LGB-Affirmative Therapists' Use of Developmental Models of LGB-Identity in Therapy. A Phenomenological Investigation

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LGB-AFFIRMATIVE THERAPISTS' USE OF DEVELOPMENTAL MODELS OF LGB-IDENTITY IN THERAPY: A PHENOMENOLOGICAL INVESTIGATION

by

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LGB-AFFIRMATIVE THERAPISTS’ USE OF DEVELOPMENTAL MODELS OF LGB-IDENTITY IN THERAPY: A PHENOMENOLOGICAL INVESTIGATION

Victoria E. Cane, Ph.D.

Western Michigan University, 2010

Socially sanctioned hostility toward sexual minority persons continues to be a reality in the United States and worldwide. Therapists working with sexual minorities have responsibility to provide non-pathologizing, affirmative therapy to these clients. A central aspect of affirmative therapy is therapists’ recognition and understanding of sexual orientation (SO) identity and developmental models of sexual minority identity have a played a vital role in promoting this understanding. Although such models have been central to the practice and training of affirmative therapy, therapists’ applied use of the models has not been empirically investigated. For this phenomenological study, nine affirmative therapists were interviewed to explore their use of developmental models of LGB identity in therapy and other ways they might address SO identity more generally. Three themes emerged from this study that directly spoke to the explored phenomena: Main Therapeutic Functions of Developmental Models of LGB Identity: Instilling Hope and Conceptualization, Therapists’ Recognition/identification of Models’ Limitations, and Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy. Therapists identified that a core aspect of addressing SO identity was allowing clients to take the lead in the process and brought to light the complex interplay between general affirmative
practice and specific attention to SO identity development. The results of this study culminated in the creation of an overarching essence unifying the nine therapists’ perspectives. This study is one of the first to empirically examine therapists’ applied use of developmental models of LGB identity and produced numerous implications for affirmative practice, training, and research. One primary implication for practice and training highlights the potential for developmental models of LGB identity to provide sexual minority clients with a sense of hope, an aspect of the models’ therapeutic utility not previously explored. Suggestions for future research include study of a wider population of affirmative therapists using other qualitative methods such as consensual qualitative research.
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The completion of this near-Herculean effort would not have been possible without some amazing people in my life. I owe an indescribable amount of appreciation to my partner in all things, Tim Cane. He has patiently supported me throughout seven years of doctoral study and three hard years of focus on this dissertation. He walks the walk of equal partnership in parenting and in life. I would also like to thank those in our life who represent family in the truest sense: Stephan Minovich, Chris and Mary Cane, The Olmsteads, and Mark and Martha Johnson.

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excellence, and keen curiosity. My identity as an ally and an affirmative counseling psychologist has been greatly enriched by my relationship with Jim. I look forward to reading his research and hopefully collaborating with him again in the coming years. I am also deeply grateful to my committee members, Mary Anderson and Ann Miles. Mary provided a sharp eye and a warm soul in perfect balance. Ann was a true sport as she agreed to swim in unfamiliar water. She did so while bringing a welcome new perspective and without disturbing the ocean. I’d also like to thank my participants whose words never felt old to me even after reading them more times than I could count.

Along this journey I realized I have some really great friends in my life. They lent me a shoulder to cry on, brought food when babies came or illness fell, said, “you can do it” when I got tired, watched my kids, or just generally made our lives better. Thank you Warren, Katie, Johanna, Matt, Kirsten, Gwen, and Jody. Lastly, I’d like to give a “shout out” to the five other beautiful and strong women in my cohort: Jody, Liz, Kenlana, Michelle, and Kara. Mothers, sisters, daughters, fighters, lovers, partners, dancers, nurturers, comedians, and now psychologists.

Victoria E. Cane
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CHAPTER I
INTRODUCTION

Institutional and personal prejudices and overt hostilities towards sexual minority persons (those who share oppression-related struggles based on their identities as lesbian, gay, bisexual, transgendered, or any other identity that transgresses societal expectations regarding male/female sexual partnerships or male/female gender presentation; Fassinger & Arseneau, 2007) continue to be a reality in the United States and worldwide and it must be recognized that anti-lesbian, gay, and bisexual (LGB) sentiment is the norm rather than the exception in U.S culture (Dworkin & Yi, 2003; Gay, Lesbian, and Straight Education Network, 2006; Herek, 1991; The New York City Gay and Lesbian Anti-Violence Project, 2007). Leaders and groups of influence in the fields of psychology and psychiatry have contributed to the sanctioned oppression of sexual minority persons (Silverstein, 1991) and even today openly unethical practices like conversion therapy take place. Increasingly, psychological and counseling organizations are endorsing standards of practice that emphasize the provision of non-pathologizing, affirmative therapy to sexual minority clients (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2010; American Psychological Association [APA], 2000).

A central aspect of providing sexual minority clients with affirmative mental health services has been therapists’ recognition and understanding of minority sexual orientation (SO) identity (Chernin & Johnson, 2003). For example, Matthews (2007) explained that affirmative therapists should have at least basic knowledge of minority SO
identity development including assessment of SO identity development and helping the client manage the coming out process. Buhrke and Douce (1991) and Kort (2008) emphasized that therapists must be able to correctly identify psychological symptoms in the context of minority SO identity development in order to distinguish pathological features from developmental tasks that might be misdiagnosed as such. Understanding LGB identity has been emphasized in guidelines published by APA (2000) regarding provision of ethical psychotherapeutic services to LGB persons and in the lesbian, gay, bisexual, and transgendered (LGBT)-related therapy competencies published by ALGBTIC (2010). Therapists’ understanding LGB identity would appear to play a role in all four of the areas highlighted by the APA guidelines: attitudes towards LGB issues/persons; LGB relationships and families; diversity issues; and education around LGB issues. ALGBTIC (2010) identified several markers of affirmative counseling competency that speak directly to knowledge of aspects of sexual minority identity development stating that competent counselors “will recognize that identity formation and stigma management are ongoing developmental tasks spanning the lives of LGBT persons” (para. 2).

There are multiple sources that can help therapists better understand minority SO identity. In their chapter on theories of LGB identity formation, Ritter and Terndrup (2002) explained that the process of minority sexual identity development “is often lifelong and evolving” (p. 89) and cited Garnets and Kimmel (1991) in writing that LGB identity “is an achieved rather than acquired status”. (p. 89). Fassinger (1991) pointed out that this lengthy process of identity development for sexual minorities occurs in an environment either devoid of or with very few role models and with a serious lack of
social and legal support. Arguably the primary means of theoretical illustration and explanation of LGB identity development have been developmental models that outline key aspects of achieving an LGB identity.

Gonsiorek and Rudolph (1991), provided some historically contextualizing information regarding the nascence of LGB identity development models. They explained that Allport (1954) was one of the first scholars to note negative developmental effects of stereotyping and prejudice. They went on to explain that a developmental perspective is necessary to understand the problems that sexual minority persons face, particularly in light of their exposure to social stigma and oppression. Regarding developmental models of LGB identity, Gonsiorek and Rudolph explained:

The coming out models are an important theoretical development. They essentially describe an additional developmental effort unique to the lives of lesbians and gay men. This developmental event occurs in addition to, not instead of, the psychological processes and other aspects of identity development throughout adolescence and adulthood. (p. 166)

The significant theoretical advancement that developmental models of LGB identity represent was echoed by McCarn and Fassinger (1996) who explained that the models assist therapists' work with sexual minority clients by helping to articulate, predict, and normalize the shared experiences associated with developing and managing an oppressed identity. Israel (2004) explained that the models can provide “a foundation for understanding the identities and experiences of LGB individuals” (p. 349) which can help both therapists and clients in work related to SO identity. LGB identity models have served the purpose of accounting for the developmental experiences and contexts of LGB persons including: growing up in a heterosexist environment, feelings of being negatively different from an early age, the significance of identity pride, and the importance of
connection to a community of similar others (Cass, 1979; Coleman, 1981/1982; Grace, 1992; Ritter & Terndrup, 2002; Reynolds & Hanjorgiris, 2000; Troiden, 1989).

One of the first published models of LGB identity development (Cass, 1979) continues to reign as the most recognized and clinically referenced model of sexual minority identity development. The Cass Model predates most published scholarship on therapy that affirms rather than pathologizes a minority SO identity. Because of the enormous impact of the Cass model, it must be recognized that the body of affirmative scholarship as it is currently known has been influenced and guided by at least this model of LGB identity development. Thus, the subjects of affirmative therapy and developmental models of LGB identity frequently overlap. For example, any scholarship on affirmative therapy by definition addresses SO identity in some way and LGB identity models are frequently used to illustrate aspects of LGB identity development (see Browning, Reynolds, & Dworkin, 1991; Chernin & Johnson, 2003; Liddle, 2007; Matthews, 2007; Shannon & Woods, 1991). Although the references mentioned in the last sentence included suggestions regarding developmentally-appropriate interventions for sexual minority clients, empirical examination of therapists’ applied use of LGB identity models or specifically exploring their process of working on SO identity in therapy is virtually non-existent. This gap in the literature was also apparent in the most recent edition of The Handbook of Counseling Psychology which included a chapter specific to sexual minority issues authored by Croteau, Bieschke, Fassinger, and Manning (2008). These authors devoted a section of their chapter to minority SO identity development models, but included no information on practical application of these models.
The focus of this study is the exploration of how LGB-affirmative therapists have used developmental models of LGB identity in therapy as well as how they have addressed SO identity more generally with their clients. This kind of empirical examination of therapists’ applied use of LGB models of identity in their affirmative work and inclusion of other means of addressing SO identity addresses the aforementioned gap in the literature. Additionally, this examination provides information related to affirmative therapy and scholarship, advancing these fields. Attending to deficits in the literature related to empirical examination of practical applications of LGB identity development models seems particularly relevant considering evidence that training for psychology graduate students around provision of therapy for sexual minorities is still lacking (Eubanks-Carter, Burckell, & Goldfried, 2005; Phillips and Fischer, 1998) and exploration of links between identity development models and affirmative therapy could improve the body of knowledge used for training.

Based on this study’s focus on minority SO identity, it should be noted that the concept of identity generally and sexual minority identity particularly is complex and difficult to define. This is partly because identity is shaped by so many factors including biology as well as society. For example, in her chapter, *Constructing Identity: The Nature and Meaning of Lesbian, Gay, and Bisexual Identities*, Broido (2000) explained some of the difficulties related to providing a conceptualization of sexual minority identity as either biological (an “essentialist” perspective) or social (a “constructionist” perspective). A full discussion of the philosophical tensions experienced around the debate between essentialist and constructionist perspectives is beyond the scope of this study. Most theory related to SO identity development is rooted in an essentialist perspective and the
very act of constructing and/or defining aspects of SO identity is essentialist in nature. Additionally, SO identity and gender identity are sometimes confused in the discussion of issues specific to sexual minorities. Because of the complexities regarding inclusion of gender identity when discussing SO identity, this study has generally focused on ways that LGB identities are addressed. This is partially because the most-used developmental models of SO identity have not accounted for gender identity and these were the models cited by therapists in this study. When it seemed inappropriate to exclude transgender identity from a particular reference, the acronym, LGBT, was used (for example, when referring to the broader community of sexual and gender minority persons). Most other times the acronym, LGB has been used. The labels, lesbian, gay, or bisexual do not encompass all the ways that sexual minorities may choose to identify. Some identify as queer or pansexual and some choose not to identify with any label at all.

Throughout this study, I have referred to myself in the first (I) rather than third person (this writer) based on my positionality to the research and some key principles of qualitative research. Because the researcher is such an integral aspect of qualitative, and particularly phenomenological study, I believed it disingenuous to rely on the more quantitative philosophy of keeping the researcher(s) distant and somewhat anonymous by referring to them in the third person.

**Overview of the Literature**

What follows is a brief overview of three main areas of scholarship (developmental models of minority sexual identity, LGB-affirmative therapy, and practical applications of LGB identity models in psychotherapy) in order to provide the
reader with an understanding of the models discussed in this study, contextual understanding of LGB- affirmative therapy, and background regarding the conceptualization of this study and its associated questions.

**Developmental models of minority sexual identity**

The Cass *Model of Homosexual* Identity Formation (1979) is inarguably the most cited (cited 461 times on the database, PsycINFO as of March 2010, more than twice the amount of any other model examined for this study), most reviewed, and most well-known developmental model of SO identity. Its popularity has likely been connected to the detail Cass provided in her model, attending to both social and personal processes of minority SO identity formation. *Cass referred to her studied population as “homosexuals”, a term now considered derogatory based on its association with the pathologizing of sexual minorities. In accordance with American Psychological Association (APA) guidelines regarding biased language in publication. I have used the group descriptor “lesbian/gay” or LG to refer to the population Cass studied.

Cass (1984b) described the process of LG identity development as encompassing the areas of self-perception as LG, the transition from perception to identification by way of interaction with others, daily strategies of identity management, and incorporation of LG identity into a sense of self. Cass (1984b) explained that an LG identity is a “typological identity” (p. 144), meaning that this type of identity is a synthesis between how one views themselves and how they believe others view them. Cass (1984b) wrote, “In essence, the process involved in the acquisition of a homosexual identity is one of identity change in which a previously held image of sexual orientation is replaced with a
homosexual image." (p. 145). She explained that this process of identity formation is developmental in nature and marked by specific stages and experiences.

Cass' (1979) model is more detailed and complex than almost all other LGB identity models because she accounts for multiple "pathways" at each stage. Pathways are possible outcomes of development and are influenced by the individual's view of their own identity, their perceptions of others' views of their identity, and the quality of interactions with both heterosexual and LG others. Cass created a six-stage model of lesbian and gay (LG) identity development beginning with the stage of "Identity Confusion" (characterized by burgeoning awareness of the personal relevance of an LG identity) and culminating in the most "complete" stage, "Identity Synthesis" (characterized by a greater sense of connection to the world overall and an expansion of identity salience beyond sexual orientation). Cass referred to bisexual identity only as a possible means of distancing oneself from LG identity.

Other developmental models of LGB identity considered seminal pieces of scholarship and reviewed here are Coleman's Developmental Stages of the Coming Out Process (1981/1982), Troiden's Model of Homosexual Identity Formation (1989, 1993), and McCarn and Fassinger's (1996) Model of Lesbian Identity Formation (cited 45, 167, and 148 times respectively, PsycINFO; March, 2010). Additionally, two other models were included for review based on their representation of "growing edge" issues in LGB-identity scholarship. The Weinberg, Williams, and Pryor (1994) Model of Bisexual Identity Formation was chosen for its explicit representation of bisexual identity; Fassinger and Arseneau's (2007) Model of Identity Enactment of Gender-transgressive Sexual Minorities highlights the scholarship's cutting edge through its break from
existing paradigms regarding LGB identity research (i.e. the authors did not refer to stages or phases, they did not assume a linear path of development, and they used the term, “enactment” rather than development). A brief review of each of the five models discussed in this paragraph follows.

Eli Coleman (1981/1982) created a five-stage model of LG identity development based on the work of developmental theorists such as Erickson (1956) and Sullivan (1953). Coleman's model begins with the stage, “Pre-Coming Out” (characterized by a lack of consciousness of same-sex attraction) and ends with “Integration” (characterized by an integrated LG self-image comprised of public and private identities). Coleman purported that previous stages of development must be resolved before movement onto next stages can take place and that social and relational influences also occur. He explained that LG persons do not necessarily transition through each stage progressively and may work on tasks from different stages simultaneously. Like Cass (1979), Coleman included both genders in his developmental model and described this group as “homosexual”, or “individuals with a predominantly same-sex sexual orientation” (p. 32).

Richard Troiden (1989) used sociological theory to construct a four-stage model of LG identity formation based on the recollected accounts of LG-identified persons. Troiden differentiated self-concept from identity explaining that self-concept is our image of ourselves generally while identity indicates how we see ourselves in specific situations. He indicated belief that one’s LG identity is fully realized when there is correspondence between three aspects of identity: self-identity as LG, perception that others identify the person as LG, and presenting an LG identity to the public. Troiden likened the identity development process to the image of a horizontal spiral with
progression through the stages back and forth as well as up and down. His model begins
with the “Sensitization” stage (characterized by feelings of being different from and
stigmatized by others) and ends with “Commitment” (where one fully engages in life as an LG person).

McCarn and Fassinger’s (1996) Model of Lesbian Identity Formation is a
foundational model of sexual minority identity development for its role in addressing
multiple critiques of the older models and being the first to illustrate both social and
individual developmental paths. McCarn and Fassinger created a four-phase model of
lesbian identity development that explicitly addressed aspects of diversity within the
overall group of lesbian women as well as differentiations between individual and group
identities. “Phases” were used instead of “stages” to convey greater flexibility regarding
the path of identity development. The first phase of this model is “Awareness”
(characterized by individual awareness of feelings of being different from others as well
as a group-oriented awareness that heterosexuality is not a universal identity despite societal messages of such). The final phase is “Internalization/synthesis” (characterized
by an individual sense of self-acceptance regarding an identity as lesbian and a group-
oriented identification with other lesbian women).

The Weinberg, Williams, and Pryor (1994) Model of Bisexual Identity Development was the first (to their knowledge) model to explicitly address bisexual identity. The authors explained that acquiring a bisexual identity involves rejection of not only heterosexual but also LG identities. They indicated that they sought to answer
questions related to similarity between bisexual and LG identity development, existence of bisexual identity as a distinct and viable identity option, and absence of a bisexual
subculture and its possible affects on the ability of persons to commit to a bisexual identity. This model begins with the stage, “Initial Confusion” (characterized by a period of doubt about one’s SO identity before finally identifying as bisexual) and ends with “Continued Uncertainty” (characterized by continuing doubt about the validity of one’s bisexual identity even after discovering and applying this label).

The Fassinger and Arseneau Model of Identity Enactment of Gender-transgressive Sexual Minorities (2007) represents the most recent scholarship in the area of minority sexual identity development and made multiple advancements regarding the contextualization and complexity of sexual identity (other reviewed models speak specifically to SO identity while this one is much broader in scope and refers to sexual identity rather than SO identity). This model also made a dramatic departure from other models in that it was the first to include transgender identity and it did not follow a linear path based on stages or phases. Through their model, Fassinger and Arseneau explained that sexual identity must be contextualized against “temporal influences” (p. 25) such as individual age and experiences of one’s cohort. Individual differences are addressed within a triangle of gender, cultural, and sexual orientations alongside the following “developmental arenas” (p. 34): health; relationships and family; education and work; and legal and political rights.

Multiple sources in the literature have provided critique of existing LGB identity models. An often-cited critique of the more seminal models of LGB identity (i.e. Cass, 1979; Coleman, 1981/1982; and Troiden, 1989) targets authors’ reliance on “out” adult White males to provide foundational basis for their models (see Diamond, 2006; Fassinger & Arseneau, 2007; Fukuyama & Ferguson, 2000; McCarn & Fassinger, 1996).
Some models’ creators have provided critique of other models; for example Cass (1984b) noted a lack of rigor in Troiden’s (1989) study while McCarn and Fassinger (1996) noted similar methodological issues related to Cass’ (1979) model. Certain authors critiqued models’ failure to acknowledge ways that physical/emotional attractions can be fluid throughout the SO identity development process and even after identity has “formed” (Diamond, 2006; McCarn & Fassinger, 1996). There has also been the more general critique of models reliance on a paradigm of stage-progression rather than a more “fluid” conceptualization of SO identity (Coleman 1981/1982; Cox & Gallois, 1996; McCarn & Fassinger, 1996; Ritter & Terndrup, 2002; Troiden, 1993).

**LGB-affirmative therapy**

The concept of LGB-affirmative psychotherapy began to take root in the early 1980’s, with the therapeutic goal being the recognition of societal oppression as the problem (and subsequent “treatment” of the consequences), not the identity itself (Silverstein, 1991). In their recent chapter on counseling psychology and sexual orientation, Croteau et al. (2008) highlighted several other important factors in the origin of LGB-affirmative therapy including the American Psychological Association’s (APA) stated intent of removing stigma connected to minority sexual identity (citing Conger, 1975) and the creation of APA’s Division 44, Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues in 1984 (citing Morgan and Nerison, 1993 and Rothblum, 2000).

In one of the first collected sources regarding affirmative therapy, Gonsiorek (1982) explained that any affirmative approach “...must be relevant to the life experience of gay men and lesbians in a society that to varying degrees is unsympathetic,
uninterested, or hostile.” (p. 6). In this same source, Malyon (1982) stated, “The goals of gay-affirmative psychotherapy are similar to those of most traditional approaches to psychological treatment and include both conflict resolution and self-actualization.” (p. 62). Malyon specified that the goal of affirmative therapy is not to change sexual orientation, but rather that a minority sexual identity is to be “valued and facilitated” (p. 62) through provision of a corrective therapeutic relationship that will hopefully offset the negative effects of a heterosexist society. Malyon explained that affirmative therapy is “not a prescription for how to do psychotherapy” but rather “a frame of reference for the accomplished clinician.” (p. 62).

Kitzinger and Coyle (2002) provided an excellent summarization of affirmative therapy with their statement:

Lesbian and gay psychology is psychology which is explicit about its relevance to lesbians and gay men, which does not assume homosexual pathology and which aims to counter prejudice and discrimination against people who are not conventionally heterosexual and to create a better world for lesbians and gay men. (p. 2)

Although the authors referred to lesbian and gay psychology, not therapy per se, the implication in this case is that these two concepts are synonymous. It should be noted, however, that LGB-affirmative psychology may refer to a much broader scope of practice including organized social justice action of practitioners, research, and public policy. The basic tenets of an affirmative approach hold that therapists:

- Take a non-pathologic stance towards minority sexual identity (Malyon, 1982).
- Identify heterosexism as the main source of psychological distress and dysfunction, not minority sexual identity (Davies, 1996).
• Understand that a neutral stance towards minority sexual identity is insufficient to address the treatment needs of this population (Davies, 1996; Fassinger, 1991).

• Examine their own biases, beliefs, and attitudes regarding minority sexual identity (Clark, 1987).

• Acquire a base of knowledge regarding LGB persons as a group (Clark, 1987).

• Actively work towards reducing heterosexism in the world in order to improve the lives of LGB people (Kitzinger & Coyle, 2002).

