertner, 2010). One participant spoke about the difficult experience of wondering whether a clinician meant to be malicious by their use of offensive language. Experiencing subtle invalidations or assaults can lead individuals to question their interpretation of the experience due to the subsequent process of assessing if the individuals meant to cause harm and whether to feel offended (Shelton & Delgado-Romero, 2011). Therefore, it could be deeply healing for clinicians to acknowledge the realities of their clients by validating their experience and taking responsibility for the unconscious bias. Even if a clinician did not mean to cause the client harm, repairing a rupture starts with validating the client's experience (Safran & Muran, 2000, 2006). This practice is consistent with respect for cultural diversity because a key aspect of multicultural work is acknowledging that people will experience things differently (D. W. Sue & D. Sue, 2012).

Highlighting the diversity of experience, it is important to note that something could feel like a microagression to one person and not to another. One participant described an experience that was identified as a microagression by a qualitative study by

Shelton and Delgado-Romero (2011), though she did not experience it this way. Upon finding out that the client was in a same-gendered relationship, the therapist noted that her sister is gay and that she is very supportive of her sister and her relationship. According to Shelton and Delgado-Romero's taxonomy of sexual orientation microagressions, making references to family members who are sexual minorities communicates the assumption that the therapist knows her issues because they know an LGB individual, which conveys a monolithic perspective of LGB people. While it made this participant uncomfortable because she was being compared to someone who identified in a way she was not yet ready to identify, she recognized and defended the therapist's intention. This example emphasizes the point that individuals experience things differently and at times, the intention behind a statement may be considered along with its impact. Other participants discussed the process of assessing the therapist's intention along with their statement, noting that it can be difficult and uncomfortable to assess intention when coping with impact. Therefore, intentions may or may not be considered alongside the impact. Moreover, intentions do not always mitigate the influence of prejudice.

In this study, another participant experienced pathologizing judgment in the therapy, in which a therapist suggested that the client's partner was a sex and drug addict due to his interest in engaging in an open relationship and periodic ecstasy use. This statement decreased the participant's comfort in the therapy because it exposed the therapist's judgment and lack of knowledge about gay male culture. The client did not feel that the clinician took his cultural context into consideration, given the fact that open relationships and periodic ecstasy use were normative for the urban gay male community

of which he was a part. This experience emphasizes the importance of clinicians having knowledge of what is culturally normative in their clients' social contexts. To this point, the APA recommends that clinicians working with LGB clients have adequate knowledge about LGB culture because applying heterosexual norms for behavior or relationship can lead to misinterpretations of abnormality (APA, 2013). Additionally, instead of demonstrating curiosity, the clinician communicated a conclusion. This comment led the participant to lie to the therapist in order to avoid discussing these topics and, subsequently, to terminate the treatment relationship.

Hearing this and other experiences led me to wonder when, if ever, judgment is helpful in therapy. After seeing the impact of mild and significant judgment in the therapy on my participants, I initially wanted to state that judgment is never helpful. However, I was aware that some types of judgment, or opinions, are vital to the workings of psychotherapy. At times, clients come to therapists to borrow the therapist's reasoning, to get a different perspective on their challenges, or to help them modify aspects of their behavior or beliefs that they do not feel are working for them. Further, clinicians hold judgments in therapy about what does and does not support clients and what does and does not constitute "health." I imagined that therapists who work with certain high-risk populations would balk at my fantasy of absence of judgment. For example, when working with clients who are struggling with a severe addiction a therapist's view of what the client needs to do is beneficial and important. Still, in these situations, it is very important for therapists to understand the way that clients benefit from their behavior. If a clinician takes a singular position against something, it often leads clients to polarize and defend the issue in question.

Therefore, I do not think that it is judgment that is helpful, but concern. Judgment is othering; it is saying that your behavior is not ok, or perhaps that it scares the therapist. That fear creates shame and distance. Concern is important in therapy; it communicates care for the client's best interest and their deserving of optimal levels of health. Even if a therapist is concerned about a behavior, it is still not helpful for behavior change to express negative judgment or to pathologize the client for being attached to it. Ideally, concern exists alongside understanding of the client's choices, and respect for the client's right to choose for themselves. This point brings to mind a study by Hook et al. (2013), which identified "cultural humility" as significantly correlated with positive therapeutic outcome and alliance. Cultural humility is the capacity for openness to the values and beliefs of a different client, while overcoming "the natural tendency to view one's own beliefs, values, and worldview as superior" (Hook et al., 2013, p. 354). In their research, this construct was positively correlated with improvements in therapy and ratings of the therapeutic alliance. Furthermore, this concept could help clinicians to identify and evaluate their judgments in order to identify which perspectives are, and are not, helpful to the client's needs and goals. I think that it is the therapist's job to be aware of their own judgments, explore what aspects are useful, try to understand the client's position, and help them evaluate their needs for themselves. This goal may sound idealistic, but it is useful to have an ideal to work towards. The importance of identifying and working with the clinician's personal judgments will be explored further in Understanding Therapeutic Practices.

Preferring Therapist Identities

Variable preferences. Questions about the influence of therapist identities form the foundation for this study and this section will discuss participants' perspectives on this matter. I will survey participants' preferences and consider influences on therapist preferences before exploring the potentials embedded within shared-orientation and cross-orientation therapeutic alliances that were noted in participants' narratives. Several participants noted preferring therapists who were members of the sexual minority, while others stated that the identity of the therapist was less important than other factors such as expertise and fit. None of the participants reported having an explicit preference for heterosexual clinicians. However, three participants discussed meaningful and transformative experiences with heterosexual counselors, suggesting that preferences are not always indicative of therapeutic benefit.

Participants' preferences around sexual orientation appeared to be influenced by contextual influences as well as personal needs around comfort and safety. Previous experiences of prejudice in therapy seemed to increase an individual's interest in seeing LGB therapists, likely as a way of protecting from further harm. Additionally, when individuals were seeking therapy for issues related to their sexuality or relationship or earlier in their sexual identity development, the desire for an LGB therapist seemed to be more significant. Participants also described contextual influences on their therapist choices such as their presenting problem and whether they had support for their LGB identity in other environments in their life. For example, one participant discussed feeling comfortable seeing a heterosexual therapist who specialized in trauma because that was her primary issue and she felt that she had multiple venues in her life to process

LGB issues. While she sought out LGB clinicians earlier in her life, she reported that her needs have changed over time. Correspondingly, a study on gender matching by Sterling et al. (1998) found that, at times, clients in cross-gender therapeutic relationships sought same-gendered support from other environments, indicating that clients can effectively receive different types of support in different settings.

Additionally, at times, participants reported prioritizing other therapist characteristics over sexual orientation, such as clinician competence. For example one participant discussed a therapeutic relationship that she ended quickly because, despite appreciating the commonality of a shared sexual orientation, she did not feel that the clinician was confident enough in her skills to adequately support her. A similar sentiment was shared when a participant reported that the sexual orientation of the therapist was irrelevant to him. In this participant's words, "I'm looking for a good therapist, not a gay therapist." For this participant, the therapist's skill was one of the most important things.

This participant also emphasized the importance of a good fit between the therapist and client, which facilitates safety and vulnerability. This participant was highlighting the importance of the client's comfort sharing their thoughts in the therapeutic process. If a client does not feel safe enough to be vulnerable and open about their internal experience, the healing potential of therapy will be limited. Because therapeutic comfort requires different ingredients for different people, the concept of a "good fit" is often used to describe client-therapist pairings that result in successful therapeutic work. For this participant, a good fit involves sensitivity to language and

nonjudgmental curiosity. A complicated part of therapy, however, is that each client may have different requirements for what would constitute a good fit for them.

The research on sexual orientation matching has not provided consistent results, though some similar findings have been indicated. Research suggests that LGB clients often prefer LGB therapists (D. R. Atkinson et al., 1981; M. A. Jones & Gabriel, 1999; M. A. Jones et al., 2003; McDermott et al., 1989). However, these preferences have become less consistent over time, which indicates that therapeutic services may be improving somewhat (M. A. Jones et al., 2003; Liddle, 1999). Furthermore, some studies indicate that a considerable portion of individuals believe that heterosexual clinicians can be equally effective (Burckell & Goldfried, 2006; M. A. Jones & Gabriel, 1999; McDermott et al., 1989), which some of this study's participants noted as well. Additionally, several studies note that clients sometimes prioritize therapist experience or expertise over therapist sexual orientation (Burckell & Goldfried, 2006; M. R. Moran, 1992), which was also reported by a few participants. In fact, in a recent review of sexual orientation matching research, Bieschke et al. (2007) have stated that LGB clients are often more concerned with their therapist's skills than their demographic identities.

A consistent finding in the literature, which was also present in this study, was that lesbian women often prefer female therapists along with sexual minority clinicians (Brooks, 1981; M. A. Jones et al., 2003; Liddle, 1997, 1999; Saulnier, 1999). This common preference is theorized to be due to a tendency for women to hold less prejudicial views than men (Balsam & Mohr, 2007; A. V. Bowers & Bieschke, 2005; Gilliland & Crisp, 1995; Herek & Capitano, 1999; Kite & Whitley, 1996; Mohr & Fassinger, 2003, Mohr & Rochlen, 1999). Several participants noted a strong preference

for seeing female clinicians, which they noted related to identities with whom they felt safest. At times, this preference was related to historical experiences of sexual trauma from men, whereas for others it related to a general climate of respect and receptivity that they reported experiencing more frequently with women. Participant narratives indicated to me that this preference is also related to the pervasive influence of sexism and a resulting desire for female clients to feel safe and have their opinions valued in the therapeutic setting.

In sum, clients have multiple reasons for their preferences in therapy. Likewise, these preferences vary because clients have had different experiences and they need different things at different times. It is my belief that while successful therapeutic work is based on numerous aspects of the client and clinician, an essential ingredient is the client's comfort discussing their experience. Consequently, factors that influence client comfort in the therapy, such as therapists' identities and practices, are important to understand. It is my hope that considering the influences of client preferences will help clinicians not to take preferences personally and to support clients in identifying and engaging in useful therapeutic experiences. Furthermore, because clinicians cannot change their identities, a useful direction in research is focusing on therapist practices that clinicians can develop (Liddle, 1996), which will be explored under the heading Understanding Therapeutic Practices.

Potentials in shared-orientation dyads. Participants who reported a preference for LGB counselors often cited the increased understanding of their experience that would come with this identity. Many psychologists have echoed this idea that the prospect of experiencing acceptance and understanding is at the root of seeking an LGB

therapist (Cabaj, 1996; Isay, 1991; Guthrie, 2006; Rochlin, 1982). Additionally, shared-orientation therapeutic dyads were attractive to participants because of the increased potential for sharing common cultural references and a resulting decrease in educating their therapist. Theoretical literature by A. C. Bernstein (2000) and Rochlin (1982) has highlighted this benefit as well. Furthermore, participants discussed seeking sexual minority therapists when their presenting problem related explicitly to their identity or their relationship, because they wanted to have specific expertise or protect vulnerable aspects of themselves from potential judgment. Many acknowledged that it is not possible to avoid judgment solely through an identity, though sharing their experience with another sexual minority felt like a way of mitigating risks.

One participant reported that it felt important to see a therapist who she knew held positive feelings towards the LGB community when she was in therapy processing ambivalent feelings about her partner's gender transition and various experiences concerning a lack of understanding about transgender issues in her LGB community. She emphasized that the therapist's love for her community allowed her to share her various feelings without needing to defend or protect LGB folks from the therapist. This narrative reminded me that it could feel very vulnerable to express negative views about a community that is marginalized by the dominant culture. LGB individuals generally do not want to perpetuate stereotypes about their identity and it could be traumatic to have a therapist reflect back negative perspectives of LGB people. This participant's experience suggests that therapeutic competence with other cultures includes having respect and appreciation for the particular community in order to provide clients the space to process varying feelings.

Despite the shared experience that many participants sought in shared-orientation therapeutic relationships, many participants also noted that sharing an identity does not necessarily mean having common experience. There is significant diversity within sexual minority experiences, particularly with regard to gender-identification, geographical location, familial support, prejudicial experience, and connection to community. Furthermore, Burckell and Goldfried (2006) argue that having an identity does not necessarily lead to competence working with that identity. One challenge inherent in shared identities is the possibility that the therapist could overly identify with their client, which could cause them to either project their own experience onto the client, or fail to recognize the client's responsibility in situations (Greene, 1997; Morrow, 2000).

For example, one participant discussed an experience with a therapist whose personal experience appeared to get in the way of their ability to support the client's experience. This participant sought counseling to process her nascent feelings about her partner's upcoming gender transition from a therapist that she perceived as transgendered. This participant felt that the clinician was pushing her to be further along in her acceptance of the transition before she was able to express her concerns. While they were both identified as "queer," their personal positioning in regards to the topic at hand was different and, as a result, the participant felt judged and unsupported. She stated that having the same identity might not be enough if the therapist is not able to recognize the differences present as well as the influence of their personal psychology. Sharing an identity may help therapists understand aspects of their clients' experience. However, this commonality is usefully supplemented by recognition of the differences between the client and clinician's experiences.

Potentials in cross-orientation dyads. As I stated earlier, no participants reported having an explicit preference for therapists identifying with the sexual majority. However, three participants discussed therapy experiences with heterosexual clinicians that felt significantly transformative and important to their psychological growth. Participants discussed being surprised and relieved by the acceptance and understanding provided by their heterosexual clinician. This finding indicates that preferences may not always be reflective of outcome. A similar distinction has been made in ethnic-matching literature, wherein studies that provide pseudoclients with two choices often indicate a preference for matched therapists, although outcome studies of client-therapist pairs indicates that preference does not have a significant influence (H. L Coleman et al., 1995).

This study began with questions about therapist identities, specifically, questions about whether and how heterosexual therapists could be useful to LGB clients. The findings of this study indicate that, with appropriate knowledge and awareness, LGB individuals can receive useful and even exemplary treatment from heterosexual clinicians. LGB clinicians are in the minority. Therefore, most participants saw heterosexual therapists when they did not actively seek out an LGB clinician. Often, these experiences occurred when clients sought other types of expertise or fit and then found themselves working with a heterosexual therapist. Because there are many communities where openly LGB clinicians are not available, the potential for heterosexual clinicians to provide competent treatment is an important finding. Using the examples of exemplary treatment that participants described, practices that lead to

competent care will be discussed in Understanding Therapeutic Practices and further outlined in Recommendations for Practice.

The main benefit that participants reported coming from their work with heterosexual therapists was the experience of acceptance from a member of the dominant culture. This experience was unique to cross-orientation therapeutic alliances and had a significant impact on the individuals who discussed it. Psychologists have consistently reported on this potential in literature grounded in clinical experience (A. C. Bernstein, 2000; Iguarta & Des Rosiers, 2004; Marmor, 1996; McWilliams, 1996). Although, to my knowledge, this effect has not been studied directly. One participant noted that the influence of experiencing acceptance from a straight person could not be overstated. This experience provided healing from previous experiences of rejection in therapy, which then facilitated her returning to therapy again in the future. This experience was a welcome deviation from her expectations of judgment and misunderstanding, which is always a risk for sexual minorities engaging with individuals in the sexual majority.

Another participant reported that her relationship with a heterosexual therapist provided a curative experience to counter wounds resulting from her mother's unsupportive reaction to her non-heterosexual sexual orientation. She noted that it feels very significant to have admiration, support, and approval from a heterosexual person because she is not likely to get those responses from her mother. Furthermore, even if she got that approval from her mother, it could not fully make amends for what her mother has already communicated. In addition to the healing approval this therapist has provided, this participant noted that there is something important about having her perspective make sense to someone who is different. She noted that it has been

powerfully healing to be seen and understood by someone who is very different, and who may not have experienced the types of things that she is experiencing first hand. She noted feeling more understood by this therapist than by any other person before and that this has had a profound impact on her self-acceptance.

Discovering that her experience was comprehendible seemed to provide a corrective counter-experience to messages indicating she was a mess that needed straightening up in some way. This and other research indicates that growing up experiencing heterosexism leads many LGB people to feel that their sexual orientation implies something pathological about them (Szymanski et al. 2008a). Not surprisingly, then, that LGB individuals cope with decreased self-esteem and increased mental health challenges (Meyer, 1995, 2003; Szymanski et al., 2008b). Psychotherapy is an opportunity to explore and evaluate these pathological beliefs and their impact on the client's way of relating to other people and their own experience. The challenge present when seeing a heterosexual counselor is the potential for re-experiencing prejudice and misunderstanding, which was discussed in Navigating Heterosexism. Nonetheless, there is an opportunity embedded in this challenge. This opportunity is that the client could experience an individual outside of the LGB community who provides acceptance, validation, and compassion for their experience. Ideally, this affirmation could help the client to more fully accept and have compassion for themselves, thus combatting internalized heterosexism and supporting a healthy sense of identity.

A secondary benefit to cross-orientation therapeutic alliances that participants discussed was the way in which differences could encourage in-depth exploration of things that similarly identified therapists may take for granted. This difference was

discussed as an alternative to the understanding that sharing an identity can provide, in so far as having a different context might lead the therapist to ask more questions about the client's experience. The difference could, in turn, help the client to reflect on why they approach things in the way that they do and whether their approach serves them. Conversely, someone who has a similar experience due to a shared identity may not ask questions due to an assumption, unconscious or otherwise, that they understand what the client is describing. In a recent meta-analysis of research on ethnic matching, Cabral and Smith (2011) also discussed this benefit to difference in the therapeutic dyad, emphasizing that differences can encourage insight and provide opportunities for the client to clarify and assess their experience. A therapist's nonjudgmental curiosity about a client's experience is an important avenue to facilitate a client's insight into their psychological perspective. While participants discussed this approach with respect to cross-orientation clinicians, the importance of this technique could encourage sexual minority clinicians to ask more questions and make fewer assumptions about their clients having similar experiences.

These findings indicate that, while challenges that cross-orientation dyads face in developing a working alliance exist, these are not always barriers to engaging in valuable therapeutic work. Similarly, recent research by Stracuzzi et al. (2011) indicates that perceived difference in sexual orientation can increase depth in the therapy when the therapist is interested in, educated about, and open to discussions about diverse experiences. When heterosexual clinicians are able to convey acceptance and support for their clients' experience, and nonjudgmental curiosity about differences, clients can benefit greatly from working with members of the sexual majority. Furthermore, there

are aspects of cross-orientation alliances that may be particularly effective in increasing self-understanding and working with internalized heterosexism. While some clients may prefer LGB clinicians, there is potential for significant healing with culturally competent heterosexual clinicians.

Understanding Therapeutic Practices

According to a study by Liddle (1996), the techniques that therapists use account for more variance in the client's experience of therapy than the therapist's demographic variables. Liddle studied the influence of exemplary and inappropriate practices originally identified by Garnets et al.'s (1991) seminal study. This researcher found that clients rated clinicians using exemplary practices as 6-12 times more helpful. Alternately, those who saw clinicians using inappropriate practices terminated after one session 80% of the time. Therefore, I will now discuss therapist practices that participants reported resulted in therapeutic benefits. Due to variability in individual's needs and wants, these may not be applicable to all clients. Likewise, there was some disagreement between participants about what therapeutic practices they appreciate. These divergent perspectives have been included in the results section and the implications of these differences will be discussed further. Nonetheless, general ideas about useful practices will be put forth, particularly when they converge with other research findings.

Additionally, through the process of analyzing these therapeutic practices and the participants' experiences of these practices, I identified underlying principles of cultural competence. These foundational principles concern valuing differences, the importance of personal work, balancing commonality with particularity, and balancing knowing with

not knowing. These are meant to be theoretical perspectives to reflect on and consider with regards to clinicians' own experiences with clients. Like most therapeutic methods, it is important to closely monitor a client's reactions and modify approaches accordingly.

Disclosure as a window into valuing difference. A challenging part of being a therapist is assessing the value of different interventions at different times, given the diversity of clients. It is unlikely that a new client will respond to any given intervention the same way a previous client did. As the concept of client-therapist fit indicates, people need different therapeutic responses to feel comfortable as a result of their individual personalities, relational styles, and experiences. Therefore, clinicians make treatment choices based on several client variables, as well as information gathered from previous experience, research, and education. Participants in this study provided a useful example of this diversity concerning the practice of therapist disclosure. Participants discussed experiencing therapist disclosure differently from each other and in different contexts.

At times, disclosure encouraged participants to feel more comfortable in the therapy. They reported that it provided the client some knowledge of the therapist as a whole person. At other times, participants experienced therapist disclosure as disconcerting. They discussed concerns that they would need to take care of the therapist or that there would not be enough space for their experience in the therapy. In particular, two participants described experiencing a therapist's disclosure as an invasion into their therapeutic space, which is a pitfall described by Geller (2003). In a qualitative study by Israel et al. (2008), which identified appropriate therapeutic practices with LGB clients, therapist self-disclosure was described as both helpful and unhelpful depending on the client and context. Disclosure felt least helpful to participants in Israel et al.'s study

when it was described as excessive. Similarly to Israel et al.'s study, participants who were put off by their therapist's use of disclosure tended to describe it as "too much," suggesting that only limited use of this practice is recommended.

This variation is echoed in the clinical literature, in which several practitioners note that disclosure can be either useful or destructive, depending on the particular context (Bloomgarden & Mennuti, 2009; Farber, 2006; Gutheil & Gabbard, 1998; Zur, 2009, 2011). Judicious therapist disclosure can increase the strength of the therapeutic alliance (Barrett & Berman, 2001; Zur, 2001), although when the therapeutic relationship is rated negatively, disclosures are less likely to be experienced as helpful (Meyers & Hayes, 2006). Consequently, many clinicians emphasize the importance of using disclosure infrequently, after thoughtful consideration of its potential influence, as well as encouraging practitioners to monitor client responses and check in about the impact of this intervention (Bloomgarden & Mennuti, 2009; Knox & Hill, 2003; Prenn, 2009; Zur, 2011). In this way, the disclosure becomes an experience that the clinician and client can use to facilitate understanding of the client's experience (Prenn, 2009). Exploring these situations with a client is a way of valuing the client's perspective on their experience, which may be particularly validating for clients with marginalized identities.

While client individuality can make clinical work challenging, it is fascinating to witness and work with the diversity of people. Even similar people can need quite different things to facilitate wellness in their lives. While reflecting on the diversity of my participant's experiences, I realized that one of the things I deeply enjoy in cross-cultural clinical work is helping people to approach their lives and solve their problems in

ways that suit them. Often, the solutions involve choices and perspectives that are not those that would facilitate my happiness.

Recognizing that clients need very different things in their lives is a natural extension of taking the differences between clients and what clients need in therapy seriously. The more I reflected on participant accounts, the clearer it seemed that cross-cultural work is facilitated by the view that there are many different ways to live a good life and have healthy relationships. This perspective strikes me as a fundamental foundation for culturally competent work: recognizing and believing that it is the therapist's job to honor differences and figure out what the client needs within their own context. This is also a place where Hook et al.'s (2013) practice of "cultural humility," or the capacity to be open to another person's beliefs and values, is important. Clients need different things in their lives to satisfy them, and simultaneously, they need different approaches in therapy. Further, because each clinical dyad has differences in their background, all clinical work is to some extent cross-cultural work. Numerous multicultural scholars also echo this perspective that clinical competence and cultural competence are equivalent (H. L. Coleman, 1998; Fuertes & Brobst, 2002; Goh, 2005; Pederson, 1991).

