The experience of therapy from the perspective of lesbian couple clients and their therapists

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The experience of therapy from the perspective of lesbian couple clients and their therapists

by

Mary Sue Green

A dissertation submitted to the graduate faculty
In partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Human Development and Family Studies

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Iowa State University
Ames, Iowa
2009

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Dedicated to my mother
Geraldine Mary (Utesch) (McKee) Lockhorst
July 17, 1942 – December 27, 1998

And in memory of my son
Keith Walter Toben
May he now be at peace.
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ACKNOWLEDGEMENTS

This research project would have been impossible without the help of so many people; it is difficult to know where to start. To my research participants—without you this paper would not have materialized. Each of you shared your unique story and experience with me in a selfless manner in order to help others who follow you into the therapeutic realm. For that I am grateful. To my transcriptionists who saved me from carpal tunnel syndrome—thank you for your hours of diligently typing verbatim transcripts from audio tapes that were not always clear. It is sincerely appreciated. To my committee members—I selected each of you for your unique strengths that you would bring to the dissertation process. Your feedback and direction were so beneficial. Thank you.

To my major professor, Megan J. Murphy—your influence in my life goes way behind this dissertation. You challenged me to change and grow as a woman, to see things from different perspectives, and to gain an appreciation of myself as a unique person. I truly believe that I would not be to this point without your firm and caring guidance. A mere thank you does not seem to be enough for someone who has changed my life in so many ways. The best to you always.

To my family—it is difficult to put into words how much each of you means to me. We were truly unconventional when it was mom that left home to go to school. Yet you all supported me in your way. Although I know thank you is not necessary, a special, special thank you to my husband, Perry, who has been with me throughout the turmoil of graduate school. Perry, you learned along with me, was patient when I was not, was grateful when I struggled to be, and was there for our children when I lived far away. You are a special light in my life that I will always cherish.
A thank you to the faculty and staff at Iowa State University—your doors were always open to me whether for celebration or tears. You were there for my graduate journey, as well as for my personal journey through life tribulations. You are the best faculty and staff every and all of those whose life you touch know how special you are.

I conclude with a thank you to my dad. It has been difficult journey since Mom died, but you have continued to be there for me and help me celebrate my life successes and to help heal life’s hurts. The word “dad” means so much more than a biological connection and when people ask who my “real” dad is, the answer is clear—YOU.
ABSTRACT

Lesbian couples often present for therapy for the same reasons as heterosexual couples; however, lesbian couples also have to negotiate societal homonegativity that devalues and marginalizes their relationships. The aim of this study was to explore a common experience of therapy from the perspective of lesbian couples and their therapists. A feminist qualitative method was used to attend to diversity within and among triads, maintain an awareness of the multiple influences on the client-therapist relationship, view the participants in their larger societal context, and consider the power dynamics that are inherent in relationships. Interviews were conducted with seven lesbian clients and five therapists utilizing a semi-structured format to inquire about their experience of therapy and what they thought influenced that experience. The interviews were recorded and transcribed verbatim. Data were analyzed through open and focused coding using a constant comparison method. Themes that emerged from the interview process indicated that the quality of the client-therapist relationship or the therapeutic alliance was central to the therapy process. Participants described working together, a sense of connection, the therapist stance as a non-expert, and the therapist as a professional as concepts that led to a positive experience in therapy. Therapists fostered a sense of connection by attending to the physical environment in their offices, creating emotional safety for lesbian couples via being caring and non-judgmental, and through the appropriate use of humor within the therapeutic context. The therapists took a non-expert stance and positioned the clients as the experts on their own lives and relationships by asking questions and letting clients lead the therapeutic process. Therapist professionalism was noted by clients when there was minimal self-disclosure and when the therapist had knowledge about the issues that lesbian couples experience in their
personal lives and in the broader societal context. Consistent with the feminist idea of multiple influences on relationship dynamics, power was seen as central in the therapeutic context as participants described the relationship between power and the themes that emerged in this study. The results have implications for clinical training programs and continuous self-monitoring by therapists.
CHAPTER 1: INTRODUCTION

Marriage and Family Therapists (MFTs) have an ethical obligation to work with clients in a way that is beneficial to the clients (American Association for Marriage and Family Therapy, 2001). In our ever-changing society, the clients that present for therapy are becoming more diverse. Research has shown that the number of lesbian and gay man (LG) clients that are presenting for therapy is disproportionate to their percentage of the population (Malley & McCann, 2002). There has also been research on what individual LG clients find to be helpful in therapy in terms of therapist qualities. What is less clear is what LG clients have found beneficial in terms of couple therapy.

Many LG couples may not present for couple therapy, but seek therapy as individuals, in part because LG couplehood is invalidated and marginalized in our society (Malley & McCann, 2002; Roth, 1985). The high level of homonegativity in the United States may also negate the option of seeking couple therapy because it is assumed by LG couples that therapists who work with couples may not have the knowledge or training to work with them. This raises questions about therapists and their levels of self-awareness, knowledge, and training in regard to working with LG couples.

It has been proposed that therapists need to be aware of their own biases and prejudices that influence their work with diverse clientele (Bernstein, 2000; Green & Twist, 2005; Plummer, 2001). Training programs are currently being challenged to incorporate information about the LG population into their curriculum; however, we are far from reaching an exemplary level of diversity training in graduate education. It appears that personal experience with the LG population is beneficial in assisting therapists in becoming aware of their biases and prejudices that may influence their therapy practice (Kidd, 2005;
Twist, Murphy, Green, & Palmanteer, 2006). It has also been reported that being supportive of gay men and lesbian human rights is related to comfort level working with LG individuals, couples, and families (Green, Murphy, Blumer, & Palmanteer, 2009).

There are a variety of approaches or techniques that have been delineated for therapists working with lesbian and gay men individuals, couples, and families (e.g., Bigner & Wetchler, 2004; Davies & Neal, 2000a; Davies & Neal, 2000b; Laird & Green, 1996). Affirmative therapy has been suggested for therapeutic work with lesbians and gay men in order to achieve positive therapeutic outcomes (Connolly, 2004; LeBolt, 1999; Simon, 2000). There are basic attitudes that a therapist can incorporate into any model of therapy to make it gay affirmative (Connolly; LeBolt; Simon), which are similar to the “common factors” argument as proposed by Sprenkle and Blow (2004). Sprenkle and Blow postulated that factors common to all therapy models are more influential in achieving positive therapeutic outcomes than any specific model or therapy technique. These common factors include the client, the therapist, and the relationship between the client and therapist (Sprenkle & Blow). Sprenkle and Blow also suggested that therapists think of individuals within their social context and be able to create an alliance with more than one individual. Critics of the common factors approach propose that this idea is too simplistic and that therapists need to think in terms of a multilevel-process model of therapeutic change (Sexton, Ridley, & Kleiner, 2004). This model of therapeutic change addresses contextual variables, as well as the client, the therapist, and the therapeutic relationship (Sexton et al.). Gay affirmative therapy, a common factors approach, and a multilevel-process model of change all propose that the client-therapist relationship or therapeutic alliance is an important factor that contributes to therapeutic outcome.
The experience of the therapeutic alliance may be different for the client than for the therapist (Hatcher, Barends, Hansell, & Gutfreund, 1995). The therapist may believe that a couple’s experience of therapy has been beneficial, whereas the couple did not experience the therapy as beneficial. In addition, the therapist may have no idea what has made the experience beneficial or detrimental for the couple. On the other hand, a couple may leave therapy believing that therapy was beneficial, whereas the therapist may believe the opposite (Doherty & Simmons, 1996). Of course, it may be the client view of whether the therapy was beneficial or detrimental that leads to long-term therapeutic benefits. Positive outcomes of affirmative therapy for lesbian and gay man individuals are similar in many ways to positive outcomes for heterosexual individuals. However, two positive outcomes that are specific to the LG population are gaining more positive views of lesbian and gay sexuality and improved relationships with self and others (Milton, Coyle, & Legg, 2002).

There has been research published in counseling journals about lesbians, gay men, the experiences they had in life, and their experiences in individual therapy. Specifically, there has been research on gay affirmative therapy from the perspective of the client (LeBolt, 1999; Milton et al., 2002) and the therapist (Milton et al.), as well as research about the non-therapeutic experiences of lesbian and gay man couples (Burn, 2000; Burn, Kadlec, & Rexer, 2005; Oswald & Culton, 2003). What seems to be lacking in the research is the experience of therapy from the perspectives of both the LG couple and the therapist. In order for therapists to become informed about their work with LG couples in therapy, it is imperative to explore the couple’s perspective, along with the therapist’s perspective, in order to exhaustively compare and contrast a common therapy experience and the influences on that experience for both the client and the therapist. I say this because if a therapist truly believes that she/he is
working with LG couples in a way that is beneficial to the client couple, when, in fact, it is not experienced that way by the couple, the therapist will continue to practice in the same way with future clients. It is only by continued awareness, self-perusal, and new knowledge that therapists can challenge themselves and their therapeutic practices to improve in ways that are beneficial for the LG couples they serve. Therefore, it is only by studying the perspectives of all members that comprise the therapeutic relationship that we may be able to understand the experience of couple therapy in ways that can result in increasing effectiveness when working with LG clientele. The purpose of this research project was to begin to fill the gap in the current knowledge base about the perspectives lesbian clients and their therapist have about a common experience of couple therapy and what influences those experiences. The specific research questions in this study were:

1. How do lesbian couples and their therapists describe a common experience of therapy?

2. What do lesbian couples and their therapists believe influenced their common experience of therapy?
CHAPTER 2: LITERATURE REVIEW

Introduction

The purpose of the current project was to explore a common experience of couple therapy from the perspective of lesbian couple clients and their therapists. In addition, I explored what influenced the experience of therapy from the perspective of LG couple clients and their therapists. To begin, I want to clarify a few terms. In this paper I refer to sex and gender. Sex refers to the biology of an individual. Gender is a societal concept that includes the ideas of male and female. The participants in this study matched in terms of sex and gender, but this is not always the case. Sexual orientation involves to whom an individual is sexually attracted—members of the same sex, members of a different sex, or both. I believe that sexuality is fluid and not categorical, but for the purpose of simplicity, the sexual orientation category in this study is lesbian. The unit of interest in this study was the couple client and their therapists. Therefore, I use the term lesbian couple client. This term indicates two women who identified themselves as being in a lesbian relationship. When I write about sexual minorities, I include all those whose sexual identity, orientation, and/or behaviors are different than those of the dominant, heterosexual culture.

All therapists have an ethical obligation to provide services to clients that are within the bounds of her or his competency (AAMFT, 2001). The number of lesbian and gay man clients presenting for therapy is increasing and therapists have an obligation to be able to work with this diverse clientele (Malley & McCann, 2002; Plummer, 1995). A therapist brings many influences to the therapeutic relationship including training, knowledge about lesbian and gay man issues, and self-awareness of biases, including homophobia. An important component of therapy is the relationship between the client and the therapist
defined as the therapeutic alliance. The following review of the literature explores ethics, lesbian and gay man clients presenting for therapy, marriage and family therapists’ training and knowledge, therapist self-awareness, the client experience of the therapeutic alliance, therapist qualities that contribute to the client-therapist relationship, and potential barriers to the therapeutic alliance. The section concludes with the rationale for the current project.

Ethics

Virtually all counseling organizations have a code of ethics. The American Association for Marriage and Family Therapy (AAMFT), The American Mental Health Counselors Association (AMHCA), The American Psychological Association (APA), and the National Association of Social Workers (NASW) all have ethical codes that call for mental health professionals licensed under their umbrella to provide assistance without discrimination, provide services that benefit the client, to refer clients to other service providers if they are not able to provide services, and to refrain from providing services that are beyond their professional competence (AAMFT, 2001; AMHCA, 2000; APA, 2002; NASW, 1999).

Homosexuality De-pathologized

Prior to 1973, homosexuality was listed as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a text used by therapists for the purpose of diagnosing and classifying mental disorders. Prior to the change in classification, it was possible that therapists worked with lesbian and gay man clients from the perspective that homosexuality was a pathology or mental illness that needed to be changed or dealt with in a way similar to other mental disorders (e.g., anxiety). Homosexuality was removed from the DSM in 1973; therefore, it is no longer considered a pathology or mental disorder. This
does not mean, however, that mental health professionals or the general population have accepted this depathologizing of homosexuality. In fact, it may have left many professionals in a quandary as to how to best work with lesbian and gay man clients that were formerly considered to be mentally ill.

Over the years, major organizations that represent therapists (e.g., AAMFT, AMHC, APA, and NASW) have included guidelines in their code of ethics that include working within a therapist’s competency with lesbian and gay man clients. Specifically, the AAMFT Code of Ethics (AAMFT, 2001) has ethical principles that address working with clients only as long as it is beneficial to clients (Principle 1.0), not discriminating based on sexual orientation (among other biases; Principle 1.1), providing referrals if a therapist does not feel able to work with clients for any reason (Principle 1.10), receiving continuing education, training, and supervision (Principle 3.1), and working within the boundaries of the therapist’s competency (Principles 3.7 and 3.11). Regardless of the change in thinking about homosexuality as a mental illness, numerous studies have shown that homophobia, homonegativity, sexual prejudice, sexual stigma, and heterosexism continue to be prominent in United States society (Herek, 1994; Yank, 1997). These attitudes could be considered a grand discourse or master narrative that influences individuals in a society; mental health professionals are not immune to these influences (Malley & McCann, 2002). My stance is that therapists have an ethical obligation to either be informed about issues lesbian and gay man clients may face or know when it is appropriate to refer lesbian and gay man clients to someone who is competent working with LG issues.
Lesbian and Gay Man Clients Presenting for Therapy

It has been reported that, based on their numbers in the general population, the number of lesbian and gay man individuals that seek therapy was disproportionately high when compared to the number of heterosexuals that receive mental health services (Balsam, Beauchain, Mickey, & Rothblum, 2006; Cochran, 2001; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2001). Malley and McCann (2002) reported that the number of LG clients presenting for therapy was increasing. As this number increases, mental health providers will continue to have more contact with culturally diverse clientele (Plummer, 1995). In the current homonegative climate, it is not surprising that a disproportionate number of lesbians and gay men seek therapy because of the inherent tensions in engaging in same-sex relationships and the lack of validation for same-sex couplehood (Malley & McCann).

This reported increase in LG clients may be due, in part, to the possibility that the utilization of mental health services is more acceptable in the LG community than in the general population (Morgan, 1992), but it may also be that the LG population has a higher level of psychological distress (Cochran, 2001) or suicidal ideations and behaviors (Balsam et al., 2006). As with any population, there is variance within diversity. For example, lesbians were more likely to present with anxiety disorders than gay men (Cochran, Sullivan, & Mays, 2003). Whatever the reason, the LG population does utilize mental health services, and mental health professionals have an ethical obligation to be able to work with sexual minority clientele or to refer them to others who can.

MFTs Working with Lesbian and Gay Man Clients

In terms of Marriage and Family Therapists, 72% of the clinical members of the AAMFT reported that approximately 1/10th of their clinical practice was with lesbian and gay
man clients (Long & Serovich, 2003). Overall, approximately 80% of MFTs indicated that they work with lesbian and/or gay man clients (Green & Bobele, 1994). Doherty and Simmons (1996) conducted a survey of AAMFT clinical members and reported that only a slight majority of MFTs (54%) felt competent working with lesbians and gay men. There was no mention of what these therapists did with these clients in terms of continuing to work with them or referring them to professionals who were more competent in working with lesbian and gay man clients.

Doherty and Simmons (1996) also reported that approximately 50% of MFTs’ cases were individual clients, 23% were couples, and 12% were families. Self-reported competency for working with these client modalities ranged from 95% to 99% (Doherty & Simmons). There was no breakdown of client modality or therapist competency by the sexual orientation of clients. When asked about client presenting problems, 30.1% of MFTs reported marital problems as a presenting problem, whereas 7.2% reported family-of-origin problems, and 5.6% reported other family problems. There was no breakdown of presenting problem by sexual orientation, so it was unclear what problems therapists were working on with their lesbian and gay man clients whom almost ½ of the MFTs did not feel competent serving.

Another consideration was that the outcome of treatment and satisfaction was not reported by sexual orientation. What was reported was that “therapists’ reports of positive outcomes were somewhat lower than clients’ reports” (Doherty & Simmons, p. 22). In conclusion, approximately 80% of MFTs reported working with lesbian and gay man clients, yet more than 50% reported they do not feel competent working with these clients. Because more LG clients are presenting for therapy and a large proportion of MFTs are working with LG clients, it is imperative that therapists become competent working with diverse clientele.
Through the current project, I add to the literature about the similarities and differences in lesbian couple client and therapist perceptions of a common experience of therapy and the influences on that experience.

**MFTs’ Training and Knowledge**

In a review of major family therapy journals from 1975-1995, Clark and Serovich (1997) found that less than 1% of published articles focused on lesbian, gay man, or bisexual issues. This is disappointing in view of the fact that the number of LG clients presenting for therapy has been increasing (Malley & McCann, 2002). In addition, in a recent survey of AAMFT clinical members, 95% of therapists reported they worked with LG clients, yet only 65% reported learning about sexual orientation issues during graduate training and 46% reported learning during clinical supervision (Green et al., 2009). Shortly after the Clark and Serovich article was published, the *Journal of Marital and Family Therapy* dedicated an entire issue to LG issues (see Issue 26, Volume 4) that covered such topics as lesbian and gay man couples in therapy (Bepko & Johnson, 2000), therapy with lesbian and gay parents and their children (Ariel & McPherson, 2000), and straight therapists working with lesbian and gay families in therapy (Bernstein, 2000). The topic of incorporating sexual orientation and other topics of diversity into MFT training continues to be explored.

**Training, Supervision, and Continuing Education**

A training model put forth by Aponte and Winter (1987) proposed that there are four “areas of expertise” needed by a clinician in order to achieve an effective therapeutic outcome (Aponte & Winter, p. 86). The reported areas included external skills, internal skills, theoretical skills, and collaborative skills. Internal skills referred to the “personal integration of the therapist’s own experiences and self in order to become a useful therapeutic
instrument” (Aponte & Winter, p. 86). A part of integrating experiences and self is becoming aware of prejudices and biases (Aponte & Winter). In the context of therapy training at the time of the Aponte and Winter article, it was stated that training programs often focus on either the technical aspects of therapeutic practice as in the practice of Salvador Minuchin and Jay Haley or clinician personal integration as in the practice of Murray Bowen and Virginia Satir (Aponte & Winter). Many graduate programs now recognize that an optimal training program would incorporate both technical therapeutic skills and personal/interpersonal therapeutic skills.

For new therapists, a good starting point for addressing potential homophobia and heterosexism is in training programs and clinical supervision. Because only 65% of AAMFT Clinical Members in a recent survey indicated they learned about sexual orientation issues in their graduate training, this is a venue that could be utilized to increase competency in working with LG clients (Green et al., 2009). Long and Serovich (2003) implored MFT training programs to address heterosexual bias because of its harmful effects to LG clients, therapist trainees, and therapist supervisors (Long, 1996). Other researchers challenged programs to place a focus on systems of privilege and oppression that define equity and social justice in the client’s life and the larger social system (McDowell, Fang, Brownlee, Young, & Khanna, 2002).

In order to address sexual orientation diversity, the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) has compelled the programs they accredit to include LG issues in their curricula, except when to do so would be against the policies of the institution (e.g., religious-based organizations). According to Long and Serovich (2003), this criterion can easily be met by including articles on LG clients on the
syllabi for a few required courses without actually going in-depth about issues specific to lesbians and gay men. In addition to course material, the supervisors in graduate training programs have an opportunity to talk with therapists-in-training about LG issues in a way that would increase trainees’ self-awareness and competency in working with lesbian and gay man clients. In fact, self-awareness of personal biases regarding these issues could be incorporated into practicum (clinical) competency criteria in training programs.

Researchers in the MFT field have published several articles on how the clinical supervisory relationship can be utilized to explore heterosexism and homophobia in marriage and family therapy training programs (Long, 1996, 2002; Long & Lindsey, 2004; Long & Serovich, 2003). Long and Serovich provided several suggestions for implementing LG issues into clinical and supervisory situations. They suggested that supervisors can:

Encourage students to explore their attitudes about sexual orientation and their level of homophobia. Questions such as the following might be explored in supervision:

Does the supervisee want to work with gay, lesbian, bisexual, and transgendered clients? If not, what are the reasons (lack of knowledge, lack of exposure, disdain)? Is it acceptable for therapists to decline to learn about sexual minority issues? Can a therapist who has moral objections to a client’s sexual orientation work effectively with that client? Might the supervisee with moral objections be interested in undermining same-sex relationships or in changing sexual orientation? How would these motives, if they became a part of the therapy, be violations of ethical codes? (p. 64)

Supervision in training programs is a prime opportunity to increase student therapists’ competencies working with same-sex couples because therapists-in-training are a “captive” audience, and supervisors can have an influence by teaching about diversity issues. Supervision or colleague consultation becomes more self-directed once a therapist is no longer in a training program.
**Personal Development and Experience**

Aside from formal training through training programs and clinical supervision, therapists can also become informed about issues specific to lesbians and gay men by reading gay fiction, viewing films on gay themes (Green, 1996), studying the professional literature that is available (Clark & Serovich, 2003; Laird, 1996), and familiarizing themselves with the daily issues dealt with by LG individuals, couples, and families (Bernstein, 2000; Milton et al., 2002). Personal friendships and experiences with LG individuals, couples, and families influenced a therapist’s comfort level with LG individuals (Herek & Capitanio, 1996; Twist et al., 2006), knowledge about LG issues and concerns (Bernstein; Milton et al.), and support for LG human rights (Green et al., 2009). Therapists can then use themselves as a tool in the therapeutic process as proposed by Aponte and Winter (1987).

**Therapist Self-Awareness and Homophobia**

Few would argue that if a therapist is uncomfortable working with LG clients, she or he should refer the clients elsewhere for services (AAMFT, 2001; Long, 1996). What may be more problematic are those who truly want to be available to LG clients, yet engage in unintentional anti-gay or subtly homophobic behaviors. Training and knowledge about LG issues and concerns can be very beneficial when a therapist is planning to work with lesbian and gay man clients. Training and knowledge, however, do not substitute for personal exploration and self-awareness (Bernstein, 2000). Homonegativity about LG individuals, couples, and families is pervasive in our culture. As members of this homonegative society, therapists are not immune to the influence of the dominant ideas about the LG population (Long & Serovich, 2003); therefore, therapists have a responsibility to be aware of the
prejudices and biases that they bring to the therapy room (Bernstein; Green et al., 2009; Green & Twist, 2005; Kidd, 2005; Plummer, 1995).

In conclusion, therapists can gain knowledge about lesbian and gay man issues, partnerships, and families through coursework, supervision in training programs, consultation with colleagues, and personal experience. If therapists do not believe they have received appropriate training in working with lesbian and gay man clients, they can refrain from doing so. Therapists are able to continue educating themselves in order to work with diverse clients and I would encourage them to do so. Because no one can be exempt from society’s negative messages about same-sex relationships, maintaining vigilance on how these negative influences affect their clinical practice with lesbian and gay man clients is imperative. Therapists can continue to enhance their self-awareness in terms of becoming cognizant of their heterosexist or homophobic biases that may influence their clinical work.

Gay Affirmative Therapy and a Common Factors Approach

There is a paucity of theoretical information on how clinicians should work with LG clients in the therapeutic environment (e.g., Bigner & Wetchler, 2004; Davies & Neal, 2000a, 2000b; Laird & Green, 1996). Several articles do, however, address gay affirmative therapy (Bernstein, 2000; Eubanks-Carter, Burckell, & Goldfried, 2005; LeBolt, 1999; Milton et al., 2002), which is a theoretical perspective focused on how to work with lesbian and gay clients (LeBolt). Those studying gay affirmative therapy have concluded that there are characteristics of the therapist and the therapeutic relationship that make the therapy process gay affirmative (LeBolt). Gay affirmative therapists pay attention to, understand, and validate the experiences of lesbian and gay clients (Davies, 2000; Eubanks-Carter et al.; LeBolt; Liddle, 1996). For example, therapists should have an understanding of the oppression,
discrimination, and harassment faced by lesbians and gay men (Davies; Eubanks-Carter et al.); knowledge about sexual identity development and the coming out process (Eubanks-Carter et al.); and awareness of the benefits of being in a lesbian or gay man relationship (Eubanks-Carter et al.). In addition, therapists who normalize homosexuality and maintain a neutral stance while clients explore their sexuality and relationships are considered to be gay affirmative (Bernstein; Eubanks-Carter et al.; LeBolt). Furthermore, therapists must be aware of the subtle biases that they bring to the therapeutic relationship and how these biases influence their clinical work with their LG clients (Bernstein; Eubanks-Carter et al.). For example, therapists should avoid the assumption that a client is heterosexual (Eubanks-Carter et al.). Finally, therapists must be aware of their own sexual identity development and how that and other experiences influence their clinical practice (Davies). It was suggested that assumptions by and attitudes of the therapist can be incorporated into many models of therapy in a way to make the therapy gay affirmative and, therefore, beneficial for clients (Davies & Neal, 2000a).

Similar to gay affirmative therapy, in the field of marriage and family therapy there is a “common factors” approach that proposed it is not any specific model or technique that influences positive therapeutic outcomes for the client, but factors that all models have in common (Sprenkle & Blow, 2004). These common factors include the client, the therapist, the relationship between the client and the therapist, and emotional experiences (Sprenkle & Blow). In terms of marriage and family therapy specifically, thinking of individuals within their social network, the involvement of more people in the treatment process, and the expanded therapeutic alliance (alliance with more than one individual) are also considered common factors (Sprenkle & Blow). Others say that accepting a common factors approach is
too simplistic and needs to be considered in terms of a model of change (Sexton et al., 2004).
A multilevel-process model of change also addresses contextual variables, the client, the therapist, and the therapeutic relationship (Sexton et al.).

**Therapeutic Alliance**

From the very beginning of the client-therapist relationship the ability to work together influences the therapeutic outcomes for the client (Horvath, 1994). This working alliance or therapeutic alliance evolves through the knowledge, characteristics, and history of both the client and the therapist and is created and maintained through their interactions. Bordin described a working alliance as the “active relational element of all change-inducing relationships” (Bordin, 1994, p. 15).

A strong and favorable therapeutic working alliance is comprised of three essential elements: task, goal, and bond (Horvath, 1994). The therapist and client work together to identify goals, negotiate tasks to reach those goals, and to create an overall partnership (bond) between the client and therapist in order to address the client’s presenting situation (Horvath). Although the collective of task, goal, and bond influences therapeutic outcomes, each element is distinct. First, task involves activities that take place in the therapeutic process. The therapeutic activities must be relevant to both the client and the therapist. In addition, the tasks must be effective and serve as a means to reach a positive solution to the client’s presenting problem. When early collaboration on tasks takes place, the task element of the therapeutic working alliance is highly predictive of therapeutic outcomes (Horvath). The tasks represent the client’s willingness to try new ways of solving problems and must be focused on the negotiated goals of therapy.
The goal element of the therapeutic working alliance is the outcome that is the target of the therapeutic relationship’s collaboration on tasks (Horvath, 1994). The idea is that the client, or client and therapist together identify the goal of therapy. The therapist then uses her or his theoretical interpretation to assist the client in achieving that goal. At times this goal may need to be negotiated as clients are sometimes unclear on what her or his goal may be or what resolution would be beneficial for the situation they are facing. It is important for a therapist to be able to clearly hear what the client would like to achieve and be able to apply a theoretical epistemology in creating tasks to reach the pertinent goal because the therapist’s epistemology serves as a guideline for addressing how problematic situations arise, how they are maintained, and what can create change. It is important that both the client and the therapist place a value on the goal. The collaboration that takes place between the client and therapist strengthens the therapeutic working alliance. Horvath proposed that the element of goal increases between the first and fifth session of the therapeutic relationship and is positively related to therapeutic outcomes.

Through the process of creating tasks and goals, the working alliance element of bond evolves. Bond refers to the reciprocal creation of trust, acceptance, and confidence between the therapist and client (Horvath, 1994). The creation of this therapeutic alliance begins in the first session. Alexander (1988) proposed that at the beginning of therapy, the therapist must present himself or herself as an expert who has credibility. This credibility will be observed by the client through the way that the therapist dresses, speaks, and behaves. During this first session, the therapist should also be able to relay to the client(s) an expectation of positive change (Alexander). This may be especially important when working with lesbian and gay man couple clients because as soon as the first session these clients will be watching for signs
of acceptance (Bernstein, 2000). In fact, Eubanks-Carter et al. (2005) proposed that that this process of looking for a therapist’s homophobic attitudes may begin with the initial phone call. I agree that the quality of the therapeutic working alliance is influenced by the therapist, the client, the interactions in which they engage, and that the early alliance (during the first five sessions) is predictive of therapeutic outcome (Horvath). If the working alliance between the therapist and client is strong, the outcome is more likely to be positive (Horvath).

Client Experience of the Therapeutic Relationship

LeBolt (1999) conducted a qualitative study of gay men and their experience of gay affirmative psychotherapy. Nine respondents participated in individual interviews that lasted between one and one-quarter hours to two hours. Data reduction techniques were used to explore “the essence of each participant’s experience” (LeBolt, p. 358). Member checks were utilized and themes were then extracted to describe the group’s experience as a whole. Utilizing a feminist, phenomenological lens, LeBolt reported that “respondents experienced a sense of connection with their therapist which was often immediate” (p. 359). The respondents described the therapeutic relationship as “comfortable,” “safe,” and “intimate.” The respondents also reported feeling “completely accepted, special, or valued” (LeBolt, p. 359). One participant reported that his therapist was not emotionally supportive or reassuring; however, he went on to say that “that’s what made the internalization [of his strength] possible” (LeBolt, p. 360).

Therapist Qualities

The gay men in LeBolt’s (1999) qualitative study on gay affirmative psychotherapy described their therapists’ personal and professional qualities. Personal qualities that the therapists had in common were that they were “kind, sensitive, concerned, or caring; and
usually as warm or friendly” (p. 359). Therapists’ professional qualities included a nonjudgmental stance that was, at the same time, curious and accepting. In addition, the therapists were attentive and were in the here and now with the client. One participant reported “projection of homophobic stereotypes” (p. 366) and a second participant said his therapist was “empathetic,” but did not “affirm the client’s gayness” (p. 360). Bernstein (2000) proposed that clients will test therapists to determine if they are “patient, nonjudgmental, responsive, and worthy of trust” (p. 449). She continued by saying that if a therapist is heterosexual and working with lesbian and gay man clients, the clients will “have their antennae out for signs of homophobia and heterosexism” (p. 449). The credibility, expertise, and trustworthiness of the therapist continue to play a role as therapy moves into Alexander’s (1988) motivational stage of therapy. This is the stage of therapy wherein a client becomes motivated to create change (Alexander).

*Therapeutic Change*

It is generally acknowledged that therapists and clients must have a strong therapeutic working alliance in order for change to take place through the therapeutic relationship. The level of bond in the therapeutic relationship may influence the client’s ability to accept challenges from the therapist during the motivation to change phase of therapy. The challenges must take place in a caring, thoughtful way and the therapist must be able to assess when the client is able to accept challenges (Horvath, 1994). “When the therapist confronted the client, s/he did so ‘gently’ and respectfully,” said a participant in LeBolt’s (1999, p. 361) study of gay men in therapy.

When working with LG couples it is also important to validate their relationship. Respondents in the Milton et al. study (2002) suggested that therapists need to have
experience in and knowledge about LG relationships. When working with couples, it is also important not to attempt to make change in one partner, but to facilitate change in the relationship (Horvath, 1994). It is especially important for heterosexual therapists working with LG couple clients not to rely on stereotypes to characterize same-sex relationships.

*Potential Barriers or Enhancers to Therapeutic Alliance*

It is difficult to determine what the potential barriers or enhancers would be in developing a quality therapeutic alliance with LG couples. Each client and therapist brings unique characteristics, experiences, and ideologies to the therapeutic relationship. What follows is a brief exploration of the factors that the client and therapist bring to therapy that may influence the creation, maintenance, and quality of a strong working alliance. These factors include the sex of the therapist, the sexual orientation of the therapist, the therapist’s disclosure of her or his sexual orientation, the intersection of therapist sex and sexual orientation, the therapist’s religious beliefs and practices, the client’s sexual identity development, and the intersection of these variables.

*Sex of the Therapist*

Sex has been a hidden dimension in the therapeutic process since couple and family therapy began (Walsh & Scheinkman, 1989). Early models did not attend to differences between sexes and, therefore, were missing an organizing principle of human experience. Feminists have critiqued early models of therapy for their lack of attention to sex and other diversity variables (e.g., race, sexual orientation). Therapists working within a feminist framework not only attend to sex as an organizing principle, they remain aware of gendered influences on social and personal relationships, including the relationship between clients and therapists. When a therapist used basic feminist principles in her or his therapy practice, men
developed a stronger therapeutic alliance with the therapist and the women did not experience an unfair advantage (Werner-Wilson, Zimmerman, Daniels-Carlson, & Bowling, 1999). In other words, adopting a feminist stance benefitted the therapeutic alliance in couple therapy. A feminist perspective promotes awareness of gender and power relations and has been expanded to include multiple forms of diversity (Walsh & Scheinkman).

Odell and Quinn (1998) explored whether therapist sex influenced first-session behaviors, the impact of the session on the client, and the length of treatment. They found that the sex of the therapist did not influence any of these variables; however, clients tended to be more cooperative with women therapists. Similarly, Jones, Botsko, and Gorman (2003) reported that working with a woman therapist was predictive of therapy sessions being rated as beneficial by lesbian and bisexual clients when compared with working with a man therapist. It is unknown if the women therapists in the Jones et al. study utilized a feminist framework in therapy. Given what we know about the influence of sex on therapeutic alliance and level of client cooperation in the first session, the question then becomes: how does the sex of the therapist influence the relationship between a same-sex couple and their therapist?

Milton et al. (2002) conducted a qualitative project that included lesbian and gay man clients and therapists and explored affirmative psychotherapy for underlying thematic content. A factor that emerged was the sex of the therapist. The results, however, were mixed. Some respondents believed the sex of the therapist was important, whereas others did not. Because of the socialization differences between sexes, it is not surprising that men and women therapists would bring different characteristics to the therapeutic relationship (Milton et al.). A [gay man] client said, “I felt I could perhaps talk a bit more openly with a man, and
talk about my homosexuality more to a man than I could to [a woman]” (Milton et al., p. 180). In contrast, a gay man client may choose a woman therapist because “he wanted some sort of mothering in a way, some supporting” (Milton et al., p. 180). Therefore, the influence of sex on the working alliance with gay men clients is unclear and there may be other factors that have more of an influence on the quality of the relationship between a gay man client and his therapist.

Sexual Orientation Matching

There is a dearth of information in the original therapeutic working alliance literature and phase of therapy literature about sexual orientation matching between a therapist and her or his clients. It has been reported that 41% of lesbian and gay man clients intentionally chose lesbian, gay man, or bisexual (LGB) therapists (Liddle, 1997). This means that 59% percent either chose heterosexual therapists or had no choice about choosing a lesbian, gay man, or bisexual therapist because LGB therapists were not available in their area.

One aspect of the first phase of therapy is instilling hope (Alexander, 1988). A [lesbian] therapist participant in the Milton et al. (2002) study stated that when an out lesbian or gay man therapist is working with a lesbian or gay man client it may provide “hope that negative views of lesbian and gay man sexuality may be overcome” because an out therapist may make being queer a “slightly better thing” than the negative, pathologizing perception of society (Milton et al., p. 181). An opposing view is that LG clients can benefit from having a “straight person who is on my side” (Milton et al., p. 180). In fact, it may be that the sexual orientation of the therapist does not influence therapy (Moran, 1992). What may be more important than sexual orientation matching is sexuality self-exploration by the therapist. A [gay man] therapist participant in the Milton et al. study proposed that:
Any therapist will need to have explored their own sexuality – probably important for any gay therapist to have explored their heterosexuality and probably for any heterosexual therapist to have found at least a small part of themselves that might loosely be described as gay. (p. 181)

Another gay man client agreed stating that it was important that “the therapist has spent some time exploring their sexuality” (Milton et al., p. 181). Bernstein (2000) concurred in her article that directly addressed creating a working alliance with lesbian and gay man clients. She said, “For straight therapists, cultivating client trust and learning to be trustworthy involve continuous self-monitoring for homophobia and heterosexism in both one’s therapeutic model and one’s personal assumptions and values” (p. 447). By these expressed ideas, it may be that sexual orientation matching is an individual preference on the part of the LG client.

