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Standing on the edge of the "Rubyfruit jungle" : lesbians recall the experience of questioning in therapy

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Emily Willstatter
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"Rubyfruit Jungle": Lesbians Recall
the Experience of Questioning in
Therapy

ABSTRACT

The purpose of this study was twofold: to pursue an existing gap in the literature on therapy with

people questioning their sexuality; and to represent a lesbian perspective on the experience of

questioning one's sexual orientation. A previous study (Jones et al., 2003) found that gay and

bisexual people who were uncertain of their sexual orientation at the start of therapy rated the

treatment as overall less beneficial than gay and bisexual people who had begun therapy while

certain of their identities. This study explored the possible reasons behind this finding by

investigating a small (N=13) but diverse group of lesbians' recalled experiences of questioning

while in therapy. Overall, while some participants described overwhelmingly negative or

positive experiences, most had middling experiences with therapy. Most participants were

content or happy with many aspects of the treatment, but felt their therapists had weak points

when it came to discussions of sexuality in particular. Many of these weak points were related in

some way to failures in attunement; several possible reasons for these failures are discussed.

Openness to questioning on the part of the therapist is linked to openness on the part of the

patient, as is the therapist's self-disclosure. Recommendations are made for a model of practice

that openly questions heterosexuality and challenges its normalcy within the therapeutic space.

STANDING ON THE EDGE OF THE "RUBYFRUIT JUNGLE": LESBIANS RECALL

THE EXPERIENCE OF QUESTIONING IN THERAPY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2016

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I would like to dedicate this thesis to all of the lesbians, and also to my dog, Louise, who sadly passed away before she could see its completion. She had really been looking forward to it. I would like to include a picture of Louise here, but I am told this may not be considered "professional" or "adult." Therefore, I will describe her here: Please picture in your mind's eye a very attractive Doberman mix with a very pleasant temperament. She is black with sort of burnt-marshmallow colored paws, muzzle, chest, and tail, and very brown eyes. Her ears are floppy and her tail is curly. She weighs about 75 pounds. She likes licking people's faces, killing small animals, running in circles, and Dove soap. She dislikes thunderstorms. She was absolutely instrumental in the development of this thesis, because she sat on a lot of the interview transcripts. I miss her very much.

This thesis, of course, could not have been accomplished without the help of my friends and family, all of whom dealt gracefully with my mounting anxiety and chaotic spending habits over the past year. Thanks are owed to my closest friend, Jess Bolz, who I'm sure will be delighted by my upcoming increased weekend availability. Thank you for always reminding me to laugh at everything, and for not letting me forget that I am most definitely gay.

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CHAPTER I

Introduction

LGBT populations have long been pathologized in the United States. Although the

mental health industry's treatment of LGBT people has certainly improved drastically since the

diagnosis of homosexuality was officially removed from the DSM in 1987, the reverberations of

this history of medical pathology still echo today. A particularly painful example is the shameful

ongoing practice of conversion therapy intended to turn LGBT children "straight," which today

is banned in only 5 U.S. states and 2 cities. National attention was brought to the issue following

the suicide of Leelah Alcorn, a young transgender woman whose parents forced her into

conversion therapy, in December 2014; a statement from President Obama decrying such

therapies was released in April 2015. Since then, conversion therapy has been outlawed in

Cincinnati, in Ms. Alcorn's home state of Ohio. But a federal ban on the practice still seems a

long way off.

Conversion therapies generally use a combination of religious rhetoric and

misappropriated psychoanalytic concepts to manipulate young people into renouncing their

LGBT identities and/or desires. The goal of such a practice is plainly exterminatory; it represents

an attack on the psyches of some of the most vulnerable among us. Because it is so clearly

grounded in homophobia, it is relatively easy to identify and to speak out against this type of

practice. But what happens when challenges to LGBT identity in therapy are less overt, and more

subtle? Following homosexuality's removal from the DSM thirty years ago, lesbian theorist

Celia Kitzinger predicted that as therapists lost the ability to pathologize homosexuality outright, therapeutic approaches to lesbianism would become more subtly heterosexist (1987). If Kitzinger's prediction was correct-- and, based on this study, I believe it was-- then, as conversion therapy is (hopefully) banned in more and more states in the coming years, I predict that we may see a similar proliferation of more subtly heterosexist therapies. As we approach this shift, now may be an ideal time to study the effects of heterosexism in therapy, and the many forms it may take with different populations.

As I began my preliminary literature review, I happened upon a mid-90s study of gay and bisexual patients in therapy (Jones et al., 2003). I was particularly interested in the study's finding that gay and bisexual patients who entered therapy while identifying as gay/bisexual, and who were unconflicted about this identity, rated therapy as more beneficial. I wondered what was going on in therapy with patients who were unsure of their identities, or, in more common parlance, "questioning." Personally, prior to identifying as a lesbian, I had questioned my sexual orientation throughout my years of therapy. As I wondered if there was evidence of heterosexist bias in my therapist's treatment of me, I was assailed by guilt and self-doubt, feeling that even having these thoughts might have constituted a betrayal of my therapist, to whom I was-- and still am-- very attached.

It soon occurred to me that my own reluctance to confront the possibility of heterosexism's influence on my therapist may have been more than a personal idiosyncrasy. It is, of course, difficult for patients in general to be critical of their therapists; I know this as someone who has been both counselor and client. Patients are often inclined to "protect" their therapists from negative feelings that may arise. Meanwhile, covert expressions of any sort of bias or prejudice, commonly referred to as "microaggressions," are likely to place people in double-

binding situations, because these acts of aggression are so subtle that they often cannot be commented on. The "victim" of a microaggression is left with a feeling that something is amiss, but is uncertain whether they can trust their own perception of the event. And in the particular double-binding situation of a therapist committing a heterosexist microaggression against a client who is questioning her sexuality, the difficulty of commenting is exacerbated by the client's own uncertainty of identity. Perhaps if she were certainly a lesbian, she would be able to give voice to her needs: "It offends me as a lesbian that you would say that; please use these words instead to refer to me," and so on. But if she is not even sure of her own positionality within the dyad, then how can she possibly confirm that anything wrong has happened? When I thought of the experience of the questioning patient in this way, I felt that questioning patients might be very likely to let incidents of heterosexism pass them by without comment. As a result, therapists might miss opportunities to learn from and better work with this population.

With these beginnings of a hypothesis in mind, I set out to answer the question: How do lesbians recall their therapists reacting as they questioned their sexual orientations in therapy prior to coming out? I chose to study lesbians in particular due to my own positionality as a lesbian, and because I felt that a considerable amount of the extant research focusing on lesbians was rather dehumanizing. I also felt that the tendency of some research to group different identity categories together, either collapsing them under "LGB(T)" or treating bisexuality in women as a mere subcategory of lesbianism, was problematic. The differences between sexual orientation labels are often very significant to those who use them, whether or not they are statistically significant. I wanted my study to reflect the personal significance of lesbian identities.

The term "lesbian" is generally understood to describe a woman who is exclusively attracted to other women. A "lesbian," for the purposes of this study, is defined as any person who identifies as such. There are ongoing debates within the lesbian community, as well as outside it, concerning the parameters of "lesbianism"-- who should have access to it, and who should not. Opinions vary widely based on how we define "women," "attraction," and "exclusive." For the purposes of this study, I did not want to attempt to quantify lesbianism by, for example, asking about whether participants had slept with men, whether they would consider doing so, whether they ever thought about it, etc. To name just a few, within the identity category "lesbian" are included transgender women, as well as cisgender women who are categorically against transgender women; nonbinary-gendered people, as well as women who believe that lesbianism applies only to those who identify straightforwardly as women; and women who identified as straight and partnered with men until middle age, as well as women who believe that a true lesbian would never sleep with a man. So, although the word "lesbian" appears to have a rather straightforward definition, its exact meaning varies depending on who is asked. Perhaps the one reliably shared quality between all lesbians is the identity of "lesbian," a term imbued with deep cultural meaning that invariably influences how the subject is experienced by others.

My intent was to produce a study that faithfully reflects the therapeutic experiences of lesbians as they discovered their identities. The following chapters will contain a review of the surrounding literature; a description of the study's methodology; a summary of findings; and a concluding discussion.

CHAPTER II

Literature Review

My intention as I began this study was to bring to light a lesbian perspective on the experience of questioning one's sexuality, and in doing so to gain a better understanding of how therapists react to their questioning patients. Because I wanted to represent lesbian perspectives, this study is grounded in a rich history of works by lesbian theorists on gay women's identity and its connection to therapy. This literature review, therefore, has quite a lot of ground to cover. For organizational purposes, it is split into three parts. The first part presents a summary of the historical relationship between gay identity and therapy, as well as current and past contributions of feminist, lesbian, and queer theories. The second part is a review of recent studies of lesbian identity in general; and the third part reviews recent empirical studies of LGBT populations' experiences in therapy.

I approached my literature review with a critical perspective, drawn from my reading of Kitzinger (1987) and Park (2005). Inherent to this perspective is an understanding that social work research on oppressed populations will always have the potential to reproduce dominant stigmatizing narratives about that population, despite what may be the best intentions of researchers. At present, the widely accepted social work frameworks of cultural competence and

multiculturalist approaches have lead social work researchers to seek information on oppressed

populations, with the hope that gathering more information about the population will lead to

increased "competence" in the social services. Implicit in the drive to research the

underrepresented "other" is the assumption that if there is insufficient competence in social

services with oppressed populations, then this is because we as practitioners lack the empirical

knowledge necessary to work with them, and not because of broader structural oppression

resulting in the tailoring of our work towards a hegemonically normative (white, male,

heterosexual, and so on) client base. Park (2005) argues that culture is seen as "deficit" within

social work literature; that is, the presence of "culture" is seen as a challenge to be worked

around and eventually transgressed by the clinician, whose stance is assumed to be naturally

devoid of any problematic "culture." By simply adding on statements about the need for "cultural

competence" to existing theoretical models and practices that are themselves rooted in

oppressive ideologies, social work educators and researchers have reified the "othering" of

oppressed populations.

 Park (2005) adds that where the term "culture" has replaced "race" or "ethnicity,"

interventions aimed at "ameliorating [cultural] differences" in racialized subjects have been

rendered palatable and even progressive in the eyes of liberal practitioners (p. 25). Kitzinger

(1987) supports the notion that a similar process has occurred within social work literature on

non-heterosexual populations. In particular, recent research on the topic of lesbian identity has

sought to provide quantifiable data on the behaviors of lesbian populations, treating its subjects

as a body of information to be studied objectively. Notions of what behaviors are and are not

natural for lesbians as well as questions of the extent of lesbian sexuality's "fluidity" pervade

these texts. Such notions, to the extent that they inform social work practice, have a direct impact

on the subjects of this study-- women who begin to articulate lesbian identities in therapy.

Although Kitzinger wrote nearly three decades ago, I found through my literature review that the

trends of liberal-humanistic discourse that she originally outlined are still reflected in present-day

studies of lesbianism.

Review of Literature: Theoretical and Historical Context

In large part due to psychology's long history of pathologizing non-straight and non-

cisgender identities, the subject of LGBT identity remains troubled in social work research and

in the minds of many LGBT individuals seeking therapy. Research on lesbian identity in

particular has its roots in the early works of male sexologists like Krafft-Ebing (1886/1997), in

which lesbians were characterized as "sick," and research was pursued in the name of identifying

the disorder's causes and its cures. This view of lesbianism as pathology persisted in social

scientific research for over a century; one psychoanalyst writing in the 1980s, for example,

described lesbians as "psychological orphans" (Moberly, 1983, p. 86) suffering from "a state of

incompletion" (p. 66). Homosexuality was listed as a mental health disorder in the first edition of

the DSM in 1952, where it was described as a "sociopathic personality disturbance" (Association

of Gay & Lesbian Psychiatrists [AGLP], 2011). The diagnosis went through several rhetorical

transformations over several decades before it was removed entirely. The disorder of

homosexuality was removed from the DSM and replaced with "Sexual Orientation Disturbance,"

or SOD, with the release of the DSM-II in 1973; newly, the diagnostic criteria for SOD required

that the patient be "in conflict with" their own sexual orientation (AGLP). However, the

diagnosis of Sexual Orientation Disturbance was seen as too vague in its criteria because,

ironically, it was believed that patients were rarely in conflict regarding heterosexuality.

Therefore, the 1980 release of the DSM-III saw SOD replaced with the more specific label of

"ego-dystonic homosexuality," or EDH (AGLP). This category was not removed altogether until

1987.

Even in the present day, pathological conceptualizations of gay attraction persist-- most

obviously in the form of religiously oriented conversion therapies, but also more covertly in the

form of social science research that presents "homosexuality anxiety" as a distinctive form of

obsessive-compulsive disorder, referred to as "Homosexual Obsessive-Compulsive Disorder" or

"H-OCD" (Williams, 2008; Williams & Farris, 2011; Bhatia & Kaur, 2015). H-OCD, according

to these researchers, is frequently misunderstood and mislabeled by clinicians as actual

homosexuality. The criteria that these authors use to distinguish between sufferers of H-OCD

and true homosexuals is closely reminiscent of the earlier DSM-approved concepts of sexual

orientation disturbance and ego-dystonic homosexuality (i.e. the true homosexual enjoys

thoughts of being with the same sex, while the H-OCD/SOD/EDH sufferer is repelled by them).