A participant whose views on disclosure have evolved over time provided an interesting perspective on this therapeutic practice. This participant, who is also a therapist, felt that while self-disclosure has seemed to be a very useful intervention in her work with therapy clients, in her own therapy she has appreciated working with a clinician who does not disclose any personal information about herself. She was surprised by how much she has benefited from not knowing much about her therapist. In

her experience, not having specific information about her therapist allows her to fantasize that the therapist understands her experience, which allows her to bring more parts of her internal experience into the therapy. Lack of information about the therapist could lead a different client to fantasize that their therapist would not understand their experience. However, if this assumption were discussed with the therapist, it could provide valuable insight into the client's tendencies and expectations. This space for unconscious assumption is the basis of the therapeutic practice of "neutrality," which is the practice if withholding personal information in order to allow the client to project aspects of their experience or relational patterns onto the therapist (Bloomgarden & Menuti, 2009; Farber, 2006; Gibson, 2012).

This perspective is important, although it contrasts with widespread recommendations for clinicians to be open about their sexual orientation with clients (L. S. Brown & Walker, 1990; Cabaj, 1996; G. W. Cole & Drescher, 2006; Guthrie, 2006; Isay, 1996; Mahalik et al., 2000, Rochlin, 1982; Russell, 2006; Satterly, 2006; Zur, 2009). Arguments in favor of disclosing the sexual orientation of the therapist maintain that clients have a right to know about identities or values that could influence the treatment and rule out clinicians who they feel will not respect their sexual orientation (A. C. Bernstein, 2000; Zur, 2011). Additionally, Guthrie (2006) has argued that therapists hiding their sexual orientation could trigger shame in the client or communicate that sexual orientations are not open to discussion. According to Isay (1991), the therapist's comfort with their own orientation may be more important than their sexual orientation because of the potential to communicate acceptance or shame.

In addition, a clinician's choices about what to disclose are influenced by numerous aspects of their self, which is why therapists are encouraged to consider their own intentions before disclosing information about themselves. According to Perlman (1991), a therapist who is disclosing information about themselves due to a wish to be seen as compassionate or understanding is acting unethically. The ability for the clinician to identify their motives is a vital part of therapeutic work. Participants indicated that they sense their clinician's compassion and understanding in other ways, which I will now discuss.

Nonjudgmental interest, internal inquiry, and talking about sex. Participants described their therapists' manners in a variety of ways, but those therapists who were noted to be exceptional all held a particular quality of presence. While different words were used, participants described a foundation of general interest in their experience, free from judgment and overwhelm. This curious and accepting other sometimes surprised participants with their ability to hear and hold their upsetting experience. The therapist's ability to honor and accept unconventional aspects of client's experience further welcomed them into the therapy space. Curiosity and interest in the client's experience was sometimes communicated through an inviting open presence, and other times, through direct questions about the client's experience and inner world. The therapists seemed to privilege curiosity and witnessing their client's self-discovery over assumptions and telling the client things about themselves. Participants reported that the experience of another person's authentic interest was healing in itself, although the knowledge gained from this approach was often also used to facilitate the client's self-awareness and psychological growth. While this description is hard to define or measure,

it does provide a valuable experiential model worth working towards. Furthermore, it connects to research suggesting that ratings of the therapeutic alliance increase when the therapist is respectful and nonjudgmental (Bachelor, 1995) as well as warm and welcoming to the client (Duff & Bedi, 2010; Dunkle & Freidlander, 1996; Hersoug et al, 2001; Najavits & Strupp, 1994).

Participant accounts indicated that their intuitive senses of practitioners were often used to make choices about treatment. While this sample may be particularly sensitive to nonverbal cues due to the overrepresentation of therapists, it may be that they are solely more conscious of these influences. It is likely that client's treatment choices are influenced by their subjective sense of practitioners, whether or not these cues are conscious to the client. Regardless, the participants in this study utilized internal senses to identify accepting and safe clinicians. Multiple participants noted that this genuine interest was not something that could be faked, at least not for long. Eventually, inauthentic interest would be sensed by the client or revealed by the presence of judgment. Participants described their sense of the clinician's personal development in a similar manner, which indicates to me that this nonjudgmental way of sitting with clients may be the result of personal attitudinal exploration done by the therapist.

These participant accounts indicate that clients can be quite tuned into the therapist and that therapeutic experiences are significantly influenced by the therapist's beliefs and behavior. Originally, models of psychotherapy were developed from a medical perspective in which the doctor would identify and solve the problems of the client (S. Freud, 1990; Robb, 2007). However, models of clinical work are increasingly acknowledging that both clinician and client influence therapeutic process (Aron, 1990;

Robb, 2007; Spezzano, 1996). Many therapeutic approaches now acknowledge that the therapist is a person whose own ideas, values, and relational patterns get stirred into the therapeutic container. If clients can sense subtle negative and positive reactions, then it would be important for therapists to increase their exposure to and acceptance of a range of relational practices and experiences. Therefore, I believe that a therapist's personal exploration of attitudes and biases is essential to competent clinical work, and that this work cultivates a nonjudgmental and curious quality of presence.

Moreover, several participants explicitly discussed the importance of the therapist doing "their own work" in order to provide culturally competent care for LGB clients. These participants discussed the value of the therapist going through a process of internal exploration, which would involve an assessment of their beliefs around sexuality, relationships, and gender. Many authors also emphasize the importance of attitudinal exploration and evaluation by clinicians wishing to work with LGB clients (A. C. Bernstein, 2000; L. S. Brown, 1996; Dworkin, 2000; Eubanks-Carter et al., 2005; McWilliams, 1996; Milton et al., 2005; Morrow, 2000). This practice is important because it can help clinicians to identify countertransferential tendencies, areas to seek more education about, and the influence of societal bias. For a clinician to be able to provide culturally competent work with sexual minorities, it is particularly important for them to have examined and counteract their own internalized heterosexism (APA, 2012; L. S. Brown, 1996; Morrow, 2000). This process is important for all therapists of sexual minorities. However, this work is particularly important for heterosexual therapists who may not have explored their relationship to these issues as a result of the privileges associated with a normative sexual identity (McGeorge & Carlson, 2011).

Societal perspectives unconsciously influence all people within a given society. Even individuals who consciously hold egalitarian values can hold unconscious judgments (Boyson & Vogel, 2008; Dovidio & Gaertner, 2000; Utessey et al., 2008). Therefore, it is the clinician's responsibility to identify, evaluate, and modify the biases they hold, in order not to impose unprocessed and inappropriate views onto their clients. This self-reflection process is the foundation of many multicultural models, including the original model of multicultural counseling provided by D. W. Sue et al. (1982). Because people hold unconscious cultural biases, "rather than deny them and allow them to unintentionally control our lives and actions, we should openly acknowledge them so that their detrimental effects can be minimized" (D. W. Sue & D. Sue, 2012, pg. 30, 2012). Moreover, Sue et al. (1992) emphasize that this reflective process is ongoing, representing the clinicians wish to continually improve and learn more about themselves and others.

On a basic level, this internal exploration is needed to assess whether a clinician can provide competent care to sexual minorities. If a clinician has beliefs or values that conflict with their ability to support an LGB individual's sexual identity, then the most compassionate form of care would be a referral to a clinician who could provide more affirmative treatment. What is particularly problematic is that some people believe "helping" an LGB individual involves changing their orientation. There is, however, a general consensus in the research that conversion therapy is destructive and ineffective (APA, 2012) and, at this point, licensing boards have declared conversion therapy to be unethical. Alternatively, if a clinician identifies prejudicial perspectives that they would like to modify, research indicates that seeking knowledge about that culture (T. B. Smith

et al., 2006) and having interpersonal experiences with members of the community in question (Pettigrew & Tropp, 2000, 2008) can reduce prejudice. If a therapist is unsure whether they can provide affirmation for LGB individuals, it may be best to refer the client elsewhere, as explicit approval is recommended in order to counteract the abundance of societal messages that communicate prejudice (Israel et al., 2008). While a nonjudgmental presence is not something that can be learned from a book, training programs can instill the value of self-reflective work, educate clinicians on the importance of affirmative treatment, and encourage therapists to be honest with themselves about their limitations in order to provide ethical treatment.

Several participants also discussed the importance of clinicians being able to discuss sexuality with comfort. This capacity was important to participants because it helped them to discuss issues concerning sex, which can be difficult to discuss. Furthermore, sexual minority identities are about sex. Therefore, acceptance and comfort with sex is foundational for accepting and working with diverse sexual orientations. Because sex and sexuality are regarded as taboo subjects in many cultures, the ability to speak directly about sexuality results from personal work as well. According to A. C. Bernstein (2000), Burckell and Goldfried (2006), Israel et al. (2008), and Milton et al. (2005), it is essential that clinicians working with LGB individuals are comfortable discussing same sex sexual practices. Explicit discussion of sexual acts supports clients in solving problems related to their sexual expression, as well as avoids increasing shame.

Fears about sexuality seem to be a significant foundation of prejudice against sexual minorities. I had an interesting experience during results analysis that highlighted

this relationship. While trying to understand a clinician's pathologizing reaction to a participant, I found myself experiencing a moment of overwhelm around the idea of male sexuality intensified by the conjunction of multiple testosterone-driven individuals, as if heterosexuality somehow tamed and contained this powerful force. I was able to identify ways in which personal fears concerning sexuality combined with social messages to influence this experience of homophobia. While this experience was unsettling to me because I am identified with an idea of myself as an ally, it helped me to understand how certain ideas could lead to misinformed fundamentalist claims that sexual minority relationships are somehow undoing the fabric of our civilization. It highlighted how homophobia connects to puritanical fears about sexuality. Furthermore, this reflection process gave me a first hand example of the pervasive nature of societal prejudice and the importance of continually acknowledging, exploring, and counteracting internalized bias. While it feels vulnerable and exposing to admit this experience in this context, I believe that this reflective process is absolutely essential and that affirmation comes from identifying and combating internalized prejudice as opposed to pretending it does not exist.

McWilliams (1996) recommends that heterosexual clinicians reflect on the development of their sexual identity and explore the potential for same sex desires in themselves in preparation for working with LGB clients. This exploration is recommended because many heterosexually identified people have not reflected upon their sexual identity development, due to the assumed normality of heterosexuality in western culture. Exploring sexual potentials within oneself can help clinicians to consider how they arrived at a heterosexual orientation and consider the work, confusion,

and internal and external navigating involved with arriving at a lesbian, gay, or bisexual orientation. Furthermore, according to Isay (1991), a therapist's comfort with their own sexuality is a part of cultural competence with this population because a clinician's unprocessed discomfort with their orientation could communicate discomfort with the client's orientation. This ease around sexuality can also help clinicians in responding to erotic transference (Greene, 1997). If a clinician is insecure about their sexual orientation in relation to LGB clients, it could prevent them from asking questions about their client's experience. Such avoidance may come from a wish to demonstrate a position of knowing, but what it does is prevent the clinician from learning about their client's experience, which would limit therapeutic utility.

Because clinicians' beliefs and values influence the client and therapy in numerous ways, it is essential for therapists to undergo continual and active processes of reflection in order to provide competent care to all clients. Personal work influences the way therapists sit with and listen to their clients, which impacts clients' safety and comfort. Further, personal exploration of attitudes about sexuality can help clinicians to determine whether they can provide affirmative work with LGB clients. If clinicians feel able to support LGB clients, then it provides clinicians with methods for continually improving their capacity for affirmation. Reflecting on therapists' own sexuality can demonstrate acceptance to clients and allow clinicians to help clients navigate challenging sexual dynamics in their lives. The personal work that clinicians do is one of the foundations of cross-cultural work, which can then be supplemented with appropriate knowledge and skills (Morrow, 2000; Sue et al., 1992).

Tensions between particularity and commonality, knowing and not knowing. Participants reported that they benefited from therapists normalizing their experience, as well as identifying the particular influence of their sexual minority status. They discussed appreciating clinical moments in which therapists connected to the similarity in their experiences, in addition to those in which differences were emphasized. This issue is consistently discussed in the literature, though it is often discussed in terms of the pitfalls of both minimizing the influence of sexual orientation and focusing on sexual orientation when it did not feel relevant to the client (A. C. Bernstein, 2000; R. Bowers et al., 2005; Burckell & Goldfried, 2006; Dworkin, 2000; Garnets et al., 1991; Israel et al., 2008; Liddle, 1996; Morrow, 2000). Garnets et al. (1991) identified both over- and under-emphasizing sexual orientation as inappropriate therapist practices, indicating that clinicians must strike a delicate balance between these two stances.

Minimizing the influence of sexual orientation is similar to the "colorblind" approach to racism, which invalidates the ways in which culture has shaped the client's experiences and may communicate discomfort or lack of competence. Ignoring the influence of sexual orientation could "silence necessary discussions of how this cultural lens defines experience" (A. C. Bernstein, 2000, p. 450). On the other hand, overly focusing on the client's sexual orientation can communicate that the clinician considers the client's sexual orientation as problematic or pathological. McWilliams (1996) discusses this issue as a balancing of the client's wish to be seen as both normal and unique, which most closely represents the perspective I heard from participants.

Similarly, concerning cross-cultural therapy, Pederson (1996) has stated that there are three primary errors that both clinicians and researchers can make, which are

emphasizing differences, emphasizing similarities, and assuming that one must emphasize one or the other. It seems that a balance of valuing both similarities and differences between the client and clinician are important for respecting clients' experiences. This balance is important with all clients, though it is likely that it will look differently with different clients. Furthermore, sexual minority and majority therapists will likely find themselves naturally emphasizing one or another. A study by Stracuzzi et al. (2011) also touches on this perspective, indicating that positive client ratings of the working alliance were correlated with clinicians who were interested in diversity and comfortable discussing both differences and similarities within the therapeutic dyad.

Recognizing the commonality of participant experiences was reported to occur through therapists treating LGB relationships as "any other relationship" and expressing empathy for and connection to the common emotional cores of experience. On the other hand, participants reported feeling like the specificity of sexual minority experience was acknowledged when clinicians utilized knowledge about LGB cultural norms and discussed the influence of heterosexism. Given the inadequacy of training programs, this indicates that most clinicians should seek additional knowledge to treat LGB clients (R. Bowers et al., 2005; Greene, 2007; Johnson, 2012).

However, one participant expressed concern about the way in which cultural knowledge can be used to stereotype clients. He noted that multicultural competence can be focused on so much that clients are defined by their culture, which he saw preventing understanding and connection. Therefore, another tension exists between utilizing cultural knowledge to understand the experiences of sexual minorities while avoiding making assumptions on behalf of this knowledge, particularly for heterosexual clinicians.

According to my analysis of participant accounts, it seems to be useful for clinicians to seek and utilize cultural knowledge while recognizing the limits of their knowledge. This humility could help clinicians with multiple aspects of their work, including being receptive to client experiences of rupture and valuing clients' views on their problems and perspectives on appropriate solutions.

Recommendations for Clinical Practice

While the findings of a qualitative study are not meant to automatically generalize to the larger population, they can inform practice with certain individuals in certain contexts. Transferring idiographic research findings is best done with an awareness of the cultural context (Fairweather & Rinne, 2012) and personality variables (Quintana et al., 2001). Because of the variance of individual behavior from one situation to another, a useful finding in research may only apply to "some of the people some of the time" (Bem & Allen, 1974, p. 512). Further, the way in which qualitative research includes contextual influences supports the transferability of qualitative findings to clinical situations (Morrow, 2005). Additionally, the correspondence of study findings with clinical literature indicates that some recommendations for practices are justified. D. W. Sue et al.'s (1982) model of multicultural competence is comprised of three dimensions: reflecting on personal beliefs, developing cultural knowledge, and implementing culturally appropriate skills. I will be presenting my recommendations within this structure.

Beliefs. The findings of this study indicate that self-reflective work on the part of the clinician is essential to providing competent cross-cultural treatment. This personal work can provide the clinician with important information about their ability to provide

affirmative treatment and personal countertransferential pitfalls. If a therapist feels unable to affirm LGB sexual orientations, referrals to affirmative treatment options should be provided (APA, 2012). Moreover, personal reflection can help the clinician to develop comfort discussing sexual practices explicitly, as well as aiding in understanding and combating internalized heterosexism. Clinicians are encouraged to work through the biases they discover within themselves in order to minimize prejudicial perspectives and decrease the frequency of microagressions in treatment. Additionally, this process of self-inquiry appears to facilitate the clinician's ability to sit with clients with nonjudgmental curiosity, which can help to develop positive working alliances with individuals from marginalized cultures. In order to provide effective cross-cultural therapy, it is important that clinicians value different ways of being in the world and avoid imposing their own worldview onto others (Hook et al., 2013).

Knowledge. It is important that practitioners working with this population seek knowledge about LGB cultural norms, practices, and terminology. Cultural knowledge is important so that the clinician can understand the client's cultural context and direct clients to appropriate external support (APA, 2012). Furthermore, familiarity and comfort with terminology is an indication of the clinician's comfort with sexual minority identities, facilitating client comfort in therapy. The "spectrum" is a particularly important concept for therapists to understand, as it emphasizes that sexual diversity represents natural variations in human expression and not a pathological response to external or internal challenges. Clinicians are also encouraged to recognize implications of variations in visibility and invisibility on clients' experiences and the challenges involved in developing sexual minority identity.

It is important for clinicians to balance an understanding of the deleterious impact of heterosexism on clients along with the resilience of LGB individuals and benefits of sexual minority identification. Holding both perspectives can help clinicians to neither over- nor under-emphasize the influence of sexual orientation on the client's presenting problem. Further, a thorough understanding of heterosexism includes recognition of the ways in which expectations of prejudice may influence the development of trust and safety in the therapy. Finally, because LGB clients are often put in the role of educating others, seeking cultural knowledge outside of the clinical hour is a way to support LGB clients and protect their therapeutic space.

Skills. Culturally appropriate skills refer to the clinician's capacity to use knowledge and reflection in their interactions with clients. Due to the invisibility of sexual orientation, clinicians are recommended to ask all clients about their sexual orientation (Matthews, 2007). Additionally, it is recommended that therapists avoid making assumptions about their client's sexual orientations or about the gender of the client's partners based on behavior or relationships discussed (Dworkin, 2000). Respecting clients' chosen identifiers and curiosity about what these identifiers mean to clients can provide clinicians with useful information about their client's identity and experience. It is recommended that therapists be sensitive with their language and receptive if clients indicate that they experience certain terminology as offensive.

Moreover, clinicians are encouraged to be receptive to any indications that the client may feel unsafe and consider how the therapist's behavior or identity may be influencing the client's comfort in the therapy. If clients indicate that the clinician has done something that was hurtful, therapists are encouraged to avoid responding

defensively, validate and explore the client's experience, take responsibility for inadvertently prejudicial messages, and explore the client's experience and needs moving forward (Safran et al., 2011). These experiences of rupture can be valuable opportunities to further understand and support clients and ruptures that are repaired are associated with improved therapeutic outcomes (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004, Straus et al, 2006). Additionally, if unprocessed or unrepaired, rupture often leads to premature termination (Rhodes et al., 1994). Understanding the significant impact of heterosexism encourages clinicians to identify and educate clients about the ways in which internalized heterosexism may be influencing their experiences of self and other. Further, acknowledging the influence of heterosexism can be deeply validating, providing a counterbalance to invalidating and minimizing messages. Educating clients about the impact of external and internal prejudice includes supporting clients in developing supportive community and understanding systems of oppression, as these have been shown to mediate experiences of internalized heterosexism in research (Szymanski & Kashubeck-West, 2008c).

Clients need different things, both in therapy and in their lives. Therefore, it is recommended that clinicians attend to client reactions to therapeutic practices and modify their behavior as necessary. Client experiences of disclosure were variable in this study. As a result, I will reiterate other practitioners' recommendations that this intervention be used carefully and infrequently (Bloomgarden & Mennuti, 2009; Henretty & Levitt, 2010; Zur, 2011). However, many practitioners recommend that the clinician be open about their sexual orientation, particularly if asked by the client (L. S. Brown & Walker, 1990; Cabaj, 1996; G. W. Cole & Drescher, 2006; Guthrie, 2006; Isay, 1996; Mahalik,

Van Ormer, & Simi, 2000; Rochlin, 1982; Russell, 2006; Satterly, 2006). This value practice is primarily in the therapist reflecting comfort and lack of shame in their sexual orientation (Isay, 1991). Therefore, those who are uncomfortable or confused about their sexual orientation may not be the best clinicians for this population. The diversity of client experiences reminds practitioners to practice cultural humility (Hook et al., 2013), which is the ability to support a different persons approach to situations and avoid human's natural predisposition to their own perspective or worldview. Humility is a useful practice, which can support the clinician in balancing the use of their knowledge with comfort not knowing or not having the answer for a given client's challenges.

Another abstract, yet essential, skill in cross-cultural work is the clinician's ability to balance working with the differences and similarities in the therapeutic relationship. Regarding and relating to the client's wish to be seen as unique and normal is a delicate process that requires subtle assessment and self-awareness on the part of the therapist. For heterosexual clinicians, this work involves recognizing the ways that LGB clients' experiences are influenced by their different sexual orientation, while also empathizing with the common human core of experience embedded within their challenges. For LGB clinicians, this work involves recognizing the common aspects of their experiences along with recognition of the ways that their experiences have been different from their clients. This practice can help LGB therapists to avoid the common pitfall of over-identification with similarly identified clients (Greene, 1997; Morrow, 2000).

If, after reflecting on their values and seeking additional training, clinicians feel capable of providing competent and affirmative treatment, they are advised to communicate their support to clients using the cues of allyship identified in this study.

This recommendation is not saying that clinicians should overtly try to demonstrate their support of LGB clients, as overt attempts to connect can be experienced as a microagression (Shelton & Delgado-Romero, 2011). On the contrary, these cues represent subtle ways that clinicians can welcome clients into their space, communicating affirmation while respecting the client's process of settling into the treatment relationship and their own timing involved in developing trust. Cues of competence involve indications of expertise on websites, affiliation with LGB coalitions or groups, pictures of diverse clientele, rainbow icons or art, ease using LGB-specific terminology, avoidance of assumptions of heterosexuality, and a general comfort with LGB clients and experiences.

Strengths & Limitations

Strengths of this study include the in-depth analysis and narrative perspective of client experiences that it has provided. It is my hope that clinicians reading this dissertation can get a taste of individual experiences, which will then arouse empathy for LGB people's experiences and inspire practitioners to seek more knowledge in order to provide more competent care. Qualitative methods tend to provide rich and nuanced findings, which are useful for clinical work because they include contextual influences and propose complex perspectives that allow for the consideration of individual variation (Hoshmand, 1989; Ponterotto, 2005a). Phenomenological research, in particular, is an appropriate method for studying the therapeutic process because of its emphasis of individual experience (Hoyt & Bhati, 2007; Hoshmand & Polkinghorne, 1992; Osborn, 1990). Therefore, the methodological approach of this study is particularly suited for exploring and informing clinical work.

There has been limited research on LGB clients' experiences in cross-orientation therapeutic dyads. Furthermore, most of it has been quantitative in nature, which is not as well suited for studying multicultural populations as qualitative approaches (Hoyt & Bhati, 2007; Morrow et al., 2001; Morrow, 2007; Ponterotto, 2002; S. Sue, 1999). Qualitative approaches are recommended for studying individuals from marginalized cultures because of their collaborative stance (Kral et al., 2002) and focus on participant perspectives (Morrow, 2007). Furthermore, qualitative studies encourage the discovery of the unexpected (Ponterotto et al., 2002; Pope-Davis et al., 2002; J. A. Smith et al., 2009; Speight & Vera, 1997), which is particularly important when a representative of the dominant culture does a study of this nature.