Practical applications of LGB identity models in psychotherapy

Compared with areas of scholarship on LGB identity and affirmative therapy, literature on practical applications of LGB identity models was far less developed. Arguably the most detailed source linking models of sexual minority identity development with therapeutic intervention was the chapter, *Psychotherapeutic Applications for Identity Formation* (Ritter and Terndrup, 2002). In this chapter, four models (Cass, 1979; Troiden, 1979; Grace, 1979; and Coleman, 1981/1982) were used as a basis for constructing therapeutic interventions such as provision of material to help the client modify negative beliefs about LGB identity (specific to early stages of development). What set this source apart from others was its level of attention to each stage of SO identity development (not focusing only on early and/or latter stages) and clear articulation of both behaviors and interventions associated with the stages. For example, Ritter and Terndrup highlighted 22 possible client behaviors and 18 possible therapeutic interventions associated with mid-level SO identity development stages (such as “Coming Out” in the Coleman [1981/1982] model).
Other sources have certainly linked developmental models of LGB identity to therapeutic work with clients. In Matthew’s (2007) chapter, *Affirmative Lesbian, Gay, and Bisexual Counseling with all Clients*, a section was devoted to SO identity development and seven LGB identity models were cited. Matthews wrote in a general sense regarding the counseling process and SO identity development but did not make specific connection between stages of development and therapeutic intervention. In a later source by Matthews, (2008), she did speak more clearly to application of lesbian identity models to therapeutic work but focused mainly on a few suggestions that might apply to clients in either early or latter stages of development. In this same source, Marszalek and Pope (2008) outlined aspects of SO identity development for gay men (using Ivey’s Developmental Counseling Therapy [DCT] Theory) and stated, “Using a DCT approach, counselors can assess the DCT style at which a client is presenting for a particular issue and provide an appropriate counseling intervention based on the client’s style.” (p. 309). The authors didn’t, however, delve very specifically into how affirmative therapists who weren’t familiar with DCT might apply this theory to practice.

Additional sources addressing practical applications of LGB identity models included a chapter by Perez and Amadio (2004) that identified knowledge of LGB identity models as one of five key areas of affirmative therapy. The authors explained that stage-theory models of LGB identity can help therapists with multiple aspects of affirmative work including conceptualization of LGB issues. In books specific to affirmative therapy by Chernin and Johnson (2003) and Kort (2008), suggestions were made regarding developmentally-appropriate interventions for sexual minority clients.
Kort used the Cass (1979) model and Erikson’s (1968) now classic lifespan stages of
development to provide stage-specific suggestions for therapeutic intervention.

Practical applications of developmental models of LGB identity were
occasionally addressed by the models’ creators. Some authors made references to
stage/phase-specific clinical issues, but the McCarn and Fassinger (1996) model was the
only one to include possible interventions based on developmental phases. McCarn and
Fassinger illustrated these interventions through three case studies. Using the case of
“Carol” (p. 526) as an example, the authors explained that as a 22-year-old African
American woman just coming into awareness of her attraction to another woman, Carol
faces multiple challenges related to the intersections of individual and group identities.
Carol was assessed at being in the second stage of individual identity (recognition of her
feelings for another woman) and the first stage of group identity (no real awareness of
other lesbian women as a group). It was also noted that Carol had existing group
affiliations (most primarily that of a Christian) that would likely conflict with her
romantic feelings for her friend. Key therapeutic tasks associated with Carol included
helping her understand her feelings of confusion and fear as well as provision of
information, resources, and referrals. The authors also emphasized that a therapist’s
responsibility is to be proactive in the community in order to change attitudes around
minority sexual identity.

Use of LGB identity models in therapy was also illustrated in some specific areas
of affirmative therapy such as career counseling with sexual minority clients. Croteau and
Thiel (1993) addressed the lack of attention to LGB identity in career literature by
utilizing LGB identity models in their outline of career-appropriate interventions. For
example, the authors explained that when a client is in later stages of LGB identity development, a career counselor may provide examples of integrating sexual orientation with work and address coping with anti-gay stigma at the workplace. This type of intervention would be less appropriate when a client is in the early stages of LGB identity development. At that point, so much of the client's energy would be devoted to making sense of their identity that attention to integration of sexual identity and career would be very difficult.

**Method**

Early LGB research, based in quantitative and positivistic approaches, has been marred by a past linked to pathologizing and objectification of its participants. Gamson (2000) identified qualitative methods as optimal for LGB research based on their foundation of giving voice to those who have been oppressed and silenced stating, “Qualitative methods, with their focus on meaning creation and the experiences of everyday life, fit especially well with movement goals of visibility, cultural challenge, and self-determination.” (p. 348). Colaizzi (1978) differentiated qualitative from quantitative approaches to psychology by highlighting the ability of qualitative research to more fully capture the understanding of a phenomenon, not just abstracted pieces of understanding.

The qualitative research method, phenomenology, was selected for this study based on its focus on the lived experiences of participants (Colaizzi, 1978). Hoyt and Bhati (2007) highlighted phenomenological study as particularly suited to counseling psychology research because rich data may be gleaned from a small sample which proves
useful when studying rarely researched populations. As evidenced by gaps in the literature, LGB-affirmative therapists qualify as such a population.

As stated previously, the purpose of this study was the illumination of LGB-affirmative therapists’ use of developmental models of LGB identity in their therapeutic work with clients as well as ways that these therapists address SO identity more generally. Questions specific to these phenomena were:

- Do LGB-affirmative therapists use developmental models of LGB-identity in therapy and if so, how?

- How do LGB-affirmative therapists address SO identity more generally with clients?

Participants

Consistent with recommendations made by Creswell (1998) regarding the appropriate number of participants in a phenomenological study, eight to ten therapist-participants were sought for this study using criterion sampling and a “snowball” technique (i.e. asking participants if they would be willing to suggest other therapists as possible participants) to identify potentially appropriate participants. Participants were invited through written contact made with agencies/offices known to provide LGB-affirmative clinical services. These agencies/offices were identified through multiple sources including the internet, phonebook, LGBT resource centers, and suggestions from colleagues and current study participants. Some key participatory criteria were used to promote the likelihood that therapists would have experience with the studied phenomena including the following: (a) participants are licensed to practice therapy in Michigan at either the masters or doctoral level; (b) participants identify and meet criteria as LGB-
affirmative therapists including viewing minority sexual orientation as a healthy, valid, and positive sexual orientation status and having engaged in training specific to LGB-affirmative counseling; and (c) participants consider LGB-affirmative therapy to be one of their main (i.e. top three) foci in counseling and have seen at least 20 clients addressing sexual orientation issues, acquiring a minimum of 50 direct contact hours with these clients and currently seeing at least one client addressing sexual orientation.

A total of 23 letters/invitations were sent out to potential participants. I received two written responses indicating that the therapists did not meet criteria and received phone contact from two therapists who indicated interest but did not ultimately meet criteria for the study. One therapist indicated interest and met criteria for the study but did not return a consent form and nine therapists did not respond. Potential participants who responded to the research invitation were briefly assessed (see Appendix E) for set criteria by means of a statement read to them by phone. Potential participants were instructed to respond to the statement indicating that they either did or did not meet the listed criteria. Potential participants who did meet criteria were informed of such and sent a packet containing two copies of a consent form (Appendix F), a demographic questionnaire (Appendix G), and a postage-paid envelope to return completed materials in.

The final pool of nine participants consisted of four lesbian-identified females, two heterosexual ally-identified females, one bisexual-identified female, and two gay-identified males. All participants identified as White. Participants in this study were affirmative therapists practicing in midsized cities in Southwest Michigan. Eight of the nine therapists identified at least ten years of practice focusing on affirmative therapy and
six identified at least 14 years; six worked in private practice settings. Three participants were licensed at the doctoral level and six at the master's level. One participant was in his late 20’s and the rest ranged in age from early 40’s to early 60’s. Six participants indicated receiving little/no LGB-specific training and little/no exposure to LGB identity models in their graduate programs while one participant described receipt of a significant amount of both in her doctoral-level graduate program. The most common forms of LGB-specific training experienced by participants were engagement in independent readings/self-study, contact with other affirmative peers/professionals, conference attendance, and supervision specific to affirmative therapy. Five participants indicated some form of exposure to LGB identity models in their training and these five also reported therapeutic use of the models.

Procedure

This section includes information regarding my background and potential biases as this study’s primary researcher, data collection, and data analysis.

**Researcher's background and potential biases**

Researcher self-exploration has been highlighted by numerous scholars (see Colaizzi, 1978; Creswell, 1998) as a means of qualitative data verification and is consistent with guidelines set forth by phenomenology’s creator, Edmund Husserl, who advocated for the phenomenological researcher to “bracket” their reactions in order to preserve integrity with their subject matter (Giorgi and Giorgi, 2003). This bracketing process was also recommended by Yeh and Inman (2007) as a means of pursuing qualitative research “best practices” in that the qualitative researcher is compelled to have
an understanding of their own views and potential biases regarding that which they are studying.

Aspects of my background and experience as this study’s primary researcher include the following: I am a 40-year-old White, female, able-bodied, non-religious counseling psychology doctoral student. My main identities include those of mother, feminist, and heterosexual-ally. I am romantically, legally, and parentally partnered with my White male mid-thirties-aged husband who has emigrated to the U.S from Scotland. I am a therapist whose clinical work has focused on clients struggling with issues of self-harm and suicidal behavior. Throughout my life I have been fairly immersed in LGB culture through close personal relationships and geographic contexts of living in major cities with flourishing gay communities (Baltimore, New York City, Paris, San Francisco, Los Angeles, and Chicago). I almost always found myself accepted in these communities even when it was clear I was romantically partnered with a male.

I have been asked on several occasions why, as a non-LGBT person, I am interested in LGBT research. One factor I have come to identify as influential to my work on LGBT issues is the belief that these issues are about me and my family. For me, the rights of sexual minorities are not about fighting for other people but recognizing what is also threatened for me personally when LGBT persons are oppressed. I consider myself a competent therapist and scholar and so it has felt most appropriate to bring these two important aspects of my professional identity to attend to questions that will hopefully benefit the practice of LGB-affirmative therapy. In doing so, I hope to make the world a better place for LGBT persons and for all of us.
Regarding potential biases, I was particularly vigilant around my interpretations of participants’ data with the aim of being as sure as possible that meanings I assigned to the data were grounded in participants’ experiences. My concern was that my interest and immersion in LGBT-identity scholarship could cause me to “over-interpret” data and assign meaning where it may not be present. Other biases that I was mindful of included the following: that I will easily connect interpersonally with the participants in my study, that therapists who identify as and meet criteria to be considered affirmative will be better informed regarding issues around sexual orientation than those who do not, and therapists who identify as and meet criteria to be considered affirmative will be able to articulately describe ways that SO identity is addressed in therapy and will have some knowledge of models of LGB identity development. These potential biases were managed through an ongoing process of journaling and use of an auditor’s perspective.

**Data collection**

I interviewed each participant twice: once in-person (see Appendix H for interview protocol) and once by phone (see Appendix J for protocol). All in-person interviews were between 60 to 90 minutes in length while phone interviews were between 20 to 45 minutes in length. All in-person interviews took place in private locations, most often the therapist’s office. The initial interview protocol was constructed to arrive at a set of questions that would best facilitate in-depth exploration of the phenomena. Questions were constructed broadly to allow for a fluid and meaning-rich exchange between the participant and myself. Questions were evaluated after the first two in-person interviews to assess whether they sufficiently arrived at rich data (it was assessed that they did and no changes were made). The second interview protocol was
created similarly, although the intention of that interview was inviting correction where necessary in addition to furthering exploration of the phenomena. After each interview, I took notes on my reactions to the interview for later use regarding examination of my potential biases.

**Data analysis**

After initial interviews were completed I transcribed each of them word for word in order to allow for rigorous examination of each participant’s data as recommended by Colaizzi (1978) and Creswell (1998). The transcription process itself furthered my immersion in the data, as I listened to each interview multiple times and verbalized participants’ words aloud to be captured by voice-recognition software (Dragon Naturally Speaking V.10). Each interview was re-checked after transcription to ensure that every word was captured accurately. Any potentially identifying information (names, agencies, locales) was removed from transcripts. Transcripts were next saved in “rich text” format and imported into the qualitative analysis program, MAXQDA 2007.

Transcripts were examined for statements salient to the phenomena of therapists’ applied use of LGB identity models and general attention to SO identity. These statements were electronically highlighted and included participants’ descriptions of their journeys as affirmative therapists, descriptions of their practice of affirmative therapy, and descriptions of ways that they addressed SO identity with clients. After this initial round of highlighting, I then went back to these statements to begin a process of data organization that included construction of “codes” and “subcodes” that represented what was highlighted. Codes might be conceptualized as the core concept of highlighted data, while subcodes were specific descriptors under that core concept. Each code was
represented by a different color that allowed for better visualization of the data. This visualization assisted with further organization of the codes/subcodes into broader “themes” emanating from the data. As the codes were organized into themes, I began to refer to them as “subthemes” and used details from what I had previously categorized as “subcodes” to illustrate the subtheme. This change in terminology was made to best fit the two main categories of organization: the broader “themes” and the more specific, “subthemes” which I assessed as better descriptors than “codes”. Every transcript was analyzed in this way with a continual editing process to arrive at the most concise and best fitting set of themes and subthemes which were continually “tested” by referring back to the data to check whether the subtheme still fit the data and/or whether there was salient data not captured by a subtheme.

An auditing step was next incorporated into the analysis process in order to promote the study’s rigor as advocated by Merrick (1999, citing Lincoln and Guba, 1985). One primary external auditor (not otherwise connected with the study) was selected to participate in the analysis process. This auditor met previously set criteria which included: status as a graduate-level student, faculty member, or licensed therapist; having some experience with LGB scholarship (either through self-study or contribution/authorship to/of at least one paper on LGB issues); and either completion of a course on qualitative research methods and/or contribution/authorship to/of a paper using qualitative research methods. My auditor was a White lesbian-identified counseling psychology doctoral student who is a published author of LGBT scholarship and had numerous experiences with qualitative data. These qualities positioned my auditor to better understand the background and context of this study which therefore helped her in
identifying areas of the data analysis that seemed inaccurate or unclear. It should be noted that my research chair, a seasoned LGB scholar, also brought an auditor’s perspective through extensive review of every aspect of this study. Although he also provided feedback regarding data analysis and organization, any specific reference to an “auditor” in this study is referring to the external auditor.

Mainly, my auditor provided feedback on accuracy of analysis and how the themes/codes/subcodes were constructed. After an initial round of my own editing process, the auditor was supplied with a complete list of themes, codes, and subcodes (and their definitions); two randomly chosen transcripts; and the journaling I did regarding my reactions to the two transcript interviews. She provided feedback on the following areas: the understandability of the themes/codes/subcodes (i.e. did definitions fit and make sense?), redundancy (i.e. did themes/codes/subcodes overlap?), and accuracy (i.e. did themes/codes/subcodes match the raw data?). She was also instructed to consider my reaction notes and whether she detected any areas of researcher bias in the transcripts or the analysis.

Although I did not integrate every item of feedback provided by my auditor, her notes helped me clarify definitions, eliminate redundancy, and maintain a sense of being “on track” regarding accuracy. An example of feedback that was integrated includes the auditor noting that the code, *LGB Research, Scholarship, and Education* did not make sense under the theme, *Addressing Identity/ Therapeutic Use of Identity Models*. As I reflected on this feedback I agreed that use of the models for scholarship was not really something done in therapy and I changed the title of the theme to, *Addressing Identity/Use and Function of Identity Models* to better encompass the functions discussed
in the study. An example of a piece of feedback that was not integrated was the auditor's note that a part of one therapist's transcript seemed to be related to assessment and she suggested that I recode that section. Upon review, I did not agree and found no evidence of the therapist engaging in assessment in that piece of their interview, but rather they were normalizing the client's experience. By each piece of feedback provided by my auditor I made a notation regarding whether the feedback was integrated or not and reasons for each. This process was also less formally done with the auditing provided my research chair; by each of his suggestions I made note whether it was integrated or whether we needed to discuss it further.

One of the final steps in the data analysis process (Colaizzi, 1978; Merrick, 1999) is a verification step known as "member checking" or allowing the participants themselves to review the researcher's analyses for accuracy. After integrating my auditor's feedback, narrative synopses (see Appendix P) were created for each interview including an overview of themes and subthemes gleaned from that particular interview as well as across participants. Included in these synopses was an initial draft of the study's essence (the collective experience across participants regarding the phenomena of practically applying developmental models of LGB identity and addressing SO identity in therapy). These synopses were sent to each participant in order to facilitate further thinking on the phenomena before the second interview and to invite correction regarding my analysis. After it was assessed that participants had reviewed their synopsis, they engaged in second interviews by phone. These interviews were conducted four to nine months after respective initial interviews took place and were 20 to 30 minutes in duration. They were audio-recorded, transcribed, and uploaded into the analysis software
as previous interviews had been. During the second interview, participants were asked to provide feedback regarding accuracy of my interpretations, any corrections or additions they would like to make, and how well the essence of the study fit their perspective.

Just as with first interviews, second interviews were reviewed for salient statements and these statements were organized into themes and subthemes. A relatively small amount of new themes/subthemes were created based on data emerging from second interviews and a shorter process of editing and “testing” against the data took place. In a few cases, participants added information to their interviews based on what they noticed in other participants’ data. All participants agreed that the essence of the study fit their perspectives. After member checks were complete, minor adjustments were made to the themes and subthemes as reflective of feedback provided by the participants.

**Results**

Between August 2008 and late July 2009, I interviewed nine affirmative therapists. All therapists presented with varying backgrounds and experiences but all were able to richly explore the phenomena of addressing sexual orientation identity with clients in therapy. Five of the therapists had experienced some form of exposure to LGB identity models in their training and used these models in some capacity in their work with sexual minority clients. Specific authors cited regarding the models were Cass (1979; four therapists), Coleman (1982; one therapist), Troiden (1989; one therapist), and McCarn and Fassinger (1996; one therapist). The information that these therapists shared about their work was used to identify salient themes related to the research questions and then finally, an overarching essence of the study.
Six major themes were identified as salient to the studied phenomena. Four of these were common to all participants: *Arrival at Identity as an Affirmative Therapist*, *Specific Strategies Used in the Practice of Affirmative Therapy*, *Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy*, and *Positive Aspects of Research Participation*. Additionally, two themes were common to the five participants who had exposure to LGB models of identity development: *Two Main Therapeutic Functions of Developmental Models of LGB Identity: Providing Hope and Conceptualization* and *Therapists' Recognition/identification of Models' Limitations*. Under the identified themes of the study, central “subthemes” were also identified and are explained in subheadings under each theme. These subthemes were noted if they were experienced by five or more therapists with the exception of the themes specific to therapeutic use of the developmental models of LGB identity; those subthemes were noted if they were experienced by three or more therapists. These subthemes provide detail regarding how the major themes were experienced by the therapists.

**Arrival at identity as an affirmative therapist**

Therapists described affinities for a variety of theoretical orientations but all shared a commitment to the practice of affirmative therapy and an identity as an “affirmative therapist”. All therapists discussed influential factors on their development of identity as affirmative and four main subthemes were identified: personal identification as a sexual minority, specific experiences in their professional life, being identified as affirmative by others, and addressing a community need for affirmative therapy.
**Personal identification as a sexual minority**

Seven participants held minority sexual orientation identities and discussed the importance of their own identities in shaping their development as affirmative therapists. One aspect of this development was recognition of an ability to empathically connect with identity-related struggles that clients brought to therapy. For example, one therapist shared how he is able to connect with the oppression-related feelings that his clients bring into therapy based on his own experiences. He stated, “Well I’m a gay man myself and obviously I understand what oppression is about, been there done that.”

**Specific experiences in their professional life**

Specific professional experiences that promoted some therapists’ development of an affirmative identity included relationships with sexual minority clients or coworkers, exposure to a clinical issue that helped reframe attitudes about sexual minority identity, or gaining LGBT-specific training in a doctoral program.

One therapist described how some of her early clinical experiences working with HIV-positive men were pivotal to her assumption of an affirmative identity, stating, “I started right away doing the AIDS work and the prevention work and that kind of evolved as I said into LGB-affirmative work in general, dealing with other types of issues as well…”

**Being identified as affirmative by others**

The influencing factor of being identified as affirmative by others was described by some therapists as a progression of becoming known for their expertise and skill in working with sexual minority clients and subsequently receiving more LGBT client referrals. This process seemed to perpetuate itself in that as therapists received sexual
minority client referrals, they became increasingly skilled and comfortable in their affirmative work which increased sexual minority referrals. This increase in both comfort/skill level and referrals acted to deepen their identities as affirmative. One therapist spoke about how her work on a variety of LGBT-related panels gained her recognition in the community as an LGBT-affirmative therapist which acted to increase SO identity-related referrals:

Well I think in the community, in the LGBT community and our community there’s certain people that get identified through affiliation in the community you know, things that I’ve done, panels that I’ve sat on, speaking engagements that I’ve done...

**Addressing a community need for affirmative therapy**

Other influencing factors on therapists’ development of an affirmative identity included recognizing a community need for affirmative services. This need was often identified through therapists hearing about sexual minority clients’ negative experiences with other therapists. Listening to clients’ negative experiences provided therapists with a determination to make a difference for these clients which also worked to solidify their identity as affirmative. One female therapist explained,

it’s always felt like a real commitment to sort of, it’s a network model but unfortunately under the oppression level still in TOWN, it’s an underground railroad network model, really, feeling hugely committed to being part of something that is still oppressed here, still sometimes coming up against people who’ve really recently had conversion therapy right across town or horrible experiences with mental health services really nearby and really in recent times...

**Specific strategies used in the practice of affirmative therapy**

The general practice of affirmative therapy was found to be highly interconnected with specific work on SO identity. It could certainly be argued that attending to SO identity in therapy is itself a specific strategy used in affirmative practice. This theme,
however, is included as separate from specific work on SO identity for the primary reason of understanding the overall context of affirmative therapy in which SO identity-specific attention is embedded. One way of understanding this “interconnected but separate” quality might be to see this theme as the larger category of “bird” while attention to SO identity is a smaller, more specific category, “eagle”. All eagles are birds but not all birds are eagles. Any attention to SO identity could be considered a part of affirmative therapy but not every part of affirmative therapy directly addresses SO identity. Under this theme, three main strategies were identified by therapists as integral aspects of providing affirmative therapy: use of validation and acceptance, therapists’ use of their own SO identities, and displaying and providing LGBT-related materials.

**Use of validation and acceptance**

Validation and acceptance are interdependent concepts and thus, difficult to operationally separate. Some therapists described validation as the embrace of those aspects of their sexual minority clients’ lives that are likely to be devalued in a heterosexist environment which simultaneously conveys acceptance to the client. Described ways of communicating validation and acceptance included taking time to focus on the client’s partner, making sure to use appropriate language when referring to clients’ loved ones, and refraining from judgment.