The H-OCD literature recommends use of cognitive-behavior therapy techniques to aid the H-

OCD sufferer; but since the diagnostic criteria proposed by the authors does not reliably

distinguish between H-OCD symptoms and the sort of internalized homophobia that is commonly recognized in non-heterosexual people's retrospective narratives of their coming-out experiences, these researchers risk medically pathologizing some very common variations in LGBT experience.

Despite the persistence of these pathological conceptualizations, the majority of social work literature on homosexuality saw an immediate shift from outright pathologization of its subjects to a "gay-affirmative" approach in the aftermath of homosexuality's official 1987 removal from the DSM. "Gay-affirmative" therapies remain the most widely accepted approach to homosexuality in social work today. However, even aspirationally gay-affirmative research and practice may still reproduce the dominant ideology of heterosexism.

Kitzinger (1987) argues that "affirmative" research on lesbianism in particular is largely predicated on a "liberal-humanistic" ideology. The liberal-humanistic position on lesbianism, as identified by Kitzinger, adheres to the following assumptions: the lesbian is at her core not significantly different from the heterosexual woman; homosexuality is a relatively small and unimportant aspect of a person and does not constitute her "whole self"; and homosexuality is equally as "natural" as heterosexuality, and thus does not pose a threat to society (p. 45). According to Kitzinger, a great deal of social work research enforces this "liberal-humanistic" position onto the lesbian subject. Perpetuation of this ideology within social work research and practice results in a form of "gay-affirmative" therapy that de-politicizes the lesbian's experience

and may, in practice, discourage her from seeing herself in the context of an oppressive heterosexist society.

Kitzinger's analysis of "the psychologized liberal humanistic world of 'individual dignity'" and its relation to lesbian identity is grounded in the assumption that the psychological concept of identity is inherently apolitical (1987, p. 45). Modern psychological identity theory is based in the work of Erikson, who developed the theory of psychosocial stages of identity development through which a person passes on the way to developing a healthy self-concept (1950). Erikson's model did not account for the many factors (i.e. systemic oppression) that may prevent a person from developing their identity in a manner considered "healthy." Additionally, Erikson's emphasis on the individual's successful acquisition of personal "virtues" (e.g. hope, purpose, love) throughout the life stages keeps the well-being of the individual carefully distinct from a wider political context.

Today, many social work researchers, educators, and practitioners draw on "stage models" of identity development modified for "minority" individuals (Cass, 1979), which are derived from Erikson's work. Cass's modified stage model is intended to account for the effect of homophobia upon the life of the individual. However, the model adheres to heteronormative goals and standards of identity development. Within these modified stage models, radical political involvement is portrayed as a phase of identity that should be surpassed in order to achieve self-actualization (alternatively referred to as "integration," "synthesis" or "maturity"). When the subject of the stage model has reached developmental "maturity," she is able to accept

members of the dominant group into her life. And critical to the oft-cited Cass model is the idea

that the "mature" lesbian is not *too* lesbian-- not too overtly or proudly gay. Being a lesbian is

only one part of the mature lesbian's identity, not more significant than any other part. From this,

it follows that connecting one's sexual orientation to one's political stance is immature, even

pathologically so. Therefore, concludes Kitzinger, "The concept of the well-adjusted lesbian...

represents an overt attempt to shape lesbian subjectivities in accordance with the individualized

and depoliticized ideological stance of contemporary liberal humanistic psychology" (1987, p.

56). Psychotherapy that rests on liberal-humanistic constructs such as stage theory may still seek

to "convert" the lesbian-- if not into a straight person, then into a socially appropriate individual

within heterosexist society, an individual whose thinking does not challenge heterosexism.

Lesbian and feminist theories. Lesbian identity and the psychoanalytic conception of

identity are especially at odds because there exists a vast body of theory on lesbian identity that

intentionally problematizes the concept of identity itself. Since the 1970s and 80s, lesbian

feminist theorists have written extensively on questions of what, if anything, is "natural" and

what, by contrast, is a social construction of patriarchal society. In the influential essay

"Compulsory Heterosexuality and Lesbian Existence," the lesbian feminist scholar Adrienne

Rich argues that heterosexuality is enforced by men onto women as an absolute imperative

(1980). Rich interrogates the cultural assumption that people are born with an innate sexual

"preference," instead suggesting controversially that "for women heterosexuality may not be a

'preference' at all but something that has had to be imposed, managed, organized,

propagandized, and maintained by force" (Rich, p. 135). Rich further suggests that lesbianism is a healthy alternative to heterosexuality that can be chosen by women, although the availability of that choice is often obfuscated by the dominance of heterosexism: "Women identification is a source of energy, a potential springhead of female power, curtailed and contained under the institution of heterosexuality" (Rich, p. 139). Rich's work provides the basis for a theory of political lesbianism-- the idea that women can and should choose to be lesbians in order to liberate themselves from men. Although the viability of political lesbianism and the related concept of lesbian separatism are still debated today, the concept of compulsory heterosexuality has itself been deeply influential to both lesbian and queer theory, and it has been a useful organizing narrative for many lesbians as they attempt to understand their past and present experiences with men.

      Queer theory. Queer theory, which emerged in the 1990s, is a body of poststructuralist theory concerned with the social construction of norms around gender and sexuality. Queer theory is often viewed in opposition to lesbian feminism due to historical schisms between the two schools of thought. However, some of queer theory's most influential proponents are lesbians, and it has had a lasting effect on academic and popular thought about lesbian identities. In fact, the widely read and frequently misinterpreted lesbian scholar and queer theorist Judith Butler, in "Imitation and Gender Insubordination," makes ample reference to compulsory heterosexuality (1990). But Butler goes further than Rich, in a sense, by questioning the innateness of our conception of lesbianism as well as heterosexuality. Butler asks: "What or who

is it that is 'out,' made manifest and fully disclosed, when and if I reveal myself as a lesbian? What is it that is now known, anything? What remains permanently concealed by the very linguistic act that offers up the promise of a transparent revelation of sexuality?" (Butler, 1990, p. 309). In asking these questions of us and of herself, Butler points to the linguistic scaffolding that makes up our current understanding of what makes a "lesbian"; this, too, is a construction. Eve Sedgwick, another influential queer theorist, makes a similar point in plainer language: "*People are different from each other*" (Sedgwick, 1990, p. 22). Sedgwick punctuates this "axiom" of her theory with a detailed list of all the ways that people may "differ" from one another sexually-- "Even identical genital acts mean very different things to different people"; "Sexuality makes up a large share of the self-perceived identity of some people, a small share of others'," etc (1990, p. 25). Both Butler and Sedgwick make a case for the inherent impreciseness of language itself, asking us if we can *really* know what is meant when we are told that a woman is a lesbian.

Lesbian-feminist and queer theories, as they attempt to deconstruct the very foundations of the language we use to speak about sexuality, stand in stark contrast to the current empirical research on lesbianism, which in many cases seeks to define lesbianism as precisely as possible by tying it to specific behaviors and practices, down to the numbers.

Review of Literature: Lesbian Identity

Averett, Yoon, & Jenkins (2012) conducted a quantitative study of the sexual behaviors and histories of 456 lesbians over the age of 50, with the stated goal of filling a gap in the

literature by addressing the treatment needs of older lesbians. The study was conducted in the

form of a 115-question online survey; the survey was emailed to various lesbian organizations,

and data was collected over a period of 6 months. The survey asked participants to disclose many

factors that were understood as components of their lesbianism: whether they had ever been in a

relationship with a woman, when they had first realized their attraction to women, how often

they had erotic fantasies about men and women respectively, how often they had sex with

women, etc. Key findings of the study were that half of the participants had previously been

married to men, and that the participants demonstrated what the authors refer to as "sexual

fluidity," based on the aforementioned marriages and on 38% of subjects reporting some

fantasies about men.

When discussing the "fluidity" of their participants, Averett et al. (2012) cast doubt upon

the veracity of their subjects' lesbian identities. They briefly nod to Rich's theory of compulsory

heterosexuality; however, they are quick to discard this idea as it pertains to their participants:

"Their past marriages to men… could be critiqued as being merely internalized heteronormative

behavior; but the critique does not provide a complete explanation when considering that 14% of

the women did not have a lesbian relationship until after age 40" (p. 505). The authors then

suggest several possible alternative reasons for lesbian's self-identification despite this fluidity,

including the possibility of simple hostility toward bisexuals. Due to the quantitative nature of

this study and its lack of open-ended questions, however, it is unknown what the subjects'

feelings were regarding their sexualities-- whether they would have thought of themselves as

"fluid," and how they conceptualized their experiences with men versus their experiences with women. The subjects also were not asked about experiences of rape or abuse; therefore, it is possible that the authors may have ascribed "fluidity" to their subjects based on accounts of relationships that were, in fact, coercive to some extent.

Diamond (2005) also takes interest in the presence of sexual "fluidity" in lesbians. The author conducted a longitudinal study of 79 nonheterosexual women who were first interviewed in person between the ages of 18 and 25. The stated goal of the study was to explore the usefulness of using "stability" of identification as a typology for sexual categorization. Follow-up interviews were conducted by phone on three occasions in the following 8 years. Sampling took place largely in LGBT-oriented college settings, resulting in a sample of mainly white women. The criterion for participation was either rejection or questioning of a heterosexual identity. Diamond defined women who identified as lesbian at each of the four assessment times as "stable lesbians"; women who claimed lesbian and nonlesbian identities at different points as "fluid lesbians"; and women who never identified as lesbian as "stable nonlesbians." The interview questions were purely quantitative; women were asked, for example, to "report the percentage of their total attractions that were directed toward the same sex on a day-to-day basis" as an assessment of same-sex attraction (2005, p. 122); a criterion that seems difficult to measure. The criteria that Diamond assessed for-- degree of physical and emotional same-sex attractions, engagement in same-sex sexual behavior and romantic relationships, and timing and perceived cause of same-sex sexuality-- were not found to demonstrate consistent differences or

similarities across "stable lesbian," "fluid lesbian" and "stable nonlesbian" subjects. Meanwhile, the voices of Diamond's subjects, and their feelings about their own identities, are noticeably absent from her research. Diamond asserts that her subjects' chosen sexuality labels, personally meaningful though they may be, are not "scientifically relevant" (p. 125). She does not, however, effectively make the case for the utility of her "new view of lesbian subtypes."

Shapiro, Rios, & Stewart (2010) offered a departure from these models that sought to quantify and/or explain the puzzling behavior of lesbians. After presenting a critique of both "stage" and "fluid" models of lesbian identity development, Shapiro et al. suggest that a broader, more comprehensive model may be needed to facilitate clinical understanding of lesbian identity. The authors present an in-depth qualitative analysis of the life narrative interviews of four different lesbian feminist scholars. This analysis is intended to demonstrate what a comprehensive model of lesbian identity development might look like. Shapiro et al. conclude that the established models of identity development may not pertain to many lesbians' experiences because lesbians do not necessarily think of their identity development in linear terms with an identifiable endpoint. Finally, they emphasize the importance of narrative research on lesbian subjectivities, invoking Kitzinger (1987) as they do so: "This research… points to the value of narrative research methods that may result in more accurate and just accounts of lesbian identity development" (Shapiro et al., p. 506). They close with a call for narrative projects with larger and more varied sample sizes.

Julian, Duys & Wood (2014) also critiqued stage models of sexual identity development as they applied to the broader category of "women who love women." Julian et al. sought to investigate the effect of homophobia and oppression on these women's identity formation processes. Through snowball sampling, 10 women living in the Midwest were selected to participate in two semistructured individual interviews. Although this study speaks more broadly about "women who love women," 9 out of 10 participants identified as gay. A distinction was drawn, however, between those who identified as lesbian with and without "political meaning." The participants were asked relatively broad questions, divided into the categories of: background, self-description, gender, relationships, experience, sexuality, identity, and summary (p. 193). Perhaps as a result of its broad scope, this study, despite identifying emergent themes within the interviews, came to the somewhat mild conclusion that women who love women experience homophobia, and this affects their sexual identity development. That said, the authors suggest, usefully, that "counselors [must] allow clients to identify their own process of sexual identity formation rather than prescribe a developmental process that may be irrelevant to their clients" (p. 199).

Review of Literature: Lesbians in Therapy

Studies of LGBT populations in therapy generally had a broader "non-heterosexual" sample base, rarely distinguishing between gay men, lesbians, and bisexual participants. Shelton & Delgado-Romero (2013) provide an assessment of non-heterosexual people's experiences of microaggressions within psychotherapy. The study's purpose was to observe the effects of the

more subtle prejudices being enacted in the therapeutic relationship, considering that more overtly homophobic practices are now widely condemned. The authors conducted a qualitative study of 16 self-identified LGBQ psychotherapy clients, who were recruited through a campus LGBT center. The data was collected through two small self-contained focus groups. The authors were able to identify seven common themes among microaggressions reported by participants: "assumption that sexual orientation was the cause of all presenting issues"; "avoidance and minimizing of sexual orientation"; "attempts to overidentify with LGBQ clients"; "making stereotypical assumptions about LGBQ clients"; "expressions of heteronormative bias"; "assumption that LGBQ individuals need psychotherapeutic treatment"; and "warnings about the dangers of identifying as LGBQ" (p. 64). These may be useful points for my study to drawn from. A notable limitation of Shelton & Delgado-Romero (2013), however, is the authors' self-identification as "heterosexual allies" (as asset which they refer to as a "strength" which allows them to avoid bias). As allies seeking to gather information from a population over whom they held power, particularly in the semi-public setting of the focus group, it is possible that Shelton & Delgado-Romero may themselves have perpetuated microaggressions among their subjects, or they may have otherwise unwittingly influenced the outcomes of the study due to their privilege.