Liddle (1996) has criticized the focus of LGB research on therapist identities, which cannot be changed, instead of practices that all clinicians can work towards incorporating. Additionally, in their review of literature on treatment with LGB clients, Bieschke et al. (2007) suggested that continued research is needed on what facilitates affirmative experiences in therapy. Similarly, Speight and Vera (1997) have encouraged researchers to explore the experiential correlates of shared-cultural and cross-cultural therapeutic dyads, as well as the meaning that these similarities and differences hold for clients. This study is a step in this direction, providing descriptions of some therapist qualities and behaviors that supported positive therapeutic experiences, as well as highlighting some that led to ineffective treatment experiences. Furthermore, ways of navigating cultural misunderstandings have been proposed, which are important because misunderstandings are frequent in cross-cultural situations (Change & Berk, 2009).

The main limitation in this study concerns sampling. A qualitative study is not meant to provide a representative sample, due to its focus on the particularity of experience. However, the characteristics of the sample raise questions about whether similar experiences would be indicated within a different group of people. The sample was primary women, professional therapists, and individuals in their 30s and 40s. Given the influence of gender on therapeutic experience surveyed in the literature review, it is possible that more men in the sample would raise different concerns. The men in my study brought in some different perspectives from the women and discussed different cultural norms influencing their lives and therapeutic experience. This discovery reminded me that cross-gender therapeutic dyads involve similar navigations of cultural differences and similarities. Moreover, most of the women in this sample presented as fairly feminine, which brought up issues of invisibility. It is likely that women who presented as more masculine and thus whose sexual orientation is more visible would bring in additional experiences. Additionally, the age range of participants provides a particular window of experience: those who were born in the 1970s and 1980s and who came of age during a particular time in LGB history. It would be interesting to interview a sample that reflected more age diversity in order to identify temporal shifts in cultural and therapeutic perspectives. However, this study reflects experiences that are somewhat specific to a particular generation.

The fact that this sample primarily represented the experiences of therapeutic practitioners is an interesting influence to consider. Unfortunately, it is also the case that a majority of participants were white and highly educated, which is a demographic that is consistently overrepresented in the research (Bieschke et al., 2000; Dowsett, 2007).

However, one benefit to the sample of therapists is that these participants were particularly aware of the techniques and approaches that their therapists used with them. Furthermore, they had language for some of their experiences in therapy due to their educational background. Additionally, many had several therapeutic experiences to compare, providing rich reflections on differences and similarities as well as an awareness of ways that they changed along with these experiences. There may be other differences between populations of therapists and the general population of which I am not yet aware. Nonetheless, research on LGB experiences needs to work to include the experiences of more socioeconomic, educational, and cultural diversity to accurately speak to the experiences of the LGB community.

Another potential limitation concerning the sample is that I had collegial relationships with a few of the participants. The use of a partially "convenience sample" was a result of challenges recruiting participants through other methods attempted. While I was initially wary of the use of colleagues, it is my belief that there were some significant benefits to this sampling as well. I was surprised and deeply grateful for the rich and personal accounts that many participants offered. Interestingly, those participants with whom I had previous rapport appeared to share more vulnerable experiences with me, indicating that having some familiarity may have encouraged them to share more openly with me. Furthermore, these collegial relationships added to my sense of responsibility to represent participant accounts thoughtfully. The relationships further emphasized the importance of utilizing an "ethics of care" (Gilligan, 1982; Noddings, 1984) in which the relationship between the researcher and research participants forms the foundation for ethical treatment.

Recommendations for Future Research

This study began to explore the client's experience in cross-orientation therapeutic dyads and gained more information about affirmative therapeutic practices with LGB clients. However, it was an exploratory study. Future research is needed to assess whether similar findings would emerge from different samples. It would be particularly important to explore these issues with samples that represented the experiences of more men, non-therapists, masculine-presenting lesbian women, and wider ethnic diversity. Moreover, samples that reflect increased age and socioeconomic diversity would also be important to research in order to build a more thorough perspective and further identify different people's experiences and needs.

Additionally, this study explored a range of experiences in both cross-orientation and shared-orientation therapeutic dyads. In order to further clarify what facilitates positive working alliances with LGB clients, qualitative research focusing on positive cross-orientation therapeutic alliances is needed. This research could provide information about a larger body of research on "ally-work" with various dimensions of identity. These projects could explore the use of cross-cultural therapeutic alliances to work with the consequences of societal systems of privilege and oppression and identify therapeutic practices that could support this process.

The present research study indicated that there exists the potential for positive experiences with cross-orientation therapeutic experiences, while also indicating that inappropriate and prejudicial experiences still occur. Because this study was done from a qualitative perspective, it is unknown what proportion of experiences with perceived heterosexual therapists are beneficial, neutral, or destructive. Therefore, survey research

using a large sample could shed light on the frequency with which both of these types of experiences occur. Further, because this type of research has occurred previously (Liddle, 1999), additional exploration could indicate the state of current therapeutic competence with LGB clients and identify how treatment has changed over time. Additionally, this research could elucidate the impact of increased LGB research and multicultural training in educational institutions.

Finally, this study identified a potential model for competent therapeutic practices and pitfalls to avoid focusing on self-reflective work on the part of the clinician. In order to identify the utility of the proposed model, it would be valuable to test it by interviewing clients who received treatment from therapists working from this perspective. This model could be compared with other affirmative training models to see if it enhances clinical work in a way that would improve LGB client experiences or clinical outcomes. Because this research suggests that therapists' self reflective work is a crucial aspect of cultural competence in various therapeutic dyads, more research could be done on different methods of supporting this reflective capacity and the consequences of undergoing reflective training.

LGB individuals frequently struggle with the psychological consequences of prejudice and psychotherapy should not be a place where such experiences are repeated. This research indicates that some therapeutic experiences ended in prejudicial ruptures that were not discussed or repaired with the clinician, which is consistent with other research on impasses in the therapy (Rhodes et al., 1994). Further research is needed to identify how clinicians can repair ruptures that result from cultural misunderstandings and utilize these experiences to build understanding and support around experiences of

oppression. Given the high therapeutic utilization rates of LGB clients (Liddle, 1997), continued research is needed about these and other issues in order to support competent treatment with this population.

Conclusion

It is incumbent upon individuals working in the field of psychology to provide affirmative and supportive treatment to LGB individuals. Clinicians have a responsibility to provide respectful and appropriate care to clients, no matter what their identities. However, affirmative treatment is also a necessity because, historically, psychological views have supported the pathologization and prejudicial conception of same-gendered sexual attraction, which continues to impact LGB individuals today. The present research was conducted in order to explore the experiences of LGB clients in therapy with counselors that they perceived as heterosexual, for the purpose of informing competent practice with this population. Seven LGB individuals, selected purposefully, were interviewed using a semi-structured approach and accounts were analyzed using Interpretive Phenomenological Analysis. The focus of this study was on cross-orientation therapeutic dyads, although these were examined along with experiences in shared-orientation dyads. As a result, analysis of accounts provided perspectives on facilitating effective therapeutic work with individuals in the sexual minority, regardless of the clinician's sexual orientation.

Findings included reflections on the process of self- and other-identification, the influence of heterosexism, preferences for therapist sexual orientations, and underlying principles of affirmative practice. In terms self-identification, the detrimental impact of categorical views of sexual identity and the influence of variations in visibility and

invisibility on the identity of participants were discussed. The identification of other people's sexual orientations appears to serve the purpose of assessing the safety and acceptance of practitioners. Furthermore, various cues were identified that participants used to assess the affirmative stances and cultural knowledge of their therapeutic practitioners.

It is important that clinicians understand the pervasive influence of external and internal heterosexism in order to support individuals from this historically marginalized population. Participants discussed various ways in which heterosexism influenced their lives. In particular, experiences of heterosexism shaped expectations of the therapy and influenced how participants approached new therapeutic experiences. Additionally, examples of judgment in the therapy were provided in order to identify more and less helpful ways of navigating cultural ruptures in the therapeutic dyad. Accounts indicate that therapeutic defensiveness prevents the repair of ruptures, whereas receptivity and validation of the client's experience may encourage further openness and dialogue about variations in the therapeutic alliance.

This study also explored participants' preferences concerning the sexual orientation of the practitioner and elucidated various reasons individuals may or may not seek similarity on this dimension of identity. Often, participants sought LGB clinicians when they were seeking support for issues that related directly to their sexual identity or desiring a therapeutic experience in which they would not have to educate the clinician about their culture. There were also participants who described beneficial therapeutic experiences with heterosexual therapists. Experiencing an accepting member of the dominant culture appeared to provide a counterbalance to internalized homophobia and a

corrective emotional experience to familial rejection. The indication that cross-orientation therapeutic alliances may be well suited for working with internalized heterosexism is significant given the pervasive influence of heterosexist bias on the health and well-being of sexual minorities and the frequency with which LGB clients seek therapeutic support from heterosexual clinicians.

Finally, underlying principles of competent cross-cultural therapy were proposed, which emphasize the importance self-reflective work on the part of the clinician. Personal work is recommended in order to increase the therapist's ability to provide nonjudgmental acceptance, discuss sexuality with ease, and value different ways of approaching relationship. Furthermore, the differences between what participants wanted and needed in therapy indicates that clinicians should be sensitive to client diversity and pay careful attention to how each individual responds to various techniques and practices. Participant accounts reflected a tension between appreciating when therapists acknowledged the particularity of their experience as sexual minorities, and when clinicians addressed the commonality and normalcy of their experience. Additionally, while participants discussed appreciating when practitioners had adequate knowledge of cultural norms and terminology, it was important that this knowledge was not used to make assumptions about the client's experience. Therefore, a balance needs to be struck between holding cultural knowledge and practicing cultural humility, which emphasizes the client's authority on their experience in order to forge a cross-cultural alliance.

An important finding of this study concerns the reparative potential embedded in cross-orientation therapeutic dyads. Furthermore, this study identified key clinical perspectives that support positive therapeutic experiences for client. It is my hope that

this study can build a foundation for the importance of "ally-work," or the use of allies to witness and support healing around social marginalization and prejudice. What occurs in the therapeutic room is influenced by political and social landscapes. Similarly to being a microcosm in which healing of familial and relational patterns can occur, the therapeutic dyad can provide the opportunity to reflect on and heal social and political injustice. This possibility can only occur if clinicians take the responsibility to look at their personal and internalized societal prejudice. However, this work holds the potential to transform the lives of those involved.

References

Abramowitz C. (1976). Are men therapists soft on empathy? Two studies in feminine understanding. *Journal of Clinical Psychology*, *32*, 434-437.

Ackerman, S. J., Benjamin, L. S., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., ... & Rainer, J. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy: Theory, research, practice, training*, *38*(4), 495.

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1-33. doi:10.1016/S0272- 7358(02)00146-0

Adams, E. M., & Betz, N. E. (1993). Gender differences in counselors' attitudes toward and attributions about incest. *Journal of Counseling Psychology*, *40*(2), 210-216. doi:10.1037/0022-0167.40.2.210

Addison, R. B. (1989). Grounded interpretive research: An investigation of physician socialization. In M. J. Packer, & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 39-58). Albany, NY: SUNY Press.

Aitken, G., & Burman, E. (1999). Keeping and crossing professional and racialized boundaries. *Psychology of Women Quarterly*, *23*(2), 277-297.

Allen, L. (2010). Queer(y)ing the straight researcher: The relationship between researcher identity and anti-normative knowledge. *Feminism & Psychology*, *20*(2), 147-165.

Allmark, P., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A., & Tod, A. M. (2009). Ethical issues in the use of in-depth interviews: Literature review and discussion. *Research Ethics Review*, *5*(2), 48-54.

Allport, G. W. (1942). The use of personal documents in psychological science. New York, NY: Social Science Research Council.

Allport, G. W. (1954). *The nature of prejudice.* Cambridge, MA: Addison-Wesley.

Altheide, D. L., & Johnson, J. M. (1994). Criteria for assessing interpretive validity in qualitative research. In N. K. Denzin and Y. S. Lincoln (Eds.) *Handbook of qualitative research* (pp. 485-499). Thousand Oaks, CA: Sage.

Aluwihare-Samaranayake, D. (2012). Ethics in qualitative research: A view of the participants' and researchers' world from a critical standpoint. *International Journal of Qualitative Methods*, *11*(2), 64-81.

American Psychological Association (2013-05-14). *Publication manual of the American psychological association* (6th ed.), American Psychological Association. Kindle Edition.

American Psychological Association Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task 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.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58,* 377–402. doi:10.1037/0003- 066X.58.5.377

American Psychological Association. (2008). Answers to your questions: For a better understanding of sexual orientation and homosexuality. Retrieved from http://www.apa.org/helpcenter/sexual-orientation.aspx

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2012)*. Retrieved from http://www.apa.org/ethics/code/index.aspx

American Psychological Association (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist*, *67*(1), 10-42. doi:10.1037/a0024659

American Psychological Association (2013). *Position statement on homosexuality*. Retrieved from http://www.psych.org/advocacy--newsroom/position-statements

Ancis, J. R., & Szymanski, D. M. (2001). Awareness of White privilege among White counseling trainees. *The Counseling Psychologist*, *29*(4), 548-569.

Ang, S., & Van Dyne, L. (Eds.). (2008). *Handbook of cultural intelligence: Theory, measurement, and applications*. New York, NY: ME Sharpe.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative health research*, *10*(3), 378-395.

Angle, S. S., & Goodyear, R. K. (1984). Perceptions of counselor qualities: Impact of subjects' self-concepts, counselor gender, and counselor introductions. *Journal of Counseling Psychology*, *31*(4), 576-579. doi:10.1037/0022-0167.31.4.576

Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, 23, 705-713.

Armstrong, D., Gosling A., Weinman, J., & Marteau, T. (1997). The place of inter-rater reliability in qualitative research: An empirical study. *Sociology*, *31*, 597-606.

Arnd-Caddigan, M. (2012). The therapeutic alliance: Implications for therapeutic process and therapeutic goals. *Journal of Contemporary Psychotherapy*, *42*(2), 77-85.

Aron, L. (1990). One person and two person psychologies and the method of psychoanalysis. *Psychoanalytic Psychology*, *7*(4), 475.

Arredondo, P. (1998). Integrating multicultural counseling competencies and universal helping conditions in culture-specific contexts. *Counseling Psychologist, 26*, 592-601.

Arredondo, P., & Perez, P. (2006). Historical perspectives on the multicultural guidelines and contemporary applications. *Professional Psychology: Research And Practice*, *37*(1), 1-5. doi:10.1037/0735-7028.37.1.1

Asher, N. S., & Asher, K. C. (1999) Qualitative methods for an outsider looking in: lesbian women and body image. In M. E. Kopala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 135-144). Thousand Oaks, CA: Sage.

Aslin, A. (1977). Feminist and community mental health center psychotherapists' expectations of mental health for women. *Sex Roles, 3*, 537-544.

Asnaani, A., & Hofmann, S. G. (2012). Collaboration in multicultural therapy: Establishing a strong therapeutic alliance across cultural lines. *Journal of Clinical Psychology*, *68*(2), 187-197.

Asta, E. L., & Vacha-Haase, T. (2013). Heterosexual ally development in counseling psychologists: Experiences, training, and advocacy. *The Counseling Psychologist*, *41*, 493-529. doi: 10.1177/0011000012453174

Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. *The Counseling Psychologist, 11,* 79-92.

Atkinson, D. R. (1985). A meta-review of research on cross-cultural counseling and psychotherapy. *Journal of Multicultural Counseling and Development, 13(*4).

138-153.

Atkinson, D. R., 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., Casas, A., & Abreu, J. (1992). Mexican-American acculturation, counselor ethnicity and cultural sensitivity, and perceived counselor competence. *Journal of Counseling Psychology*, *39*(4), 515.

Atkinson, D. R., & Hackett, G. (1998). Introduction. In D. R. Atkinson, & G. Hackett (Eds.). *Counseling diverse populations* (2nd ed., pp. 3-28). Dubuque, IA: Brown & Benchmark.

Atkinson, D. R., & Wampold, B. E. (1993). Mexican Americans' initial preference for counselors: Simple choice can be misleading. *Journal of Counseling Psychology*, *40*, 245-248.

Atkinson, D. R., Wampold, B. E., Lowe, S. M., Matthews, L., & Ahn, H. N. (1998). Asian American preferences for counselor characteristics: Application of the Bradley-Terry-Luce model to paired comparison data. *The Counseling Psychologist*, *26*(1), 101-123.

Atkinson, P. (2005). Qualitative research—Unity and diversity. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research 6*(3). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/4

Atkinson, P., Coffey, A., & Delamont, S. (2003). *Key themes in qualitative research: Continuities and changes*. Walnut Creek, CA: Rowman Altamira.

Atkinson, P., & Silverman, D. (1997). Kundera's Immortality: The interview society and the invention of the self. *Qualitative Inquiry*, *3*(3), 304-325.

Awosan, C. I., Sandberg, J. G., & Hall, C. A. (2011). Understanding the experience of black clients in marriage and family therapy. *Journal of Marital and Family Therapy*, *37*(2), 153-168.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology, 42,* 323–337.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The Heart and Soul of Change: What Works in Therapy* (pp. 133-137). Washington, DC: American Psychological Association. doi: 10.1037/11132-004

Bahn, S., & Weatherill, P. (2013). Qualitative social research: A risky business when it comes to collecting "sensitive'data." *Qualitative Research*, *13*(1), 19-35.

Balsam, K. F., Beauchaine, T. P., Mickey, R. M., & Rothblum, E. D. (2005). Mental health of lesbian, gay, bisexual, and heterosexual siblings: Effects of gender, sexual orientation, and family. *Journal of Abnormal Psychology*, *114*(3), 471-476. doi:10.1037/0021-843X.114.3.471

Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54,* 306–319.

Balsam, K. F., & Szymanski, D. M. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *Psychology of Women Quarterly, 23,* 258–269.

Banister, S. (2007). Ethical issues and qualitative methods in the 21st century: How can digital technologies be embraced in the research community. *Journal of Ethnographic and Qualitative Research*, *1*, 1-10.

Barbour, R. (2000). The role of qualitative research in broadening the "evidence base" for clinical practice. *Journal of Evaluation in Clinical Practice*, *6*(2), 155-163. doi:10.1046/j.1365-2753.2000.00213.x

Barbour, R. (2001). Checklists for improving rigor in qualitative research: A case of the tail wagging the dog? *British Medical Journal*, *322*, 1115–1117.

Barbour, R., & Barbour, M. (2003). Evaluating and synthesizing qualitative research: the need to develop a distinctive approach. *Journal of Evaluation in Clinical Practice*, *9*(2), 179-186.

Barker, J. C., Herdt, G., & de Vries, B. (2006). Social support in the lives of lesbians and gay men at midlife and later. *Sexuality Research & Social Policy*, *3*(2), 1-23.

Baron, J. (1996). Some issues in psychotherapy with gay and lesbian clients. *Psychotherapy*, *33*(4), 611-616.

Barrett, M. S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting And Clinical Psychology*, *69*(4), 597-603.

Beckstead, A. L., & Israel, T. (2007). Affirmative counseling and psychotherapy focused on issues related to sexual orientation conflicts. In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 221-244). Washington, DC: American Psychological Association.

Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist, 32,* 651-691.

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.

Bernstein, A. C. (2000). Straight therapists working with lesbians and gays in family therapy. *Journal of Marital and Family Therapy*, *26*(4), 443-454. doi:10.1111/j.1752-0606.2000.tb00315.x

Bernstein, B. L., Hofmann, B., & Wade, P. (1987). Preferences for counselor gender: Students' sex role, other characteristics, and type of problem. *Journal of counseling psychology*, *34*(1), 20.

Bernstein, R. J. (1985). From hermeneutics to praxis. In R. Hollinger, *Hermeneutics and praxis*. Notre Dame, IN: University of Notre Dame Press.

Betz, N. E., & Fitzgerald, L. F. (1993). Individuality and diversity: Theory and research in counseling psychology. *Annual Review of Psychology*, *44*(1), 343-381.

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Research on therapist variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 257–310). New York, NY: Wiley.

Biaggio, M., Orchard, S., Larson, J., Petrino, K., & Mihara, R. (2003). Guidelines for gay/lesbian/bisexual-affirmative educational practices in graduate psychology

programs. *Professional Psychology: Research and Practice, 34,* 548-554. doi:10.1037/0735-7028.34.5.548

Bias, adj., n., and adv. (2013). In *Oxford English Dictionary Online*. December 2013. Oxford University Press. Retrieved from http://www.oed.com.opac.sfsu.edu/

Bieschke, K. J., McClanahan, M., Tozer, E., Grzegorek, J. L., & Park, J. (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 (2000). *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients*. Washington, DC: American Psychological Association.

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* (2nd ed., pp. 293-315). Washington, DC: American Psychological Association.

Biggerstaff, D. (2012). Qualitative research methods in psychology, psychology - selected papers, Dr. Gina Rossi (Ed.), ISBN: 978-953-51-0587-9, *InTech*, Retrieved from http://www.intechopen.com/books/psychology-selected-papers/qualitative-research-methods-in-psychology

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research In Psychology*, *5*(3), 214-224. doi:10.1080/14780880802314304

Binson, D., Blair, J., Huebner, D. M., & Woods, W. J. (2007). Sampling in surveys of lesbian, gay and bisexual people. In I. H. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 375–418). New York, NY: Springer.

Bird, C. M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry*, *11*(2), 226-248.

Blatt, S. J., Corveleyn, J., & Luyten, P. (2006). Minding the gap between positivism and hermeneutics in psychoanalytic research. *Journal of the American Psychoanalytic Association*, *54*(2), 571-610.

Blier, M. Atkinson, D., Geer, C. (1987) Effect of clt gender and counselor gender and sex roles on willingness to see the counselor. *Journal of Counseling Psychology 34*(1), 27-30.

Bloomgarden, A. & Mennuti, R. B. (2009). Therapist self-disclosure: Beyond the taboo. In A. Bloomgarden & R. B. Mennuti (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 3-16). New York, NY: Routledge.

Bloor, M. (1997) Techniques of validation in qualitative research: A critical commentary. In G. Miller & R. Dingwall (Eds.), *Context and method in qualitative research* (pp. 37-35). London, UK: Sage.

Borden, L. A., Lopresto, C. T., Sherman, M. F., & Lyons, H. Z. (2010). Perceptions of self-disclosing counselors among lesbian, gay, and bisexual individuals. *Journal of LGBT Issues in Counseling*, *4*(2), 54-69. doi:10.1080/15538605.2010.481958

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working

alliance. *Psychotherapy: Theory, Research, and Practice, 16,* 252-260.

Borgman, A. L. (2009). LGB allies and Christian identity: A qualitative exploration of resolving conflicts and integrating identities. *Journal of Counseling Psychology*, *56*(4), 508–520.

Bowers, A. V., & Bieschke, K. J. (2005). Psychologists' clinical evaluations and attitudes: An examination of the influence of gender and sexual orientation. *Professional Psychology: Research And Practice*, *36*(1), 97-103. doi:10.1037/0735-7028.36.1.97

Bowers, R., Plummer, D., & Minichiello, V. (2005). Homophobia in counseling practice. *International Journal for the Advancement of Counseling, 27,* 471–489. doi:10.1007/s10447-005-8207-7

Bowman, D., Scogin, F., Floyd, M., & McKendree-Smith, N. (2001). Psychotherapy length of stay and outcome: A meta-analysis of the effect of therapist sex. *Psychotherapy: Theory, Research, Practice, Training*, *38*(2), 142.