One therapist explained that for her, validation and acceptance were communicated through her choice of language, through her general presence with the client, and through her emphasis on empowering the client. She expressed,

…whatever space my client is in if I am willing to enter into that space and simply be present to them without judgment without distraction without you know, you know, body language that says you know, ‘oh no’
you know whatever; that person will move into the deepest part of what they need to learn, they will move themselves out of pain.

Another female therapist described the importance of accepting the client wholly, even when they may be presenting with dysfunctional beliefs, explaining,

it's really important to honor whatever appears to be resistance because I know that those ideas or those blindnessess are there for a reason, they are either learned or they were self-protective at one time because you know I was raised to be homophobic and I thought that way for a long time and I wish that was different but that's a reality.

For this therapist, it was important to recognize the homophobic culture that both she and her clients have been raised in and to recognize ways that this culture influences the client’s belief system. She recounted that if she challenged this belief system too overtly (i.e. from a stance of non-acceptance), this would push the client away.

*Therapists’ use of their own SO identities*

Certain therapists identified that a key element of providing affirmative therapy is allowing experiences of their own SO identities (lesbian, gay, bisexual, or heterosexual ally) to inform the therapy process. This was achieved in a variety of ways including modeling a sense of joy and satisfaction related to one’s minority SO identity, normalizing aspects of SO identity through personal examples, and using one’s SO identity experiences to intuitively connect with subtle issues the client may not be verbalizing. One female therapist encapsulated some of the ways the therapist’s SO identity is used with her statement,

...my belief is that part of LGB affirmative therapy is doing some mentoring and so I choose my disclosure very carefully to ensure that it’s used only in therapeutic ways however when someone is clear about, is becoming clear or has become clear about their own sexual identity I will disclose that [her identity as a lesbian woman] as well and if somebody is struggling with a particular issue that I am familiar with either through my own experience or through other clients that I’ve worked with or through
friends or relatives then I will disclose some information about you know, here are some types of ways that I've known that other people have handled this.

**Displaying and providing LGBT-related materials**

The display and provision of LGBT-related materials in the therapy space was also a key strategy in the practice of affirmative therapy. Some therapists discussed the importance of having LGBT-related books visible on their shelves and having easy access to print and other media resources for clients’ benefit. These factors were discussed in terms of providing a place where clients could visibly see these resources which was ultimately affirming to them, regardless of whether clients explored them. Therapists also discussed the utility of using resources that clients could take with them to explore on their own. One female therapist described how sharing LGBT-related materials with a particular client helped ease their sense of isolation. Another female therapist discussed the important of having LGBT materials in her office, explaining, “A lot of it [an affirmative approach] just has to do with how the office is set up, the books that are out, you know the magazines that are out…”

**Specific strategies used when addressing sexual orientation identity in therapy**

In addition to strategies identified in the practice of affirmative therapy, all therapists identified several strategies specific to addressing SO identity with their clients. These were described as techniques aimed at promoting the client’s development of a healthy, integrated, positive SO identity and constructing a life authentic to that identity. Therapists discussed five main strategies used when working on SO identity with clients: assessing SO identity in therapy, allowing the client to lead the way in work on SO identity, attending to the client’s chronological age and corresponding development,
attending to catalysts and cautions regarding broaching the topic of SO identity, and addressing family-of-origin and romantic relationship issues.

**Assessing for SO identity-related issues in therapy**

Before therapists engaged in therapeutic work attentive to SO identity, all nine described the importance of assessing for SO identity issues. This assessment seemed aimed more at identifying whether SO identity should be addressed with the client rather than assessing a particular stage of SO identity development. Assessment was achieved in a variety of ways including asking about SO identity on intake (pre-therapy information gathering) forms or during intake interview, attending to LGB-related names or topics introduced in therapy by either the therapist or the client, and asking the client directly about SO identity.

One therapist described how he assesses for SO identity issues in the initial history-gathering phase of therapy. He explained that partially based on his own experience around not wanting to label his early SO identity as gay, he does not ask clients directly about how they identify, as this may be too threatening to them in the initial phase of therapy. He explained,

> …actually the very first session when I do an intake it’s part of our forms and I never use the word gay, lesbian, transgendered, bisexual with a client. I always start out you know when I, I always ask them are they attracted to men are the attracted to women or both and if they use the term gay or lesbian then that’s fine but I don’t introduce that term…

**Allowing the client to lead the way in work on SO identity**

All therapists identified the importance of allowing clients to lead the process of therapeutic work on SO identity. The described significance of this aspect of work on SO identity was connected to recognition of clients’ vulnerabilities as they explored the
possibility they may hold an oppressed identity, wanting to promote the clients’ autonomy and empowerment, and preserving/promoting a sense of trust in the therapy relationship. Based on the frequency of this theme occurring in the study and all nine therapists’ expressed enthusiasm for the importance of this theme, it became the most significant theme of the study.

One female therapist stressed that not allowing the client to lead the process of addressing their SO identity would interfere with the therapeutic process. The example that she illustrated spoke to the issue of a therapist wanting the client to address SO identity more for the therapist than for the client. She explained:

As long as a client is actively engaged then you have room to really have an impact but the minute and this is just for me, I mean the minute that I attempt in any way to get my own needs met through therapy it’s a potential interference and I try really hard not to do that.

Another female therapist went on to explain: “...so it’s [so. Identity] addressed only if it’s an issue and my preference is always for it to be addressed by the client…”

*Attending to the client’s chronological age and corresponding development when working on SO identity*

Multiple therapists identified that a central element of addressing SO identity with clients is considering their client’s age and the general aspects of development that correspond to that age. Attending to these factors helped these therapists to view the client holistically and to adjust their SO identity-specific interventions to better fit their clients. Some therapists described shifting the language they used related to SO identity to better suit the client’s age in order to facilitate the flow of addressing SO identity in therapy and promote the therapeutic alliance. For example, one therapist described how being more flexible in her SO identity-related language (i.e. not discussing the client’s
identity as if it has been solidified) helps her younger clients feel safer in the therapeutic relationship. This therapist also described how her client’s age affects the way she discloses her own identity as lesbian in therapy, explaining, “I will adjust that [how she discloses her own identity] according to age group, sometimes when people are pretty young in their questioning the words they’re ready for or the concepts they’re ready for, I’m as gentle as possible.”

**Attending to catalysts and cautions regarding broaching the topic of SO identity**

Attending to catalysts (cues from clients to address SO identity with them) and cautions (cues to back off from the topic of SO identity) was cited as a central SO identity-specific strategy by all therapists. Catalysts included the therapist’s intuitive sense of SO identity saliency for the client while cautions included the therapist’s observation of discomfort in their client and making assumptions about how the client may or may not identify. For example, some therapists identified that an important factor in deciding whether to address SO identity is their client’s non-verbal communication. This communication might include the client’s body language/posture, what is not being said in a session, a noticed hesitation, muscle agitation, or facial displays of emotions such as disgust or shame. Some therapists described using their observations of clients’ non-verbal communication to delay addressing SO identity as potentially threatening to the client (a caution) while others discussed use of non-verbal cues to alert them to the necessity of addressing potentially SO-related issues with the client (a catalyst). One female therapist described how she might use her sense of what is being left out of a client’s story to attune her to the potential necessity of addressing the topic of SO identity, explaining:
It’s about what’s not being said in a session too, I guess that’s vague but if someone’s coming in and not talking about their partner or not talking about their relationships or not talking about being sexual. Like for example if I’m working with, you know, 18 to 26-year-olds and they’re not talking about being sexual I’ll often wonder about what that’s about.

**Addressing family-of-origin and romantic relationship issues as they relate to SO identity**

All nine therapists identified multiple strategies related to addressing family-of-origin and romantic relationship issues in the context of SO identity. Addressing these issues included working with family members of sexual minority persons to better understand aspects of SO identity so that they could ultimately respond more empathically to the sexual minority person (thus in some cases the client was not a sexual minority person but the family member), helping clients manage SO identity-related conflicts in their family relationships, facilitating exploration of the ways that issues related to SO identity affect romantic relationships, helping clients with transition out of heterosexual relationships, and helping clients develop and maintain healthy romantic relationships.

One female therapist described how increasing parents’ understanding and empathy of sexual minority identity issues is a central aspect of working on SO identity in therapy. She described a particular instance when she worked with a parent on understanding their child’s behaviors from an SO identity-related perspective. For her, it was important that she provide the parent with information about SO identity development so that they could contextually understand that what their child was doing was not necessarily willful engagement in “dangerous” behavior, but was actually adaptive. From a therapeutic perspective, this therapist saw her job as validating the parent’s concern and then facilitating the parent’s understanding of SO identity in a way
that helped her to make sense of the behaviors so she could better connect with her child. She explained that she told the parent,

Your kid didn’t just do this to make you crazy and it’s not something that they’re just doing to get attention and it isn’t anything anybody else never did and there’s a reason why it happens and it is not always neat and tidy or completely safe but it is psychologically important.

**Main therapeutic functions of developmental models of LGB identity:**

*Providing hope and conceptualization*

In discussion of use of developmental models of LGB identity (referred to as “the models”) in therapy, two main therapeutic functions were described: providing clients with a sense of hope and assisting therapists with multiple facets of client conceptualization.

**Providing hope**

Some therapists reflected on the models' utility in providing clients with a sense of hope and possibility for the future. In general, these therapists appeared to be focusing on providing this sense of hope through discussion of aspects of the models with their clients, particularly illustrating latter stages of development. One therapist discussed how her exposure to the models infused her with hope regarding her own SO identity which she was then able to transfer vicariously to her clients. She recalled that the message she took from the models and one that she wanted to convey to client was this:

This [SO identity development] is really really hard right now but here’s what you have to look forward to, you know this does get better and here are some of the ways that it can get better and here is, you know also to instill hope.

Hope was also provided through use of the models to normalize aspects of SO identity development which worked to decrease the client's sense of isolation in their experience.
**Assisting with client conceptualization**

Another main therapeutic function of the models cited by some therapists is assisting with client conceptualization. In general, client conceptualization is influenced by therapists’ theoretical orientations and certainly not limited to a client’s SO identity. For this theme, however, conceptualization focused on how these therapists think about their clients generally and specifically in the context of the client’s SO identity. For example, client conceptualization might include thinking about the broader ways a client may have coped with long-term oppression and invalidation regarding SO identity and specifically, how they are coping with these issues in their workplace.

Some therapists described how the models provide them with a framework to assist them with conceptualizing their client’s SO identity development which ultimately helped them in choosing appropriate strategies to meet their client’s identity-related needs. One male therapist described how knowledge of the models, particularly the Cass (1979) Model, helps him be better attuned to the client’s needs. For example, in the following quote we see how this therapist is more mindful of “rolling with” (i.e. being careful to meet the client where they are) his client, especially in earlier stages of SO development:

> I mean I don’t sit with a client and say, ‘Oh you’re in the confusion stage’, I mean that’s ridiculous, so it’s not, it’s more for my benefit to help me gauge okay where is this person at? Like is this, do we need to go, if a person is in an earlier stage let’s be a little more, let’s kind of roll with some things and try to be mindful of where he’s at.

**Therapists’ recognition/identification of models’ limitations**

The five therapists in this study who did use LGB models of identity in their work with clients all acknowledged and identified some central limitations to the models and
three main critiques were identified: models as linear and limited, models as clinical and depersonalizing, and the potential for models to be used inflexibly without attention to context.

*Models as linear and limited*

Certain therapists reflected that, in reality, SO identity development does not progress in the neatly defined stages that might be implied in most developmental models of LGB identity. Additionally, these therapists critiqued models’ failure to account for the ways that lifespan issues intersect with and influence SO identity. They explained that many of the nuances of SO identity development that they had either personally experienced or witnessed in their clients’ experiences are not accounted for in the models.

For one male therapist, his experience working with multiple sexual minority persons in therapy allowed him to observe that their SO identity did not follow the stage-like progression outlined in most LGB identity models. He reflected that at times his clients seemed to skip forward in stages of SO identity development and at other times return to earlier stages, explaining:

I've seen other [LGB] models that have been structured similar to the Cass model and some of them, I just, I think the stages are fine, it’s a natural progression. Some people I don’t think that people move through those like that, you know. I mean sometimes people do you know sometimes people move through those, sometimes people jump, sometimes people regress.

*Models as clinical and depersonalizing*

Some therapists explained that they limited their therapeutic use of LGB models of identity development based on a perception that they seemed clinical and depersonalizing. For these therapists, there were multiple concerns related to using developmental models of LGB development in therapy including the concern that any
direct use (i.e. showing a model to a client) would impart an idea that aspects of clients’
lives could be categorized, which would seem invalidating. One female therapist
explained,

I would never refer to it [SO identity development] as a theory because
our work isn’t, our work is relational it’s not, that would just make it
formal or would just take away from what we know about this is, what we
know, not we may, what we know. It’s always, I use that inconclusively as
part of how I explain things because it has many meanings, it could mean
to them well what we the scholars know, they don’t know there are
scholars, they don’t even know anybody researches this, they don’t care
really. But they do care that I get it or that they’re safe or that the panics
of coming back off that choice has intrusive thoughts of suicide or
intrusive thoughts of, I mean they have, those are the things they have to
know that I get it…

Models used inflexibly without attention to context

Some therapists described a critique that related more to how the models might be
used rather than the models themselves. These therapists explained a perception that
information presented in the models may be adhered to inflexibly which could potentially
impede the process of therapy or worse, harm the client. These therapists explained that
overreliance on LGB identity models may allow for important information to be missed
while other aspects of a client’s SO identity development (such as deciding against
coming out at work) might be mistakenly viewed as dysfunctional from certain models’
perspectives. For example, the most widely used model (Cass, 1979) as reflected both in
the literature and in this study generally purports that a sexual minority person who isn’t
“out” at work would be considered less mature in their SO identity development than one
who is. This concern was voiced by a female therapist who discussed her experience with
older adult lesbian women stating, “How mismeasured and misconstrued their [older
adult lesbian women] experiences would be if we just went with this straight, you know, application of the kind of original ways that Cass or others were coming across.”

**Positive aspects of research participation**

All therapists discussed experiencing their participation in this study as positive which seemed connected to participants seeing themselves as similar to other affirmative therapists, experiencing greater self-awareness regarding their work, and experiencing their work as valued. Two subthemes were identified: fellowship with other affirmative therapists and increased self-awareness.

**Fellowship with other affirmative therapists**

After all first interviews were complete, therapists were sent early-draft summaries of findings from their interview as well as a drafted synopsis of findings from all other participants. This information allowed therapists the chance to review the accuracy of interpretations gleaned from their interview; but it also gave therapists a chance to read about other participants’ experiences. Some therapists identified that this experience gave them a sense of validation in seeing similarities between themselves and other participants. These similarities seemed to create a sense of fellowship with other affirmative therapists even though identities of all therapists were kept confidential. Some therapists described this sense of fellowship and similarity as affirming in that it instilled a sense of connection with other therapists and a sense of being “on track” regarding therapeutic interventions as well as provided encouragement to continue providing affirmative services.

For one female heterosexual-ally therapist, this sense of connection to other therapists was particularly salient in that it acted to offset a sense of insecurity regarding
identifying as a heterosexual-ally and wondering if her lack of identification as a sexual minority prohibits her from providing quality affirmative services. She explained, “Well they [the affirmative interventions described] were very similar. You know it was interesting, they were very similar experiences, you know most of your participants are GLBT and actually I didn’t see that much difference.” Seeing that her services were comparable to those provided by sexual minority therapists offered her reassurance and a sense of validation.

**Increased self-awareness**

Most therapists reported that taking part in the research required thinking deeply and critically about their work which increased their self-awareness. Some therapists expressed that participation in this study pushed them to articulate what it is they actually do when providing affirmative therapy which, although difficult, allowed them to understand their work in a new way. One female therapist explained:

> It [participation in the study] made me, you know, think more about, you know, what underlies the actions that I take as a therapist and that’s always good for me as a therapist. And you know the other is just always wanting to improve the way that I relate to anybody that walks through my office and one of the ways to do that is to think about what I would want from my own experience and that just prompted me to think about it in that way.

**Affirmative therapists’ collective experience addressing sexual orientation identity with clients and using developmental models of LGB identity in therapy**

The nine therapists interviewed for this study all shared a passion for the practice of affirmative therapy that transcended theoretical orientation. Therapists held a variety of sexual orientation identities but all shared a common identity as an “affirmative therapist”. Therapists described several influential factors regarding their development of
this identity including personal identification as a sexual minority, specific professional experiences, being identified as affirmative by others, and addressing a community need for affirmative therapy. All therapists identified key strategies used in their practice of affirmative therapy; the three main strategies being ample use of validation and acceptance (embracing those aspects of their sexual minority clients’ lives that are likely to be devalued in a heterosexist environment), use of their own SO identities in therapy (through positive modeling, normalizing, and using their experiences to intuitively connect with the client), and displaying and providing LGBT-related materials (making sure clients can easily view and access materials related to sexual minority issues).

In addition to general affirmative practice, all therapists identified key strategies specific to addressing SO identity with their clients. These strategies were aimed at promoting the client’s development of a healthy, integrated, positive SO identity and constructing a life around that identity. Four main strategies were identified: allowing the client to lead the process of addressing identity, attending to the client’s chronological age and corresponding development (age-influenced stylistic adjustments made regarding how SO identity is addressed), attending to catalysts and cautions regarding broaching the topic of SO identity (cues from clients to either address or back off from the topic), and addressing family-of-origin and romantic relationship issues (helping clients manage SO identity-related disruptions in their family relationships and develop and maintain healthy romantic relationships, etc).

The strategy, “allowing the client to lead the process of addressing identity” became the most significant strategy found in this study based on its frequency of occurrence and all nine therapists’ expressed enthusiasm for its importance regarding
therapeutic attention to SO identity. This importance was connected to recognition of clients’ vulnerabilities as they explore the possibility they may hold an oppressed identity, therapists’ wish to promote their clients’ autonomy and empowerment, and preserving/promoting a sense of trust in the therapy relationship.

Five of the nine therapists in this study had some form of exposure to LGB models of identity in their training and used these models to some degree in their affirmative work with clients. These therapists described a variety of experiences regarding the depth and quality of their exposure and how they integrated the information gleaned from these models into therapy. They identified two main therapeutic functions of developmental models of LGB identity: promoting a sense of hope (particularly through illustration of models’ latter stages of development) and assisting with multiple facets of client conceptualization (through models’ descriptions of specific behavioral and emotional markers of SO identity development). These therapists all acknowledged and identified some central limitations to the models including their tendency to present SO identity development as too simplistic and linear, the perception of the models as clinical and depersonalizing, and their potential to be used inflexibly without attention to context.

Therapists described a range of positive reactions to participating in this study. These reactions seemed mainly connected to feeling validated for their affirmative work. Therapists also described how reading the summary of themes from other participants sparked a sense of fellowship with other therapists and of being “on track” regarding their own work. An additional benefit of research participation described by therapists was
gaining an increased awareness of their work through articulating their own processes regarding affirmative therapy and ways that they address SO identity with their clients.

Discussion

This section provides a synopsis of ways that results addressed this study’s questions and a brief contextualization of these results against the literature. Readers are referred to Chapter Five for a more complete review of the ways that relevant results addressed the questions posed in this study and were both supported by and diverged from the literature. This section also reviews implications for practice and training as well as limitations/future directions associated with this study.

Synopsis of results in relation to research questions and the literature

Three themes are highlighted here as directly addressing the questions posed in this study. The first research question was, “do LGB-affirmative therapists use developmental models of LGB-identity in therapy and if so, how?” Five of the nine therapists who participated in this study indicated having some form of exposure to LGB models of identity in their training and used these models to some degree in their affirmative work with clients. Thus, for these therapists, an integral (and obvious) link to their practical use of the models was gaining prior exposure to them. Based on information gleaned from these therapists, the answer to the first part of the first question appeared to be, “Yes, if they have any knowledge of the models.” The second part of the first question asked, “How do therapists use developmental models of LGB-identity?” which was addressed by two themes: Main Therapeutic Functions of Developmental Models of LGB Identity: Providing Hope and Conceptualization and Therapists’
Recognition/identification of Models’ Limitations. The second question investigated in this study was, “How do LGB-affirmative therapists address SO identity more generally with clients?” This question was primarily addressed under the theme, Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy. A brief review of these themes and highlights of their contextualization against the literature follows.

Under the theme, Main Therapeutic Functions of Developmental Models of LGB Identity: Providing Hope and Conceptualization, therapists discussed use of the models to provide clients with a sense of hope and possibility for the future. In general, therapists provided this hope through discussion of aspects of the models that conveyed a sense of positivity regarding minority SO identity development, particularly the latter stages of development. In some ways, what these therapists described regarding conveyance of hope was similar to normalizing the client’s experience. Use of developmental models of LGB identity to normalize aspects of minority SO identity development has been discussed and/or illustrated in a few sources of literature (Kort, 2008; McCarn & Fassinger, 1996; Ritter & Terndrup, 2002) but use of the models to provide clients with hope reflects an aspect of models’ practical application possibly unexplored in the literature before this study. This theme also included ways that some therapists used the models to assist with client conceptualization which was comparatively well-documented (Chernin & Johnson, 2003; Croteau & Thiel, 1993; Israel, 2004; Kort, 2008; Matthews, 2008; McCarn & Fassinger, 1996; Perez & Amadio, 2004; Ritter & Terndrup, 2002). The second theme, Therapists’ Recognition/identification of Models’ Limitations, captured a critique of the models as clinical and depersonalizing which was connected to some therapists’ choice to limit therapeutic use of the models or not use them at all. This
finding was only somewhat reflected in literature reviewed for this study (see Cox & Gallois, 1996).

The theme, *Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy*, spoke to the strategies aimed at promoting the client’s development of a healthy, integrated, positive SO identity and constructing a life authentic to that identity as identified through five main techniques: assessing SO identity-related issues in therapy, attending to catalysts and cautions regarding broaching the topic of SO identity, allowing the client to lead the way in work on SO identity, attending to the client’s chronological age and corresponding development when working on SO identity, and addressing SO identity in relation to family-of-origin and romantic relationship issues. The last technique mentioned here was most supported in the literature (see Bridges & Croteau, 1994; Browning, Reynolds, & Dworkin, 1991; Chernin & Johnson, 2003; Kort, 2008; Patterson, 2007; Ritter & Terndrup, 2002; Shannon & Woods, 1991). Techniques related to assessment and attending to catalysts and cautions in SO identity-specific work corresponded least to the literature and reflected nuances related to the broader areas of SO identity assessment possibly unexplored before this study.