*Disclosure of Sexual Identity*

Bernstein (2000) suggested that for straight therapists who are working with lesbian and gay clients, “raising the issue of sexual orientation in the first session is a critical step in creating a therapeutic relationship that is based on openness and conducive to building trust” (p. 448). A gay man therapist in the Milton et al. (2002) study agreed that it was important for the therapist to know about the client’s sexual identity early in therapeutic relationships so it could be considered during the therapeutic process. A second therapist stated his belief that it should be the client’s decision on whether or not to raise the issue of her or his sexuality. Gay man clients have mixed opinions about early disclosure of their sexual identity. One client stated that he needed to talk about his sexual identity early in the therapeutic relationship, whereas a second client stated that it was risky for him to look at his
sexual identity (Milton et al.). In addition to disclosure of client sexual identity, disclosure of the therapist’s sexual orientation could also be considered.

Out of 14 therapists in the Milton et al. (2002) study, only one therapist stated that the therapist must always be explicit about her or his sexuality when dealing with LG clients. The rest of the therapists hesitated to embrace an all-or-nothing stance. They felt that it was important to consider disclosing therapist sexual orientation and when it would or would not be beneficial for clients. For example, a gay man therapist stated that he thought it would not be therapeutic to disclose his sexual identity to LG clients who were ambivalent about their own sexual orientation. A second gay man therapist concluded that “a shared sexuality does not guarantee a similarly of experience and does not automatically confer a shared understanding” (Milton et al., p. 184).

Intersection of Sex and Sexual Orientation

Creating and maintaining strict categorical delineation between the influence of sex and sexual orientation and their influence on the therapeutic alliance is difficult. Categories are fluid and dynamic with individuals seldom fitting completely into one category (McCall, 2005). Liddle (1996) explored the intersection of sex and sexual orientation of the therapist and its relationship with ratings of helpfulness by lesbian and gay man clients. Incorporated into her study was whether or not a therapist disclosed her or his sexual orientation to clients. Liddle reported that therapists who self-identified as a gay man, lesbian, bisexual man, bisexual woman, or heterosexual woman received higher ratings of helpfulness by lesbian and gay men clients than therapists who had not disclosed their sexual orientation. This adds a layer of complexity to teasing out the influences of sex and sexual orientation on therapeutic alliance because heterosexual women therapists were found to be as helpful as
lesbian and gay man therapists. It appears, therefore, that there are mixed results overall regarding the sex and sexual orientation of the therapist, as well as the intersection of the two, in terms of helpfulness as perceived by the client.

*Religious Beliefs and Practices of the Therapist*

An often unstudied potential barrier to the therapeutic alliance is the religious beliefs and practices of the therapist. A common sense approach would state that if a therapist had a high level of religious beliefs and practices she or he would consider homosexuality to be wrong and, possibly, a sin. A common sense approach, however, is a simplistic way of saying “we don’t know.” Current research has reported a relationship between fundamentalist religious denominations and higher levels of sexual prejudices, as well as a relationship between frequent attendance at religious services and a higher level of sexual prejudice when compared to those individuals who identify as non-religious individuals or are members of liberal denominations (Herek & Capitanio, 1996). Some organized religions espouse a “love the sinner, hate the sin” philosophy (Rosik, Griffith, & Cruz, 2007). Religions are comprised of three components: authoritarianism, fundamentalism, and religious beliefs (Laythe, Finkel, & Kirkpatrick, 2001). Authoritarianism includes high levels of submission, aggression, and conventionalism. Fundamentalism is defined as narrow-mindedness and an inability to consider multiple viewpoints (Kellstedt & Smidt, 1991). When considering religious beliefs, attention must be given to individual values (Vicario, Liddle, & Luzzo, 2005). More frequent attendance at religious services and placing a higher value on obedience were related to more negative attitudes towards lesbians and gay men. Broad mindedness and imaginativeness were related to positive attitudes towards lesbians and gay men (Vicario et al.). A recent study to be published in the *Journal of Homosexuality* reported that a higher level of
religious practices by therapists was completely mediated by a higher level of support for
lesbian and gay man human rights (Green, Murphy, & Blumer, in press). Therefore, the
relationships between the religious beliefs and practices of the therapist and their influence
on working with LG clients are complex and require further study.

**Sexual Identity Development**

The final potential barrier to creating a strong therapeutic alliance is homosexual
identity development, also discussed as a model for the coming out process. First,
heterosexuals also have a sexual identity development process. This is a process that most are
familiar with and involves developing an interest in different-sex relationships. As pre-
adolescents, most children engage in same-sex friendships and activities. As a child moves
into the pre-teen/teen years, she or he begins to engage in more mixed-sex activities, which
eventually leads to an interest in different-sex dating (Galambos, 2004). This process is
different for lesbian and gay male adolescents and three linear models and one non-linear
model of sexual identity development are discussed.

*Linear models of sexual identity development.* Three major linear models of
homosexual identity development have been proposed by Cass (1979), Coleman (1982), and
Troiden (1989). Cass proposed a six-stage theory, Coleman proposed a five-stage coming-out
model, and Troiden embraced a four-phase representation of homosexual identity
development. The theories as discussed here assume sexual identity development in terms of
adolescents. Females and males may enter these stages at different ages and experience the
stages differently (Blumenfeld, n.d.). In addition, some stages may not be entered until
adulthood.
The three linear models of homosexual identity development agree that at some point lesbian and gay man individuals begin to experience a sense of differentness when they compare themselves to their peers (Troiden, 1989). During early adolescence, they enter a phase of identity confusion when they become aware of feelings of affection and/or attraction for individuals of the same sex (Cass, 1979; Coleman, 1982; Troiden). Eventually, the adolescent moves to a stage that Troiden terms identity assumption. This stage of homosexual identity development incorporates the identity tolerance and identity acceptance phases as outlined by Cass and parallels the coming out phase as described by Coleman. During this identity assumption phase, individuals begin to have contact with other lesbians and gay men. They may believe that they are homosexual, yet hesitate to identify as a lesbian or as a gay man because of societal messages, discrimination, or fear of rejection by friends and family. During this exploration phase, Coleman suggested that many who do not develop a more positive self-image may experience a developmental lag that is not addressed until after adolescence. If experiences with other lesbians and gay men are positive during this time, individuals are able to move toward identity acceptance (Cass).

As they assume a homosexual identity, lesbians and gay men move further into the lesbian and gay community and become more comfortable with their sexual identity (Cass, 1979; Coleman, 1982; Troiden, 1989). It is at this point that lesbian and gay man adolescents may enter their first relationship (Coleman; Troiden) and a sense of identity pride begins to develop (Cass). During this stage of identity pride, lesbian and gay man youth begin to adopt an “us-versus-them” mentality, reject heterosexuals and their institutions, and may become active in trying to eliminate homophobia through education and political change (Cass; Troiden). They disclose their sexual orientation to more people and begin to move toward
integrating their public and private identities into a unified self-image (Cass; Coleman; Troiden). This integration of identity may be a life-long process.

*Non-linear model of sexual identity development.* Other researchers have proposed a non-linear model of sexual identity development. D’Augelli (1994) proposed that sexual identity development is inherently personal, but takes place within a sociopolitical context. A variety of factors influence sexual identity development and these factors vary by individual, social situation, culture, and historical time (D’Augelli). In his developmental model of sexual identity development, D’Augelli identified six interactive processes that are involved in lesbian and gay man identity development. These processes are interrelated and are in various combinations throughout an individual’s life.

In the process identified as exiting heterosexual identity, an individual must recognize that her/his feelings and attractions are not heterosexual in nature and must begin to share with others that they are a lesbian or gay man (D’Augelli, 1994). During the development of a personal lesbian or gay man identity status, a person experiences a sense of stability that summaries her/his thoughts, feelings, and desires. Part of this process is challenging internal myths about what it means to be a lesbian or a gay man (Evans, Forney, & Guido-DiBrito, 1998). Another process is becoming a lesbian or gay offspring by disclosing to parents and beginning to define the parent-child relationship after this disclosure (D’Augelli). This renegotiating of the parent-child relationship can be difficult and may take a long time. Evans et al. proposed that this may be especially difficult for college students who are reliant on the financial support, as well as emotional support, of their parents while they complete their education.
During the sexual identity process, individuals develop a lesbian or gay intimacy status (D’Augelli, 1994). This is more difficult for lesbians and gay men when compared to heterosexuals because of the invisibility of lesbian and gay man couples in our society (Evans et al., 1998). Some individuals will make a commitment to social and political action as part of their sexual identity development (D’Augelli). Other individuals may never make a commitment to social and political action because of the personal risk involved such as discriminatory practices (Evans et al.). For example, by becoming socially or politically active, lesbians and gay men may face losing their current employment because there is no protection via anti-discrimination policies or laws (Blumer, 2008).

A final thought on sexual identity development comes from a social constructionist perspective. From this perspective, Horowitz and Newcomb (2001) proposed that the process of sexual identity development is an interactive process and individuals construct their sexual identity using their social context. This process is interactive and ongoing. They discussed three separate categories of sexual desire, behavior, and identity; separating these categories “releases homosexuality from solely a sexual preference” (Horowitz & Newcomb, p. 15). This may help us to understand the complexity in self-identification such as Latino men who identify as heterosexual, yet have sex with other men (Morales, 1996).

There is a dearth of literature on how homosexual or sexual identity development may influence the therapeutic alliance. Sexual identity development may influence the working alliance with lesbian and gay couples on two levels. First, the developmental level of the individuals in the relationship may be different. For example, one person may be at a phase in which she/he has integrated the public and private selves and is easily able to disclose her/his sexual identity to others, whereas the partner may be at a point where she/he
has acknowledged that she/he is homosexual and has entered a same-sex relationship, yet are just moving out of a phase where she/he is able to “tolerate” that she/he ia a lesbian or gay man. These differences in sexual identity development may be key in exploring what is happening in the couple’s relationship. Gay affirmative therapy proposed that therapists must be aware of LG issues such as sexual identity development and coming out in order to work effectively with LG individuals, couples, and families.

The second level in which sexual identity development may influence the therapeutic working alliance involves the therapist’s stage of sexual identity development. Therapists who want to work effectively with lesbians and gay men must be aware of homosexual identity developmental models and other lesbian and gay man issues (Bernstein, 2000; Connolly, 2004; LeBolt, 1999). They also need to be aware of their own sexual identity development and how their own developmental stage may influence their clinical work with lesbian and gay man clients. It is generally accepted that sexuality is fluid, therefore discrete categories of homosexual and heterosexual do not exist. Therefore, a heterosexual therapist needs to consider if there is even the smallest part of her or him that is not heterosexual. If they have not considered this proposition, they may unintentionally assume a position of heterosexual sexual identity development and/or not attend to the sexual identity development of their clients and its influence on their clients’ relationship or the therapeutic relationship. In addition, a non-heterosexual therapist needs to remain aware of her or his own sexual identity development because if they, for example, are in a phase of identity tolerance, that may influence their ability to work compassionately with lesbian and gay man clients.
Intersectionality

Processes in relationships are complex; therefore, we cannot look for simple understandings of these complex processes. Instead of any one factor being an influence on the client-therapist relationship, it is more likely that the intersection of factors is exerting influence. The intersection of any of the variables discussed previously may provide an understanding of the influences on client-therapist relationships (e.g., sex and sexual orientation; sexual orientation and religious practices, etc.).

Therapeutic Alliance Summary

Therapists have the responsibility of creating and maintaining a warm, supportive environment for the client (Horvath & Luborsky, 1993; Rogers, 1946) through an understanding of LG issues (LeBolt, 1999; Milton et al., 2002), maintaining a nonjudgmental stance (LeBolt; Milton et al.), and attending to the social context of their LG clients (Malley & Tasker, 1999). Failing to do so not only threatens the therapeutic working relationship, it also leads to inadequate, homophobic, and potentially abusive practices (Green et al., 2009; Malley & McCann, 2002; Malley & Tasker). Therapists must be aware of their biases in order to facilitate a strong therapeutic alliance with clients that can result in a positive therapeutic outcome.

Current Project

Therapists have an ethical obligation to work with clients within their competencies as a therapist. More lesbians and gay men are presenting for therapy and therapists have a professional obligation to be prepared to work with this clientele. The research literature has shown that the relationship between the therapist and the client is important in obtaining positive therapeutic outcomes. Therapist qualities that LG clients have found beneficial are
the therapist adopting a nonjudgmental stance, knowing about LG issues, and knowing about their own sexuality. Therapists agreed that these qualities are important in order to obtain beneficial outcomes for LG clients. Studies have explored the client’s perception of a therapy experience and the therapist’s perception of a therapy experience. What has not been explored is a common experience of therapy from the perspective of both the lesbian couple clients and their therapists. The purpose of this study was to bridge this gap in the literature by exploring a common experience of therapy from the perspective of the lesbian couple client and their therapists. The research questions explored in this qualitative study were:

1. How do lesbian couples and their therapists describe a common experience of therapy?

2. What do lesbian couples and their therapists believe influenced their common experience of therapy?
CHAPTER 3: METHODOLOGY

The purpose of this research was to hear the voices of LG couple clients and their therapists about the influences on a common experience of therapy; however, no gay men volunteered to participate. Studying couples through a feminist qualitative paradigm provides an opportunity for researchers to study the couple unit while making space for diversity within and among couples (Daly, 1992; Thompson, 1992). By exploring couples as a unit, researchers can get a richer account of the couples’ experience and all the resulting contradictions that arise when hearing multiple perspectives (Daly; Valentine, 1999). In addition, a feminist perspective can help connect the personal experiences of lesbian couples to the larger societal context and challenge traditional concepts and assumptions about lesbians and their relationships (Thompson). It is important to connect their experience to the larger societal context because of the homonegativity and homophobia in our communities.

In addition, a feminist paradigm attends to issues of power that provided me with an opportunity to attend to the influence of power on the experience of therapy and within the researcher-respondent relationship. The few qualitative studies that have focused on therapy with LG clients explored the experience from the perspective of individuals or the perspective of therapists. This study closes a gap in the literature by exploring a common experience of therapy from the perspective of lesbian couple clients and their therapists through a feminist qualitative lens.

Feminist Qualitative Paradigm and Therapy Research

As a challenge to dominant positivistic paradigms, the qualitative paradigm came forth in what Sprenkle and Piercy (2005) called the third trend in family therapy research. Qualitative research on family therapy can record in more detail the subtleties and
complexities of therapy (Atkinson, Heath, & Chenail, 1991). Feminist ideology and qualitative research are complementary in the field of family therapy research. If therapists want to be able to navigate in culturally diverse worlds (Plummer, 1995) and use culture as a central principle for practice (Laird, 2000), they can choose to adopt a feminist stance. Although different theorists refer to this stance in different ways (e.g., not knowing, non-expert), what it means is that the therapist is aware of the impact of her or his own biases and assumptions and how they influence the therapy they provide.

Feminist: Researcher and Therapist

From a feminist family therapy perspective, Whipple (1996) qualitatively explored how therapists developed a feminist identity; five major themes emerged in her study that had been proposed by earlier researchers. The first theme was the nonhierarchical relationship between the therapist and the client. Second was the idea that gender and gender messages can be a topic in feminist family therapy. Third, feminist family therapists supported and promoted egalitarian couple relationships rather than male-dominated relationships. Fourth, empowering clients to make changes in their lives was a goal of feminist family therapists. Finally, the fifth theme that emerged was affirming women while addressing oppression with both sexes (Whipple). These are not new ideas in feminist family therapy as nonhierarchical relationships (Avis, 1991; Oakley, 1981), gender and sexual orientation (Hare-Mustin, 1987), egalitarian relationships (Goldner, 1989), empowerment (Walters, Carter, Papp, & Silverstein, 1988), and affirmation (Heriot, 1983) have been explored by feminist pioneers in feminist family therapy. The focus of feminist family therapy is attending to power within the client relationship and also between the client and
the therapist. The feminist themes expressed here are similar to the themes associated with feminist research methodology.

Feminist researchers attend to the relationship between the researcher and the respondent (Bloom, 1998; DeVault, 1996; Oakley, 1981; Reinharz, 1992) in part by using reciprocal questioning during the interview process (Oakley). Reciprocal questioning refers to a researcher-respondent relationship in which each can ask questions of the other. In other words, the researcher asks the respondent questions and the respondent is also able to ask the researcher questions. This sets up a nonhierarchical, more egalitarian relationship because a researcher is “prepared to invest her own personal identity in the relationship” (Oakley, p. 41). Feminist researchers also pay attention to the topics of power, gender, gender identity, class, race, and sexual orientation while empowering respondents in ways that can create social change (Reinharz).

Feminist Methods and Methodology

Feminists have found interviewing to be a way of gathering information about the experiences of respondents (Oakley, 1981; Reinharz, 1992). They do not embrace traditional, positivist ways of conducting interviews which involve the researcher being an objective gatherer of information with power and the respondent being a subject to be studied (Reinharz). Instead, feminist researchers view the interview as an opportunity to engage in a reciprocal interaction with respondents (Bloom, 1998; Oakley; Reinharz). Feminist researchers learn to listen in a way that reveals emotions and provides us with openings for asking questions that will garnish a richer dialogue (Anderson & Jack, 1991; DeVault, 1990).
Assumptions about Respondents

A number of factors influence how researchers conduct qualitative research interviews. When conducting research that involves understanding experiences through the respondents’ “meaning frame” (Hollway & Jefferson, 2005, p. 155), a feminist researcher must be aware of her or his assumptions about respondents. These assumptions are seldom thought about consciously or thought of in terms of how they influence the interview questions, the interview process, or the interpretation of data. Some of the common assumptions about respondents discussed by Hollway and Jefferson include the idea that the respondent shares meanings with the researcher, is knowledgeable about her/his experience (actions, feelings, relations), can access knowledge accurately (accurate memory), and can translate this knowledge to the researcher.

Interview Location

In addition to assumptions about respondents, there are also practicalities involved in interviewing research respondents. Although the location can vary, it is important to have a location that is as quiet as possible (Esterberg, 2002). It is also imperative to take into account the subject matter and consider where the respondents would be the most comfortable. However, the first decision regarding the location of interviews is to decide who will make this decision—the researcher or the respondent. This decision should be “examined within the social context of the study being conducted” (Herzog, 2005, p. 25). Because interviews take place in many aspects of our lives, they have become a “social event” (Herzog, p. 26) in which “the parties negotiate the social definition of the interview situation” (Herzog, p. 27). The researcher and the respondent are both influenced by multiple subjectivities including gender, race, class, and sexual orientation that influence the interview
experience (Herzog). Each of these subjectivities contributes to the power dynamics between the researcher and respondent. In addition, there is intersubjectivity (Bloom, 1998) in that there are reciprocal interpretations of the other person and her/his behavior within the interview context. In other words, the respondent interprets the researcher and her/his behavior at the same time that the researcher is interpreting the respondent and her or his behavior (Herzog).

Herzog (2005) proposed that the researcher, from her position of power, needs to be flexible in terms of the interview location. The interview location that is chosen by the respondent not only reflects the “attitudes, tactics, and negotiations” (Herzog, p. 28) of the respondent within the research power structure, but also reflects a “symbolic dialogue” with the researcher (Herzog, p. 29). Interviews can be held in the researcher’s office, a laboratory setting, a public place, or in the respondent’s or researcher’s home (Herzog). Ideally, the location should provide peace and privacy. When interviews are being tape recorded, background noise can make a tape difficult to transcribe. Privacy is required, especially if the topic is one that is likely to produce emotional responses or be of a sensitive nature (Herzog).

When discussing topics that are emotional, sensitive, or private, interviews can take place in the respondent’s home (Bennett & McAvity, 1985; Herzog, 2005). When respondents are in a familiar setting, it can offer a sense of “intimacy and friendliness” (Herzog, p. 27). A potential ethical concern is that a sense of security and intimacy would “lull some [couples] into disclosing more about themselves than they had originally planned” (LaRossa, Bennett, & Gelles, 1985, p. 101).
Interviewer-Interviewee Relationship

In addition to who decides the interview location, an interview is influenced by the researcher-respondent relationship. A feminist paradigm takes into consideration issues of power in all relationships. Thinking in terms of interviews in general society, there are inherent power differences between the interviewer and interviewee. For example, in the employer-employee and physician-patient relationships, the employer and physician have more power than the employee and patient. The same can be said of the researcher-respondent relationship in the world of research with the researcher potentially having more power than the respondent. The researcher-respondent relationship, however, is complex and it was suggested that researchers not fix themselves “in a permanent position of power” (Bloom, 1998, p. 40). The influence of power differentials on the research process is “subtle and complex” (McCorkel & Myers, 2003, p. 199) and it is necessary to understand how they influence our interactions with each other (Bloom). One way to attenuate this power differential is to embrace a “we” relationship that is more collaborative in nature (Oakley, 1981).

There is debate about whether or not researchers can develop a full “we” relationship with respondents. Oakley (1981) proposed that feminist researchers must develop a “we” relationship in order to challenge a patriarchal model of research, yet others proposed a balance wherein when asked, researchers share personal information with respondents in order to be seen as a “thou” by the participant, yet find a balance that does not lead to a domination of the researcher’s experience in the interview process.
Therapist versus Researcher Role

Interviewing in qualitative research has often been referred to as pseudo-therapeutic as research respondents are often sharing intimate information with the researcher in a safe and comfortable environment (Bennett & McAvity, 1985; LaRossa et al., 1985; Valentine, 1999). Respondents may look to the researcher as a person who can answer questions about their lives or experiences or as someone who can provide guidance. During conjoint interviews, researchers may be seen as having a therapist role (Bennett & McAvity; LaRossa et al.) and there could be an expectation that the researcher will act as mediator during any conflicts or disagreements (Valentine). This view of the researcher as therapist may also induce the respondents to “disclose much more intimate information” to the researcher than if they saw the researcher as only a researcher (LaRossa et al., p. 103). Because researchers may be viewed as a pseudo-therapist, researchers are often cautioned against placing themselves in this delicate situation by maintaining objectivity and distance from their respondents (LaRossa et al.). From a feminist perspective, this distance and objectivity is not necessary (Oakley, 1981; Reinharz, 1992). Feminist researchers have the opportunity of “locating themselves in the middle ground between stranger and friend” (Bloom, 1997, p. 111). Oakley strongly suggested that the researcher-respondent relationship is much more than an objective undertaking and that disclosing information to research respondents is not only appropriate, but necessary in order to reduce potential exploitation. The researcher-respondent relationship can and should resemble a friendship in that there will be reciprocity in information sharing (Oakley).

From a feminist perspective, the therapist and client co-construct meaning in the therapy room (Dahl & Boss, 2005). Similarly, the researcher and respondent co-construct
meaning during the interview process. Feminist therapists are more likely to practice in a collaborative manner and often maintain a stance of transparency, sharing aspects of themselves with their clients.

The Interview Process

When studying families, the unit of study can include couples, triads, or the entire family. Researchers then need to make a decision about what family members will be interviewed and whether they will be interviewed together or separately. The next section explores the benefits and potential consequences of the conjoint interviewing of couples as opposed to individual interviews.

Traditional Interviews with Couples and Families

Traditionally, when information has been gathered regarding couple or family experiences, one person was chosen to be interviewed. The person chosen was often the woman for a number of reasons. First, the woman was thought to have a greater “knowledge” about couple and family life or she was chosen because she is viewed as the spokesperson for the couple/family (Valentine, 1999). Second, the woman was thought to be more available and more willing to be interviewed than the man (Allan, 1980). It should be obvious that difficulties arise when exploring the experience of diverse families, for example same-sex couples, as there is no way to differentiate between the individuals via sex.

From a family systems perspective, a family (or couple) needs to be thought of and studied as a whole because of the mutual influence that takes place in the system (Whitchurch & Constantine, 1993). Although the idea of studying families as a whole has been proposed since family systems theory and other families theories have been introduced, research on conjoint interviewing of family members is less plentiful. Allan (1980) became a
proponent of conjoint interviewing when it proved to be beneficial during his research on family patterns of sociability. His seminal piece listed several advantages and disadvantages of conjoint interviews; he cautioned that he was not “claiming that interviewing husbands and wives jointly is inevitably superior to interviewing them individually,” but that there are times when conjoint interviews are beneficial (Allan, p. 206).

Interviewing Together or Separate

There are pros and cons to interviewing couples together versus interviewing them individually. The first consideration is the unit of study. For the current research, I explored the experience of couple therapy and considered the couple and the therapist as the unit of study. For reasons that are outlined below, I chose to interview the therapist individually and the client couple conjointly.

Advantages

One benefit of interviewing a couple together is that a richer, more detailed account can be gathered (Valentine, 1999) and partners will stimulate their partner either subtly or by demand (LaRossa, 1978). Conjoint interviewing can also result in the production of more symbolic and emotional material (Bennett & McAvity, 1985) and partners have the opportunity to challenge each other’s versions (Valentine). When interviewing couples, the couple tends to negotiate and mediate the information they provide to create a single collaborative account (Valentine). This blended view assists the couple in creating a “we identity” (Hertz, 1995, p. 437), which may be especially important when working with same-sex couples as it serves as a way to validate their partnership in a way that is seldom done in the larger societal context.
In addition to negotiation and mediation, interviewing couples together elicits expanded information (Allan, 1980; Bennett & McAvity, 1985). This expanded information includes validation and corroboration of each other’s memories, ideas, and opinions, as well as clarification of differences and contradictions (Allan; Bennett & McAvity). When separate interviews are conducted, contradictions and differences in partner stories often do not emerge until after data collection and it is often too late to clarify or rectify the stories (Hertz, 1995). By interviewing couples together, a researcher is able to observe the processes that are used to negotiate a shared meaning (Valentine, 1999) and the interactions (verbal and nonverbal) that take place (Allan; Valentine). These processes and interactions provide additional material for exploration and analyses (Allan).

**Disadvantages**

Interviewing couples together can be challenging for researchers. Researchers need to pay attention to interactions (Allan, 1980), body language (Valentine, 1999), and gestural cues (Allan) that may imply disagreement or discomfort on the part of the partner who is not currently talking. Not all partners may be able to directly challenge their partner when their experience or ideas contradict the story being told (Boeije, 2004). Some partners use protective or defensive communication strategies when their partner is present, but will use an offensive strategy when their partner leaves the room (Boeije). A researcher must also be prepared for having a situation wherein one partner may try to dominate the conversation (Allan) or try to put their story forth as the “right” story (Hertz, 1995, p. 437). This situation may be offset by the value of couples developing a “division in remembering” in which partners ask the other to share something because they believe their partner tells it better (Hertz, p. 437).
Interviewing couples together can also provide a challenge to researchers because they need to build rapport with two people instead of one (Allan, 1980). It has also been discussed that couples may not want to share their views (Valentine, 1999) or may not have the freedom to express emotional conflict (Hertz, 1995) if their partner is present. When working with couples there is also the potential challenge that the couple will have divergent views and conflict and expect the researcher to act as mediator (Valentine, 1999). These divergent views or contradictions can provide a rich source of information (Allan, 1980; Bennett & McAvity, 1985). A final challenge when interviewing couples together is the potential lack of confidentiality (Allan; LaRossa et al., 1985) and/or privacy (Hertz, 1995).

Informed consent and issues of confidentiality are challenges when a researcher decides to conduct conjoint interviews. Informed consent is a central ethical consideration in research. Through the informed consent document researchers inform respondents about the potential risks and benefits of participating in the research (Diener & Crandall, 1978). In addition, it needs to be made clear to respondents that they can withdraw from the research at any time. LaRossa and colleagues (1985) talked about “special contingencies” regarding informed consent when working with families within a qualitative paradigm (p. 98) because it is difficult to maintain confidentiality when conducting conjoint interviews.

**Method**

In society, the voice of lesbians is routinely silenced. The queer population as a whole is marginalized. In this research I utilized a feminist qualitative paradigm to give “voice to respondents so that their voice was not silenced, disengaged, or marginalized” (Creswell, 1998, p. 196).
Respondents and Procedures

Recruitment

Prior to contacting potential respondents, I received approval for my research from the Office of Responsible Research, Institutional Review Board (IRB). A copy of the approval letter is included in Appendix A. Several points influenced my decision about inclusion criteria for respondents in this study. Sexual minority individuals and couples are marginalized in society. Bisexual individuals are further marginalized within the queer community (Bradford, 2004). Therefore, in this study participants had to identify as lesbian. Second, a plethora of information about lesbians and gay men appeared in professional journals during the late 1990s to 2000s that may have raised the awareness of therapists and researchers. This literature explored such topics as the inclusion of lesbian and gay man issues in journals (Clark & Serovich, 1997), how to work with lesbian and gay man clients in therapy (LeBolt, 1999), reasons lesbians and gay men are presenting for therapy (Bepko & Johnson, 2000), and addressing sexual orientation in supervision (Long & Lindsey, 2004). Articles about LG issues may have influenced self-reflection by therapists and researchers. Therefore, only couples who attended therapy in the past three years were included in this study.

Couples attend therapy for a variety of reasons. The reason a couple attended therapy sessions was not relevant. Couples may have started therapy for couple issues or for individual purposes. It could have been that an individual began therapy and the partner was asked to join them for one or more sessions. In the current mental health field, couple therapy is seldom covered by insurance and clients incur out-of-pocket expenses. Therefore, it may be that a therapist saw a client for “individual” problems, but invited a partner to participate
one or more times in order to explore a specific topic or issue. The focus of the current study was on the experience of couple therapy from the perspective of lesbian clients and their therapist. This experience could have taken place in one session of couple therapy. The therapeutic alliance or relationship begins during the first session; therefore, the couple had to have attended at least one therapy session together.

Furthermore, the reason for terminating therapy was not considered. It could have been that a couple ended therapy, a therapist ended therapy, or there was an agreement to end therapy. Clients could have decided to terminate therapy because of the therapist-client relationship, resolution of the presenting problem, relocation, or a variety of other factors. In addition, a therapist could have decided to terminate therapy because therapeutic goals have been reached, they felt appropriate progress was not being made and chose to refer to another professional, clients consistently missed or canceled appointments, or a number of other reasons.

In order to be included in this study, the potential client respondents had to identify as lesbian, have attended at least one session of therapy as a couple in the past three years and continue to be in the same relationship, and be willing to have the therapist participate in an individual interview. This turned out to be problematic because the partners in the first couple that contacted me identified as lesbian and transgender, respectively. Transgender was not a part of the inclusion criteria. In addition, I heard from potential respondents who said that they identified as bi-sexual, but were in a lesbian relationship. Furthermore, potential respondents contacted me to say that they had attended individual therapy to address relationship issues, but her/his partner did not attend sessions. Finally, lesbian couples end their relationship for a variety of reasons. The requirement that the couple had to be in the
same relationship as when they attended couple therapy turned out to be restrictive. Because of these barriers to recruiting research participants, I contacted my doctoral committee members and asked for their approval to change the criteria for inclusion in my study. The revised criteria stated that 1) potential respondents had to identify as being in a lesbian relationship; 2) potential respondents had to have attended therapy individually or as a couple in the past three years; 3) potential respondents had to have discussed relationship issues in therapy; and 4) potential participants had to be willing to let me contact her or his therapist about participation in the research via an individual interview.

In order to be included in this study, therapist respondents had to be licensed or working toward licensure as a mental health professional in the state in which they provide mental health services. The type of licensure could vary, for example a therapist may be a licensed marital and family therapist (LMFT), licensed mental health counselor (LMHC), licensed independent social worker (LISW), or a psychologist. In the geographic location in which this study took place, the number of licensed marital and family therapists was fairly low (approximately 164); therefore, licensure as a marital and family therapist was not required for participation in the study. The actual length of clinical experience with heterosexual or homosexual clients was not a consideration. Therapists at all levels of clinical experience may work with lesbian and level of experience may not be related to the ability to be self-reflective or knowledgeable about lesbian issues and concerns. Finally, the clinical theoretical orientation of the therapist was not a consideration. As explored previously, characteristics of the therapist and the therapeutic relationship make therapy gay affirmative as opposed to the therapist’s theoretical orientation.
In order to locate potential respondents for the study, I used informal gatekeepers. Informal gatekeepers are “widely respected” members of a community and often “looked to for guidance” when individuals are trying to decide if they should participate in a research project (Seidman, 1998, p. 39). I began by sending emails (Appendix B) to 62 LG friends, acquaintances, and those I had met in organizations or at workshops. Attached to the email was an IRB-approved flier (Appendix C). In addition, I sent 180 letters with a flier enclosed via regular mail to LGBT organizations and bars, as well as churches and businesses that were listed as LGBT-friendly (ACCESSline, 2007). Nineteen letters were returned undeliverable. One month after the first email, I sent a second recruitment email to the same individuals, followed by a third email two months later. Ten months after the third email I placed an ad in an LGBT newspaper (see Appendix D). Finally, five months after the ad appeared in the newspaper, I made a final recruitment push via email to a small number of acquaintances. Overall, recruitment took one and one-half years from October, 2007 through June, 2009. Through each phase of recruitment, I utilized a purposeful snowball sampling method in order to locate other participants (Patton, 2002). In qualitative studies, purposive snowball sampling is used instead of random sampling (Seidman). I wanted to “go to such depth in the interviews that surface considerations of representativeness and generalizability are replaced by a compelling evocation of an individual’s [in this case couples’] experience” (Seidman, 1998, p. 44).

All client participants responded to my recruitment efforts via email. I then contacted them by phone to negotiate a day, time, and location for an initial meeting and interview. I decided to interview client couples first so I could talk to them about contacting their therapist about participating in a separate interview. In most cases, the client(s) contacted the
therapist prior to the client interview. This allowed the clients to sign releases so the therapist could talk to me about the therapist’s experience of therapy. All clients whose therapist requested a release agreed to the release. I then contacted therapist respondents by regular mail (see Appendix E) and included a copy of the informed consent form with the letter so they would have adequate information about the study to make a knowledgeable decision about whether or not they wanted to participate. All therapists responded to the letter by email. After I received a response from a therapist, I visited with her/him by phone and email to ensure her/his willingness to participate in the research and to schedule the interview.

**Initial Meeting**

For all research participants, I intended to schedule an initial meeting so I could answer any questions about the research project, have participants sign an informed consent form, and collect basic demographic information. In addition, the initial interview was an opportunity for me to begin building rapport with each participant with the expectation that when I began the interview process there would be an initial feeling by the respondents that I was trustworthy and that it was safe to share information with me. All participants, however, preferred to sign the informed consent and share basic demographic information immediately prior the interview, thereby eliminating the need to schedule two meetings; this included couple client participants who preferred to have the three of us sit down for the initial meeting just prior to the interview. For client participants, I offered to meet with each partner individually to answer questions and collect demographic information in order to provide them with a degree of confidentiality; however, they all declined individual meetings.

I created two informed consent forms for this study—one for clients and one for therapists (see Appendices F and G). The purpose of an informed consent form is to present
the potential participants with more information about the study and the procedures involved so they can make an informed decision about whether or not they want to participate. My informed consent documents also included potential risks and benefits. The risks associated with participating in this study were no more than a participant may experience in daily life; however, I anticipated that participants may experience emotional distress when talking about their experience of therapy. Therefore, I provided all participants with a list of LGBT-friendly therapists (ACCESSline, 2007; see Appendix H). The potential benefits of this study were plentiful. As stated in my informed consent documents:

It is hoped that the information gained in this study will benefit multiple audiences. For clients, I would like to empower them by assisting them in becoming aware of their rights as a client and by validating their experiences as individuals, couples, families, clients in therapy, and in our larger societal context. For therapists, I would like to foster curiosity and a willingness to become aware of subtle heterosexism in their clinical practices, as well as awareness of the power of both the client and therapist in the therapeutic relationship and the larger societal context. For training institutions, I would like to challenge them to evaluate their programs for intentional and unintentional homophobic and heterosexist biases. For the larger society, I would like to instill an awareness that all people deserve and should be able to expect respect and confirmation of their diverse life experiences.