Boysen, G. A., & Vogel, D. L. (2008). The relationship between level of training, implicit bias, and multicultural competency among counselor trainees. *Training And Education In Professional Psychology*, *2*(2), 103-110. doi:10.1037/1931-3918.2.2.103

Bradfield, B. (2007). Examining the lived world: the place of phenomenology in psychiatry and clinical psychology. *Indo-Pacific Journal of Phenomenology*, *7*(1), 1-8.

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*(2), 228-242.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi:10.1191/1478088706qp063oa

Breakwell, G. M., & Rose, D. (2006). Theory, method and research design. *Research Methods in Psychology*, 2-23.

Brenner, C. (1979). Working alliance, therapeutic alliance, and transference. *Journal of the American Psychoanalytic Association,* 27, 136-158.

Breuer, F. & Roth, W. (2003). Subjectivity and reflexivity in the social sciences: Epistemic windows and methodical consequences. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *4*(2), Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/698/1511.

Brewer, M. B., & Brown, R. J. (1998). Intergroup relations. In D. T. Gilbert & S. T. Fiske (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 554-594). New York, NY: McGraw-Hill.

Bridges, D. (2001). The ethics of outsider research. *Journal of Philosophy of Education*, *35*(3), 371-386.

Briggs, C. L. (2002). Interviewing, power/knowledge, and social inequality. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research* (pp. 911-922). Thousand Oaks, CA: Sage.

Brinkmann, S., & Kvale, S. (2005). Confronting the ethics of qualitative research. *Journal of Constructivist Psychology*, *18*, 157-181.

Brinkman, S. & Kvale, S (2008). Ethics in qualitative psychological research. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 263-279). London, UK: Sage.

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, *21*(1), 87-108.

Broido, E. M. (2000). Ways of being an ally to lesbian, gay, and bisexual students. In N. J. Evans & V. A. Wall (Eds.), *Beyond tolerance: Gays, lesbians, and bisexuals on campus*. Lanham, MD: American College Personnel Association.

Brooks, V. R. (1981). Sex and sexual orientation as variables in therapists' biases and therapy outcomes. *Clinical Social Work Journal*, *9*, 198-210.

Brooks, A. K., & Edwards, K. (2009). Allies in the workplace: Including LGBT in HRD. Advances in developing human resources, *11*, 136–149.

Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosenkrantz, P. S., & Vogel, S. R. (1970). Sex-role stereotypes and clinical judgments of mental health. *Journal of Consulting and Clinical Psychology*, *34*(1), 1.

Brown, L. M., Tappin, M. B., Gilligan, C., Miller, B. A., & Argyris, D. E. (1989). Reading for self and moral voice: A method for interpreting narratives of real-life moral conflict and choice. In M. J. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 141-164). Albany, NY: SUNY Press.

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

Brown, L. S. (1994). *Subversive dialogues.* New York, NY: Basic Books.

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

Brown, L. S. (2008). Reflection on Kashubek-West, Szymanski, and Meyer's major contribution. *The Counseling Psychologist*, *36*, 639-644. Doi: 10.1177/0011000008320080

Brown, L. S., & Walker, L. E. (1990). Feminist therapy perspectives on self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 135–154). New York, NY: Plenum.

Bruner, J. (1987). Life as narrative. *Social Research*, 11-32.

Bryan, L. A., Dersch, C., Shumway, S., & Arredondo, R. (2004). Therapy outcomes: Client perception and similarity with therapist view. *The American Journal of Family Therapy*, *32*(1), 11-26.

Buck, D. M & Plant, A. (2011). Interorientation interactions and impressions: Does the timing of disclosure of sexual orientation matter? *Journal of Experimental Social Psychology*, *47*, 333-342.

Buhrke, R. A., & Douce, L. G. (1991). Training issues for counseling psychologists in working with lesbians and gay men. *Counseling Psychologist, 19,* 216-234. doi:10.1177/0011000091192006

Burckell, L. A., & Goldfried, M. R. (2006). Therapist qualities preferred by sexual-minority individuals. *Psychotherapy: Theory, Research, Practice, Training, 43,* 32-49. doi:10.1037/0033-3204.43.1.32

Caelli, K. (2000). The changing face of phenomenological research: Traditional and American phenomenology in nursing. *Qualitative Health Research, 10*, 366-377.

Caelli, K., Ray, L., & Mill, J. (2003). "Clear as mud": Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, *2*(2), 1-13.

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.

Cabral, R., Smith, T. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling, 58*(4), 537-554. doi: 10.1037/a0025266

Camic, P. M., Rhodes, J. E., & Yardley, L. E. (2003). *Qualitative research in psychology: Expanding perspectives in methodology and design*. Washington, DC: American Psychological Association.

Campbell, L. F., Norcross, J. C., Vasquez, M. T., & Kaslow, N. J. (2013). Recognition of psychotherapy effectiveness: The APA resolution. *Psychotherapy*, *50*(1), 98-101. doi:10.1037/a0031817

Campos, P. E., & Goldfried, M. R. (2001). Working with gay, lesbian, and bisexual clients. *Journal of Clinical Psychology/In Session: Psychotherapy in Practice*, *57*, 609–613.

Caputo, J. D. (1987). *Radical heremeneutics: Repetition, deconstruction, and the heremeneutic project*. Bloomington, IN: Indiana University Press.

Casas, J. M., Brady, S., & Ponterotto, J. G. (1983). Sexual preference biases in counseling: An information processing approach. *Journal of Counseling Psychology*, *30*, 139-145.

Casas, J. M., Ponterotto, J. G., & Gutierrez, J. M. (1986). An ethical indictment of counseling research and training: The cross-cultural perspective. *Journal of Counseling & Development, 64*(5), 347-349.

Case, K. A. (2007). Raising White privilege awareness and reducing racial prejudice: Assessing diversity course effectiveness. *Teaching Of Psychology*, *34*(4), 231-235. doi:10.1080/00986280701700250

Case, K. A. (2012). Discovering the privilege of whiteness: White women's reflections on anti-racist identity and ally behavior. *Journal of Social Issues*, *68*, 78-96.

Case, K. A., Iuzzini, J., & Hopkins, M. (2012). Systems of Privilege: Intersections, Awareness, and Applications. *Journal of Social Issues*, *68*(1), 1-10. doi:10.1111/j.1540-4560.2011.01732.x

Cass, V. (1979). Homosexual identity formation: A theoretical model, *Journal of Homosexuality*, *4*, 219-235.

Chang, D., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*(4), 521-536. doi:10.1037/a0016905

Chang, D., & Yoon, P. (January, 2011). Ethnic minority clients' perceptions of the significance of race in cross-racial therapy relationships. *Psychotherapy Research, 21*(5), 567-582.

Childers, S. M. (2012). Against simplicity, against ethics analytics of disruption as quasi-methodology. *Qualitative Inquiry*, *18*(9), 752-761.

Christians, C. G. (2007). Neutral science and the ethics of resistance. In N. K. Denzin & M. D. Giardina (Eds.), *Ethical futures in qualitative research: Decolonizing and politics of knowledge* (pp. 44-66). Walnut Creek, CA: Left Coast Press.

Christianson, A. (2005). A Re-emergence of reparative therapy. *Contemporary Sexuality*, *39*(10), 8-17.

Chojnacki, J., & Gelberg, S. (1995). The facilitation of a gay/lesbian/bisexual support-therapy group by heterosexual counselors. *Journal of Counseling and Development, 73*(3), 352-354.

Cieurzo, C., & Keitel, M. A. (1999). Ethics in qualitative research. In M. Kopala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 37-48). Thousand Oaks, CA: Sage.

Clarke, A. (2006). Qualitative interviewing: encountering ethical issues and challenges. *Nurse Researcher*, *13*(4), 19-29.

Clarke, B. H. (1997). Hermeneutics and the "relational" turn: Schafer, Ricoeur, Gadamer, and the nature of psychoanalytic subjectivity. *Psychoanalysis and Contemporary Thought*, *20*(1), 3-68.

Clark, T. (2010). On 'being researched': why do people engage with qualitative research?. *Qualitative Research*, *10*(4), 399-419.

Clemence, A. J., Hilsenroth, M. J., Ackerman, S. J., Strassle, C. G., & Handler, L. (2005). Facets of the therapeutic alliance and perceived progress in psychotherapy:

Relationship between patient and therapist perspectives. *Clinical Psychology & Psychotherapy*, *12*(6), 443-454.

Cochran, S. D. & Mays, V. M. (2000). Estimating prevalence of mental and substance-using disorders among lesbians and gay men from existing national health data. In A. M. Omoto & H. S. Kurtzman (Eds.), *Sexual orientation and mental health: Examining identity and development of lesbian, gay, and bisexual people* (pp. 143-166). Washington, DC: American Psychological Association.

Cochran, S. D., & Mays, V. M. (2009). Burden of psychiatric morbidity among lesbian, gay, and bisexual individuals in the California Quality of Life Survey. *Journal of Abnormal Psychology, 118*(3), 647-658.

Cochran, S. D., Sullivan, J., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting And Clinical Psychology*, *71*(1), 53-61. doi:10.1037/0022-006X.71.1.53

Cohen, M. (1987). A historical overview of the phenomenologic movement. *IMAGE - Journal of Nursing Scholarship*, *19*(1), 31-34.

Cohen, M. & Omery, A. (1994). Schools of phenomenology: implications for research. In J. M. Morse (Ed.) *Critical issues in qualitative research methods.* Thousand Oak, CA: Sage.

Cohen, S. (2001). *States of denial: Knowing about atrocities and suffering*. Cambridge, UK: Polity Press.

Cole, E. R. (2008). Coalitions as a model for intersectionality: From practice to theory. *Sex Roles*, *59*(5/6), 443-453.

Cole, G. W., & Drescher, J. (2006). Do tell: Queer perspectives on therapist self-disclosure-introduction. *Journal of Gay & Lesbian Psychotherapy*, *10*(1), 1-6.

Coleman, E. (1982). Developmental stages of the coming out process. In J. Gonsiorek (Ed.), *Homosexuality and psychotherapy: A practitioner's handbook of affirmative models* (pp. 31- 44) New York, NY: Haworth Press.

Coleman, H. L. (1998). General and multicultural counseling competency: Apples and oranges? *Journal of Multicultural Counseling and Development*, *26*, 147-1156.

Coleman, H. L., Wampold, B. E., & Casali, S. L. (1995). Ethnic minorities' ratings of ethnically similar and European American counselors: A meta-analysis. *Journal of Counseling Psychology, 42*, 55– 64.

Coleman, H. L. & Wampold, B. E. (2003). Challenges to the dvelopment of culturally relevant, empirically supported treatment. In D. B. Pope-Davis, H. L. K. Coleman, W. Ming Liu, & R. L. Toporek (Eds.) *Handbook of multicultural competencies in counseling and psychology* (pp. 227-246). Thousand Oaks, CA: Sage.

Cook, A. S., & Bosley, G. (1995). The experience of participating in bereavement research: Stressful or therapeutic?. *Death studies*, *19*(2), 157-170.

Conger, J. J. (1975). Proceedings of the American Psychological Association for the year 1974: Minutes of the annual meeting of the Council of Representatives. *American Psychologist*, *30*, 620-651. doi: 10.1037/h0078455

Conley, T. D., Calhoun, C., Evett, S. R., & Devine, P. G. (2002). Mistakes that heterosexual people make when trying to appear non-prejudiced: The view from LGB people. *Journal of Homosexuality*, *42*(2), 21-43.

Conley, T. D., Devine, P. G., Rabow, J., & Evett, S. R. (2003). Gay men and lesbians' experiences in and expectations for interactions with heterosexuals. *Journal of Homosexuality, 44*, 83-109.

Conroy, S. A. (2003). A pathway for interpretive phenomenology. *International Journal of Qualitative Methods, 2*(3). Article 4.

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology*, *49*(2), 255-263.

Constantine, M. G. (2007). Microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54,* 1-16. doi:10.1037/0022-0167.54.1.1

Constantine, M. G., & Ladany, N. (2000). Self-reported multicultural counseling competence scales: Their relation to social desirability attitudes and multicultural case conceptualization ability. *Journal of Counseling Psychology, 47,* 155-164.

Constantine, M. G., & Sue, D. W. (2007). Perception of racial microaggressions among Black supervisees in cross-racial dyads. *Journal of Counseling Psychology, 54,* 142-153. doi:10.1037/0022-0167.54.2.142

Cornelius-White, J. H. (2002). The phoenix of empirically supported therapy relationships: The overlooked person-centered basis. *Psychotherapy: Theory, Research, Practice, Training*, *39*(3), 219.

Corrigan, O. & Tutton, R. (2006). What's in a name? subjects, volunteers, participants and activists in clinical research. *Clinical Ethics*, *1*(2), 101-104

Cottone, J. G., Drucker, P., Javier, R. A. (2002). Gender differences in psychotherapy dyads: Changes in psychological symptoms and responsiveness to treatment during 3 months of therapy. *Psychotherapy: Theory, Research, Practice, Training 39*(4), 297-308. doi. 10.1037/0033-3204.39.4.297.

Court, D., & Abbas, R. (2013). Whose interview is it, anyway? Methodological and ethical challenges of insider-outsider research, multiple languages, and dual-researcher cooperation. *Qualitative Inquiry*, *19*(6), 480-488.

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

Creswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd Ed). Thousand Oaks, CA: Sage.

Creswell, J. W. (2006). *Qualitative inquiry and research design: Choosing among five approaches.* Thousand Oaks, CA: Sage.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.

Crits-Christoph, P., Gibbons, M., Hamilton, J., Ring-Kurtz, S., & Gallop, R. (2011). The dependability of alliance assessments: The alliance-outcome correlation is larger than you might think. *Journal of Consulting & Clinical Psychology*, *79*(3), 267-278. doi:10.1037/a0023668

Croom, G. L. (2000) Lesbian, gay, and bisexual people of color: A challenge to respective sampling in empirical research. In B. Green & G. L. Croom (Eds.). *Education, research, and practice in lesbian, gay, bisexual, and transgendered psychology: A resource manual* (pp. 263-281). Thousand Oaks, CA: Sage.

Croteau, J. M., Bieschke, K. J., Phillips, J. C., & Lark, J. (1998). Moving beyond pioneering: Empirical and theoretical perspectives on lesbian, gay, and bisexual affirmative training. *The Counseling Psychologist*, *26*, 707-711.

Croteau, J. & Talbot, D.M. (2000). Understanding the landscape: An empirical view of lesbian, gay, and bisexual issues in the student affairs profession. In V.A. Wall and N. J. Evans (Eds.), *Towards acceptance: Sexual orientation issues on campus* (pp. 3-28). Lanhan, MD: University Press of America.

Dahlberg, K. (2006). The individual in the world—the world in the individual: Towards a human science phenomenology that includes the social world. *Indo-Pacific Journal of Phenomenology*, *6*, 1-9.

Danziger, K. (1990). *Constructing the subject: Historical origins of psychological research*. Cambridge, UK: Cambridge University Press.

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative health research*, *12*(2), 279-289.

Davis, T. A., & Ancis, J. (2012). Look to the relationship: A review of African American women substance users' poor treatment retention and working alliance development. *Substance Use & Misuse*, *47*(6), 662-672. doi:10.3109/10826084.2012.654882

Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K. et al. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development, 85*, 401-409.

DeBlaere, C., Brewster, M. E., Sarkees, A., & Moradi, B. (2010). Conducting research with LGB people of color: Methodological challenges and strategies. *The Counseling Psychologist, 38,* 331-362.

Del Re, A. C., Horvath, A. O., Flückiger, C., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review*, *32*, 642-649.

Dennet, D., & Ghaemi, N. (2003). *The broken mind*. Unpublished manuscript, Department of Philosophy & Department of Medicine, Tufts University, Boston, MA, USA.

Denzin, N. K. (1992). *Symbolic interactionism and cultural studies: The politics of interpretation*. Cambridge, MA: Blackwell.

Denzin, N. K. (1995). Symbolic Interactionism. In J. A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking Psychology* (pp. 43-58). Thousand Oaks, CA: Sage.

Denzin, N. K. (2009). The elephant in the living room: Or extending the conversation about the politics of evidence. *Qualitative Research*, *9*(2), 139-160.

Denzin, N. K., & Giardina, M. D. (2007). *Ethical futures in qualitative research: Decolonizing the politics of knowledge*. Walnut Creek, CA: Left Coast Press.

Denzin, N. K., & Lincoln, Y. S. (Eds.) (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.) (1998). *Strategies of qualitative inquiry*. Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (2000). The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*, (pp. 1-28). Thousand Oaks, CA: Sage.

Denzin, N. K, & Lincoln, Y. S. (2003). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (pp. 1-45). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The SAGE handbook of qualitative research*. Thousand Oaks, CA: Sage.

Denzin, N. K., Lincoln, Y. S., & Giardina, M. D. (2006). Disciplining qualitative research 1. *International Journal of Qualitative Studies in Education*, *19*(6), 769-782.

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice*, *12*(2), 174-183.

Descartes, R. (1951). *Meditations*. New York, NY: Liberal Arts Press. (Original work published 1641)

Devine, P. G., Monteith, M. J., Zuwerink, J., & Elliot, A. J. (1991). Prejudice with and without compunction. *Journal of Personality and Social Psychology, 60*, 817-830.

Diamond, L. M. (2006). What We Got Wrong About Sexual Identity Development: Unexpected Findings From a Longitudinal Study of Young Women. In A. M. Omoto, H. S. Kurtzman (Eds.), *Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people* (pp. 73-94).

Washington, DC, US: American Psychological Association. doi:10.1037/11261-004

Diamond, M. (2000). Sex and gender: Same or different. *Feminism & Psychology*, 10, 46-54.

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2009). Researching sensitive topics: qualitative research as emotion work. *Qualitative Research*, *9*(1), 61-79.

Dillon, F. R., Worthington, R. L., Savoy, H., Rooney, S., Becker-Schutte, A., & Guerra, R. M. (2004). On becoming allies: A qualitative study of lesbian-, gay-, and bisexual affirmative counselor training. *Counselor Education and Supervision*, *43(3),* 162-178.

DiPlacido, J. (1998). Minority stress among lesbians, gay men, and bisexuals: A consequence of heterosexism, homophobia, and stigmatization. In G. Herek (Ed.), *Psychological perspectives on lesbian and gay issues: Vol. 4. Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 138–159). Thousand Oaks, CA: Sage.

DiStefano, T. M., Croteau, J. M., Anderson, M. Z., Kampa-Kokesch, S. & Bullard, M. A. (2000). Experiences of being heterosexual allies to lesbian, gay, and bisexual people: A qualitative study. *Journal of College Counseling, 3*, 131-141.

Dixon-Woods, M., Shaw, R. L., Agarwal, S., & Smith, J. A. (2004). The problem of appraising qualitative research. *Quality and Safety in Health Care*, *13*(3), 223-225.

Dobrosavljev, D. (2002). Gadamer's hermeneutics as practical philosophy. *FACTA UNIVERSITATIS-Series Philosophy, Sociology, Psychology and History*, (09), 605-618.

Dolinsky, A., Vaughan, S. C., Luber, B., Mellman, L., & Roose, S. (1998). A match made in heaven?: A pilot study of patient-therapist match. *The Journal of psychotherapy practice and research*, *7*(2), 119-125.

Dollinger, S. J., & Leong, F. T. (1993). Volunteer bias and the five-factor model. *The Journal of Psychology*, *127*(1), 29-36.

Dorland, J. M., & Fischer, A. R. (2001). Gay, lesbian, and bisexual individuals' perceptions: An analogue study. *The Counseling Psychologist*, 29, 532-547.

Dovidio, J. F., & Gaertner, S. L. (2000). Aversive racism and selection decisions: 1989 and 1999. *Psychological Science*, *11*, 315-319.

Dovidio, J. F., Gaertner, S. E., Kawakami, K., & Hodson, G. (2002). Why can't we just get along? Interpersonal biases and interracial distrust. *Cultural Diversity and Ethnic Minority Psychology*, *8*(2), 88.

Dowsett, G. W. (2007) Researching gay men's health: The promise of qualitative methodology. In I. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (pp. 419-441). New York, NY: Springer.

Drescher, J. (1999). The therapist's authority and the patient's sexuality. *Journal of Gay & Lesbian Psychotherapy, 3*(2), 61-80**.**

Duhigg, J. M., Rostosky, S. S., Gray, B. E., & Wimsatt, M. K. (2010). Development of hetero-sexuals into allies: A qualitative exploration. *Sexuality Research and*

Social Policy, 7, 2–14. doi:10.1007/s13178-010-0005-2

Duncombe, J., & Jessop, J. (2002). "Doing rapport" and the ethics of "faking friendship." In M. Mauthner, M. Birch, J. Jessop, & T. Miller (Eds.), *Ethics in qualitative research* (pp. 107-122). Thousand Oaks, CA: Sage.

Duff, C. T., & Bedi, R. P. (2010). Counsellor behaviours that predict therapeutic alliance: From the client's perspective. *Counselling Psychology Quarterly*, *23*(1), 91-110.

Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology*, *43*(4), 456.

Durso, L. E., & Meyer, I. H. (2013). Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sexuality Research & Social Policy: A Journal of The NSRC*, *10*(1), 35-42. doi:10.1007/s13178-012-0105-2

Dworkin, S. H. (2000). Individual therapy with lesbians, gays, and bisexuals. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and therapy with lesbians, gays, and bisexuals* (pp. 157–181). Washington, DC: American Psychological Association Press.

Earle, V. (2010). Phenomenology as research method or substantive metaphysics? An overview of phenomenology's uses in nursing. *Nursing Philosophy*, *11*(4), 286-296.

Eaton, T. T., Abeles, N., & Gutfreund, M. J. (1988). Therapeutic alliance and outcome: Impact of treatment length and pretreatment symptomatology. *Psychotherapy: Theory, Research, Practice, Training*, *25*(4), 536.

Eatough, V. & Smith, J. A. (2008). Interpretive Phenomenological Analysis. In C. Willig & W Stainton-Rogers (Eds.) *The Sage handbook of qualitative research in psychology* (pp 179-194). Los Angeles, CA: Sage Publications.

Eisner, E. W. (1981). On the differences between scientific and artistic approaches to qualitative research. *Educational Researcher*, *10*(4), 5-9.

Eisner, E. W. (2003). On the art and science of qualitative research in psychology: Expanding perspectives in methodology and design. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 17-30). Washington, DC: American Psychological Association.

Ellenberger, H. F. (2008). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York, NY: Basic Books.

Elliott, R. (1989). Comprehensive Process Analysis: Understanding the change process in significant therapy events. In M. J. Packer, & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 165-184). Albany, NY: SUNY Press.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for the publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Ellis, C. (2007). Telling secrets, revealing lives relational ethics in research with intimate others. *Qualitative Inquiry*, *13*(1), 3-29.

Epstein, R. S. (1994). *Keeping boundaries: Maintaining safety and integrity in the psychotherapeutic process.* Washington, DC: American Psychiatric Press.

Eubanks-Carter, C., Burckell, L.A., & Goldfried, M.R. (2005). Enhancing therapeutic effectiveness with lesbian, gay, and bisexual clients. *Clinical Psychology: Science and Practice, 12*(1), 1-18.

Fade, S. (2003). Communicating and judging the quality of qualitative research: the need for a new language. *Journal of Human Nutrition and Dietetics*, *16*(3), 139-149.

Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: a practical guide. *Proceedings of the Nutrition Society*, *63*(4), 647-654.

Fairweather, J., & Rinne, T. (2012). Clarifying a basis for qualitative generalization using approaches that identify shared culture. *Qualitative Research*, *12*(4), 473-485.

Falomir-Pichastor, J.M., & Mugny, G. (2009). "I'm not gay…I'm a real man!": Heterosexual men's gender self-esteem and sexual prejudice. *Personality and Social Psychology Bulletin, 35*, 1233-1243.

Farber, B. A. (2006). *Self-disclosure in psychotherapy*. New York, NY: The Guilford Press.

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., & 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. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (2nd ed., pp. 19–50). Washington, DC: American Psychological Association.

Fassinger, R. E., & Richie, B. S. (1997). Sex matters: Gender and sexual orientation in training for multicultural counseling competency. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 83-110). Thousand Oaks, CA: Sage.

Feagin, J. R., Orum, A. M., & Sjoberg, G. (1991). *A case for the case study*. Chapel Hill, NC: UNC Press.

Fell, G. R., Mattiske, J. K., & Riggs, D. W. (2008). Challenging heteronormativity in psychological practice with lesbian, gay, and bisexual clients. *Gay & Lesbian Issues & Psychology Review*, *4*(2), 127-140.

Fine, G. A. (1993). The sad demise, mysterious disappearance, and glorious triumph of symbolic interactionism. *Annual Review of Sociology*, 61-87.

Fine, M. (1994). Working the hyphens. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 70-82). Thousand Oaks, CA: Sage.

Fingerhut, A. W. (2011). Straight allies: What predicts heterosexuals' alliance with the LGBT community? *Journal of Applied Social Psychology, 41*, 2230-2248.

Finlay, L. (2002a). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*(2), 209-230.

Finlay, L. (2002b). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531-545.

Finlay, L. (2005). "Reflexive Embodied Empathy": A phenomenology of participant-researcher intersubjectivity. *The Humanistic Psychologist*, *33*(4), 271-292.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude." *Journal of Phenomenological Psychology*, *39*(1), 1-32.

Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998). Reconceptualizing multicultural counsel-ng: Universal healing conditions in a culturally specific context. *The Counseling Psychologist*, *26*, 525-588.

Fischer, C. T. (Ed.). (2006). *Qualitative research methods for psychologists: Introduction through empirical studies*. Access Online via Elsevier.

Fisher, C. B. (2000). Relational ethics in psychological research: one feminist's journey. In M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp. 125-142. Washington DC, US: American Psychological Association.

Fiske, S. T. (1998). Stereotyping, prejudice, and discrimination. In D. T. Gilbert & S. T. Fiske (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 357–411). New York, NY: McGraw-Hill.

Fitzpatrick, M., Iwakabe, S., & Stalikas, A. (2005). Perspective divergence in the working alliance. *Psychotherapy Research*, *15*(1-2), 69-80.

Flick, U. (2002). Qualitative research-state of the art. *Social science information*, *41*(1), 5-24.

Flores, L. Y. (2011). Therapeutic and theoretical considerations in a therapist's disclosure of sexual and gender identity to patients. *Therapeutic And Theoretical Considerations In A Therapist's Disclosure Of Sexual And Gender Identity To Patients*, 2. doi:10.1037/e656162011-001

Flückiger, C., Horvath, A. O., Ackert, M., Del Re, A. C., Symonds, D., & Wampold, B. E. (2013). Substance use disorders and racial/ethnic minorities matter: A meta-analytic examination of the relation between alliance and outcome. *Journal of Counseling Psychology*, *60*(4), 610-616. doi:10.1037/a0033161

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative inquiry*, *12*(2), 219-245.

Ford, M. P., & Hendrick, S. S. (2003). Therapists' sexual values for self and clients: Implications for practice and training. *Professional Psychology: Research And Practice*, *34*(1), 80-87. doi:10.1037/0735-7028.34.1.80

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Freeman, M. (2011). Validity in dialogic encounters with hermeneutic truths. *Qualitative Inquiry*, *17*(6), 543-551.

Freud, S. (1990). Recommendations to physicians practising psycho-analysis. In R. Langs (Ed.), *Classics of Psychoanalytic Technique* (pp. 391-396). Oxford, UK: Rowman & Littlefield.

Freud, A. (1985). *The analysis of defense: The ego and the mechanisms of defense revisited*. (J. Sandler, Trans.) New York, NY: International Universities Press. (Original work published 1936)

Frieswyk, S. H., Allen, J. G., Colson, D. B., Coyne, L., Gabbard, G. O., Horwitz, L., & Newsom, G. (1986). Therapeutic alliance: its place as a process and outcome variable in dynamic psychotherapy research. *Journal of Consulting and Clinical Psychology*, *54*(1), 32-38.

Fuertes, J. N., & Brobst, K. (2002). Clients' ratings of counselor multicultural competency. *Cultural Diversity and Ethnic Minority Psychology, 8*(3), 214-223.

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training, 43,* 480–490. doi:10.1037/0033-3204.43.4.480

Fukuyama, M. A., & Ferguson, A. D. (2000). Lesbian, gay, and bisexual people of color: Understanding cultural complexity and managing multiple opressions. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual, Clients* (pp. 81-106). Washington, DC: American Psychological Association.

Gadamer, H. G. (1989). *Truth and method*. (J. Weinsheimer & D. G. Marshall, Trans.). New York, NY: Continuum. (Original work published 1960)

Garnets, L., Hancock, K., Cochran, S., Goodchilds, J., & Peplau, L. (1991). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. *American Psychologist, 46,* 964-972. doi:10.1037/0003- 066X.46.9.964

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27*, 143–153.

Geertz, C. (1973). *The interpretation of cultures: Selected essays*. New York, NY: Basic Books.

Geller, J. (2003). Self-disclosure in psychoanalytic-existential therapy. *Journal of Clinical Psychology, 59*(5), 541-554.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology*, *41*, 296-306.

Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice.* New York, NY: John Wiley.

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*(3), 356-364. doi:10.1037/0022-0167.42.3.356

Gelso, C. J., & Mohr, J. J. (2001). The working alliance and transference/ countertransference relationship in psychotherapy: Their manifestation with racial/ethnic and sexual orientation minority clients and therapists. *Applied & Preventive Psychology, 10,* 51–68. doi:10.1016/S0962- 1849(05)80032-0

Gemignani, M. (2011). Between researcher and researched an introduction to countertransference in qualitative inquiry. *Qualitative Inquiry*, *17*(8), 701-708.

Gergen, K. (1985). The social obstructionist movement in modern psychology. *American Psychologist, 40,* 266-275.

Gergen, K. (1989). The possibility of psychological knowledge: A hermeneutic inquiry. In M. J. Packer, & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 239-258). Albany, NY: SUNY Press.

Gergen, K. (2001). Psychological science in a postmodern context. *American Psychologist, 56*, 803-813.

Getz, C., & Kirkley, E. (2006). Shaking up the status quo: Challenging intolerance of the

lesbian, gay, and bisexual community at a private Roman Catholic university. *College Student Journal, 40*, 857-869.

Goh, M. (2005). Cultural competence and master therapists: An inextricable relationship. *Journal of Mental Health Counseling, 27*(1), 71-81.

Gibbs, G. R. (2007). Analyzing qualitative data. In U. Flick (Ed.), *The Sage qualitative research kit*. London, UK Sage.

Gibson, M. F. (2012). Opening up: Therapist self-disclosure in theory, research, and practice. *Clinical Social Work Journal*, *40*, 287-296.

Gilbert, L. A. (1992). Gender and counseling psychology: Current knowledge and directions for research and social action. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology (*2nd ed., pp. 383-416). New York, NY: Wiley.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Gilliland, B., & Crisp, D. (1995, August). *Homophobia: Assessing and changing attitudes of counselors-in-training*. Paper presented at the 103rd annual convention of the American Psychological Association, New York.

Giorgi, A. (2000). Concerning the application of phenomenology to caring research. *Scandinavian Journal of Caring Sciences*, *14*(1), 11-15.

Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing science quarterly*, *18*(1), 75-82.

Giorgi, A. (2008). Concerning a serious misunderstanding of the essence of the phenomenological method in psychology. *Journal of Phenomenological Psychology*, *39*(1), 33-58.

Giorgi, A. (2010). Phenomenological psychology: A brief history and its challenges. *Journal of Phenomenological Psychology*, *41*(2), 145-179.

Giorgi, A. (2012). The descriptive phenomenological psychological method. *Journal of Phenomenological Psychology*, *43*(1), 3-12.

Giorgi, A. & Giorgi, B. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes & L. Yardley (Eds.) Qualitative research in psychology: Expanding perspectives in methodology and design (pp. 243-273). Washington, DC: American Psychological Association.

Given, L. M. (Ed.). (2008). Postmodernism. In *The SAGE encyclopedia of qualitative research methods* (Vol. 2, pp. 655–659). Thousand Oaks, CA: Sage. Retrieved from http://go.galegroup.com/

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New York, NY: Aldine.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The qualitative report*, *8*(4), 597-607.

Goldstein, E. G. (1997). To tell or not to tell: The disclosure of events in the therapist's life to the patient. *Clinical Social Work Journal, 25*, 41–58.

Goldstein, S. B., & Davis, D. S. (2010). Heterosexual allies: A descriptive profile. *Equity & Excellence In Education*, *43*(4), 478-494. doi:10.1080/10665684.2010.505464

Gonsiorek, J. (1991). The empirical basis for the demise of the illness model of homosexuality. In J. Gonsiorek & J. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 115- 136). Newbury Park, CA: Sage.

Gonsoriek, J. C. (2004). Reflections from the conversion therapy battlefield. *The Counseling Psychologist*, *32*, 750-759. doi: 10.1177/0011000004267621

Goodman, M. B., & Moradi, B. (2008). Attitudes and behaviors toward lesbian and gay persons: Critical correlates and mediated relations. *Journal of Counseling Psychology*, 55(3), 371-384. doi: 10.1037/0022-0167.55.3.371

Graham, D. L., Rawlings, E. I., Halpern, H. S., & Hermes, J. (1984). Therapists' needs for training in counseling lesbians and gay men. *Professional Psychology: Research And Practice*, *15*(4), 482-496. doi:10.1037/0735-7028.15.4.482

Grantham, R. J. (1973). Effects of counselor sex, race, and language style on black students in initial interviews. *Journal of Counseling Psychology*, *20*(6), 553-559. doi:10.1037/h0035188

Gray-Little, B., & Kaplan, D. (2000). Race and ethnicity in psychotherapy research. In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological change: Psychotherapy processes and practices* (pp. 591–613). New York, NY: Wiley.

Greene, B. (1994). Lesbian and gay sexual orientations: Implications for clinical training, practice, and research. In B. Greene & G. Herek (Eds.), *Psychological perspectives on lesbian and gay issues: Vol. 1. Lesbian and gay psychology: Theory, research, and clinical applications* (pp. 1-24). Thousand Oaks, CA: Sage.

Greene, B. (1997). Ethnic minority lesbians and gay men: Mental health and treatment

issues. In B. Greene (Ed.), *Ethnic and cultural diversity among lesbians and gay men* (pp. 216-239). Thousand Oaks, CA: Sage.

Greene, B. (2007). Delivering ethical psychological services to lesbian, gay, and bisexual 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., pp. 181-200). Washington, DC: American Psychological Association.

Greenson, R. R. (1965). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly, 34*(1), 155-181.

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102,* 4-27. doi:10.1037/0033-295X.102.1.4

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interven- tions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43,* 531–548. doi:10.1037/0033-3204.43.4.531

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology*, *29*(2), 75-91.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, *2*, 163-194.

Gubrium, J. F., & Holstein, J. A. (1995). Qualitative inquiry and the deprivatization of experience. *Qualitative Inquiry*, *1*, 204–222.

Gubrium, J. F., & Holstein, J. A. (2002). From the individual interview to the interview society. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview*

research (pp. 3-32). Thousand Oaks, CA: Sage.

Gubrium, J. F., & Holstein, J. A. (2012). Narrative practice and the transformation of interview subjectivity. In J. F. Gubrium, A. B. Marvasti, & K. D. McKinney (Eds.), *The SAGE handbook of interview research: The complexity of the craft* (27-44, 2nd ed.). Thousand Oaks, CA: Sage.

Guenther, K. M. (2009). The politics of names: rethinking the methodological and ethical significance of naming people, organizations, and places. *Qualitative Research*, *9*(4), 411-421.

Gunzenhauser, M. G. (2006). A moral epistemology of knowing subjects theorizing a relational turn for qualitative research. *Qualitative Inquiry*, *12*(3), 621-647.

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry*, *150*, 188-196.

Gutheil, T. G., & Gabbard, G. O. (1995). The concept of boundaries in clinical practice: Theoretical and risk- management dimensions. In D. N. Bersoff (Ed.), *Ethical conflicts in psychology* (pp. 218–223). Washington, DC: American Psychological Association.

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry, 155*, 409-414.

Guthrie, C. (2006). Disclosing the therapist's sexual orientation: The meaning of disclosure in working with gay, lesbian, and bisexual patients. *Journal of Gay & Lesbian Psychotherapy, 10,* 63–77. doi: 10.1300/J236v10n01_07

Hadjistavropoulos, T., & Smythe, W. E. (2001). Elements of risk in qualitative research. *Ethics & Behavior*, *11*(2), 163-174.

Haldeman, D. C. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology, 62,* 221-227. doi:10.1037/0022-006X.62.2.221

Haldeman, D. C. (2000). Therapeutic responses to sexual orientation: psychology's evolution. In B. Green & G. L. Croom (Eds.). Education, Research, and Practice in Lesbian, Gay, Bisexual, and Transgendered Psychology: A Resource Manual (pp. 244-262). Thousand Oaks, CA: Sage Publications.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counselling and Psychotherapy Research*, *5*(2), 96-104.

Hein, S. F., & Austin, W. J. (2001). Empirical and hermeneutic approaches to phenomenological research in psychology: A comparison. *Psychological Methods*, *6*(1), 3.

Hammersley, M. (1995). Theory and evidence in qualitative research. *Quality and Quantity*, *29*, 55-66.

Hammersley, M. (2010). Reproducing or constructing? Some questions about transcription in social research. *Qualitative research*, *10*(5), 553-569.

Hammersley, M., & Traianou, A. (2011). Moralism and research ethics: a Machiavellian perspective. *International Journal of Social Research Methodology*, *14*(5), 379-390.

Harrison, D. K. (1975). Race as a counselor–client variable in counseling and psychotherapy: A review of the research. *The Counseling Psychologist, 5,* 124-133. doi:10.1177/001100007500500130

Hatcher, R. L. (2010). Alliance theory and measurement. *The therapeutic alliance: an evidence-based guide to practice. Guilford, New York*, 7-28.

Hatfield, G., (2011). René Descartes, In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*. Retrieved from http://plato.stanford.edu/archives/sum2011/entries/descartes/

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counseling Psychology, 52,* 146-155.

Haverkamp, B. E., Morrow, S. L., & Ponterotto, J. G. (2005). A time and place for qualitative and mixed methods in counseling psychology research. *Journal of Counseling Psychology*, *52*(2), 123-125. doi:10.1037/0022-0167.52.2.123

Haverkamp, B. E., & Young, R. A. (2007). Paradigms, purpose, and the role of the literature formulating a rationale for qualitative investigations. *The Counseling Psychologist*, *35*(2), 265-294.

Hegeland, I. M. (2005). "Catch 22" of research ethics: ethical dilemmas in follow-up studies of marginal groups. *Qualitative Inquiry*, *11*(4), 549.

Heidegger, M. (1962). *Being and time*. (J. Macquarrie, & E. Robinson, Trans.)Oxford, UK: Blackwell. (Original work published 1927).

Helms, J. E. (1994). How multiculturalism obscures racial factors in the therapy process: Comment on Ridley et al. (1994), Sodowsky et al. (1994), Ottavi et al. (1994),

and Thompson et al. (1994). *Journal of Counseling Psychology*, *41*(2), 162-165. doi:10.1037/0022-0167.41.2.162

Helms, J. E., & Richardson, T. Q. (1997). How "multiculturalism" obscures race and culture as differential aspects of counseling competency. *Multicultural counseling competencies: Assessment, education and training, and supervision*, *7*, 60-79.

Helms, J. E., & Talleyrand, R. M. (1997). Race is not ethnicity. *American Psychologist*, *52*(11), 1246-1247. doi:10.1037/0003-066X.52.11.1246

Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review, 30,* 63-77. doi:10.1016/j.cpr.2009.09.004

Henwood, K., & Pidgeon, N. (1992). Qualitative research and psychological theorising. *British Journal of Psychology*, *83,* 97-11.

Henwood, K., & Pidgeon, N. (2003). Grounded theory in psychological research. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 131–155). Washington, DC: American Psychological Association.

Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in counseling* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Herek, G. M. (1984). Beyond "homophobia": A social psychological perspective on attitudes towards lesbians and gay men. *Journal of Homosexuality*, *10,* 1-21.

Herek, G. M. (1994). Assessing heterosexuals' attitudes toward lesbians and gay men: A review of empirical research with the ATLGBscale. In B. Greene & G. M. Herek (Eds.), *Lesbian and gay psychology: Theory, research and clinical applications*

(pp. 206-228). Thousand Oaks, CA: Sage.

Herek, G. M. (1995). Psychological heterosexism in the United States. In A. R. D' Augelli & C. J. Patterson (Eds.), *Lesbian, gay, and bisexual identities over the lifespan: Psychological perspectives* (pp. 321-346). New York, NY: Oxford University Press.

Herek, G. M. (1996). Heterosexism and homophobia. In R. P. Cabaj & T. S. Stein (Eds.) Textbook of homosexuality and mental health (pp. 101-113) Washington, DC: American Psychiatric Press.

Herek, G. M. (2000a). The psychology of sexual prejudice. *Current Directions In Psychological Science (Wiley-Blackwell)*, *9*(1), 19-22.

Herek, G. M. (2000b). Sexual prejudice and gender: Do heterosexuals' attitudes toward lesbians and gay men differ? *Journal of Social Issues*, *56*(2), 251.

Herek, G. M. (2002). Heterosexuals' attitudes toward bisexual men and women in the United States. *Journal of Sex Research*, *39*(4), 264.

Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues*, *63*(4), 905-925. doi:10.1111/j.1540-4560.2007.00544.x

Herek, G. M. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States: Prevalence estimates from a national probability sample. *Journal of Interpersonal Violence, 24,* 54-74. doi:10.1177/0886260508316477

Herek, G. M., & Capitano, J. P. (1999). Sex differences in how heterosexuals think about lesbians and gay men: Evidence from survey context effects. *Journal of Sex Research*, *36*(4), 348-360.

Herek, G. M., & Garnets, L. D. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3,* 353-375.

Herek, G. M., Gillis, J., & Cogan, J. C. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology*, *67*(6), 945-951. doi:10.1037/0022-006X.67.6.945

Herek, G. M., Gillis, J., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology*, *56*(1), 32-43. doi:10.1037/a0014672

Herek, G. M., & Glunt, E. K. (1993). Interpersonal contact and heterosexuals' attitudes toward gay men: Results from a national survey. *Journal of Sex Research*, *30*(3), 239-244.

Herek, G. M., Kimmel, D. C., Amaro, H., & Melton, G. B. (1991). Avoiding heterosexist bias in psychological research. *American Psychologist, 46,* 957–963. doi:10.1037/0003-066X.46.9.957

Hersoug, A. G., Høglend, P., Monsen, J. T., & Havik, O. E. (2000). Quality of working alliance in psychotherapy: Therapist variables and patient/therapist similarity as predictors. *The Journal of Psychotherapy Practice and Research*, *10*(4), 205-216.

Heshusius, L. (1994). Freeing ourselves from objectivity: Managing subjectivity or turning toward a participatory mode of consciousness? *Educational Researcher, 23*(3), 15-22.

Hill, C. E. (2005). Qualitative research. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate, dialogue on the fundamental questions* (pp. 74-80). Washington, DC: American Psychological

Association.

Hill, C. E. (2006). Qualitative research. In J. C. Norcross, L. E. Beutler, & R. L. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 74-81). Washington, DC: American Psychological Association.

Hill, C. E. & Knox, S. (2002). Therapist self-disclosure. In J. C. Norcross (Eds.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 255-265). Oxford, England: Oxford Unversity Press.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52,* 196-205.

Hill, C. E., Thompson, B. J., Cogar, M. C., & Denman, D. W. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert processes. *Journal of Counseling Psychology*, *40*(3), 278.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide for conducting consensual qualitative research. *The Counseling Psychologist, 25,* 517-572.

Hodson, G., Dovidio, J. F., & Gaertner, S. L. (2010). The aversive form of racism. In J. L. Chin (Ed.), *The psychology of prejudice and discrimination: A revised and condensed edition* (pp. 1-13). Santa Barbara, CA: Praeger.

Holahan, W., & Gibson, S. A. (1994). Heterosexual therapists leading lesbian and gay therapy groups: Therapeutic and political realities. *Journal of Counseling and Development*, *72*, 591-594.

Holland, A. L., Atkinson, D. R., & Johnson, M. E. (1987). Effects of sexual attitude and sex similarity on perceptions of the counselor. *Journal of Counseling Psychology*, *34*(3), 322-325. doi:10.1037/0022-0167.34.3.322

Hollinger, R. (1995). *Hermeneutics and praxis*. Notre Dame, IN: University of Notre Dame.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3,* 345–357.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. r., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353-366. doi:10.1037/a0032595

Hooker, E. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques, 21*, 18-31.

Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology*, *56*(2), 163-173.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9-16. doi: 10.1037/a0022186

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223–233.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology*, *61*(4), 561–573.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy. *Journal of Counseling Psychology, 38,* 139-149.

Hoshmand, L. T. (1989). Alternate research paradigms: A review and teaching proposal.

The Counseling Psychologist, 17, 3-79.

Hoshmand, L. T., & Polkinghorne, D. E. (1992). Redefining the science-practice relationship and professional training. *American Psychologist*, *47*(1), 55.

Hoyt, W. T., & Bhati, K. S. (2007). Principles and practices: An empirical examination of qualitative research in the Journal of Counseling Psychology. *Journal of Counseling Psychology*, 54(2), 201.

Hubbard, G., Backett-Milburn, K., & Kemmer, D. (2001). Working with emotion: issues for the researcher in fieldwork and teamwork. *International Journal of Social Research Methodology*, *4*(2), 119-137.

Hubbard, R. R., Snipes, D. J., Perrin, P. B., Morgan, M. R., DeJesus, A., & Bhattacharyya, S. (2013). Themes in heterosexuals' responses when challenging LGBT prejudice. *Sexuality Research and Social Policy*, *10*(4), 269-278.

Husserl, E. (1979). *The crisis of European sciences and transcendental phenomenology* (D. Carr, Trans.). Evanston, IL: Northwestern University Press. (Original work published 1954)

Hyde, J. S. (1991). *Half the human experience: The psychology of women* (4th ed.). Lexington, MA: Heath.

Ibrahim, F. A., & Arredondo, P. M. (1986). Ethical standards for cross-cultural counseling: Counselor preparation, practice, assessment, and research. *Journal of Counseling & Development*, *64*(5), 349-352.

Igartua, K. J., & Des Rosiers, P. (2004). Transference and countertransference in therapy with lesbian patients: Contrasting views from lesbian and heterosexual therapists. *Journal of Lesbian Studies*, *8*(1/2), 123-141.