**Implications for practice and training**

This section highlights implications for practice and training as derived from the three main areas of results from this study: general affirmative practice, specific attention to SO identity in therapy, and the practical application of developmental models of LGB identity. Additionally, an implication related to therapists’ demographic information is included.
This study provided an empirical examination of the practice of affirmative therapy of which there are astoundingly few (Bieschke, Perez, & DeBord, 2007). Findings from this study shed light on areas of affirmative practice explored very little in the literature (empirical or otherwise). Although this study’s focus was not on general affirmative practice, it was found that general affirmative practice was so entwined with specific attention to SO identity that it would have been impossible not to produce results speaking to the practice of affirmative therapy and three main strategies were identified. The one that most diverged from the literature regarding depth of the topic (and thus most clearly advancing the existing body of affirmative scholarship) was therapists’ use of their own SO identities (lesbian, gay, bisexual, or heterosexual ally) to inform the therapeutic process. Therapists described ways that they integrated their SO identities into their affirmative work including modeling a sense of joy and satisfaction related to their minority SO identity, normalizing aspects of SO identity through personal examples, and using their SO identity experiences to intuitively connect with subtle issues the client may not be verbalizing.

The detailed descriptions provided by therapists regarding the strategy of using their SO identities to inform their work not only provides information regarding affirmative practice but speaks to a growing edge in affirmative training. This strategy supports the importance of therapist training programs’ inclusion of self-exploration regarding SO identity in their curricula. A recent study examining trainees’ experiences of what best facilitated their growth around LGB issues suggested that self-exploration is best facilitated over time in environments that promote the personal growth of the therapist (Grove, 2009). Additionally, literature on more cutting-edge aspects of
affirmative therapy such as addressing internalized heterosexism has identified that a central aspect of training in this area is the promotion of therapists' self-awareness through exercises like journaling; exercises that can only take place over time (Kashubeck-West, Szymanski, & Meyer, 2008). One possibility for facilitating the deeper-level self-exploration needed to train therapists on LGBT issues is a multiple-week class specific to LGBT counseling and my hope is that more graduate programs in psychology will regularly offer (if not require) this kind of class. These kinds of self-exploration opportunities in affirmative training would promote the likelihood that more therapists could draw from their own experiences around SO identity to inform their work.

Although therapists in this study did provide much needed information on ways that affirmative therapy is enacted generally, they also brought to light the importance of training specific to affirmative therapy. The majority of therapists who took part in this study described receipt of little to no affirmative training in their graduate programs and although they all sought training elsewhere, their experiences reflected some deficits in relying on sources of training such as contact with colleagues or supervision. One area where these deficits may have played a role was in therapists’ lack of attention to racial or socioeconomic factors as intersecting with SO identity. Although therapists discussed other intersecting factors such as the client’s age and religion, therapists did not mention attention to the client’s race or socioeconomic status which was likely influenced by the predominance of private practice settings in this study, where most clients are White and middle class. It is also possible that lack of attention to race and culture as intersecting
with SO identity was equally influenced by a dearth of competent affirmative training where attention to identity intersections would be highlighted.

Another area where a training deficit was evident was in therapists’ lack of exposure to what are inarguably some of the best means of training around minority SO identity: developmental models of LGB identity. Few therapists were able to specifically cite models they had encountered or delve very deeply into the content of the models. It should be noted, however, that even with this limited exposure to the models, the critiques that therapists associated with them were consistent with critiques that are reflected in the general literature which underscores the need for scholars to attend to critiques related to models’ linearity and over-simplification of SO identity development. It is also important to note that participating therapists would quite possibly disagree with this categorization of lack of exposure to developmental models of LGB identity as a training deficit. One therapist described an intentional avoidance of the models based on her view of them as clinical and depersonalizing. Other therapists who did use the models appeared to do so in a way that addressed their concerns with them as both overly-linear and clinical (i.e. not using the models directly with clients) which is an adaptation that could be linked to therapists’ high level of experience.

The multiple deficits in therapists’ affirmative training pointed to a need for more comprehensive efforts in areas of training and competency. In some cases, therapists described these deficits themselves and in other cases the deficits were apparent based on incongruence between what therapists reported as affirmative practice and what is reflected in the literature as affirmative practice. Affirmative therapy as a subspecialty of psychotherapy interventions could be considered fairly new (roughly 25 years old) and
early literature described it more as a general approach than a theoretical orientation (see Malyon, 1982). However, it should be noted that pioneering authors like Malyon (1982) and Gonsiorek (1982) who advocated for such a stance were rooted in their own theoretical perspectives and may have had difficulty envisioning affirmative therapy as indeed a much-needed “prescription” for how to provide competent psychotherapy to sexual minorities. Other therapy approaches have been extensively documented and even “manualized” (i.e. standardized to a degree) in order to promote competent delivery of the therapy (see multiple manuals on Cognitive-Behavior Therapy [CBT], Dialectical Behavior Therapy [DBT], Acceptance and Commitment Therapy [ACT], etc). This kind of attention to competent delivery of therapy has allowed for greater empirical study of treatment approaches like CBT and DBT which have become some of the most empirically supported in the field of psychotherapy (Feigenbaum, 2007; National Alliance on Mental Illness, 2010; Powers, 1999; Rathus & Miller, 2002.) Calls for more empirical support of affirmative therapy have not been answered and this may be connected to lack of clarity and precision related to its constitution. Thus, greater attention to both the practice of affirmative therapy and its empirical support are needed. Additionally, we need better ways to assess that affirmative therapists are adequately trained which could be promoted by research-driven attention to graduate programming and curricula content.

Therapists in this study provided rich information that went beyond general affirmative practice into specific exploration of attending to SO identity in therapy. Although the topic of therapeutic attendance to SO identity is reflected in multiple ways and sources, empirical investigation of how therapists specifically attend to SO identity in
their work has been missing from the literature. Therapists illuminated ways that they promote their clients' development of a healthy and positive minority SO identity. One of the most significant strategies employed by therapists in this aim was allowing the client to lead the way in work on SO identity. This strategy, although well represented in general psychotherapy literature, is reflected in just a few sources specific to affirmative therapy. Strategies like this one can potentially provide affirmative practitioners and those providing affirmative training with information that goes beyond the "it's okay to be gay" basics as called for by Bieschke, Perez, & DeBord (2007, p. 3).

The final area of results reviewed here brings to light therapists' practical application of developmental models of LGB identity in their work. The applied use of these models has not been empirically explored despite the models' significant role in scholarship and training related to affirmative therapy. Therapists revealed some key ways that they practically applied these models including using the models to provide clients with a sense of hope and possibility. This strategy was little reflected in reviewed literature and has great potential to be integrated into more cutting-edge training material on affirmative therapy. The potential benefits of linking developmental models of LGB identity with provision of hope may be supported by a recent study (Moe, Dupuy, & Laux, 2008) showing that more advanced SO identity development was associated with the presence of hope. The study didn't address the question of whether provision of hope could advance SO identity development but it appears a likely possibility that therapists who can convey a sense of hopefulness regarding minority sexual identity to clients may help them in their development of a positive SO identity.
In addition to implications derived from the three main areas of results, demographic information from therapists produced an implication related to practice and training. Therapists discussed a sense of isolation from each other and a perceived distance from existing scholarship on LGBT issues. Clearly, this sense of isolation can be exacerbated by practicing in settings and geographic areas that limit one’s contact with affirmative peers, research, and scholarship. Two factors were at play here for the majority of therapists: they practiced in private settings and these settings were located in southwest Michigan. Private practice settings often have limited personnel and financial resources that constrain therapists’ time and access to current research and training on LGBT issues. For example, personal subscription to online databases/scholarly journals and membership in professional organizations is often perceived as cost-prohibitive to therapists and this barrier was mentioned by one privately-practicing female therapist who stated:

Well part of the problem when you graduate at the doctoral level is you lose your library privileges and in loss of library privileges you lose access to a variety of journals, I mean you can subscribe but they’re very expensive and that’s prohibitive really. I mean if there’s a reason there’s an article or two we would be willing to pay for but then you have to research it in a very different way and then I think it’s time consuming in a way that isn’t really conducive to private practice.

The private-practice setting also limited some therapists’ contact with other affirmative peers. In many private practices, therapists operate in relative isolation and are not afforded the same “in the hallway” consultations that group practices, community agencies, or other counseling centers allow. These isolating factors were likely compounded by the geographical setting that all therapists operated in (mid-sized cities in southwest Michigan). Trainings and resources specific to practice with LGBT clients are
occasionally available in southwest Michigan but the opportunities related to affirmative therapy are clearly less available here than they are in areas with more thriving LGBT communities (like San Francisco and New York). Much of the literature on LGBT training has centered on what is provided in psychology graduate programs (see Grove, 2009; Kashubeck-West, Szymanski, & Meyer, 2008; Miville et al. 2009; Walker & Prince, 2010). Chernin and Johnson (2003) briefly mentioned workshops/seminars and communication with colleagues as means of accessing affirmative training but there remains a clear need for more specific suggestions targeting some of the day-to-day barriers therapists in this study discussed regarding training. One suggestion might be exploring the effectiveness of social networking sites like Facebook regarding the organization of peer-supervision meetings for affirmative therapists.

**Limitations and future directions**

As with all studies, this one has multiple limits that warrant discussion. It should be noted that almost every limitation could also be posited as a strength but the focus of this section is exploration of ways that future studies might expand on information gleaned from this study. Areas of limitation explored in this section include those related to phenomenological study, diversity of participants in this study, specific constructs of this study such as inclusion criteria, the data gathering and analysis process of this study, and the general process and outcome of therapy. Suggestions related to these limitations are interwoven throughout.

The first limitation examined here relates to use of a phenomenological research method. As with any phenomenological study, the results are best understood in the context of a small number of participants and are unable to be generalized to a larger
population. Future studies may want to use other qualitative methods like consensual qualitative research or grounded theory in order to gather a broader range of information. Quantitative methods may also be drawn upon to provide information that may be generalized to others.

Another limitation more directly related to this study is lack of diversity among the nine therapists who participated. These therapists were relatively diverse regarding SO identity but they lacked diversity regarding race, gender, age, level of experience, and practice setting. All participants were White, seven were female, seven were over the age of 50 or turned 50 during their participation, eight would be considered highly experienced therapists reporting ten years or more of practice focusing on affirmative therapy, and six worked as private practitioners. Additionally, all participants practiced in the southwest Michigan area with seven practicing in one local city and two in a city very close by.

Although the areas of homogeneity mentioned in the last paragraph have benefits regarding the commonality of experience across participants, a more diverse sample could have yielded richer information. For example, because training opportunities are usually greater in settings like community mental health sites, group practices, and university counseling centers, the fact that most of the study’s participants practiced privately may have limited their access to training specific to affirmative therapy. Additionally, because most of the participants were over the age of 50, there was an inherent cohort effect regarding the training they received (or didn’t receive) during their graduate programs and how long it had been since they had that training. Attention to issues of SO identity in psychology graduate programs is a relatively recent phenomenon
and thus; if participants received this training during the eighties and nineties, the likelihood of accessing training specific to affirmative therapy and/or LGB identity was modest at best. Regarding therapists’ distance from the bulk of their training, statements about their recollection of the models or how long it had been since they’d fully reviewed them seemed to support that this distance played a part in their difficulty articulating what drew them to a particular model. Again, this homogeneity regarding participants’ ages, types of practice, and locations may have provided some advantage in greater ability to contextualize results but this possible cohort effect may have negatively impacted participants’ abilities to explore the material presented to them around practical use of LGB identity models in therapy.

The next area of limitation explored here relates to ways that participating criteria were set. As explained in Chapter Four (see Therapeutic use of LGB Models of Identity Development: Exposure Equals Utilization), I purposely did not require that therapists had experienced prior exposure to LGB models of identity development. This was in part because I did not equate exposure to LGB identity models with meeting criteria to be considered an affirmation therapist. In retrospect, my failure to include prior exposure to LGB identity models as part of participating criteria likely limited the ability of most participating therapists to delve very deeply into one of the main topics of this study: how do therapists use developmental models of LGB identity in their practice?

Most participants received little to no exposure to LGB-specific issues including models of identity development during their graduate training and only a few gained exposure to LGB models of identity development after completion of their graduate training. Thus, although all of the participants identified as affirmative and met criteria
for the study, four had no exposure to these models and did not use them in their therapy. Additionally, I now realize that simply having some exposure to these models does not necessarily correlate to understanding the model or being able to articulate reasons for using a model in therapy. The five therapists who did have exposure to LGB identity models described a variety of experiences regarding the depth of this exposure, how they accessed this exposure, and how they integrated the information gleaned from these models into therapy. For example, some therapists seemed to have a more current relationship to the models as evidenced by their ability to name models and cite specifics regarding stages in a particular model while others could not name a particular model. Therapists’ abilities to discuss and critique nuanced aspects of these models seemed heavily influenced by how recent their exposure was and how much study they had done regarding a particular model. Additional criteria around level of exposure to and understanding of developmental models of LGB identity may have been helpful (although this heightened criteria may have also made recruitment very difficult).

Several limitations relate to the data gathering and analysis processes. Initial in-person interviews with participants all lasted approximately an hour but rarely took the 90 minutes allotted for the interview. Second interviews were significantly shorter and were conducted by phone. It was my perception that rich material sought through these interviews was successfully gathered but there are some limitations to note regarding their length. Firstly, I spent roughly one face-to-face hour with each participant which is considered a relatively limited period of time for in-depth qualitative exploration. It is possible that the shorter-than-allotted times for both first and second interviews were related to flaws in the interview questions or interviewing technique. For example, there
were several points during the interview process where I recall making the choice not to delve deeper into what I perceived to be incongruence in a therapist’s information. What drove this choice was likely my background as a therapist and not wishing to “challenge” the client (or in this case, the participant) as this might disrupt the connection between us. In retrospect, my interviews may have benefited from a more “research-driven” eye where I returned to questions more persistently than I would as a therapist. The use of focus groups (multiple participants meeting together to be interviewed) may have allowed for deeper exploration of the research questions as therapists may have felt some comfort with probing each other about issues and adding relevant information based on what was being brought up in the group. Additionally, all participants were given the opportunity to provide correction and add information through a “member-checking” process [see Chapter Three, Step 7, data verification (member checking)] but this step occurred roughly half-way through the analysis process and multiple changes were made in the realm of data analysis post-member check. This aspect of rigor may have been strengthened by the addition of another member-checking step closer to the completion of data analysis.

The last area of limitation explored here relates to the process and outcome of therapy. Therapists, more than any other field, are exposed to a certain amount of self-reflection and self-exploration in their training. Thus, therapists are likely able to have an open discussion of their own work. However, all therapists have “blind-spots” (aspects of their work with clients where information may be overlooked or misinterpreted) and all therapists are subject to human fallibilities. Therefore, reliance on therapist self-report has limitations. This may be addressed through an external source viewing the therapist’s
work and adding this perspective to the data. Additionally, the perspective of the client was missing from this study. In the future, it will be necessary to gain the client’s vital perspective on efficacy of affirmative/SO identity-related strategies. Lastly, this study did not speak to any aspect of outcome regarding the process of affirmative therapy. Although strategies were identified which were not previously examined in empirical study, we do not have any information regarding how use of these strategies might affect the outcome of therapy.

**Conclusion and Reflections**

The material shared by therapists in this study addressed existing gaps in the literature regarding empirical study of affirmative therapy and work on SO identity. Therapists shared candid detail regarding their experiences providing affirmative therapy, specifically attending to SO identity with their clients, and practically applying developmental models of LGB identity. From these details, numerous strategies were identified which will hopefully shed light for readers on multiple “how” questions related to work on SO identity. For example, therapists shared actual, “nuts and bolts” techniques connected to these strategies, not just abstract ideas. It is my hope that this kind of candid information from therapists working “in the trenches” will help bridge existing gaps between research and practice.

Illumination of these more nuanced techniques may also help advance LGBT-related training. Better LGBT-related training in psychology graduate programs and through post-graduate workshops could help reduce therapeutic missteps that commonly occur with sexual minority clients. For example, it has been contended that therapists’
avoidance of SO identity issues is a common error made by mental health professionals 
(Perez & Amadio, 2004, citing Gonsiorek, 1993a) and conversely; some therapists may 
over-focus on achieving a resolution of sexual identity, especially with younger clients 
(Perez & Amadio). Greater exploration of specific strategies used in affirmative practice 
generally and attending to SO identity specifically could help therapists-in-training (and 
more advanced therapists with little affirmative experience) be better prepared for work 
with sexual minority clients.

This study also produced results that speak to the beneficial power of research and 
particularly, qualitative research. The way research is conducted can promote its potential 
to benefit a range of recipients that include not only “the usual” audience of 
scholars/practitioners but also clients, and the participants themselves. Therapists in this 
study supported qualitative research’s potential to have an immediately positive and 
empowering effect on participants. All therapists described ways that they felt their 
participation directly benefited them including feeling more connected to other 
affirmative therapists and increasing their self-awareness regarding their work. Some 
therapists also discussed feeling appreciated by having a researcher take an interest in 
their work. What therapists shared regarding their experience of participation in this 
study supports claims by authors such as Gamson (2000) that qualitative methods are 
optimal for LGB research. Gamson stated, “Qualitative methods, with their focus on 
meaning creation and the experiences of everyday life, fit especially well with movement 
goals of visibility, cultural challenge, and self-determination.” (p. 348). Research that 
invites the participant to deeply explore aspects of their experience and communicates a 
sense of value for this experience thus becomes a kind of therapy for the participant.
Specific to my own growing edges as an LGBT scholar/researcher and affirmative practitioner, the therapists in this study brought to light the complexity involved in separating general affirmative practice from specific attention to SO identity development. For example, when this study was early in conception I tended to view therapist attention to SO identity as distinct from general affirmative therapy. This complex and, at times, false distinction was also reflected by therapists who tended to describe aspects of latter-stage SO identity development such as romantic relationship-building as general affirmative therapy work rather than as related to SO identity. Through discussions with my research chair, I began to understand that constructing a life authentic to one’s SO identity was identity-work. I now have a deepened understanding of the interconnection between attention to SO identity and affirmative therapy that I believe will contribute to my future efforts regarding affirmative research and engaging in affirmative practice.

My role as a researcher in this study also raised multiple questions for me regarding social justice and ways that I might be more proactive regarding the challenge of heterosexism and the promotion of civil rights for sexual minorities. I believe that as a researcher I am obligated to address issues of social justice and it is my assertion that providing better quality affirmative services to sexual minority and questioning persons is in service of social justice. This study was aimed at the “micro” level, examining the work of nine affirmatively-identified therapists practicing in Southwest Michigan. I drew on my background as a therapist and scholar to gather information from these therapists with the aim of advancing the field of affirmative therapy. I believe that the process of sharing this information and examining their work in context also had a directly
beneficial effect on these therapists. It is my hope that this study contributes to therapists being better equipped to work with LGBT clients in such a way that these clients can develop a positive sense of self and thrive in/challenge the status quo of heterosexism, homophobia, and gender oppression. This hope takes on heightened relevance in light of information related to the negative experiences of LGBT and questioning youth in schools (Birkett, Espelage, & Koenig, 2009). For example, it has been reported that over 90% of LGBT youth sometimes or frequently hear homophobic remarks in their school (words such as "faggot", "dyke", or "queer") and sometimes these remarks come from faculty or school staff. Sadly, LGBT youth are almost twice as likely as their non-gay peers to be threatened with or injured by a weapon at school and this kind of harassment is linked to greater risk of suicidal behavior (Suicide Reference Library, 2006). Affirmative therapists can potentially counter the devastating effects of this kind of hostile environment and help their clients develop a positive, resilient minority SO identity. Although I believe that this study did speak to issues of social justice, it is my aim to take my future research to a more “macro” level, examining social policy and ways that heterosexism may be interrupted institutionally and societally.

Lastly, my experiences with participating therapists had a directly beneficial effect on me aside from helping me to complete my dissertation. I had the opportunity to meet with nine therapists committed to their work and who deeply cared about the lives of LGBT people. These therapists gave of their time generously and shared aspects of their work that helped me better understand my own work as a therapist. These therapists’ commitment to affirmative work also helped me forge a new resolve to focus more on affirmative therapy in future research and in my practice as a therapist. I am
deeply grateful for the time I spent with each of these therapists and I will remember
them long after this study has been completed.
CHAPTER II
LITERATURE REVIEW

This chapter focuses on the literature most relevant to this study’s purpose: the illumination of how LGB-affirmative therapists use developmental models of minority sexual identity in their work with clients as well as how these therapists address sexual orientation (SO) identity more generally. The chapter begins with a review of selected developmental models of sexual minority identity to provide the reader with an understanding of the models themselves including their shared and differentiating qualities. Illustrated models were chosen based on their prominence in LGB scholarship and their representation of “growing edge” issues in LGB-identity scholarship such as identity intersections, focus on bisexual identity, and attention to group identities. Next, literature on LGB-affirmative therapy is presented to provide the reader with contextual understanding regarding the nascence of affirmative therapy and common themes in the literature. This literature was also used as a basis for operationally defining “affirmative therapist” and explaining central aspects of affirmative therapy. Lastly, literature related to the practical application of LGB identity models in therapy was reviewed. Although this area of literature was found to be far less developed than the previous two, it served as the most relevant to this study. The few sources directly addressing the application of LGB identity models in therapy were instrumental in guiding the conceptualization of this study. Primarily, these sources helped with constructing questions aimed at deeper understanding of how affirmative therapists have integrated these models into their daily
work with clients. Each main section of this review culminates with critiques specific to that area of literature.

Models of LGB Identity Development

The concept of identity generally and LGB identity particularly is complex and difficult to concisely explain. This complexity is reflected in the variety of theories/explanations of LGB identity formation posed by scholars, some of which have been highlighted here. In their chapter on theories of LGB identity formation, Ritter and Terndrup (2002) explained that development of one’s sexual identity is an individual process based on interactions between how one makes personal meaning of sexual identity and societal expectations regarding this identity. They stated, “The process of blending essential characteristics [those we are born with] of the self with social constructs [socially based, not biological] of the community to form a sexual minority identity is often lifelong and evolving.” They also explained, “In a sense, the formation of a gay, lesbian, or bisexual identity is an achieved rather than acquired status”. (citing Garnets and Kimmel, 1991, p. 89). Fassinger (1991) pointed out that this lengthy process of identity development for sexual minorities occurs in an environment either devoid of or with very few role models and with a serious lack of social and legal support.