At the end of the interview, all participants received a $20.00 gift certificate. In order to determine where the gift certificate should be from, I consulted the Human Rights Campaign (HRC) 2005 Corporate Equality Index (CEI; Human Rights Campaign, 2005). I wanted to select a gay-friendly business that had locations throughout the state. The HRC CEI utilized a scale from 0-100 in which higher scores indicated a more-gay-friendly business. Businesses were considered gay-friendly based on the following: 1) they had a nondiscrimination policy in place; 2) partner benefits were available; and 3) sexual minority groups had been established. I chose to purchase gift certificates from Borders which had a HRC CEI score of 100% for the previous four years (HRC).
**Participants**

I gathered demographic information from all participants by completing the Respondent Demographic Information sheet (see Appendix I). I chose to complete the form myself so that I could expand or follow up on information provided by the respondent as needed. During the collection of demographic information, I asked participants to choose a pseudonym that I would use throughout the writing of this paper as a way to protect the identity of all research participants. Figure 1 shows the connections between clients and their therapists.

**Figure 1. Connection between clients and their therapists**

I interviewed a total of 12 participants (seven clients and five therapists). All seven client participants identified as lesbian—no gay men responded to my recruitment efforts. In order to protect the identity of participants, demographic information will be shared within
the text and no demographic tables will be included. The therapist participants in this study included four women and one man. One woman therapist identified as lesbian and the other four therapists identified as heterosexual. All participants identified their gender as matching their biological sex. The average age of client participants was 29 years (range 19 to 41 years) and the average age of therapist participants was 38 years (range 24 to 56 years) with an overall average age of 33.5 years. The majority of respondents identified as White (67%; four clients and four therapists); with two participants (clients) identified as Native American-White, one participant identified as Mexican-American (client), and one participant identified as Asian (therapist). In only one case was the race of the client partners the same (White), and in only one case was the race of the client couple and the therapist the same (White).

Overall, the income of participants ranged from $1,000 per year to $80,000 per year with the client respondents having a lower average income ($21,286) than the therapist respondents ($39,800). The overall years of education were slightly higher for therapist participants (17.6 years) than client participants (15.4 years). Participants identified their relationship status in a variety of ways. The clients identified their relationships as “complicated,” “committed,” “married in Canada,” “dating,” and “single in a relationship.” Therapist participants identified their relationships as “cohab,” “partnered,” “married for life,” “engaged,” and “married.” The identification of spirituality and/or religion was also diverse. Overall, 42% (5) of all participants identified as Christian (three clients and two therapists). That means that 58% (7) identified as something other than Christian. Two identified as “non-practicing Catholic” (one client and one therapist), two identified as “none” (two therapists), two identified as agnostic (two clients), and one client identified as
practicing Native American tradition. The therapist participants had a range of clinical experience between three months and 28 years. Four of the five therapists had previously attended therapy as a client and six of the seven client participants had worked with more than one therapist over the course of their life.

**Interview Process**

The interviews took place at a location that was negotiated by the research respondents and me, with the respondents’ comfort being of utmost concern. The clients were interviewed as a couple, when possible, and the therapist was interviewed as an individual. I interviewed the therapist separately from the client couple because of power differentials in the therapist-client relationship and because the individuals may not have been comfortable sharing their experience in front of each other. I chose to apply an in-depth interviewing methodology. Researchers who have interviewed couples together have had interviews that lasted from one to two hours (Horowitz, 1999; Touroni & Coyle, 2002) to up to four hours (Daly, 1992). I left the length of the interview up to the discretion of the respondents. After signing informed consents and collecting demographic information, the interviews ranged between 1½ hours and three hours. I anticipated that respondents would differ in the amount of time they had available, yet no participant ended an interview because of time constraints.

For this study, I used a semi-structured interview format (See Appendix J) to explore the couple clients’ and therapists’ experiences of therapy. I used a semi-structured format to ensure that information regarding the experience of therapy was explored. I used open-ended questions in order to hear the experience of therapy with minimal influence from me (Reinharz, 1992). In qualitative research, each interview builds on previous interviews
(Charmaz, 2006). There were times when participants brought up a topic and I asked follow-up questions. There were times when I asked questions based on interviews with previous participants.

In two cases I interviewed one partner about the experience of couple therapy (See Figure 1). Nicole chose to not participate in the interview about her and her partner Lilith’s experience of couple therapy. I interviewed Kate individually about her experience of couple therapy with her partner, Brandi. Brandi had been previously interviewed about her individual therapy for relationship issues. Because the couple had ended their relationship, I did not interview the couple together and I did not interview Brandi a second time.

All interviews were tape recorded and transcribed verbatim by me and by undergraduate research assistants who had completed human subjects training and were approved by the IRB (DeVault, 1990). After each interview, I jotted down notes to assist me in self-reflexivity. My field notes included my observations, thoughts, and feelings. My personal thoughts and emotions provided me with a valuable source of data that enhanced my self-reflexivity of my attitudes, experiences, and expectations (Campbell, 2002; Goodwin & O’Connor, 2006).

Sufficiency

Saturation refers to a point in data gathering when the researcher is not learning anything new (Glaser & Strauss, 1967). In other words, the same information is being repeated by successive respondents. Dey (1999) proposed that researchers attempt to reach sufficiency instead of saturation. Themes emerge from the data collected by the researcher. These themes are suggested by the data and are not meant to be discrete, unmovable categories (Charmaz, 2006). Therefore, I utilized the sufficiency criteria for saturation.
The number of participants required in qualitative research paradigms is relatively small. A qualitative research design is utilized to understand the in-depth story of a participant instead of trying to generalize the findings to the larger population (Chamaz, 2006). A small respondent base may also occur because of the nature of the research project. In the current study, I explored the experience of therapy from the perspective of couple clients and their therapists. The percentage of couples that present for couple therapy is small compared to the percent of individuals that present for therapy. In addition, couplehood is marginalized in our society which may cause an additional barrier to seeking therapy as a couple. Finding couples who attended therapy and were willing have me contact their therapists may have further reduced the number of potential respondents.

To address the number of participants needed in my study in order to reach a sufficient amount of evidence for emergent themes, I turned to the qualitative studies on the experience of therapy for lesbian and gay clients and therapists who work with lesbian and gay clients. Most studies on the experience of therapy for lesbian and gay clients are quantitative (Kidd, 2005; Liddle, 1996; Simon, 2000). The few studies that do utilize a qualitative paradigm reported between nine and 14 participants (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; LeBolt, 1999; Mair & Izzard, 2001; Milton et al., 2002; Moran, 1992). In this study, I interviewed a total of 12 participants (seven clients and five therapists) to reach sufficiency.

Analyses

I employed a feminist qualitative research paradigm for methodology, analyses, and interpretation of emergent themes. A feminist research paradigm allowed me to attend to diversity (e.g., sex, sexual orientation, and race) and variance within diversity, while paying
attention to power issues. After the interviews were transcribed, I used open coding to explore the data in the couple clients’ story and their therapist’s story about the experience of therapy (Strauss & Corbin, 1990). After this initial coding, I wrote down my ideas about the themes that were emerging. I made notes of the ideas that emerged from each couple client’s story and their therapist’s story. Appendix K is an example of my early memo writing. I then returned to the data and shifted my focus from looking within each story to looking at similarities and differences between stories (Miles & Huberman, 1994; Strauss & Corbin).

First, I looked at each couple client-therapist unit for commonalities and differences. Second, I looked at all couple client stories for similarities and differences. Third, I looked at all therapist stories for similarities and differences. Finally, I reviewed all the data for consistent themes between and among all participants. After finding general categories between and among couple clients and therapists, I again returned to the data with a more focused coding method to synthesize the codes that emerged during the open coding process. Through this constant comparison method, I was able to recognize when I reached sufficiency (Charmaz, 2006; Strauss & Corbin). Throughout the coding process I used memos and charts to assist me in exploring recurring themes, connections between themes and sub-themes, and to help ensure thematic saturation (Charmaz; Emerson, Fretz, & Shaw, 1995; Esterberg, 2002; Glaser & Strauss, 1967).

During open and focused coding, I created charts of broad categories that included client, therapist, experience, and interactions in the left column (see Appendix L for an example). In the left column I wrote broad categories (e.g., client, therapist, experience, interaction). In the right column I included the words of the respondent that I thought fit under each broad category. I then utilized the second (middle) column to write potential
emergent themes based on the words of the participant. I made every effort to use the participants’ words for emerging themes. There were times, however, when participants used different words that I believed were expressing the same thematic idea. In these instances I named a theme based on my experience and knowledge as a therapist and as a researcher (Chamaz, 2006). For example, I named the theme Working Together to reflect couple clients’ and therapists’ ideas about the therapist being on the inside or outside and engagement in the therapy process. I returned to the data multiple times to compare and contrast the ideas that were emerging until I felt comfortable that I had found all the emergent themes that were consistent across participants.

Rigor, Trustworthiness, and Validity

Several strategies can be used to enhance the rigor of research, including prolonged engagement, triangulation, peer debriefing and support, member checks, and peer review (Creswell, 1998; Padgett, 1998). A minimum of two of these strategies should be used in qualitative research (Creswell). Throughout the entire research process, I consulted with colleagues about the research process. I utilized member checks by sharing the broad category chart mentioned above with each respondent. I contacted research participants to ask how they would like to receive this information—electronically or by regular mail. All participants preferred to receive the information electronically. In my email I thanked participants once again for participating in my research. I asked each of them to review the category document and to let me know if I was representing their thoughts/ideas accurately or if I did not interpret something the way they meant it. All participants responded and stated that they thought my categories with their words accurately represented their thoughts.
and ideas about their experience of therapy. Through such member checks the trustworthiness and credibility of the project is increased (Creswell; Padgett).

Triangulation can include multiple forms of data or methods of data collection. The strongest qualitative research designs are those that include multiple forms of data and/or data collection (Esterberg, 2002). In the current research, I used triangulation in the form of multiple interviews because I interviewed couple clients and their therapists for a total of three perspectives of the same therapy experience. Because some partners chose not to participate in the research, there are two cases in which I interviewed only one partner and, therefore, have two views of the same therapy experience (the client and the therapist). In addition, I compared data between client and therapist, among clients, and among therapists, and, finally, among all clients and therapists.

I also chose to use peer review to enhance the trustworthiness of the study. As my data analyses progressed and I began to contemplate the results and discussion portions of this paper, I contacted peer reviewers. The peer reviewers for this project included a colleague who is a qualitative researcher and therapist, a colleague who is a therapist, and a lesbian who is a therapist but not a respondent in the current project (Lincoln & Guba, 1985). I chose to utilize a qualitative researcher, a therapist, and a lesbian as peer reviewers because I wanted a variety of perspectives and I felt that these three positionings would be beneficial. It just so happened that the qualitative researcher and lesbian were also therapists. I had difficulty finding a lesbian to act as peer reviewer, perhaps because the lesbian population in the local area is so small and intermingled. In fact, I had chosen a peer reviewer and was preparing to contact her when I discovered via a social networking site that she is friends with one of the lesbian participants. Therefore, I contacted a colleague in another state to ask
if she could recommend a lesbian that could act as peer reviewer. Therefore, one peer reviewer is someone who was recommended by a trusted colleague, although I do not know her personally.

As part of the peer review packet, I included a cover letter (see Appendix M), the introduction of my dissertation, a figure that showed how clients and therapists were connected, demographic information on participants, a model that showed the themes that emerged, four transcripts of clients, therapists, or both, and a copy of my in-progress Results section. I asked the reviewers to provide feedback and to let me know if their thoughts and ideas were similar to mine or if they saw emergent themes that I might have missed. All three reviewers completed their tasks and provided feedback to me via email and phone conversations.

In addition to rigor and trustworthiness in terms of triangulation, peer checks, member checks, and audit trails, validity is also important in terms of interpretation (Lincoln & Guba, 2000). Throughout my writing I engaged in reflexivity that exposed my biases, thoughts, and emotions (Campbell, 2002; Lincoln & Guba, 2000). While interpreting my data, I attempted to maintain a stance of fairness to ensure that all voices, perspectives, and concerns were heard (Lincoln & Guba, 2000). I gave attention to my biases that may obviate my ability to hear shades of grey in the respondent’s stories. I enhanced this attention to my biases by utilizing member checks wherein respondents had the opportunity to review emergent themes and provide feedback. In addition, I utilized peer reviews by a qualitative researcher, a therapist, and a lesbian and received feedback on my ideas about emergent themes, interpretations, and writings. Through self-reflexivity, I included my thoughts and
emergent biases or dilemmas that I encountered throughout the data collection, interpretation, and writing processes.

Reflections

As a feminist qualitative researcher, it is important for me to position myself in relation to my study as a way to allow the readers of my paper to assess how and to what extent my biases, thoughts, and emotions influenced the research process (Campbell, 2002; Chamaz, 2006; Lincoln & Guba, 2000). By adopting a feminist perspective, I was able to reflect on a number of issues, including my assumptions about the respondents, my relationship with the respondents, biases that emerged during the research process, and emotions in the research process.

My assumptions about respondents were important no matter what research paradigm or method I chose to employ. Being aware of these assumptions assisted me in a number of ways. For example, my assumptions informed how I asked questions, how I interpreted data, how I envisioned my position, and how I understood the ways in which I influenced the research process and interpretation of data.

As a therapist who regularly worked with clients, I believed I needed to remain aware of the idea that the respondents were constructing an image of me that would influence the interview process. With therapy clients, initial impressions were important, yet therapy was usually more than a one-time meeting and misimpressions could be discussed and explored in subsequent sessions. In this study, I conducted one in-depth interview with the length determined by the respondents; therefore, I had one and only one opportunity to be observed by them. The impression of me that the respondents developed would begin prior to the interview when the interview location was being negotiated.
I was acquainted with several of the participants—either through the university or through LGBT organizations. I had visited with a few people on several occasions. I had seen others at organization meetings and spoken to them briefly. A few I only knew through their partners and we had never been formally introduced. The rest were total strangers. I thought that being familiar with respondents would make the interview process easier. Familiarity, however, was not a major influence. Rather, power dynamics were influential in the interview process.

Power dynamics are present in all relationships and by utilizing a feminist qualitative paradigm I was able to reflect on the power dynamics that were active in my relationships with respondents. Power issues included the age, sex, race, sexual orientation, education, and experiences of the researcher and respondent. In several of the relationships, I was in a position of power because of age, race, sexual orientation, and education. In other relationships, respondents had more education and/or clinical experience than I did. I experienced times when I asked questions hesitantly which reflected my feeling that the respondent was in a position of power even though I was the researcher. At other times, I was aware of my power with respondents. Several respondents were either younger than me, were lesbian, had less education, and/or had less clinical experience. When working with respondents with whom I felt like I was in a position of power, I attempted to be more aware of my influence and the importance of how I asked questions so that I did not influence the way the respondent answered.

As I reflected on the times I felt I was in a position of power, I came to the conclusion that a bias I had was that I value self-reflection. I remembered times when some participants did not seem very self-reflective. I returned to the transcripts to explore this phenomenon.
When a participant was not self-reflective, I (in hindsight) became frustrated and my questions became more direct and from a position of power. I also brought my experience as a clinical supervisor and advanced doctoral student to these relationships. I struggled to maintain a researcher stance and wanted to help the non-reflective participants through their own self-exploration. In addition, if a respondent was not verbose in her or his answers, I found myself “filling in” the gaps and simply receiving a “Huh-huh” in response. I would then use my position of power to directly ask them to respond to the questions because I wanted to use their words in my writing.

Adopting a position of power with participants who were not self-reflective or who were not verbose in their answers had an influence on my interpretation of data because I wanted to focus on the “negatives” in the transcription instead of letting ideas emerge from the data. This focus on the negative was an assumption that I brought to this research project as I had originally anticipated that the majority of clients had negative experiences of therapy with homophobic, heterosexist therapists. I was afraid that I would not hear shades of gray. Even being aware of my bias did not preclude me from looking for the negatives in any therapy experience. I also had to consider how I influenced or helped co-create the meaning of the respondents’ experience of therapy. I had many discussions with colleagues and again with peer reviewers. The peer reviewers saw the same information I did in terms of “negatives;” however, the dialogue with others led me to reflect on the concepts of protecting identity, confidentiality, and writing about what I saw in the data.

**Identity, Confidentiality, and Writing**

Something I re-learned from this research process was how small the lesbian community is in the geographic area in which the study took place. This was evident in that I
was acquainted with several participants to varying levels. It also became apparent when I attempted to locate a peer reviewer who identified as lesbian. My challenges came when I was considering how to protect the identity of participants, providing confidentiality for clients, and writing what was emerging from the data.

As a feminist researcher, I felt it was important that respondents chose a pseudonym in order to protect their identity. What I had not considered was that client or therapist participants may tell me confidential information that their therapist or client may not know. For example, a couple client shared information with me that painted their therapist in a fairly negative light. My conundrum was how can I write about what was emerging from the data without breaking the confidentiality of the couple. Additionally, how could I share what I was seeing in the data without others being able to identify either the couple client or the therapist? My “safe” choice to protect the identity and confidentiality of respondents would have been to exclude this data from my results. Yet, by excluding the information I would not be attending to negative case analyses and would not be including respondents’ full stories. Therefore, I decided to relay the content of the message from respondents in a way that protected the identity of participants and did not break respondents’ confidentiality. I saw this as a learning experience. In the future when I am interviewing people for varied perspectives on a common experience, I can choose the pseudonyms and share more through my interpretation of the participants’ voices instead of using the verbatim words from the transcript.

*Emotions in the Research Process*

As I got closer to beginning data collection, I realized I had begun to deal with fear about how I would change as a person as I conducted my dissertation research. Much of the
research on emotions that I located discussed the emotional responses that researchers have about the respondents (Bloom, 1998; Kleinman, 1991) or the emotions the researcher had about the experiences of the respondents (Campbell, 2002; Campbell & Wasco, 2000; deMarrais & Tisdale, 2002). In addition, there was research on the researcher’s ability to deal with the respondent’s emotions (Beale, Cole, Hillege, McMaster, & Nagy, 2004). Because I am a therapist, dealing with the emotions of respondents did not cause me a great amount of concern. I did have some concerns about insulting or hurting respondents’ feelings by asking questions from my “straight” position (Bloom, 1999) or making assumptions based on stereotypes (Conley, Calhoun, Evett, & Devine, 2001).

As a therapist I have been able to create a strong working alliance with diverse clients and I believed I was also able to create a valuable research relationship with the respondents. This relationship fell somewhere between acquaintance and friend. There were times when the respondents were validating me and my research ideas. There were times when I cried because of the pain I heard in the respondent’s story. I asked each participant what it was like being interviewed and every single respondent described it as a positive experience.

What I had not anticipated prior to this study was the lingering emotional bond I would experience with respondents. When I speak of emotional bonds in this sense, it is not necessarily of the affectionate type. I have walked away from this project thinking of some participants as awesome women who would make great friends. I have also walked away thinking of some participants as people that I really would not want to get to know better. This is something I continue to reflect on and consider how this may influence my future research projects—especially if I choose to do multiple interviews with the same people.
When adopting a feminist perspective, researchers need to be aware of their own feelings and how they influenced their work (Campbell & Wasco, 2000). I agree that emotional engagement during research can provide a valuable source of data (Campbell, 2002), expand research (deMarris & Tisdale, 2002), and provide researchers with an insight into their work (Campbell & Wasco). I believe in the feminist idea of researchers sharing their emotions and thoughts through reflexivity in their writing. Yet, the reality of doing so has been daunting. Through sharing myself in writing, I experienced a sense of vulnerability.

Bloom (1998) stated that when researchers are looking at themselves, they need to be “constructive and genuine, not self-blaming” (Bloom, p. 149). Reinharz (1992) wrote about feminist methodology perhaps setting the bar high for researchers, which could create unrealistic standards and result in silencing some researchers. I tend to hold myself up to sometimes unrealistic expectations. From my understanding of feminist methodology, it is not about being perfect, but about being authentic and real—warts and all. By engaging in honest self-reflexivity, I am a “real, historical individual” (Harding, 1987, p. 9). I also believe it exposed my learning curve and allowed me to seek assistance from other feminist qualitative researchers and to learn about different qualitative methodologies and methods. I could empower myself by allowing myself to have a voice.

What I needed to remember is that emotionally engaged research needs to be guided by an ethic of caring not only for research respondents, but for myself (Campbell, 2002). Campbell proposed that some researchers find their emotionality a helpful resource; I agree with this idea. Although Campbell thought that her research would be beneficial for researchers in fields related to her topic of sexual assault, I believed that my topic for me constitutes an “emotionally charged social problem” (Campbell, p. 125). I had spent time
thinking about how my research would affect others and it seemed I needed to spend more
time thinking about how my research had affected me. I empowered myself by allowing my
voice to be heard.

I know that a qualitative researcher is affected by the research that she/he conducts
(Campbell, 2002). I know that in addition to the affective experience of being a qualitative
researcher, there would be a change in me as a person. My values and beliefs could be
challenged. I was using a feminist methodology which included honest self-reflexivity. I
knew that what I went through would become part of my writing because I would be
disclosing my self-reflexivity in my writing (Harding, 1987). What I did not know was the
feeling of accomplishment that I would feel by sharing the voice of the respondents through
the voice of my interpretations.
CHAPTER 4: RESULTS

As more lesbian and gay clients present for therapy, therapists need to be prepared to work with sexual minorities in the therapeutic context. Empirical research has explored the experience of individual therapy from the perspective of lesbian and gay clients (LeBolt, 1999). Researchers have also reported on the experience of individual therapy with sexual minority clients from the perspective of therapists (Milton et al., 2002). What has been lacking in the field is an exploration of the experience of couple therapy from the perspective of sexual minority clients and their therapists. The purpose of the current project is to contribute to closing the gap in the current literature.

The themes and sub-themes below emerged from interviews with a total of 12 participants. I interviewed seven clients and five therapists. All of the clients identified as lesbians. One therapist identified as lesbian (Simone) and four therapists identified as heterosexual. One of the heterosexual therapists was a man (Tiger), while the other four therapists were women. All participants chose their own pseudonyms and two of the women clients chose “masculine” names. In keeping with a feminist perspective in research, I believe it is important for me to attend to potential power issues in the researcher-participant relationship (Bloom, 1998; Oakley, 1981). Therefore, to maintain a more egalitarian, collaborative relationship with participants, I used the names that the participants chose as pseudonyms. Client participants were Lilith, Christopher, Wes, Brandi, Kate, Carmen, and Ashley. Lilith’s partner, Nicole, chose not to be interviewed. Therapist participants were Sarah, Simone, Mary, Maigan, and Tiger. Simone worked with two couples (four clients) and I interviewed her twice. Carmen and Ashley (clients) worked with two therapists (Maigan and Tiger) and I interviewed both therapists.
Experience of Therapy

My purpose in conducting this project was to explore with lesbian clients and their therapists what influenced their experience of therapy. After I collected demographic information, the first question I asked each participant was, “How would you describe your experience of therapy?” I begin by sharing the participants’ voices about their experience of therapy. I share their experience of therapy in order to set the context for their ideas of what influenced that therapy experience. Most clients and therapists described their experience of couple therapy in positive terms. Simone described her experience of working with Kate and Brandi as “frustrating,” but a “learning experience.” Carmen and Ashley talked about aspects of therapy with their therapist Maigan that they did not like; however, they still described the experience of therapy as being “good.” I begin with Lilith.

When asked about her experience of therapy with her therapist, Sarah, Lilith said, “I really liked couples therapy. It was very helpful for both of us.” Lilith went on to say,

The therapy has meant a lot for me as on a personal level as well the couple level. It [therapy] means a lot because of the fact that not only am I dealing with the gay and lesbian issues, the couple issues, and the regular everyday school issues, but also my own personal issues. Counseling, it sounds silly, but it’s important to me.

Kate shared her experience of couple therapy with her therapist Simone and added that sessions were useful, but difficult. Kate stated, “I found couples therapy to be pretty useful to my partner [Brandi] and I. Yeah, I really enjoyed our sessions. They were difficult for sure, but yeah.” Brandi reflected on her experience of therapy with her therapist Mary as being difficult, but rewarding when she shared,

I would say it’s been an incredibly positive relationship. I find that I am respected more for who I am as a person. I look at this round of therapy as probably one of the best things that I’m doing in my life right now. It’s horribly difficult, but rewarding at the same time.
Wes responded to the question about her experience of therapy with her therapist Simone with her attention on safety and calmness when she and her partner, Christopher, were working with Simone. Wes said,

It was very comforting. As I first walked in, I felt safe and didn’t feel any time of tension of the reason why we were there for being a same-sex couple. Just a very calm, open-minded energy.

Wes’s partner, Christopher, followed up on Wes’s comment and said, “It was very calming.”

Christopher then expanded her statement when she reflected,

I think it was probably the most life-changing, put new faith in people, forcing to learn more about myself, thrilled to have learned something new, thankful that I walked out with my best friend.

Christopher’s response elicited laughter from Wes and me when she turned to Wes after her “best friend” comment and stated, “Go ahead and top that.” The conversation continued,

Wes: I can’t. I think it [experience of therapy] was reassurance; reassurance of possibilities. God, she did good [referring to Christopher’s comment].

Mary Sue: I know I’m trying not to let these tears fall. “I walked out with my best friend.”

Wes: Oh, yeah. We lost each other for a while there. That was a tough one. God, I can’t top that one. I think the meaning I got was just that everything can be fixable. I think there’s a possibility that everything can. It taught me not to give up right away. I was a person that just kind of did throw things and…

Christopher: Easier to run.

Wes: It was easier to run than try to fix and the meaning of being able to step back and not run from something.

Christopher: I’m serious. I look back and I think two of the best things that we ever did in our relationship—well, actually there’s three things. One, was we had counseling before we had a commitment ceremony. We had a phenomenal faith leader. She was great. She was awesome. Two, we got Cecil, our little Shar-Pei, and then the third one was seeing Simone.
Wes: Who knew?

Christopher: I mean seriously those two people, their influences in our lives, or my life in particular, helped me take out some of those tools and I think I maybe knew of that, but really took ‘em out and actually put ‘em on a shelf in the house that, if need be, we can take it out and use it. I’m a huge proponent of therapy.

Carmen and Ashley worked with two therapists. First they worked with Maigan and approximately one year later they worked with Tiger. Their experience with each therapist was different, but they both said they thought therapy went well. When talking about her experience with Maigan, Carmen said, “I would say it was good, for me at least. Definitely opened my eyes a lot.” Carmen was going to therapy because it was important to her partner Ashley, yet her idea about the process of therapy changed. She shared,

I think me going through therapy kind of showed Ashley that I do care, that I do want things to work out. It was a step for her at least [turned to Ashley] to show you that I do care cause it’s [therapy] something that I’d never been to. I mean there was a point in time where I was against it, I guess, for me going. It kind of opened my eyes. That it’s a good thing, I guess it helped me through a lot of processes. It was a way to get my feelings validated and things that I couldn’t go through on my own. I knew there was someone, someone to listen.

Ashley had more experience going to therapy than her partner Carmen. Ashley talked about therapy being a place to express feelings to someone who cannot share the information with others. She said,

Well, I guess therapy has always meant the same thing to me. It’s a place for me to express my feelings and talk about things and get a different perspective on something. I like therapy. I like being able to talk to somebody and tell somebody something and know that legally they can’t say anything [to others].

Although it was not intended, Ashley and Carmen began comparing the similarities and differences in their experiences with their therapists Maigan and Tiger. When asked about their experience working with Tiger, Carmen said, “Overall, I would say a lot better than
what we experienced with Maigan.” Ashley shared that “they were kinda complete opposites.” She went on to say,

Well, one thing she [Maigan] did do she brought a lot of information and research, which was really good information and research, but it was really hard to figure out how to do the things. Tiger has given us a lot of tools on how to use them. And he will take the tools and compare them to everyday things. So not just, “Well we want to accomplish these goals,” but “Here’s a way how you can do it or if that’s not working, here’s another way.” So we’ve just had a lot of ways to implement the things that we have learned.

Carmen agreed with Ashley when she talked about Tiger teaching them things they can do when they are stuck in a rut. Carmen shared,

I think I had a better experience with Tiger. He’s, like you said [to Ashley], that he gave us the tools to know when we are stuck in a rut, what the options we can do are, or at least try to see if we can get past that.

Overall, clients expressed positive experiences of therapy with their therapists. My goal in this project was to explore the experience of therapy from the perspective of lesbian couple clients and their therapists to look for commonalities. In this project, therapists, too, described their experience of therapy with lesbian clients in positive ways. Sarah [therapist] shared her experience with Lilith and Nicole,

Overall, a really great experience. I felt like that they liked me as a person and that they appreciated me as a therapist or found value, which doesn’t always happen, but it’s nice when it does.

For Sarah, working with Lilith and Nicole was a learning experience and she felt a measure of success. Sarah said,

It was meaningful to me because it was a new experience [working with a lesbian couple] and it challenged me, but that I was able to kind of rise to the occasion, if you will, and that it went well. It’s meaningful to me because I consider it a success story for me. I mean they’re not together anymore, but that was the good choice for them and that overall we had a really positive experience together. I really enjoyed working with them.
Simone [therapist] agreed with Sarah’s perspective of working with her clients as being fun when she talked about her experience with Christopher and Wes, “The first word that comes to my mind is fun. They were a really fun couple. I really enjoyed working with them.” Simone gained more than a sense of fun working with Christopher and Wes; she also found working with Christopher and Wes to be a learning experience. As a lesbian therapist, her experience with this lesbian couple highlighted for her how much of herself she had been leaving outside the therapy room. Simone reflected,

Well, what it meant for me personally, as a therapist, I think it was probably one of the first times that I was able to bring all of me into the room. It sort of highlights how much of me gets left outside the room. I’m not spending as much time or energy [now] being straight—trying to be a straight therapist.

Tiger also expressed his experience working with lesbian clients Carmen and Ashley in terms of fun. He said, “Working with them has been great fun. It has been very nice to work with them. I’ve really enjoyed my experience with them so far.” Carmen and Ashley were the first lesbian or gay couple that Tiger worked with and he talked about how his work with them provided him with self-confidence and motivation. He shared,

I think it has helped me to become more confident in my work with a gay and lesbian couple. It is, just the next time I have an intake of another couple, I’m going to think about the positive experience that I have with Carmen and Ashley. That’s going to be the motivation to keep working with couples—gay and lesbian couples.

Maigan [therapist] talked about comfort when she shared her experience working with Carmen and Ashley in couple therapy. Maigan said, “I felt that we had a great relationship and it seemed they were comfortable with me and I was comfortable with them.” Maigan went on to say, “It was probably the first client system that I had that I felt I really had a good therapeutic relationship with.” Similar to Tiger, Carmen and Ashley were the first lesbian or gay couple that Maigan had worked with in a therapeutic context. She talked about
the therapy experience as teaching her “that the processes in their relationships are very similar to those of heterosexual couples and the theory will work the same, but at the same time you need to consider culture and how that’s coming into play.”

When Mary [therapist] shared about her experience of working with Brandi in individual therapy, her focus was on her lesbian client when she responded about their continuing client-therapist relationship. Mary said,

I feel it’s a good working relationship. I think it’s a therapeutic relationship that’s allowing her to address some of the things she came into therapy for. We have very open dialogue. I believe it’s a trusting relationship that she feels she can bring issues and can feel respected.

Simone’s experience with clients Kate and Brandi was different than her experience with clients Christopher and Wes. When asked about her experience of therapy with Kate and Brandi, Simone responded, “My whole overall feeling in the room with them was a little bit frustrated, I think.” She continued, “It was difficult. It was hard work.” Although Simone described her work as difficult, she clarifies that she was not “miserable.” Simone said,

As I’m talking, it probably sounds like it was miserable working with them, but I didn’t feel miserable working with them. It was sort of a challenge. I had my therapist hat on, it was a challenge and I genuinely liked both of them for their different selves. But bringing them together was a lot of work.

As clients and therapists described their experience of therapy, it seemed to me that the majority had a positive experience in therapy. In the case of Simone, although she described her experience as frustrating, she liked her clients.

Emergent Themes

In this section, I identify the themes that emerged from the participants’ data. As I reviewed the data for the influences on the experience of therapy for the participants in this study, the grand theme of the client-therapist relationship emerged. Within the client-
therapist relationship grand theme, several themes emerged. A theme that emerged was working together as a team. Clients and therapists agreed that they worked together as a team in the therapeutic context. A second theme to emerge was a sense of connection between the client(s) and therapist. Sub-themes that emerged under connection included the physical environment, emotional safety, and humor in the therapeutic context. A third theme that emerged was the non-expert stance of the therapist. Therapists discussed asking questions and letting clients lead the therapy process. Clients talked about the therapists asking questions and not leading. A fourth theme that emerged was the therapist as a professional. This theme included sub-themes involving the therapist’s level of self-disclosure and knowledge. Appendix S shows my conceptualization of the themes and sub-themes that emerged from the data.

Grand Theme

As I began reviewing the data for emergent themes, the grand theme of the client-therapist relationship emerged. I used my knowledge as a therapist and as a professional in the couple and family therapy field to define this grand theme because the themes that were emerging from the data all related to the relationship between the client and the therapist. Clients and therapists talked about how they worked together in the therapeutic context. Working together is an indication of the working relationship or working alliance between a client and therapist. Clients talked about how they felt connected to their therapist which is an indication of the relationship between the client and the therapist. Therapists and clients agreed that therapists took a non-expert stance and positioned the clients as the expert on the client’s life and relationship which is an indication of working in a collaborative relationship that was created between the client and the therapist. Clients discussed how they viewed their
therapist as a professional and this is an indication of the (professional) relationship between the client and the therapist. Therefore, all themes that emerged can serve as indicators of the relationship that was created and maintained between the client and the therapist during the therapeutic process. After I discuss the emergent themes in this study, I will discuss power in terms of its influence on the client-therapist relationship. I will use the participants’ words to tell their stories of how they viewed power in the client-therapist relationship and any connection they made between power and the themes that emerged.

Themes and Sub-Themes

Working Together

Working together was important to all participants. Working together was described in various terms, but client participants described it as being in the therapy process together.

In this section, I will share the voices of the clients followed by the voices of the therapists. Wes and Christopher were the first participants to talk about their therapist Simone being inside the client system with Wes and Christopher, while being outside enough to be objective. Wes explained Simone’s inside-outside position when she said,

I think she [Simone] allowed us to be us and she just kind of let us be in our own box and she’s on the outside just letting us be. I don’t think it would have worked if she was inside, but she was enough inside.

Christopher concurred when she stated, “She’d come in every once in a while. We were in a cage and she’s like, ‘Okay, it looks like they’re going to get really ugly here, try this.’”

When Kate reflected on her therapist’s position, she related it to how Simone’s office was set up and its influence on creating face-to-face dialogue while allowing the therapist to be a part of what was occurring in the room. She shared,
I would say she was outside in terms of Brandi and I were facing one another in similar chairs and she [Simone] was maybe four to five feet away in a chair, so it facilitated face-to-face dialogue between Brandi and I. We could also, if she was asking questions, easily turn and face her and it had the feeling of an open dynamic…it didn’t seem intrusive. I suppose in the definition she would have been outside of that rather than inside, but it felt more like a conversational triangle in a lot of ways in terms of body language. It would have been more that she was part of what was occurring in the room, but we were the priority and she was suggesting things or asking questions to get more information.

Building on a previous interview, I asked Carmen and Ashley about Tiger’s position with the client system. Carmen and Ashley felt that Tiger was on the inside. Carmen stated, “I feel like he’s in it with us.” Ashley agreed and continued, “I think that the reason I feel like that is because when we are with him he acts like he really does care. He wants us to succeed.” When working with Maigan, however, Ashley felt that she was on the outside. Ashley shared,

I guess it was really hard for me to talk to someone the same age as me and someone that I know hasn’t experienced a lot of clientele. I tried to go in as open as I could and we tried for as long as we could, but in the back of my mind I just kept thinking, “She’s the same age as me.” So I guess it was just really hard to let that guard down with her and try and establish a relationship.

Ashley felt that she did not let her guard down with Maigan. Carmen agreed that Maigan was on the outside, yet she still believed they had a good therapy experience. Carmen said,

I would still say it was good. It was my first case [experience in couple therapy] and it took me through a lot of aspects of counseling even though I did go individually, but I didn’t know what to expect [in couple therapy], so it wasn’t completely horrible to where I wouldn’t go back.

While Christopher, Wes, Kate, Carmen, and Ashley talked about inside-outside positions, Lilith talked about working together as all of them being engaged in the process. Although the clients and therapist were all engaged in the process, the process of engagement was displayed in different ways. Lilith shared,
Sarah was very, very much into helping us and very, very much into doing anything she could to make sure we felt we were going places and doing what we needed to do. I’m perfectly fine with counseling, I don’t have a problem with it and I was very much engaged in trying to find out what my issues were along with the couple issues were. Nicole was very into it, too, just in a very, “I’m not going to admit that I’m actually into this,” kind of way. We were all very engaged in it, just maybe not as much as others or in different ways.