Igram, D. (1985). Hermeneutics and truth. In R. Hollinger, *Hermeneutics and praxis* (pp. 32-53). Notre Dame, IN: University of Notre Dame Press

Irvine, A., Drew, P., & Sainsbury, R. (2013). "Am I not answering your questions properly?" Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews. *Qualitative Research*, *13*(1), 87-106.

Isay, R. A., (1991). The homosexual analyst: clinical considerations. *The Psychoanalytic Study of the Child*, *46*, 199-216.

Isay, R. A. (1996). *Becoming gay: The journey to self-acceptance.* New York, NY: Henry Holt.

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice, 39,* 361-368. doi:10.1037/0735-7028.39.3.361.

Israel, T., & Selvidge, M. M. D. (2003). Contribution of multicultural counseling to counselor competence with lesbian, gay, and bisexual clients. *Journal of Multicultural Counseling Development, 31*, 84-98.

Ji, P. (2007). Being a heterosexual ally to the lesbian, gay, bisexual, and transgendered community: Reflections and development. *Journal of Gay and Lesbian Psychotherapy, 11*, 173-185.

Ji, P., Du Bois, S. N., & Finnessy, P. (2009). An academic course that teaches heterosexual students to be allies to LGBT communities: a qualitative analysis. *Journal of Gay and Lesbian Social Services, 21*(4), 402-429. doi:10.1080/10538720802690001.

Johnson, L., & Caldwell, B. (2011). Race, gender, and therapist confidence: Effects on satisfaction with the therapeutic relationship in MFT. *The American Journal of Family Therapy, 39*, 307–324, doi: 10.1080/01926187.2010.532012

Johnson, S. D. (2012). Gay affirmative psychotherapy with lesbian, gay, and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry, 82*, 516–522.

Jones, E. E. (1982). Psychotherapists' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology*, *38*, 722-731.

Jones, E. E., Krupnick, J. L., & Kerig, P. K. (1987). Some gender effects in a brief psychotherapy. *Psychotherapy, 24,* 336-352.

Jones, E. E., & Zoppel, C. L., (1982). Impact of client and therapist gender on psychotherapy process and outcome. *Journal of consulting and clinical psychology, 50*(2), 259-272. doi: 10.1037/0022-006X.50.2.259

Jones, M. A., Botsko, M., & Gorman, B. S. (2003). Predictors of psycho-therapeutic benefit of lesbian, gay, and bisexual clients: The effects of sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice, Training, 40,* 289-301. doi:10.1037/0033- 3204.40.4.289

Jones M. A. & Gabriel M.A., (1999). Utilization of psychotherapy by lesbians, gay men, and bisexuals: Findings from a national wide. *American Journal of Orthopsychiatry, 69*(2), 209-219.

Jourard, S. M. (1971). *The transparent self*. New York, NY: Van Nostrand Reinhold.

Josselson, R., Leiblich, A, & McAdams, D. P. (Eds.) (2007). *The meaning of others: Narrative studies of relationships.* Washington, DC: American Psychological Association.

Kant, I. (1998) Critique of pure reason. (P. Guyer & A. W. Wood, Trans.) Cambridge, UK: Cambridge University Press.

Kaplan, A. G. (1979). Toward an analysis of sex-role related issues in the therapeutic relationship. *Psychiatry: Journal for the Study of Interpersonal Processes, (42)*2, 112-120.

Karlsson, R. (2005). Ethnic matching between therapist and patient in psychotherapy: An overview of findings, together with methodological and conceptual issues. *Cultural Diversity and Ethnic Minority Psychology, 11,* 113-129. doi:10.1037/1099-9809.11.2.113

Kaufman, J. S., Carlozzi, A. F., Boswell, D. L., Barnes, L. L., Wheller-scruggs, K., & Levy, P. A. (1997). Factors influencing therapist selections among gays, lesbians and bisexuals. *Counselling Psychology Quarterly*, *10*(3), 287.

Keenan, E. K., Tsang, A. K. T., Bogo, M., & George, U. (2005). Micro ruptures and repairs in the beginning phase of cross- cultural psychotherapy. *Clinical Social Work Journal, 33*(3), 271-289.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of *DSM–IV* disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593-602.

Kihlstrom, J. F. (1987). The cognitive unconscious. *Science*, *237*(4821), 1445-1452.

Kidd, S. A., & Kral, M. J. (2005). Practicing participatory action research. *Journal of Counseling Psychology, 52*, 187-195.

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. doi:10.1037/0033- 3204.42.3.395

Kincheloe, J. L., & McLaren, P. L. (2000). Rethinking critical theory and qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 279-313). Thousand Oaks, CA: Sage Publications.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male.* Philadelphia, PA: Saunders.

Kisiel, T. (1985). The happening of tradition: Hermeneutics of Gadamer and Heidegger. In R. Hollinger (Ed.), *Hermeneutics and praxis* (pp. 3-31). Notre Dame, IN: University of Notre Dame Press.

Kite, M. E., & Whitley, B. E. (1996). Sex differences in attitudes toward homosexual persons, behaviors, and civil rights: A meta-analysis. *Personality and Social Psychology Bulletin, 22,* 336-353.

Kitzinger, C. (1996). Speaking of oppression: Psychology, politics, and the language of power. In E. D. Rothblum, and L.A. Bond (Eds.) *Preventing heterosexism and homophobia* (pp. 3-19). Thousand Oaks, CA: Sage.

Kivlighan, D. M., Clements, L., Blake, C., Arnez, A., & Brady, L. (1993). Counselor sex role orientation, flexibility, and working alliance formation. *Journal of Counseling and Development, 72*, 95-100.

Kivlighan, D. M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counseling Psychology*, *47*(3), 362-371. doi:10.1037/0022-0167.47.3.362

Klein, J. (2012). "Francis Bacon". In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Winter 2012 ed.). Retrieved from http://plato.stanford.edu/archives/win2012/entries/francis-bacon/

Klein, P., & Westcott, M. R. (1994). The changing character of phenomenological psychology. *Canadian Psychology/Psychologie Canadienne*, *35*(2), 133-158. doi:10.1037/0708-5591.35.2.133

Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. *Journal of Counseling Psychology*, *50*(4), 466-481. doi:10.1037/0022-0167.50.4.466

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology, 44*, 274-283.

Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, *59*(5), 529-539.

Koch, S. (1981). The nature and limits of psychological knowledge: Lessons of a century qua "science." *American psychologist*, *36*(3), 257.

Koch, T. (1995). Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *Journal of Advanced Nursing*, *21*(5), 827-836. doi:10.1046/j.1365-2648.1995.21050827.x

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing*, *24*(1), 174-184. doi:10.1111/1365-2648.ep8555348

Kooden, H. (1991). Self-disclosure: The gay male counselor as agent of social change. In C. Silverstein (Ed.), *Gays, lesbians, and their counselors: Studies in psychotherapy* (pp. 143–154). New York, NY: Norton.

Kopala, M. E., & Suzuki, L. A. (1999). *Using qualitative methods in psychology*. Thousand Oaks, CA: Sage.

Kral, M. J., Burkhardt, K. J., & Kidd, S. (2002). The new research agenda for a cultural psychology. *Canadian Psychology/Psychologie Canadienne*, *43*(3), 154-162. doi:10.1037/h0086912

Kramer, U., de Roten, Y., Beretta, V., Michel, L., & Despland, J. N. (2009). Alliance patterns over the course of short-term dynamic psychotherapy: The shape of productive relationships. *Psychotherapy Research*, *19*(6), 699-706.

Kuhn, T. S. (1962) *The structure of scientific revolutions*. Chicago, IL: University of Chicago Press.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.

Kvale, S. (1999). The psychoanalytic interview as qualitative research. *Qualitative Inquiry*, *5*(1), 87-113.

Kvale, S. (2003). The psychoanalytic interview as inspiration for qualitative research. *Qualitative research in psychology: Expanding perspectives in methodology and design*, 275-297.

Kvale, S. (2006). Dominance through interviews and dialogues. *Qualitative Inquiry*, *12*(3), 480-500.

Kvale, S. (2008). Qualitative inquiry between scientistic evidentialism, ethical subjectivism and the free market. *International Review of Qualitative Research*, *1*(1), 5-18.

Kivlighan, D. R., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counseling Psychology*, *47*(3), 362-371. doi:10.1037/0022-0167.47.3.362

Lam, A. G., & Sue, S. (2001). Client diversity. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 479-486.

Lambert, M. J. (1991). Introduction to psychotherapy research. In L. E. Beutler & M. Cargo (Eds.), *Psychotherapy research: An international review of programmatic studies* (pp. 1-11). Washington, DC: American Psychological Association.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 357.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow: Pearson Prentice Hall.

Lapadat, J. C., & Lindsay, A. C. (1999). Transcription in research and practice: From standardization of technique to interpretive positionings. *Qualitative Inquiry*, *5*(1), 64-86.

Larkin, M., Eatough, V., & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory & Psychology*, *21*(3), 318-337.

Lebolt, J. (1999). Gay affirmative psychotherapy: A phenomenological study. *Clinical Social Work Journal, 27*(4), 355-370

Lather, P. (1986). Research as praxis. *Harvard educational review*, *56*(3), 257-278.

Lather, P. (1994). Fertile obsession: Validity after poststructuralism. In A. Gitlin (Ed.), *Power and method: Political activism and educational research* (pp. 36-60). New York, NY: Routledge.

Latour, B. (2000). When things strike back: a possible contribution of 'science studies' to the social sciences. *The British Journal of Sociology*, *51*(1), 107-123.

Latts, M. G., & Gelso, C. J. (1995). Countertransference behavior and management with survivors of sexual assault. *Psychotherapy: Theory, Research, Practice, Training*, *32*(3), 405.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), 1.

Lebolt, J. (1999). Gay affirmative psychotherapy: A phenomenological study. *Clinical Social Work Journal*, *27*, 355-270.

Lee, E. (2012). A working model of cross-cultural clinical practice. *Clinical Social Work Journal*, *40*, 23-36. doi: 10.1007/s10615-011-0360-3

Leighton, D. L. (1982). As I knew them: Navajo women in 1940. *American Indian Quarterly, 6*, 34-51.

Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. In J. M. Morse (Ed.), *Critical Issues in Qualitative Research Methods* (pp. 95–115). Thousand Oaks, CA: Sage Publications.

Lerum, K. (2001). Intimate ethnography, and the production of critical knowledge. *Qualitative Inquiry, 7*(4), 466-483.

Levitt, H. M., Ovrebo, E., Anderson-Cleveland, M. B., Leone, C., Jeong, J. Y., Arm, J. R., ... & Horne, S. G. (2009). Balancing dangers: GLBT experience in a time of anti-GLBT legislation. *Journal of Counseling Psychology*, *56*(1), 67.

Lewis, R. J., Derlega, V. J., Griffin, J. L., & Krowinski, A. C. (2003). Stressors for gay men and lesbians: Life stress, gay-related stress, stigma consciousness, and depressive symptoms. *Journal of Social and Clinical Psychology, 22*, 716-729

Li, L. C., & Kim, B. S. K. (2004). Effects of counseling style and client adherence to Asian cultural values on counseling process with Asian American college students. *Journal of Counseling Psychology, 51,* 158-167.

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. doi:10.1037/ 0022-0167.43.4.394

Liddle, B. J. (1997). Gay and lesbian clients' selection of therapists and utilization of therapy. *Psychotherapy: Theory, Research, Practice, Training, 34,* 11-18. doi:10.1037/h0087742

Liddle, B. J. (1999). Recent improvement in mental health services to lesbian and gay clients. *Journal of Homosexuality*, *37*(4), 127-137.

Liddle, B. J. (2000). Gay and lesbian clients' ratings of psychiatrists, psychologists, social workers, and counselors. *Journal of Gay & Lesbian Psychotherapy*, *3*(1), 81-93.

Liljestrand, P., Gerling, E., & Saliba, P. A. (1978). The effects of social sex-role stereotypes and sexual orientation on psychotherapeutic outcomes. *Journal of Homosexuality*, *3*(4), 361-372.

Lincoln, Y. S. & Guba, E. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.) *Handbook of qualitative research* (2nd ed., pp. 105-117).Thousand Oaks, CA: Sage.

Lincoln, Y. S. & Guba, E. (2000) Paradigmatic controversies, contradictions, and emerging confluences, In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 163-188), Thousand Oaks, CA: Sage.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, *14*(5), 726-735.

Lowe, S. M., & Mascher, J. (2001). The role of sexual orientation in multicultural counseling: Integrating bodies of knowledge. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 755-778). Thousand Oaks, CA: Sage.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Cleghhorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York, NY: Brunner/Mazel.

Luborsky, L., Diguer, L., Seligman, D. A., Rosenthal, R., Krause, E. D., Johnson, S., . . . Schweizer, E. (1999). The researcher's own therapy allegiances: A "'wild card'" in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice, 6,* 95-106. doi:10.1093/clipsy/ 6.1.95

Lumsden, K. (2012). "You are what you research": Researcher partisanship and the sociology of the "underdog." *Qualitative Research, 13*(1) 3-18.

Lyons, H. Z., Bieschke, K. J., Dendy, A. K., Worthington, R. L., & Georgemiller, R. (2010). Psychologists' competence to treat lesbian, gay and bisexual clients: State of the field and strategies for improvement. *Professional Psychology: Research And Practice*, *41*(5), 424-434. doi:10.1037/a0021121

Lyons, H. Z., & Bike, D. H. (2010). Designing and interpreting qualitative research in multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (3rd ed., pp. 413-426). Thousand Oaks, CA: Sage.

Mabe, A. R., & Rollin, S. A. (1986). The role of a code of ethical standards in counseling. *Journal of Counseling & Development*, *64*(5), 294.

Madill, A., & Gough, B. (2008). Qualitative research and its place in psychological science. *Psychological Methods*, *13*(3), 254.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Jfournal of Psychology*, *91*(1), 1-20.

Mahalik, J. R., van Ormer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology.* Washington, DC: American Psychological Association.

Mair, D., & Izzard, S. (2001). Grasping the nettle: Gay men's experiences in therapy. *Psychodynamic Counselling*, *7*(4), 475-490.

Mallinckrodt, B. (1996). Change in working alliance, social support, and psychological

symptoms in brief therapy. *Journal of Counseling Psychology*, *43*(4), 448-455. doi:10.1037/0022-0167.43.4.448

Mallinckrodt, B., & Nelson, M. L. (1991). Counselor training level and the formation of the psychotherapeutic working alliance. *Journal of Counseling Psychology*, *38*, 135-138.

Malterud, K. (2001). Qualitative research: Standards, challenges, and guidelines. *The lancet*, *358*(9280), 483-488.

Maramba, G. G., & Nagayama Hall, G. C. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology, 8,* 290-297. doi: 10.1037/1099-9809.8.3.290

Marecek, J. (2003). Dancing through minefields: Toward a qualitative stance in psychology. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 49-69). Washington, DC: American Psychological Association.

Marecek, J. (2011). Numbers and interpretations: What is at stake in our ways of knowing? *Theory Psychology, 21*, 220-240. doi: 10.1177/0959354310391353

Marmor, J. (1996). Nongay therapists working with gay clients a personal reflection. In R. Cabaj & T. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 539-545). Washington, DC: American Psychiatric Press.

Martin, D., Garske, J., & Davis, K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438-450.

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., pp. 201-220). Washington, DC: American Psychological Association.

Matthews, C. R., Selvidge, M., & Fisher, K. (2005). Addictions counselors' attitudes and behaviors toward gay, lesbian, and bisexual clients. *Journal of Counseling & Development*, *83*(1), 57-65.

Maxwell, J. A. (2004). Reemergent scientism, postmodernism, and dialogue across differences, *Qualitative Inquiry*, *10*(1), 35–41.

Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal*, *311*(6997), 109.

McCarthy, P. R., & Betz, N. E. (1978). Differential effects of self-disclosing versus self-involving counselor statements. *Journal of Counseling Psychology*, *25*(4), 251-256.

McDonald, M., & Wearing, S. (2013). Conceptualisation of the self in humanistic psychology: Heidegger, Foucault and the sociocultural turn. *Journal of Phenomenological Psychology*, *44*, 37-59.

McDermott, D., Tyndall, L., & Lichtenberg, J. W. (1989). Factors related to counselor preference among gays and lesbians. *Journal of Counseling and Development, 68*, 31-35.

McFadden, J. (1996). A transcultural perspective: Reaction to C. H. Patterson's "Multicultural counseling: From diversity to universality." *Journal of Counseling*

& Development, *74*(3), 232.

McGeorge, C., & Carlson, T. S. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy*, *37*(1), 14-26.

McHenry, S. S., & Johnson, J. W. (1993). Homophobia in the therapist and gay or lesbian client: conscious and unconscious collusions in self-hate. Psychotherapy, *30*, 141-151.

McIntosh, P. (1998). White privilege: Unpacking the invisible knapsack. *Race, class, and gender in the United States: An integrated study*, *4*, 165-169.

McLeod, J. (2001). *Doing counseling research* (2nd ed.) Thousand Oaks, CA: Sage.

McLeod, J. (2003). *Doing counseling research*. Thousand Oaks, CA: Sage.

McWilliams, N. (1996). Therapy across the sexual orientation boundary: Reflections of a heterosexual female analyst on working with lesbian, gay, and bisexual patients. *Gender and Psychoanalysis, 1*(2), 203-221.

Mergendoller, J. R. (1989). Good and ill will: War resistence as a context for the study of moral action. In M. J. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 119-139). Albany, NY: SUNY Press.

Merrick, E. (1999). An exploration of quality in qualitative research: Are "reliability" and "validity" relevant? In M. Koppala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 25-36). Thousand Oaks, CA: Sage.

Mertens, D. M. (2012). Ethics and social justice in ethnocultural qualitative research. In D. K. Nagata, L. Kohn-Wood, & L. A. Suzuki, (Eds.), (2012). *Qualitative*

strategies for ethnocultural research (pp. 61-84). Washington, DC, US: American Psychological Association. doi: 10.1037/13742-004

Messer, S. B., & Wampold, B. E. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice, 9*, 21-25. doi:10.1093/clipsy.9.1.21

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 7*, 9-25.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*, 674-697.

Meyer, I. H. (2010). Identity, stress, and resilience in lesbians, gay men, and bisexuals of color. *The Counseling Psychologist*, *38*(3), 442-454.

Meyer, I. H. (2013). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychology of Sexual Orientation And Gender Diversity*, *1*(S), 3-26. doi:10.1037/2329-0382.1.S.3

Meyer, I. H., Dietrich, J., & Schwartz, S. (2008). Lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay, and bisexual populations. *American Journal of Public Health*, *98*, 1004-1006.

Meyer, I. H., & Wilson, P. A. (2009). Sampling lesbian, gay, and bisexual populations. *Journal of Counseling Psychology, 56,* 23–31.

Meyers, D., & Hayes, J. A. (2006). Effects of therapist general self-disclosure and countertransference disclosure on ratings of the therapist and session. *Psychotherapy: Theory, Research, Practice, Training*, *43*(2), 173-185.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology*, *11*(5), 799-808.

Michell, J. (2003). The quantitative imperative positivism, naive realism and the place of qualitative methods in psychology. *Theory & Psychology*, *13*(1), 5-31.

Miller, W. L., & Crabtree, B. F. (2008). Clinical Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 331-375). Thousand Oaks, CA: Sage Publications.

Miller, M. J., & Sheu, H. (2008). Conceptual and measurement issues in multicultural psychology research. *Handbook of counseling psychology* (pp. 103-120). Hoboken, NJ: Wiley.

Miller, T., Mauthner, M., Birch, M., & Jessop, J. (Eds.). (2012). *Ethics in qualitative research*. Thousand Oaks, CA: Sage.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Miville, M. L., Gelso, C. J., Pannu, R., Liu, W., Touradji, P., Holloway, P., & Fuertes, J. (1999). Appreciating similarities and valuing differences: The Miville-Guzman Universality-Diversity Scale. *Journal of Counseling Psychology*, *46*(3), 291-307. doi:10.1037/0022-0167.46.3.291

Milton, M. Coyle, A, Legg, C. (2005). Countertransference issues in psychotherapy with

lesbian and gay clients. *European Journal of Psychotherapy, Counseling and Health, 7*(3), 181-197.

Mintz, L. B., & O'Neil, J. M. (1990). Gender roles, sex, and the process of psychotherapy: many questions and few answers. *Journal of Counseling & Development*, *68*(4), 381-387.

Misgeld, D., & Jardine, D. W. (1989). Hermeneutics as the undisciplined child: Hermeneutic and technical images of education. In M. J. Packer, & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 259-274). Albany, NY: SUNY Press.

Mishler, E. G. (1979). Meaning in context: Is there any other kind? *Harvard Educational Review, 49,* 1-19.

Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews* (Vol. 3). Norwood, NJ: Greenwood.

Mishler, E. G. (1990). Validation in inquiry-guided research: The role of exemplars in narrative studies. *Harvard Educational Review*, *60*, 415-442.

Mishler, E. G. (1991). *Research interviewing: Context and narrative*. Harvard University Press.

Mohr, J. J. (2002). Heterosexual identity and the heterosexual therapist: An identity perspective on sexual orientation dynamics in psychotherapy. *The Counseling Psychologist,* 30, 532. doi: 10.1177/00100002030004003

Mohr, J. J., & Fassinger, R. E. (2003). Self-acceptance and self-disclosure of sexual orientation in lesbian, gay, and bisexual adults: An attachment perspective. *Journal of Counseling Psychology*, *50*(4), 482-495. doi:10.1037/0022-

0167.50.4.482

Mohr, J. J., Israel, T., & Sedlacek, W. E. (2001). Counselors' attitudes regarding bisexuality as predictors of counselors' clinical responses: An anlogue study of a female bisexual client. *Journal of Counseling Psychology*, *48*(2), 212-222. doi:10.1037/0022-0167.48.2.212

Montgomery, S. A., & Stewart, A. J. (2012). Privileged allies in lesbian and gay rights activism: Gender, generation, and resistance to heteronormativity. *Journal of Social Issues*, *68*, 162-177.

Moules, N. (2002). Hermeneutic inquiry: paying heed to history and hermes. *International Journal of Qualitative Methods*, *1*(3), 1-40.

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*(1), 5-22. doi:10.1037/a0014572

Moran, D. (2000). *Introduction to Phenomenology*. London, UK: Routledge.

Moran, M. R. (1992). Effects of sexual orientation similarity and counselor experience level on gay men's and lesbians' perceptions of counselors. *Journal of Counseling Psychology*, *39*(2), 247-251.

Morgan, K. S. (1992). Caucasian lesbians' use of psychotherapy: A matter of attitude? *Psychology of Women Quarterly*, *16*, 127-130. doi:10.1111%2Fj.1471-6402.1992.tb00244.x

Morin, S. F. (1977). Heterosexual bias in psychological research on lesbianism and male homosexuality. *American Psychologist*, *32*(8), 629-637. doi:10.1037/0003-066X.32.8.629

Morrison, M. A., & Morrison, T. G. (Eds.). (2008). *The psychology of modern prejudice.* New York, NY: Nova Science.

Morrow, S. L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay, and bisexual clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 137-156). Washington, DC: American Psychological Association.

Morrow, S. L. (2003). Can the master's tools ever dismantle the master's house? Answering silences with alternative paradigms and methods. Invited reaction to major contribution on methodological and content review of lesbian-, gay-, and bisexual-related articles in counseling journals: 1990-1999. *The Counseling Psychologist, 31,* 70-77.