In her chapter, Constructing Identity: The Nature and Meaning of Lesbian, Gay, and Bisexual Identities, Broido (2000) explained some of the difficulties related to providing a conceptualization of sexual minority identity as either biological (an “essentialist” perspective) or social (a “constructionist” perspective). A full discussion of the philosophical tensions experienced around the debate between essentialist and
constructionist perspectives is beyond the scope of this study. Most theory related to SO identity development is rooted in an essentialist perspective and the very act of constructing and/or defining aspects of SO identity is essentialist in nature. Social influences are included under the rubric of an essentialist perspective. The interplay between "inner" or more biologically-focused qualities and "outer" or more socially-influenced aspects of SO identity are apparent in the ways that developmental models of LGB identity are constructed. For example, in every model reviewed for this study there are references to both self-perception/internal process and social perceptions/external processes as connected to SO identity development. For example in Troiden's (1989) model, the experience of confusion related to one's SO identity is influenced by the social stigmatization of sexual minorities.

In their chapter on gay and lesbian identity development, Gonsiorek and Rudolph (1991), provided some historically contextualizing information regarding the nascence of sexual minority identity development models. They explained that Allport (1954) was one of the first to note negative developmental effects of stereotyping and prejudice. Gonsiorek and Rudolph indicated that a developmental perspective is necessary to understand the problems that sexual minority persons face, particularly in light of their exposure to social stigma and oppression. Regarding sexual minority identity models, the authors explained:

The coming out models are an important theoretical development. They essentially describe an additional developmental effort unique to the lives of lesbians and gay men. This developmental event occurs in addition to, not instead of, the psychological processes and other aspects of identity development throughout adolescence and adulthood. (p. 166)
The importance of LGB identity models to advancing the field of affirmative therapy was echoed by McCarn and Fassinger (1996) who explained that the models have assisted therapists’ work with sexual minority clients through normalizing and predicting their shared developmental experiences around managing an oppressed identity.

It would be highly impractical and extremely tedious for the reader if every existing model of minority sexual identity was included in this review. Therefore, six models were chosen for review based on a variety of factors including their prominence in LGB scholarship and their representation of “growing edge” issues in LGB-identity scholarship. For example, the Fassinger and Arseneau (2007) model breaks previously established, unwritten “rules” regarding construction of identity development models (i.e. the authors did not refer to stages or phases, they did not assume a linear path of development, and they used the term, “enactment” rather than development).

The Cass Model of Homosexual* Identity Formation (1979) was chosen because it is unarguably the best known and most used model of sexual minority identity development. Evidence of its popularity is found in the database, PsycINFO (an electronic database of published literature and dissertations widely used by psychological professionals and other scholars) where it was cited 461 times as of March 2010, more than twice the amount of any other model examined for this study. Its popularity has likely been connected to Cass’ attention to detail, providing insight into both the social and personal processes of sexual minority identity formation. Perez and Amadio, (2004) touched on this aspect of Cass’ work, explaining that this attention makes her model more therapeutically applicable. Cass’ model is unique in that it is the only one to provide for multiple developmental possibilities (called “pathways”). These pathways correspond...
to each stage of SO identity development and include individual as well as social factors. Although Cass did not specify therapeutic interventions targeted towards each stage of development, it is likely that therapists have been able to review her information regarding the multiple pathways and clearly identify relevant strategies based on this information.* Cass referred to her studied population as “homosexuals”, a term now considered derogatory based on its association with the pathologizing of sexual minorities. In accordance with American Psychological Association (APA) guidelines regarding biased language in publication. I have used the group descriptor “lesbian/gay” or LG to refer to the population Cass studied.

Other sexual minority identity development models considered seminal pieces of scholarship include Troiden’s Model of Homosexual Identity Formation (1989, 1993) and Coleman’s Stages of the Coming Out Process (1981/1982) cited 167 and 45 times respectively (PsycINFO; March, 2010). The Cass (1979), Troiden, and Coleman models are arguably three of the best-known models of minority sexual identity development and were chosen for review based on their foundational position in LGBT scholarship. Also reviewed in this chapter is the Weinberg, Williams, and Pryor (1994) Model of Bisexual Identity Formation which was chosen for its explicit representation of the “B” (bisexual) in LGB identity. This model was the first (to the authors’ knowledge) to specifically address bisexual identity and was chosen over another reviewed bisexual identity model (Brown’s 2002 Model of Bisexual Identity Formation) because it explained bisexual identity more clearly and used client-derived data as its basis. Brown based his model on much of Weinberg, Williams, and Pryor’s information and although he brought up several salient points of critique regarding the Weinberg et al. model, he failed to clearly
improve on the model’s structure, methodological soundness, or clarity. McCarn and Fassinger’s (1996) *Model of Lesbian Identity Formation* was chosen for its role in addressing multiple critiques of the older models and being the first to clearly differentiate and illustrate both social and individual developmental paths. Additionally, as time has passed since the first models were created, this model has assumed a more seminal status, having now been cited 148 times in PsycINFO (March, 2010). Fassinger and Arseneau’s (2007) *Model of Identity Enactment of Gender-transgressive Sexual Minorities* was chosen for its representation of the scholarship’s growing edge. With this model, Fassinger and Arseneau defy existing paradigms regarding LGB identity research in multiple ways including rejection of stage-like patterns and inclusion of gender and cultural orientations alongside sexual orientation. A review of the six chosen models follows:

**Cass**

Since its publication in 1979, Vivien Cass’ Model of Homosexual Identity Development has become the most cited, widely researched, and influential minority sexual identity model (McCarn & Fassinger, 1996). Cass’ model was specific to gay men and lesbian women and did not include bisexual identities in its scope although it did refer to adoption of a bisexual identity as a way of distancing oneself from lesbian/gay (LG) identity. I chose to review Cass’ original (1979) model and incorporate information she later published in 1984 and 1996. This is because the 1979 version of her model is the most cited version and continues to dominate the literature in terms of influence. Although Cass later contributed to multiple articles and chapters which explored her model and expounded on LGB identity theory (see Cass 1984a, 1984b, 1996); she did not
make changes to the structure of her original model. Thus, the 1979 version is still her most current.

Cass (1984b) described the process of LG identity development as encompassing the areas of self-perception as LG, the transition from perception to identification by way of interaction with others, daily strategies of identity management, and incorporation of LG identity into a sense of self. Cass (1984b) explained that an LG identity is a "typological identity" (p. 144), meaning that this type of identity is a synthesis between how one views themselves and how they believe others view them. Cass (1984b) wrote, "In essence, the process involved in the acquisition of a homosexual identity is one of identity change in which a previously held image of sexual orientation is replaced with a homosexual image." (p. 145). She explained that this process of identity formation is developmental in nature and marked by specific stages and experiences. Cass’ model is more detailed and complex than almost all other LGB identity models because she accounts for multiple “pathways” at each stage. Pathways are essentially possible outcomes of development and are influenced by how the individual views their own identity, how they perceive others view their identity, and the quality of interactions with both heterosexual and LG others.

Cass (1984a) noted that of “hundreds” (p. 107) of articles regarding LG identity, none clearly defined the concept and the body of literature as a whole seemed wrongly disconnected from more established, general theories of identity. She called for a more scientific approach to the subject in order to provide clearer definition of LG identity and give researchers a common language. In order to provide more scientific support for her model’s validity, Cass (1984b) constructed two corresponding measures of LG identity,
The Homosexual Identity Questionnaire (HIQ) and The Stage Allocation Measure (SAM). The HIQ is a paper-and-pencil instrument that consists of 210 items measuring 16 dimensions of LG identity including “commitment”, or the degree to which a person self-ascribes an LG identity, and “group identification”, or the degree of a sense of belonging to the LG community. The SAM provides information on how a person’s LG identity development might correspond to Cass’ (1979) stages through provision of profiles of LG persons in each of the stages followed by asking respondents to choose the stage that best fits them. Cass (1984b) found general support for her hypotheses that those in a certain stage of LG identity fit the description of that stage better than those in other stages and participants at a particular stage showed greater similarity to the profile of that stage compared to participants at other stages.

Cass’ model of homosexual identity development

Stage one, identity confusion

In the “identity confusion” stage, a person becomes consciously aware that LG identity may be relevant to them. Identity at this point is that of potentially being LG and feelings of alienation prevail based on incongruence of this information with the previously held belief that one is heterosexual. Three pathways of development are highlighted as possibilities at this stage based on whether being LG is personally viewed positively (pathway one) or negatively (pathway two). There is also the possibility (pathway three) of identity foreclosure or complete rejection of LG identity. Cognitive and behavioral strategies related to this stage might include ceasing all behavior believed to be related to being LG (this would occur if the client views LG identity negatively and they believe they may indeed be LG).
Stage two, identity comparison

This stage is marked by a shift towards the possibility that one may be LG and confusion regarding identity is reduced. There may be feelings of grief and loss when recognizing that previously held assumptions such as access to basic civil rights are no longer valid. Behaviors at this stage are centered on managing this loss as well as managing feelings of being different that may be exacerbated by social/geographical isolation. At this stage, group memberships may work to increase (i.e. heterosexist religious affiliation) or decrease (i.e. feminist groups) feelings of alienation. Of course, there are many other group affiliations which may also increase or decrease LG persons’ alienation just as there is the possibility that groups such as feminist organizations may actually increase alienation rather than alleviate it. Four pathways are possible at this stage based on whether one views adoption of a LG identity as positive and worthwhile (pathway one), positive but not worthwhile (pathway two), negative but worthwhile (pathway three), or negative and not worthwhile (pathway four). The overall aim during this stage is reduction of feelings of alienation and those who do not foreclose their LG identity deal with the fact that they are likely LG. If foreclosure does not occur and the person does not progress in their development, they may experience intense self-hatred and suicide might be considered an option. If they do progress; they may consider making further contact with LG others as a way of decreasing feelings of alienation.

Stage three, identity tolerance

Persons in this stage have a sense of increased probability of being LG which correlates to greater commitment to the identity. This increased commitment allows for greater focus on one’s sexual, emotional, and social needs. At this point, one makes
contact with other LG persons more out of necessity (to alleviate social isolation) than desire. How these contacts are interpreted (positively or negatively) profoundly affects developmental progress. For example, favorably interpreted contacts with LG others contribute to positive feelings about LG others which leads to an increase in positive feelings about oneself and greater commitment to self-identification as LG. This greater commitment leads to further seeking out of contacts with LG others not solely out of necessity but now out of desire. Six pathways are possible at this stage based on whether one’s view of self as LG is positive (pathway one) or negative (pathway two), whether contacts with the LG community are viewed positively (pathway three) or negatively (pathway four), and the interactions between these evaluations (pathways five and six).

Stage four, identity acceptance

In this stage a person experiences increased contact with LG others which validates their LG identity. Mere “tolerance” of LG identity moves towards acceptance as the power of stigma is diffused. People in this stage may feel increasingly at peace with and stable in their identity. When a person in this stage perceives that their identity may be viewed negatively by others; they may employ stigma management strategies including selectively coming out, selectively passing as heterosexual, and limiting contact with those likely to be unsupportive. Two pathways are possible at this stage: (1) happiness with identity/ability to cope with unacceptance and (2) satisfaction with identity/inability to cope with unacceptance. “Happiness” vs. “satisfaction” implies that one pathway celebrates identity while the other is merely “okay” with the identity. When positive feelings regarding identity increase, this causes confrontation with the reality of social stigma and movement onto stage five may occur.
Stage five, identity pride

This stage is marked by devaluation of heterosexuality when one realizes that it is very difficult to fully live and express themselves in society (a society that discriminates against sexual minorities) as openly LG. Acceptance of LG identity transitions to preference for LG identity and contact with heterosexuals is decreased. In this stage, one experiences feelings of pride and loyalty to the LG community and anger towards a heterosexist, unjust society. It is explained that “Purposeful confrontation with the establishment is seen as the only way to validate the belief that homosexuality is good.” (p. 233). As one in this stage becomes less concerned with acceptance from society, they are freed to be more openly “out”. Coming out can work to increase the environmental sphere where the person is seen as LG, thus supporting their identity and promoting congruence between public and private selves. Two pathways are possible at this point: if contacts with heterosexuals are negative, then a negative view of heterosexuals is reinforced (pathway one); if contacts are positive, this might challenge the negative view of heterosexuals (pathway two) and move the person towards stage six.

Stage six, identity synthesis

This stage is characterized by less labeling of heterosexuals as globally “bad”. Those heterosexuals deemed supportive are reevaluated which works to increase the person’s sphere of social contacts. The subsequent decrease in the number of the “enemy” correlates to a decrease in anger and feelings of alienation. There is a greater sense of connection to the world overall and the focus of identity expands beyond sexual orientation. This path continues unless something happens to bring the focus back to sexual orientation, at which point strategies are adopted aimed at restoration of
congruence between self-perceptions and societal perceptions. For example, one in this stage might experience a coworker making a heterosexist comment which brings a negative focus to one's sexual orientation identity. A behavioral strategy might be to increase contact with LG others in order to regain a sense of safety while simultaneously employing a cognitive strategy of devaluing the person who made the comment. This allows for a bolstering of one's self-view while decreasing the significance of the negative views of others.

**Coleman**

Eli Coleman (1981/1982) posed a five-stage model of LG identity development contextualized alongside other developmental theories such as Erickson (1956) and Sullivan (1953). A central aspect of these theories highlighted by Coleman is the preposition that previous stages of development must be resolved before movement to the next stage can take place. Coleman explained that his model does not assume that all LG people transition through each stage progressively and that some may work on tasks from different stages simultaneously. Coleman stated, “While the development of many individuals is in fact more chaotic, fluid, or complex than this model describes, the framework remains useful as a way to understand these people and can assist therapists and clients if used in a flexible manner.” (p. 32). Like Cass (1979), Coleman included both genders in his developmental model and described this group as “homosexual”, or “individuals with a predominantly same-sex sexual orientation” (p. 32).
Coleman's developmental stages of the coming out process

First stage, pre-coming out

This stage is characterized by a lack of consciousness of same-sex attraction accompanied by the likely manifestation of dysfunctional behaviors aimed at keeping this knowledge repressed. Of those in this stage, it is explained, “They can only communicate their conflict through behavioral problems, psychosomatic illnesses, suicide attempts, or various other symptoms.” Resolution of this stage and subsequent progress in development requires acknowledging same-sex desire and facing “the existential crisis of being different.” (p. 33)

Second stage, coming out

In this stage, one acknowledges same-sex desire first to the self and next to selectively chosen others. Coming out to others is necessary for the promotion of self-acceptance and it is explained, “No one can develop self-concepts such as ‘accepted,’ ‘valued,’ or ‘worthwhile’ all alone. One must take risks to gain acceptance from others.” (p. 34). It is highlighted that one in this stage should come out only to those likely to be accepting of this news, as a negative reaction at this point can function to damage the self-concept. Conversely, if the reaction at this stage is positive, it can serve to counteract a negative self-concept and “The existential crisis begins to resolve in a positive direction.” (p. 34)

Third stage, exploration

This stage is characterized by sexual experimentation, formation of relationships with other LG people, and formation of a LG identity. At this stage, contact with other openly LG persons promotes a healthy and positive development of identity. Key tasks at
this stage include development of interpersonal skills to promote the development of relationships with other LG persons as well as development of competence as a healthy and balanced sexual person (meaning feeling attractive and capable sexually while not relying on sexual conquest for self-esteem). It is noted that during this stage, adult LG persons may experience a kind of delayed adolescence because they were never able to truly engage in the normal developmental aspects of adolescence such as displaying open affection for and dating those to whom they are attracted.

_Fourth stage, first relationships_

In this stage, one moves from desire for exploration in relationships to desire for more commitment. The key task in this stage is to be able to establish and maintain a romantic relationship in a hostile environment. It is explained that first relationships are “characterized by intensity, possessiveness, and lack of trust” (p. 38) and that a common result of these stressors is infidelity. Coleman indicated that LG persons usually do not have the same relationship skills that heterosexual persons have developed partially due to lack of viable role models and representation in the media. It is also stated that first relationships often occur before LG identity has been fully formed and this poses further challenges to the relationship.

_Fifth stage, integration_

This stage is characterized by an integrated LG self-image that is comprised of public and private identities. Romantic relationships that occur when one is in this stage tend to be more stable and successful. It is explained that LG persons in this stage continue to encounter the developmental challenges of life generally such as aging but
that these challenges are more easily met than if one encounters them at earlier stages of LG identity development.

**Troiden**

Richard Troiden (1989) explained that he used sociological theory to construct a four-stage model of LG identity formation based on the recollected accounts of those who fully identify as LG. He indicated that this model is a revision of his earlier (1979) work which was based on Plummer’s (1975) “interactionist” or socially constructed model of male homosexual identity development. Troiden explained that his more current model incorporated aspects of minority sexual identity models by Ponse (1978) and Cass (1979, 1984) and emphasized the influence of “sexual scripts” (p. 44) or the ways that humans learn and organize their behaviors related to sexuality. These scripts are influenced by culture and provide the cognitive and affective “boundaries” (p. 44) regarding behavior. Troiden differentiated self-concept from identity, explaining that self-concept is our image of ourselves generally while identity indicates how we see ourselves in specific situations. He indicated belief that one’s LG identity is fully realized when there is correspondence between three aspects of identity: self-identity as LG, perception that others identify them as LG, and presenting an LG identity to the public.

He described his model as based on “ideal types” (p. 47) explaining, “Ideal types are not real; nothing and nobody fits them exactly. They represent abstractions based on concrete observations of the phenomena under investigation.” Troiden likened the identity development process to the image of a horizontal spiral with progression through the stages not linear but rather back and forth and up and down. He also indicated that his
model was organized around “life stages” (p. 47) and in all but the last stage he included developmental age ranges.

**Troiden’s formation of homosexual identities model**

*Stage one, sensitization*

This stage occurs before puberty when most adolescents are unaware of the personal relevancy of an LG identity and is characterized by feelings of being different from and stigmatized by others. Bell, Weinberg, & Hammersmith (1981a) are cited in explaining that gender-based behaviors are more responsible for these feelings of marginality than behaviors based on sexual attraction to others. Troiden (1989) explained that reviewing past childhood behaviors and later reinterpreting them as consistent with being LG seems to be a necessary component of LG identity formation.

*Stage two, identity confusion*

Troiden (1989) indicated that this stage typically occurs during adolescence. The identity confusion stage is characterized by dissonance between the realization of the possibility of being LG and the previously held belief that one is heterosexual. This is described as a “limbo” (p. 53) state where identity as LG has not been established but heterosexual identity is no longer a certainty. This identity confusion is fueled by the experience of same-sex attraction, the stigmatization of LG people, misperceptions regarding LG people, and the level of variability regarding sexual experience (for example, experiencing attraction to both sexes). Responses to the confusion include the denial of the possibility of LG identity, seeking treatment to “fix” the possibility of LG identity, avoidance of same-sex-based feelings, taking an active anti-LG stance in order
to distance oneself from the identity, escaping thoughts about identity through chemical substances, and acceptance of possible same-sex attractions.

*Stage three, identity assumption*

This stage occurs around late adolescence and is characterized by the adoption of LG identity both to self and to select others. During this stage, regular contact is made with other LG people, sexual experimentation occurs, and LG culture is explored. Cass (1979) is cited in explaining that the quality of contacts with LG others can serve to perpetuate and exacerbate a negative self-view or challenge this view and promote identity development. Ponse (1978) is cited in describing LG persons who have little or no contact with LG others as being in a state of “disembodied affiliation” (p. 206). Once an LG identity is adopted, persons must employ stigma-management strategies including “capitulation” (p. 61) or avoidance of LG behavior; “minstrelizing” (p. 62) or expressing their LG identity in stereotyped, restricted ways such as wearing “gender-inappropriate fashions” (p. 62); and “passing” (p. 62) or adopting heterosexual behaviors in order to avoid detection as LG. At the end of this stage an LG identity is beginning to be accepted.

*Stage four, commitment*

In the “commitment” stage, one fully engages in life as an LG person and this stage is often marked by the beginning of a serious relationship. Troiden (1989) did not indicate age specificity for this stage but it may be assumed, based on previous stage information, that it occurs sometime during adulthood. In this stage, one feels more comfortable with and accepting of their LG identity. Internal indicators of this stage include cohesion between the emotional and sexual aspects of self, assigning more
positive meaning to LG identity, viewing an LG identity as valid, being satisfied with an LG identity, and experiencing more positive emotions after identifying as LG. External characteristics of this stage include development of romantic relationships with same-sex others, coming out as LG to heterosexual others, and reduction of avoidance strategies in managing stigma.

**Weinberg, Williams, and Pryor**

The Weinberg, Williams, and Pryor (1994) Model of Bisexual Identity Development represents the first (to their knowledge) model to explicitly address bisexual identity. The authors explained that acquiring a bisexual identity involves rejection not only of a heterosexual identity but also an LG identity. They indicated that they sought to answer questions related to similarity between bisexual and LG identity development, existence of bisexual identity as a distinct and viable identity option, and absence of a bisexual subculture and its possible affects on the ability of persons to commit to a bisexual identity. Summarily, the authors asked, “For our subjects, then, what are the problems in finding the ‘bisexual’ label, understanding what the label means, dealing with the social disapproval from two directions, and continuing to use the label once it is adopted?” (p. 27). In order to create their model, the authors interviewed (1983) 49 male and 44 female bisexual-identified persons primarily of Caucasian race and all living in San Francisco. They found that four stages of bisexual identity development captured the experiences of their participants.
Weinberg, Williams, and Pryor’s model of bisexual identity formation

Stage one, initial confusion

This stage is characterized by a period of doubt about one’s sexual identity before finally identifying as bisexual. Some participants in this stage reported strong feelings for both sexes and a struggle with how to categorize or make sense of the feelings. Others indicated unawareness that there was a label other than heterosexual or LG and some struggled with feelings of homophobia leading to denial of their bisexual identity. This period is described as one of intense turmoil and psychological distress.