Saulnier (2002) investigated the physical and mental health care preferences of lesbian and bisexual women. A total of 33 lesbian and bisexual women participated in five focus groups, with the number of participants ranging from 4 to 15 per group. Two of the groups

accommodated middle- and working- class women, one was a youth group, one was for older African-American women, and one was for women who frequently attended bars. These groups were asked semistructured and open-ended questions about their medical treatment expectations, experiences, and desires. The women's experiences were categorized on a continuum between "homophobia" and "lesbian affirmation." Many overtly homophobic experiences with physical and mental health care providers were described within the groups. The purpose of the study was to underscore a need for enhanced lesbian-affirmative practices in the health care professions, and it does this effectively by demonstrating the range of negative experiences its participants endured in seeking health care. Saulnier's frequent conflation of bisexual women with lesbians, however, is contradictory to her overall message of the need for education and acceptance. Saulnier also distinguishes between instances of "heterosexism," here considered more mild, and "homophobia," considered more extreme, with insufficient justification; it is unclear, for example, why a lesbian's experience of sexual harassment by her gynecologist should not be classed as homophobic (p. 359). Ultimately, it may be problematic to attempt to distinguish cleanly between examples of homophobia and heterosexism because they do not seem to represent two distinct phenomena.

Jones, Botsko, & Gorman (2003) conducted a quantitative study of the predictors of psychotherapeutic benefit for lesbian, gay, and bisexual clients. In the mid-90's, the authors conducted a mail survey of 600 current or former psychotherapy patients who identified themselves as lesbian, gay, or bisexual. Participants were asked to complete a 12-page

questionnaire providing a detailed history of their experience in psychotherapy. The study found that clients who started therapy in later years and attended a higher number of sessions rated therapy as more beneficial. Therapists who were trained as social workers and psychologists received higher ratings than those who were trained as analysts or psychiatrists. Finally, and most directly relevant to my study: clients who began therapy while identifying as LGB, and were unconflicted about this identity, rated therapy as more beneficial. Jones et al. speak to the lack of research on the relationship between certainty of sexual identity and therapeutic benefits. The authors also point out the concerning nature of this population's apparently reduced benefit from therapy: "Coming to terms with one's sexuality can be a wrenching and disruptive process that can... lead to self-destructive behavior" (p. 297). Clients who are in the process of articulating a non-straight identity may be especially at-risk; yet, evidently, they are not benefiting from therapy as much as those who are certain of their LGB identities at the onset of therapy.

Conducting this literature review brought to my attention the lack of lesbian voices in some research on lesbians. But my interest was piqued most by that last finding of Jones et al.; *why* might there be a gap in satisfaction with mental health services for questioning people? I then sought to address that question, specifically as it pertained to lesbians.

CHAPTER III

Methodology

The goal of this exploratory, qualitative study was to work toward filling an existing gap in research on questioning populations by looking at the experiences of lesbians who questioned their sexuality while in therapy. This study sought to identify some of the factors at play in therapy with questioning patients by soliciting lesbian women's recalled interactions with their therapists at the time of questioning.

The study consisted of 13 semi-structured narrative interviews with lesbian-identified participants. Audio recordings of the interviews were taken for later analysis, with participants' permission. The design of semi-structured narrative interviewing was selected in order to organically solicit participants' stories. Researchers (Kitzinger, 1987; Shapiro, Rios, & Stewart, 2010) have spoken to the importance of soliciting detailed lesbian narratives, in order to create a more accurate and comprehensive picture of lesbian identification. At the beginning of each interview, it was explained to participants that the researcher's prepared questions were intended to serve as guidelines, but that the interview did not have to follow a strict, scripted format. Many of the prepared questions were, in fact, often answered inadvertently as the participant spoke broadly about her experience, although they still served as reminders for topics to refocus on.

The interviews consisted of open-ended questions which were divided roughly into three sections. First, in "contextualizing the therapeutic experience," participants were asked general questions about their time in therapy, characterizing their initial "presenting problems" that led them to seek therapy, their relationship with the therapist(s), etc. Then, in "the therapist's reactions to questioning," the questions more specifically pertained to the experience of questioning and the therapist's interventions. Finally, the "concluding questions" were more theoretical in nature, e.g. asking the participant what she might recommend to a therapist working with a youth who is in a similar situation to the one she was in. Throughout the interviews, probes were used to further explore how participants felt about their therapists' interventions, or lack thereof.

Sample

This small-scale study was not intended to be generalizable to a larger population. For that reason, purposive and snowball sampling were used. Participants were sought through "Queer Exchange" Facebook groups; through posts to the researcher's own personal Facebook page; through the use of a Tumblr blog that I created specifically for the purpose of recruiting participants; through flyers distributed in common lesbian locales (cafes, bars, and bookstores); and through requests for members of the LGBT community who were known to the researcher to pass on these postings. Electronic posts and flyers included the researcher's contact information. They briefly described the study and its purpose, inclusion criteria, and what the interview process entailed. They also disclosed the researcher's own positionality as a lesbian, and described potential benefits to participants. Once potential participants contacted the researcher, they electronically signed and returned a letter of consent which explained their right to withdraw from the study for any reason. Once consent was secured, interviews were scheduled.

The criteria for inclusion in this study were as follows: participants must A) currently identify as lesbian, and B) have questioned and/or struggled with their sexual orientation while in therapy. It was not required that participants have identified as lesbian prior to termination of the therapeutic experience, mainly because of the difficulty in pinpointing when such concrete "identification" begins or ends. For the purposes of this research, it was assumed that if the participant currently identifies as lesbian, and "questioned" while in therapy, then their experience constitutes a shift toward what would eventually become a lesbian identity. Also, participants may have been in therapy for any length of time, with any number of practitioners, and they may have remained in therapy or have terminated it. It was also not required that participants had "come out" to their therapists at any point-- after all, a great deal of questioning takes place internally. It was thought that restricting the sample based on any of these parameters might have potentially skewed the sample toward either negative or positive therapeutic experiences.

Race alters a person's experience within the mental health care system as well as how others react to their claiming of the lesbian identity. In order to take into account these important factors, a racially diverse sample was sought through snowball sampling.

This study was limited in its scope because I primarily used electronic sources like Facebook and Tumblr, as well as my own personal connections, to recruit participants. Due to my use of these resources, the sample was skewed toward a relatively young sample, which is representative of my peer group. Age certainly affects how a person's lesbian identity is perceived (i.e. a 40-year-old-woman who is married to a man may be more likely to be disbelieved or discouraged from lesbian identification.) This is an avenue where future research is needed.

Data Collection

   Qualitative data was collected through interviews lasting approximately one hour. Interviews were conducted via phone, Skype, Google Hangouts, or FaceTime. The audio of each interview was recorded with its participant's written permission. Interviews were later transcribed by the researcher, with all potentially identifying information removed. Audio recordings and transcriptions were kept in a password-protected file accessible only to the researcher. As is required by the federal guidelines for human subject research, when this information is no longer needed, and after a period of three years, both the recordings and transcriptions will be destroyed. Signed consents, similarly, were kept in a secure location separate from the other materials, and will also be destroyed after three years have passed. To further protect the confidentiality of participants, their names, as well as the names of other people in their narratives, have all been replaced with pseudonyms.

   As interviews and transcriptions progressed and more data was accumulated, potential themes appeared within the data. I developed a codebook to keep track of the frequency of various themes in participant responses. As I transcribed the data, I pulled quotations from the interviews that were illustrative of particular themes. When I finished collecting my data, I organized the most prevalent themes into three broader categories: therapist responses that were seen as problematic, therapist responses that were seen as beneficial, and common patient experiences.

CHAPTER IV

Findings

This chapter will present the findings of a qualitative analysis of lesbians' recalled experiences being in therapy as they questioned their sexuality. The intent of the researcher was to A) illuminate lesbian perspectives on the experiencing of questioning, and B) investigate what possible factors might account for questioning patients' reduced satisfaction with therapy. Interviewees were asked what sorts of therapist reactions and attitudes they had hoped for; whether their therapists met those expectations; and what sorts of therapeutic practices they thought would be most helpful either to themselves or to people in similar "questioning" periods. Close analysis of each participant's response uncovered specific themes and trends in the ways therapists treated their questioning patients, and how patients reacted to the treatment. When the studied themes are observed as a whole, it becomes clear that there are many common desires among questioning lesbians in the therapeutic environment, which are only occasionally fulfilled.

For greater clarity, the data analysis has been organized into four sections, three of which are divided into subsections, as follows. In section 1, demographic data will be listed. In section 2, therapist practices that were seen as problematic will be detailed in five subsections: 1) The therapist's presumption of the patient's attraction to men; 2) The therapist's underreaction to the patient's disclosure of sexuality; 3) The therapist's overreaction to the patient's disclosure; 4) The therapist's desire to "solve" the issue of the patient's sexuality; 5) Espousal of religious

(Christian) views on the part of the therapist. In section 3, therapist practices that were desired or seen as beneficial will be detailed in the following ten subsections: 1) Therapist's demonstration of interest, curiosity, and willingness to explore patient sexuality; 2) Therapist's attunement to patient's particular situation and feelings around sexuality; 3) Therapist's honesty and self-disclosure; 4) Therapist's "insider knowledge"; 5) Therapist's acceptance of "non-traditional" coming-out narratives; 6) Visible symbols of LGBT acceptance in therapist's office; 7) Affirmation, acknowledgement, and belief in the patient's sexuality; 8) Normalization of patient sexuality; 9) Assurance that coming out is not a "death sentence"; 10) Unambiguous allying with patient in cases where family is unsupportive. In section 4, common patient experiences will be detailed in the following subsections: 1) "Dropping hints" about sexuality for therapist to pick up on; 2) Self-scrutiny and self-doubt; 3) Avoidance; 4) Reluctance to criticize therapist. Illustrative quotes have been inserted throughout each section in order to reflect participants' narratives as accurately as possible. Pseudonyms have been used in order to protect the privacy of all participants.

Demographic Data

At the beginning of each interview, each of the 13 participants was asked to report the following demographic information: age, gender, race, geographical location, education (highest degree received), and relationship status. The mean age of participants was 22.4, with a median of 23 and a range of 18 to 28 years of age. Although all participants identified as lesbians, they espoused a number of gender identities. Eight participants identified as women (seven cisgender women and one transgender woman). Among these eight, one participant stated she had gone through a period of gender questioning, but had ultimately decided to continue identifying as a woman. The other five participants identified outside of binary male/female classification. These

five described their genders using the following terminology respectively: "agender"; "nonbinary transgender woman"; "pending"; "fluid"; and "masculine-centered." Seven participants were white, and six were people of color. Out of these six, one participant identified as Indian, one identified as Latina/Cuban-American, two identified as Black, and two identified as multiracial (describing themselves respectively as "Asian and Hispanic," and "Korean, Cuban, and white"). Four participants reported that they were currently located in California; two were located in New York; two were located in Massachusetts; and the other five were scattered across a variety of states: Oregon, Pennsylvania, Georgia, Texas, and Florida. It should be noted, however, that at least five participants had grown up in other states and relocated at some point in adulthood, so some of their therapeutic experiences took place in other states. Seven participants were in the process of studying for their undergraduate degrees. Three others reported having received some college credit, but no degree. Of the remaining three, one participant had obtained a Master's degree; one was studying for a Master's; and one had obtained a vocational certificate. Seven participants identified as single, five stated they were currently in a relationship, and one was engaged.

There is additional relevant demographic data outside of these required demographic questions. Eleven out of thirteen participants (85%) mentioned that they had alternatively identified as bisexual or queer prior to identifying as a lesbian. Among those two that did not mention previously identifying as bisexual or queer, both mentioned having had prior sexual and/or romantic relationships with men. Also, five out of thirteen participants (38%) disclosed experiences of assault and/or abuse.

Therapist Practices Seen as Problematic by Participants

        Presuming patient is attracted to men. Seven participants spoke about their therapists' assumptions that they were interested in men, and that they would continue to be in the future. These participants may have felt more comfortable discussing their sexuality in therapy if their therapist had not assumed, prior to their coming out as lesbian, that they were attracted to men. Kayla and Brooke, both of whom had experienced prolonged abuse in their relationships with men, each wished that their therapists had not taken their attraction to men for granted. Kayla stated she came out as a lesbian to her therapist at least partially in order to get him to stop asking her about boys:

> [When] I finally just actually said I was a lesbian, of course he's like, "Oh, so your relationships with guys, that must have been horrible right?" I was just trying to have [him] stop asking whether I'm gonna date a guy or whatever… I was just kinda tired of the, "Do you have a boyfriend or a girlfriend?" [And I wanted him to] stop doing weird things, like kinda idealizing my abusive relationship with the boy that I dated… [I would have been more comfortable if] he had not assumed that I am interested in guys, which I guess some people permit that, because I have dated them, so obviously I would be interested or whatever, but… [Also, his] subtle devaluing of my relationship with my ex-girlfriend, like that relationship was not as deep as my relationship with the first guy... Since he'd been bringing up that relationship as the thing that should tether me to dating men or whatever, I didn't want to deal with that.