Sarah agreed with her client, “I felt like Lilith wanted to go there [be engaged, be challenged] and she was just waiting for me to ask the questions.” Sarah’s experience with Lilith’s partner Nicole was somewhat different, as she attended to creating an alliance with both clients. Sarah said,

I was trying to maintain a balance and that I was trying to keep Nicole engaged. I already knew she didn’t like therapy and she didn’t like the process and so I was scared that if I really pushed her that I would lose her. So I tried not to let that natural alliance [with Lilith] kind of overshadow my relationship with Nicole because it could have been easy to kind of fall in line with her [Lilith] and then create a weird dynamic with Nicole.

As a therapist, Simone shared Sarah’s view of working together and balancing the relationships with her clients, Christopher and Wes.

It was just like the three of us there working it out so I didn’t feel like an outsider kind of injecting, I don’t know if that’s the right word, but inserting myself into somebody else’s relationship. In the therapy room, it felt to me like it was the three of us figuring it out. I felt like I was sort of part of the process and not just an outside observer. [conversation continued]

I think obviously in any couple you have two people and so you have to engage with each of them in a different way because they’re different. I think I was able to engage with her [Christopher] on a different level—in a different way than I did Wes. [conversation continued]

I try to elicit information and responses and reactions from both people so that it’s not focused on one person as the problem. In a lot of cases I think you can relate to one person and not the other, and sometimes it’s easy to build an alliance with one person and blame the other. I think I make a very conscious effort to deal with, to not spend all the time on one person’s issues, and on each issue whether it’s brought up by one person or the other. I try to elicit information and responses and reactions from both people so that it’s not focused on one person as the problem.
Simone felt that she, Christopher, and Wes were working together to figure things out. Simone talked about an inside-outside position with Kate and Brandi a bit differently. She shared,

You have to be inside a little bit if you’re going to try to get the essence of what they’re saying, but you also have to be outside a bit enough so that you can be objective so that when Brandi is over here saying, “So you were saying this,” and it’s not what Kate was saying you can be objective enough to say, “Wait a minute, that’s not what I heard.” So it’s kind of being in and out.

Simone talked about engaging with Christopher and Wes in different ways. She had the same experience with Kate and Brandi. Simone said,

I think I was able to connect with Brandi in an emotional way and empathize with her and things like that, but that approach didn’t work with Kate. Kate was, in session anyway, much more in her head in a cognitive way. Everything had to make cognitive sense.

Similar to Simone with Christopher and Wes, Maigan discussed not putting blame on one client and focusing on the circularity of the problem when she said, “I’ve tried really hard to, I felt like I didn’t want to focus on one or the other and so we really focused on the circularity of the problem, not putting blame on either one of them.” Tiger also felt he, Carmen, and Ashley worked as a team. He shared an analogy,

I think it is like a team really, but I try to emphasize, not necessarily verbally, that they are in the driver’s seat really and I am in the car with them, lets say. So I’m helping, providing feedback, direction maybe, “Hey you know,” kind of talking out with them about this direction or that direction or whatever, but they are the ones turning the wheel—I’m not turning the wheels. And so, yeah, all of us [are] in the same car, but I’m somewhat of a backseat driver, but I’m with the driver.

Tiger did not verbalize to his clients working as a team, but Mary takes a different perspective. Mary makes a clear statement of working together. She said, “I clearly say to the individuals I work with that I don’t know everything, but we can figure things out.”
The therapists in this study discussed the importance of maintaining a balanced alliance when working with a couple. I returned to the data to tease out how clients may perceive this balancing act. Kate talked about Simone making sure both persons were heard when she stated,

Our therapist [Simone] was really adept at making sure that we both had a chance to speak. One of the issues within our relationship was a power differential that we were uncomfortable with and having talked about that, she was really intentional about making sure that didn’t exist within the [therapy] room and made sure that both folks were being heard and that was great.

Carmen and Ashley concurred with the idea that their therapist elicited information from both of them. Ashley stated, “He [Tiger] always validates whatever either one of us says and he always says that neither one of us are right or wrong, but it’s our opinion and it’s our feelings and they’re right for us.” Kate, Carmen, and Ashley shared that their therapists made sure both parties were heard and neither party was blamed. Christopher talked about wanting her therapist, Simone, to validate her point of view and blame her partner for their problems; however, Simone would not do that. Christopher said,

We go in there wanting to get fixed or get help, but we also want to say, “It’s not me—it’s this person right here and I’m looking for you to validate that.” I think a lot of people go in with that. So you kind of go in with that and it’s kind of like, “I certainly couldn’t have been doing anything wrong and this person is going to show you that I was a good person,” and nope, not so much. You know, she really got honest, “Nope, not having that here, not taking sides.” [Simone was] not validating anything in particular that would have been detrimental to the other person participating.

Lilith looked at balancing differently. She talked about learning about her and her partner’s individual issues and how they influenced their relationship issues.

I think I found out more about myself and then her rather than the couple of us together which was actually very, very helpful in the couple’s part of it. That’s kinda why it helped so much to realize my personal issues and then her own issues because they played into the issues that we had together but I never looked in to as that is what
it was two separate things. It was very helpful. We pretty much worked through the issues we each had individually that influenced our relationship together.

Carmen and Ashley had a similar experience with Tiger. They talked about the way Tiger worked with them as individuals and as a couple.

Carmen: I think he acknowledges us as individuals when he needs to, but when he needs to acknowledge us as a couple, he does. He knows that this may be an individual problem that maybe it’s my view that’s wrong or hers, but when he does, it’s a couple problem.

Ashley: I agree. Yeah. A lot of the time is spent on individuals in our relationship, I guess. So it’s not just that we’ve talked about what we want individually, but what do we want as a couple type thing. So, that’s all I would say. That’s a good answer [to Carmen].

Clients and therapists agreed that the client’s engagement with the therapist is important, but therapists discussed the importance of engagement and caring within the partnership. Simone talked about Christopher and Wes engaging with her and with each other when she stated,

They [Christopher and Wes] were engaging with me, they were engaging with each other. It was obvious that they both wanted their relationship to work and, for any therapist, I think it’s more fun working when both people are in it versus one that’s kind of resistant so I didn’t have that experience with them.

Sarah talked about how she could see that her clients cared about each other. She shared,

They interacted with each other. I mean you could see they care, the tenderness between them at times and they definitely weren’t afraid of, there were times when it was almost like I wasn’t in the room, that they were just in that moment together. And that they weren’t afraid to be doing that in front of me.

Simone and Maigan also talked about situations where clients were not engaged with each other or fully committed to the relationship. In her work with Kate and Brandi, Simone believed that one partner had already made a decision about the relationship prior to attending couple therapy. Simone shared, “Actually I think it [her feeling of frustration
working with Kate and Brandi] came about because I had the feeling from pretty early on that one of the partners was already checked out and was just sort of going through the motions and coming to therapy just to say she had tried everything.” Maigan shared a similar experience when she talked about how therapy ended with Carmen and Ashley. Maigan said, “They broke up and I got a frantic call from Ashley asking to meet for a session.”

In some cases a partner will go to therapy by oneself to explore how her/his individual issues influence her/his relationship. This was the case with Brandi. I was curious as to how Mary would describe her relationship with Brandi’s absent partner, Kate, so I asked, “So you do have a relationship with Kate?” Even though Kate was not in the therapy room, the relationship between Brandi and Kate was in Mary’s mind while she worked with Brandi. Mary was “engaged” with the absent partner in a supportive way.

I think my relationship with the person I work with is most often supportive of that other individual [the partner]. So I don’t easily buy, and that’s my own maybe years of experience, that it’s always the other guy’s fault. So I think I’m supportive and I would be when people come in and they’ve got relationship problems. It would be, in a way, supportive of that other person, and say, “How does that affect Kate when you do that?” and “What would you like to be different because I know you don’t want to treat someone you care about that way.”

Clients and therapists agreed that they worked together as a team in the therapeutic context.

*Connection*

A second theme that emerged from the data was the idea of connection between the client and therapist. I discuss the general sense of connection between clients and therapists before addressing the sub-themes that emerged. Clients and therapists were able to make a connection that facilitated engagement and working together toward a common goal. I wanted to know how this idea of feeling connected came about. When I explored connection, three sub-themes emerged: physical environment, emotional safety, and humor. From both
client and therapist perspective, it appears that the concept of feeling connected and seeing the therapist as human involved the interconnected components of physical environment, emotional safety, and humor that resulted in an overall sense of connection. When Brandi talked about her relationship with Mary, she said,

I feel personally connected to her. I think that kind of the whole human to human relationship piece has been big. That she kind of, she sees me and I see her as another human being.

Wes also described a sense of being connected to Simone, “You just knew that she connected and it was like, ‘I’ve been there, done that.’ We all connected somehow.” Wes’s partner, Christopher, continued, “I just don’t know, but she did. There was this unspoken exchange of energy.”

Carmen and Ashley talked about Tiger being welcoming, open, and honest which facilitated feeling connected. Ashley said, “From the very get go he was just really open and honest and just really welcoming.” When I asked what influenced her sense of connection with Tiger, Carmen shared,

I think just the way he came at us, I guess. Like our first session he asked us what was wrong, why are you here, what do you want from here and he still validates that every single time every session we go to. He’s like, “So from here where do you want to go now? Where do you see yourself going with counseling in general? What do you want to work on?” So, just the way that he kind of approaches us. Kind of gives us a say in the relationship, I guess.

While others talked about connecting on a personal level or through perceived common experiences, Lilith talked about her connection with Sarah in a slightly different way. She said,

She’s [Sarah] very interested in learning about it all which I think definitely helped our relationship because if she would have just been like, “Uum, huh, oh, yeah, okay.” and not really been like, “Oh well, this isn’t necessarily a counseling session, but can you explain this part of it to me?” Then I think it would have been a much
quieter relationship between the two of us. I feel very comfortable talking to her because of the fact she is willing to try to learn where I am coming from and all of that kind of stuff.

Lilith’s partner was somewhat different because she was participating in therapy sessions for Lilith and not because she believed that therapy would be helpful. Yet according to Lilith, even Nicole was able to make a personal connection with Sarah. “She’d [Nicole] be like, ‘I don’t like therapy’ and Sarah would be like ‘What?’ at first. It wasn’t Sarah she didn’t like, it was what Sarah does.”

When Kate talked about her and her partner, Brandi, working in couple therapy with Simone, she talked about the three of them having the same motivation or working toward the same goal,

One of the things she [Simone] said at the end was, “I’m not here to make, my motivation isn’t to see your relationship stay together, it’s to help you make the best decision you can,” and to make that very clear was good to hear because it was the same motivation we were walking in with.

Clients agreed that there was a connection with their therapist. I returned to the data and explored how this connection was created. As I continued to review the various transcripts, I discovered that clients and therapists had commonalities in their dialogue and three sub-themes under connection emerged: the physical environment, emotional safety, and humor.

*Physical environment.* The physical environment created by the therapist influenced the clients’ feeling of connection with their therapist. In this section, I will share the words of the clients followed by the words of the therapists. When I asked Christopher and Wes what they thought influenced their experience of therapy, Wes stated,

It looked like someone was there [in Simone’s office]. That you walked in and it wasn’t sterile. I guess you saw a little bit of her, too. You’d walk in and get to know who you’re going to speak to. She had a picture of her dog, plants, some old knick
knack things, little personal weird things that people like. [Having these things meant] she was a human being. She’s there to help me, but at the same time she just, she’s real. I like real.

When Brandi was talking about what influenced her experience of therapy with Mary, she commented on Mary’s office when she said,

Tiny, tiny little thing that I really like about her—there’s a tree that’s right outside the window and I face the window and there’s a tree. She has bird feeders and bird houses out there and I really like birds and bird watching and I feed birds around here [Brandi’s home].

Carmen and Ashley also commented on the environment in Tiger’s office and how it created a sense of being connected and being safe. Carmen talked about Tiger’s office,

Well, I like to be around palm trees, the ocean and that happens to be kind of like how his office is set up. It’s blue and its two or three palm trees in there and for me it’s just like that relaxes me, that makes me open up and warm up. I’ve always been that way. I like palm trees. So for me that’s what it was. Just the way he decorated his office.

As a follow up to Carmen’s comments, I asked Ashley if she felt the same way about Tiger’s office. Ashley focused on different aspects of the Tiger’s office. While Carmen likes palm trees and blue oceans, Ashley likes bright colors and comfortable furniture. She shared,

I just liked the really big couch. Cause it’s homey. I figured when we walked in there she [Carmen] would like the palm trees in there and he has this plant up on his desk and it’s got these beautiful orange flowers and I love bright colors.

In fact, Tiger’s décor made such an impression on Ashley that she shared Carmen’s comments. Ashley said,

Well, she [Carmen] likes the green part and I like the orange part so she’s like, “We need to ask Tiger what kind of flower that is so we can get one when we move.” And I’m like, “Well, then it will remind us of therapy and we’ll never fight!”

Some therapists have no choice in how their therapy room is set up. This is the case with Sarah and Maigan. Lilith did not comment on Sarah’s therapy environment; however,
Carmen and Ashley did comment on Maigan and Tiger’s separate therapy environments. 

About Maigan’s office, they shared,

Carmen: She’d always sit like seven feet away from us.

Ashley: Yeah, and we were on really uncomfortable chairs and…

Carmen: You know, Tiger will sit probably from me to you [indicating me sitting to her right at a small table], maybe closer. It’s very personable. With her it was kind like you could probably throw a ball over there.

Because the topic of office set up came up in other participants’ interviews and during the interview with her clients, I asked Maigan about the physical layout of her therapy room. She stated,

Right now it’s set up so the clients are sitting next to each other on one side of the room and I’m on the other, but I always think it’s interesting the distance between the two because they’re a lot farther from us than they are from one another in the room.

I followed up by asking Maigan what her ideas were about how that distance may or may not influence collaboration [her word] in the therapeutic relationship. Maigan said, “I would think that it would influence collaboration. They’re feeling not as connected to me being farther away. Or me sitting farther away, maybe they feel less connected to me.” When I asked if this distancing was intentional on her part, Maigan talked about physical distance in the therapy room in terms of boundaries between the client and therapist. She said, “Probably, unconsciously. They obviously have very different roles and it’s kind of a separation of the clients and the therapist.”

Therapists also saw the importance of how an office is set up. Mary talked about her office reflecting her as a person. She shared,

There’s me in that office. I mean me the person and me the professional because I have my books and obviously my license and my diploma. I also have some plants and an antique mirror that’s me, the person. I have bird feeders out and that’s who I
am as a person. I love birds. I find them calming. I know that green things, growing things are helpful to people. I’m comfortable with people sitting in any of the chairs in my office. It doesn’t matter to me and I let people know that. When I first bring them in the office I say, “Whatever’s comfortable for you. You choose.” You know, part of the job of therapy—I can’t do my job as a professional if somebody is so uptight in my office and thinks, “Oh my God, I can’t move in here because what if I spill my bottle of water?” They can’t be comfortable.

Above, Mary’s client Brandi talked about the window in Mary’s office and the fact that there was a bird feeder outside the window. This was a focal point for Mary, also, when she talked about her office. Mary shared,

I have bird feeders outside my window and it’s very interesting to me. This is something I’ve never been able to do until I’m in the office I’m in now for the last four years probably. I have bird feeders out and that’s who I am as a person. I love birds. I find them calming. I wouldn’t trade my office. It’d take me a lot.

Like Mary commented earlier, Simone talked about how she as a person is reflected in her office. She collects and decorates her office with images of her favorite animal. Many of her decorations are very unique. She shared that all of her clients know she loves and is fascinated by that animal. In his office, Tiger tried to create an environment reminiscent of where people might like to be. He said,

I think my room is very warm and welcoming. I have foliage in my room. It’s sort of a palm tree and so it’s kind of like a going to Hawaii, you know? So the people see kind of, they are sort of working in a different place—a place where you want to be.

Overall, clients and therapists agree that the way an office is set up and the items in an office can influence a client’s feeling of being connected to the therapist. A feeling of being connected was important to participants. Kate connected the physical layout of her therapist’s office to emotional safety in the therapy environment. Kate said,

The environment was really nice in terms of feeling comfortable and safe both physically and emotionally. I think the structure of the environment [made it safe]. It was set up that it was a conversation between Brandi and I and she [Simone] was asking questions and just the physical layout was safe.
This sense of safety emerged as a sub-theme of emotional safety that created a sense of connection between a client and therapist.

*Emotional safety.* A therapist’s office can contribute to a feeling of connection; however it takes more than the physical environment to create a safe atmosphere for therapy. In this section, I share the view of clients, followed by the view of the therapists. Clients do not present for therapy when everything is going well. Clients present for therapy when there are problems; therefore, a sense of emotional safety was important to them. For example, Christopher and Wes shared,

Christopher: We had a lot of life happen to us all at once.

Wes: Yeah, that was pretty dark, those were dark times.

Christopher: It was a dark time.

For same-sex couples, the response from a therapist can make an important first impression on clients as to whether or not there is emotional safety in the therapeutic environment and, as Christopher expressed, the thought of entering a non-supportive therapeutic environment can be terrifying.

I can’t imagine having gone through what we were going through personally and then to actually walk into an office and have anything but that [an atmosphere that was supportive of their same-sex relationship]. I am in a loving, committed relationship with a phenomenal person and it’s like I forget that society, I totally forget that it [their relationship] isn’t loved and supported by all. You’ve got, that’s why I can’t even, I mean I was nervous, I don’t know, I can’t imagine going into a non-supportive or unsupportive [therapy environment]. Holy hell!

Christopher’s partner, Wes, discussed her first impression of Simone and related it to the energy that was emitted and that Simone did not react to them being two females in a relationship.
In her office, I had an energy that just felt a little bit safer than my experience in the past with other therapists meaning, um, just as a person I have a hard time opening up, my first impression and energy of her, I guess. The concern was that she just made me feel safe. It was a first kind of, I don’t know how to explain it, a first impression. Just a very calm, open-minded energy compared to my experience with my past one that I just felt tension and I wondered why. She [Simone] really was very, she gave out no energy of being judgmental at all. She didn’t skip a beat when she noticed it was two females, I guess.

First impressions were also important to Carmen when she and her partner Ashley were working with Maigan. Carmen believed that her overall experience with Maigan was good, but she commented on her first impressions. Carmen shared,

You know how when you meet people and you just kind of get a first impression? I guess, and I think for me, she [Maigan] didn’t give me a good first impression and so I carried that all the way through the end.

Ashley had a similar experience with Maigan and made a connection between emotions, and safety, “Maigan and safety? I think that only one time I can remember that I felt safe enough to show any real emotion and cry.” Ashley went on to make a connection between sharing and safety in the experience she and Carmen had with Maigan when she said, “We didn’t really tell her anything we hadn’t told our friends. So it was kinda like we never really disclosed any really personal information that our closest friends didn’t know, I guess.”

Carmen and Ashley’s experience with Tiger was different. With him they felt a sense of safety. Ashley connected safety to being able to cry. She shared, “I just started bawling in the first session with Tiger, I just started bawling, like halfway through.” When I asked what made them feel safe with Tiger, Ashley talked about the way Tiger interacted with them. She said,

I guess the way he interacts with us. He doesn’t sit there with his little notepad and his pen and when we say something writing everything down and just looking at the paper, but he makes eye contact with us, he interacts in a conversation.
Carmen followed Ashley’s thought and added,

And he [Tiger] thinks his way through. I feel like he puts himself in the issue, I guess, and you can even visually see him think through the issue and he’ll say like, “Is this how it is?” or “What do you guys think?” “Do you think it’s different?” I feel like he walks in our footsteps sometimes.

Ashley concurred, “Oh yeah, or he’ll say, ‘Is this what I heard you say?’ and things like that which is nice.” Ashley also talked about her belief that Tiger does not make an issue of them being lesbians and that he actually cares and wants them to succeed. She stated,

Well, the reason I feel like that [safe] is because when we are with him he acts like he really does care. He wants us to succeed. It doesn’t matter that we’re two lesbians, he just wants us, as a couple, to succeed and to make it. He just really portrays that he cares and so that’s a nice feeling that somebody would really want you to make something of yourselves as couple.

Lilith’s thoughts were similar to Ashley’s when she explained safety as being achieved because her therapist Sarah accepted her just the way she is and did not act like it was cool to be around someone who is gay. Lilith shared,

She’s [Sarah] very accepting of what I had to say and honestly I don’t know whether she agrees with homosexuality or not, but as far as I know she has never given me any reason to think that what I do in my own personal life is wrong. She’s never said anything to disagree with the way that I am or like the looks never crossed her face. Ya know, some people get that look that is like, “Oh that’s cool you’re gay.” She’s never been like that. It’s a lot easier to talk to somebody who accepts you than somebody who is just, “Oh, you’re gay.”

Brandi also talked about Mary being accepting and not reacting to Brandi being a lesbian.

Brandi also added the importance of using gay positive language.

She’s incredibly open and accepting of me being gay. She uses gay positive language and that’s a really important thing for me. I don’t like in other situations that somebody said, “Oh, well, your friend Kate,” or something. She [Kate] is my friend, we’re good friends, but by using that kind of language that’s disrespecting my relationship. [Mary] had always been very respectful and open and positive. If there were another LGBT person in town that was looking for a counselor I would definitely recommend her because she just doesn’t even blink an eye.
Carmen and Ashley also addressed the fact that Tiger did not seem to hesitate when talking about lesbian issues.

Ashley: Also then like when gay marriage became legal, he talked about it and then when Carmen said, “Yeah, we’re gonna move to California,” he was like, “What! Why? You can’t even get married there! Why are you moving there? What?” And it was just funny because he just acted like we’ve been together for a while so he just assumed that [marriage] was the next step that we were going to take in our life eventually and that made me feel comfortable because he wasn’t saying, “Oh, gross, you guys should never get married, you guys should never have rights.” So I guess he just kind of let it slip a little that he thought gay marriage was okay, I guess.

Carmen: Yeah, and he never hesitates. You know how some people, when you talk about gay and lesbians, it kind of makes them uneasy and you can kinda tell?

Brandi, Carmen, and Ashley talked about their therapists not hesitating or blinking an eye because they were lesbians and how that made them feel safe. Therapists also had ideas about how they create a safe environment for clients. First, Tiger talked about the importance of creating a safe environment for same-sex couples because of society’s marginalization of same-sex relationships. Tiger shared,

As a therapist you want to create a safe environment for them, for anybody really, but particularly for clients like Ashley and Carmen who, in our society, [their relationship] is still marginalized. So the reality for them is that the society is still very averse to gay and lesbian couples.

I followed up by asking how he creates a safe environment. Tiger talked about being non-judgmental. He shared,

One way to be safe is, of course, to be not very judgmental and try not to impose my own beliefs and values, even though I do have my own beliefs and values and so it’s not always easy, but it is something that I have to be very mindful of and be very deliberate and realize that in my role as a therapist that’s my role is to work with people and to help people.
Sarah agreed with Tiger’s idea of not being judgmental or making assumptions. She discussed the importance of validating a client’s relationship and how that can help them feel safe and comfortable. Sarah said,

I think the biggest part was just letting them kind of lead how things went initially. That trying to show them that I wasn’t going to make assumptions and that, I was going to take their word for it, kind of. That they could explain to me who they are, what their relationship is like, and that I wasn’t going to judge that or question that or anything. I think that’s probably the biggest difference how I create a relationship with other clients and with them. That I feel like that [validating the client relationship] maybe is more important with them. I think it’s important with any client, but maybe more so with them because they probably, they’re lucky they have supportive families, but I know that they have to face that kind of stuff out in the world, of trying to defend who they are and trying to defend their relationship as legitimate. And so if I can show them that I don’t question that at all that that would help them trust me and feel comfortable with me and talk openly with me.

Maigan also talked about validating clients and included using silence and nonverbal cues. Maigan shared,

I think it’s important to give them that time of silence…that time to process what we’re doing. Validating them when they talk about how they’re feeling, both verbally and nonverbally. Nodding, smiling at them, praising them. Being really transparent and saying this is a safe place and asking them how we can make it feel comfortable to them.

When Mary talked about creating a safe environment, she talked about respect and nurturing. I asked her to describe nurturing and to provide me an example. She shared,

I think that nurturing is a multifaceted word. It’s a word with lots of degrees in it. I’ll use the word degrees. So, I have seen therapists that walk out and look at a client, don’t say a word, open their door, and expect the client to come in. They don’t even greet the individual. They might say something about, “Okay,” and that’s it. By that cue, this individual is supposed to know that they’re supposed to get up and walk to the chair and those are really relatively cold individuals, I would say. So, I don’t even think those clients receive the basic respect, let alone nurturing. Then there’s somebody wanting me to be their mother and I certainly will not. I’m not a caretaker, but I can nurture.

If someone is—I’ve had people in my office that I know are diabetic and if they haven’t eaten and they start getting shaky I will say, “Can I get you some peanut
butter and crackers,” or “A piece of fruit might be helpful.” That’s nurturing. They can’t do their therapy if they are so uncomfortable that they’re having difficulty staying present in my office. It might be if they’re coughing I will get them a glass of water. That’s nurturing. It’s respectful to walk down the hall behind them. It might just be putting my hand, if that’s okay with them, on their arm. That’s nurturing.

Clients and therapists agreed that a safe environment was important in the therapeutic context and that it created a sense of connection between the client and therapist. Humor also contributed to a sense of connection.

Humor. A sub-theme that emerged quite early in my interviews with clients and therapists was humor. The clients and therapists in this study found humor as a way to make a personal connection, to engage with each other, and to, at times, alleviate the seriousness of therapy. In this section, I will share the words of each client followed immediately by the words of their therapist.

As a client, Brandi saw humor as part of being human and she shared,

She’s [Mary] got a great sense of humor. We laugh a lot and that’s a strong personality characteristic for me is that I laugh and I like to make jokes and kind of poke fun at myself and others and she’ll laugh along with that and I think that’s good. It brings kinda the human element to things.

Brandi’s therapist Mary also saw humor as part of herself as a person. She said,

I see humor as a way of making me more of a person. I’m a person, and as a person I use humor, and to take that out of that [therapy] process would be unnatural for me.

When Brandi and Kate were in couple therapy, however, Kate saw the use of humor differently than Brandi’s perception of her therapy experience with Mary. Kate talked about her characteristics and attempts at humor, but her memory was unclear about the role it played in therapy. She reflected that perhaps her partner, Brandi, and her therapist, Simone, did not find it appropriate to the situation.
I think that there were times that I cracked jokes because it’s what I do when I’m uncomfortable or because I use humor as a tool. My perception was that this is a way for me to communicate that this is difficult for me. It [humor] could have [played a role], it could have, and that would have been probably because I would start it, but no, I don’t think it was inherent to it, no. Not that I can remember, but again, I know that I use kind of snappy retorts and sarcasm and jokey sort of stuff to make that kind of connection. I remember hearing from Brandi, “I don’t think that this is a laughing matter.” I wouldn’t perceive that she [Simone] was humorless I just don’t see that she saw that as appropriate at that time.

Simone agreed with her client Kate that humor would have been inappropriate in the therapy experience she had with Kate and Brandi. Simone said,

One of the things I think I recall them saying or Brandi saying was that she is typically a very bubbly, sort of happy, outgoing person and that’s not who I experienced in the therapy sessions. Humor—if there was humor it was just little snippets here and there.

Lilith’s partner, Nicole, did not like nor believe in the therapy process and saw humor as the way for their therapist, Sarah, to make a connection with Nicole. Lilith said,

Sarah definitely had to meet her [Nicole] with humor. The humor was the relationship that they [Nicole and Sarah] had that made it so that my partner could actually talk openly and think of it as not being counseling and the weird science that she doesn’t buy into.

From her position as a therapist, Sarah saw humor as contributing to the atmosphere of therapy and enjoyed watching the dynamics that evolved in the therapy room. Sarah shared,

The dynamics between the two of them, that they had great senses of humor and would just play off of each other. That was just fun to watch. That they could kind of joke with me and even kind of rib me a little bit, but that it was fine, that we had built that relationship and that that was okay.

For Ashley and Carmen, humor did not play a role in their relationship with their first therapist, Maigan, and Maigan concurred when she said, “Maybe humor is a part of being connected in therapy and feeling safe because it’s a safe feeling. It’s a safe emotion. I don’t
know that we [Maigan, Carmen, Ashley] used humor that much.” It did, however, play a role in Carmen’s and Ashley’s relationship with Tiger and facilitated learning. Carmen shared,

…he’s kind of humorous too. Like he’ll give us advice or he’ll interpret what we’re talking about in a session and he’ll say, “Well, if you know anybody that doesn’t fight you tell them they’re wrong because it’s not healthy for you not to fight.”

Ashley continued,

Well, and the last time he told us that fighting shows passion, it’s just how you fight that is bad or whatever. So he’s like, “You two have lots of passion for each other,” and we’re like, “Yes! At least we have one good thing that comes out of therapy!” So we just laughed. My experience in therapy isn’t that you laugh. It’s more like crying and sadness and you tell your fears or your secrets or whatever, but with him it’s sometimes that and its fun and its learning.

Carmen concluded,

Its kinda like if we’re having a moment where me and Ashley are looking at each other and we know, “Uh oh,” he just cracks a joke and kinda livens up the environment so it’s not so serious and kinda makes us just laugh like, “Oh, you know you don’t have to be so serious all the time or fight all the time.” It’s okay what we’re going through, it’s normal, it’s not completely bad. I mean for me at least, it fits with my personality that I like the humor, but at times I do like the serious person talking to us.

Tiger also saw humor as playing a role in his therapeutic relationship with Carmen and Ashley and for him it reflected the way he had changed. He shared,

I have become more comfortable with them also…I think through my interaction with them, interaction has become more relaxed, I would say, less formal sometimes. So like sometimes now we laugh and joke a little bit in session and I find myself laughing with them and using humor a little more in therapy. And I don’t think that was happening in the first few sessions. The first few sessions were all pretty business like.

As a therapist, Simone also saw value in humor, “They [Christopher and Wes] would laugh and joke when it was appropriate, but they were also serious when it was appropriate.” Clients Christopher and Wes did not talk about humor in the therapy relationship, although Christopher described therapy using a humor metaphor, “It’s almost like having a little
impromptu. Like a comedy where she [Simone] provides a stage and kind of a context in which you work, but the script is not hers at all.”

For Brandi, humor was a necessary element in the individual therapy process and she summed it up by saying, “I need to laugh about my life because I feel like I’ve had some pretty shitty things happen so I need to be able to laugh as part of the healing process.”

**Therapist Stance as Non-Expert**

A third theme to emerge was the stance of the therapist. I chose the term “non-expert stance” after reviewing the therapists’ interviews because the therapists described the client as being an expert in their own lives. Therapists can take a stance that places them as the expert in the therapy room. These therapists may have a preconceived idea of how relationships should work and what changes need to be made to create a “normal” relationship. This stance is more directive than a non-expert stance. A non-expert stance positions the client as experts in their lives; and the therapist as a person who can assist the clients in facilitating change. All the therapists in this study talked about taking a non-expert stance. Mary (therapist) said, “I am the professional, but I’m not the expert. They are the expert in their own life and they know it best.” As I returned to the data, ideas emerged as to how therapists took a non-expert stance with clients. Simone related a non-expert stance to meeting clients where they are when she said,

I think you really have to meet them [clients] where they are and start there because they are the experts of their own life and their own situation and you’re there as a facilitator, not somebody to dictate what’s going to happen. I mean they are the people in the relationship and I think my expertise was really drawing them, each one of them out in a way that sort of facilitated some repair, some healing between the two of them. I guess the collaborative thing was just helping them facilitate between the two of them what works for them because I’m not the expert on their relationship.
When Sarah and I were talking about language she used when working with lesbian clients, Sarah shared that language and self-identifying may be even more important for clients who are culturally diverse. She said,

I mentioned before that my best friend is Hispanic and through her I learned how powerful those labels can be and choosing those labels for yourself of how you describe yourself, whether it’s Hispanic or Mexican or Latina.

Sarah begins to relinquish the expert stance early in the therapeutic relationship when she said, “Like that first conversation—what do you want me to call you? How would you like to be identified?” Following up on the importance of self-identification, Sarah said, “Recognizing that for anybody having that choice to describe yourself and to have other people recognize and appreciate that is important.”

After Maigan mentioned that the client is an expert in her/his own life, I followed up by asking Maigan how she conveyed a non-expert stance to Carmen and Ashley. She talked about transparency and not giving advice. She shared,

I didn’t give advice and I really told them that. I think I was very transparent about that and said that, “You are the only experts on your lives. You know what you’ve done in the past that’s worked for you guys. You know yourselves way better than I know you, so let’s talk about how you perceive the problem, how you perceive it being solved. What you see is going on and let’s talk that through a little.” If I would have walked in there acting like the expert, I don’t think it would have been received quite as well.

Mary stated that the clients are the experts in their own lives and she is not the expert. I followed up by asking Mary how she portrays a non-expert stance, she talked about empowering Brandi when she said, “If I give her feedback she’s open to say, ‘Hmm, maybe that fits.’ I say, ‘Don’t own it if it’s not yours,’ and she’s able to say, ‘Nah, it doesn’t fit,’ if it doesn’t fit!” Sarah talked about letting the clients be in charge of the process while she guides. Sarah said,
[I let them know that] they were going to be in charge of this process, too, and kind of guide it and I wasn’t going to try to impose some structure or value system or any kind of judgments on them.

Therapists positioned clients as the experts on their relationships and their lives by taking a non-expert stance. A way that the therapists positioned the clients as the experts on their own relationship was to check-in or ask questions to make sure that they [the therapists] understood the meaning the clients attempted to convey. Checking in takes the form of clarifying and asking questions and taking a not-knowing stance. The asking of questions may be even more important with lesbian clients. Therapists and clients talked about therapists asking questions about the clients, therefore making them an expert on their own lives, and also asking questions about language. Sarah mentioned that sometimes her clients used words she wasn’t familiar with. I asked her to explain. She shared,

I mean [they would use] words like “homo” or, I don’t think they ever used the word queer or fag or anything like that, but they would say things to me like, “Oh, just wait until you get two lipstick lesbians together” and stuff like that.

Sarah also talked about checking in and changing the focus of therapy if needed. She shared,

Occasionally I would just check in and talk about the process, how the process of therapy was, and were we talking about the things they felt like were important. And if they weren’t, then we’d refocus and that I wouldn’t take that personally. You don’t want to be doing a bad job. But that’s necessary, to check with them and make sure they’re getting what they need because they know better than you do what they need.

Tiger and I talked about terms he used when working with Ashley and Carmen. He shared, “I’m trying to think if I’m using the word partner with Ashley and Carmen…I’m not sure if they themselves use that word, but I think I might have used it because I thought maybe they were comfortable with that.” I followed up by asking Tiger if there were terms that Carmen and Ashley used that he was not familiar with and he stated, “Not from Carmen
and Ashley, per se, but in working with another gay individual I have learned some terminology,” indicating that he had asked questions to clarify language with clients.

In terms of positioning clients as the experts on their own lives, Tiger shared that he verbalizes to the clients that they are the experts on their own lives. When I asked other ways he conveys a non-expert stance, he shared that he asks questions,

I sometimes would say to my clients that they are the experts when it comes to them. About when it comes to their life, I am not the expert, they are the expert. They know more about themselves than anybody else. I try to check with them regularly. “Is this helpful?” “Is there something else you would like to talk about,” or “What would you like to talk about?” “What would you like to gain from today’s session?” “What would be helpful to you today?” “What would you like to take away from today’s session?” Things like that.

Mary was talking about language and I asked if terms have come up that are not in her vocabulary. She responded,

I have said, “I don’t understand that word,” or “I’m not sure what you just told me.” So I just ask. I think once there’s some kind of relationship and there’s the basics, then people are—I mean certainly individuals like Brandi—are willing to set me straight, or help me understand.