Stage two, finding and applying the label

Those in this stage discover the term, “bisexual”, and realize that this label describes them. One participant described hearing the term, “bisexual” for the first time in a psychology class. For some, this stage was characterized by discovering that physical intimacy with the gender they were less sexually familiar with was equally pleasurable, while others simply felt their attraction to both sexes was too intense to choose between them. Some discussed being encouraged by others to adopt a bisexual identity or finally finding a place (usually separate from LG organizations) accepting of bisexual identity. Some gender differences were highlighted during this stage, particularly around the connection between encouragement from others and adoption of a bisexual identity. It was noted that for women, this factor appeared more salient and sometimes perceived as coercive if they were encouraged by their male partners in order to engage in multiple-party sexual activity.
Stage three, settling into the identity

Stage three is characterized by further identification with being bisexual, usually taking place years after sexual behavior with partners of different genders. Movement into this stage is correlated with greater self-acceptance. The person in this stage experiences less anxiety about the identity, worrying less about others not accepting the identity. For some, this transition was helped by a bi-supportive community. An example of a participant’s statement that exemplifies this stage is, “I just decided I was bi. I trusted my own sense of self. I stopped listening to others tell me what I could or couldn’t be.” (p. 32). It was noted that 90% of participants interviewed in the construction of this model denied that they were transitioning towards either exclusively heterosexual or LG identities but when asked about whether they might one day identify as either heterosexual or LG, 40% answered affirmatively. This possibility was commonly connected to being in an exclusive relationship with one partner.

Stage four, continued uncertainty

The last stage in this model is characterized by continuing doubt about the validity of one’s bisexual identity even after discovering and applying this label. This uncertainty is linked to social invalidation of a bisexual identity, particularly by the LG community. Gender differences were noted here, as some women indicated confusion regarding how political implications of their choice in sexual partner affected their identity. Both men and women experienced confusion related to lack of sexual behavior that expressed their bisexual interests and/or being in a long-term, monogamous relationship. Of the participants interviewed, it was found that 24.5% of males and 22.7% of females were presently confused about their sexual identity.
McCarn and Fassinger

Susan McCarn and Ruth Fassinger (1996) presented a model of lesbian identity development that explicitly addressed aspects of diversity within the overall group of lesbian women as well as differentiations between individual and group identities. They explained that their model drew heavily from theories of women’s and racial identity development which helped to redress deficits inherent in previous models. For example, racial identity theory influenced the authors’ attention to the role of oppression on lesbian identity. The authors explained, “Common to both processes [racial identity development and LGB identity development] is moving the reality of the experience of oppression from unconsciousness to consciousness, then addressing the issues raised by a changed awareness of oppression.” (p. 516). The authors pointed out that these similarities also exist between LGB identity development and feminist women’s identity development.

Other LGB-identity model deficits addressed by McCarn and Fassinger (1996) included the lack of rationale for including male and female gender groups in the same sample and the “oversimplified” notion that identity progression occurs linearly and culminates in “immutable same-sex relational orientation” (p. 520) and a politicized, “out” status. They explained that the positioning of this status as an indication of fully developed LGB identity unduly places burden on those who have been oppressed in ways that racial/ethnic minority identity models have not. Regarding inclusion of both genders, the authors indicated multiple elements of minority sexual identity that would not be captured by including male and female genders such as the societal repression of women’s sexual behaviors. The authors further explained that their model also accounted for individual and group trajectories of identity development, explaining that LG persons
must navigate their personal awakening around sexual identity while simultaneously navigating membership in a newly relevant group. These two tracks of identity development also intersect with and influence each other, as progression through individual aspects of identity would be very difficult without some engagement in group identity processes.

Unlike references to developmental “stages” outlined in most sexual minority identity models, McCarn and Fassinger (1996) used the term, “phases”, to convey greater flexibility regarding identity development. The authors also refrained from using “coming out” behavior as an indicator of developmental progression based on the contextual limitations associated with such behavior. Specifically, the authors noted that use of coming out to illustrate developmental progress seems to wrongly place responsibility for the effects of oppression on the person being oppressed. The McCarn and Fassinger model was also one of few with a basis of empirical support, specifically the use of a Q-sort validation method on 38 lesbian-identified females from diverse backgrounds and races (Fassinger and Miller, 1996).

**McCarn and Fassinger’s model of lesbian identity formation**

**Phase one, awareness (individual)**

In this phase of individual identity development, one becomes aware of feelings of being different from others based on desires that sway from heterosexual (and thus, self-predicted) norms. Assumptions about the heterosexuality of self and others are now questioned.
Phase one, awareness (group)

In this first phase of group identity, a woman becomes aware that not all people are heterosexual and that heterosexism is the societal norm. This discovery is likely to produce feelings of confusion rather than anger.

Phase two, exploration (individual)

This phase is characterized by exploration and examination of issues brought into awareness during the first phase. It is likely that women in this phase have developed intense feelings for and/or relationships with other women or another woman.

Phase two, exploration (group)

The “exploration” phase of group identity development is characterized by active examination of one’s fit with other lesbian women as a group and of the group itself. Knowledge about the group is actively sought during this phase. Depending on a woman’s attitudes regarding lesbian identity before this phase, she may experience a complex array of emotions regarding this new knowledge, ranging from anger and guilt to great joy.

Phase three, deepening/commitment (individual)

Women in this stage of individual identity development now have a more solidified sense of their sexual identity as it relates to being with other women. “It is here that the emerging lesbian is likely to recognize her desire for other women as within herself and, with deepening self-awareness, will develop sexual clarity and commitment to her self-fulfillment as a sexual being.” (p. 523). It is noted that individual commitment is likely linked to tasks related to commitment to lesbians as a group.
Phase three, deepening/commitment (group)

The “deepening/commitment” phase of group identity is characterized by an increased awareness of the oppression of lesbian women and their value as a group. “It involves a commitment to create a personal relationship to the reference group, with awareness of the possible consequences entailed.” (p. 525). During this phase, one may experience an intense connection to lesbian women as a group and actively reject heterosexual culture, resulting in a multitude of emotional reactions such as rage, pride, excitement, and confusion.

Phase four, internalization/synthesis (individual)

In this last phase of identity development, one experiences an increased sense of self-acceptance around a lesbian identity likely occurring after years of exploration and work on personal resolution of conflicts. Women in this stage have fully integrated their identities as lesbian into their overall sense of selves and are at least in process of developing a group connection whether or not they are fully “out” in all spheres of life.

Phase four, internalization/synthesis (group)

In this last phase of group identity, one has identified with and redefined lesbian women as a group and has internalized this group identification into an overall sense of self. Although one taking an active, political stance against heterosexism is not a necessity at this stage, it is assumed that one is aware of the oppression associated with identifying as lesbian. When a woman reaches this stage of development, it is stated, “She will have traversed the path from rage, anxiety, insecurity, and rhetoric to directed anger, dedication, and self-love as a lesbian woman.” (p. 525).
Fassinger and Arseneau

Ruth Fassinger and Julie Arseneau’s (2007) Model of Identity Enactment of Gender-transgressive Sexual Minorities represents multiple advancements made in the scholarship regarding the contextualization and complexity of sexual identity and is the most recently published model of minority sexual identity reviewed for this study. The authors made a dramatic departure from previous models by including transgender identity, rejecting a linear path of identity development based on stages or phases, and reliance on a philosophy based on social deconstruction rather than a positivistic stance. The authors did not make any attempt at following an empirically supported (i.e. positivistic) framework for their model. They discussed the existing debate regarding “essential” (biologically based) vs. “socially constructed” (socially based) theories of sexual orientation and provided a model aiming to deconstruct the group classifications it addressed.

The Fassinger and Arseneau model is described as a “model of identity enactment of gender-transgressive sexual minorities” (p. 22). This description speaks to the commonalities between those who identify as LGB and those who identify as transgendered (T) in that all of these descriptors imply a shared oppression and stigma based on transgressing gender norms. The authors acknowledged, however, that despite this shared experience, identity is highly complex and there are numerous difficulties associated with “…discussing sexual minority population groupings as if they were distinguishable, homogeneous entities with an indisputable sociosexual identity existing across time and place.” (p. 20).
According to the Fassinger and Arseneau (2007) model, sexual identity must be contextualized against “temporal influences” (p. 25) such as individual age and experiences of one’s cohort. Individual differences are addressed within a triangle of gender, cultural, and sexual orientations alongside the following “developmental arenas” (p. 34): health; relationships and family; education and work; and legal and political rights. Visually, the model is depicted as a triangle of the three aforementioned orientations around a smaller circle of individual differences. From this circle emanates the developmental areas mentioned previously. More explicit detail regarding orientations and arenas is provided below:

**Fassinger and Arseneau’s model of identity enactment of gender-transgressive sexual minorities**

**Gender orientation**

It is noted that gender serves as a highly significant organizer of our experiences. Gender orientation refers to the behaviors, emotions, and cognitions that are associated with one’s sense of self as a gendered person (usually one’s sense of being male or female). Others’ gender-based expectations of us and the way that we perceive ourselves as gendered also play key roles in our gender orientation. Gender orientation is distinct from, though often mistakenly conflated with, sexual orientation.

**Sexual orientation**

Sexual orientation refers to the behaviors, emotions, and cognitions that are associated with one’s sense of self as a sexual and relational person and is often tied conceptually to the gender of one’s intimate partner(s). It is noted that this is problematic because there are a myriad of factors that might play into our choice of partner other than
gender. “The term, ‘sexual orientation’ typically is used to distinguish among lesbian, gay, bisexual, and heterosexual people…” (p. 30).

*Cultural orientation*

Cultural orientation refers to those factors in one’s life such as (but not limited to) race, socioeconomic status, religion, geographic location, etc. that intersect with and mutually influence one’s sexual identity. For example, racial identity may have a significant effect on the overall experience of sexual minority persons and may also dictate how the person self-labels. For many LGB-identified persons, their religious identity has caused great personal conflict based on religious doctrines of homonegativity.

*Arena of health*

Described as a “personal arena” (p. 35), this developmental area pertains to those factors of physical health and healthcare that affect one’s sexual identity. It is noted that sexual minority persons “…share similar experiences of persistent institutionalized discrimination that sanctions inadequate or biased provision or outright refusal of proper services…” and that healthcare for sexual minorities is thus either unavailable and/or underutilized (p. 35). There are numerous links between physical health factors and sexual identity including the impact of the AIDS virus on the identities of gay men, higher rates of tobacco and alcohol use in lesbian women, and underutilization of preventative gynecological services for lesbian women (leading to higher risk of undetected cancer).
**Arena of relationships and family**

In this arena, it is explained that sexual minority couples face many of the same issues and challenges that heterosexual couples do without the benefits of multiple sources of support and basic freedoms that heterosexual persons have access to. These supports include legal sanction of the relationship, public acknowledgement of the couples’ legitimacy, and media access to a view of family life that resembles one’s own. It is also noted that sexual minority couples must also manage ongoing issues of identity development in addition to other relationship stressors.

**Arena of education and work**

In the social arena of education and work, it is explained that sexual minorities commonly experience discrimination, harassment, and sometimes threats to their personal safety. Gender differences are noted here, with women more likely to have lower pay and numerous other barriers to their career advancement. “For women in same-sex relationships, the impact of discriminatory workplace environments is magnified, given that the likelihood of at least one partner facing difficulties is increased.” (p. 40).

**Arena of legal and political rights**

In this sociopolitical arena, the legal and political difficulties and injustices for sexual minorities are highlighted. Some of those reviewed include issues related to basic civil rights, discrimination in the workplace, harassment of sexual minority youth in the school system, and denial of rights to sexual minority couples and families. It is noted here that these issues are even more precarious for those who identify as transgendered.
Critiques of the models

One of the most levied criticisms of the more seminal models of LGB identity (i.e. Cass, 1979; Coleman, 1981/1982; and Troiden, 1989) has focused on their reliance on "out" adult White males to provide foundational basis for their models. Problems with relying on the White male experience to represent the experiences of white women and all persons of color have been well reviewed in multiple facets of literature (see McCarn and Fassinger, 1996 and Fukuyama & Ferguson, 2000 for specifics regarding use of White male sexual minority persons to represent non White male sexual minorities). Diamond (2006) explained that reliance on identity "achieved" or "out" participants is problematic because by definition, it is capturing data only from those who already self-define as gay or lesbian. Furthermore, the foundational basis is often anecdotal, reflective, and lacking methodological soundness.

Of the previously mentioned authors, Cass was the only one to attempt at validating her model through a corresponding measure of identity. There are, however, some noticeable flaws in her methodology. She wrote (1979) that her model was based on "several years of clinical work" (p. 219) with LG people but did not outline how. Cass (1984b) explained that she constructed and used two measures (The Homosexual Identity Questionnaire and The Stage Allocation Measure) to provide validation for her model. These measures were not externally validated, however, as Cass was the sole designator of how the stages were described in these measures. One aspect of her attempt at validation involved asking participants to read profiles of persons fitting a particular stage and then pick the profile that fit the participant best. The profiles themselves,
however, were authored by Cass using responses she imagined would be fitting, a research technique lacking any external validation.

Although Troiden (1989) wrote that his model was based on empirical support, he provided little detail regarding his methods. Troiden explained that he studied how LG persons (defined in the article as "committed homosexuals, men and women who have defined themselves as homosexual and adopted homosexuality as a way of life" [p. 43]) recall the process of identity formation. The reader is left with little information regarding how he chose his participants, how diverse his participants were, how he gathered the information from them, or even how many persons he interviewed and what questions he asked. There is also the problematic nature of relying on recalled information gathered from those who clearly identify as LG (see Diamond 2006). Cass (1984b) noted that Troiden's empirical support lacked rigor in that there were no independent auditors of his interpreted data.

Other criticisms of the seminal models have included their overreliance on individual rather than social identity trajectories (McCarn & Fassinger, 1996), their confounding of these trajectories (McCarn and Fassinger), and their failure to capture contextualizing factors regarding identity development, particularly gender (Diamond, 2006; McCarn and Fassinger, 1996; Sophie, 1986), race (Fukuyama & Ferguson, 2000; Greene, 2007; Parks, Hughes, and Matthews, 2004), and age (D’Augelli, 2006). More specifically on the subject of sexual identity and race, it is argued that these seminal models rely too greatly on a “politicized”, “out” identity as being the only path to identity integration which does not adequately address the social realities of many LGB persons of color (McCarn and Fassinger, 1996; Perez and Amadio, 2004).
McCarn and Fassinger (1996) also pointed out that existing LGB identity models have failed to acknowledge the fluidity of attraction for many, even at the last stages of identity development. In fact, Diamond (2006) found in her study of lesbian-identified young women that exclusive same-sex attraction was the minority, writing,

"Thus, whereas traditional sexual identity models presume that the main 'work' of sexual identity development involves acknowledging and accepting same-sex attractions, these findings show that reconciling, reconsidering, or rediscovering other-sex attractions is a common and important part of a long-term identity maintenance that may have important developmental implications. (p. 79)."

Diamond pointed out that in LGB-identity research, individuals are motivated to report synthesized identities and edit out periods of questioning as inconsistent with their story or as possible evidence of their "denial" about their identity. She reported that 70% of her respondents changed their identity label at least once after initially coming out.

Regarding the only model reviewed here to explicitly address bisexual identity (Weinberg, Williams, and Pryor, 1994), there were numerous flaws in the methodology used to construct the model. The authors described interviewing 49 male and 44 female bisexual-identified persons in order to create their model but did not provide the reader with any details regarding how the interviews were structured or how participants were recruited and chosen. Their sample lacked diversity in that they were all actively taking part in activity at a bisexual support center in San Francisco, they all resided in San Francisco, the participants were primarily of Caucasian race, and the interviews were all completed ten years (in 1983) before the model was constructed and published. This leaves the reader wondering about the current applicability of aspects of this model. For example, it seemed that discovery of the term, "bisexual" played a large role in bisexual identity formation. This term is now much more widely used given the explosion of
media sources that have occurred over the past 20 years. There was also no explanation given regarding how data was analyzed and whether external auditing systems were used to promote rigor of the model.

Of all the models reviewed in this chapter, the most empirically supported and validated was the McCarn and Fassinger (1996) model. The authors were able to address several important methodological flaws they identified in Cass' (1979) model, namely more purposive sampling and greater diversity among participants. This model also explicitly addressed gender differences between men and women regarding identity development as well as attending to both social as well as individual aspects of identity. Efforts to validate the model were reviewed in the Fassinger and Miller (1996) article which addressed applicability of the model to gay males. Information provided in the Fassinger and Miller source indicated greater attention to methodological rigor than other models including use of a Q-sort technique to validate the model, details regarding support of hypotheses, and the existence of possible race-based differences in responses. Although I found no specific critiques of this model in the literature, I did experience some confusion regarding the authors' explanation of necessity regarding separately addressing the identity development of lesbian women while purporting that the model appears to apply equally well to gay males (see Fassinger and Miller).

It is perhaps ironic that one of the model authors reviewed here (Fassinger) who seems most attentive to empirical support and rigor is also responsible for constructing a model (Fassinger and Arseneau, 2007) truly postpositivistic in its approach. By this, I mean that it appears based on the postpositivist philosophy that knowledge can never be truly achieved through the application of scientific rules or methods (Phillips and
The Fassinger and Arseneau model is so significantly departed from the existing paradigm regarding sexual minority identity models and identity models generally that common methods of empirical support (both quantitative and qualitative) seem almost impossible to apply. I believe this will pose an interesting challenge for future sexual minority researchers and for Fassinger herself. Additionally, this model was not developmental in nature and spoke to identity enactment rather than formation.

In addition to the more specific points of critique discussed, there also exists the more general critique of using a paradigm of stage-progression rather than a more “fluid” conceptualization of identity. Multiple scholars of LGB identity warn against inflexible reliance on identity models to provide insight into LGB clients’ treatment needs (Broido, 2000; Coleman, 1981/1982; Fassinger & Arseneau, 2007). The flipside criticism is that without structure and clear delineation in identity models, clients are left without useful tools of self-definition (Ritter and Terndrup, 2002). Ritter and Terndrup also presented the point that misguided therapists may use a fluid approach to argue that identity can be guided towards heterosexuality. The problems associated with a less structured approach to identity conceptualization present as particularly salient regarding critique of the Fassinger and Arseneau (2007) model, a model too new for existing critique in the literature. My main contention with the Fassinger and Arseneau model was its lack of analysis regarding clinical application and an over-broadness in scope that seemed to miss the authors’ stated intent of “focusing practice (e.g., counseling and therapy, education, training, advocacy) more sharply” (p. 20).
LGB-affirmative Therapy

This section begins with a brief historic overview of psychological and psychiatric response to minority sexual orientation in order to contextualize the subject. In his analysis of psychiatric responses to minority sexual identity, Silverstein (1991) explained that social, legal, and medical responses to sexual behaviors are steeped in Judeo-Christian philosophy largely connected to the overall religious influence on U.S. and Western cultures generally. Silverstein made analogies between stigmatization of same-sex sexual behaviors, the witch hunts of the 16th and 17th centuries, and prohibitive immigration policies in the early 20th century as examples of using diagnoses to enforce social behavior.

The pathological categorization of minority sexual identity has and continues to be connected with a series of “treatments” aimed at cure of this “pathology” including biomedical (prenatal, surgical, and hormonal) and psychological approaches. Surgical interventions have included the transplantation of testicular tissue from a heterosexual male into a castrated receptor with unsuccessful results. Hypothalamotomies, castrations, and hormone administration have also been performed to address non-heterosexual behavior, unsuccessfully (Silverstein, 1991). Although these horrific medical “treatments” have long been abandoned in the professional community, psychological approaches such as conversion therapy continue to openly exist despite guidelines in psychiatry and psychology that discount the validity and morality of such approaches. “Conversion” therapy (named for its intent to convert one from non-heterosexual to heterosexual) espouses that minority sexual orientation can and should be changed and is exemplified by organizations such as the National Association for Research and Therapy
of Homosexuality (NARTH). NARTH’s website provides links for accessing “treatment” aimed at change of one’s minority sexual orientation.

Although the pathologization of minority sexual orientation continues to occur, its challenge has gained steady steam propelled by an important event in 1973. In that year, the American Psychiatric Association removed homosexuality as a psychiatric diagnosis/disorder from the Diagnostic and Statistical Manual of Mental Disorders. This decision was spurred by events that occurred in 1972 at the annual meeting of the Association for the Advancement of Behavior Therapy where gay activists demonstrated against behavioral conversion techniques such as aversion “therapy”. It should be noted that this decision did not come without homophobia-laced criticisms and was not officially accepted by the influential organization, the American Psychoanalytic Association until 1991 (Drescher, 2002).

At the time of the diagnostic removal of homosexuality, there existed few places where LGB persons could seek psychological services not aimed at changing their sexual orientation (Silverstein, 1991). The concept of LGB-affirmative psychotherapy began to take root in the early 1980’s, with the therapeutic goal being the recognition of societal oppression as the problem (and subsequent treatment of the consequences), not the identity itself (Silverstein). In their recent chapter on counseling psychology and sexual orientation, Croteau, Bieschke, Fassinger, and Manning (2008) highlighted several other important factors in the origin of LGB-affirmative therapy including the American Psychological Association’s (APA) stated intent of removing stigma connected to minority sexual identity (citing Conger, 1975) and the creation of APA’s Division 44,

In one of the first collected sources regarding affirmative therapy, Gonsiorek (1982) explained that any affirmative approach “...must be relevant to the life experience of gay men and lesbians in a society that to varying degrees is unsympathetic, uninterested, or hostile.” (p. 6). He added that models must be clinically useful and applicable across a range of functioning. In this same source, Malyon (1982) stated, “The goals of gay-affirmative psychotherapy are similar to those of most traditional approaches to psychological treatment and include both conflict resolution and self-actualization.” (p. 62) Malyon specified that the goal of affirmative therapy is not to change sexual orientation, but rather that a minority sexual identity is to be “valued and facilitated” (p. 62). This is done through provision of a corrective therapeutic relationship that will hopefully offset the negative effects of a heterosexist society. Malyon explained that affirmative therapy is “not a prescription for how to do psychotherapy” but rather “a frame of reference for the accomplished clinician.” (p. 62).

Kitzinger and Coyle (2002) provided an excellent summarization of what affirmative therapy is with their statement,

Lesbian and gay psychology is psychology which is explicit about its relevance to lesbians and gay men, which does not assume homosexual pathology and which aims to counter prejudice and discrimination against people who are not conventionally heterosexual and to create a better world for lesbians and gay men. (p. 2)

Although the authors referred to lesbian and gay psychology, not therapy per se, the implication in this case is that these two concepts are synonymous. It should be noted, however, that LGB-affirmative psychology may refer to a much broader scope of practice
including organized social justice action of practitioners, research, and public policy. The basic tenets of an affirmative approach hold that therapists:

- Take a non-pathologic stance towards minority sexual identity (Malyon, 1982).
- Identify heterosexism as the main source of psychological distress and dysfunction, not minority sexual identity (Davies, 1996).
- Understand that a neutral stance towards minority sexual identity is insufficient to address the treatment needs of this population (Davies, 1996; Fassinger, 1991).
- Examine their own biases, beliefs, and attitudes regarding minority sexual identity (Clark, 1987).
- Acquire a base of knowledge regarding LGB persons as a group (Clark, 1987).
- Actively work towards reducing heterosexism in the world in order to improve the lives of LGB people (Kitzinger & Coyle, 2002).