Before she came out to him as a lesbian, Kayla's therapist had already demonstrated a deep belief not only in her attraction to men, but also in the sanctity and desirability of her past

relationship with a man, despite her having described that relationship as abusive. In part because of this, Kayla had resolved to "do most of my questioning work with myself, outside of therapy."

Brooke, meanwhile, wished that a therapist with whom she was otherwise "lowkey in love" had picked up on her signals that she was not happy in her abusive relationship with a man, which was still ongoing as she went to therapy.

> I know I was dropping hints about not being into the relationship I was in. And while I was seeing all these therapists, there was no way you could look at me and not know that I was gay... My first [therapist], the one that I really liked, she never like, asked me to interrogate my relationship with this person… I would drop these really big hints that things were wrong, but I would paint them as positive things that I was happy with… I don't remember [coming out] ever being a conversation that was happening, but I did go into overtime like, coding myself [as gay], whether that was intentional or not… It would have been sooo amazing if she ever went, "Do you even like him?" or, "Are you attracted to this person?"... It would have opened up so much that we could have explored… I think it would have made me feel safe in the long run. And it's not like she didn't ask me difficult questions; like, I've almost passed out in therapy from dealing with trauma stuff, and I didn't resent her for that. So, I wish she had been a little more observant…

Brooke, like several other participants, was hesitant to criticize her therapist's professional judgment, conceding that "maybe I was too vulnerable to broach that conversation." However, she observes here that her therapist had already demonstrated a capacity to work with her vulnerabilities, even to the point where she had passed out in therapy, and that this had not caused notable strain in their relationship. She concludes that her therapist, who was otherwise

more than competent, had made an oversight by continuing to assume her relationship with her boyfriend, and with men in general, was unproblematic.

Finally, Tegan, who underwent an intense period of self-scrutiny and anxiety around her sexual and racial identity in high school, wondered what might have happened if her therapist had not presumed that she was attracted to boys.

I remember talking to her about how when I had crushes on boys, it felt weird. That was all I was capable of saying at that point: "When I am into boys, I feel terrible, I feel like I'm a worthless human being, and something about me is wrong…" I talked to her about how I was worried about not having a boyfriend, and how I couldn't figure out how to date guys. And her response was just, you know, "Wait for it, you don't have to rush into it." I wouldn't have wanted her to impose anything on me, but if she'd said like, "You don't have to be attracted to boys"; if she hadn't assumed that I was actually attracted to boys, and [that I] still would be down the line, [then] I think that would have maybe kicked off the process of me questioning [my sexuality] more rigorously and more seriously. And that might have helped me come out as a lesbian to myself sooner.

Both Brooke and Tegan here describe situations where their attempts to bring their difficulties navigating attraction to men into therapy were not picked up on; they both speculate that if their therapists had responded by questioning their attraction to men, it might have been highly beneficial-- "opening up so much to explore" or "kicking off the process of questioning." This data suggests that questioning on the part of the therapist might make room for questioning on the part of the client; and likewise, if a therapist is closed off to questioning the patient's sexuality, the patient's ability to question themselves is significantly hindered.

Brushing over or dismissing patient's disclosure. Ten participants recalled comments that had caused them to feel dismissed after raising questions about their sexuality in therapy. Some of these dismissals were explicit redirections ("I don't think you are [gay]"; "Maybe you are just scared of relationships"), but most of them took the more implicit form of "deferrals"-- reassurances that the issue of sexuality did not need to be discussed at the time, often because the patient was "still young," and would figure things out later. This seems to be a common response to questioning teenagers; of the seven participants who spoke extensively about being in therapy while they were in high school, four mentioned receiving these "deferral"-type responses. The "deferral" often used generalizing platitudes rather than speaking to the patient's personal experience. It had the effect of discouraging the patient from further speaking about their sexuality. Gabby, who had had many negative experiences of this kind in therapy as a teenager (e.g. a counselor who told her that "everyone experiments"), said she was anxious about receiving another "deferral" from her therapist in college:

I feared that she was gonna placate me and be like, "It's normal, you're in college, everybody goes through this…" I was kind of afraid that the gayness would have been brushed over like, "It doesn't matter"-- not in the good way, but like, "Everybody does this, you're not really gay… This is just a phase, whatever is going on, it'll pass; all college kids experiment, who know what you are, and it's fine…"

Marcie spoke of the invalidation and depression she felt post-"deferral," as well as what she felt was the implicit homophobic message in her therapist's comments:

[She said,] "Well, you might not know right now, things change… You're still young and you're still figuring things out." And that's the same response I got from a lot of other adults in my life, and it just made me feel like, well… I've been thinking about this for a

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very long time, and I didn't wanna be told, like, "There's still hope for you to change";

that's basically the message I got. "You might not be gay, there's still hope."

Meanwhile, Tegan was told that she should "give it time," because there was "no need to rush into dating"; and Spencer was told that she didn't "have to think about this right now."

The striking similarity of these comments toward questioning teenagers speaks to a lack of sensitivity to the needs of this population among mental health providers. When a therapist is unnerved or does not know what to say, platitudes are easy to fall back on; but their effect is to cause a patient to her particular situation is not being attended to. Furthermore, these statements can have a pathologizing effect-- as Spencer noted, "She was right that I *didn't* have to think about it, but it was *all* I was thinking about!" Well-intentioned though some such comments may be, they may nonetheless connote that the patient is unusual or even pathological for wanting to understand her sexuality at a young age.

Overreacting to patient's disclosure. Although the brushing over of patient sexuality was a common experience and a common fear among participants, eight participants also feared that their therapists would overreact to their disclosures or overfocus on their sexuality, which would have a stigmatizing effect. Participants sought an in-between, where their therapists would meet their needs when discussing sexuality, but would not view their sexuality as a "problem" or a "big deal."

Amy mentioned that her therapist, whom she otherwise felt was very supportive, would sometimes bring up her sexuality in uncomfortable ways:

Even when I had a really good therapist, it was something that was often brought up, and… I think people can think it's more influential than it actually is. And it was brought up like, "Oh, you felt uncomfortable in this situation; is that because you're gay and you

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felt different from everyone else?" And sometimes… it was just not relevant. And it's not

like all of my anxiety and everything ties back to the fact that I'm gay and that's this like,

horrible truth…

When asked what might have been a positive response to her coming out, Kayla, whose therapist

reacted by remarking on how "horrible" her relationships with men must have been, said:

Probably nothing more than "Oh, okay, well, good to know…" It feels weird when

people are like, extremely excited… I just want a very peaceful, "Oh, I acknowledge

that." And then to go on to the rest of my life.

Pushing to 'solve' patient's sexuality. Five participants felt that therapists could at

times be overly focused on finding a "solution" to the question of their sexuality, rather than

sitting with and exploring the existing ambiguity and its personal meaning to the patient.

"Solution-focused" therapist behavior in this context includes focusing on the selection of a

label, or attempting to diminish the patient's negative feelings around sexuality rather than

exploring and working with them. The effect of this solution-focused therapy was stifling to

patients who wanted do more exploratory work around their sexualities. Several participants

spoke to the importance of staying with patient ambiguity. Gabby recommended a more open-

ended approach:

[I would recommend] doing an open-ended-- exploring the ambivalence as opposed to

finding a solution… Like, "We're not here to fix you being gay, or to fix your feelings

about being gay, we're just here to figure out how you feel about it."

Spencer appreciated that her therapist had allowed her "room" to explore her sexuality:

She gave me room to be like, "If this is what it is, it is what is its; if it's not, if you're

questioning, that also is what is is." Her giving me space to let it be exactly what it was,

was really helpful… It's like these boxes-- gay, bi, straight… She didn't try to box me

into anything.

Meanwhile, Kayla connected her reluctance to explore her sexuality in therapy to her previous

negative experiences with mental health professionals and their anxiety about "solving"

problems. Having seen professionals who would try to "fix" her bipolar disorder, she did not

want to experience the same with regard to her questions about sexuality:

Sometimes I think that people want you to get to like, comfort, or a happy place, but it's

just that a lot of things make me uncomfortable, because of the world. And probably, for

me, what's been more healthy is being okay with being uncomfortable and like, weird,

and feeling kind of bad… And not expecting myself to find super-happiness, I guess…

So, in terms of sexuality, I don't think it would have been helpful, at that point in time,

for someone to be like, "Okay, I hear what you're saying and you're definitely a lesbian,"

or, even less helpful, "You're definitely bi..." That's a problem I have with mental health

people is that they tend to try to fix it right then, like, "We'll have this fixed in 2-3

sessions" or something, and that never works… And the expectation-- their frustration

starts to show through… So I didn't want that at all with regards to sexuality, either.

Kayla here identifies how the therapist's desire to find a "solution" to the patient's situation can

place undue pressure on the patient, or engender feelings that questioning is itself pathological.

She later added that "It was kind of interesting to see what happens when I really get down to the

nitty-gritty of how I identify, so it would have been less fun if this guy's sitting here like, 'Well,

hmm, I see.'" Kayla viewed her questioning as an important personal creative and intellectual

process, referring to it as her "gender and sexuality and journey." She felt that her therapist's

anxieties about finding a solution might have resulted in him imposing his own views of sexuality onto her, and this might have hindered her process more than helped it.

Espousal of religious (Christian) views. Four participants mentioned Christian views on the part of the therapist that ultimately hindered the therapeutic process in some way. Because many members of the LGBT community are religious themselves, a problematic relationship to religion on the patient's part should not be assumed. However, therapists should be aware of the context of religious trauma that many LGBT patients may bring to therapy. They may have had traumatic experiences being rejected by friends, family, and communities on the basis of religion.

Although widely condemned, religious conversion therapy remains practiced in the United States today. Cameron's parents sent her to a Christian boarding school, from which she was summarily discharged after she refused to accept that "homosexuality was wrong and a sin and a choice that I was making." Afterwards, her parents promptly sent her to a different therapeutic boarding school program, which Cameron described as "not religious-- much more *spiritual*" (i.e. not espousing any particular denomination), and where "they didn't think homosexuality was a problem at all." She credited this latter experience with making her a "more well-rounded person" and attributed a lot of its success to its lack of organized religion:

> The first type of program I went to, I would never recommend that, but the second one, absolutely. So maybe any non-religious type therapy would be good for sure, especially if the parents are very conservative and closed off to caring about it… it's good to be around educated people that can inform them.

Meanwhile, Marcie, who states her anxiety and depression as a teenager was linked directly to her fears about her sexuality and the consequences of identifying as a lesbian, had

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tried to assess her therapist's position on LGBT issues by asking about her religion. Marcie was

coming off the heels of an experience where a close friend "basically converted to hardcore

Christianity," and asked her to attend a youth group. Marcie accepted and began to attend the

groups-- "I was like, oh, maybe if I become religious then I won't be gay anymore!"-- but

eventually left after group leaders asserted that being gay was "a choice." Shortly afterwards, she

was cut off by the friend who had invited her, who did not support her "lifestyle." As a result,

Marcie was wary of Christian identity and religiosity in general:

> I had asked [my therapist, before I ever came out to her,] if she was a Christian… after I
>
> went through that whole Christianity phase, because I was like, "Oh well, what's she
>
> gonna think about me if she's religious?" And she said she was [a Christian]. And then I
>
> was like "Oh, well, is your church accepting of that stuff?" [LGBT identity] And she's
>
> like, "Oh yeah, they're very open." But I still just had really negative feelings about
>
> anything religious…

This therapist did not attempt to push religious views onto Marcie. But what stands out in this

anecdote is the therapist's lack of intervention. Elsewhere, Marcie noted with frustration that her

therapist often "just kinda took whatever I said at face value," and overall wished that she had

been more explorative in her approach. In this instance, we can imagine how Marcie's sense of

safety might have been enhanced if the therapist had openly and nonjudgmentally asked about

what it meant for Marcie to have a Christian therapist, what she meant by "accepting" or "open,"

etc.

In cases where the therapist's religion is a source of discomfort for the patient, this

potential rupture can be used productively. For example, Callie's therapist, whom she described

as a "liberal nun," would invoke her own religious status when challenging Callie's internalized

homophobic views: "I don't think it is wrong to be gay, and I'm a nun, so I don't see why you should think it is." For Callie, whose internalized homophobia was a result of her very religious Christian upbringing, this message was important to hear.

Therapist Practices Seen as Beneficial by Participants

      Demonstration of interest, curiosity, and willingness to explore sexuality. Eleven participants indicated that the therapist's demonstration of interest and curiosity regarding their sexuality would have helped them feel comfortable questioning in therapy. It was common for participants to feel reluctant to speak about their sexuality in therapy; they often wondered whether it was extraneous or irrelevant to their mental health issues. They wondered whether their therapist would be able to tolerate it, and whether it was worth the risk of being rejected. It is important for therapists to counteract this undercurrent of shame by expressing their willingness to explore the patient's sexuality.

      Callie, for example, was initially very reluctant to speak in-depth about her sexuality in the way that her therapist wanted her to, stating that at times she felt "forced to explore myself more than I was ready to." She concluded, however, that her work with this therapist, while it was difficult for her at the time, was ultimately helpful, particularly because her therapist had been "the only safe person" she could speak to about her sexuality. When asked what might have happened if her therapist had "backed off" and stopped pursuing the subject of her sexuality, Callie responded:

> I probably would have been a little more lost. Like, I wouldn't have explored myself as much, I guess. And if she wouldn't have asked me the questions she asked me, I wouldn't have known where I stood.