Morrow, S. L. (2004). Finding the "yes" within ourselves: Counseling lesbian and bisexual women. In D. R. Atkinson & G. Hackett (Eds.), *Counseling diverse populations* (3rd ed., pp. 366-387). Boston, MA: McGraw-Hill.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250-260.

Morrow, S. L. (2007). Qualitative research in counseling psychology conceptual foundations. *The Counseling Psychologist*, *35*(2), 209-235.

Morrow, S. L. (2012). Sexual orientations and identities: Critical issues in counseling psychology. In E. Altmaier & J. Hansen (Eds.), *Oxford handbook of counseling psychology* (pp. 409-433). New York, NY: Oxford University Press.

Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist*, *32*(5), 641-650.

Morrow, S. L., Castañeda-Sound, C. L., & Abrams, E. M. (2012). Counseling psychology research methods: Qualitative approaches. In N. A. Fouad (Ed.), *Handbook of Counseling Psychology* (pp. 93-117). Washington, DC: American Psychological Association. doi: 10.1037/13754-004

Morrow, S. L., Rakhsha, G., & Castañeda, C. L. (2001). Qualitative research methods for multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed.) (pp. 575-603). Thousand Oaks, CA: Sage.

Morse, J. M. (1992). The power of induction. *Qualitative Health Research*, *2,* 3-6.

Morse, J. M. (1994). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: Sage.

Mottier, V. (2005). The interpretive turn: History, memory, and storage in qualitative research. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 6*(2). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/456

Moustakas, C. E. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Muran, J., Safran, J. D., Gorman, B. S., Samstag, L., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, *46*(2), 233-248. doi:10.1037/a0016085

Murphy, H. E. (2012). Improving the lives of students, gay and straight alike: Gay-straight alliances and the role of school psychologists. *Psychology in the Schools, 49*(9), 883-891. doi: 10.1002/pits.21643

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*(2), 183-189. doi:10.1037/0735-7028.33.2.183

Nagata, D. K., Kohn-Wood, L. E., & Suzuki, L. A. (2012). Reflections on the application of qualitative strategies in ethnocultural research. In D. K. Nagata, L. E. Kohn-Wood, & L. A. Suzuki (Eds.), *Qualitative strategies for ethnocultural research* (pp. 257-265). Washington, DC: American Psychological Association.

Nagel, T. (1989). *The view from nowhere*. Oxford, UK: Oxford University Press.

Najavits, L. M., & Strupp, H. H. (1994). Differences in the effectiveness of psychodynamic therapists: a process-outcome study. *Psychotherapy*, *31*(1), 114–123.

Neimeyer, G. J., & Diamond, A. K. (2001). The anticipated future of counselling psychology in the United States: A Delphi poll. *Counseling Psychology*

Quarterly, *14*(1), 49-65. doi:10.1080/09515070110057513

Nickerson, R. S. (1998). Confirmation bias: a ubiquitous phenomenon in many guises. *Review of General Psychology*, *2*(2), 175.

Noddings, N. (1984). Caring: A feminine approach to ethics *and* moral education. Berkeley, CA: University of California Press.

Norcross, J. C. (2001). Purposes, processes and products of the task force on empirically supported therapy relationships. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 345-356. doi:10.1037/0033-3204.38.4.345

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, *48*(1), 4-8. doi:10.1037/a0022180

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, *48*(1), 98-102. doi:10.1037/a0022161

Norlyk, A., & Harder, I. (2010). What makes a phenomenological study phenomenological? An analysis of peer-reviewed empirical nursing studies. *Qualitative Health Research*, *20*(3), 420-431.

Nystrom, N. (1997). *Mental health experiences of gay men and lesbians.* Paper presented at the American Association of Science. Houston, TX.

Objectivity (n.d.) In *Oxford English Dictionary Online*. Oxford University Press. Retrieved from http://0-www.oed.com.opac.sfsu.edu/view/Entry/129639?redirectedFrom=objectivity#eid

Omoto, A., & Kurtzman, H. (2006). *Sexual Orientation And Mental Health: Examining Identity And Development In Lesbian, Gay, And Bisexual People*, Washington, DC: American Psychological Association.

O'Neill, P. (2002). Tectonic change: The qualitative paradigm in psychology**.** *Canadian Psychology/Psychologie Canadienne*, *43*(3), 190-194. doi:10.1037/h0086915

Osborn, J. W. (1990). Some basic existential-phenomenological research methodology for counselors. *Canadian Journal of Counseling*, *24*(2), 79-91.

O'Shaugnessey, T., & Spokane, A. R. (2012). Lesbian and gay affirmative therapy competency, self-efficacy, and personality in psychology trainees. *The Counseling Psychologist, 41*, 825-856.

Otis, M. D., Rostosky, S. S., Riggle, E. D. B., & Hamrin, R. (2006). Stress and relationship quality in same-sex couples. *Journal of Social and Personal Relationships, 23,* 81-99.

Overgaard, S. (2003). Heidegger's early critique of Husserl. *International Journal of Philosophical Studies*, *11*(2), 157-175.

Owen, I. R (2008). Learning from twentieth century hermeneutic phenomenology for the human sciences and practical disciplines. *The Indo-Pacific Journal of Phenomenology*, *8*(1), 1-12.

Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). "No-show": Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology*, *59*(2), 314-320. doi:10.1037/a0027091

Owen, J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, *48*(3), 274-282.

doi:10.1037/a0022065

Owen, J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling & Psychotherapy Research*, *11*(3), 204-212. doi:10.1080/14733145.2010.491551

Pachankis, J. E., & Goldfried, M. R. (2013). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychology of Sexual Orientation And Gender Diversity*, *1*(S), 45-58. doi:10.1037/2329-0382.1.S.45

Packer, M. J. (1985). Hermeneutic inquiry in the study of human contact. *American Psychologist*, *40*(10), 1081-1093. doi:10.1037/0003-066X.40.10.1081

Packer, M. J., & Addison, R. B. (Eds.). (1989). *Entering the circle: Hermeneutic investigation in psychology*. New York. NY: SUNY Press.

Pacifica Graduate Institute. (2013). *2013/2014 Clinical psychology dissertation handbook*. Retrieved from http://www.pacifica.edu/pdf/dissertation_handbooks/CPHandbook2013-2014.pdf

Parham, T. A., & Helms, J. E. (1981). The influence of black students' racial identity attitudes on preferences for counselors' race. *Journal of Counseling Psychology, 28,* 250-257.

Patterson, C. H. (1996). Multicultural counseling: From diversity to universality. *Journal of Counseling & Development*, *74*(3), 227.

Patterson, C. J. (2007). Lesbian and gay family issues in the context of changing legal and social policy environments. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual,*

and transgender clients (pp. 359-378, 2nd ed.). Washington, DC: American Psychological Association.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). London, UK: Sage.

Pederson, P. (1990). The multicultural perspective as a fourth force in counseling. *Journal of Mental Health Counseling*, *12*, 93-95.

Pedersen, P. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development*, *70*, 6-12.

Pedersen, P. (1996). The importance of both similarities and differences in multicultural counseling: Reaction to C. H. Patterson. *Journal of Counseling & Development*, *74*(3), 236.

Pedersen, P. B. (1997). The cultural context of the American Counseling Association Code of Ethics. *Journal of Counseling & Development*, *76*(1), 23-28.

Perlman, G. (1991). The question of self-disclosure in the treatment of a married gay man. In C. Silverstein (Ed.), *Gays, lesbians, and their therapists* (pp. 201–209). New York, NY: Norton.

Peterson, Z. D. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy: Theory, Research, Practice, Training*, *39*(1), 21-31. doi:10.1037/0033-3204.39.1.21

Peshkin, A. (1988). In search of subjectivity—One's own. *Educational Researcher, 17*(7), 17–21.

Pettigrew, T. F., & Tropp, L. R. (2000). Does intergroup contact reduce prejudice: Recent meta-analytic findings? In S. Oskamp (Ed.), *Reducing prejudice and discrimination: "The Claremont Symposium on Applied Social Psychology*" (pp. 93–114). Mahwah, NJ: Erlbaum.

Pettigrew, T. F., & Tropp, L. R. (2008). How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators. *European Journal of Social Psychology*, *38*(6), 922-934. doi:10.1002/ejsp.504

Phillips, J. C. (2000). Training issues and considerations. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 337-358). 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., Ingram, K. M., Smith, N. G., & Mindes, E. J. (2003). Methodological and content review of lesbian-, gay-, and bisexual-related articles in counseling journals: 1990-1999. *The Counseling Psychologist,* 31, 25-62. doi: 10.1177/0011000002239398

Phinney, J. (1996). When we talk about American ethnic groups, what do we mean? *American Psychologist, 51,* 918-927.

Pilkington, N. W., & Cantor, J. M. (1996). Perceptions of heterosexual bias in professional psychology programs: A survey of graduate students. *Professional Psychology: Research And Practice*, *27*(6), 604-612. doi:10.1037/0735-7028.27.6.604

Pitman, G.E. (2002) "Outsider/insider: The politics of shifting identities in the research process." *Feminism & Psychology, 12*(2), 282-8.

Platt, L. F., & Lenzen, A. L. (2013). Sexual orientation microagressions and the experience of sexual minorities. *Journal of Homosexuality*, *60*(7), 1011-1034. Doi: 10.1080/00918369.2013.774878

Polkinghorne (1983). *Methodology for the human sciences: systems of inquiry*. Albany, NY: State University of New York Press.

Polkinghorne, D. E. (1984). Further extensions of methodological diversity for counseling psychology. *Journal of Counseling Psychology, 31, 416-429.*

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences.* Albany, NY: State University of New York Press.

Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Balle & S. Halling (Eds.), *Existential–phenomenological perspectives in psychology: Exploring the breadth of human experience* (pp. 41-60). New York, NY: Plenum Press.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*, 137-145.

Ponterotto, J. G. (2005a). Integrating qualitative research requirements into professional psychology training programs in North America: Rationale and curriculum model. *Qualitative Research in Psychology, 2*, 97-116.

Ponterotto, J. G. (2005b). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*, 126-136.

Ponterotto, J. G. (2005c). Qualitative research training in counseling psychology: A survey of directors of training. *Teaching of Psychology, 32*, 60-62.

Ponterotto, J. G. (2010). Qualitative research in multicultural psychology: Philosophical underpinnings, popular approaches, and ethical considerations. *Cultural Diversity And Ethnic Minority Psychology*, *16*(4), 581-589. doi:10.1037/a0012051

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). Revision of the Multicultural Counseling Awareness Scale. *Journal of Multicultural and Counseling Development, 30,* 153–180.

Ponterotto, J. G., & Grieger, I. (2007). Effectively communicating qualitative research. *The Counseling Psychologist, 35,* 404-430.

Ponterotto, J. G., Kuriakose, G., & Granovskaya, Y. (2008). Counselling and psychotherapy. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 455–471). London, UK: Sage.

Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). Preventing prejudice: A guide for counselors, educators, and parents (2nd ed.). Thousand Oaks, CA: Sage.

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: Analysing qualitative data. *British Medical Journal*, *320*(7227), 114-116.

Pope-Davis, D. B., Toporek, R. L., Ortega-Villalobos, L., Ligiéro, D. P., Brittan-Powell, C. S., Liu, W. M., et al. (2002). Client perspectives of multicultural counseling competence: A qualitative examination. *Counseling Psychologist, 30,* 355-393.

Poteat, V. P., Sinclair, K. O., DiGiovanni, C. D., Koenig, B. W., & Russell, S. T. (2012). Gay-straight alliances are assciated with student health: A multischool comparison of LGBtq and heterosexual youth. *Journal of Research on*

Adolescence, *23*(2), 319-330.

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* (2nd ed., pp. 119-146). Washington, DC: American Psychological Association.

Pratto, F., & Stewart, A. L. (2012). Group dominance and the half-blindness of privilege. *Journal of Social Issues*, *68*(1), 28-45. doi:10.1111/j.1540-4560.2011.01734.x

Prejudice, n. (2013). In *Oxford English Dictionary online*. Oxford University Press. Retrieved from http://0-www.oed.com.opac.sfsu.edu/view/Entry

Prenn, N. (2009). I second that emotion! On self-disclosure and its metaprocessing. In A. Bloomgarden & R. B. Mennuti (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 3-16). New York, NY: Routledge.

Prilleltensky, I. (2008). The role of power in wellness, oppression, and liberation: The promise of psychopolitical validity. *Journal of Community Psychology*, *36*(2), 116-136.

Putnam, H. (1981). *Reason, truth and history*. Cambridge, UK: Cambridge University Press.

Quillman, T. (2012). Neuroscience and therapist self-disclosure: Deepening right brain to right brain communication between therapist and patient. *Clinical Social Work Journal*, *40*(1), 1-9. doi:10.1007/s10615-011-0315-8

Quintana, S. M (2007). Racial and ethnic identity: Developmental perspectives and research. *Journal of Counseling Psychology*, *54*(3), 259-270. doi: 10.1037/0022-0167.54.3.259

Quintana, S. M., Troyano, N., & Taylor, G. (2001). Cultural validity and inherent challenges in quantitative methods for multicultural research. In G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 604-629). Thousand Oaks, CA: Sage.

Rasmussen, M. (2006) *Becoming subjects: Sexualities and secondary schooling*. NewYork, NY: Routledge.

Ratcliff, J. J., Lassiter, G. D., Markman, K. D., & Snyder, C. J. (2006). Gender differences in attitudes toward gay men and lesbians: the role of motivation to respond without prejudice. *Personality and Social Psychology Bulletin*, *32*, 1325-1338.

Ratner, C. (2002). Subjectivity and objectivity in qualitative methodology. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research 3*(3), Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/829

Reid, K., Flowers, P., & Larkin, M. (2005). Interpretative phenomenological analysis: An overview and methodological review. *The Psychologist*, *18*, 20–23.

Rennie, D. L. (1989). *Taxonomy of the client's experience of psychotherapy.* Unpublished manuscript, York University, Department of Psychology, North York, Ontario, Canada.

Rennie, D. L. (1992). Qualitative analysis of the client's experience of psychotherapy: The unfolding of reflexivity. In S. G. Toukmanian & D. L. Rennie (Eds.),

Psychotherapy process research: Paradigmatic and narrative approaches (Vol. 41, pp. 427-437). London, UK: Sage.

Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology*, *41*, 427-437.

Rennie, D. L. (2004). Reflexivity and person-centered counseling. *Journal of Humanistic Psychology, 44,* 182-203.

Rennie, D. L. (2012). Qualitative research as methodical hermeneutics. Psychological Methods, *17*(3), 385-398. doi: 10.1037/a0029250

Rennie, D. L., Watson, K. D., & Monteiro, A. M. (2002). The rise of qualitative research in psychology. *Canadian Psychology, 43,* 179-189.

Reynolds, A. L. (2003). Counseling issues for lesbian and bisexual women. In M. Kopala & M. Keitel (Eds.), *Handbook of counseling women* (pp. 53–73). Thousand Oaks, CA: Sage.

Ridley, C. R. (1995). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention*. Thousand Oaks, CA: Sage.

Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and therapy* (2nd ed.). Thousand, Oaks, CA: Sage.

Ridley, C. R., Liddle, M. C., Hill, C. L., & Li, L. C. (2001). Ethical decision-making in multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 165–188). Thousand Oaks, CA: Sage.

Riggle, E. D. B., Whitman, J. S., Olson, A., Rostosky, S. S., & Strong, S. (2008). The positive aspects of being a lesbian or gay man. *Professional Psychology:*

Research and Practice, 39, 210-217.

Richardson, T. Q., & Molinaro, K. L. (1996). White counselor self-awareness: A prerequisite for developing multicultural competence. *Journal of Counseling and Development*, *74*, 238-242.

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York, NY: Guilford Press.

Roades, L. A., & Mio, J. S. (2000). Allies: How they are created and what are their experiences? In J. S. Mio & G. I. Awakuni (Eds.), *Resistance to multiculturalism: Issues and interventions* (pp. 63–82). Philadelphia, PA: Brunner/Mazel.

Robb, C. (2007). *This changes everything: The relational revolution in psychology*. Macmillan.

Robertson, J., & Fitzgerald, L. F. (1990). The (mis)treatment of men: Effects of client gender role and life-style on diagnosis and attribution of pathology. *Journal of Counseling Psychology*, *37*(1), 3-9. doi:10.1037/0022-0167.37.1.3

Rochlin, M. (1982). Sexual orientation of the therapist and therapeutic effectiveness with gay clients. *Journal of Homosexuality, 7,* 21–29. doi:10.1300/J082v07n02_05

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-106.

Rohlf, M. (2010). Immanuel Kant. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Fall 2010 ed.). Retrieved from http://plato.stanford.edu/archives/fall2010/entries/kant/

Rorty, R. (1985). Postmodern bourgeois liberalism. In R. Hollinger (Ed.), *Hermeneutics and praxis* (pp. 214-221). Notre Dame, IN: University of Notre Dame Press.

Rosenthal, R., & Rosnow, R. L. (1975). *The volunteer subject*. Oxford, UK: Wiley.

Ross, M.W. (1990). The relationship between life events and mental health in homosexual men. *Journal of Clinical Psychology, 46*, 402-411.

Rossiter, A., Walsh-Bowers, R., & Prilleltensky, I. (1996). Learning from broken rules: Individualism, bureaucracy, and ethics. *Ethics & Behavior, 6,* 307-320.

Rotosky, S. S., & Riggle, E. D. B. (2002). "Out" at work: The relation of actor and partner workplace policy and internalized heterosexism to disclosure status. *Journal of Counseling Psychology, 49,* 411-419.

Rostosky, S., Riggle, E. 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*(1), 56-66. doi:10.1037/a0013609

Rubin, H. J., & Rubin, I. S. (2005) *Qualitative interviewing: the art of hearing data* (2nd ed). Thousand Oaks, CA: Sage.

Russell, G. M. (2000). *Voted out: The psychological consequences of anti-gay politics.* New York, NY: New York University.

Russell, G. M. (2006). Different ways of knowing: The complexities of therapist disclosure. *Journal of Gay & Lesbian Psychotherapy*, *10*(1), 79-94.

Russell, G. M. (2011). Motives of heterosexual allies in collective action for equality. *Journal of Social Issues, 67*, 376–393.

Russell, G. M., & Richards, J. A. (2003). Stressor and resilience factors for lesbians, gay men, and bisexuals confronting antigay politics. *American Journal of Community Psychology, 31,* 313-328.

Ryan, K. E., & Hood, L. K. (2004). Guarding the castle and opening the gates. *Qualitative Inquiry*, *10*, 79-95. Doi: 10.1177/1077800403259483

Ryle, G. (1971). *Collected papers. Volume II Collected essays, 1929-1968*. London, UK: Hutchinson.

Safran, J. D., & Muran, C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training*, *43*(3), 286-291.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science*, *16*(2), 1-8.

Satterly, B. A. (2006). Therapist self-disclosure from a gay male perspective. *Families in Society: The Journal of Contemporary Social Services*, *87*(2), 240-247.

Saulnier, C. F. (1999). Choosing a health care provider: A community survey of what is important to lesbians. *Families in Society, 80*, 254-262.

Saulnier, C. F. (2002). Deciding who to see: Lesbians discuss their preferences in health and mental health care providers. *Social Work, 47*, 355-365.

Savin-Williams, R. C. (2006). Who's gay? Does it matter? *Current Directions In Psychological Science (Wiley-Blackwell)*, *15*(1), 40-44. doi:10.1111/j.0963-7214.2006.00403.x

Savin-Williams, R. C., & Vrangalova, Z. (2013). Mostly heterosexual as a distinct sexual orientation group: A systematic review of the empirical evidence. *Developmental Review*, *33*(1), 58-88.

Schore, A. N. (2003). *Affect regulation and the repair of the self*. New York, NY: Norton.

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms*. Thousand Oaks, CA: Sage.

Schwandt, T. A. (1999). On understanding understanding. *Qualitative Inquiry*, *5*, 451-464. doi: 10.1177/107780049900500401

Schwandt, T. A. (2001). *Dictionary of qualitative inquiry*. Thousand Oaks, CA: Sage.

Schwandt, T. A. (2003). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and Issues* (pp. 292-331). Thousand Oaks, CA: Sage.

Scheurich, J. J., & Young, M. D (1997). Coloring epistemologies: Are our researh epistemologies racially biased? *Educational Researcher*, *26*(4), 4-16.

Schrödinger, E. (1935). The present status of quantum mechanics. *Die Naturwissenschaften*, *23*(48), 1-26.

Sciarra, D. (1999). The role of the qualitative researcher. In M. Kopala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 37-48). Thousand Oaks, CA: Sage.

Scott, D. A., Valery, P. C., Boyle, F. M., & Bain, C. J. (2002). Does research into sensitive areas do harm? Experiences of research participation after a child's diagnosis with Ewing's sarcoma. *Medical Journal of Australia*, *177*(9), 507-511.

Seale, C., Gobo, G., Gubrium, J. F. & Silverman, D. (2004). Introduction: Inside qualitative research. In C. Seale, G. Gobo, J. F. Gubrium & D. Silverman (Eds.), London, UK: Sage.

Sehgal, R., Saules, K., Young, A., Grey, M. J., Gillem, A. R., Nabors, N. A., & ...

Jefferson, S. (2011). Practicing what we know: Multicultural counseling competence among clinical psychology trainees and experienced multicultural psychologists. *Cultural Diversity and Ethnic Minority Psychology*, *17*(1), 1-10. doi:10.1037/a0021667

Seidman, I. E. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd ed.). New York, NY: Teachers College Press.

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). Dropout and therapautic alliance: a meta-analysis of adult individual psychotherapy. *Psychotherapy*, *47*(4), 637-645. doi:10.1037/a0021175

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology*, *58*(2), 210-221.

Shidlo, A. (1994). Internalized homophobia: Conceptual and empirical issues in measurement. In B. Greene & G. M. Herek (Eds.), *Lesbian and gay psychology: Vol. 1. Theory, research and clinical applications* (pp. 176–205). Thousand Oaks, CA: Sage.

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research And Practice*, *33*(3), 249-259. doi:10.1037/0735-7028.33.3.249

Siegel, J. D. (1999). The developing mind: Toward a neurobiology of interpersonal experience. New York, NY: Guilford Press.

Simon, W . E. (1973). Age, sex,and title of therapist as determ inants of patients'

perferences. *Journal of Psychology, 83,* 145-149.

Simons, J. A., & Helms, J. E. (1976). Influence of counselors' marital status, sex, and age on college and noncollege women's counselor preferences. *Journal of Counseling Psychology*, *23*(4), 380.

Simons, H. W., Berkowitz, N. M., & Moyer, R. J. (1970). Similarity, credibility, and attitude change: A review and a theory. *Psychological Bulletin, 73,* 1-16.

Singley, D. B., & Sedlacek, W. E. (2009). Differences in universal-diverse orientation by race-ethnicity and gender. *Journal of Counseling & Development*, *87*(4), 404-411.

Small, R. (2001). Codes are not enough: What philosophy can contribute to the ethics of educational research. *Journal of Philosophy of Education*, *35*(3), 387.

Smith, J. A. (1989) *The nature of social and educational inquiry: Empiricism versus interpretation.* Norwood, NJ: Ablex.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology*, Psychology and Health, 11*, 261-71.

Smith, J. A. (2003) *Qualitative psychology: a practical guide to research methods*. Thousand Oaks, CA: Sage.