Besides asking questions about terms, Mary’s behavior also reflected a non-expert stance through her willingness to learn and her ability to verbally share her lack of knowledge. This not knowing stance does not mean that the therapist does not have information that informs her. It means that she views clients as experts on their lives and does not portray herself to know all the answers. Mary said,

I need to learn from them [clients] or I don’t know that I can help them very well. I clearly say to the individuals I work with that I don’t know everything, but we can figure things out. We can figure out the best road to take, perhaps. I might have to ask some questions, and I will say to an individual in session, “I don’t know the answer to that, but let’s do some figuring out,” or “I don’t know the answer to this, but I can talk with my supervisor,” or “I can do some research and we’ll talk about it next time.”
Therapists were able to describe how they take a non-expert stance. Clients described this non-expert stance in different terms and, similar to their therapists, they talked about their therapist asking questions and clarifying information. Clients also talked about their therapist not leading the sessions, but talking about what the clients wanted to talk about.

Lilith was talking about her therapist, Sarah, being willing to learn. I followed up by asking if there were terms that were used that Sarah was not familiar with. Lilith answered, “I was never very exposed to gay culture or any of that kind of thing. So all the words that she probably was learning, I was learning too.” Like her therapist, Lilith talked about Sarah letting the clients lead the sessions when she said,

She [Sarah] is always very willing to talk about whatever it is that I had to say. She always did her best to make sure that if we [Lilith and Nicole] didn’t want to talk about what she brought up or if we didn’t like the way that she was going about it, she would try something new.

Lilith also talked about Sarah asking questions and her willingness to understand. She said,

As we got going she [Sarah] got very comfortable, not being afraid to question the things that we talked about when we talked about our relationship or to ask questions about things. While she didn’t always necessarily understand completely the issues she was always very, very willing to try to understand them.

Building on information from other interviews, I asked Simone if language was an issue for her when working with lesbian clients. She responded with an example of clarifying information. Simone said,

Language was not an issue for me with Wes or Christopher. I can say that when I worked with gay male clients they said things that, “I don’t know what that means.” I will, and I do ask for clarification.

Simone did not talk specifically about letting the clients lead, but Christopher explained Simone’s style as not leading when she said, “I mean it was free flowing and she didn’t particularly direct it. She’d throw out a topic and then let it go from there. It wasn’t leading.”
Wes added to the dialogue when she talked about Simone checking in, “It’s like, ‘This is what I heard,’ and ‘Is this what you meant?’”

Kate also had the experience of working with Simone in couple therapy and what she shared was similar to what Christopher and Wes said about Simone utilizing clarification. Kate stated,

She was willing to clarify things. We talked about being married, she asked what kind of terms we used for each other and we said, “Partner was our phrase of choice.” Once we said, “Partners is the language that we use,” that was consistent throughout. There weren’t any missteps [on Simone’s part].

Brandi related clarifying information to being human and confirms Mary’s stance of not knowing everything that Mary shared. Brandi said,

She’s very good at being like, “Wait hold on a second,” and “Could you explain this more just so I’m with you on the same page?” She is very good at clarifying when she needs to. Which to me again is kind of that human scale sort of stuff—she doesn’t pretend like she’s all knowing.

Carmen and Ashley agreed that both Tiger and Maigan conveyed the idea that they were the experts in their own lives through the asking of questions and going with what they [Carmen and Ashley] said. Carmen said that Tiger goes as far as using silence to force her and Ashley to take the lead, “If we’re in a rut and we can’t think of anything [to talk about], he’ll go sit in that chair over there and wait till we talk.” Ashley added,

If we’re not saying anything, he’ll just say something we maybe talked about before or something that we said at the initial visit that we wanted to work on and he’ll be like, “Now, one of you two can come up with whatever it is you want to talk about today.” So, he’s like, “If I have to pick it, it’s not going to be anything fun so you guys might want to pick it because it’s gonna be beneficial for you.” And so we asked him, “Well, you pick it,” and he said, “No, you pick it cause it’s not for me it’s for you.”

Maigan also used questions and letting her clients, Carmen and Ashley, lead the sessions as ways to portray a non-expert stance. Carmen shared, “She [Maigan] asked a lot of ‘how do
you feel’ kind of questions like ‘What do you think?’ She asked our opinion a lot. She always kind of went with what we said.” Ashley agreed with her partner and stated, “She just would go with what we were saying or we always pretty much had the last say.” When talking about Tiger taking an expert stance, Ashley connected the expert stance to power when she said,

I think he takes a non-expert stance to a point just so that we still can see he’s human. We still can see that he has things that go on in his life too, but then when he needs to be in control, he knows when it’s time to say, “This is another way you can do it,” or “This is the information I have.”

Clients and therapists agreed that therapists take a non-expert stance by asking questions and not leading. At the same time, clients expect the therapists to be professional, as reflected in the next theme.

Therapist as Professional

A fourth theme that emerged was the therapist as a professional. Christopher expressed how important it was to her that therapists and other health practitioners are “professionals” when working with lesbian clients. She stated,

I think in matters of the heart and mind and physical being, I think that is one of the ultimate places that you have to be, that you would hope and expect them to be professionals and to really look at what they’re doing, what they have a license for, and the purpose that they’re doing it. I think that any point in a therapist’s or doctor’s position that they would ever compromise any of that and not look at their oath to help people. Corporations will run and people will lose their savings, okay, so there’s Enron’s. But at the end of the day you haven’t crushed a being. That would be the worst place for somebody to not be a professional. That would be the worst place for a person to be discriminating. That is so unfair and so, I mean, we’ve had challenges with doctors’ appointments and things like that and you step back and you’re like, “You’re kidding me! In the big picture, does this [being a same-sex couple] really seriously matter?” Her [Wes’] health, our mental health, our well-being, it’s the core, I just couldn’t tolerate it. You seriously took an oath to help people.

Clients described a variety of factors that indicated to them that their therapist was a professional. For example, Carmen described ways that Tiger was a professional when she
said, “He’s always very professional and I mean from the way he talks to us, to the way he dresses, to the way he even looks at us sometimes.” Kate also commented on Simone’s appearance in terms of being a professional when she said, “Appearance wise, she was casual, wasn’t in a suit or anything, but was neat in appearance and comfortable with herself, took notes, and came back to them.” Kate also talked about the professional environment in Simone’s office when she shared,

It was like when you walked in I knew I was entering an environment that said, “This is something we take seriously. We have protocols that are in place and we have systems that are in place because this is a professional environment.”

Two sub-themes that emerged from the client interviews that influenced clients’ perceptions of their therapist’s professionalism were therapist self-disclosure and therapist knowledge. I will begin with stories of self-disclosure and follow that with clients’ ideas about their therapist’s knowledge. After sharing the clients’ words, I will share the therapists’ words.

*Therapist self-disclosure.* When clients described their therapist as being a professional, I followed up by asking what influenced their idea that she/he was a professional. I also broached this topic with therapists. A common theme from clients and therapists involved the level of therapist self-disclosure, with lower levels of self-disclosure an indication to clients of the therapist’s professionalism. Therapists shared that they believe some self-disclosure is acceptable as long as the disclosure is minimal and for the purpose of helping the client. Some self-disclosure helped the clients see the therapist as a person, yet the self-disclosure was not on a personal level. Wes shared, “She [Simone] didn’t get real personal, but she would say, “Well, I have experience.” Christopher agreed with her partner Wes when she shared about Simone’s self-disclosure. Christopher said,
You’re right, they were just pieces, just not anything in particular, but it did also transfer that person outside the office and made me think she’s going through the same thing or she lives and breathes the same exact challenges or to an extent.

Christopher went on to try and explain how Simone shared herself, but didn’t share her actual experiences. Christopher said,

[She never came straight out and said what happened to her] she was very guarded about it, I don’t want to say guarded. It just wasn’t appropriate. There was absolutely no reason or time to have her share her stuff.

Unbeknownst to Christopher and Wes, Simone identified as a lesbian. After they shared that they now knew that Simone is a lesbian, I asked Christopher and Wes if Simone had talked about her sexual orientation in session. Christopher responded, “She didn’t do that whole, ‘Hi, I’m a lesbian, too, so now we’re in a club together, you can totally be honest, can totally let your guard down.’ None of that. And she could have played that card.” When I asked Christopher why she thought Simone did not do that, she responded, “I think it’s because she’s an ultimate professional.”

When working with Christopher and Wes, Simone did not self-disclose that she is a lesbian. She did share with Kate and Brandi in the first few sessions that she is a lesbian. Kate reflected that this self-disclosure did not affect her level of trust with Simone as a professional. Kate said,

She self-disclosed that she identified as a lesbian, which I think was unnecessary, but yet at the same time was nice to know. It didn’t affect my level of trust with her as a professional. I had a good sense that she knew what she was doing and felt comfortable and all that sort of stuff, but knowing that I didn’t have to explain anything.

Other than self-disclosing she was a lesbian, Kate did not recall any other major self-disclosure by Simone. Kate shared,
I think at one point we talked about being at the farmers’ market over the weekend and she mentioned that she enjoyed the farmers’ market or something like that. Just that she, I mean nothing in any major way. We didn’t talk about anything family oriented or her educational experiences or professional experiences, nothing really like that. If there was anything it was like, “It was a good weekend for the farmers’ market,” that sort of thing.

When Carmen and Ashley talked about professionalism and self-disclosure, they began by focusing on their first therapist, Maigan. Initially, Maigan self-disclosed that she had relatives who are gay and this increased Carmen’s level of trust. Carmen shared,

I think it kinda helped, too, when Maigan told us that she did have some experience as far as being around the gay-lesbian community. I think she told us like her aunt or her uncle was gay or lesbian and for me that made me kind of break down the wall and [be] like, “Okay, I can trust this person.” I think she even said she had friends that were lesbian or gay, so I mean that helped me open up a lot more.

Carmen and Ashley went on to talk about their second therapist, Tiger. After Ashley shared that they were the first lesbian couple that Tiger worked with, I asked if she knew his sexual orientation. She responded,

No, I don’t think it would really matter. He’s got pictures of his kids, but could be…so it doesn’t…I mean…I never really thought of him like that [in terms of sexual orientation]. I guess I just thought of him as somebody that was there to help. I never really cared what he was.

Later in the interview, we revisited Tiger’s self-disclosure. Carmen and Ashley related that Tiger did not disclose much about himself. They once again brought up the picture of the children in Tiger’s office and how they made the heterosexist assumption that they were his children and that he was not a gay man.

Carmen: He hasn’t really self disclosed anything about him…he never talks about his kids, if he has a wife, if he has a partner, family, where he’s from, I mean he’s never really told us anything.

Ashley: But he never even told us about his kids. The only reason we, well we don’t even know if those are his kids.
Carmen: True.

Ashley: They could be his niece and nephew. We don’t even know. We just assume.

Carmen: I dunno. I think it helps to kind of keeps it professional, not getting into where do you hang out, where do you live.

Brandi was sharing that Mary was very knowledgeable about LGBT issues and terms, so I followed up by asking if she knew Mary’s sexual orientation. I present the conversation that resulted,

Brandi: Yeah, she’s straight. Yeah.

Mary Sue: That came up in conversation?

Brandi: She talks about her husband. Yeah. Yep. She’ll…I mean not often, umm… but she talks about being married and husband and stuff so I guess I’m making the assumption that she identifies as heterosexual. She is in a heterosexual relationship. Umm…but uh, but I haven’t asked her if she’s ever had same sex relationships or anything like that, but she describes her relationship with her husband to be very positive and stuff. So I assume that it’s a good healthy relationship for her. [conversation continued]

I would see her as someone who would probably be okay with having had a same sex relationship or experience or something. I don’t think that she’d be like, “Absolutely not,” because we talk a lot about functioning in the grayer areas and that’s a comfortable place for me and she talks about that being a comfortable place for her. So I would assume that it would be a fluid thing for her. I wouldn’t be surprised if she said, “I had a same sex relationship.”

Brandi and I were talking about Mary’s self-awareness and I commented that Brandi knew that Mary is self-aware because she self-disclosed. Brandi responded,

Yeah, but it’s [Mary’s self-disclosure] appropriate, it’s appropriate. It’s rather minimal but it’s influential to me, like it opens up a little door every time. Oh, cool birds, right on. Oh, cycling, cool. Oh, you have a grandkid, cool. Oh, going to a conference, I like going to conferences, too. That sort of stuff. So it affirms my experience. I think it probably affirms her experience too.

A final idea about therapist self-disclosure was presented from the perspective of clients. Two clients shared that they had more information about their therapist than what
they were comfortable with. They gained this information through a series of events including seeing their therapist in an environment in which many people socialize. What followed for the clients was that they knew about the therapist’s friends, lifestyle, and behaviors. They were uncomfortable with this information and did not feel they were able to bring the topic to the therapy room. Instead, as one client said, “I think [the therapist] got to pick and choose when [she/he] wanted to be professional.” Her partner continued by saying, “That was probably a lot of the reason why we never really got that close [to the therapist] and it [therapy] wasn’t really that beneficial.” The client compared the situation with her therapist to her own experience as a professional. She said, “I try very hard to keep those two things separate [personal and professional self] which is why I don’t go out in and I don’t live in the town where I work and I like it that way.” The clients did not place blame for the situation and one stated, “We aren’t saying that was her/his fault or our fault or anything. It was just really weird and I just felt like it was an unfortunate circumstance.”

In addition to client comments on therapist self-disclosure, therapists also talked about their use of self-disclosure and using self-disclosure when it was clinically appropriate or beneficial for the clients. Maigan talked about sharing with Carmen and Ashley in the first two to three sessions that she had gay relatives and she felt this disclosure enhanced her relationship with her clients when she said,

I also thought that by me self-disclosing my own experiences with the LGBT community, I have an aunt that’s a lesbian and an uncle who’s gay, that was really a way to join with them also. I think that helped our relationship in disclosing that.

Tiger also believed that some self-disclosure is beneficial in the therapeutic relationship, as long as the focus stays on the client. He reflected,
Self-disclosure—I think it’s important, but then I think you have to gauge how much you do that based on the feedback you get from your clients as well. So, ultimately, therapy is really the focus, in my mind, [therapy] is about them and their hour is their time and I’m mindful of that, trying to make sure that I am not trying to make it become more about me. Again, based on the feedback—if they say, “Can you tell me more about your experience?” then, of course, I’m going to share, so as long as it’s helpful.

All of Simone’s clients [Christopher, Wes, Kate] agreed that Simone used minimal self-disclosure. Simone explained,

You know, coming back on working with Wes and Christopher, I don’t recall self-disclosing anything really. I can’t think of anything we discussed where it would’ve been helpful. I don’t just disclose for the hell of it, you know? I don’t just disclose for the hell of it…If people do ask directly I do tell them. I mean I wouldn’t sort of explode and, “Why is that important?” but I don’t lie. I don’t think lying is therapeutic.

When Simone and I were talking about self-disclosure during the second interview about her experience with Kate and Brandi, we revisited the fact that she did not self-disclose her sexual orientation to Christopher and Wes. Since that time, Simone has seen them at various LGBT events when Simone was with her partner. Simone did not recall disclosing to Kate and Brandi that she was a lesbian, but she did comment that if she did it may have had something to do with the clients not having to explain an issue. Simone said,

I’m not sure why I did [disclose her sexual orientation]. I don’t remember doing that. I think it would have, and I don’t know if it has anything to do with why I did it or not I’m just speculating, if because of the issues they were dealing with due to their positions, if they would have had to explain or felt that they would have had to explain what that was like and what it meant, for instance, to be a prominent lesbian professional or couple what other people look to, I think it would have taken a lot of time.

Mary talked about self-disclosure when she said, “A small amount in the right places, but that it’s inappropriate for too much of it to come out all the time.” Mary then related self-disclosure to her self-awareness as a therapist and provided an example. She shared,
So if I’ve got stuff going on, like recently or over Christmas my father was in the hospital. He’s 95—he had to go in a nursing home. I’m a human being, I can be preoccupied by that. I might miss something [during the session], or if somebody comes in and they’re dealing with an elderly parent, and I have to watch that I am not overly identifying with what they’re going on, that I’m maintaining some kind of distance from that, and I’m not bringing my own stuff to my feedback to them. Or I think the other thing that can happen at that time is that I don’t share too much of myself. That I’m not disclosing too much. Because my own belief is that some disclosure makes me human. A small amount in the right places, but that it’s inappropriate for too much of it to come out all the time.

Similarly, Tiger talked about sharing his own values and beliefs in the therapeutic process and being able to know when it was appropriate to share those values. He reflected,

In my other aspect of my life I may have certain beliefs and values that may not necessarily fit with the [client] situation that comes before me, so I like to separate it out, compartmentalize, I guess, my life really. When I’m in the role of a therapist, I put away, basically, put my personal beliefs and values aside in some ways. Although I know you cannot completely ignore those, in fact, not with Carmen and Ashley, but with others I have shared openly my beliefs and values because the situation presented for us to share—both the client and myself—to be really open about our, each others’ beliefs and values.

Tiger and Sarah also felt it was important to the therapeutic process to disclose that their experience with their client was the first time they had worked with a lesbian or gay couple. Sarah stated, “They had straight out asked me if I had ever worked with any lesbian clients before and I said, ‘Nope, you’re my first one!’ And they didn’t give me any trouble about that at all, so it was really great.” Tiger had an experience similar to Sarah’s in that Carmen and Ashley were the first lesbian couple he worked with. Carmen shared, “And he told us the first time that we went that we were the first lesbian couple that he’s worked with.”

The clients who participated in this study saw minimal self-disclosure as a sign that their therapists were professionals. An exception was that when therapists self-disclosed their experiences with lesbians and gay men, clients saw it as appropriate and it allowed clients to be more open with their therapist. Clients were uncomfortable when they had what they
considered too much information about their therapist’s personal life. Therapists stated that they thought self-disclosure was beneficial when it was clinically (professionally) appropriate. Simone was the only therapist to disclosure her sexual orientation to a client and that was only with one couple. The second aspect of being a professional that emerged from the client interviews was the therapist’s level of knowledge.

Therapist knowledge. Therapists can gain knowledge about working with lesbian and gay clients in a variety of ways. I was interested in clients’ perceptions of how their therapists did or did not prepare for working with lesbian and gay clients. In this section, I will share the clients’ perceptions of how their therapists prepared to work with lesbian and gay clients, followed by the therapists’ stories of how they gained knowledge in order to work with lesbian and gay clients. I begin with the clients’ ideas about the importance of the therapist having a general knowledge about gay culture.

Clients believed that therapists working with lesbian couples need to have a general knowledge about gay issues. Kate exemplified this when she discussed the difference between not knowing certain “gay” words versus thematic issues and provided examples from her therapy experience with Simone. Kate said,

My perspective on that would be that if there were some things that, like if there was a vernacular issue like lipstick lesbian, if you used a word like that, that’s fine to clarify. If I need to explain why it might be difficult to come out to parents, that’s a thematic sort of thing and you [therapists] should have an understanding of that.

One of the things that we [Kate and Brandi] had talked about were some transissues and she [Simone] asked what that meant within our relationship, but had at least enough of a knowledge of what that was so we didn’t have to explain the whole binary gender system—like she got it. Yeah, she wanted to know more about how it fit rather than what it meant.

Sometimes when you’re working with folks, well prior to this…some of the conversations with the doctor about “here’s how the dynamics work within our
relationship” and the marriage piece and talking about family support—[we] had to explain some of those things because his experience hadn’t been exclusively [with lesbian and gay patients] or he didn’t have that perspective.

I think you can be a successful counselor if you’re unaware those things [issues] of gay couples, but I think it makes you more effective if you do know. I don’t think you need to be gay to know that, but I think you need to have an understanding of these are some of the losses that people can experience. I had a good sense that she [Simone] knew what she was doing and felt comfortable and all that sort of stuff, but knowing that I didn’t have to explain anything.

Christopher and Wes also worked with Simone and agreed with Kate that the therapist needs to have a general knowledge about the gay culture. Christopher shared,

   Well, and know every aspect of the community, like all the initials and that stuff, too. I mean you can’t just say, “I’m a lesbian and I get it.” {Wes laughs} I’m not sure, seriously, I’ll be talking with people with regards to transgender that are gays that are people that just don’t get it, so I think you’d have to have background, even if you want to specialize in the African-American community, for example. It is a culture—it is a culture, it is a society, it is a group, a community that has defined itself in some fashion and there’s information that you need to know.

Brandi described her therapist, Mary, as being “with it” in terms of gay culture and language. She shared,

   She actually seems pretty knowledgeable to me. Like, I don’t know that, I’ve ever used the term ‘lipstick lesbian’ or anything, but I’ve said things before of sort of gay culture sort of stuff. And she’s aware, she’s with it.

Lilith had a somewhat different perspective than Christopher, Wes, and Brandi on her therapist Sarah having knowledge of gay culture. When Sarah admitted she had no experience working with lesbian clients, Lilith and Nicole helped to educate her. Lilith stated that Sarah’s willingness to learn made up for Sarah’s lack of knowledge about gay culture. Lilith shared,

   Well, see Sarah never worked with a [lesbian] couple before so I don’t think she had any kind of experience, necessarily, with a gay couple. I mean she was very much supportive and very open to the ideas that we talked about.
I definitely think that we were educating her a lot. She was very honest about the fact that she didn’t have any experience in it which, honestly, I was fine with it. Ya know, while she didn’t always necessarily understand completely the issues she was always very, very willing to try to understand them. So as far as I’m concerned that completely made up for her lack of knowledge and our educating her.

The data above emerged as clients talked about their therapist having a general knowledge of gay culture. Therapists can also gain knowledge through clinical training, clinical experience, and personal experience. Brandi was unsure if therapists were trained to work with gay clients as part of their curriculum. She shared her ideas about Mary’s training when she said,

I don’t even know if she has any formal training or anything. She just has an air about her. Like, I don’t know, I’ve never asked her. She went through her MSW program somewhat recently, I think, but I don’t really know if that’s part of the curriculum yet in the social work world. I don’t know if the social work field is yet talking about LGBT client work or anything.

Kate expressed her hope that training programs, clinical supervision, or peer consultation included working with diverse populations.

I guess it would be my hope that not only through her [Simone’s] own experiences as a lesbian and having an understanding of some things that might be a cause of that, but within her professional preparation that there would be, especially doing couples work, that there would be an understanding of the different dynamic potential in terms of moving in a society that says that your relationship has less value and internalized homophobia and all that sort of stuff. I would hope that would be part of her academic preparation or through practicum experiences or conversations with other therapists or supervisor sort of things.

Ashley talked about Tiger’s experience and using the knowledge he has gained through research, schooling, or on his own. She shared,

I think with him [Tiger] he had so much experience that I’m sure he has done a little bit of research throughout his years of schooling, he just kind of talks from just his knowledge he has…I think just him being older, too, he’s just got more life experience and more educational experience and more experience with clients and I’m sure through his life he’s came across gays and lesbians before—either had friends or family or something.
Carmen agreed with Ashley and shared that she believed Tiger has both personal and clinical experience. Carmen said,

The way he talks maybe a little bit of both [personal and clinical experience]. I mean obviously he does have more clinical experience, maybe not with gays and lesbians, but just in general with therapy. I mean the words, he doesn’t even say like husband or wife, he just always says partner. Like he kinda just really comes out so maybe he does have some experience with gay and lesbian couples outside of the clinic just the way he kinda acts. That’s my vibe I get at least.

Clients talked about the clinical and personal experience of their therapists. Kate related Simone’s experience to providing Simone with professional tools to assist clients in therapy. Kate shared,

Our perception was that she [Simone] had tools to help us and so I think she brought in that sense of, “I’m here to be of assistance to you,” and either knew that that was her responsibility or felt that was her responsibility. I think she probably brought in that professional knowledge and experience of. “I have a sense of how to conduct a session that’s going to facilitate growth or bring new information out.”

Brandi talked about Mary’s potential personal experience with gays and concluded that because of trust maybe she didn’t need to know how Mary prepared to work with lesbians and gays. Brandi shared,

I mean maybe one of her colleagues is gay. So yeah, I would be surprised if she didn’t have a gay person in her life. Again, like I said, I don’t know, there’s a question mark of what kind of relationship or friendship that she has with the other counselor [who is a lesbian]. I don’t know if they ever talk because we’re a couple and they know we’re a couple. Like if there is consulting that happens there, I don’t know. But I trust her and so I feel like I almost don’t even need to know because it’s okay.

When talking about personal experience, however, being a lesbian may not be enough preparation when working with lesbian and gay clients. After working with Simone, Christopher and Wes discovered that she was a lesbian when they began seeing her at LGBT events with her partner. Wes commented on being a lesbian and a therapist when she said,
Well, I don’t know. I think people who are passionate about trying to help others, I think she [Simone] did the research—even though I’d be a lesbian if I became a therapist, I’d want to get hands on. I think she did some reading.

Brandi took personal experience a step further and talked about the person of the therapist when she shared,

Maybe she reads books, so maybe she just is cool. There’s just cool people out there that don’t have to take a class to be cool about gay stuff. {Laughing.} Clearly for you [Mary Sue], it’s previous to your education, I assume, that you’re just like, “Oh I’m cool with this.” Who knows what that is? Is that reading a newspaper article, is that seeing somebody when you’re a kid, I don’t know…You’re born ally, you know, like I think that can happen. I would regard her [Mary] to be a pretty self-aware person. Umm…and I say that because I think she views the world in a very holistic sort of way and to me they are kind of a hand-in-hand sort of thing, like self-awareness leads to being able to see the bigger picture.

Clients had a variety of ideas about how their therapists prepared for working with lesbian and gay clients. When therapists provided an opening, I followed up by asking how they prepared to work with lesbian and gay clients. Therapists prepared for and learned about working with lesbian and gay clients by seeking knowledge, clinical experience, and coursework. Therapists also talked about the influence of their family and clinical supervision. What follows are the therapists’ stories of gaining knowledge about the lesbian and gay population.

Although therapists had varying length of experience, when they talked about how they gained knowledge about working with sexual minority clients, similar topics emerged. For example, therapists talked about learning by clinical and work experience. Maigan shared,

I think just being at the clinic you see a lot of diversity and not necessarily in age, but in race and ethnicity. I’ve had previous work experiences where I worked with families of low SES so I think that’s helped me [attend to diversity].
Sarah talked about learning from her clients when she said, “I learn a lot from all my clients, but I learned a lot from them. It was a learning experience for sure.” Tiger talked about learning through clinical and work experience, as well as by doing research for presentations. He said,

Mostly I would say [I gained knowledge about lesbian and gay clients] from my clinical experience, as well as from my work experience. Just talking to people, presenting at different places and so I had to write proposals and you do research for presentations, things like that. So I would say mostly from clinical and from reading articles and things like that for presentation-type stuff…I mean some of my earlier clients educated me as well…Not from Carmen and Ashley, per se, but in working with another gay individual I have learned some terminology or some new things I did not know before.

Sarah also mentioned a presentation as preparing her to work with lesbian clients, especially Lilith and Nicole. She shared,

It just so happened that I had done a presentation for a class about the use of the internet in sexual issues and that I was aware of how the internet could be used as a tool to explore your sexuality or your gender identity or your self identity and that it just so happened that this was something that they [Lilith and Nicole] had done, that this couple had done was using the internet. So in that way, I was somewhat prepared and I kind of reviewed that information.

Sarah and Tiger talked about learning from clients and Mary agreed. Mary stated that she needs to learn from clients when she said, “I need to learn from them [clients] or I don’t know that I can help them very well.” Although Mary did not talk about presentation preparation in terms of learning about working with lesbian and gay clients, she did talk about ways that she sought knowledge. She shared,

When I first started working with gay and lesbian individuals and some transgendered individuals when I was at [a local county psychiatric hospital] I needed to do some reading, and some work, and some more awareness, some talking with colleagues. I had to have a knowledge of different cultural aspects as well.
Mary also said she learned from “workshops, reading, supervision, and from individuals themselves. Being involved in a professional organization has been extremely helpful in expanding my knowledge. [conversation continued]

The other thing that I think where I learned from in terms of the gay and lesbian population is [gay] colleagues from my professional organization when I was involved—had friends that were gay or lesbian. That’s sometimes an easy way to ask a question or learn.

Simone is a lesbian and a therapist. When I asked where she learned about working with lesbians she said, “Life experience. Life experience first of all.” However, she felt that she was not fully prepared to work clinically with sexual minority clients. She made a time and monetary investment to gain more knowledge. Simone said,

As part of the [her] residency, I told them that I wanted to be part of this training in Chicago. So one Friday a month I would drive to Chicago and spend eight hours—and this program could’ve been twice as long. It could’ve been a year course in a graduate program all by itself because there was so much information it would make my head spin. So that’s what I did. It was a pretty expensive thing because I had to pay for the course and then drive over on Thursday nights and stay in a hotel and so it was time expensive and money expensive, but very, very much worth it. It was a course on clinical work with LGBT individuals, couples, and families. And that’s what taught me how to be a lesbian, a therapist, as well as other information about how things affect this population. Because you live it, but you don’t really evaluate it or pull it apart. So that’s what I did. I knew I needed more information; because it wasn’t enough just to have life experience.

Aside from seeking knowledge through trainings, workshops, for presentations, and from clients, therapists can also seek knowledge through the media. Sarah shared how her ears perk up when she hears about lesbian and gay issues being discussed. She said,

I guess how I knew about that [Employment Non-Discrimination Act and the Matthew Sheppard Act]—it was just from the news and just paying attention to those issues when I see it in the [university newspaper] or I see it on CNN, that my ears kind of perk up and I pay attention to that stuff.

Tiger talked about paying attention to the media after he started working with Carmen and Ashley in a clinical relationship. Tiger shared,
I think these days anytime I hear or see any news about gay and lesbian, I’m reading about it. So I feel like I’m on top of things in terms of what is going on in our state and in our country. So I’m in tune with the issues. Before I probably would not have read as much, even on the news. But now, if there’re any headlines about gays and lesbians, I’m reading about it. So I think that’s one way of preparing.

All therapists attend training programs and receive clinical supervision and the therapists talked about their training and clinical supervision experiences; however, their experiences were somewhat different. Sarah said that she learned about working with sexual minority clients through her coursework. Maigan talked about taking a diversity course.

Maigan shared, “The diversity course that we [she and her fellow students] took, we did a lot of reading on diversity, as well as a lot of reflection and self-of-the-therapist issues.” Mary was unsure about learning to work with sexual minority clients through coursework when she shared, “I don’t remember having one graduate class. That’s how I’ll say that because I don’t and I graduated in 1979, so perhaps there was one and I forgot.” Simone, however, clearly remembers her education on sexual minority clients in graduate school. Simone shared,

So I walked into my graduate program the first day with a sea of White faces. It was a small sea, but it was a sea of White faces and then I’m like, “Okay, I’m the diversity.” My experience in graduate school with information regarding LGBT stuff was me educating the rest of the class. I graduated having had…I think I had a class that was going to spend one session talking about LGBT stuff which was at the end of the curriculum and something else kind of got crowded into that so it got moved back and so that session was merged with LGBT stuff and self-care.

Therapists also talked about supervision that they received during graduate school and during their practicum or internships. Their experiences were not all the same. Sarah reflected that supervision was helpful, but not any different than supervision for any of her other cases. Sarah shared,

Well, I think it [supervision] was helpful, but I don’t think it was really any different than my other cases. I felt like my supervisor was aware, he was sensitive that these were two lesbians living in central Iowa with a limited social network and that
they’ve been together for a long time since they were very young and he was aware of the influences that that could have on the relationship. But the things we talked about [in supervision] and the suggestions that he gave me weren’t necessarily specific to working with the LGBT population.

Maigan also said that her supervision was not specific to working with sexual minority clients. Maigan said,

I felt like there wasn’t a whole lot of attention to their sexual orientation [in supervision], that we focused a lot on the theory, but maybe that was because that was my first semester and I think [my supervisor] really tried to ingrain getting grounded in theory when you’re working with individuals and then as our supervision experience went on, there could be less focus on integrating theory and more on diversity and ethics and all those other things you need to keep in mind.

Mary’s experience with supervision was somewhat different. Mary’s supervisor encouraged her to seek knowledge. Mary shared,

My graduate practicum supervisor taught me that [to seek information], and I can clearly remember the exact instant that came into my head because when I did my graduate practicum placement I didn’t go somewhere because of the specific practice area, because I wasn’t sure what I wanted at that point except to be a social worker. I went because of her reputation as a supervisor. I thought, “Well if I don’t know where I want to go I might as well have a good supervisor,” and she had a stellar reputation. So I went because of her and there was one instance where I was extremely frustrated about having to gather some information, so she [the supervisor] often gave me one lead, and, “You find it and we’ll talk tomorrow.” I found it and she calmly set it aside and she says, and the moral of this story is: “There’s always a reason for not knowing, but there’s seldom a reason for not finding out,”—and I’ve never forgotten that quote.

Therapists are people, too, and begin learning prior to their formal college education. Maigan said, “My family acceptance of that—of gay and lesbian couples—I think influenced how I worked with them [Carmen and Ashley].” When Sarah talked about her coursework informing her, she continued by talking about the influence of her family. Sarah reflected,

Definitely it’s [coursework] brought more focus to some of the issues for me that I think overall I’m just generally sensitive to differences because of the way I was raised and that my parents had taught me to be a tolerant person and to accept
differences; and I think then the academics really just brought into focus some of the specific issues.

Mary’s family also influenced her as a person through their intolerance of tolerance. Mary shared,

My family was really accepting, very accepting, of other individuals. I mean people just were, they weren’t other than, or less than, or different than, they just were, and we had foster kids in our home when I was growing up. Intolerance was not tolerated in our household. We would have been reprimanded or disciplined in some way for intolerance. It wasn’t just that we couldn’t do it, my parents lived that. I guess it was a gift from them. I would say that it was a gift. That has worked well in the profession I chose. Maybe it wouldn’t work well [laughing] if I was an attorney! But it’s worked well in this field and perhaps that’s why I ended up in this field.

Therapists prepared for working with lesbian and gay clients in a variety of ways and in a variety of formats. They learned through clinical and work experience, seeking knowledge, coursework and supervision, and family. Their experiences may have not been the same, but the topics they discussed in terms of learning about working with sexual minority clients in clinical practice were. All therapists could identify how they prepared for or gained knowledge about working with lesbian and gay clients.

Power

As a feminist researcher, I view power as being inherent in all relationships. In this section, I share the participant’s words about power and how power did or did not influence their relationship with their therapists. As a brief introduction, I share the words of Christopher, Wes, and Kate.

When I was visiting about power with Christopher and Wes, I asked what they think of when they think of power. Wes responded, “Control. Absolute control. Control, exposure.” Christopher continued, “Well, it’s control and we’re both kind of control freaks or we prefer…we don’t hand over power or control very easily and when you walked in that
[therapy room] door you had to check that at the door.” Wes and Christopher talked about power being about control. Kate, however, said the therapist does not have “determining power” which may indicate “absolute control.” Kate shared, “I don’t know that I perceived that Simone had determining power. We weren’t going in front of a judge that said either you get to stay together or you don’t. That wasn’t that sort of power.”

I share the words of the participants as they relate to the themes that emerged from the data. I italicized the words that reflect the themes that were discussed earlier in order to clarify the connections between power and the themes as perceived by the participants. For this section, I used headings that reflect power and the theme that emerged.

**Power and connection.** Mary (therapist) shared her idea that clients have power in the client-therapist relationship because they can find someone who they can connect with—and they may have to visit with more than one therapist to find that connection. Mary said,

> I think Brandi is a really good example of that [lesbians having power in the therapeutic relationship]. Finding someone they can connect with and being who they are gives them the power in that relationship and that may take more than one therapist.

Mary assists clients by talking about clients finding the right connection with a therapist. She shared,

> That’s something that I also invite my people to do. The very first time when I talk with them I say, “If it’s not me, we can help you find someone else,” and I acknowledge—in fact this is how I say it, “You didn’t know who you were coming to see most of the time from Jack and the Beanstalk and if it’s not me it can be someone else and that’s okay because not everybody can fit with everybody.”

Mary went on to talk about how when a client is honest, honesty gives them power. Honesty is a relationship component that indicates connection. She said,
The other thing that gives them power is being honest. If people are dishonest with me nobody wins. They have no power in the relationship. They may feel like they have [power], but they don’t.

Clients also discussed power in terms of honesty. Christopher added trust to the relationship connection. Christopher said that in therapy “you are naked” and she continued, “…so if you give up that [power], if you totally open up, you are handing over your power to an extent. I mean there’s nothing to protect you. You have got to trust that person [the therapist].”