In addition to these “basics”, numerous authors have expanded on the definition of affirmative therapy and have called for therapists to be knowledgeable on key topics regarding minority sexual identity including: issues related to lesbian-identified women (Browning, Reynolds, & Dworkin, 1991), issues related to bisexually-identified men and women (Firestein, 2007; Fox, 2006;), issues related to LGB college students (Eldridge & Barnett, 1991), issues related to identity intersections such as sexual orientation and race (Fassinger, 1991), knowledge of the ways that the AIDS epidemic has impacted the LGB community (Fassinger, 1991), knowledge of clinical issues such as eating disorders and substance abuse (Fassinger, 1991), knowledge of the importance of confidentiality and appropriate maintenance of boundaries with clients (Fassinger, 1991; Perez & Amadio, 2004), development across the lifespan for LGB clients (Perez & Amadio, 2004), family
therapy with sexual minority adolescents (Coenen, 1998), and vocational issues for LGB people (Browning et al., 1991; Croteau & Thiel, 1993). Of these sources, many were published in a 1991 special issue of The Counseling Psychologist focusing on LGB-affirmative therapy, while others came from counseling psychologists devoted to advancing work on minority sexual orientation.

There is still a general shortage of empirical research concerning provision of therapy to sexual minority persons (Bieschke, K. J., Perez, R. M., & DeBord, K. A., 2007). In their chapter devoted to review of empirical study of the experiences of sexual minority persons in therapy, Bieschke, Paul, and Blasko (2007) provided an excellent overview of research related to sexual minority clients’ perceptions of therapists, factors that influence the efficacy of therapy with sexual minorities, therapists’ attitudes towards sexual minorities, and issues related to conversion therapy. The authors found only eight studies pertaining to the experience of therapy for sexual minority persons and all (except one) evaluated these experiences generally (i.e. not specific to affirmative therapy; see Dorland and Fischer, 2001; Jones and Gabriel, 1999; Liddle, 1999 among others). These studies have clear value in helping to differentiate affirmative from non-affirmative therapy but some clearly missed the call to deepen the understanding of affirmative practice beyond the basics (Croteau et al., 2008). For example, the Dorland and Fischer (2001) study presented heterosexist and non-heterosexist analogue vignettes of a counseling intake interview to 126 LGB-identified participants. Not surprisingly, the vignette containing heterosexist language resulted in lower evaluations of the therapist’s efficacy and less likelihood of engaging in treatment with that therapist.
Of studies examining affirmative therapy specifically (of which I found three); all were qualitative in nature. Through analysis of interviews with affirmative therapists and clients who have received affirmative therapy, Milton, Coyle, and Legg (2002) found that affirmative therapy must be supported by affirmative training. The authors also found support for the idea that affirmative therapy is an approach qualified by the therapist’s beliefs and skills rather than a theoretical orientation. Lebolt (1999) analyzed interviews with nine males who had received affirmative therapy and identified numerous therapist traits as helpful including general qualities of being empathic and specific qualities of knowledge of the gay community. The most methodologically sound and comprehensive article was a grounded-theory study done by Pixton (2003) which identified six main qualities of affirmative therapy including having a non-pathological view of LGB identity, provision of a sense of safety and freedom in the counseling space, and specific LGB-related skills that the counselor brings into the therapeutic relationship.

Bieschke, Paul, and Blasko (2007) highlighted several important research implications concerning examination of psychotherapy with sexual minority persons. One important implication is the deeper understanding of what constitutes affirmative therapy both from the client and therapist perspective. They stated,

Our belief is that as the mental health professions have become increasingly affirmative via the provision of guidelines and resolutions, trainees and professionals may profess to be affirmative without delving very deeply into what that means for them and how such attitudes may manifest in therapy. (p. 310).

Another research implication is expansion of study “…beyond White, relatively affluent, well-educated lesbian and gay clients.” (p. 310). This expansion would include exclusive study of clients who identify as bisexual. The authors also pointed to the need for empiric
study of provision of ethical (i.e. methods other than conversion) treatment to persons conflicted about sexual orientation.

**Critique of the affirmative-therapy literature**

A basic critique of existing literature related to provision of therapy to sexual minority persons is that it remains relatively general and does not provide the necessary, deeper understanding regarding affirmative therapy. As touched on previously, analogue studies such as Dorland and Fischer’s (2001) do not provide much help to clinicians already committed to the support of affirmative therapy. I believe that one remedy in this area is increased empirical study of the process of affirmative therapy specifically. Early calls for such examination (Bieschke, Paul, and Blasko, 2007; Gonsiorek, 1982; Harrison, 2000; Ritter & Terndrup, 2002) have been made and do not appear to have been answered. This lack of research is particularly troubling in light of evidence showing that lgb persons consistently use counseling services more frequently than the non-lgb population (Bieschke, Paul, and Blasko, 2007 citing Bieschke, McClanahan, Tozer, Grzegorek, and Park, 2000; Cochran, Sullivan, and Mays, 2003; Jones and Gabriel, 1999). This lack of literature is likely connected with the still underdeveloped areas of research and scholarship on lgb issues as well as lack of counselor training in this area (Bieschke, Perez, & DeBord, 2007; Perez & Amadio, 2004). Of the empirical studies that do exist, qualitative approaches have certainly made inroads regarding advancement of affirmative therapy. Despite flaws in methodology (for example, Lebolt [1999] inadequately described participants), studies such as Pixton’s (2003) do provide answers to questions regarding what sexual minority clients find helpful in terms of affirmative therapy.
Practical Applications of LGB Identity Models in Psychotherapy

This final section of this literature review represents the most relevant scholarship regarding the topic of this study. Literature addressing the practical application of developmental models of LGB identity is scarce and this area was the least evolved of the areas of literature reviewed. This research lacuna is in sore need of remedy, particularly considering evidence that training for psychology graduate students around provision of treatment to sexual minorities is lacking (Phillips and Fischer, 1998) and more clearly articulated links between identity development models and provision of affirmative therapy could help address this training deficit. For example, in their work on integration of sexual minority concerns into student training, Buhrke and Douce (1991) emphasized that trainees must be able to correctly identify symptoms in the context of sexual minority identity development in order to distinguish pathological features from developmental tasks that might be misdiagnosed as such. Knowledge of minority sexual identity development provided through study of developmental models could likely help in this regard.

Additionally, understanding of LGB identity is emphasized in the guidelines set forth by the APA (2000) regarding provision of ethical psychotherapy services to LGB persons and in the competencies set by the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC, 2010). It is explained in the introduction to APA’s guidelines that affirmative therapists should have at least a basic understanding of LGB identity and access to more detailed information. Therapists should also have some awareness of their own attitudinal biases regarding LGB identity as well as awareness of ways that intersections of identities (such as sexual orientation and race)
affect LGB clients. In fact, understanding LGB identity would appear to play a role in all four of the areas highlighted by the APA guidelines: attitudes towards LGB issues/persons; LGB relationships and families; diversity issues; and education around LGB issues.

ALGBTIC (2010) identified several markers of affirmative counseling competency that speak directly to knowledge of aspects of sexual minority identity development. For example, they write that competent counselors “will recognize that identity formation and stigma management are ongoing developmental tasks spanning the lives of LGBT persons” (para. 2). It is clear from sources such as this and others that having an understanding of sexual minority development is an important aspect of affirmative therapy. While therapists can certainly form a variety of strategies using information gleaned from developmental models of LGB identity, few sources in the literature go beyond cursory suggestions regarding these strategies and there has been no empirical study therapists’ practical application of the models.

Of existing sources that integrate LGB-identity models into therapeutic work with clients; the most complete was the chapter, *Psychotherapeutic Applications for Identity Formation* (Ritter and Terndrup, 2002). In this chapter, four models (Cass, 1979; Troiden, 1979; Grace, 1979; and Coleman, 1981/1982) were used as a basis for constructing therapeutic interventions such as provision of material to help the client modify negative beliefs about LGB identity. What set this source apart from others was its level of attention to each stage of SO identity development (not focusing only on early and/or latter stages) and clear articulation of both behaviors and interventions associated
with the stages. Some of the details regarding their stage/phase-specific therapeutic interventions are highlighted below:

**Ritter and Terndrup's phase-specific interventions**

*First phase*

The authors explained that in the first phase of LGB identity development (referred to as “sensitization” by Troiden and “pre-coming out” by Coleman), clients are early in their exploration of the possibility of sexual minority identification. In this early phase, depression and substance abuse are common issues and should be assessed by the therapist in addition to suicide risk.

*Second phase*

The authors explained that movement to the second phase of identity development (referred to as “identity confusion” and “identity comparison” by Cass and “coming out” by Coleman) is often spurred by clients’ encounters with information regarding LGB identity that is personally significant to them. Key tasks for the therapist during this phase are provision of empathy as the client engages with challenging material, slowing the pace of the therapy process so that the client can fully explore identity, provision of material to help the client modify negative beliefs about LGB identity, and allowance for a grieving process around the loss of a dominant identity.

*Third phase*

The third phase (referred to as “identity tolerance” by Cass and “identity assumption” by Troiden) is characterized by a deepening sense of LGB identity and subsequent disclosure of this identity to others. Therapeutic tasks for this phase include
provision of information on identity formation and the LGB community, normalizing developmental issues, and continuing to support the coming out process.

**Fourth phase**

The transition from phase three to four (referred to as “identity acceptance” by Cass and “commitment” by Troiden) is correlated to perception of quality of interaction with the LGB community, influencing embrace or mere toleration of LGB identity. Therapeutic tasks at this phase include support of their clients’ participation in the LGB community as a vital component to clients’ lives as LGB persons. It is noted that another main developmental task in this phase is establishment of intimate relationships and that therapists may assist clients through couples counseling if warranted. Additionally, therapists may help clients in this phase to reevaluate vocational goals if necessary.

**Fifth phase**

The final phase of identity development (referred to as “identity pride” and “synthesis” by Cass and “integration” by Coleman) is characterized by deeper immersion in the LGB community, anger at heterosexist oppression, and possible desire to separate from heterosexuals followed by the relinquishment of this anger and desire for separation. Therapeutic tasks during this phase include validation of the client’s pride and anger while challenging thinking that qualifies heterosexuals as “all bad”, helping clients explore ways that they are alike and different from other LGB persons, and helping the client to monitor negative self-images rooted in heterosexism.

A few other sources in the literature provided more than cursory information regarding practical application of identity models. An example is the Perez and Amadio (2004) chapter highlighting knowledge of LGB identity models as one of five key areas
of affirmative therapy. Perez and Amadio explained that stage-theory models can help with conceptualization of LGB issues as well as assisting clients with integrating their sexual identity into their overall sense of self. They explained that these models can also help with understanding and managing multiple identities, particularly multiple oppressed identities. The authors pointed out that an understanding of LGB identity development is particularly salient when working with clients on issues of coming out. They named Cass’ (1979) model as one that can be very useful in guiding therapists to meet their clients’ developmental needs.

In some cases, the models’ constructors made either passing or overt references to stage/phase-specific clinical issues. Cass (1979) explained that LG persons in the first stage of identity development rarely discuss their identity conflict with others “except where help is required to maintain or to initiate strategies for coping with the incongruency…” (p. 225). This information might help a therapist to recognize the potential vulnerability a client might experience when sharing their identity struggles. In a later work (1984b), Cass outlined measures she constructed to assess the validity of her model. One might surmise that aspects of these measures have clinical utility (specifically the cognitive, affective, and behavioral descriptions pertaining to each stage), but there were no suggestions offered in the article. Coleman (1981/1982) made passing references to clinical issues in his model, pointing out that “…behavioral problems, psychosomatic illnesses, [and] suicide attempts…” were possible manifestations of conflict experienced in the pre-coming out stage of LG identity development. He then explained that “…breaking through defense barriers and acknowledging same-sex feelings” (p. 33) were keys to resolving this identity confusion.
These tasks could arguably be promoted by a therapist, but again; no clear suggestions regarding therapeutic intervention were offered. The McCarn and Fassinger (1996) model was the only one to specifically attend to therapeutic interventions, specifically through the illustration of three case studies. Using the case of “Carol” (p. 526) as an example, the authors explained that as a 22-year-old African American woman just coming into awareness of her attraction to another woman, Carol faces multiple challenges related to the intersections of individual and group identities. Carol was assessed at being in the second stage of individual identity (recognition of her feelings for another woman) and the first stage of group identity (no real awareness of other lesbian women as a group). It was also noted that Carol had existing group affiliations (most primarily that of a Christian) that would likely conflict with her feelings for her friend. Key therapeutic tasks outlined for Carol included empathic response to her feelings of confusion and fear as well as provision of information, resources, and referrals. The authors also noted that therapists should be proactive in the community in order to change attitudes around minority sexual identity.

Practical application of LGB identity models in therapy was highlighted in some specific areas such as career counseling. Croteau and Thiel (1993) addressed the lack of attention to LGB identity in the career literature by utilizing LGB identity models in their outline of career-appropriate interventions. For example, they explained that when a client is in later stages of LGB identity development; a career counselor may focus on provision of examples of integration of sexual orientation with work as well as provide examples of coping with anti-gay stigma at the workplace. This type of intervention would be less appropriate when a client is in the early stages of LGB identity.
development. At that point, so much of the client's energy would be devoted to making sense of their identity that attention to integration of sexual identity and career would be very difficult.

**Critique of the literature on practical applications of LGB identity models in psychotherapy**

Obviously, one the largest problems connected with this section of the literature review is its scarcity. There are several critiques to note regarding the Ritter and Terndrup (2002) scholarship on affirmative therapy and the applied use of LGB identity models. One is their reliance on models that place heavy emphasis on “coming out” as an essential task for healthy development. This is an aspect of multiple developmental models of LGB identity that has been shown to be incongruent with the lives and realities of many sexual minorities, particularly those of color (Fukuyama and Ferguson, 2000; Greene, 2007; Parks, Hughes, & Matthews, 2004). For example, Ritter and Terndrup included encouraging and challenging clients to disclose their LGB identities as a second-phase therapy intervention without discussing ways that this might be problematic not only for LGB persons of color, but for many White LGB persons as well.

Regarding other sources that stress the importance of developmental models of LGB identity (see Coenen, 1998; Eldridge & Barnett, 1991; Matthews, 2007; Pope and Barret, 2002) the main critique is lack of clear articulation regarding the specific role that LGB identity development models can play or ways therapists might use these models. For example, Dworkin (2000) stated, “The therapist must assess what part of the therapy process sexual identity will play in order to treat the LGB client adequately.” (p. 159) and went on to briefly review three identity development models, but made no connection between the models and specific interventions. Eldridge and Barnett (1991) made the
recommendation; “Become familiar with models of lesbian and gay identity formation” (p. 169) as a specific aspect of therapy, but included just two sentences for the section and no information as to how the models should be used. Some sources supported the call for “…the creative enhancement of the identities of LGB people…” (Morrow, 2000, p. 137) but did not even mention LGB models of identity development (see Davies, 1996; Morrow, 2000; and Shannon & Woods, 1991).

Neither the reviewed models’ constructors (with the exceptions of McCarn and Fassinger, 1996) nor scholars (with the exception of Ritter and Terndrup, 2002) appeared to have devoted much time towards suggestions for therapeutic application of the models. This seemed a broad oversight considering that the most cited models were all likely created with an intention of clinical utility, a hypothesis partially based on the backgrounds of the models’ creators. For example, in the biographical information provided for the reviewed models’ creators, only Weinberg, Williams, and Pryor (creators of the bisexual identity model reviewed in this chapter) did not list credentials/background as practicing therapists and all of the models touched on psychological issues associated with various stages of sexual identity development. Addressing this potential oversight provided part of the inspiration for the research questions in this study.
CHAPTER III

METHODOLOGY

_If psychology is considered a natural science, then phenomenology precedes it because it is basic to all existence. We operate in an internal world from which we cannot escape._ Kendler, 2005, p. 320

This study was aimed at articulation of the lived experiences of LGB-affirmative therapists regarding the phenomenon of using developmental models of LGB identity in therapeutic work with clients. Additionally, I was interested in discovering more about how LGB-affirmative therapists attend to sexual orientation (SO) identity more generally. This chapter is focused on the phenomenological methodology used in this study.

As previously discussed in Chapter Two, there is virtually no empirical research examining affirmative therapists’ practical use of LGB identity models. The lack of study on this topic is hardly surprising given the dearth of empirical examination of affirmative therapy generally. With this study, needed information has been contributed to the literature in the areas of therapeutic use of developmental models of LGB identity and other ways that SO identity is addressed in therapy. This chapter includes an overview of qualitative research, rationale for phenomenological methodology, and a detailed description of this study’s phenomenological procedures.
Qualitative Research and Rationale for a Phenomenological Approach

Colaizzi (1978) differentiated qualitative from quantitative approaches to psychology by highlighting the ability of qualitative research to more fully capture the understanding of a phenomenon, not just abstracted pieces of understanding. As Colaizzi put it, “The traditional [quantitative] psychologist knows precisely and reliably how something which he doesn’t know what it is influences something else which he doesn’t know what it is.” (p. 56) Although I do not feel the need to justify use of a qualitative methodology as a viable and rigorous standard of research; I do wish to outline a few key points regarding my choice of a qualitative approach. Firstly, a qualitative approach seemed appropriate for a study focusing on LGB issues. Early LGB research, based in quantitative and positivistic approaches, has been marred by a past linked to pathologizing and objectification of its participants. Areas of scholarship such as women’s and race/ethnicity studies were influential to the advancement of LGB research in that they incorporated issues of social justice and gave voice to the justifiable skepticism of participants regarding research (Gamson, 2000). Gamson identified qualitative methods as optimal for LGB research based on their foundation of giving voice to those who have been oppressed and silenced stating, “Qualitative methods, with their focus on meaning creation and the experiences of everyday life, fit especially well with movement goals of visibility, cultural challenge, and self-determination.” (p. 348).

Secondly, use of a qualitative method seemed appropriate based on this study’s generation from the discipline of counseling psychology, the subfield of psychology known for (among other things) its emphasis on social justice and the importance of identity development to the lives of clients. There are now numerous scholars who have
advocated for the use of qualitative methods in counseling psychology (see Hoyt and Bhati, 2007; Polkinghorne, 2005) and psychotherapy research (see McLeod, 2001). In his work specific to use of qualitative methods in the field of counseling, McLeod pointed out that the process of doing qualitative research on the topic of psychotherapy mirrors the process that it studies. Specifically, the researcher's act of clarifying and constructing meaning is similar to the therapist's goal of helping the client to make meaning and gain understanding of their world. McLeod advocated for the use of qualitative methods in psychotherapy research for multiple reasons including: its ability to bring attention to the cultural and social needs of both clients and practitioners; its ability to give voice to those who have been silenced by oppression; its intrinsic demand that researchers acknowledge the social context of their participants; and its ability to promote a foundation of innovation regarding psychotherapy rather than one of mere verification.

My identity and background as a psychotherapist also fit well with my choice of a qualitative approach. Skilled psychotherapists possess multiple qualities that prepare them for engagement in qualitative research. Psychotherapists are trained to actively listen to clients, provide clients with a sense of safety, direct clients to certain topics when warranted, and to use their own self-exploration as a means of promoting a reflexive and reciprocal interaction with the client. McLeod (2001) discussed the personal qualities of the researcher and how they play a role in the purpose and rigor of qualitative study. Noted as particularly salient, McLeod highlighted the quality of "reflexivity" (p. 196) and its connection to the researcher's awareness of the moral dimension of research, their consideration of the processes through which text is co-constructed and their attention to the necessity for new approaches to writing and communication of research
findings. Additionally, Polkinghorne (2005) has discussed counseling psychologists' prime positionality to be effective interviewers.

My specific choice of the qualitative approach of phenomenology was based on its focus on the lived experiences of its participants (Colaizzi, 1978). Because the focus of this study was the lived experiences of LGB-affirmative therapists regarding the phenomena of using developmental models of LGB-identity in therapy and addressing SO identity generally, phenomenological methodology seemed most fitting. Additionally, McLeod (2001) and Hoyt and Bhati (2007) outlined several key points supporting the fit of phenomenology with this study. McLeod provided an excellent rationale for the use of a phenomenological approach to the study of counseling and psychotherapy with his explanation that both phenomenology and psychotherapy require a certain amount of bracketing of assumptions, deep description of an issue, and the construction of a new perspective. Hoyt and Bhati highlighted phenomenological methods as particularly well suited to counseling psychology research for their ability to glean rich data from small samples which is vital to the study of rarely researched populations. Few studies have included LGB-affirmative therapists as participants; thus phenomenology appeared to present as an excellent method for this study for multiple reasons.

The beginnings of phenomenology as a system of inquiry date back to the early twentieth century birth of psychology as a science and both fields actively pursued the study of human consciousness (Giorgi and Giorgi, 2003). Phenomenological studies have a long and established history of illuminating the experiences of participants (Creswell, 1998) in addition to having a solid grounding in systematic methodology. This method is used to answer questions about the “essence” of the examined phenomenon and capture
commonalities across participants regarding their experiences with the phenomenon (Creswell, Hanson, Plano Clark, and Morales, 2007). The focus of phenomenology is on the description of the experience, not on analysis or explanation of the experience. Giorgi and Giorgi (2003) explained this clearly with their statement:

In general, phenomenological psychological research aims to clarify situations lived through by persons in everyday life. Rather than attempting to reduce a phenomenon to a convenient number of identifiable variables and control the context in which the phenomenon will be studied, phenomenology aims to remain as faithful as possible to the phenomenon and to the context in which it appears in the world. (p. 26)

To conclude this section on use of a qualitative (specifically phenomenological) approach for this study, some philosophical foundations regarding this research are reviewed. Haverkamp and Young (2007) and Ponterotto (2005) have advocated for researchers to work from a philosophical base, helping them determine the best research method for their questions as well as said method’s standards of validity. I acknowledge a personal attraction to the philosophic foundations of qualitative study. These foundations are those connected with the possibility of multiple and socially constructed meanings associated with post-positivism. The results of phenomenological research are not intended to be presented as an uncontested “reality”; as they are always filtered through the experience of the researcher (Giorgi and Giorgi, 2003). This lack of “certainty” is not troubling to me, as it is the variety of filters (researchers and participants) which I find most interesting as opposed to a singular result that may be generalized. Although I appreciate the knowledge that numbers can bring us, I am much more interested in the words of participants, especially when it comes to questions related to psychotherapy. This is perhaps because at heart I see myself as a writer and practicing clinician more than a scientist and words hold more power than numbers likely ever will for me. That
being said, I am also a scholar with a strong appreciation for structure and organization. This aspect of my identity is one that appreciates sharp attention to detail and "backing up" (i.e. "rigor") one's assertions as much as possible. This combination of using participants' words and experiences to glean meaning along with rigorous attention to details is in keeping with the phenomenological approach.