Callie contrasted this past experience with her current therapist's approach:

[With my current therapist,] we don't really talk about that stuff as much, especially since I'm not dating anybody. I feel like it's not something that interests her; like she doesn't really care about it. It's not something that she's gonna bring up to me or anything like that… I feel comfortable talking to her about stuff. I just don't really talk to her about my sexuality anymore… I don't feel as comfortable talking to her about that. I try not to bring it up…

When the therapist's willingness to work with the patient's sexuality is not expressed, the patient will often, not unreasonably, fill in the blanks based on experiences in their other relationships. Recognizing and responding therapeutically to the patient's insecurities around sexuality work is a matter of attunement.

Attunement: attending to patient's particular feelings and needs around sexuality.
The theme of attunement was present in every interview. Generally, the least successful therapeutic relationships were those in which the patient's disclosures around sexuality were overlooked, dismissed, or pushed aside in favor of other topics. These relationships were characterized by failures of attunement; the therapists had failed to recognize the importance of this topic to the patient.

The most successful therapeutic relationships, meanwhile, were those in which the therapist was able to adjust in order to work with the patient at her own pace, according to her particular needs. A pertinent example is the case of Tara, who at the time of the interview was only "out" to her therapist. As a young woman who was still, for the most part, "in the closet," Tara was still visibly uncomfortable speaking aloud about her sexuality. But she explained how her therapist had worked closely with her to help her eventually reach a place where she could come out as a lesbian to herself. Picking up on Tara's conflicting feelings and intense anxieties

about speaking about her sexuality, and about using the word "lesbian" in particular, her therapist waited a number of months before asking Tara if she would be comfortable speaking out loud what her sexual orientation was, or writing it down. Tara chose to write it down, but even this act was difficult and frightening, and took her quite a bit of time. She recalls, however, that her therapist waited patiently as she hesitated to write something down. Eventually she wrote down that she was "not straight," and then amended her statement to read "I am a lesbian" in a subsequent session. She recalls also that her therapist thanked her for being comfortable enough to tell her, "because it took a lot for me to say it."

Tara's case is an example of excellent attunement between therapist and patient. Her therapist was able to recognize the particular source of Tara's anxieties around sexuality, and how they tied into her more general anxieties about expressing herself and being understood. She responded accordingly by offering Tara ways of expressing herself that could be more comfortable. According to Tara, once she had come out to her therapist in writing, she began to feel more free to express herself in therapy generally, not only on the topic of sexuality. She stated she had been looking forward to therapy more since then, and that there were fewer moments of silence in the therapy room.

With effective use of attunement, the therapist is able to respond in a way that reflects the patient's own understanding of her sexuality. For example, Callie felt somewhat let down by her therapist's accepting, but rather unenthusiastic response to her coming out as a lesbian. She reflected on how her previous, more affirming therapist, with whom she had tentatively identified as bisexual, might have responded:

[My current therapist] was just like, "Oh, okay." I think my [previous] therapist probably would have been like… "You discovered yourself, and I know it's been a long road.

You've dealt with this for a long time." And I feel like she just would have been very

congratulatory of me, and very happy for me. Like, "Good job, you finally figured it out,

even though you sometimes do still question, you've got it mostly figured out, and that's

a good step to take; good job, I'm proud of you, I'm happy for you."

Callie wished for her therapist to react in a way that reflected the personal importance of her

coming out and the struggle it took for her to get there. Other participants, meanwhile, would

have preferred a more muted response.

Overall, the data demonstrated that lesbians do not have a common, unified view on

sexuality. For example, some participants viewed their sexuality as something innate from birth,

while others viewed their identification as lesbian as having elements of choice. Some

participants wanted to be reassured of their ability to have a "normal" (i.e. monogamous)

relationship, while others would have wanted these concepts of normality to be challenged.

Participants had varying understandings of what a "lesbian" was, as well as varying definitions

of womanhood. And, perhaps most critically, many participants viewed the process of coming

out as inextricably linked to other biopsychosocial factors in their life, such as race, mental

illness, transgender status, and status as an abuse survivor. Of course, the particulars of these

factors varied widely from person to person. All of this difference underscores the importance of

the therapist's attunement to the situation of the individual. In the absence of attunement, the

therapist runs the risk of enforcing their own notions of what it means to be a lesbian onto the

patient, rather than helping them through the process of reaching their own personal

understanding.

Therapist's honesty and self-disclosure. Seven participants expressed their appreciation

for therapists who were honest about the limits of their knowledge, and open about their social

positionality and privilege relative to the patient. Brooke, for example, stated that her therapist's openness about having been in a relationship with a woman, and about being a fellow abuse survivor, had drastically increased her feeling of safety in the relationship. She added:

> I had a really difficult time with opening up to her, because she was a therapist; and I told her that straight up… And she was like, "That's fine, I wouldn't trust me either; I'm an authority figure, dude, I have so much power over you. Of course I'm not gonna expect you to trust me…" She was like, very receptive to that, and aware of the boundaries, I guess. I feel like her being aware of how much power she had over me also made it easier for us to negotiate boundaries.

Brooke's therapist was able to establish an atmosphere of safety by acknowledging both traits she had in common with Brooke, and ways in which she held institutional power in their relationship. This provided a corrective emotional experience to contrast with Brooke's previous experiences in relationships where power was abused.

Conversely, in less successful therapeutic relationships, the existing balance of power would remain unspoken. In these cases, therapists would avoid admitting that aspects of the patient's life were beyond their scope of experience, even when it had become clear that this was the case. Patients often stated that they would have preferred their therapists to be honest and ask them about something when they did not fully understand it. Carol recalled of her therapist:

> I didn't like that he told me that he understood, that he "got it," because he had lesbian clients. I think, looking back, I would have wished that he'd said, like, "I don't get"-- or, "I might not get it, but I want to, so like, call me out if I'm misunderstanding," or something like that.

Kayla, who went through a period of gender questioning before eventually identifying as a lesbian, stated that her therapist's reaction to her initial questions about gender dissuaded her from being open to him about questioning her sexuality:

> I think he just didn't know what nonbinary meant at all… He kind of pretended to know what he was talking about. It was a really weird session because I was trying to talk about that, and about not really being sure where I fit in with gender, and he was like, "So you're gonna be trans now?" and asking me if I felt like a boy. And I was like, "That's not what I'm asking for." …If you don't get it, that's fine… Admit that you don't get it, and I can explain more, or I can tell you, "I don't know how to explain, but that's how I feel."

Both Carol and Kayla wished that their therapists had been open about not "getting it," giving their patients the opportunity to speak to their own subjective experiences.

Tegan, meanwhile, recalled an experience early on in treatment that ruptured and later reinforced her trust in her therapist. Tegan had told her therapist that she felt she was disliked by her classmates at least partially because of their homophobic and misogynistic prejudice against her, "even if they aren't conscious of it." Her therapist had challenged this idea, causing Tegan to doubt her therapist's trust in her:

> She was like, "They're not doing it on purpose." And that made me feel really invalidated and weird. And I kind of went home from that session questioning whether I wanted to go back to her… But then what really surprised me and gained my trust was, in the next session, she immediately opened with apologizing for how she'd acted last session. She was like, "You know what, I read over my notes from the last session, and I thought about what you said, and I wanna say that I'm sorry, I didn't mean to invalidate-- and

you're probably right that in some sense, what you perceive as your classmates' dislike of you could be driven by homophobia and misogyny. And you're right for saying that, and your feelings are valid, and I shouldn't have questioned that." And the fact that she was ready to apologize and like, work again toward trusting my feelings and my thoughts, was really meaningful to me.

Tegan's therapist had demonstrated her honesty and willingness to hold herself accountable for what happened in the therapeutic relationship. As a result, Tegan's comfort and trust in her therapist was strengthened.

Overall, participants valued therapists who were open, honest, and engaged in self-disclosure. Carol noted, additionally, that her therapist's "blank-slate" style was "challenging [for someone] coming into queer identity," and she stated that in the absence of her therapist's self-disclosure, she had "filled in the blanks" with her anxieties about his negative judgments. Disclosing thoughts of questioning is often quite risky for the patient. Engaging in some degree of self-disclosure can help the patient to feel as if they "know" the therapist and can begin to predict how their own disclosures will be received. Therefore, self-disclosure can be an important tool in increasing patients' feelings of safety.

Insider knowledge. Seven participants stated that they valued therapists who possessed knowledge of LGBT issues beyond basic or commonly studied topics. For example, Tasha noted gratefully that her therapist "had a lot of contextual and historical knowledge." She elaborated:

She's a Native American activist ally, and she was kinda connected to the trans community of the area. And she had mentioned to me the history of colonialism, and what happened to Two-Spirit people, and I was like "Woah, she's awesome!"

Tasha, a black transgender lesbian, began initially questioning her gender while she saw this therapist. Her therapist, an older white cisgender lesbian, had effectively communicated her interest, knowledge, and support of the transgender community and related anti-racist causes, to the extent that Tasha both trusted her and saw her as a lesbian role model. Tasha also noted that having this contextual and historical knowledge of other transgender people helped her to feel less isolated as she began identifying as transgender.

We might contrast this with the experience of Kayla, a black cisgender lesbian who also went through a period of gender questioning. Although Kayla suspected that her (white, cisgender, male) therapist was also gay, she felt that the gap between their experiences was too great for him to be of real help to her as she questioned her gender and sexuality.

I didn't, so much, want the influence of this white cis man on my gender and sexuality journey, which, for me, is also wrapped up in race. 'Cause I know that's a very different experience, even if the gay thing is the same, kind of. But I think that probably gay men, especially white gay men's experiences, are like completely different from anything that I have experienced… I don't think he had the perspective necessary to like, tell me anything either way… Being on Tumblr and seeing all of these lesbians talk about their own experiences, one of the things that really helped me was hearing butch lesbians talk about their experience with gender. And I don't know where he would get that voice.

Meanwhile, Tegan, who felt that her therapist was quite beneficial and supportive overall, identified a similar "experiential hurdle" between herself and her therapist, who had explicitly identified to her as straight:

I feel like she maybe wasn't ready to talk about the nuances of queerness with me, but she was able to talk about, "Oh, being queer, homophobia's a thing." But she maybe

wasn't well-versed, or able to talk as much, about like, compulsory heterosexuality, and

the more nuanced aspects of identification as queer.

Tegan further explained that although she was able to talk about "practical aspects of queerness"

with her therapist, e.g. how her parents and friends reacted to her, she found it difficult to broach

more complex internal issues, such as how she could be sure that she was a lesbian instead of

bisexual. She also felt that her identification as a lesbian was "kind of a decision," and wondered

if her therapist, coming from an outsider's perspective, would have understood this. She

speculated that her therapist may have been trained mainly to work with "practical issues" when

it came to LGBT clients. However, for Tegan, who experienced extreme anxiety and self-doubt

around her identity, counseling focused on these more nebulous issues might have been more

helpful:

> Maybe if she had somehow introduced me to like, the [theoretical] language-- Or, maybe
>
> if she'd in some way shown herself to be like, aware of the nuances of sexuality. That
>
> would have sort of begun the process of me thinking about it, and seeing her as someone
>
> who could have helped me voice these things.

Therapists who possessed "insider knowledge" were able to use this knowledge to A) provide

their clients with important referrals and resources, and B) demonstrate their interest and support

to their questioning clients. Their possession of this knowledge was not necessarily dependent on

their sharing identities with the clients [i.e. being members of the LGBT community].

Acceptance of "nontraditional" narratives. Within the LGBT community, certain

"coming-out" narratives are more common and/or accepted than others. Six participants

indicated a desire for therapists who were open to narratives that are considered "nontraditional."

For example, Brooke, a survivor of childhood sexual assault who described herself as primarily

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"sex-repulsed," felt that her experiences did not match up with common narratives of gay sexuality.

> I feel like there's a weird narrative: Once you come out as gay, like, you're healed and everything's gonna be great and awesome. And I feel like I don't have the space to be like, "I dunno, dude, maybe not"... And growing up reading gay fanfiction, there's a lot of trauma stuff. But after [the characters] come to terms with all that, they have this like, beautiful healthy untraumatized relationship, and it's great cry-sex all the time, they love each other so much. And I'm like, "I'm never gonna have great cry-sex; it's gonna be really traumatic cry-sex, if that ever happens."

Even with a therapist who she loved, Brooke felt that her remaining celibate was not seen as a healthy option; she wondered what it would have been like if her therapist had interrogated her desire to have a "healthy" relationship to sex.

The acceptance of "nontraditional" narratives may be especially important to transgender people, especially those who seek medical transition. Tasha spoke extensively about her struggles to receive hormone replacement therapy. She was turned away from a number of clinics for various reasons-- mainly her lack of financial stability. Tasha added that if she had mentioned her identification as a lesbian, it almost certainly would have been counted against her, noting that she knew another trans woman who had been denied hormones because she had identified as asexual. Many mental health professionals have extremely strict criteria that must be adhered to in order for a person to qualify for hormone treatment; therefore, Tasha, and many other transgender women, have ended up telling a "rehearsed" and edited version of their "narrative" in order to receive hormones. Tasha noted the particular importance of the therapist's acceptance of nontraditional narratives:

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People who aren't just the regular kind of "cool" where they're like, okay with the gays, like, "L-G-B's, they're nice, but we're not a bunch of fags in here"-- There has to be some way to acknowledge that you're more inclusive, within that spectrum. Like, a non-traditional kind of story is welcome. Because I guess the whole reason any of us are in there, is because we have non-traditional stories.