Christopher’s partner agreed and said,

Being honest, I think, in therapy, being truly honest. I think the power of being, it’s like you got be honest here. I think that’s the biggest fear that you need to be honest with yourself and the person you’re here to seek help with. I think that’s the power and control that you’re giving up. This is, you have to be honest. I think it just, to give up, not your lives, but just being honest with, “Okay I do have some issues,” and acknowledging it and admitting that’s the whole of just [conversation continued]

Because of the things I’m battling I’m not being honest with myself so I need someone to give me the tools to understand that the honesty, one, is okay and two, retrain the honesty.

As a follow up question, I asked Christopher and Wes if Simone being honest with them gave her power. Christopher replied,

Oh, yeah, because otherwise she’d [the therapist] make you stay. That’s what I was trying to say. You had to be honest otherwise they had the power to extend therapy or extend the hour of hell or just to continue or keep digging or terminate it.

Christopher and Wes talked about them trusting their therapist and them being honest. Kate talked about the relationship between her trust in her therapist Simone; in this discussion, she touched on the idea of the therapist being honest. Kate said,

I think her [Simone’s] power came from us trusting her to help us and to be effective in that and to do the things we were coming to her to do. We were giving her a certain amount of power in terms of, “We’re going to trust you to say things and to make observations about us that we might not be able to recognize or that might be uncomfortable to hear,” and there’s a power associated with that, not to abuse that and be nasty or manipulative. I think that if you’re going to use your power justly and
for good, you [therapist] have to be honest. I think when dishonesty comes into play is when manipulation comes into play, either overt or in a subversive sense. Like if she [Simone] saw something that was going on and didn’t say something or twisted something, she would be using the power she had as a therapist to elicit a certain response either from Brandi or from myself or to make us think about things in a certain direction and so I trust that in that giving of power [to Simone] that she’s going to be honest. If I had questions about her honesty I would be hesitant to give her that power.

_**Power and therapist stance as non-expert.**_ The connection between power and the therapist stance was the most common theme that emerged under the grand sub-theme of power. Therapists talked about having power in the relationship and ways that they can minimize that power. Maigan talked about her awareness of power and her clinical theoretical orientation when she said, “Power. That’s obviously something I’m very aware of because of my training and I think by taking that postmodern not knowing approach it’s minimized because there is a power differential.” Maigan then talked about ways she tries to minimize her power in the client-therapist relationship and tied it back to her asking questions and clients being the experts in their own lives. She shared,

[I] minimize power by _asking them questions_ and being very transparent with them about _[them] being experts on their lives_ and wanting them to come to their own solutions because they know themselves best and I’m just here to facilitate that process.

Simone talked about the therapist as the person in power then shared her idea about ways that she, as a therapist, can “even the playing field”. Simone brought the topic of power back to the theme of the clients as experts. Simone said, “I think the therapist can do things to engage clients in a way that evens the playing field more, but I think initially when they walk through the door the therapist is the person in power.” I followed up by asking Simone how a therapist can level that playing field. She responded,
Well, I think one of the things that’s necessary is to meet the clients where they are. Because if you don’t meet them where they are and you have expectations that they should be somewhere else, then it’s basically you’re saying, “Well you’re doing it wrong,” or “You should do this,” or “You shouldn’t be here.” You know what I mean? So I think you really have to meet them where they are and start there because they are the experts of their own life and their own situation and you’re there as a facilitator, not somebody to dictate what’s going to happen.

Tiger talked about clients having power because they are asking for help, which shows they are in control of their life (experts in their own lives). Tiger saw his role as that of facilitator when he shared,

I think clients have a lot of power in many ways. They are the ones coming to me and they’re saying, “I want you to help me,” basically. And so I am there to help them and so with that then, they are really the one initiating this process so they are in control of their life and they have already, by the time they come to my office, they have already initiated the process of change. And so they are coming to me to engage me to help facilitate that process.

Tiger shared earlier that he believed that clients are the experts in their own lives. For him, being an expert on their own lives gives clients power in the therapeutic relationship. He stated,

They know more about themselves than anybody else and so I really try to let them know that they have a lot of power already. I think that’s important to help them recognize their abilities and their capabilities and power…I think they have already demonstrated that [power] and then I see them demonstrating continuously throughout the therapeutic process in many ways.

Earlier I shared that Tiger’s client, Ashley, stated that Tiger knows “when he needs to be in control” and can use his power to say, “This is another way you can do it,” or “This is the information I have.” Ashley went on to say, “He can fluctuate whether he wants us to be in power or if he wants to be the one with power.” Overall, however, Carmen and Ashley believed that Tiger gave them the power. Carmen shared that she does not feel that Tiger has
power, but that he puts the power with them. She stated that Tiger will lead them into
conversation, but ultimately he is listening and not leading. Carmen explained,

With Tiger it’s like I don’t feel like he does have power, but he kind of puts it with
us. Like he’ll lead us into our conversations, but ultimately he’s listening and we’re
[Carmen and Ashley] talking through our issues together.

Ashley and Carmen then went on to say that knowing what they wanted from therapy gave
them power. They shared,

Ashley: I guess and we just always went in

Carmen: Optimistic.

Ashley: Huh-huh, and respectful and wanting the same back in return and, like you
said [to Carmen], knowing exactly what it is that we want and we’re going to get that
one way or another. And I think he knew that we knew what we wanted.

Carmen related the power she and Ashley had in therapy with Tiger taking a non-expert
stance and not leading them. She said,

Well, I think that we bring the issues to the table that we want to talk about. For
example, we’ll have three issues, he’ll never just pick one or he’ll just never have a
predetermined issue to talk about when we come in. We’ll come in and he’ll say,
“Well, what do you want to talk about today?” and we’ll pick something and we’ll
just go from there. We just get to pick and choose what we want to talk about, when
we want to talk about it, and if we don’t want to talk about it he’ll give us all the time
we need to figure out what we want to talk about.

*Power and therapist as professional.* By nature of the position, therapists are
professionals who have services to offer—and clients pay for those services. When I asked
Carmen and Ashley what power they had in the client-therapist relationship with Tiger,

Ashley quipped, “Well, we pay him.” Brandi talked about her therapist, Mary, having power
because she has services to offer. Brandi also said that Mary “gives her the steering wheel”
indicating that Mary is not leading the therapy. Brandi shared,
What gives her [Mary] power—the orientation of things in general is I come seeking services and assistance and she has services to give, and so that in and of itself, minute one, day one, gives her power. I have power in a sense that she usually, always, I think, right at the beginning, “How are you?” “How’ve you been?” “How’s the last week been?” and that’s deferring to me. That’s saying, “Here’s the steering wheel; you drive” sort of thing.

Mary worked with Brandi in therapy and talked about the therapist having power because clients are coming to her as a professional who can help. Mary touched on clients sharing information with their therapist that others may not know. In addition, therapists provide a diagnosis which gives the therapist power. Mary shared,

I need to always be aware that I’m in a position of power with my clients. They give it to me by virtue of coming to me for help. By virtue of I’m the professional and I need to always be aware of that and not to use that in inappropriate ways. I want to give them power in their life I don’t want to be a source of taking that away. We [therapists] have power by virtue of we put a diagnosis down and send that in to some insurance company. That’s a huge piece of power over somebody’s life. We have information that they may not have shared with anyone else in their entire life and that’s a huge piece of power.

Like Mary, Simone talked about the therapist having power in the client-therapist relationship. She also talked about the clients sharing information. Simone said,

Well, I think at the beginning of therapy people come in and they’re really anxious and scared. They’re coming and spilling their guts to somebody they don’t know. So I think in the beginning, a therapist will probably, realistically, honestly the whole time the therapist is the one who has the power.

Brandi, Mary, and Simone talked about the power that is inherent in the position of the therapist. Tiger talked about power and how he uses his inherent power as a therapist to empower clients. Tiger shared, “One of the ways that I work with clients is to empower them, to help them recognize their own strengths and the things that they are doing well already.” Earlier I shared that Mary encourages clients to say if something does not fit for them which is an indication that Mary empowers her clients. She went on to say that sticking
up for herself or himself gives the client power. She said, “Being willing to stick up for themselves I think also gives them power to say, ‘Oh, no that doesn’t fit. That doesn’t fit for me. No, I didn’t quite see it that way.’ That gives them power.” Kate discussed power in the client-therapist relationship in terms of the clients giving power to the therapist. Kate also commented on her ability to empower herself and her perception of her partner’s power in the therapeutic context. Kate stated,

I believe, really strongly, like I have the power. I can invite people into my life to help me and that’s me giving my power. I have the power to give that power because I don’t perceive that I’m powerless.

I think in therapy she [Brandi] probably felt that she had power because there were things she couldn’t answer if she didn’t want to or if there’s something that I said that she disagreed with, she would comment on that.

Tiger talked about empowering clients and talked about using his power and connected it to the sub-theme of self-disclosure in order to normalize the clients’ problem. He reflected,

Sometimes I think it’s [self-disclosure] helpful because I think it normalizes for them, “Oh, yeah [someone else has experienced this],” because sometimes therapists are about being in the position of power and so when they hear that you yourself have some similar issues or have gone through some of those issues, then I think it kind of empowers them because then they can see, “Okay, I’m not alone in this. I can also do this.”

A therapist’s knowledge emerged as a sub-theme of the therapist as professional.

Brandi shared her idea about power and education when she said,

In terms of me and life in general, because I’m such an education nut I believe very strongly in that people with more education, not 100% because there are some very bull-headed, idiotic people out there with PhD’s or Master’s or whatever. But if these are good people and they invested themselves in that education process, that should be respected and that you know they have something to offer.

Brandi went on to talk about the influence of age on power dynamics when she said,
The age piece I think again is a value thing of, “Did your parents teach you to respect your elders,” sort of a thing. So I think if people treat their age and education right, like in a respectful sort of way, then one should look to that as good things. But I also think that there’s a lot of middle-aged people with fancy letters behind their name that know less than I do and should not be respected and should not be trusted and I choose as much as I can to not communicate with them.

Mary talked about the sub-theme of knowledge providing her with power, but that knowledge needed to be used carefully. She also talked about how being female gave her power. Mary said,

I have two things I’m thinking about. One is that the knowledge I have certainly is a piece of power but I also need to be careful with that because it’s not fitting in each situation. Okay, every piece of knowledge I have doesn’t fit with every client so I need to be discriminatory in its use—in my use of that knowledge. The power I have as a female in that office. That’s the other thing because I think that’s very important. Whether that’s with a lesbian client, whether that’s with a male client who has a straight partner, whether that’s with a young client that may see me as their mother—so that’s the other piece.

Tiger talked about his power as a therapist and about the power his clients had. Tiger was the only male to participate in this research. In addition, he was older (52 years) than his clients (college age). I asked him if he thought his gender or age influenced the power dynamics in his relationship with Ashley and Carmen. He responded by attending to his age when he said,

That’s a good question. I think my age may have something to do with the perception of power, I think. I think Carmen and Ashley are basically college age and they are looking at me as someone who is significantly older than them which can be really observable by my grey hairs. I think that definitely has some impact. So they’re being somewhat differential in all the, I don’t see them as taking issue with what I say or maybe [they are] more compliant when I give them homework and assignments and things like that because they see me more in the role of a teacher or similar to maybe a professor or something like that. And so I think that definitely plays a part.

I asked Tiger again, “How about the fact that you’re a man?” and he responded,

Yeah, I don’t know about that one. I don’t think that [being a man] has much to do with their perceptions of me having power because if it was in a different culture,
maybe like some other like my own original culture, but here in this culture I don’t see that as that big of an issue.

After discussing her therapist’s power and her own power in the client-therapist relationship, Brandi provided her bottom line in terms of who has the power in the client-therapist relationship. Brandi stated,

It’s the client that has power. The therapist is the one who has the perceived power—the knowledge, the degree, the skills, and the job, and the clinic, and all of that sort of stuff, but it’s really the everyday Joe that comes in that has the power. There you go.

Results Summary

During this project, I interviewed 12 participants. Those participants were lesbians who had attended therapy and their therapists. I wanted to explore client and therapist perspectives of a common experience of couple therapy and to attempt to understand what influenced that experience. The client-therapist relationship emerged from the data as a grand theme. Several themes emerged under the grand theme of the client-therapist relationship. A sense of working together emerged from both clients and therapists as they indicated a “we are in this together” mentality. Clients and therapists also talked about how they had a connection with each other. Clients and therapists agreed that the clients are the experts in their own lives and therapists portrayed this non-expert stance through asking questions and allowing the clients to lead the topics in sessions. Although clients and therapists had a connection and worked together, clients also talked about the importance of their therapist being a professional. This professionalism was conveyed through the sub-themes of the therapist’s knowledge and minimal self-disclosure. Finally, I turned my attention to power in the client-therapist relationship and shared the words of the clients about power influences in the therapeutic context. A figure showing the emergent themes is in Appendix N.
CHAPTER 5: DISCUSSION

I conducted this study to explore a common experience of therapy and what influenced that experience from the perspective of lesbian couple clients and their therapists. The purpose of my exploration was to help close a gap in the literature on working with lesbian couples in therapy. Researchers have explored the experience of individual therapy from the perspective of gay men clients (LeBolt, 1999) and the experience of individual therapy with lesbian and gay men clients from the perspective of therapists (Milton et al., 2002). There is little literature on the experience of therapy with lesbian couple clients. In addition, there is a dearth of literature that reports on the influences on a common experience of therapy from the perspective of lesbian and gay man couples and their therapists.

In this study, I interviewed 12 lesbian clients and their therapists about their experience of therapy and their ideas about what influenced that experience. No gay man couples volunteered to participate in this study. This lack of response from gay man couples could be attributable to a variety of factors. First, gay man couples may be less likely to engage in research endeavors. Second, gay man couples are less likely to attend therapy (Modricin & Wyers, 1990). Third, my recruitment efforts may have somehow missed the gay man couples in the local area. For whatever reason, all client respondents were lesbians.

Aspects of the client-therapist relationship emerged from the participants’ stories as the themes that influenced the common experience of therapy. In this chapter, I discuss the themes that influenced the experience of therapy from the perspective of research participants. The themes include the grand theme of the client-therapist relationship, as well as themes of working together, connection, therapist stance as non-expert, and therapist as professional. As a feminist researcher, I attended to issues of power in the client-therapist
relationship. All the participants in this study had an awareness of power and were able to
discuss the concept of power within the context of the therapeutic relationship. I discuss the
topic of power last and describe how the participants connected power to the various major
themes that emerged. Each theme will be compared with previous empirical research and
suggestions for clinical and/or training practices will be discussed. I also share my ideas for
future research.

Client-Therapist Relationship

Lesbian clients present for therapy because they are requesting assistance as they
navigate the road of life. They arrive at the therapeutic juncture for a variety of reasons. The
clients in this study presented for therapy because there were problems in their relationship.
The reason for therapy is not the focus of this research; however, some of the presenting
problems for lesbian couples are the same as heterosexual couples who seek therapy (Bigner
& Wetchler, 2004; Connolly, 2004). A major difference, though, is that lesbian couples also
have to negotiate the heterosexist, homonegative stereotypes and myths that infiltrate society
and influence their mental and relationship health (Bepko & Johnson, 2000; Connolly;
Malley & McMann, 2002). Therapists are imbedded in this societal context and are not
immune from the influences that negate lesbian experiences and couplehood (Long &
Serovich, 2003). Not acknowledging that society engages in the oppression of lesbian
couples reinforces the heterosexist status quo (Nichols & Schwartz, 2008). In order to engage
in ethical clinical practice (AAMFT, 2001; AMHCA, 2000; APA, 2002; NASW, 1999),
therapists must be prepared to work effectively with lesbian couples within the couples’
personal and societal context (Malley & McCann; Patterson, 2007; Plummer, 1995).
The lesbian couples in this study described their therapy experience as “useful,” “helpful,” “comforting,” “life changing,” and “eye opening.” The therapists in this study described their therapy experience as “meaningful,” “motivating,” “enjoyable,” and a “learning experience.” All participants in this study explained their experience of therapy in positive terms similar to the participants in previous studies (LeBolt, 1999; Milton et al., 2002; Simon, 2000). After reviewing the transcripts, I identified the grand-theme of client-therapist relationship because it was indicated by the emergent themes. I used my knowledge as a therapist and researcher in the family studies field to identify the grand-theme of the client-therapist relationship because the basis of any therapeutic experiences is the relationship that forms and is maintained between the client and the therapist (Bordin, 1994; Connolly, 2004; Horvath & Lubrosky, 1993; LeBolt; Simon).

Working Together

The participants in this study talked about the client and therapist working together during therapy. The term therapeutic alliance or working alliance is used to describe the client-therapist relationship and is considered a pantheoretical concept (Horvath & Lubrosky, 1993). Bordin (1994) described the working alliance or working together as the “active relational element of all change-inducing relationships” (Bordin, p. 15). Clients described their therapists as being inside and being engaged in what was going on in the room while at the same time being outside enough that she/he could be objective. The therapist was able to move from the inside to the outside depending on the dialogue that was taking place between the clients. In essence, dialogue took place between the clients. The therapist was able to move inside the client system to provide feedback, make suggestions, or ask questions in order to help the clients, or could move outside to observe. In reality, therapists do not
choose to be inside or outside of the client system, but are part of the client system (Cheon & Murphy, 2007). A therapist cannot avoid using themselves as an instrument of change in the therapeutic context (Aponte & Winter, 1987). What is important is that therapists need to maintain a vigilant awareness of their part in the lesbian couple system and the influence they exert on that system (Cheon & Murphy). Whether the therapist was inside or outside of the occurring dialogue, the couple continued to be the focus of therapy. The clients in this study talked about the therapist validating both partners’ ideas and not taking sides, as well as being intentional about making sure that both partners were heard. A common factors approach highlights therapist qualities that include validating and hearing the differing perspectives of clients (Sprenkle & Blow, 2004). The clients said they learned about themselves as individuals and how their individual issues influenced their relationship and found this to be helpful in negotiating their couple dynamics. This is an example of the mutual influence that is inherent in a couple system (Whitchurch & Constantine, 1993)

A variety of factors have influenced the lesbian couple client’s perceptions of their therapist being inside versus outside. When clients perceived the therapist as being caring and wanting to be helpful, they described the therapist as being inside. In one case when a young, White lesbian couple (24 and 25 years, respectively) worked with a White, heterosexual woman therapist around the same age (24 years) with limited experience (3 months), the clients described the therapist as being outside. Yet when the same couple client worked with an older (52 years), Asian, heterosexual man therapist with more experience (14 years) the therapist was perceived as being inside. It is difficult to determine if age, sex, experience, or ethnicity influenced the couple’s perception of caring and helpfulness. In fact, it may be the intersection of two or more of these factors that influenced whether or not the
client perceived that the client and therapist worked together in a way that was therapeutically beneficial (Laird, 2000). Sexual orientation was not a consideration as the client described both therapists as heterosexual (which is how the therapists identified). The literature on the importance of sexual orientation matching is mixed (Bernstein, 2000; Jones et al., 2003; LeBolt, 1999; Liddle, 1997; Milton et al., 2002; Moran, 1992; Spitalnick & McNair, 2005). A more thorough discussion of the influence of the therapist’s sexual orientation is provided in the section on therapist self-disclosure.

The therapists in this study said that the clients and therapists were working together and that they were a team that was trying to “figure things out” together. The therapists believed that they were somewhat inside while still being outside in order to maintain objectivity. Davies (2000) described lesbian clients and therapists working collaboratively as the therapist being a companion on the therapeutic journey and not being the tour guide. The therapists in this study talked about balancing their relationship (alliance) with each lesbian client so there was no blaming and in order to build a strong alliance with both partners—a concept explored within the common factors framework (Sprenkle & Blow, 2004). When working with couples, it is also important not to attempt to make change in one partner, but to facilitate change in the relationship (Horvath, 1994). Therapists in this study facilitated change in the couple by eliciting information from both clients and remaining aware of the different ways in which they interacted with the partners that make up the couple client unit. For example, one partner may need to be met on an emotional level while the other partner needs to be met on a cognitive level. Therapists need to have the flexibility to meet clients in different ways and on different levels. In fact, when only one partner presents for therapy, the therapist still creates a relationship with the absent partner by not taking sides and by being
supportive of the absent partner. An experienced therapist (28 years) in this study did not place the blame for problems on the absent partner, but instead made clarifying statements about how behaviors and actions on the part of the present partner may influence the absent partner and the couple relationship. This is an example of a therapist working from a systems perspective even if the therapy work involves an individual working on relationship issues because she is aware of the mutual influence between individuals in the couple system (Whitchurch & Constantine, 1993).

The therapists in this study addressed the partners’ individual issues when working with both partners because of the impact individual cognitions and behaviors have on the couple relationship, yet therapists were able to convey to the clients the message that the couple relationship was the client unit. As part of working together, it is important that therapists and couple clients are engaged in the therapy process; however, therapists also commented on the engagement and interaction between the partners. The therapist’s observation of the caring interaction between partners did not appear to be related to the potential outcome of therapy for the participants in this study and some couples who interacted affectionately terminated therapy because they decided to end their relationship. This was not considered a good or bad outcome of therapy by the therapists; in fact, one therapist stated that the decision to end the couple relationship “was the good choice for them.” This scenario, however, may reflect a difference between heterosexual and lesbian couples. Lesbian couples exist in a much smaller social network and may be more likely to remain friends after a relationship ends. In fact, one couple terminated therapy because they ended their relationship, but then reunited and attended couple therapy a second time with a different therapist.
The results of this study indicated that therapists need to be an integral part of the therapy process and to have input or be inside enough to engage the clients in ways that were therapeutically beneficial. At the same time, the therapist needed to be outside enough to maintain objectivity. An inside/outside position for the therapists influenced clients’ perception of the therapist as caring and helpful. A variety of individual factors may influence a client’s perception of the therapist being inside/outside or simply outside. It is more likely that the intersection of client and therapist variables such as age, sex, and ethnicity, as well as the clinical experience of the therapist may have more influence on ratings of helpfulness and therapeutic benefit from the perspective of lesbian couple clients than single factors. Similar to previous research, sexual orientation does not seem to be a variable related to clients and therapists working together in a therapeutic context. Therapists need to avoid blaming either partner for the problems in the couples’ relationship, to explore individual issues for their influence on the couple relationship, to validate the ideas of both partners, and to make sure both partners feel that their voices are heard.

Connection

The clients in this study reported feeling connected to their therapists. Connection between the client and therapist can be defined as the bond component of the therapeutic alliance and the sense of connection that takes place immediately (Burkard, Pruitt, Medler, & Stark-Booth, 2009; LeBolt, 1999). The therapeutic bond involves the reciprocal trust and acceptance between the client and therapist that is enhanced when the therapist is genuine and authentic (Blow & Sprenkle, 2001; Horvath, 1994). By being genuine, a therapist is able to stay client-centered and accepting of how the client sees oneself (Rogers, 1946). A therapist is authentic when her/his feelings and behaviors are congruent. Through being
congruent, the therapist can have authentic interactions with clients that will lead to change in the therapeutic context (Nichols & Schwartz, 2008). Clients talked about feeling connected to their therapist because of the physical environment (therapist’s office), feeling emotionally safe, and because humor was used within the therapeutic context.

Physical Environment

Client and therapist participants in this study discussed the environment of the therapist’s office as being an important component in making a connection, similar to participants in previous studies (Bedi, Davis, & Williams, 2005; LeBolt et al., 1999). Clients described seeing the therapist as human because of the items in the therapist’s office. A therapist may not have a say in the size or furniture provided in her/his clinical office, but the items that the participants in this study discussed were plants, decorations, and knick knacks that transferred the therapist outside of the therapy room. In other words, the couple could imagine the therapist as a person outside of the professional realm. The way an office was decorated provided the clients with a sense of calm and was described as being “welcoming” and “comfortable.” The therapists in this study also talked about the therapist having bits of themselves in the office through the items they chose for decoration.

The way the furniture is arranged was mentioned by couple clients and they discussed the distance between the clients and the therapist. The clients in this study preferred to have the therapist near versus far away. One client mentioned that her therapist sat “seven feet away from us” and believed that this may have influenced her sense of connection to her therapist. The therapist acknowledged that she did sit a distance from the clients and attributed this to maintaining the separate therapist-client role boundaries. This distance between the therapist and the couple client could be an indication of unintentional anti-gay or
homonegative behavior. Clients liked a room set-up that allowed dialogue between the 
partners, while at the same time they could easily turn to the therapist when she/he was 
speaking.

The results of this study indicate that therapist attention to how they decorate their 
offices and what items they display provides clients with a glimpse of whom the therapist is 
outside of the therapy room and facilitates a sense of connection with lesbian couples. The 
way a therapist organizes the furniture in their room can enhance or attenuate a feeling of 
connection for clients. What may be best is furniture that is close together and allows 
dialogue between clients while at the same time allowing the therapist to easily join the 
conversation.

*Emotional Safety*

Feeling safe was a theme that clients and their therapists found important. The couple 
clients in this study had first impressions of their therapists that indicated to them that the 
therapy context was safe and a place that they could open up and talk (Bernstein, 2000). If 
this first impression was less than positive, the feeling was carried throughout the entire 
therapy experience. Similar to the participants in LeBolt’s (1999) study, the clients in this 
study defined their therapists as “accepting,” “caring,” and “non-judgmental.” Clients noted 
that their therapist did not “hesitate” or “blink an eye” about working with a same-sex 
couple—indicating a level of comfort working with lesbian clients and discussing lesbian 
issues as described in previous studies (Bachelor, 1995; Bepko & Johnson, 2000; Bieschke, 
Paul, & Blasko, 2007; LeBolt). In other words, the therapists did not react in any negative 
manner to meeting a lesbian couple client during the first session. In addition, the therapists 
made eye contact instead of focusing on taking notes, emitted a feeling of caring, and were
able to discuss current events that affect lesbian couples (e.g., same-sex marriage) comfortably. The therapists used language that was inclusive of sexual minority clients, such as the term partner, that influenced the clients’ feeling of safety in the therapeutic context.

The therapist participants in this study said they thought it was particularly important for them to create a safe environment for lesbian couples whose relationships are marginalized by society. This view is supported by previous reports about the marginalization of lesbian relationships (Malley & McCann, 2002; Roth, 1985) and previous literature that states it is the responsibility of the therapist to create a supportive environment (Horvath & Luborsky, 1993; Rogers, 1946). A common factors approach also delineates the therapist’s responsibility to provide a safe therapeutic context for clients (Blow & Sprengle, 2001). Therapist participants were adamant that lesbian couple clients should not have to defend their relationship in the therapeutic context. Clients will test therapists to determine if the therapist is non-judgmental (Bernstein, 2000). The therapists in this study talked about the importance of being non-judgmental and accepting the way clients define themselves and their relationship, which supports previous research (Bachelor, 1995; Bernstein, 2000; LeBolt, 1999; Milton et al., 2002).

**Humor**

Humor was part of the client-therapist relationship for the participants in this study and was used to make a connection and engage with each other. Clients and therapists described humor as a way to bring a human element to the therapy process instead of always being serious in therapy. This is similar to previous research on the purpose of humor in the therapeutic context (Bergman, 1985; Goldin & Bordan, 1999). Humor is a way to reduce anxiety and to strengthen the therapeutic alliance between the client and therapist (Goldin &
Bordan; Schnarch, 1990). The use of humor for the participants in this study was important because it is a “safe emotion” and part of who they are as a person, yet humor needs to be used appropriately (Franzini, 2001). In the case of Brandi and Kate working with Simone, Kate and Simone both stated that humor in their therapy experience would not have been appropriate because of the Brandi’s distress—even though Simone said Brandi described herself as usually being “bubbly, happy, and outgoing.” Therapists have the responsibility of using humor appropriately and also attending to humor that the clients use. The therapists in this study used humor to teach, lighten the mood, and as a therapeutic intervention. These are appropriate uses of humor in the therapeutic context (Goldin & Bordan).

Therapists’ awareness of spontaneous humor on the part of the clients and the ability to confront the inappropriate use of humor by clients that takes the form of sarcasm or as a way of demeaning a partner is important. It is beneficial to clients if therapist are mindful of the multiple purposes that humor can serve (e.g., sarcasm, demeaning, to cover discomfort) and have the ability to evaluate the purpose of the humor and accept responsibility to immediately address the misuse of humor by the clients (Franzini, 2001). When working with lesbian couples it may be especially important to use humor cautiously and appropriately. First, when working with any couple (lesbian or heterosexual) a therapist needs to be certain that neither client will feel offended or that the humor is not used to demean one partner. Second, there are cultural differences in expressing humor in therapy and therapists’ ought to be sure that their knowledge about sexual minority issues is comprehensive enough that humor is appropriate and not offensive to either lesbian partner (Goldin & Bordan, 1999). The use of humor by the therapist may be more appropriate after a strong therapeutic alliance has been created and all people involved are more comfortable,
although the monitoring of humor on the part of the clients begins in the first session. Finally, the continuous use of humor to the point that the seriousness of the presenting issue is ignored will not benefit clients. A balance of humor and seriousness is best.

Therapist Stance as Non-Expert

The client participants in this study stated that their therapists made it clear that they (the clients) were the experts on themselves and their relationship. Therapists agreed that they take a non-expert stance and position the clients as the experts. Therapists make a choice on how they work with clients—whether they want to work from a collaborative stance or an expert stance. A collaborative stance is a positioning by the therapist as a non-expert and allows the client to be an expert on their own lives. A common factors approach calls this “de-emphasizing therapist expertise” (Blow & Sprenkle, 2001, p. 393). This non-expert stance does not preclude therapists from using their professional knowledge (Amundson, Stewart, & Valentine, 1993). This position asserts that the clients know more about themselves, their lives, their relationship, and what has worked for them in the past than their therapist knows. This may be especially true when working with lesbian couples because of their individual and couple contexts as persons oppressed by the dominant culture. According to Horvath (2001), therapists who are able to collaborate with clients are able to create a quality working alliance.

One way the participants in this study described the therapist taking a non-expert stance and positioning the clients as the experts was through the use of questions. Therapists used questions as a way of clarifying information, checking to see if therapy was going in the direction the couple wanted it to go, and to gain an understanding of the meaning the couple was trying to convey. The therapist behaviors described by participants have been reported as
important in previous literature (Bepko & Johnson, 2000). The use of questions begins during the first session. A therapist can position the clients as the expert by asking how they identify themselves and how they describe their relationship. One therapist participant said, “I learned how powerful those labels can be and choosing those labels for yourself.” It is important for clients to be able to describe themselves and their relationships in their own terms and to receive acceptance from the therapist. When a therapist is able to communicate respect for and an appreciation of the couple’s perspectives, it has a positive impact on the therapeutic alliance (Bachelor, 1995; Castonguay & Goldfried, 1994; Diamond, Liddle, Houge, & Dakof, 1999).

Asking questions may be even more important when heterosexual therapists are working with lesbian clients because there may be language or contextual differences between lesbian couple clients and therapists (Bernstein, 2000; Conley et al., 2001). The participants in this study believed that, in general, there were no problems with language and the clients reported that therapists were good about checking to make sure the therapist understood what the client was saying. In fact, clients talked about gay culture language and terms that they were not familiar with and that they were learning along with their therapist. As Lilith said, “I was never very exposed to gay culture or any of that kind of thing. So all the words that she (her therapist) probably was learning, I was learning, too.”

Therapists also supported a non-expert stance by having the clients lead the therapy process and empowering the clients. The clients in this study said they were able to lead the way and “have the last say” during sessions. They indicated that they were able to choose the topics to be discussed in therapy. Therapists can empower couples by letting them know that the client can disagree with what the therapist says and have a dialogue about the differing
perspectives between clients and therapists. Not all lesbian clients will verbally disagree with their therapist so the therapist has the main responsibility for being able to explore whether or not the client agrees with the therapist’s perceptions. In addition, therapists must remain open to learning from the couple and being able to say when they [the therapists] do not know something (Bepko & Johnson, 2000). This not-knowing stance is not be confused with a therapist’s lack of professional knowledge. As one therapist participant said, “Every piece of knowledge I have doesn’t fit with every client so I need to be discriminatory in my use of that knowledge.” Professional knowledge, per se, is only important in the current therapeutic situation if it fits within the client’s personal context (Knobloch-Fedders, Pinsof, & Mann, 2004). Therefore, a not-knowing stance is about the therapist checking in and asking the clients for more information and how the topic being discussed is situated in the life of the couple.

The therapist’s stance as non-expert influenced the relationship between couple clients and their therapists. Therapists need to be willing to ask questions, clarify meaning, and be prepared to say they don’t know when they don’t know. By positioning the couple as the experts on their lives and their relationship, therapists can empower the clients to define themselves and their relationships, while at the same time providing the space for dialogue when the couple and therapist perspectives diverge. Accepting and appreciating lesbian couples within their own contextual experience can increase the therapeutic alliance and strengthen the relationship between the client and therapist. Adopting a non-expert stance and positioning clients as the experts on their life and relationship reduces the chance that therapists will use their own experience and knowledge to construct the problem presented by the lesbian couple (Eubanks-Carter et al., 2005).
Therapist as Professional

The clients in this study said it was important to them that their therapist is professional. Professionalism was identified in the way the therapists dressed and spoke. This finding supports Alexander’s (1988) idea that at the beginning of therapy the therapist has to present as a professional who has credibility. In addition to the way therapists dressed and spoke, clients talked about the therapist’s minimal self-disclosure and the therapists’ knowledge of sexual minority issues as contributing to their perspective that their therapist was a professional.

Therapist Self-Disclosure

Therapists have to make clinical decisions on when to self-disclose information and how much to disclose. Clients and therapists agreed that minimal self-disclosure on the part of the therapist was most appropriate and an indicator of the professionalism of the therapist. This finding supports previous research that stated that therapist disclosure occurs infrequently in therapy (Hill & Knox, 2001). When therapists did use self-disclosure, it was for clinical reasons and the focus stayed on the client and was not redirected to the therapist (Knox, Hess, Petersen, & Hill, 1997). The reasons for disclosing were to normalize the experience of the clients or to provide reassurance; for example, disclosing that the therapist had personal experience with lesbians and gay men. The purpose was not to meet the needs of the therapist—that would be considered inappropriate (Hill & Knox).

For the participants in this study, there appears to be a connection between therapist self-awareness and appropriate use of self-disclosure because the therapists in this study reflected on when to use self-disclosure and when not to use self-disclosure. In fact, the therapists were mindful of the purpose for their self-disclosure and were aware that there may
be times when they could over-identify with the experience of the client and during those
times it would be best of the therapist did not self-disclose. The minimal self-disclosure by
the therapists in this study involved topics such as the farmers market, hobbies, family ties,
and weekend activities or non-personal information, as well as sharing their personal
experience with lesbians and gay men (Hill & Knox, 2001). Clients felt that the appropriate,
minimal self-disclosure by therapists made the therapists more human, was an indication that
the therapist was a person outside of the therapy room, and that the therapist had experience
dealing with life situations. In one situation, a couple described their therapist’s unintentional
self-disclosure via public venues. By observing their therapist in various public venues, the
couple stated they knew more information about their therapist’s lifestyle and behaviors than
they were comfortable with. They stated they felt the therapist could choose when to be
professional and when not to be professional and this influenced their comfort working with
the therapist.

Therapist self-disclosure of sexual orientation has shown mixed results in previous
research (Bernstein, 2000; Jones et al., 2003; LeBolt, 1999; Liddle, 1997; Milton et al, 2002;
Moran, 1992; Spitalnick & McNair, 2005). In this study, one therapist self-disclosed that she
was a lesbian to one couple, but not to another couple. The lesbian therapist did not
remember self-disclosing her sexual orientation to her clients, but stated that if she did, it was
for clinical reasons. She also said, “If people do ask directly, I do tell them. I don’t lie. I don’t
think lying is therapeutic.” The participants in the Milton et al. study stated that it was
important that a therapist consider disclosing therapist sexual orientation when it would
benefit clients. In our heterosexist society, heterosexual therapists have less to lose by
identifying their sexual orientation than lesbian or gay man therapists. Heterosexual
therapists may need to refer a lesbian client if the client prefers a lesbian therapist; however, a lesbian or gay man therapist has to out her or himself in a professional sense and this may have multiple ramifications (Bernstein).