Smith, M. (2001). Sigmund Koch as critical humanist. *American Psychologist*, *56*(5), 441-444. doi:10.1037/0003-066X.56.5.441

Smith, T. B. (2009). Culturally congruent practices in counseling and psychotherapy: A review of research. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (3rd ed., pp. 439–450). Thousand Oaks, CA: Sage.

Smith, J. A., Eatough, V. (2006) Interpretive phenomenological analysis. In G. Breakwell, S. Hammond, C. Fife-Schaw, & J. Smith (Eds.) *Research methods in psychology* (3rd ed., pp. 322-341). Thousand Oaks. CA: Sage.

Smith J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London, UK: Sage.

Smith, J. A., Hare, R., & Van Langenhove, L., (1995). Ideography and the case study. In J. A. Smith, R. Harre, & L. Van Langenhove, L. (Eds.), *Rethinking Psychology* (pp. 59-69). London, UK: Sage.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). London, UK: Sage.

Smith, J. K., & Hodkinson, P. (2011). Relativism, criteria, and politics. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 915-932, 3rd ed.). Thousand Oaks, CA: Sage.

Smith, N. G., & Ingram, K. M. (2004). Workplace heterosexism and adjustment among lesbian, gay, and bisexual individuals: The role of unsupportive social interactions. *Journal of Counseling Psychology, 51,* 57–67. doi:10.1037/0022-0167.51.1.57

Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology*, *53*(1), 132.

Smith, T. B., Rodríguez, M., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, *67*(2), 166-175. doi:10.1002/jclp.20757

Smyth, W. E., & Murray, M. J. (2000). Owning the story: Ethical considerations in narrative research. *Ethics & Behavior*, *10*(4), 311-336.

Smythe, E., & Spence, D. (2012). Re-viewing literature in hermeneutic research. *International Journal of Qualitative Methods*, *11*(1), 12-25.

Snarey, J., & Bridgers, L. (2006). James, William. In E. M. Dowling & W. G. Scarlett (Eds.), *Encyclopedia of religious and spiritual development* (pp. 227-231). Thousand Oaks, CA: SAGE Reference. Retrieved from http://go.galegroup.com/

Sophie, J. (1986). A critical examination of stage theories of lesbian identity development. *Journal of Homosexuality*, *12*(2), 39-51.

Spence, D. P. (1989). Rhetoric vs. evidence as a source of persuasion: A critique of the case study genre. In M. J. Packer, & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 205-222). Albany, NY: SUNY Press.

Speight, S. L., & Vera, E. M. (1997). Similarity and difference in multicultural counseling: Considering the attraction and repulsion hypotheses. *Counseling Psychologist, 25,* 280-298.

Spezzano, C. (1996). The three faces of two-person psychology development, ontology, and epistemology. *Psychoanalytic Dialogues*, *6*(5), 599-622.

Spiegel, S. B. (1976). Expertness, similarity, and perceived counselor competence. *Journal of Counseling Psychology*, *23*(5), 436-441. doi:10.1037/0022-0167.23.5.436

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.

Steele, D. P. (1989). A critical hermeneutics for psychology: Beyond positivism to an exploration of the textual unconscious. In M. J. Packer, & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 223-238). Albany, NY: SUNY Press.

Stein, H. L. (1997). Gender differences in emotional empathy of clinical psychology graduate students. *Dissertation Abstracts International*, 57(8-B), 5345.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision, 39*(7), 551-555

Sterling, R. C., Gottheil, E., Weinstein, S. P, Serota, R. (1998). Therapist/patient race and sex matching: Treatment retention and 9-month follow-up outcome. *Addiction, 93*(7), 1043-1050.

Stevenson, M. R. (2007). Public policy, mental health, and lesbian, gay, bisexual, and transgender 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. 379-398, 2nd ed.). Washington, DC: American Psychological Association.

Stewart, T. L., Latu, I. M., Branscombe, N. R., Phillips, N. L., & Ted Denney, H. H. (2012). White privilege awareness and efficacy to reduce racial inequality improve White Americans' attitudes toward African Americans. *Journal of Social Issues*, *68*(1), 11-27. doi:10.1111/j.1540-4560.2012.01733.x

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychology Review*, *13*(6), 593-618.

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Shapiro, D. A., Agnew-Davies, R.,

et al. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships U-shaped or V-shaped? *Journal of Counseling Psychology, 51,* 81-91.

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology, 15*, 215-224.

Stotzer, R. L. (2009). Straight allies: Supportive attitudes toward lesbians, gay men, and bisexuals in a college sample. *Sex Roles, 60*(1-2), 67-80. doi:10.1007/s11199-008-9508-1

Stracuzzi, T. I., Mohr, J. J., & Fuertes, J. N. (2011). Gay and bisexual male clients' perceptions of counseling: The role of perceived sexual orientation similarity and counselor universal-diverse orientation. *Journal of Counseling Psychology*, *58*(3), 299-309. doi:10.1037/a0023603

Strauss, J. L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P., & ... Beck, A. T. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology*, *74*(2), 337-345. doi:10.1037/0022-006X.74.2.337

St. Pierre, E., A. & Roulston, K. (2006). The state of qualitative inquiry: A contested science. *International Journal of Qualitative Studies in Education*, *19*(6), 673-684.

St. Pierre, M. (2012). Under what conditions do lesbians disclose their sexual orientation to primary healthcare providers? A review of the literature. *Journal of Lesbian Studies*, *16*(2), 199-219. doi:10.1080/10894160.2011.604837

Sue, D. W. (1990). Culture specific strategies in counseling: A conceptual framework. *Professional Psychology, 24,* 424-433.

Sue, D. W. (2004). Whiteness and ethnocentric monoculturalism: Making the "invisible" visible. *American Psychologist*, *59*(8), 761-769. doi:10.1037/0003-066X.59.8.761

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation.* Hoboken, NJ: Wiley.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53,* 440-448.

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist, 54,* 1070-1077.

Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist*, *58*(11), 964-970. doi:10.1037/0003-066X.58.11.964

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20,* 64-68.

Sue, D. W., Bernier, J. B., Durran, M., Feinberg, L., Pedersen, P., Smith, E., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10,* 45–52.

Sue, D. W., Bucceri, J., Lin, A. L., Nadal, K. L., & Torino, G. C. (2007). Racial microaggressions and the Asian American experience. *Cultural diversity and ethnic minority psychology, 13,* 72-81. doi:10.1037/ 1948-1985.S.1.88

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life:

Implications for clinical practice. *American Psychologist, 62,* 271-286. doi:10.1037/0003-066X.62.4.271

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., et al. (1998). *Multicultural counseling competencies: Individual and organizational development.* Thousand Oaks, CA: Sage.

Sue, D. W., Ivey, A. F., & Pedersen, P. D. (1996). *A theory of multicultural counseling and therapy.* Pacific Grove, CA: Brooks/Cole.

Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology, 24,* 420-429.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. New York, NY: Wiley.

Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse: Theory and practice*. New York, NY: Wiley.

Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1991). Community mental health services for ethnic minority groups: a test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, *59*(4), 533.

Suzuki, L. A., Prendes-Lintel, M., Wertlieb, L., & Stallings, A. (1999). Exploring multicultural issues using qualitative methods. In M. Kopala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 123-133). Thousand Oaks, CA: Sage.

Suzuki, L. A., & Quizon, C. (2011). Interdisciplinarity in qualitative research with ethnocultural populations. In D. K. Nagata & Kohn-Wood, L. (Eds.), *Qualitative*

strategies for ethnocultural research (pp. 21-40), Washington, DC: American Psychological Association.

Swank, E., Woodford, M. R., & Lim, C. (2013). Antecedents of Pro-LGBT Advocacy among Sexual Minority and Heterosexual College Students. *Sexuality Research and Social Policy*, *10*(4), 317-332.

Szymanski, D. M. (2005). A feminist approach to working with internalized heterosexism in lesbians. *Journal of College Counseling, 8,* 74-85.

Szymanski, D. M. (2006). Does internalized heterosexism moderate the link between heterosexist events and lesbians' psychological distress? *Sex Roles, 54,* 227-234.

Szymanski, D. M. (2009). Examining potential moderators of the link between heterosexist events and gay and bisexual men's psychological distress. *Journal of Counseling Psychology*, *56*(1), 142-151. doi:10.1037/0022-0167.56.1.142

Szymanski, D. M., & Carr, E. R. (2008). The roles of gender role conflict and internalized heterosexism in gay and bisexual men's psychological distress: Testing two mediation models. *Psychology of Men & Masculinity, 9*, 40-54. doi:10.1037/1524-9220.9.1.40

Szymanski, D. M., & Chung, Y. B. (2003). Feminist attitudes and coping resources as correlates of lesbian internalized heterosexism. *Feminism and Psychology, 13*, 369-389.

Szymanski, D. M., & Ikizler, A. S. (2013). Internalized heterosexism as a mediator in the relationship between gender role conflict, heterosexist discrimination, and depression among sexual minority men. *Psychology of Men & Masculinity*, *14*(2), 211-219. doi:10.1037/a0027787

Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008a). Internalized heterosexism: A historical and theoretical overview. *The Counseling Psychologist, 36,* 510-524. doi:10.1177/0011000007309488

Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008b). Internalized heterosexism: Measurement, psychosocial correlates, and research directions. *The Counseling Psychologist, 36,* 525-574. doi:10.1177/ 0011000007309489

Szymanski, D. M., & Kashubeck-West, S. (2008c). Mediators of the relationship between internalized oppressions and lesbian and bisexual women's psychological distress. *The Counseling Psychologist, 36,* 575-594. doi:10.1177/ 0011000007309490

Szymanski, D. M., & Kashubeck-West, S. (2008d). Rejoinder and an update: Recent advances in correlates of internalized heterosexism. *The Counseling Psychologist*, 36, 654-659. doi: 10.1177/0011000008320078

Szymanski, D. M., & Meyer, D. (2008). Racism and heterosexism as correlates of psychological distress in African American sexual minority women. *Journal of LGBT Issues in Counseling, 2*(2), 1-15.

Taber, B., Leibert, T., & Agaskar, V. (2011). Relationships among clt-therapist personality congruence, working alliance, and therapeutic outcome. *Psychotherapy, 48 (4)*, 376-380.

Talley, P. F., Strupp, H. H., & Butler, S. F. (1994). *Psychotherapy research and practice: Bridging the gap*. New York, NY: Basic Books.

Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social & behavioral research*. Thousand Oaks, CA: Sage.

Thompson, A. R., & Russo, K. (2012). Ethical dilemmas for clinical psychologists in conducting qualitative research. *Qualitative Research in Psychology*, *9*(1), 32-46.

Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology*, *41*(2), 155-161. doi:10.1037/0022-0167.41.2.155

Thompson, S., & Phillips, D. (2007). Reaching and engaging hard-to-reach populations with a high proportion of nonassociative members. *Qualitative Health Research*, *17*, 1292-1303. doi: 10.1177/1049732307307748

Tillman, J. G. (1998). Psychodynamic psychotherapy, religious beliefs, and self-disclosure. *American Journal of Psychotherapy*, *52*(3), 273.

Tillmann-Healy, L. M. (2003). Friendship as method. *Qualitative Inquiry*, *9*, 729-749. Doi: 10.1177/1077800403254894.

Tilly, S. A. (2003). "Challenging" research practices: Turning a critical lens on the work of transcription. *Qualitative Inquiry*, *9*, 750-773. doi: 10.1177/1077800403255296

Todres, L., & Galvin, K. (2005). Pursuing both breadth and depth in qualitative research: Illustrated by a study of the experience of intimate caring for a loved one with Alzheimer's disease. *International Journal of Qualitative Methods*, *4*(2), 1-11.

Tomlinson-Clarke, S., & Camilli, G. (1995). An exploratory study of counselor judgments in multicultural research. *Journal of Multicultural Counseling & Development*, *23*(4), 237-245.

Toomey, R. B., Ryan, C., Diaz, R. M., & Russell, S. T. (2011). High school gay-straight alliances (GSAs) and young adult well-being: An examination of GSA presence, participation, and perceived effectiveness. *Applied Developmental Science, 15*, 1-11.

Tozer, E. E., & Hayes, J. A. (2004). Why do individuals seek conversion therapy? The role of religiosity, internalized homonegativity, and identity development. *Counseling Psychologist, 32,* 716-740. doi:10.1177/0011000004267563

Tozer, E. E., & Hayes, J. A. (2004). Why do individuals seek conversion therapy? The role of religiosity, internalized homonegativity, and identity development. *Counseling Psychologist, 32,* 716-740. doi:10.1177/0011000004267563

Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality*, *17*, 43-73.

Tryon, G., & Kane, A. S. (1990). The helping alliance and premature termination. *Counselling Psychology Quarterly*, *3*(3), 233.

Trimble, J. E., & Fisher, C. B. (Eds.). (2006). *The handbook of ethical research with ethnocultural populations & communities.* Thousand Oaks, CA: Sage.

Tye, M. (2013). Qualia. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Fall 2013 ed.). Retrieved from http://plato.stanford.edu/archives/fall2013/entries/qualia/.

Unger, R. K., & Crawford, M. E. (1992). *Women and gender: A feminist psychology*. Philadelphia, PA: Temple University Press.

Vandermause, R. K., & Fleming, S. E. (2011). Philosophical hermeneutic interviewing. *International Journal of Qualitative Methods*, *10*(4), 367-377.

Van Langenhove, L. (1995). The theoretical foundations of experimental psychology and its alternatives. In J. A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking Psychology* (pp. 10-23). Thousand Oaks, CA: Sage.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. New York, NY: State University of New York Press.

Vasquez, M. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist*, *62*(8), 878-885.

Vera, E. M., & Speight, S. L. (2008). Social justice and counseling psychology: A challenge to the profession. In R. W. Lent & S. D. Brown (Eds.) *Handbook of counseling psychology* (4th ed). Hoboken, NJ: John Wiley.

Vidich, A. J., & Lyman, S. M. (2000). Qualitative methods: Their history in sociology and anthropology. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 37–84). Thousand Oaks, CA: Sage.

Vidich, A. J. & Lyman, S. M. (2003) Qualitative methods: Their history in sociology and anthropology. In N. K. Denzin & Y. S. Lincoln (Eds.) *The landscape of qualitative research* (pp. 55-130). Thousand Oaks, CA: Sage.

Vocisano, C., Klein, D. N., Arnow, B., Rivera, C., Blalock, J. A., Rothbaum, B., & ... Thase, M. E. (2004). Therapist variables that predict symptom change in psychotherapy with chronically depressed outpatients. *Psychotherapy: Theory, Research, Practice, Training*, *41*(3), 255-265. doi:10.1037/0033-3204.41.3.255

Vogel, D. L., & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-

disclosure. *Journal of Counseling Psychology*, *50*(3), 351-361. doi:10.1037/0022-0167.50.3.351

Wade, P., & Bernstein, B. L. (1991). Culture sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition. *Journal of Counseling Psychology, 38,* 9-15.

Walling, S., Suvak, M. K., Howard, J. M., Taft, C. T., & Murphy, C. M. (2012). Race/ethnicity as a predictor of change in working alliance during cognitive behavioral therapy for intimate partner violence perpetrators. *Psychotherapy*, *49*(2), 180-189. doi:10.1037/a0025751

Walsh, R. A. (1996). The problem of unconsciousness in qualitative research. *British Journal of Guidance & Counselling*, *24*(3), 377.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. New York, NY: Routledge.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. N. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empiricially, "all must have prizes." *Psychological Bulletin*, *122*(3), 203.

Washington, J., & Evans, N. J. (1991). Becoming an ally. In N. J. Evans & V. A. Wall (Eds.), *Beyond tolerance: Gays, lesbians, and bisexuals on campus* (pp. 195-204). Washington, DC: American College Personnel Association.

Watkins, M., & Shulman, H. (2008). *Toward psychologies of liberation*. New York, NY: Palgrave Macmillan.

Watson, C. (2009). The "impossible vanity": Uses and abuses of empathy in qualitative inquiry. *Qualitative Research*, *9*, 105-117. doi: 10.1177/1468794108098033

Watson, Z. P., Herlihy, B., & Pierce, L. (2006). Forging the link between multicultural competence and ethical counseling practice: A historical perspective. *Counseling & Values*, *50*(2), 99-107.

Webb, C. A., DeRubeis, R. J., & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting And Clinical Psychology*, *78*(2), 200-211. doi:10.1037/a0018912

Weiner-Levy, N., & Popper-Giveon, A. (2012). When horizons do not merge: Perplexity, doubt, and research implications. *Qualitative Inquiry*, *18*, 20-30.

Werner-Wilson, R., Michaels, M. L., Thomas, S., & Thiesen, A. M. (2003). Influence of therapist behaviors on therapeutic alliance. *Contemporary Family Therapy*, *25*(4), 381-390.

Wertz, F. J. (1986). Reliability of psychological research. *Journal of Phenomenological Psychology*, *17*(2), 181-205.

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52,* 167-177.

Wertz, F. J. (2011). The qualitative revolution and psychology: Science, politics, and ethics. *The Humanistic Psychologist*, *29*, 77-104.

Westerman, M.A. (2011). Conversation analysis and interpretive quantitative research on psychotherapy process and problematic interpersonal behavior. *Theory & Psychology*, *21*, 155-178.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist*, *62*, 563-574.

Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, *11*(4), 522-537.

Wiles, R., Crow, G., Heath, S., & Charles, V. (2008). The management of confidentiality and anonymity in social research. *International Journal of Social Research Methodology*, *11*(5), 417-428.

Williams, E. N., & Hill, C. E. (2001). Evolving connections: Research that is relevant to clinical pactice. *American Journal of Psychotherapy*, *55*(3), 336-343.

Williams, E. N., & Morrow, S. L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy research*, *19*(4-5), 576-582.

Wisch, A. F., & Mahalik, J. R. (1999). Male therapists' clinical bias: Influence of client gender roles and therapist gender role conflict. *Journal of Counseling Psychology, 46,* 51-6.

Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis, 11,* 203-214.

Wolsko, C., Park, B., Judd, C. M., & Wittenbrink, B. (2000). Framing interethnic ideology: effects of multicultural and color-blind perspectives on judgments of groups and individuals. *Journal of Personality and Social Psychology*, *78*(4), 635.

Worthington, R. L., Mobley, M., Franks, R. P., & Tan, J. A. (2000). Multicultural counseling competencies: Verbal content, counselor attributions, and social desirability. *Journal of Counseling Psychology, 47,* 460-468.

Worthington, R. L., & Reynolds, A. L. (2009). Within-group differences in sexual

orientation and identity. *Journal of Counseling Psychology*, *56*(1), 44-55. doi:10.1037/a0013498

Worthington, R. L., Savoy, H., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and social identity. *The Counseling Psychologist*, *30*(4), 496-531.

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology*, *54*(4), 351-361. doi:10.1037/0022-0167.54.4.351

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*(2), 215-228.

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. doi:10.1177/0011000006292596

Yin, R. (1989). *Case study research* (revised ed.). Newbury Park, CA: Sage.

Yin, R. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage.

Yin, R. (2012). *Applications of case study research* (3rd ed.). Los Angeles, CA: Sage.

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., Lowe, S., & Lee, E. (2005). Beyond ethnic match: Effects of client-therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology, 33,* 569-585. doi: 10.1002/jcop.20067

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37*, 369-376.

Zhang, N., & Burkard, A.W. (2008). Discussions of racial difference and the effect on client ratings of the working alliance and counselor credibility. *Journal of Multicultural Counseling and Development*, *36*, 77-88.

Zilcha-Mano, S., Dinger, U., McCarthy, K. S., & Barber, J. P. (2013). Does alliance predict symptoms throughout treatment, or is it the other way around? *Journal of Consulting And Clinical Psychology, 82*(6), 931-935. doi:10.1037/a0035141

Zlotnick, C., Elkin, I., & Shea, M. T. (1998). Does the gender of a patient or the gender of a therapist affect the treatment of patients with major depression? *Journal of Consulting and Clinical Psychology, 66,* 655-659.

Zur, O. (2007). Self-disclosure. In O. Zur (Ed.), *Boundaries in Psychotherapy: Ethical and Clinical Explorations* (pp. 149-165). Washington, DC: American Psychological Association. doi:10.1037/11563-00

Zur, O. (2009). Therapist self-disclosure: Standard of care, ethical considerations, and therapeutic context. In A. Bloomgarden & R. B. Mennuti (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 31-53). New York, NY: Routledge.

Zur, O. (2011). Self-disclosure & transparency in psychotherapy and counseling: To disclose or not to disclose, this is the question. Retrieved from http://www.zurinstitute.com/selfdisclosure1.html

Appendix A: Interview questions

- Can you tell me about how you came to see the heterosexual therapist?
- What did you think about your therapist's sexual orientation before, during, and after treatment?
- Please tell me about your experience in therapy.
- Do you think your therapist's sexual orientation affected your experience of therapy; and if so, how?
- What did the difference in sexual orientation mean to you?
- Can you describe experiences that improved or damaged your relationship with your therapist?
- Can you describe things that your therapist did or did not do that made you feel that your sexual orientation was either affirmed or stigmatized?
- How did this therapeutic experience influence your life?
- How did that experience compare with other experiences you have had in therapy?

Appendix B: Informed Consent

Title of the Study: Client Understandings of the Cross-Orientation Therapeutic Relationship: An Interpretive Phenomenological Analysis
Brief Description of the Study: This study will explore the experience of lesbian and gay clients in their work with heterosexual therapists. The influence of this difference on the therapeutic relationship and process will be explored from the perspective of the client.
1. I agree to have Rebecca Goettsche ask me a series of questions about my experiences in therapy with a heterosexual therapist, as well as comparative experiences with heterosexual or sexual minority therapists.
2. I understand that these questions will be asked in a mutually agreed upon location and will take approximately 90 minutes. One week after the interview, I understand that I will receive a call from Rebecca in order to follow-up about my experience being interviewed. After the interviews are transcribed and themes have been identified, I will have the option of reviewing Rebecca's interpretations and offering feedback or clarification.
3. I realize that the purpose of asking these questions is to assess lesbian and gay clients' experiences, explore the role of sexual orientation difference in therapy, and identify helpful and unhelpful therapist practices for sexual minority clients.
4. I understand that some of the questions might be annoying to me or lead to the discussion of upsetting topics. Should I wish to seek psychological services after this experience, I will receive a referral to an affirmative therapist, the cost of which will be my responsibility.
5. Participation in this study is voluntary. I understand that I can refuse to answer any question and can withdraw from this study for any reason up to one month after the interview. I also recognize that the researcher may not use my interview material in the final product of the research.
6. I understand that all interview materials will remain confidential. My name will not be connected to the transcript or audio recording and my interview will only be seen by the investigator. I am aware that some direct quotes will be included in the published dissertation with disguised identifying information, including a pseudonym. I further understand that communications conducted over cell phone or e-mail cannot be protected.
7. I understand that this research may result in increased understanding of affirmative treatment for LG clients by the therapy practitioners, which may or may not be of immediate value to me personally.
8. I understand that I am not receiving any compensation for my participation in this study.
9. I have received information about this study and the place of my interview in it by Rebecca Goettsche. I understand I can reach her at any time if I have questions by calling XXX-XXX-XXXX.
10. This research is part of dissertation research at Pacifica Graduate Institute and is conducted under the supervision of Dr. Oksana Yakushko, who can be reached at XXX-XXX-XXXX.

Signature _____
Date _____