Visible symbols of LGBT acceptance. Four participants stated that when trying to assess whether it was safe to come out or to engage in the questioning process with their therapists, they would look for visual symbols of the therapist's openness to discussing LGBT issues. Amy recalled a consent form she had filled out at intake that had mentioned a policy of no discrimination against patients regardless of sexual orientation, as well as posters in her counselor's office that mentioned sexual orientation as possible topic of discussion; Tegan stated that spotting a Judith Butler book on her therapist's shelf had made her more comfortable discussing her sexuality in therapy. Conversely, the omission of such materials may give patients the opposite message. For example, Naomi recalled that her therapist's bookshelf had many books on human sexuality, "but nothing on anything other than being straight, as far as I know." She added that if there was even one book in his office with a title that alluded to non-straight sexuality, she might have been more comfortable discussing her sexuality.

Affirmation, validation and belief in patient sexuality. Seven participants spoke about the importance of having their feelings about sexuality validated, and feeling that they were believed by their therapists. Spencer stated that she felt it was most important for questioning patients to feel acknowledged-- "Acknowledgement that this is real, and no matter the conclusion, this is still real, and it's a valid path, a valid question." Considering that five participants also mentioned experiencing ongoing questioning, doubts, and anxieties about their

sexuality after coming out as a lesbian, affirmation and reinforcement of the therapist's belief in the patient's reality may still be important long after patients have come out.

Normalization of patient sexuality. Seven participants recalled wanting their therapist to provide reassurance that their sexuality was "normal." Historically, there has been conflict in the LGBT community over what Spencer called "normalization versus assimilation." For example, some have argued that the legalization of same-gender marriage in the United States simply represents the assimilation of LGBT people into the oppressive power structure of marriage. Although Spencer, a student of queer theory, was aware of conflicts like these, she stated that nonetheless, it was a comfort to be "normalized" in therapy:

> I was not made to feel different… I know I and a lot of queer people struggle with like, normalization versus assimilation. I know I love my culture; I love that it's different. I don't want to assimilate. So, some people would want the reaction to be different, I guess. They would want a bigger reaction than like, "Oh, okay, what's the weather like outside?" But for me that reaction was… I think, really helpful. She was fine with it. It really was nothing to be fine with, actually, like it was less than that.

Several other participants stated that their therapists had increased their feelings of normalcy by not focusing heavily on the topic of sexuality. Carol stated that she felt more comfortable speaking about her sexuality with a therapist who did not "focus" on it:

> I feel like she didn't focus on my queer identity at all; it was just something that was like, naturally understood by her, which felt really supportive. I felt like I could talk about things that were related to being queer, more openly, because she like, had an understanding of that… It didn't feel like this like, highlighted part of my identity, it was just something about my life, I don't know, or my relationship.

Gabby recalled that her therapist's "non-reaction" to her attraction to women was a healing

experience after a lifetime of stigmatization and pathologization:

> She made it seem like it was so normal. I did my undergrad in an area where a lot of
>
> people were not okay with it… And so to go into therapy and have her like, process my
>
> feelings as if they were any normal feelings about a relationship, was really refreshing…
>
> It was kind of like, "This normal person is not making a big deal out of it, therefore I'm
>
> fine"... She just kind of treated it like it was me having romantic feelings for someone;
>
> they just happened to be the same gender as me.

Callie, meanwhile, spoke specifically about the normalization of questioning behaviors:

> [It would be helpful for questioning people] to know they're not wrong. 'Cause I felt
>
> wrong a lot. I felt like, "Why am I having these feelings, nobody I know has had these
>
> feelings"... But just that it's not wrong to feel that way, and a lot of people, I guess, have
>
> to question themselves. I read [online] that for girls that are gay, they like, come to terms
>
> with it later in life because of the way that society puts dating on us, and I think that's
>
> true. So like, just to know that even if you question for a long time, that's not wrong; not
>
> everybody knows right away.

Callie mentioned elsewhere that she had only heard of people *knowing* they were gay; "Nobody

like, questioned it. So if I was questioning it, then it must not have been real; I must have been

thinking of these ideas on my own." Therefore, normalizing the questioning process itself may

be especially important, particularly for patients whose mental illnesses, like Callie's, may cause

them to doubt their own perceptions.

"This is not a death sentence." Closely related but still distinct from the desire for

normalization was the participants' desire to be reassured that that identifying as gay was not

equivalent to a "death sentence," or to a very difficult future. Four participants mentioned that they had wanted reassurance around their fears for the future. Spencer recalled of her therapist:

Having someone who 100% is like, "This isn't a death sentence, you're a person and this does not change that in any way…" I think [that] was helpful.

Marcie imagined she would have benefited greatly from receiving this type of reassurance:

Just some reassurance [would have helped]-- even if they said something like, "Sometimes you might not know 'till later, but if you think you're sure, just know that just because you're gay doesn't mean your life is over; there's so many gay people out there."

And Cameron recalled:

I just wanted to accept myself, and know that it wasn't gonna be like, a really hard life; like really hard to be normal, and have a normal family, and stuff like that.

For Tasha, things were somewhat more complicated. As a black transgender lesbian, the high rates of murder and suicide of transgender women of color weighed heavily on her:

[When you come out,] your material reality gets worse, but you're overall happier, and that's why anyone bothers… I had that overarching "death sentence" feeling… Once you have the idea that basically your family can abandon you and you could end up homeless, on the basis of only this, and if you were in the closet then that wouldn't happen; that's when things start to feel like a death sentence… At some point you just bump into that material reality. And it feels like, "How can I help this person in an hour, when the next 23 hours of the day are going to abuse them?"… Maybe the best way to deal with it is to eliminate within people's minds, as quickly as you can, the just-world fallacy. Like, get

the idea in their heads that, hey, maybe the world kind of sucks, and you don't deserve to

suffer.

Tasha is mindful of the fact that patients' fears and perceptions of coming out as a "death

sentence" may be very much justified, particularly if their mortality rate is increased by other

factors (such as race and/or transgender status). While it may be helpful for many patients to be

reassured that "it gets better," therapists should also be prepared to help patients confront the

difficult reality that coming out may physically endanger them. Ideally, therapists should respond

with empathy to patients' expressed fears without attempting to downplay their seriousness.

      Allying with patient if family is unsupportive. Of the six participants that spoke about

their difficulty dealing with their parents' reactions to their coming out, three mentioned the

value of having their therapist as an ally. Cameron recalled instances in which her counselors at

boarding school had spoken to her parents, who had originally sent her to conversion therapy,

about the validity of her sexuality:

> When my counselor would confirm something I was saying as a valid statement, I'd be
>
> like, "Could you tell my parents that that's valid?"... So that was big for me, just being
>
> able to have someone back me up.

Similarly, Callie recalled an instance in which a therapist had brought her mother, who was

"not happy" about her sexuality, in for a family therapy session:

> I was dating [a woman] then, and I told [my therapist] how I really didn't feel
>
> comfortable with my mom about stuff like that. And she actually brought her in, and was
>
> sitting down and talking to her. [She told my mom] this story about how this family
>
> wants to go see something in Europe, and then instead their flight gets derailed or
>
> something, and they to go to a different place. And so, the sight they saw instead was still

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really beautiful. So, even though your daughter isn't gonna grow up to marry a man,

she's still a really beautiful person, and you should still accept her for what she is,

because-- the path the she's on isn't a bad path, it's just a different path. And so, my mom

was kind of forced to accept it, I guess. And it just kind of helped me a lot with that.

Naomi, meanwhile, wished that she could have received this type of support from her therapist,

who instead rejected her in a way that was later mirrored by her parents:

I wanted him to be on my side because I didn't think my parents would be, and I felt I

would stand a better chance with them if I had him on my side, because I knew he had a

good relationship with my parents.

Overall, if possible, it may be beneficial for therapists to openly ally with patients in

cases where parents are unsupportive post coming-out.

Common Patient Experiences

Dropping hints about sexuality. Five participants mentioned that they had "dropped

hints," whether consciously or unconsciously, around therapists who they were considering

coming out to. This usually occurred in instances where patients were hesitant to speak about

their sexuality. They would sometimes try to circumvent the uncomfortable experience of

"coming out" by dropping these hints and hoping that their therapist would come to some

understanding of them. Amy, who felt very uncomfortable discussing sexuality in general with

her therapist, recalled her fear and hope that her therapist would pick up on the hint she had

dropped by wearing a "Legalize Gay" t-shirt:

I was like "Hmm, I wonder if she'll notice this and bring it up? And then I'll talk about

it." But she didn't and I was just like, "Okay…" I kind of wanted it to happen, but at the

same time, I was really nervous… I thought maybe she'd be like, "Oh, Legalize Gay, is

that an issue you care about?" And I'd be like, "Yes, because I'm gay," or not straight.

And I honestly feel like had I disclosed that to her, it would have been very helpful to her,

because it was a large part of my issues with my mom and stuff like that… [It would

have] helped her to help me.

Kayla recalled that she had dropped hints for her therapist when she had felt conflicted--wanting

her therapist to acknowledge her relationship with a woman, but not wanting to be pressured to

talk about her previous experiences with men:

I was trying not to talk about it, really, but also not have him think that my girlfriend was

a boy. And so, I'm sure he was very confused for a while… Sometimes I would use her

actual pronouns ["she/her"] because I thought maybe if I just dropped it in, it wouldn't be

a big deal, and we wouldn't have to actually discuss it? Just like, he'd catch on, but also

simultaneously catch on that I don't want to talk about it, I dunno…

Kayla wished for the type of attunement that Tara's therapist exhibited. Tara recalled that at the

beginning of her work with this therapist, she had done a lot of "talking around" the issue of

sexuality:

I would say how I felt about it, but I wouldn't explicitly say "I'm not straight," or "I'm

gay" or something. It was just-- using different words, being vague about it… I would

talk about how I felt uncomfortable when I thought about being in a relationship with a

guy, getting married, stuff like that. Or that I was uncomfortable with things other people

said.

Tara noted that she felt her therapist "knew what she was talking about," but recognized and

responded to her need to take her time to speak about it explicitly. So, Tara's therapist was able

to "catch on" to her hints while also adjusting to work at a pace that was comfortable.

Self-scrutiny and self-doubt. Themes of self-scrutiny and self-doubt were present in ten interviews. Other biopsychosocial factors, such as mental illness or parental rejection, could increase participants' tendency toward self-doubt. Spencer, who had been in therapy for anxiety and depression, recalled that she had gone through a difficult period where she "struggled to believe what she told herself":

> I was dating a girl… but I couldn't like, believe that I loved her, and it was very detrimental to me, and I was really questioning everything… I've worried a lot about like, if I actually love people. I always have that fear… Even if I'm being as honest as I can, I often don't feel like I'm being honest...

Similarly, Tegan, who also struggled with anxiety, recalled experiencing an intense period of self-doubt:

> I feel like that really intense period of self-scrutiny probably lead to a lot of the mental health issues… that made me want to go to therapy in the first place. 'Cause I was just like, in a constant state of doubt. At that point I was like, "I know I like girls to some degree, but do I really like girls, because I like girls in a different way than I like boys"... It was so confusing, and I felt like I was like, appropriating queerness when I called myself queer, and then I felt guilty, because I wasn't doing it the right way… I was also trying to figure out my mixed [racial] identity at the same time, and that would be really painful and difficult for me… All the time, I was like, "I'm lying to myself about everything!"

Brooke discussed her self-doubt in the particular context of being a childhood sexual assault survivor:

I was in there for sexual trauma. And so, so much of my anxiety was like, "Oh my god, am I only into women because this horrendous thing happened to me as a kid?" So I didn't really want to explore that, or bring it up. In retrospect, I think I was afraid of my therapist being like, "Oh, you're only this way because of this…"

In several of these cases, the patients were too anxious to bring up their self-doubt in therapy. Therapists should be aware that patients are likely to experience self-doubt and engage in self-checking behaviors even after coming out.

Avoidance. Avoidance of the subject of sexuality was common in both therapists and patients. Avoidance was a theme in seven interviews. In several of these cases, avoidance on the part of the therapist was noted to trigger avoidance on the part of the patient. For example, Amy recalled that she had avoided bringing up her sexuality with therapists who seemed uncomfortable addressing the topic:

I remember this one time my therapist was like, "So, because you're, like…"; She didn't say "gay." And I was like, "Because I'm gay?" She was hesitant to say the word… I appreciated the fact that my second therapist was willing to go there, whereas other therapists usually would not talk about it as much. They would almost see it as like, offensive to me if they brought it up without my bringing it up, like the therapist who didn't even want to say the word "gay" without me granting her permission.

In other cases, participants noted that their therapists seemed to be focused on "other topics," such as the patient's mental illness, and so they felt that the topic of their sexuality was extraneous or irrelevant to the therapy. Callie stated, regarding a previous therapist:

She focused more on the depression part of it. I didn't talk to her about anything with my sexuality, because I still wasn't 100% comfortable with it yet… She seemed more like,

focused on other things, I guess, and I just didn't wanna complicate things by bringing

that up…

Especially in the case of patients who struggled with internalized homophobia, it was important

for therapists to regard sexuality as a subject equal in importance to other aspects of the patient's

life.