The heterosexual therapists in this study did not disclose their sexual orientation, but the lesbian couple clients assumed the therapists were heterosexual. In fact, the couple who worked with a lesbian therapist who did not disclose her sexual orientation assumed she was heterosexual until they began to see her and her partner at LGBT events and functions. The clients in this study picked up on terms the therapist used that indicated a heterosexual orientation (e.g., boyfriend, husband). Lesbian and gay clients begin to assess the therapist for potential homophobia at the beginning of therapy (Bernstein, 2000) and this assessment may include the therapist’s use of inclusionary or exclusionary terms such as husband. Clients also picked up on what they believed were cues of heterosexuality such as a picture of children. As stated earlier, the way a therapist decorated her or his office influenced the lesbian couple client’s sense of connection to the therapist and it also provided clues to the therapist’s sexual orientation.

None of the clients in this study asked the therapist about the therapist’s sexual orientation and the clients indicated that the therapist’s sexual orientation was not important; however, the clients in this study said that if they believed it was important, they would ask directly. Although some clients in this study said they would ask a therapist about her or his sexual orientation if they thought it was important, not all clients may be comfortable questioning a therapist. Therefore, responsibility for the voluntary disclosure of therapist sexual orientation rests with the therapist. The reason(s) they are self-disclosing and the amount of self-disclosure is critical in order to maintain a professional identity from the
perspective of their lesbian clients. Self-disclosure is used appropriately when the focus remains on the lesbian couple client and the reason for disclosure is to normalize the couple’s experience or for purpose of reassurance. Diligent self-awareness and self-reflection on the part of the therapist assists the therapist in determining if they are disclosing in order to meet their own needs (e.g., when they are dealing with stressors in their own lives that may cause them to over-identify with the lesbian couple client). In addition, awareness of client perceptions when therapists find themselves in the same social arenas as their clients is important because behaviors and social locations may influence the clients’ perceptions of the therapist as a professional.

**Therapist Knowledge**

Therapists can create a safe environment that leads to a stronger therapeutic alliance by having a basic understanding of lesbian issues when working with lesbian couple clients (Milton et al., 2002). The participants in this study talked about the importance of the therapist having an understanding of lesbian issues so that the client’s general societal context did not have to be explained. Understanding the societal context of the couple was more important to the couples in this study than an understanding of specific terms that may be used. Clients in this study did not mind educating therapists on terms if it was necessary and, as discussed above, client and therapist participants’ perspectives concurred that the therapist would ask questions to clarify the meaning the clients were trying to convey. What was more important to the couple clients in this study was an overall understanding of and comfort discussing the issues faced by sexual minority clients. This finding supports multiple studies that purport that knowledge about sexual minority issues is imperative when working with lesbian clients (Bernstein, 2000; Bieschke et al., 2007; Milton et al.; Moran, 1992;
Language itself was not a concern for the participants in this study and, in fact, clients said that there were terms used by sexual minority individuals that they were not familiar with. Lilith said that she was not raised in a gay culture and any words her therapist learned during therapy, she learned right along with her. Gay language may not be specific to the sexual minority, but more of a gay culture phenomenon that LGBT individuals and allies may be familiar with, but not all lesbians may know.

The therapists in this study learned about working with lesbian clients in general, and lesbian couples specifically, from a variety of sources, which is consistent with previous literature that reported 78% of therapists learned about lesbian and gay man individuals, couples, and families from three or more places (Green et al., 2008). Of the five therapists in this study, only two talked about having coursework that covered clinical work with sexual minority clients and none discussed learning about clinical work with sexual minority clients in clinical supervision during their training programs. Clinical supervision is an optimal way for supervisors to engage in dialogue with therapists-in-training about lesbian and gay issues (Green et al., 2008; Long, 1996; Long, 2002; Long & Lindsey, 2004; Long & Serovich, 2003). Although 72% to 80% of AAMFT Clinical Members reported working with sexual minority clients in therapy (Bernstein, 2000; Long & Serovich), only 65% reported learning about lesbian and gay clients in their training programs and only 46% reported learning about lesbian and gay clients in clinical supervision (Green et al., 2008).

Many clinical programs are required to include sexual minority diversity within their curriculum, but this requirement is often met by incorporating an article on lesbians and gay men into a few courses instead of providing in-depth training on lesbian and gay issues (Long & Serovich, 2003). Malley and Tasker (2004) reported that over 90% of the
respondents in their study remember little teaching or discussion of how to work with lesbians or gay men during their clinical training. In fact, COAMFTE-accredited training programs that are associated with a religious-based institution do not have to attend to sexual minority clients in order for the institution to “protect the core beliefs of their institution” (Long & Serovich, p. 61).

All therapist participants in this study talked about gaining knowledge about working with sexual minority clients through their clinical work. This does not appear to be unusual in clinical practice as it has been reported that as many as 95% of therapists who work with sexual minority clients gained knowledge through clinical experience (Green et al., 2008). This is concerning considering that only 54% felt competent working with sexual minority clients (Doherty & Simmons, 1996). Learning about working with sexual minority clients in clinical practice may not be a best practice on the part of the therapist unless this learning is complemented by close clinical supervision by a supervisor who is experienced in working with lesbian clients. Although some clients in this study did not mind teaching their therapists about sexual minority issues to some extent, this modality of learning places responsibility for the therapist’s knowledge on the clients and may not be the most beneficial to clients. In fact, most clients in this study indicated that they wanted their therapist to have a general knowledge of lesbian and gay issues, although they were willing to answer questions by the therapist when the therapist was attempting to clarify information in order to understand the message the client was trying to convey.

Personal experience with sexual minority individuals is related to comfort working with lesbian clients (Herek & Capitanio, 1996; Kidd, 2005; Twist et al., 2006). For the therapist participants in this study, personal experience came from having lesbian or gay man
colleagues or family members. Therapists’ families influenced therapists’ comfort with
lesbian clients because while they were growing up the therapists learned about accepting
individuals and couples from diverse backgrounds. The diversity may not be specific to
sexual minority individuals and couples, but therapists transferred their family learning about
other types of diversity to sexual minority diversity. Plummer (1995) talked about being able
to navigate in a multicultural world and the findings of this study supports the idea that
acceptance of diversity can increase a therapist’s comfort and ability to work with diverse
clientele.

The therapists in this study had personal experience with sexual minority individuals,
couples, and families through workshops, community organizations, journal articles, and the
media. This finding supports previous research that stated therapists learned about lesbian
clients from more than one place (Green et al., 2008). The therapists in this study were
interested in and willing to seek out knowledge about sexual minority clients. In fact, the one
lesbian therapist in this study did not feel that being a lesbian prepared her to work with
sexual minority clients. If a therapist is not willing to gain knowledge about the continuing
and ongoing sexual minority issues faced by lesbian couple clients, it may be best that they
not work with lesbian clients. Because of the homonegativity in our society, I found it
interesting that therapists talked about learning about sexual minority issues through the
media. Yet therapists in this study followed sexual minority issues offered by the media in
order to inform themselves about their lesbian couple client’s social context. This study took
place during the time of the 2008 presidential elections when same-sex marriage was a
platform issue. At the same time, in the state in which the study took place the state Supreme
Court decided that same-sex marriage was not unconstitutional and same-sex marriage
licenses were available (Iowa Supreme Court, 2009). These two situations increased the amount of media coverage about sexual minority issues, especially in terms of same-sex marriage.

Therapists who work most effectively and ethically with lesbian clients are those who have a general knowledge of lesbian issues (Greene, 2007). This general knowledge does not constitute the therapist being an expert, but being able to dialogue with the client from an informed stance. Clients may be willing to teach therapists about lesbian issues, but this responsibility should not fall to the clients. The therapists ought to take the initiative to learn about sexual minority issues before working with lesbian clients (Bernstein, 2000). Therapists can learn about sexual minority issues in a variety of places, including training programs, clinical supervision, workshops/conferences, family-of-origin, personal experience, professional journals, and the media. What may be most important is the willingness of the therapist to seek knowledge before working with lesbian clients (Greene) and to continue to seek knowledge. Gaining knowledge ought not to be exclusively limited to clinical experience. Training programs and clinical supervision can attend to sexual minority diversity in order to train clinicians who can work effectively and ethically with sexual minority clients (Long & Serovich, 2003). Families-of-origin who embrace diversity provide a fertile ground for exploring additional forms of diversity. Organizations that accredit clinical training institutions must review their policies to eliminate institutionalized discriminatory practices regarding sexual minority clientele in order to train therapists who can practice ethically with lesbian and gay man couple clients.
Power

I conducted this study within a feminist framework that attended to power issues. The participants in this study also were aware of power dynamics that are inherent in relationships. Participants in this study talked about power in the client-therapist relationship and how that power was related to the emergent themes of connection, therapist stance as non-expert, and the therapist as professional. The therapists and clients in this study had different perspectives about power in the therapeutic relationship, but they agree that it is not the presence of power itself, but the way that power is used that is important. Therapists discussed inherent power because of their position as therapist, yet stated the clients also have power. Clients talked about honesty giving them power and them choosing to give power to the therapist, although they acknowledged that the therapist has inherent power.

Power and Connection

Clients and their therapists stated that the couple had power in the therapeutic context because they were able to choose a therapist. The idea that clients are able to choose a therapist could be problematic because clients may not see themselves as a consumer who employs a mental health professional. In addition, with the current focus on managed care in our society, clients may not have a choice about whom they see for therapy. Consumer choice is a topic that therapists can broach in the first session to help couples make an informed decision about who they want to work with within the therapy context. Making a positive connection is not inherent in all client-therapist relationships and therapists can assist clients by talking about the fit of the relationship. Therapists must remain aware that not all clients and therapists will be a good fit and be willing to be transparent about fit and refer the couple to another therapist when appropriate.
The clients in this study said they gained power when they were honest in the therapy context. The relationship between honesty and client power was discussed by both client and therapist participants. Therapists, too, need to be honest and use their power for good instead of for manipulating the client unit. This finding supports previous research about the need for therapist honesty and authenticity (Blow & Sprenkle, 2001; Horvath, 1994). There appeared to be a circular causality with honesty in the therapeutic relationship. When couples trusted the therapist, they were honest. When therapists were honest, the couple trusted the therapist. When the couple trusted the therapist and saw the therapist as honest, the clients gave power to the therapist through trust and honesty. Therefore, clients and therapists need to be honest in therapy to increase trust and connection in the client-therapist relationship.

*Power and Therapist Stance as Non-Expert*

All therapists in this study talked about the power they have in the client-therapist relationship, indicating that they all have a level of self-awareness about power issues in the therapeutic context. The therapists in this study stated they minimized the influence of their power by asking questions and positioning the clients as the experts on their lives and relationships. Therapist and client participants agreed that positioning the clients as experts in their own lives minimized the therapist’s power. Therapists who position themselves as experts based on knowledge are likely to have a rigid view of the client and the client relationship, thereby forcing societal norms on the lesbian couple (Amundson et al., 1993). Positioning the lesbian couple as the expert also empowered the clients and facilitated the idea that the therapist is a facilitator of change and not the expert on what is best for the couple. Clients saw the therapist as giving them power by deferring to them through asking questions, by utilizing active listening, and by letting the clients choose the topics discussed
in therapy. Active listening is related to lesbian couples’ perceptions of a quality therapeutic alliance (Bachelor, 1995). Clients saw themselves as having power in the client-therapist relationship when they knew what they wanted to gain from therapy. This expectation could be problematic as not all clients know what they want from therapy. Therapists can be transparent about the power that the couple has and the ways that the couple have utilized their power in the past and during the therapy process. In general, when therapists work collaboratively with clients, it provides the therapist an opportunity to be self-reflective about the use of power in the therapeutic relationship.

_Power and Therapist as Professional_

Client and therapist participants in this study agreed that therapist power is inherent in the client-therapist relationship that supports previous research (Amundson et al., 1993). Participants noted that therapists had power because of their position as mental health professionals who had a service to offer that was paid for by the client. Therapists who perceive their clinical knowledge as certainty negate alternative ways of being and become deaf to the stories of their lesbian clients (Amundson et al.). Therapists noted that they had power because the couple shared information with them during therapy that the couple did not share with others.

The therapists in this study used their power to empower clients by recognizing the couple’s strengths while working from a strength-based perspective that acknowledged what the couple was already doing well (Berg & De Jong, 1996; White & Epston, 1990). Therapists also empowered clients by letting them know that they could disagree with the therapist’s perspective. Not all lesbian clients will feel empowered to disagree with their
therapist. Therapists must be willing to discuss disagreement early in the therapy process and remain aware that clients may not verbally disagree with the therapist.

Therapists can address power issues in the client-therapist relationship by utilizing self-disclosure to normalize the lesbian couple’s experience (Bedi et al., 2005). Utilizing self-disclosure can also instill hope that there are solutions to the problems that couple is facing (Alexander, 1988). From a common factors perspective, instilling hope influences the quality of the client-therapist relationship (Blow & Sprenkle, 2001).

Power and Demographics

Client and therapist demographics can be sources of power in the client-therapist relationship. Education, age, sex, race, and sexual orientation have been discussed in previous literature as sources of power (Bernstein, 2000; Greene & Boyd-Franklin, 1996; Jones et al., 2003; LeBolt, 1999; Laird, 2000; Liddle, 1997; Milton et al, 2002; Moran, 1992; Morales, 1996; Spitalnick & McNair, 2005). These power variables emerged in the current study; however, the interpretations are complex.

Clients talked about the therapist’s knowledge, degree, skills, position, age, and experience as a mental health professional as power variables for the therapist. Therapist participants talked about age as a power factor when the therapist was older than the client and about the clinical experience of the therapist. One therapist stated she thought being female gave her power no matter the sex or orientation of her client, yet the one man participant in this study did not see his sex as being a power factor since his therapeutic work was in the American culture instead of the culture in which he was raised. This may be an example of male privilege that proposes that those with the power are unaware of the power they have. A feminist family therapy perspective proposes that gender is a dimension of all
social interactions, including therapy, and attention needs to be given to the power differences based on the sex of the client and the sex of the therapist (Walters et al., 1988). It is not unusual for men to have difficulty understanding that being a man gives a person power because, at times, they have felt powerless in their personal relationships (Walters et al.). Additionally, in the current situation there is the intersection of sex and cultural difference with one culture being more individualistic and the second being more collectivist with the oppression of women more visible (Connolly, 2004; Greene & Boyd-Franklin, 1996; Morales, 1996). It is difficult to discern which demographic variable may have influenced power in the client-therapist relationship. In fact, it is most likely that the intersection of variables influenced the relationship between the lesbian couple clients and their therapist.

**Future Directions**

The purpose of this study was to explore the influences on a common experience of therapy from the perspective of lesbian couple clients and their therapists. I utilized a feminist qualitative research paradigm in order to elicit a thick, rich description of these influences. The experiences expressed here were those of lesbian couple clients and it cannot be anticipated that the same ideas would be expressed by gay man couple clients. Several topics were discussed by participants that did not emerge as themes in this study. Just because these topics did not become themes in this study does not mean that they are not important to the experience of therapy for lesbian couple clients and their therapists. Therefore, these topics serve as an impetus for future research.

First, the therapists in this study had between three months and 28 years of clinical experience. There was little indication that there was a direct link between the clinical experience of the therapist and the lesbian couple client and therapist’s experience of therapy.
In fact, knowledge about sexual minority issues may or may not be related to the length of clinical experience. A well-informed therapist with little clinical experience may have clients that are more satisfied with therapy than an experienced therapist that is not knowledgeable about sexual minority issues. Therefore, future research could address whether or not there is a link between clinical experience and the experience of therapy on the part of lesbian couple clients and their therapists and whether knowledge about sexual minority issues mediates this relationship.

Literature has shown that sexual identity development is an important issue for sexual minority clients (Cass, 1979; Coleman, 1982; D’Augelli, 1994; Troiden, 1989). Some clients in this study acknowledged that one partner was struggling with identity development and coming out issues, yet differences in identity development and coming out did not emerge as an influence on the experience of therapy for the participants in this study. Future research on the clinical experience of lesbian couples could focus on how identity development differences in partners influences their experience of therapy and whether or not therapists attend to these differences. In addition, the relationship between development differences and power in the couple relationship could be explored for their influence on therapy.

Clients in previous research reported that it was important that therapists explored their own sexual identity development if they were working with sexual minority clients (Moran, 1992). The lesbian therapist and one heterosexual therapist in this study stated that they had explored their own sexual identity development. The heterosexual therapist said that she thought it influenced her ability to work with a lesbian couple. However, sexual identity exploration by the therapist did not emerge as a theme in this study as influencing the lesbian couple clients’ or therapists’ experience of therapy. Future research should explore if and
how heterosexual therapists who work with lesbian clients attend to their own sexual identity development and the influences this exploration has on the experience of therapy from the perspective of lesbian couples and their therapists.

Some therapists in this study talked about learning to attend to diversity from their family-of-origin. Two therapists stated they thought this early learning influenced their ability to work with lesbian couple clients. In addition, clients discussed their family and family culture during therapy as being either supportive or non-supportive—often having different levels of support from family members within the couple. However, the influence of family of origin on the lesbian couple and on the therapist did not emerge as having an influence on the experience of therapy or the formation of the therapeutic alliance (Knobloch-Fedders et al., 2004). We begin life embedded in our family of origin and the family provides the context and culture of our reality; therefore, future research could address the family’s influence on therapy experiences for both lesbian couple clients and therapists.

I anticipated that societal homonegativity and homophobia would influence the therapy experience of lesbian clients and their therapists. The therapists in this study were aware of current events in terms of lesbian and gay issues and they acknowledged that lesbian couples were marginalized in society. Clients talked about the societal influences on them as individuals and as a couple, but did not believe that society influenced their experience of therapy. One couple discussed how people in their social network criticized them for going to therapy as a couple and perpetuated the idea of serial monogamy or promiscuity by telling the couple that they could always find a different partner. They stated they felt marginalized by their lesbian and gay man friends. Societal homonegativity, homophobia, and internalized homophobia did not emerge as themes in this study. Future
research could include in-depth, multiple interviews over time to explore the influence that society and internalized homophobia have on lesbian couples and therapists and the relationship between society and the experience of therapy.

A therapist’s minimal use of self-disclosure when it was clinically beneficial for a client emerged as a sub-theme in this study. Therapists indicated self-awareness when they talked about when they should and should not self-disclose. Clients talked about the types of topics that are appropriate to disclose. One couple stated that they were uncomfortable with how much information they knew about their therapist. Future research could consider the relationship between the therapist’s self-awareness and the use of self-disclosure on the premise that a therapist needs to be aware of the purpose of self-disclosure and when and what is appropriate to share with lesbian clients for the purpose of therapeutic benefit.

The intersection of demographic variables in this study was complex and difficult to tease out. This complexity may be an indication of a lack of awareness on the part of the participants, me not asking the right questions, or simply an indication that demographic variables intersect and the inherent difficulty in determining which variable may be influencing the experience of therapy from the perspective of clients and their therapists. Future research methodology could address the complexity of intersectionality in order to delineate the influence that specific demographic variables (or the intersection of demographic variables) have on the experience of therapy from the perspective of lesbian and gay man couple clients and their therapists.

One therapist in this study identified as a lesbian and she talked at length about the difficulty of acting like a straight therapist. She also commented that she was the diversity in her graduate program, being a lesbian was not enough to inform her about working with
sexual minority clients, and the relief she felt when she could bring all of herself into the therapy room when she was working with a lesbian couple. She stated, “I was able to bring more of myself into the room than I do with some couples.” Future research could address the lack of congruence for lesbian therapists between their personal self and their professional self. Becoming a therapist is a development process that has been reported in terms of heterosexual norms. Feminist researchers have indicated the importance of the congruence of the personal feminist self and the professional feminist self (Blumer, Green, Compton, & Barrera, in review; Whipple, 1996). Little attention has been given to the development process of becoming a lesbian therapist and reaching congruence between personal and professional identities.

A final area of interest for future research is the influence of religious beliefs and values on the experience of therapy from the perspective of lesbian clients and their therapists. One therapist talked about setting aside personal values and beliefs based on Christian doctrine in order to work with lesbian and gay individuals and couples in the therapeutic context. Research has shown that there is a direct relationship between religious practices and comfort working with lesbian and gay man clients (Green et al., in press). Research has also shown that there is a relationship between conservative, authoritarian beliefs and homonegativity (Herek & Capitanio, 1996). Yet there is a dearth of literature on how the spiritual or religious beliefs and practices of lesbian clients and their therapists influence the experience of therapy. In fact, a popular book used in marriage and family therapy programs to teach therapists-in-training about the models of couple and family therapy has a mere three paragraphs on spirituality (see Nichols & Schwartz, 2008, p. 316). Spiritual and religious beliefs often act as a coping mechanism for lesbian clients and for
therapists (Pargament, 1997), yet continue to be ignored in the therapeutic context. In addition, lesbian couples are often ostracized by organized religions. Future research should explore the influence of spiritual and religious beliefs, values, and practices on the part of lesbian clients and their therapists for their influences on the experience of therapy.

Conclusions

The results of this study bring forth several points for discussion among clinicians who work with lesbian couples.

1. A quality client-therapist relationship is imperative when working with lesbian couples in clinical practice.

2. Lesbian couple clients benefit from a collaborative stance that is experienced as working together in the therapy context.

3. Therapists can create a sense of connection with their lesbian couple clients by attending to the physical environment of their office, by creating emotional safety, and by utilizing appropriate humor in therapy after a strong working alliance has been created.

4. Lesbian couple clients benefit from a therapist stance that positions the clients as the experts on their own lives and relationship.
   a. Therapists can position clients as the expert by asking questions and allowing clients to lead in the therapy session.

5. Therapists can position themselves as professionals who use minimal self-disclosure when working with lesbian couple clients and only when it is clinically beneficial.
a. Therapists must remain aware that clients may receive information about the therapist through means other than self-disclosure, e.g. being in the same social venue.

6. Therapists can position themselves as professionals with lesbian couple clients by having a general knowledge of sexual minority issues.

7. Therapists can attend to and be transparent about power differentials in the relationship between lesbian clients and their therapist.

Although the current project adds to the literature in the field of couple therapy with lesbian clients, historically speaking, the exploration of sexual minority couple clients’ experience and their therapists’ experience of therapy is in its infancy. Additional research is needed to inform therapists on how to work effectively and ethically with lesbian and gay man couples in clinical practice.
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APPENDIX A: IRB APPROVAL LETTER

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

DATE: August 9, 2007

TO: Mary Sue Green
4380 Palmer Bldg.

CC: Megan J. Murphy
4380 Palmer Bldg.

FROM: Jan Canny, IRB Administrator
Office of Research Assurances

IRB ID: 07-376

Approval Date: 9 August 2007
Date for Continuing Review: 8 August 2008

The Chair of the Institutional Review Board of Iowa State University has reviewed and approved the protocol entitled: "The Experience of Couples Therapy from the Perspective of Lesbian and Gay Clients and Their Therapists." The protocol has been assigned the following ID Number: 07-376. Please refer to this number in all correspondence regarding the protocol.

Your study has been approved from 9 August 2007 to 8 August 2008. The continuing review date for this study is no later than 8 August 2008. Federal regulations require continuing review of ongoing projects. Please submit the form with sufficient time (i.e., three to four weeks) for the IRB to review and approve continuation of the study, prior to the continuing review date.

Failure to complete and submit the continuing review form will result in expiration of IRB approval on the continuing review date and the file will be administratively closed. All research-related activities involving the participants must stop on the continuing review date, until approval can be re-established, except when necessary to eliminate imminent hazard to research participants. As a courtesy to you, we will send a reminder of the approaching review prior to this date.

Please remember that any changes in the protocol or consent form may not be implemented without prior IRB review and approval, using the "Continuing Review and/or Modification" form. Research investigators are expected to comply with the principles of the Belmont Report, and state and federal regulations regarding the involvement of humans in research. These documents are located on the Office of Research Assurances website or available by calling (515) 294-4566, www.compliance.iastate.edu.

You must promptly report any of the following to the IRB: (1) all serious and/or unexpected adverse experiences involving risks to subjects or others; and (2) any other unanticipated problems involving risks to subjects or others.

Upon completion of the project, please submit a Project Closure Form to the Office of Research Assurances, 1138 Pearson Hall, to officially close the project.
APPENDIX B: RECRUITMENT EMAIL/LETTER

Introductory email/letter:

Hello,

I am contacting you because either you expressed an interest in my dissertation research project entitled “The Experience of Couples Therapy from the Perspective of Lesbian and Gay Clients and Their Therapists” or because your name was given to me by a mutual acquaintance as someone who may be interested in my research. I am now ready to begin interviewing couples.

In order to participate in this research, individuals must self-identify as gay or lesbian; have attended therapy as a couple within the last 3 years; be willing to have their therapist participate in this project; be able to participate in a joint, in-depth interview; be available for additional interviews if extra time is needed; and be available to provide feedback on themes that emerge from their interview. All information will be kept confidential. Participation in this research is voluntary and participants may withdraw at any time with no consequences. Each participant will be given a gift certificate as compensation for their time.

If you would like to read more information about this research, please review the Informed Consent document enclosed with or attached to this letter. If you are interested in participating in this research, you may contact me by email at lgeouple@iastate.edu or by phone at (515) 294-6317. Please feel free to share this email with others whom you believe may be interested in participating in this research. Thank you in advance for your assistance in locating research participants!

Sincerely,

Mary Sue

Go out and make it a great day!

Mary Sue Green
Marriage and Family Therapy Program
4380 Palmer Building
Iowa State University
Ames, Iowa 50011
(515) 294-6317

Megan J. Murphy, Ph.D.
Marriage and Family Therapy Program
4380 Palmer Building
Iowa State University
Ames, Iowa 50011
(515) 294-2745

Use of e-mail is not a secure form of communication; thus, confidentiality cannot be ensured. If you received this e-mail message in error, please immediately notify the sender. Thank you.
APPENDIX C: RECRUITMENT FLIER

Attention: Lesbian and Gay Couples

You are invited to participate in a research project entitled

The Experience of Couples Therapy from the Perspective of Lesbian and Gay Clients and Their Therapists

Participation includes an in-depth interview.

Participants must:

♦ Identify as lesbian or gay
♦ Have attended at least 1 session of therapy as a couple in the past 3 years and continue to be in the same relationship
♦ Be willing to have the therapist participate in an individual interview

All information will be kept confidential. Participation in this research is voluntary and participants may withdraw at any time with no consequences. A gift certificate will be given to each participant as compensation for your time.

Contact person: Mary Sue Green at lgcouple@lastate.edu
APPENDIX D: NEWSPAPER AD

Newspaper ad:

Lesbian and Gay couples who have attended therapy as a couple within the last 3 years or are currently in therapy and are still in the same relationship are invited to participate in a research project entitled “The Experience of Couples Therapy from the Perspective of Lesbian and Gay Men Clients and Their Therapists.” Participation includes an in-depth interview, all information will be kept confidential, participation is voluntary, and participants may withdraw at any time with no consequences. Compensation will be provided. If you are interested in participating or would like more information, please contact Mary Sue Green by email at lgcouple@iastate.edu or by phone at (515) 294-6317.
APPENDIX E: RECRUITMENT EMAIL/LETTER FOR THERAPISTS

Introductory e-mail/letter to therapists:

Dear [Name]:

You are being contacted because a current or former client of yours has agreed to participate in a research project entitled “The Experience of Couples Therapy from the Perspective of Lesbian and Gay Clients and Their Therapists.” Part of the research project is interviewing the therapist about his/her experience working with the lesbian or gay male client couples in therapy. Please note that this research is about the experience of therapy—not the therapy itself or the reason the client was presenting for therapy.

If you are interested in being involved in this research project, I would ask that you:

1. Contact me by email at lgcouple@iastate.edu or by phone at (515) 294-6317.
2. Be available for a brief phone conversation with me so I can ensure your willingness to participate in the research and to schedule our initial meeting.
3. Be available for an initial meeting so that I can answer any questions about the research project, have you sign an informed consent form, and collect basic information, e.g. name, contact information, years of clinical practice, etc.
4. Be available for an in-depth interview to explore your experience of couples’ therapy with your lesbian or gay couple client. The length and location of the interview will be determined by you.
5. Be available for additional interviews if extra time is needed.
6. Be available to review and provide feedback on themes that emerge from your interview.

All information will be kept confidential. Participation in this research is voluntary and participants may withdraw at any time with no consequences. You will be given a gift certificate as compensation for your time. If you would like to read more information about this research, please review the Informed Consent document enclosed with or attached to this letter. If after your review, you are interested in participating in this research or have any questions about this research, please contact me by email at lgcouple@iastate.edu or by phone at (515) 294-6317.

Thank you so much for your help and I hope to hear from you soon!

Sincerely,

Mary Sue Green, M.S.

Go out and make it a great day!

Mary Sue Green
Marriage and Family Therapy Program
4380 Palmer Building
Iowa State University
Ames, Iowa 50011
(515) 294-6317

Megan J. Murphy, Ph.D.
Marriage and Family Therapy Program
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Ames, Iowa 50011
(515) 294-2745

Use of e-mail is not a secure form of communication; thus, confidentiality cannot be ensured. If you received this e-mail message in error, please immediately notify the sender. Thank you.
APPENDIX F: CLIENT INFORMED CONSENT

INFORMED CONSENT DOCUMENT

Title of Study: The Experience of Couples Therapy from the Perspective of Lesbian and Gay Clients and Their Therapists

Investigators: Mary S. Green, M.S.
Megan J. Murphy, Ph.D.

This is a research study. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.

INTRODUCTION

The purpose of this study is to explore the experience of couples therapy from the perspective of lesbian and gay clients and their therapists. You are being invited to participate in this study because you are or were a client of a therapist in the state of Iowa.

DESCRIPTION OF PROCEDURES

If you agree to participate in this study, your participation will involve contact over no more than one year. During the study you may expect the following procedure to be followed:

1. A brief phone conversation with me so I can ensure your willingness to participate in the research and to schedule our initial meeting.
2. An initial meeting so that I can answer any questions about the research project, have you sign an informed consent form, and collect basic information, e.g. name, contact information, etc.
3. An in-depth interview as a couple to explore your experience of couples therapy. The length and location of the interview will be determined by you.
4. Be available for additional interviews if extra time is needed.
5. Be available for an individual interview at your request.
6. Be available to review and provide feedback on themes that emerge from your interview.

The in-depth interview will be recorded on audio cassette and will be transcribed verbatim (word for word). You may refuse to answer any question or to engage in any conversation with the interviewer. You may also ask for the tape recorder to be turned off at any time. You may withdraw from the study at any time with no consequences.

RISKS

While participating in this study you may experience the following risks: You will experience no more risk than what you experience in your daily life.
BENEFITS

If you decide to participate in this study, you may not receive any direct benefit. It is hoped that the information gained in this study will benefit multiple audiences. For clients, I would like to empower them by assisting them in becoming aware of their rights as a client and by validating their experiences as individuals, couples, families, clients in therapy, and in our larger societal context. For therapists, I would like to foster curiosity and a willingness to become aware of subtle heterosexism in their clinical practices, as well as awareness of the power of both the client and therapist in the therapeutic relationship and the larger societal context. For training institutions, I would like to challenge them to evaluate their programs for intentional and unintentional homophobic and heterosexist biases. For the larger society, I would like to instill an awareness that all people deserve and should be able to expect respect and confirmation of their diverse life experiences.

COSTS AND COMPENSATION

You will not have any costs from participating in this study. You will compensated with a $20 gift certificate for participating in this study.

PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled.

CONFIDENTIALITY

To ensure confidentiality to the extent permitted by law, the following measures will be taken. If the results are published, your identity will remain confidential. All care will be taken to protect your identity and any potentially identifying information. Pseudonyms will be used for all participants. You will have the opportunity to read themes that emerge from your interview and ask for information to be removed or rewritten. The audio cassettes containing the interviews will be kept in a locked drawer in a locked room. The transcripts will be kept on a password protected computer in a locked room. Documents with potentially identifying information will be destroyed by May 2010.

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies, auditing departments of Iowa State University, and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information.
QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study. For further information about the study contact Mary Sue Green at lgcouple@iastate.edu or (515) 294-6317 or Megan J. Murphy, supervising faculty, at mjmurphy@iastate.edu or (515) 294-2745.

If you have any questions about the rights of research participants or research-related injury, please contact the IRB Administrator, (515) 294-4566, IRB@iastate.edu, or Director, (515) 294-3115, Office of Research Assurances, Iowa State University, Ames, Iowa 50011.

******************************************************************************

PARTICIPANT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document and that your questions have been satisfactorily answered. You will receive a copy of the written informed consent prior to your participation in the study.

Participant’s Name (printed)_____________________________________________

___________________________________________ (Date)

(Participant’s Signature) (Date)

INVESTIGATOR STATEMENT

I certify that the participant has been given adequate time to read and learn about the study and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits and the procedures that will be followed in this study and has voluntarily agreed to participate.

_____________________________________________ (Date)

(Signature of Person Obtaining Informed Consent)

ORA 10/06
APPENDIX G: THERAPIST INFORMED CONSENT

INFORMED CONSENT DOCUMENT

Title of Study: The Experience of Couples Therapy from the Perspective of Lesbian and Gay Clients and Their Therapists

Investigators: Mary S. Green, M.S.
              Megan J. Murphy, Ph.D.

This is a research study. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.

INTRODUCTION

The purpose of this study is to explore the experience of couples therapy from the perspective of lesbian and gay clients and their therapists. You are being invited to participate in this study because a current/former client has indicated interest in being included in this project and you are a therapist licensed or working toward licensure in the state of Iowa.

DESCRIPTION OF PROCEDURES

If you agree to participate in this study, your participation will involve contact over no more than one year. During the study you may expect the following procedure to be followed:

1. A brief phone conversation with me so I can ensure your willingness to participate in the research and to schedule our initial meeting.
2. An initial meeting so that I can answer any questions about the research project, have you sign an informed consent form, and collect basic information, e.g. name, contact information, years of clinical practice, etc.
3. An in-depth interview to explore your experience of couples therapy with your lesbian or gay couple client. The length and location of the interview will be determined by you.
4. Be available for additional interviews if extra time is needed.
5. Be available to review and provide feedback on themes that emerge from your interview.

The in-depth interview will be recorded on audio cassette and will be transcribed verbatim (word for word). You may refuse to answer any question or to engage in any conversation with the interviewer. You may also ask for the tape recorder to be turned off at any time. You may withdraw from the study at any time with no consequences.

RISKS

While participating in this study you may experience the following risks: You will experience no more risk than what you experience in your daily professional life.
BENEFITS

If you decide to participate in this study, you may become more aware of how you experience couples therapy with lesbian and gay clients and this awareness may enhance your therapeutic practice. It is hoped that the information gained in this study will benefit multiple audiences. For therapists, I would like to foster curiosity and a willingness to become aware of subtle heterosexism in their clinical practices, as well as awareness of the power of both the client and therapist in the therapeutic relationship and the larger societal context. For clients, I would like to empower them by assisting them in becoming aware of their rights as a client and by validating their experiences as individuals, couples, families, clients in therapy, and in our larger societal context. For training institutions, I would like to challenge them to evaluate their programs for intentional and unintentional homophobic and heterosexist biases. For the larger society, I would like to instill an awareness that all people deserve and should be able to expect respect and confirmation of their diverse life experiences.

COSTS AND COMPENSATION

You will not have any costs from participating in this study. You will be compensated with a $20 gift certificate for participating in this study.

PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled.

CONFIDENTIALITY

To ensure confidentiality to the extent permitted by law, the following measures will be taken. If the results are published, your identity will remain confidential. All care will be taken to protect your identity and any potentially identifying information. Pseudonyms will be used for all participants. You will have the opportunity to read themes that emerge from your interview and ask for information to be removed or rewritten. The audio cassettes containing the interviews will be kept in a locked drawer in a locked room. The transcripts will be kept on a password protected computer in a locked room. All documents with potentially identifying information will be destroyed by May 2010.

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies, auditing departments of Iowa State University, and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information.
QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study. For further information about the study contact Mary Sue Green at lgcouple@iastate.edu or 515-294-6317 or Megan J. Murphy, supervising faculty, at mjmurphy@iastate.edu or (515) 294-2745.

If you have any questions about the rights of research participants or research-related injury, please contact the IRB Administrator, (515) 294-4566, IRB@iastate.edu, or Director, (515) 294-3115, Office of Research Assurances, Iowa State University, Ames, Iowa 50011.

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PARTICIPANT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document and that your questions have been satisfactorily answered. You will receive a copy of the written informed consent prior to your participation in the study.

Participant’s Name (printed) __________________________________________________________

(Participant’s Signature) ____________________________________________________________ (Date)

INVESTIGATOR STATEMENT

I certify that the participant has been given adequate time to read and learn about the study and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits and the procedures that will be followed in this study and has voluntarily agreed to participate.