Reluctance to criticize therapist. Five participants were very reluctant to criticize their

therapists, and would often backtrack and doubt their own perceptions of events in the

therapeutic relationship. Carol wondered frequently if she had recalled aspects of the relationship

incorrectly:

I could be wrong and maybe projecting because of my fear of other people's responses…

Or maybe he *was* like this, but…

Brooke also wondered if her criticism of her therapist's work was unfounded, since "she's the

professional." Meanwhile, Naomi, a transgender lesbian whose attempts to come out had been

rejected by her therapist and subsequently by her parents, seemed to direct all of the anger that

she might have felt towards them onto herself:

I wish I could have been more patient, and I wish I could have taken more time to say it,

instead of throwing it all out at once, for the most part. And along with that, not saying

everything at once. Just being like, "Listen, I'm a girl," and then, three weeks later, "I

like girls, and those things don't conflict." And I did the same thing when I came out to

my parents, I gave them too much information at once, and I think that de-contributed, so

like, I did it twice, so I don't learn…

Through this data analysis, many possible explanations for questioning patients'

decreased satisfaction with therapy became apparent. Within the data, themes that stood out

were: the value of attunement, openness, honesty, and self-disclosure on the part of the therapist;

the frequency of unconscious expressions of the therapist's internalized heterosexist bias; and

avoidant behaviors on both sides of the dyad.

CHAPTER V

Discussion

Overall, the results of this study reflected the predictions that Kitzinger (1987) made shortly after homosexuality's removal from the DSM: Practices that explicitly pathologize lesbianism, although they have certainly not been eliminated, are now far less common, although heterosexism itself, as a social force, is no less common. Heterosexism, therefore, continues to manifest in the therapy room. It is simply forced by social convention to express itself in a different, less explicit mode. These subtler expressions of heterosexism, which are unlikely to be covered by anti-discrimination policies and the like, are perhaps most commonly referred to as "microaggressions."

Feelings of self-doubt and uncertainty about what has transpired are common among those who experience microaggressions; and those who are in the process of questioning their sexuality are, perhaps more than any other group, defined by their self-doubt. Moreover, "calling out" one's therapist can be extremely stressful, due to the therapist's inherent position of power over the patient, and the patient's wish to see the therapist as professional and "good." Therefore, when a person just beginning to question their sexuality experiences a homophobic microaggression in the therapy room, they are unlikely to bring the injury to the attention of their therapist. For example, when therapists made comments that were received as subtly dismissive of patients' sexualities, participants in this study commonly responded by refraining from bringing up their sexualities further, in accordance with their therapists' apparent wishes. Due to

this dynamic, therapists in such situations may remain unaware of causing their questioning patients any discomfort, and so they may proceed to treat future patients in the same fashion, resulting in something of a vicious cycle.

Kitzinger (1987) also argued that psychoanalysis itself was antithetical to the development of lesbian consciousness; this study, however, suggests that therapy in fact has the potential to significantly benefit women during the process of questioning. If the confidentiality and emotional safety of the therapeutic relationship have been established, the therapist may be the first person with whom the patient is able to give voice to their questioning. The therapist is then capable of providing respite from the hostility that the patient may be experiencing in everyday life, whether this hostility comes from friends and family, or from the patient's own internal saboteur. The therapist can aid the patient in reality-checking in the face of abusive homophobic messages from trusted others that may threaten the patient's sense of self and stability. The therapist's acceptance and support of the patient may result a corrective emotional experience if the patient has been rejected by others. The therapist may be able to connect the patient to relevant resources in the form of support groups, websites, and other sources of connection and useful information. Opening up about questioning or coming out to a therapist may alleviate the everyday anxiety experienced by patients and improve the therapeutic relationship as a whole. Finally, many participants stated their questioning was directly linked to mental health issues such as depression and anxiety. If therapists avoid the discussion of sexuality in favor of focusing on the patient's mental illness, they may end up overlooking issues that are in fact crucial to its treatment.

This study's sample included participants whose experiences were either overwhelmingly positive or overwhelmingly negative, but the most common experience was a middling one,

where the therapy was seen as beneficial in other areas, but failed to meet some or most of the patient's needs related to sexuality. Even in cases where participants expressed gratitude and "love" for their therapists, a majority of these participants still identified shortcomings in their therapists' approaches specifically pertaining to issues of sexuality.

Attunement

A majority of the therapists' failures were linked to difficulties with attunement. This study suggests that the prevalence of failures in attunement with questioning patients may be attributed to: 1) the therapist's unchecked internalized heterosexism; 2) the basis of LGBT trainings in a framework of cultural competence; and 3) the focus of LGBT trainings on "practical" matters.

Internalized heterosexism. "Internalized heterosexism" here refers not to homophobia as an individual phenomenon, but to a person's absorption of homophobic messages, which they may then reproduce socially without intending to do so. To a degree, regardless of our own sexual orientations, all of us may be said to have internalized heterosexism, by virtue of growing up in a heterosexist society. Participants in this study reported extreme failures of attunement even with therapists whom they knew were not straight. Therefore, it is important for therapists of all sexualities to ensure that they do not act out their internalized heterosexist prejudice with their patients.

Whereas directly refuting a patient's sexuality and telling her that she is "wrong" is an overt expression of homophobia, internalized heterosexism is constituted by a series of implicitly homophobic beliefs and assumptions. When therapists are unaware of the functioning of their own heterosexist assumptions, and therefore unable to interrogate them, their attunement to their patients is inhibited. Internalized heterosexism may be understood as the driving force that, for

example, causes a therapist to maintain an unflagging belief in her female patient's attraction to men, despite the patient's expressions of uncertainty. Likewise, when therapists tell questioning teenagers that they don't need to worry about sexuality at their age, and they will figure it out when they are older, they are also operating under internalized heterosexism. Internalized heterosexism may also cause therapists to see sexuality as something less relevant to therapy than other issues, regardless of the degree of urgency with which the patient views it. Patients' own internalized heterosexism, meanwhile, increases the difficulty of confronting the therapist over such microaggressions, or even recognizing that they have occurred.

A basis in cultural competence. A great deal of trainings aimed at helping mental health service providers to work effectively with an LGBT clientele are based in a framework of cultural competence. Unfortunately, therapists whose knowledge of LGBT patients is based in such a framework may be likely to experience failures of attunement. Implicit in the logic of "cultural competence" is the assumption that it is possible to gain objective knowledge of the "culture" being studied; and, once one gains enough of this knowledge, one may be pronounced "competent" in working with members of the culture. This assumption is at odds with the experiences of many of the questioning women in this study, whose sexual and romantic experiences with women and men, definitions of lesbianism, and personal attachment to the "lesbian" label, among other factors, varied widely. Lesbians' conceptualizations of their identity, in other words, are so varied that each therapist has something to learn from each client about the meaning of lesbianism. If the therapist assumes that she is "culturally competent" enough to know what lesbianism means to her client without interrogating it, she risks imposing her own cultural definition of lesbianism upon her client. This sort of dynamic may have been at play with the therapist who was dismissive of her client's confusion about the possibility of

remaining attracted to men after she had already come out as a lesbian, because, in the client's words, "she thought I had already established my sexuality." This therapist may have had some culturally informed idea that a gay person's relationship to sexuality is generally unproblematic after they have officially "come out," and therefore she assumed that the patient's continued questioning after coming out could not be of much importance. Because she had made this assumption, the therapist was not available to support her client through a very unsettling and stressful questioning period. Because the therapist's lack of attunement signaled a lack of interest in the subject, the client responded by refraining from speaking very much about her sexuality in subsequent sessions.

Furthermore, empirical studies of lesbianism have a tendency to impose scientific borders on the meaning of lesbianism-- to measure the validity of a woman's lesbian identification by investigating how many times she thought women were attractive versus men, or how many men she had been with sexually throughout her lifetime, for example (Diamond, 2005; Averett et al., 2012). Such studies do not accurately represent the personal experiences and identities of the subjects. A therapist whose practice with LGBT clients is informed by such empirical studies may contrast his client's narrative with the ones deemed more convincingly lesbian, and pronounce her lacking in evidence of lesbianism. The therapist who told his client that he didn't think she was a lesbian, and suggested that perhaps she was just scared of relationships, may have been operating under this logic. Therapists who draw excessively on previously established narratives of lesbianism may be less open to learning about how their patients view and experience lesbianism, and, as a result, less attuned to their patients in general.

Finally, cultural-competence-based trainings may focus on defining terminology and identities used within the LGBT community, with the goal of reducing the therapist's ignorance

and thus increasing their "competence." However, having access to this information-- knowing, for example, the semantic difference between the terms "transgender" and "transsexual"-- does not necessarily improve a therapist's ability to respond therapeutically to a client who is unsure of her sexuality. Nor do such trainings necessarily help therapists to develop a practice that implicitly affirms all sexualities, whether or not they are working with straight-identified clients. Therapists may be equipped with specialized knowledge to be used when a client is known to identify as LGBT, rather than generalized knowledge that should be applied to all patients, "out" or not. Therefore, these therapists may be less attuned to the needs of clients who are not yet "out," leaving such clients at a significant disadvantage.

A focus on practical matters. Trainings on LGBT clients may focus primarily on the "practical" aspects of identity, such as helping clients through the process of coming out, and helping them respond to homophobia from those around them. As a result, therapists may be less equipped to help clients contend with their internal experience of sexual identity. In particular, trainings and educational materials may place a strong emphasis on the importance of "coming out" as a significant life event, although LGBT people often come out on many occasions to many different people over the course of their lifetimes; some LGBT people may be unable to come out to important others in their lives, and in fact may never do so; and the fact that a person has come out does not mean that their relationship to sexuality is comfortable or unproblematic. The study indicates that the more cerebral work of understanding and processing the personal meaning of one's own sexuality may be especially important to people who are in the process of questioning. Therapists whose trainings on LGBT issues have focused mainly on "practical" issues may be inclined to focus on identity development and so may be less attuned to the needs of their questioning clients to explore their internal experiences.

LGBT identities are complex and diverse in personal meaning, and they may be viewed therapeutically as entailing opportunities for the client to discover new things about herself, rather than a burdensome series of life tasks or difficulties. Such a view is more beneficial to the client's ego strength than a heavy or exclusive focus on the social problems that the client may foreseeably face.

Honesty and Self-Disclosure

The question of the appropriateness of self-disclosure remains something of a controversial topic in social work literature. Judging when it is appropriate to disclose personal information may also be understood as a function of attunement. However, in most instances where self-disclosure was brought up in this study, participants were grateful for their therapist's disclosures, especially with regard to sexuality.

For the questioning patient, giving voice to questioning or "coming out" may constitute a very intense act of self-disclosure. Therefore, in these cases, the therapist's own disclosure-- regardless of whether or not he is straight-- serves to destigmatize the act of disclosure and increase the patient's feeling of safety.

Openness to Questioning

Many participants in this study saw a direct link between their therapists' openness to questioning and their own ability to do so. Participants imagined that if their therapists had begun to interrogate their attraction to men, they might have been inspired to do so themselves earlier on in their lives. When questioning occurs within the therapeutic dyad, it may be understood as a collaborative process between patient and therapist. In order for the patient to safely give voice to her questioning within therapy, it is necessary for the therapist to also take an active role in questioning the patient's sexuality.

"Actively participating in questioning" does not necessitate literally asking the patient questions which she may or may not be ready to answer. Such decisions must be made on an individual basis. Rather, active participation here means avoiding the presumption that the patient is heterosexual, demonstrating curiosity and supportive interest around the subject of sexuality, and remaining open to the possibility of a non-heterosexual identity for all patients. In this way, questioning on the therapist facilitates questioning on the part of the patient.

Conversely, the therapist's tacit acceptance of heterosexuality will stifle questioning impulses in the patient. Take, for example, the patient who responds to her therapist's avoidance of sexuality-related discussions by avoiding them in turn. Because she is in the uniquely vulnerable situation of not knowing her identity, the questioning patient may be especially invested in trusting the quality of her therapist's professional judgment. In order to avoid facing the difficult possibility that her therapist may hold some some sort of homophobic bias, the patient is prepared with a variety of learned heterosexist explanations that conveniently leave her solely responsible for any discomfort she experiences around the subject of sexuality. To name a few: her sexuality is inappropriate, or irrelevant to the therapy; or, she is being silly, or deceitful, or "faking it" for attention; or, she is obviously not a lesbian, because if she were, she would have already known it. To create a space where the patient's questioning can safely occur, the therapist must challenge the voice of her vicious internal critic, by proactively interrogating the assumption of heterosexuality within his practice.

Sociocultural Context

The importance of therapeutic attunement to the context of the individual is underscored by the pronounced diversity of experience within this small sample of lesbians. Sociocultural

factors affected participants' understanding of lesbianism in particular, as well as their experiences in therapy more broadly.

Race. The concept of intersectionality, an important contribution of black feminist theory, is helpful in understanding the role of race in the lives of lesbians (Crenshaw, 1989). According to intersectionality theory, the interactions between multiple forms of oppression create the particular conditions of the multiply oppressed subject; so, she can only be understood when all of these forms of oppression, and their interactions, are taken into account. One participant in this study stated she felt her white male therapist, whom she suspected was gay, would not be able to understand her experience as a black lesbian in particular. She elaborated: "I felt I couldn't articulate to a white dude… the ways that black women specifically are gendered and non-gendered… It would be like, me teaching him about the ins and outs of the ways that racism and misogyny and homophobia affect black lesbians." Although her therapist may have experienced homophobia, she doubted he would comprehend how multiple forms of oppression in her life had intersected to create her specific relationship to gender as well as sexuality.