(Signature of Person Obtaining Informed Consent) ________________________________ (Date)

ORA 10/06
APPENDIX H: MEMBERS OF THE HELPING PROFESSION

Members of the Helping Profession

Marriage and Family Therapy Clinic
4380 Palmer Building
Iowa State University
Ames, IA 50011
(515) 294-0534

Richard Joens
550 39th St
Des Moines, IA 50312
(515) 279-6200

Keith Schrag
233 S. Walnut Avenue #B
Ames, IA 50010-6725
(515) 232-3482

Central Iowa Psychological Services
1200 35th St., Suite 707
West Des Moines, IA 50266
(515) 222-1999

Suzanne Zilber
600 5th St
Ames, IA 50010
(515) 232-5340

Judy Christensen
809 Central Ave, Suite 420
Fort Dodge, IA 50501
(515) 955-1836

Peg O'Rourke
610 N 4th Street #110A
Burlington, IA 52601
(319) 754-8035

Karen Wall
1551 Indian Hills Drive, #221
Sioux City, IA
(712) 252-1473

Bonnie Williams
101 2nd Street SE, Suite 700
Cedar Rapids, IA 52401
(319) 364-5106
APPENDIX I: RESPONDENT DEMOGRAPHIC INFORMATION SHEET

Respondent Demographic Information*

<table>
<thead>
<tr>
<th>Respondent Number</th>
<th>Date/Time</th>
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Informed Consent Signed □

<table>
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Name

Address

Phone(s)

Email

Preferred method of contact

What is your highest completed level of education? (e.g. bachelors, masters, doctorate, other)

What was your major?

What do you do for a living?

What is your individual income?

What is your sex?

What is your age?

How would you define your sexual orientation?

How would you define your current relationship status?

How would you describe your race?

What is your religion?
Have you had the experience of therapy?

If yes, what was the reason you began therapy?

If yes, was this individual, couple, or family therapy?

How many different therapists have you worked with as a client?

What length of time did you work with each therapist?

How many sessions did this include?

For client respondents:

If you have had more than one therapist, what is the name of the therapist we will be talking about today?

How did you decide which therapist you wanted to talk about?

For what reason did you begin therapy with this therapist?

Is this therapy experience current or in the past?

If the therapy was in the past, why did you end therapy?

If you are a therapist:

How long have you been in clinical practice?

In what states have you practiced?

What is your current licensure or what licensure are you working toward?

If you are an LMFT, what is your AAMFT membership category? (e.g. clinical, associate, approved supervisor)
What is your current, primary work setting? (e.g. academic, community agency, hospital, private practice)

How would you describe your clinical theoretical orientation?

What % of your clinical practice is with individuals?

What % of your clinical practice is with couples?

What % of your clinical practice is with families?

*To be completed by the researcher.
APPENDIX J: INTERVIEW QUESTIONS

For this research, I plan to use a semi-structured interview format to explore the clients’ and therapists’ experiences of couples therapy. I will begin with open-ended questions, with follow-up questions based on respondents’ answers. Open-ended questions I plan to ask the clients are:

1. How would you describe the experience you had in couples therapy?
   a. What do you think influenced your experience of therapy?
   b. How would you describe your relationship with your therapist?
   c. How would you describe the way you and your therapist interacted?

2. How would you describe your partner’s experience in couples therapy?
   a. What do you think influenced your partner’s experience of therapy?
   b. How would you describe your partner’s relationship with your therapist?
   c. How would you describe the way your partner and your therapist interacted?

Open-ended questions I plan to ask the therapists include:

3. How would you describe the experience you had working with [clients’ names] in couples therapy?
   a. What do you think influenced your experience?
   b. How would you describe your relationship with your clients?
   c. How would you describe the way you and your clients interacted?

Additional questions include:

4. How did the therapist prepare for working with lesbian and gay men couple clients?
5. What are the clients’ thoughts about the therapist’s knowledge about and understanding of lesbian and gay male issues?
6. What meanings do the lesbian and gay male couples and the therapists make of the therapy process?
APPENDIX K: EXAMPLE OF EARLY MEMO

Lilith, Christopher, Wes (and Brandi) all talk about trying to find out/explore their individual issues along with the couple issues. L willing to educate the therapist, whereas C and W do not discuss this. I believe B mentions this.

Lilith and Christopher talk about the importance of therapy and C goes on to say it is the best thing she’s ever done. Note: Lilith continued with individual therapy after couple’s therapy.

Lilith and Christopher talk about sexuality is an important part of their life, but there is more to them. Mary says, “I wouldn’t do it any different with say Brandi, than I would be with somebody that was straight and didn’t come for problems because of their sexual orientation.”

Brandi says, “And it’s not about helping the cause at every turn but it’s, to me-it’s so much about please just see me as a regular individual. I am just like you. I am, you know. One component of my life is different but, you know you have a different hair color than I do and it’s the same thing.”

Lilith and Sarah and Brandi/Kate

I am not sure where it fits, but I keep coming back to S comparing race and sexual orientation and Lilith talking about being Native-White and how she has had to deal with invisibility in terms of who she is out to as a Native and as a lesbian. Sarah talks about her best friend who is Hispanic.

Uh, and Kate has a Native American background in her family members and stuff. It’s not an active, over-active component of her life or anything, um, but, with grandparents and stuff there’s a very clear societal-the whiter the better sort of thing. It’s not really talked about much in her family.

Sarah talks about family influences and how she came out as heterosexual. Lilith’s family found out accidently and some relatives still do not know because of religion. Similarly (?) Chris and Wes are “recovering” from a traditional religion and changed to a more liberal denomination.

Sarah compares sexual orientation issues today with Jim Crow laws.

Lilith talks about how societal issues make it harder to be gay, while Sarah says that has increased her awareness. Societal issues don’t seem to be necessarily good or bad, but just are. There was discussion about engagement, humor, and mutual growth.

Sarah by learning more about lesbianism and Lilith by learning more about her individual issues and how they influence her couple issues. There was discussion about the clients leading and the therapist letting clients go where they wanted to. In this case, Lilith was
definitely educating Sarah. Sarah stated she had to ask more questions and asked different questions because Nicole self-identified as transgendered.

Lilith talked about Sarah being overwhelmed, but getting comfortable. Sarah talks about her being nervous, but getting more comfortable and gaining confidence. Nicole did not like therapy, but was able to be open and willing. Could it be that Nicole was guarded similar to Chris and Wes. Lilith talks about them working on their individual issues that influence their couple issues, while Sarah talked about balancing the alliance. Sarah and Lilith agree that they had an easier time working together because of similarities. At times Nicole appeared distracted, but still engaged—just in a different manner. Lilith describes it as she wants to be engaged and Nicole has to be engaged in the process. Sarah’s interest in lesbianism and willingness to learn were repeated.

Humor was important in the relationship between Sarah and Nicole. Is humor something that a therapist can use? Does this have to come from the client? Kate said that there was no humor in her couples experience, while I believe Brandi mentions humor in her individual sessions.

Lilith and Sarah both talk about sexuality being a big part of someone, but not all of someone. Lilith talks about how she is open and out about her sexuality, yet terrified that people will find out.

Sarah talks about the clients being direct and Lilith talks about volunteering information and Nicole telling it how it is. Brandi also talked about being direct. Need to check on others.

Simone, Christopher, and Wes

It seems the themes are beginning to fall under different themes than I started with.

I am seeing safety and comfort on both sides, along with Simone being comfortable and being able to experience growth within the therapeutic relationship (bringing more of self into therapy room). Christopher and Wes also experienced personal growth and relationship growth. This growth was influenced by the safety and comfort.

The three worked as a team with Simone as a facilitator. She was able to be outside, yet inside as part of the team. Simone facilitated this by eliciting info from both, not validating one or the other, letting them be in their box, just letting them be themselves. S also “meets them where they are”.

All had commitment: Christopher and Wes to their relationship; all 3 to the therapy process; Simone to the clients; and Simone to helping.

Perspectives of power different somewhat, but therapist is able to “even the playing field” through teamwork and eliciting information from all.
Honesty, openness, lack of defensiveness, being genuine were all gained through the safe/comfortable environment. Simone being human also contributed to the environment.

The categories of client, therapist, experience, and interactions seem to be floating away to be replaced by more similar experiences. Therapist and clients had similar experiences and share similar traits.

Simone talks about C and W and their humor and C and W do not talk about this, yet talk about them having a little impromptu comedy where S provides the stage and context, but C and W provide the script. During our interview there was a LOT of laughter. –check with Christopher and Wes about the place of humor in their experience.

Brandi and I also had humor throughout our conversation

Sarah and Kate self-reflection
Sarah said she thought she could help this couple and that she wanted to help me. She enjoys being self-reflexive. Kate delineates self-reflection and reflection.

Me

I continue to read Charmaz. I was beginning to think I was doing something wrong because I attempted during open coding to find categories based on the literature and to highlight the respondent’s words. I felt I was not staying close enough to the data-my ideas kept shifting-I saw different things emerging. As I kept reading I began to realize that going back to the data (interviews) is expected as I proceed with focused coding of interviews so that I find the actions and processes that emerge from one interview in the previous transcripts. Whew! Am getting excited now instead of believing that I am going about this all wrong. I believe I need to trust my gut and if I intuit that something is important, get it down and see if it fleshes out in other interviews.

Me and others

Humor came out in the conversation with Sarah, Christopher and Wes, Brandi and check for others. We laughed throughout the interview when it was appropriate. How does this reflect the client-therapist relationship. Was humor used in an interview when it was not used in therapy or vice versa. What are the healing powers of laughing? Does this serve a function? Does it relieve nervousness even if the person does not realize they are nervous? Can we tell when it is genuine humor and an attempt at alleviating anxiety?

Sarah and Christopher/Wes

Sarah discusses the influence of technology on sexual orientation issues. Chris and Wes discovered while I was with them that Simone actually advertises as working with sexual minority clients. They had not looked her up before to know this and they did not know she was a lesbian.
Demographic Influences

Age at coming out
Age at getting into current relationship
Age going into therapy

Simone
Look up Simone’s definition of open, genuine, honest.

Simone: When I say genuine I think of somebody who is being real you know, and I think you can be real but not necessarily be open. So when I say Wes was genuine and-well I think Wes was more genuine but I think she was very real, you know? Like I said there was no pretense about her. She was open in that it wasn’t as if she was hiding anything you know, or wanting to keep something hidden, guarded, you know, and um, but open also as in accepting. I think as far as I know both of them were in the process, very honest because they were able to say things to the other that you know, would have been really hard to say. In front of the other that would have been really hard to say.

Mary: Um, I think sometimes people have difficulty disclosing because of their past, because they’ve been shamed or punished, or have been judged, and so it’s harder for them to disclose. I don’t see that as dishonesty, I think of that as a process of getting to a point that they can disclose more or talk more freely. But I think there are those individuals that come in with kind of an agenda such as I’m in a crumby relationship and it’s all their fault and I’m going to tell you why they’re so bad. But they’re very unwilling... And so that’s not honesty. That’s not what the therapeutic process is about for them. It’s about that other person and getting permission to leave or you know, I am the way I am because my mother was so mean to me. Then there are those that I’ve run across that purposely withhold information-like don’t tell me that they’re on probation or that they’ve got their fifth OWI or something.

Christopher and Wes
Wes: Being honest, I think, in therapy, being truly honest. I think the power of being, it’s like you got be honest here. I mean, I think that’s the biggest fear that you need to be honest with yourself and the person you’re here to seek help with, you know. I think that’s the power and control that you’re giving up. This is, you have to be honest. I think it just, to give up, I mean, not your life, but just being honest with okay I do have some issues and acknowledging it and admitting that’s the whole of just
Christopher: And they have the power to further extend it if you don’t continue to if {indistinguishable}. You have to continue to come in.
Wes: Power and control are just letting go and letting your emotion out there. I think you’re just at the time, just {indistinguishable}…confession. It is confession {laughter} we’re talking about.

Sarah
Talks about trust=respect?
As I look for themes it seems that therapist behaviors and therapist-client interactions are so closely related they cannot be separated. There must be another theme in there that does fall into the general categories of “therapist” and “interactions”. This was similar with Sarah’s describing her experience and incorporating client behaviors and interaction patterns. With Sarah there was also a blurring of societal influences and how she prepared herself because she stays up-to-date on what is happening in society in terms of sexual orientation issues. Wanted to work with lesbian couple because thought she could help them. Wanted to do this interview because she could help me. Confident she could provide a positive experience to couple and was confident she could give a good interview.

Sarah, Christopher, Wes, Simone

Chris and Wes talk about mutual growth and Sarah and Simone talk about their growth as therapist.

Sarah and Lilith
Sarah: Lilith was usually always engaged in what we were talking about in therapy and was trying to keep things focused and kind of keep things moving.
Client as therapist. I believe I will see this again with Kate’s experience. In a way, Christopher and Wes were also like this trying to keep things focused.

Lilith/Nicole, Brandi/Kate
All talk about butch and fem. This did not come up with Chris/Wes

Mary and Kate and Simone and Brandi
These 2 talk about how there is a structure to the therapy in terms of people sitting in the same place every session. Is this normal. Does this indeed build safety and trust.

Mary and Mary Sue
We both have bird feeders, blinds that let in natural light, and believe in having plants.

Mary: “Well I’m talker too!” This sentiment was expressed by Mary, but it seems to me that Brandi, Kris, Kelsey, Christopher, Wes, and me are also talkers! Does this mean something?! Brandi: I’m a huge talker. I’m absolutely an extrovert and I flap my lips, like always talk too much probably.

Reflections on why people don’t come in as a couple and what does this mean for my dissertation?
Mary: Well, I think sometimes those issues that are being—the easiest one to answer, the one that comes up most often is that the other partner isn’t willing to come in. I don’t think I have a problem you go fix it. I mean that’s the top one. Another piece is that—and I think you know, certainly with Brandi is I know I’ve got these issues I have to work on. Now they affect the relationship but they’re not the primary cause of why I’m coming. I’ve got stuff I want to address. Then at some point it could be something couple, but that’s not the primary focus.
Brandi: I think if she were to come into the relationship it would be, like into the therapeutic relationship, it would be, umm…there would be kind of the occasional like well why don’t you talk about what we talked about the other night. Sort of, that kind of stuff, like nudging. Umm…but she also, in a positive way, points out stuff that I either intentionally or conveniently don’t {laughing} include. You know she’s a very, she’s an excellent listener, and so she will remember things and be like well what about this or that time that this happened or whatever? So umm…I think that would be a contributor but I think I like the individual thing because it’s like I’m journeying on my own. It’s a process between Kathy and I.

I think my theory is that there are people out there that don’t want to, lots of people, that don’t want to talk about that other stuff with their partner because they want their relationship to be about now. About, you know that, I think that people have this idea that they’re born-again. I am going to use the phrase born again, but not in the Christian sense. But they’re born again when they start a new relationship and so they’re context of that relationship should only be that time. Lee and I have been together for five years so we should only have that time. I mean it’s ludicrous. Like there are very active things from my childhood, my teenage years, parenting, all that sort of stuff that I feel is important—is very important and valuable to talk about with her because it influences my day-to-day interactions. It influences how I think about sex, how I think about becoming a parent, how I think about finances. You know, but I think there are so many people even if there in healthy relationships. I think it’s unhealthy to not talk about that stuff.

That’s just my theory about maybe why you don’t get a lot of couples is because we don’t want to show weakness to our partners. That to me is a trust issue, it’s an honest with self and others issue, and people are unwilling-because that’s dirty work you know-unwilling to do that and I think for my relationship with Lee that has deepened our relationship in so many ways that we recognize that there’s this stuff over her 33 year life span and my 26 year. You know, that we have five years together and there’s a lot of stuff that’s happened in there. But there’s a depth to it when you talked about who you were before then.

Mary – she talks in generalities, should I cut down to Brandi only and in general?

Mary and Christopher (maybe Simone?)
Talk about therapists being professional

Mary and Simone**find Simone’s
Address honesty and the difference between not being able to share and deliberately withholding information.
Supportive, cheerleading—does Simone use similar words? Sarah?

Mary and Sarah
Both had families who were very accepting of diversity.

Has anyone else talked about nurturing?

Mary and ?
Did anyone else saying anything about having power as a female?

**Sarah and Mary**  
As straight therapists they have both “pondered” their sexuality.

**Brandi**  
She talks about her developmental level and compares her first therapy experience at 16 during the coming out process to this experience where she asked around about therapists and asked questions of the therapist—was direct in the first session.

**Physical arrangement of office**  
Mentioned by Brandi, Mary, Christopher and Wes, Simone, Kate---not mentioned by Sarah who had no choice.

**Brandi and Wes**  
They talk about families not being supportive of therapy.

**Brandi, Christopher, Wes**  
Talk about them presenting lesbian couples as normal and not fulfilling the stereotypes about the LGBT community.

**Brandi and Chris**  
Talk about how the societal influences on out there, but you can’t change that.  
Brandi: I do look at it in the sense of I have a privilege and I have an opportunity and it’s a waste of time at times to focus on the homophobia and to focus on the negative and be angry. But I always think of it in a sense of like I want to, I want to help present a positive light and I feel like there’s a lot of people in the LGBT community that do not present a positive light for themselves. it’s important for me that they see us together and as a normal couple because I think that will change and help influence them [medical field] in terms of the next time they get somebody who comes in their office who’s in a same-sex relationship or identifies as gay, or bi, or whatever that they’ll be like OK! Normal person! Normal medical treatment you know? But I have the opportunity, I have the privilege to be able to influence in a positive way. We recognize these problems what’re we going to do about it and what I do about it is I live my daily life.  
Christopher: If it is something you can change [in society], great. If it’s not, then I probably shouldn’t devote a lot of energy to it. so you take it, you look at it, and you go, can I fix this, can I move it in any fashion. If I can’t then I probably need to put that one away on that shelf and look at the pieces that I can and right now I’m doing it by building a safe solid core with my partner which in turn builds a good family, which we share with our families and our friends and we show them how normal we are. And we educate people every day and so it’s my hope that by doing that slowly that big piece that I put on the shelf, you know, those little ripples will finally get to it.

**Check on meaning of therapy and meaning of interview for each**  

**Laughter in therapy-interview-couple relationship?**
Brandi comments on laughter with Kate. Humor between Chris and Wes. Laughter with Lilith and Nicole.

Focused on what was good about the experience; but should I mentioned what was not good about previous experiences—Wes, Chris, Brandi.

**Brandi and Me**
Brandi and I both talk about the fear of change—
Brandi: “I know it’s a continual process but I feel like this is—it’s like I’m knocking on the door you know, of like a new component of my life, a new part of my life, which scares me shitless you know, because it’s like all of this is like going to be kind of a different identity.”
Mary Sue: As I get closer to beginning data collection, I realize I have begun to deal with fear about how I will change as a person as I conduct my dissertation research. I know that in addition to the affective experience of being a qualitative researcher, there will be a change in me as a person. My values and beliefs will probably be challenged.

**Brandi**
Brandi and Sarah talk about the therapist keeping up on the news. Does this come out in other interviews?

Look at Wes’ family stuff and add if not there.

Client theme: Professionalism of the therapist and self-disclosure though words and behaviors.

Partial theme—lesbian is only part of who people are.
Partial theme—forgetting that couplehood is not accepted by all; hesitancy to attend couple therapy; validation by therapists of relationship, etc.
### APPENDIX L: EXAMPLE OF CHART SENT TO RESPONDENTS FOR REVIEW

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
<th>Christopher’s and Wes’s words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>Client guarded, a rock, nervous</td>
<td>• I was so guarded, it’s like I’m not laying dirty laundry out here.</td>
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<tr>
<td></td>
<td></td>
<td>• I was a rock going in [to therapy]. Just all the frustrations. I had a lot of them.</td>
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<td></td>
<td></td>
<td>• I mean I was nervous. I can’t imagine going into a non-supportive or unsupportive [therapy atmosphere]. Holy hell!</td>
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<tr>
<td></td>
<td></td>
<td>• I kind of did some of that heterosexism, where it’s like I felt a little awkward initially talking about it. Not disrespecting our relationship in any fashion, but being sensitive to maybe this person doesn’t get it.</td>
</tr>
<tr>
<td>Respect for therapist and process</td>
<td></td>
<td>• We respected what she was doing and it was obviously working so it’s like we still don’t have, we don’t know how to use these tools very well or we’re just not in a position that we can do that.</td>
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<tr>
<td></td>
<td></td>
<td>• I really think it does come down to respect and I think that she earned my respect pretty quickly into the therapy.</td>
</tr>
<tr>
<td>Clients committed to relationship and wanted things fixed</td>
<td></td>
<td>• I kind of did some of that heterosexism, where it’s like I felt a little awkward initially talking about it. Not disrespecting our relationship in any fashion, but being sensitive to maybe this person doesn’t get it.</td>
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<tr>
<td></td>
<td></td>
<td>• I think the desire to make this work. I think we both walked in with a sincere desire, I think in the heart of hearts, I think on the front end it’s like okay, well, let’s just one last chance or whatever. I think at the heart of it all, we really, really wanted</td>
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Open
Handing over power
Checking power (control) by the door
Honesty, need to show full being

it to be fixed and so I think as it continued on, those layers did peel off and it was like okay there is hope and we can do this and this is being supported.

• Yeah. I think we were committed to the relationship and we didn’t know how to fix it and we put, I put all my hope and dreams that this could do it, so. I think if somebody went in with the idea that they didn’t want it fixed, I mean, therapy’s only to be as good as what they believe in.

• I think if you’re committed to getting better, you have to [leave society influences outside the door]. I mean I think it comes into play and you have to take it out and look at it, but look at it for what it is. If it is something you can change, great. If it’s not, then I probably shouldn’t devote a lot of energy to it. I mean there are going to be times that there are going to be relationships that you just can’t fix or a church that there is no way in hell that the Catholic church is going to ever, probably not in my lifetime, so you take it, you look at it, and you go, can I fix this, can I move it in any fashion. If I can’t then I probably need to put that one away on that shelf and look at the pieces that I can and right now I’m doing it by building a safe, solid core with my partner which in turn builds a good family, which we share with our families and our friends and we show them how normal we are. And we educate people every day and so it’s my hope that by doing that slowly that big piece that I put on the shelf, those little ripples will finally get to it. I can’t exert my energy there. I have to look and see where I can fix it and I can fix this, which will fix this,
Lesbian is part of identity, but not whole identity

which will fix this.

• That was the first time I had actually ever opened up a lot, I mean, growing up even with parents, I mean I think I opened more up to at least to Simone more than I ever thought I would. I mean it was the most honest, I think you always think that you’re going to say I’m not even going to bring it up, but I think that you just kind let your guard down.

• [Power is] Being honest, I think, in therapy, being truly honest. It’s like you got be honest here. I mean, I think that’s the biggest fear that you need to be honest with yourself and the person you’re here to seek help with. I think that’s the power and control that you’re giving up. This is, you have to be honest. I think it just, to give up, I mean, not your lives, but just being honest with ‘okay I do have some issues and acknowledging it. Power and control are just letting go and letting your emotion out there. It’s a cleansing.

• If I don’t show my full being then I’m not being honest with myself, I’m not being honest to the people and showing respect to them. So I can’t imagine walking into an environment where it’s not safe to share that.

• Because there’s no way that you’d ever get to the core because you can’t get to the, I mean you can’t get past that armor [if you are not honest].

• If you totally open up, you are handing over your power to an extent. I mean there’s nothing to protect you. You have got to trust that person.

• It’s [power] control and we’re both kind of control freaks or we prefer, we don’t hand over power or control very easily and when you walked in
that door you had to check that at the door. It was just like, okay, we’ll set this over by the door.

- And they [therapists] have the power to further extend it if you don’t continue to if you don’t give it up. You have to continue to come in.
- [Power is] Being honest, I think, in therapy, being truly honest. It’s like you got be honest here. I mean, I think that’s the biggest fear that you need to be honest with yourself and the person you’re here to seek help with. I think that’s the power and control that you’re giving up. This is, you have to be honest. I think it just, to give up, I mean, not your lives, but just being honest with ‘okay I do have some issues and acknowledging it. Power and control are just letting go and letting your emotion out there. It’s a cleansing.

- I never, seriously, I don’t wake up and go I’m a lesbian. I’m a lesbian. I really don’t. How I identify myself, it’s like are you kidding me? I am in loving, committed relationship with a phenomenal person and it’s like I totally forget that society, I totally forget that it [our relationship] isn’t loved and supported by all.

<table>
<thead>
<tr>
<th>Therapist</th>
<th>Honesty, terminating therapy</th>
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<tbody>
<tr>
<td></td>
<td>Sincerity</td>
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<tr>
<td></td>
<td>Not taking sides</td>
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- And I appreciate that she did that [said they were done with therapy], too. It’s like, well, you can just continue to come see me, I’m not going to do anything for you, but it’s money.
- Because of the things I’m battling I’m not being honest with myself so I need someone to give me the tools to understand that the honesty one is
| Wanted to help | okay and to retain the honesty.  
| | • She was sincere. There was sincerity. So having *those* characteristics or providing that environment is going to allow me to be a better and more true person and to get more out of the therapy.  
| Safety | • I think a lot of people go in with that [validating that it’s the other person in the wrong] and so you kind of go in with that and it’s kind of like I certainly couldn’t have been doing anything wrong and this person is going to show you that I was a good person and nope, not so much. , she wasn’t going to allow that. Nope, not having that here, not taking sides, not validating anything in particular that would have been detrimental to the other person participating.  
| Listening | • She wanted to get to the problem.  
| Earned respect | • It didn’t feel like in-out environment with her. It felt like a very, she wanted to help us and give us tools and it didn’t feel like a fast-food place.  
| Was human | • [Christopher: Because I think that we wear this kind of crust or suit of armor out in the real world and so then to walk in and most people they have to take off their coat to be in a therapist’s office, we have to take off the armor and then the coat.] Wes’s response. She made you want to talk more.  
<p>| | • I kind of did some of that heterosexism, where it’s like I felt a little awkward initially talking about it. Not disrespecting our relationship in any fashion, but being sensitive to maybe this person doesn’t get it. She listened not only to the words, but she... |</p>
<table>
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<tr>
<th>Self-disclosure, playing a card, being professional</th>
<th>listened beyond the words.</th>
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<tbody>
<tr>
<td>• I really think it does come down to respect and I think that she earned my respect pretty quickly into the therapy.</td>
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<td>• I think what it [having knick knacks, plants, etc.] did was it automatically transferred her outside of the office and in a relationship or in a home and dealing with the same things. It really humanized her. That she lives and breathes the same exact challenges or, to an extent.</td>
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<tr>
<td>• And even that [sharing herself] would be just like a change in her face or hearing something, you could tell that she’s just totally relating it to something that she dealt with. It was interesting. It was never, there was never any personal really disclosure at all.</td>
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<tr>
<td>• [It was like Simone was saying] I totally know how you feel. It was just mostly body language and facial.</td>
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<tr>
<td>Connected, inside-outside</td>
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<tr>
<td>Allowed clients to be selves</td>
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<tr>
<td>She didn’t do that whole hi, I’m a lesbian, too, so now we’re in a club together, you can totally be honest, can totally let your guard down. None of that. And she could have played that card.</td>
<td></td>
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<tr>
<td>Provided direction, non-defensive</td>
<td></td>
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<tr>
<td>Wanted to be a better therapist</td>
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<tr>
<td>Removed labels</td>
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that any point in a therapist’s or doctor’s position that they would ever compromise any of that and not look at their oath to help people. That [therapy room] would be the worst place for somebody to not be a professional. That would be the worst place for a person to be discriminating. Her health, our mental health, our well-being, it’s the core, I just couldn’t tolerate it.

- I think her life experience influences her therapy. [personal life experiences were not shared by Simone]
- It looked like someone was there [in Simone’s office] that, you walked in and it wasn’t sterile, I guess you saw a little bit of her, too. She had a picture of her dog, plants, some old knick knack things, little personal weird things that people like. [Having these things meant] she was a human being. She’s there to help me, but at the same time she just, she’s real. I like real.

- You just knew that she connected and it was like I’ve been there done that. We all connected somehow. It’s not the first time that she’d heard [the topics being talked about in therapy].

- I think she allowed us to be us and she just kind of let us be in our own box and she’s on the outside just letting us be. I don’t think it would have worked if she was inside, but she was enough inside.
- And she let us be who we are and just developed us in a better, positive way. Kind of fixed the broken, took the broken leaves off and just re-patched it. Good fix.

- You could tell she wanted to become
<table>
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<tr>
<th>Experience</th>
<th>Safe environment</th>
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- That wasn’t allowed [blaming the other person]. You couldn’t even muster up the energy, you’re like oh, right {in a soft voice}. She made is so you didn’t have to yell, you didn’t have to get defensive. You never felt on the defense with her. You were there for a reason.

- Not everyone can do this profession [therapy]. I mean you got to remove those labels. I think a good therapist, you just got to remove all labels.

- I can’t imagine having gone through what we were going through personally and then to actually walk into an office and have anything but that [a healthy, safe environment]. I don’t know where we would be. I think it would have been really, really challenging to make it.

- It was very comforting as actually I first walked in I felt safe and didn’t feel any time of tension of the reason why we were there for being a same-sex couple.

- I had an energy that just felt a little bit safer than my experience in the past with other therapists my first impression and energy of her, I guess. The concern was that she just made me feel safe. It was a first kind of a first impression.

- Just a very calm, open-minded arms energy

- That’d [therapy] be that one just safe, totally sterile place where none of that unhealthy energy and environment [societal influences] is coming in and polluting it.

- It [going into an unsupportive therapy environment] would make me further
Life changing

Excited, learning
Reassurance of possibilities
Everything can be fixable

distance myself, I think.
• It’s one place [therapy] that you’d always think was going to be your safe zone even though I think if you fight going in, it’s like okay, this is should be safe and they’re going to be not discriminating. It’s like you got to be shitting me, I’m in here [therapy], I’m paying you! You’re supposed to help people! Help people, not gender or anything, but individuals and wow, you don’t even get it here!
• Even if you just want to say ‘we’ just in the environment for therapy for same-sex couples, I mean, we as a community need a safe environment like that, and there’s not that and there’s no that too many. Like you said, men, the gay men, are so much more even, I can’t imagine. It’s like we don’t choose to live like this. I think that’s the whole thing that I think a lot of people that are going in, who are going to seek help, it’s like trust me, if I, to make our lives simpler we don’t want to be the outcasts, we don’t. I’ve been in hate crimes, it’s the last thing I’d want to be involved in, but I can’t choose, change who I am.
• I can’t imagine going into a non-supportive or unsupportive [therapy atmosphere]. Holy hell!

• I think it was probably the most life-changing um, put new faith in people, forcing to learn more about myself, thrilled to have learned something new, thankful that I walked out with my best friend.
• I’m serious. I look back and I think two of the best things that we ever did in our relationship-well actually there’s three things. One, was we had
counseling before we had a commitment ceremony. We had a phenomenal faith leader. She was great. She was awesome. Two, we got Cecil, our little Shar-Pei, and then the third one was seeing Simone. I mean seriously those two people, their influences in our lives or my life in particular helped me take out some of those tools and I think I think I maybe knew of that, but really took ‘em out and actually put ‘em on a shelf in the house that if need be we can take it out and use it. I’m a huge proponent of therapy.

- I think we were a little disappointed when she said that’s it, you’re done. [Wes response: As long as you use the tools.]

- And I never even got upset. I’m a person who kind of gets defensive and I never, we never raised our voices, never got upset

- I was excited to actually go and learn different tools. I learned the bad and good about myself. I mean, I was wanting that from her. I was really wanting her to see what she sees from outside of the box.

- Reassurance of possibilities. I think the meaning I got was just that everything can be fixable. I think there’s a possibility that everything can. It taught me not to give up right away.

- I think the meaning I got was just that everything can be fixable. I think there’s a possibility that everything can. It taught me not to give up right away. I was a person that just kind of did throw things and-- It was easier to run than try to fix and the mean of
| Interactions | Comedy stage Free flowing Exchange, team All grow Inside-outside | being able to step back and not run from something.  
• Not everyone can do this profession [therapy]. I mean you got to remove those labels. I think a good therapist, you just got to remove all labels.  
• It’s almost like having a little impromptu. Like a comedy where she provides a stage and kind of a context in which you work, but the script is not hers at all. I mean it was free flowing and she didn’t particularly direct it. I mean, she’d throw out a topic and then let it go from there. It wasn’t leading.  
• It was more of an exchange.  
• It was a team.  
• You learn from the experiences of other individuals and you educate one another somehow, someway at different levels. I think she can learn something from us and we can learn something from her. I think it’s a mutual thing that that’s how you grow on both sides.  
• [Discussing whether Simone was outside or inside] We were in a cage {Wes laughs} and she’s like, okay it looks like they’re going to get really ugly here, try this [and would step inside].  
• Influences are close and hurtful, not at the societal level  
• Things that came into play in our therapy was not the big societal, it was actually the closer, friends, family.  
• The things that you think are safe. And you do kind of have, in theory, control over, well you really don’t.  
| Outside Influences | Influences are close and hurtful, not at the societal level |
| Hope that in school they teach about evolving society | but it’s more close and a lot more hurtful than what Joe Blow on the radio says.  

- Well, I kind of want to go society shouldn’t influence my therapist—society should influence my therapist. I’m thinking, I want to say well I think society shouldn’t influence our therapist, society should influence our therapist, but then I’m thinking that if society turned into a evangelical…I think that a person in that position [therapist] watches, I hope that they see it in a healthy, watching society evolve and what we thought was an illness years ago or what we thought was unacceptable years ago would only be proven that it’s…That can be used so many different ways because you could say we want society to evolve…I think that when you’re out in society you look at it and you evaluate it and can you apply the good criteria to, okay, this is a good thing, this is bad thing. It’s my hope that we all have those tools and it would be my hope that in school they would teach further considering what they’re dealing with. |
| --- | --- |
| I love this and it seems to be a metaphor for their relationship and for the therapy relationship. | • Christopher: Her goal was to  
• Wes: provide a healthy, safe environment. |
APPENDIX M: COVER LETTER FOR PEER REVIEWERS

Hello!

Thank you so much for agreeing to peer review for my qualitative dissertation!

I am including
1. the introduction of my dissertation which tells you a little about the study
2. a figure that shows how clients and therapists are connected
3. demographic info on participants
4. a model that shows the themes that emerged.
5. 4 transcripts of either clients or therapists
6. a copy of my Results section (in progress)

I would ask that you review the transcript and then compare it to your participant’s comments that I included under each theme in the Results. See if they hang together for you. If they don’t, let me know. If they do, let me know☺ If you see any themes in the transcripts that I missed, please let me know.

The major themes that emerged are:

Grand Theme that influenced the experience of therapy: Client-Therapist Relationship

Major Themes with sub-themes

- Teamwork
- Connection
  - physical environment
  - emotional safety
  - use of humor
- Client as Expert
  - asking questions
  - not leading
- Therapist as Professional
  - self-disclosure
  - therapist knowledge
- Power
  - power played out in several major themes, but I chose to make it its own theme

Please work in whatever way is comfortable for you. When you are finished you can either send me your comments by email or return the packet to me with your comments written on the documents I sent to you. I would like to have some feedback by July 28.
BIOGRAPHICAL SKETCH

Mary Sue McKee Green was born on May 5, 1960 in Hawarden, Iowa. She attended West Sioux Community High School in Hawarden and completed her bachelor’s degree at Briar Cliff University in Sioux City, Iowa. Her graduate work was completed at Iowa State University in Ames, Iowa. During her graduate education, Mary Sue received the American Association for Marriage and Family Therapy Graduate Student Research Award and the National Council on Family Relationships Graduate Student of the Year Award. She was also honored as the Graduate Student of the Year by the Iowa Association of Marriage and Family Therapy (IAMFT), by the YWCA for her contribution to “eliminating racism and empowering women”. She also received the Iowa State University Teaching Excellence Award and was honored as Outstanding Faculty by the Iowa State University Interfraternity Counsel and Collegiate Panhellenic Council. Mary Sue was active at the state level and served on the IAMFT Board of Directors and Ethics Committee. She presented at numerous national conferences and published in peer-reviewed journals on the topics of feminist mentorship, therapist comfort level working with the lesbian and gay population, the influence of therapist religious practices on comfort working with lesbians and gay men, creating a collaborative research team, therapist support of lesbian and gay human rights, and the importance of therapist self-awareness.