Class. Access to money drastically impacted participants' experiences of therapy. Financially privileged participants enjoyed easier access to mental health services, and, once services had been obtained, they were more able to be discerning customers, switching service providers if they were unsatisfied. Participants with financial troubles had fewer options, and therefore they were more likely to stay with affordable service providers even if there were difficulties in the relationship. Even if these participants found an effective and affordable service provider, their financial circumstances exacerbated the difficulty of attending regular

appointments. One participant noted that she had to terminate therapy with her beloved therapist because of the combined time commitments of work and college.

Mental illness. Most participants had some sort of mental health diagnosis; these presenting issues were their stated reasons for originally entering therapy. Participants noted that difficulties with questioning their sexuality had exacerbated existing mental health issues like anxiety and depression. Those whose disorders caused them to doubt their own perception of reality had increased difficulty with the questioning process. One participant in particular, who had been institutionalized and was placed residential treatment from a young age due to her mental illness, had experienced great difficulty viewing her lesbianism as non-pathological and separate from her disorder.

Experiences of abuse. Certain concerns were particular to lesbian survivors of abuse. Some participants mentioned fearing that their lesbianism was a product of the abuse they had experienced, or that others would perceive them this way. Survivors of domestic violence with a male partner noted that their abusive partners had been dismissive or made fun of their struggles with sexuality, incorporating their struggles with sexuality into the ongoing abuse.

Transgender status. Participants occupied a range of gender identities. In particular, being a transgender woman had a significant effect on women's experiences in therapy. Transgender women must meet with therapists in order to access hormone replacement therapy. However, in order to qualify for hormone treatment, they must present a narrative that is acceptable to the gender therapist-- one from which lesbianism, among other non-typical (non-heterosexual) identities, is absent. As a result, for many transgender women, therapy may be quite the opposite of therapeutic; it may be a stressful exercise in saying the right thing at the time in order to get the right results. Considering the high rate of trauma among transgender

women (especially women of color), more research on therapy with this group is strongly recommended.

Limitations

Due to the relatively small number of participants (N=13), the results of this study are not broadly generalizable to lesbians as a group. The collection of narrative data allows us access to complex and multifaceted personal experiences that may not be accessible through quantitative instruments. The intent of this study was not to create generalizable statements about a singular "lesbian experience," but to draw from the experiences of a small but diverse group of lesbians in order to gain insight into potential barriers that may prevent questioning women from benefiting from therapy.

It also must be conceded that, as is true of all retrospective studies, the data in this study cannot be said to be 100% reliable because it consists purely of participants' recalled experiences, the accuracy of which cannot be determined.

The scope of this study was limited by the small age range of participants, all of whom were between 18 and 28 years of age. The recruiting grounds used by the researcher-- cafes, college campuses, and various internet communities-- are mainly populated by young people. Therefore, the study was not able to access the narratives of older lesbians. This limitation is unfortunate, as we can imagine that there are significant differences in experience when coming out later in life. For example, women who begin to question their sexualities while married to men are faced with a distinct set of stressors, and therapists may react to these women differently. Therefore, further research on older lesbians and their experiences within therapy is recommended.

Conclusion and Recommendations

Within this study's sample, there were women who had formed alliances with their therapists after coming out, women who terminated with their therapists after coming out, and women who never came out to their therapists at all. The therapists who treated the women in this last group may very well still be under the impression that their clients were heterosexual, or that, in any case, sexuality was not an issue that needed to be explored within the therapy. So, recommendations based on this study will apply not just to lesbians as a group, and not just to "questioning women" as a group, but to every person a therapist works with, whether or not the client identifies as straight.

I propose that if a therapist sees each person, including herself, in the context of a society where heterosexuality is imposed upon all people, then she will better be able to guide clients as they come to new understandings of sexuality. The absorption of heterosexism at a young age can be quite damaging to a person's psyche, as it affects the way we interpret our own feelings, relationships, and desires (i.e., "everyone says I like my male friend, so I must like him; but no matter how close I am with my female friend, I'm sure I don't like her, since no one does that"). Finding the language to disentangle oneself from these assumptions can be an arduous task. A therapist who views heterosexuality through a political lens, as a set of behaviors that people are punished for not performing, may be better equipped to aid clients in the search for this language.

Working through this lens of "politicized heterosexuality" also means looking inward, to understand how one's own sexuality is constructed-- effectively putting the therapist on the same uncomfortable ground as the patient. If the therapist is able to do this successfully, then her

openness to alternative possibilities for the client's sexuality, as well as her increased attunement

to the needs of her client, will naturally follow.

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SMITH COLLEGE

2015-2016
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

………………………………………………………………………….

Title of Study:

Therapists' Reactions as Clients Move Toward Lesbian Identification: An Exploratory Study

Investigator(s):

Emily Willstatter, School for Social Work

………………………………………………………………………….

Introduction
- You are being asked to be in a research study of therapy's effect on lesbian identity.
- You were selected as a possible participant because you currently identify as a lesbian and you stated that you questioned your heterosexual identity whilst in therapy.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of the study is to investigate how therapists react when previously heterosexually-identified female clients begin to question their heterosexuality and lean toward a lesbian identity.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
- If you agree to be in this study, you will be asked to do the following things: speak with me over the phone/Skype/FaceTime or other program for an interview lasting about one hour.

Risks/Discomforts of Being in this Study
- The study has the following risks: Because you will be asked questions concerning your personal identity and experiences relating to the development of that identity, participation in this study may foreseeably bring up difficult or uncomfortable emotions.

- A list of LGBT-friendly mental health resources, compiled by the New York City Queer Mental Health Initiative, is available online for your use in the event that you seek follow-up support: https://docs.google.com/document/d/1bPK0dIOob_LWpfq8qkiU1bpuX8z8aUjZ9fqdXZVSv_E/pub

Benefits of Being in the Study
- The benefits of participation are: You will have an opportunity to speak about your personal experiences with mental health treatment, and to bring attention to issues in mental health practices that affect you as a lesbian in particular.
- The benefits to social work/society are: This study will work toward filling a gap in research on lesbian women who questioned their sexuality during the therapeutic process. This research may ultimately contribute to mental health professionals' ability to provide beneficial treatment to individuals who are in the process of questioning their sexuality.

Confidentiality
- Your participation will be kept confidential. I will speak to you from a private room in my apartment. I will tape the audio of our interview. In addition, the records of this study will be kept strictly confidential. The audiotape of our interview will be kept in a password-locked file which only I have access to, and destroyed after three years in keeping with federal regulations. Within the interview transcription and within my final report, any potentially identifying information that you provided (i.e. names, locations) will be disguised to protect your confidentiality.

Payments/gift
- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by 05/01/16. After that date, your information will be part of the thesis, dissertation or final report.

 Right to Ask Questions and Report Concerns
- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Emily Willstatter, at ████████████████████████████████████. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will have access to a list of LGBT-friendly mental health resources in the event that you experience emotional issues related to your participation in this study.

....

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

....

1. I agree to be [audio or video] **taped for this interview:**

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

Appendix B:

HSR Approval Letter

SMITH COLLEGE

January 5, 2016
Emily Willstatter

Dear Emily,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Claudia Staberg, Research Advisor

Appendix C:

Interview Questions

Interviewees are invited to tell their stories, with the following questions used as probes/reminders as needed.

(Part 1) Contextualizing the therapeutic experience

- What were your original reasons for entering therapy? (i.e. voluntary or involuntary? Dx? Related to sexuality? Etc.)
  - **Probe:** Was this your first time in therapy or had you had prior experiences with it? What were they like?
- What was happening in your life when you began to question your sexuality? (Gen. context; How old were you? Significant life events-- successes/tragedies? In school, working? Etc.)
- Could you name things that initially lead you to question your sexuality? (i.e. events, dreams, crushes, shifts in political views)
- What was your relationship to therapy like? (i.e. Did you enjoy it, dread it?)
  - **Probe:** How would you describe your relationship to *this therapist* in particular? (Warm, cold, inviting, judgmental, like a parent, like a doctor…)

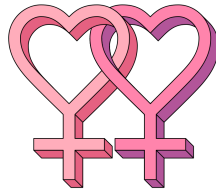**(Part 2) The therapist's reactions to questioning**

- Before you questioned your sexuality, had you already formed an impression of how your therapist felt about non-heterosexual sexuality? (Based on comments, materials in their office, etc.)
  - **Probe:** Did you have an idea of their opinion about *your* sexuality in particular? (Had they been previously affirming of your heterosexuality?)
- Is there a certain way you wished, hoped, or feared that your therapist would react to your questioning?
  - **Probe**: To what extent were these expectations fulfilled/not fulfilled?
- Can you tell me about your therapist's initial reaction(s) to your questioning?
  - **Probe:** What feelings did their reaction bring up for you? (What feelings does it bring up now?)
- *If* you continued working with your therapist, how did you feel when approaching the topic of sexuality?
  - **Probe:** How did your therapist approach or react to this topic as therapy progressed? (Did their position seem to change or stay stagnant?)
- *If* you began to identify as a lesbian while in therapy, can you tell me about your therapist's reaction to this?

○ **Probe**: What feelings did their reaction bring up for you? (What feelings does it bring up now?)

(Part 3) Concluding questions

- What do you think might have been most helpful to you as you questioned your sexuality in therapy?
    - o **Probe:** … And/or to questioning people, and/or to lesbians in general?
- We are nearing the end of the interview. Is there anything else about your experience that you would like to share before we are done?
- Thank you for participating in this study. Do you have any questions to ask of me?

PARTICIPANTS NEEDED FOR

AN EXPLORATORY STUDY OF LESBIANS IN THERAPY!

Are you:

-a LESBIAN

-who has BEEN IN THERAPY

-and QUESTIONED/STRUGGLED WITH heterosexuality while you were in therapy?

If you answered "yes" to all of the above, then you qualify to participate in my thesis research! I am a master's student at Smith College School for Social Work, in the process of finishing up my final year of graduate studies in Brooklyn. I am also a lesbian! For my thesis **I am investigating how therapists responded as clients began to question their sexualities,** and eventually moved toward a lesbian identity. Lesbians who were unsure of their identities when they started therapy are an understudied and underserved population, so by participating in my study you would be contributing to research that might someday be very helpful to people like you!

Should you agree to participate, I will interview about your experiences in therapy via phone/Skype/FaceTime for about one hour. With your permission, audio of the interview will be recorded, and later I will transcribe it with all potentially identifying information about you disguised.

I will be interviewing participants until April 10, and as of now, I still need many more people for my study! If you are interested in participating, feel unsure of whether you qualify, or have any other questions about this study, please contact me using one of the following:

EMILY WILLSTATTER: ███████████████████████

THIS STUDY PROTOCOL HAS BEEN REVIEWED AND APPROVED BY THE SMITH COLLEGE SCHOOL FOR SOCIAL WORK HUMAN SUBJECTS REVIEW COMMITTEE (HSRC).

Emily
January 8 · New York, NY · ☀ ▼

Hello, it's time for me to start recruiting for my thesis, so, you know what that means!

Facebook friends & friends of friends (of friends)! Are you:
-a LESBIAN
-who has BEEN IN THERAPY
-and QUESTIONED/STRUGGLED WITH heterosexuality while you were in therapy?

If you answered "yes" to all of the above, then you qualify to participate in my thesis research! I am a master's student at Smith College School for Social Work, in the process of finishing up my final year of graduate studies in Brooklyn. I am also a lesbian! For my thesis I am investigating how therapists responded as clients began to question their sexualities, and eventually moved toward a lesbian identity. Lesbians who were unsure of their identities when they started therapy are an understudied and under-served population, so by participating in my study you would be contributing to research that might someday be very helpful to people like you!

If you agree to participate, we can meet face-to-face in a private location, or do a Skype/FaceTime/phone interview. Interviews are expected to take about one hour. With your permission, audio of the interview will be recorded, and then destroyed after I have transcribed it for my records. All potentially identifying information about you will be disguised to protect your confidentiality.

If you are interested in participating, feel unsure of whether you qualify, or have any other questions about the study, please contact me through email (since Facebook messages are notoriously buggy):

Otherwise, PLEASE do pass this on to friends & colleagues who may be interested/qualify! Thank you for your support.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

👍 Like   💬 Comment   ➤ Share

biglesbianstudy:

Hello tumblr! Are you:

- **a lesbian**
- **over 18 years old**
- **who has been in therapy**
- **and questioned/struggled with your sexuality while in therapy?**

If all of the above apply to you then you may qualify to participate in my graduate thesis! **I am studying how lesbians recall their therapists reacting to their questioning/leaning toward same-gender attraction.** Please send me an ask or IM if you are interested... Otherwise, please reblog this post to spread it along!

If you choose to participate then I will email you a consent form with more detailed information. You can expect to be interviewed for about one hour, using Skype, FaceTime, Google Hangout, or a simple phone call if you are uncomfortable showing your face for any reason. You can choose to withdraw from the study during the interview if you grow uncomfortable or for any other reason. And, of course, any potentially personally identifiable information about you will be disguised (like names and places where you received treatment). I will keep an audio recording of the interview, which I will transcribe with names altered and later destroy.

I only have until April 10, 2016 to collect my data and I'd like to complete *at least* 3 more interviews by then, preferably more. So, if you're at all interested please do send me a message at your earliest convenience!

A bit more information about me will be available on my FAQ page, but if something is not answered, feel free to ask.

Thanks so much for your support and have a sapphic day! **This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).**