**Steps in Phenomenological Research**

A variety of sources were used to identify key methodological steps in conducting this phenomenological study. As was hopefully evident from my prior explanation of phenomenological research, there is no definitive right way of conducting this type research. There are, however, numerous points reiterated by scholars regarding promotion of quality in conducting phenomenological research and these have been drawn on to draft the steps used for this study. The steps are listed below and followed by systematic explanation of how each step was conducted.

1. Conduction of a thorough literature review for use in construction of research questions as well as later triangulation regarding data (Haverkamp and Young, 2007).

2. Articulation of a thorough self-exploration for use in examining connections to and potential biases regarding the research topic (Colaizzi, 1978; Creswell, 1998). Reactions and thoughts regarding the data were tracked throughout the data collection/analysis process (Giorgi and Giorgi, 2003).
3. Identification of the studied phenomenon and construction of relevant research questions (Colaizzi, 1978; Wertz, 2005).

4. Identification and recruitment of participants who are able to shed light on the phenomenon in question (Polkinghorne, 1989).

5. Collection of data via participant interviews (Giorgi and Giorgi, 2003).

6. Transcription and analysis of the data (Colaizzi, 1978; Creswell, 1998). Analysis steps included the following:
   a. Evaluation of interview protocol after completion of first two interviews.
   b. Remaining interviews were completed. All interviews were transcribed and uploaded into qualitative analysis software, MAXQDA 2007.
   c. Each transcript was read thoroughly and statements relevant to the studied phenomena were electronically highlighted.
   d. Statements were organized into a system of themes/codes/subcodes that were continually revised to best reflect the data.
   e. An auditor was provided with two randomly chosen transcripts, corresponding reaction notes, and the “master” list of themes/codes/subcodes. The auditor next provided feedback and each transcript was reviewed noting this feedback. The auditor was given a third transcript, reaction notes, and an updated master list; feedback was again provided until it was deemed that the best fitting set of themes/codes/subcodes had been arrived at.
f. Narrative synopses were created for each interview including an overview of themes/codes/subcodes gleaned from that particular interview as well as across participants. The whole system of themes/codes/subcodes was examined to create an initial core essence of the study. Synopses, including the essence, were sent to participants to invite correction and prepare them for their second interview.

7. Evaluation of the data’s truthfulness through multiple avenues culminating in a presentation of the findings (Creswell, 1998; Merrick, 1999, citing Lincoln and Guba, 1985). This process encompasses those aspects of research designed to support its findings and includes terminology such as *rigor*, *truthfulness*, and *veracity*.

8. Additional analysis was completed after reviewing feedback from the member-checking process and incorporating additional feedback from the research chair. Findings were revised based on this additional analysis.

**Step 1: The literature review**

Although some qualitative scholars discourage the researcher’s examination of literature regarding their topic as potentially biasing, Haverkamp and Young (2007) pointed out that literature-provided verification is particularly useful in qualitative approaches such as grounded theory and phenomenology. The literature review was used as a means of immersion in the subject matter and constructing appropriate research questions. In early phases of this dissertation including construction of a study outline and initial interview protocols, my literature review helped to ground the study’s conceptualization in scholarship related to LGB identity and affirmative therapy. I used
the literature to help construct a meaningful set of criteria to identify appropriate
participants (those who had experience with the phenomena in question). For example,
one of the basic tenets of affirmative therapy as highlighted in my literature review is the
acquisition of knowledge regarding LGB persons as a group (Clark, 1987) and this
knowledge acquisition became a criterion I used to define therapists as affirmative. My
literature review was also used to guide the construction of open-ended questions
regarding my research topic (Israel, 2004; Ritter & Terndrup, 2002). Later, in the analysis
phase of this study, the literature review was used as a means of grounding me to my data
through contextualization (understanding the circumstances and background for the data)
and triangulation (perspectives other than the researcher’s and the participant’s)
(Haverkamp & Young). The literature review was also essential to the discussion chapter
of this study where the results are reviewed in the context of existing scholarship.

**Step 2: Researcher self-exploration**

The step of researcher self-exploration has been highlighted by numerous scholars
(Colaizzi, 1978; Creswell, 1998) as a means of establishing qualitative rigor and is very
much in line with guidelines set forth by phenomenology’s creator, Edmund Husserl.
Husserl advocated for the phenomenological researcher to “bracket” their reactions in
order to preserve integrity with their subject matter (Giorgi and Giorgi, 2003). The
phenomenological researcher examines all aspects of what draws them to their subject or
reasons they are engaging in this particular research at this particular time (Colaizzi,
1978). Colaizzi further explained that the “hard science” concept of researcher objectivity
is debunked with phenomenology; that understanding a concept is sufficient:
[the researcher] will discover that understanding the investigated phenomenon qualifies exquisitely as a criterion for research knowledge, specifically, an understanding that does not set out explicitly and exclusively to master, control, or dominate it—though never disqualifying his [sic] results should they turn out to have technical relevance. (p. 56)

In the spirit of examining my own motivations and potential biases regarding my research, I explain some essential points of my background, current life, and my positionality to the studied phenomena. I am a 40-year-old White female doctoral student in counseling psychology. I am a mother to two young boys. I am the partner to my 35-year-old White male husband who has emigrated to the U.S from Scotland. I am a therapist who works primarily with clients struggling with issues of self-harm and suicidal behavior. I identify as a feminist and admit to struggling with issues of identity around being married (specifically being a wife, a word I have some disdain for likely connected to societal stereotypes about what “wife” and “femininity” entail). When I use the term, “identity”, I realize that my struggles have very little to do with the notion of who I am, but rather more to do with societal expectations around what my roles are as I hold these identities (wife, mother, White woman, feminist, heterosexual, etc.).

Throughout my life I have been fairly immersed in LGB culture through relationships with those close to me and geographic contexts of living in major cities with flourishing gay communities (Baltimore, New York City, Paris, San Francisco, Los Angeles, and Chicago). I almost always found myself accepted in these communities even when it was clear I was romantically partnered with a male. I have never felt quite right with identifying as heterosexual because this has never felt like the “right” descriptor of the various aspects of my sexuality. I still feel this way, but I have come to recognize that “heterosexual” fits best regarding overt sexual behavior and to claim another identity would make me question my own motives in doing so. By this, I mean
that I would never want to use a minority SO identity to gain “street credential” with the community and people I love and there are still too many open questions in my mind to take on an identity other than heterosexual. I’ve made an agreement with myself that if and when another descriptor feels right to me and I can look myself and anyone else in the eye and not flinch from it, then I will consider no longer identifying as heterosexual.

Early into my doctoral program (beginning in fall 2003), I found myself in what I perceived as the strange position of no longer living near a robust LGB community, no longer in daily and close relationship with numerous LGB persons, and more immersed in LGB scholarship than ever. Before relocating from Chicago to a much smaller Midwestern town to begin doctoral study, I had been involved in LGB social justice work for years. I believe the main impetus for that work was a strong feeling that anti-LGB prejudice is fundamentally wrong and should be fought. Although I still feel that way, I believe I have grown to recognize the larger and more subtle fabric of heterosexism that infuses my culture and my life. I did not know what “heterosexist” meant before entering this doctoral program and I certainly would have claimed no part in perpetuating it. This began to change for me as I recognize the heterosexist privilege I held in living in relative safety and anonymity with my family. Had the legal benefits of marriage not been available to us, I’m not sure how we would have negotiated living in the same country and the chance for us to co-parent our children would probably have been lost.

I’ve been asked the question, “Why are you doing gay research when you’re not gay?” outright and I admit to admiring the questioner’s boldness in asking. I think I have part of the answer while other parts have not made themselves clear to me yet. I believe that LGBT issues are about me and my family. I believe that a better world for LGBT
people is a better world for me and my family and I want to do whatever I can to build that world. This issue is not only about fighting for other people but recognizing what is also threatened for me personally when LGBT persons are oppressed (my rights and safety as a woman, the way I express my gender identity, the way[s] my identity[ies] are perceived and acted on by others, the way[s] my sons will be able to express their identity[ies], and so on). I consider myself a competent therapist and scholar and so it felt most appropriate to bring these two important aspects of my professional identity to attend to questions that will hopefully shed light on LGB-affirmative therapy. In doing so, I hope to make the world a better place for LGBT persons and for all of us.

I should also note here that although I consider myself an LGBT-affirmative therapist; I do not work primarily with the LGBT population and have amassed fewer hours addressing concerns related to clients’ SO identities than the nine therapists interviewed for this study. Before I explain more about this, I will provide some information regarding my professional background. My history as a mental health practitioner began in 2000 when I started work for a community agency in Chicago. My job entailed provision of a variety of clinical services including individual and group counseling, case management, and crisis intervention. At this time, I was also engaged in graduate work towards the completion of a master’s degree in counseling as well as volunteer work for two agencies: one providing health-related services primarily for sexual minority women and one providing services for homeless women and other women in need. In 2001 I began private study of Dialectical Behavior Therapy (DBT) and incorporating aspects of this therapy such as skills training into my work with clients. DBT was formulated to address the severe problematic behaviors associated with
Borderline Personality Disorder (BPD; Linehan, 1993). The most problematic and frequently occurring of these behaviors are those associated with suicide and self-harm. In 2003, I completed an intensive training course in DBT while finishing my master’s internship in Chicago. After that point, I continued my private study of DBT and continued to incorporate aspects of the treatment into my approach with clients. From 2005 to the present, I have worked as a therapist on a DBT treatment team (as well as other clinical sites) in Kalamazoo, Michigan. In August 2009 I began my yearlong clinical internship at Western Michigan University’s Counseling and Testing Center.

Although I have amassed more than 3000 direct client hours since finishing my master’s degree and have seen approximately 15-20 sexual minority clients for therapy, SO identity was rarely the main therapeutic issue for any of these clients while I worked with them. As I recollect my overall work with the majority of these clients, many of them were quite comfortable with their SO identities and were coming to therapy to address issues such as depression and dysfunctional behaviors. A main aspect of my work as a DBT therapist involves building a trusting and validating relationship with the client and engaging them in exploration of the function(s) of their behaviors. In order to provide a sense of focus and structure to the treatment and to promote the client staying alive and thus remaining in treatment, suicidal and self-harming behaviors are prioritized in every therapy session. If it were discovered in the course of DBT with a particular client that their SO identity was connected to suicidal or self-harming behavior, then it would be prioritized as integral to reducing these behaviors. For example, if a client identified that thoughts such as “I am an unworthy person because I am gay” preceded a suicide attempt, then these thoughts would be part of immediately addressing the suicidal
behavior. Of course, *how* the thoughts are challenged depends on the therapist; an affirmatively-trained therapist would be better equipped to challenge these thoughts for multiple reasons. Once the client progresses in therapy and suicidal/self-harming behaviors are significantly reduced or eliminated, then the client moves on to issues more related to the quality of their life. These issues would certainly include the quality of primary relationships and one's sexual health and identity but the DBT therapist would basically follow the client's lead at this point regarding what to focus on.

Although I have had less clinical experience working with the LGBT population than many affirmative therapists, I do wish to acknowledge my training in this area and my immersion in LGBT scholarship. I consider myself lucky to have had the experience of taking part in a three-credit graduate level class focusing on all aspects of counseling sexual minority clients taught by my research advisor who was recently named the most productive LGBT scholar in counseling psychology (Smith, 2010). This class was taught over the course of 16 week semester, an experience generally unavailable to those seeking training in affirmative therapy. The format of this class allowed for immersion in LGB scholarship while also providing time for students to engage in their own self-exploration around sexual orientation. This format seemed more conducive to engaging in the kinds of self-challenges needed to develop competency in affirmative therapy, particularly for heterosexual therapists (rather than a shorter workshop format). In addition to this class, I have been engaged in LGBT scholarship since beginning the doctoral program in 2003. Most of this work has been supervised by my research advisor who has been able to offer keen mentorship and challenge regarding my development as an LGBT scholar. This background equipped me to be able to evaluate therapists on
meeting criteria as LGB-affirmative and to actively engage them in discussion of the process of affirmative therapy.

I have recognized that my background and training around LGBT issues as well as my identity as an affirmative therapist have influenced both my therapy approach with all clients and my interactions with colleagues. For example, it is now a part of my general style to refrain from assuming the gender of persons my clients discuss as romantic interests or partners. I realize that I often do this in a way that introduces some of my beliefs and values regarding sexual orientation. For example, I might state in the beginning of my work with a client that I do not like to assume I know the gender of anyone they may be talking about. I usually do not explain that this is done in an attempt to reduce heterosexist bias, but my hope is that this is communicated. I have yet to encounter a single client expressing offense by my lack of assumption, but if this occurred, I would address this with them openly.

Through this self-examination, I have realized that I address SO identity probably more with colleagues than with clients. This comes up in numerous ways, but mainly with colleagues working with clients who are experiencing a high amount of shame related to their sexual orientation or colleagues who seem less knowledgeable regarding sexual orientation issues. I have brought up aspects of LGBT identity development with these colleagues and have made specific therapeutic suggestions connected to identity. I have never discussed specific models with colleagues but have used a variety of models (mainly Cass, 1979 and McCarn & Fassinger, 1996) to inform my own work and subsequently presented this work to them. For example, I have shared several papers I’ve written on transgender identity which include information on LGBT identity models.
In my work with individual sexual minority clients, I estimate that the majority of those I’ve worked with have presented with identity issues corresponding to Cass’ (1979) stages of “identity tolerance”, “identity acceptance”, “identity pride”, and “identity synthesis” and McCarn and Fassinger’s (1996) “deepening/commitment” and “internalization/synthesis” individual phases. Key identity elements that I have encountered corresponding to these stages/phases are clients presenting as “okay” with their sexual minority identity (rather than celebratory or proud of it), clients becoming increasingly accepting of their identity in certain environments, clients proudly identifying as LGB through display of buttons/jewelry and tattoos, and clients who openly identify as LGB in all spheres of their life and have many heterosexual friends.

Therapeutic tasks that I am attentive to when working with sexual minority clients include communicating a sense of safety and validation regarding their identity. I do this differently with clients depending on my “read” of them and my interpretations regarding what may work as far as validation. As an example from my work, I have asked a female client who openly identifies as a sexual minority through display of jewelry how she identifies (for examples, as lesbian, as queer, as bisexual, or none of these) and what this identity has meant to/for her. When the timing has felt right, I have asked about clients’ coming out experiences and what their receptions have been from family and friends. From a DBT perspective, these histories provide very useful information regarding clients’ histories of invalidating environments, one of the key etiological factors in BPD. I try to be aware of showing my clients an affirmative perspective rather than telling them that I am affirmative of their identity. For example, I almost never say to a client “I am a heterosexual ally who believes in LGBT rights and equality.” or any statement that
sounds like that. My belief is that if I am making statements like that then I have failed in some way to simply be present with the client as an affirmative, heterosexual-ally therapist. Statements like that also strike me personally as sounding somewhat pressured regarding gaining connection with the client, a stance unlikely to be helpful to the process of DBT (or any other therapy for that matter). What is more therapeutically helpful is noticing when I am tempted to make a statement sounding like that, prompting me to explore what this might be about for me and my relationship with the client.

Similar to my use of LGB identity models when discussing sexual minority identity issues with colleagues, I rarely refer to specific models when working with sexual minority clients. I mainly use information from the models to help assess and normalize identity issues. For example, I may notice that a client openly identifies as lesbian in all spheres of her life and denies any specific problems related to this identity ("deepening/commitment" or "internalization/synthesis" individual phases of McCarn and Fassinger’s Model) but she has few LGB friends and no sense of LGB social support ("awareness" or "exploration" phases of McCarn and Fassinger’s Model). After a few discussions of this factor in her life, she acknowledges that it would be helpful to have some connection with LGB others and I provide information that this is indeed the case for many sexual minority persons and this information may serve the purpose of developing pride and joy regarding her identity. My task at this point would be to help her become aware of LGB community resources and provide her with encouragement and support regarding accessing those resources. I would also be attentive to whatever other identity factors (such as age, race, socioeconomic status) may be present in the client’s life that might affect connection with LGB others.
Regarding potential biases, my main concern was that my interest in LGBT-identity and identity models and the associated immersion I have had in LGB scholarship might misguide my interpretations, causing me to identify themes insufficiently grounded to the data. In other words, my interpretations might be too heavily weighted towards my perspective rather than rooted in the perspective and words of the participant. One phenomenological research method I used to minimize the influence of my assumptions was to “bracket” them or hold a place for them outside of the scope of the data and analysis. I did so by keeping a log of assumptions and reactions related to each interview with participants. This step is one recommended by Yeh and Inman (2007) as a means of pursuing qualitative research “best practices” in that the qualitative researcher is compelled to have an understanding of their own views and beliefs regarding that which they are studying. Some noted biases that I was mindful of included:

- That I would easily connect interpersonally with the participants in my study. This assumption was based on my history of having close interpersonal relationships with sexual minority persons as well as generally connecting well with other therapists.

- That therapists who identify as and meet criteria to be considered affirmative would be better informed regarding issues around sexual orientation than those who do not.

- That therapists who identify as and meet criteria to be considered affirmative would be able to articulately describe ways that SO identity is addressed in therapy and would have some knowledge of models of LGB identity development.
I also used an external auditor’s perspective to ensure interpretations grounded in the data. Three analyzed transcripts (the entire interview and corresponding codes) were submitted to this auditor along with a master coding sheet (explaining and defining each code) and the noted reactions/biases for each transcript. It was requested of the auditor that she note any places where she detected bias in any of the interpretations/codes and no observed biases were reported. More explanation regarding the auditing role in this study is provided later in this chapter.

**Step 3: Identification of the phenomenon and construction of research questions**

This study next involved identification of the phenomena in question and the relevant research questions (Colaizzi, 1978; Wertz, 2005). Colaizzi explained that the success of the researcher’s questions depends on the participants’ experience of the relevant phenomenon, distinct from their technical knowledge of it. In the case of this study, the phenomena are LGB-affirmative therapists’ use of developmental models of LGB-identity in therapy and any other ways they therapeutically address clients’ SO identities. As evidenced by an extensive search of the literature, there is scant information available regarding therapists’ practical use of LGB identity models, inspiring the formulation of the following questions for this study:

- **Do LGB-affirmative therapists use developmental models of LGB-identity in therapy and if so, how?**

- **How do LGB-affirmative therapists address SO identity more generally with clients?**
Step 4: Identification and recruitment of appropriate participants

The next step in this research was gaining access to participants who can provide the rich material sought (their experiences with the phenomena) and are able to articulate these experiences (Polkinghorne, 1989). Consistent with recommendations made by Creswell (1998) regarding the appropriate number of participants in a phenomenological study, eight to ten therapist-participants were sought for this dissertation. Creswell explained that when the phenomenological researcher successfully targets participants who have experienced the phenomenon in question, higher numbers of participants are unnecessary. Nine therapist-participants were ultimately recruited for this study, a number which allowed for the relatively in-depth interviewing and analysis process associated with phenomenology.

Certain participatory criteria were set for therapists in order to promote the probability that they would have had extensive experience with the phenomena and would therefore be able to fully explore and articulate their experiences. My original aim was also to capture a sample relatively balanced in terms of racial, gender, age, and sexual orientation representation. As Polkinghorne (1989) stated, “The purpose of selecting subjects in phenomenological research is to generate a full range of variation in the set of descriptions to be used in analyzing phenomena…” (p. 48). Ultimately, this balance was somewhat achieved regarding sexual orientation but not in terms of race, gender, age, level of experience, or practice setting. Only White-identified therapists responded to the study invitation and sources such as participating therapists and other professionals were unable to identify any affirmative therapists of color. In terms of gender, out of the pool of 23 therapists identified as potentially criteria-meeting, only
four were male (or had a traditional male name). Of these four, one did not meet criteria, one did not respond to my study invitation, and two participated.

Based on literature (Skovholt and Ronnestad, 1992) pertinent to the development of counselors, I sought therapists who had finished at least master’s level training and had acquired the requisite number of clinical hours to attain licensure to practice therapy in Michigan. Counselor development scholarship tells us that therapists who are in earlier stages of training tend to be more focused on following rules and meeting professional expectations than on development of one’s personal style and self-exploration as a therapist. My main focus in recruiting therapists was that they were experienced in provision of affirmative therapy and the requirement of at least a master’s level licensure regarding clinical practice was set to promote this possibility.

Skovholt and Ronnestad (1992) completed an empirical study of counselors practicing at various stages of training and development sampled over a lifetime and noted key developmental indicators as counselors gain experience. For instance, the authors noted that as counselors progress past formal training they move from “received knowledge” or knowledge gained from others to “constructed knowledge” or knowledge that emanates more from the self (p. 510). The authors explained that as counselors gain freedom from following the rules associated with formal training, they are better able to continue the learning process more independently through means such as use of mentors, reading research, or journaling. The specialized training and necessary self-awareness associated with provision of affirmative therapy are thus most likely to take place in the years following completion of master’s degree requirements for counselors. Although it is certainly possible that more novice therapists have had experiences and training related
to LGB affirmative therapy, I was most interested in speaking with therapists who had engaged in this type of work over a period of time and who would be best equipped for in-depth exploration regarding therapeutic processes.

Potential participants were identified using criterion sampling (Creswell, 1998) which involved setting specific participatory criteria designed to facilitate investigation of the phenomena. For this study, the criteria were selectively identified to ensure that participants identified as LGB-affirmative and had sufficient experience addressing sexual orientation in therapy. Criteria were identified with the assistance of my research advisor, a licensed psychologist who has had a significant amount of experience with LGB-affirmative practice/scholarship and included the following:

- Participants are licensed to practice therapy in Michigan at either the masters or doctoral level. Only those therapists practicing within 90 minutes driving distance from me were recruited in order to facilitate in-person interviews. This geographic criteria meant that only therapists practicing in Michigan were recruited and thus the requisite of Michigan licensure. The requirement of licensure was put in place to promote the probability that participating therapists would be more advanced regarding counselor development and thus better able to introspect regarding their approach to therapy.

- Participants identify and meet criteria as LGB-affirmative therapists. For the purposes of this study, LGB-affirmative means that:
  - Participants view minority sexual orientation as a healthy, valid, and positive sexual orientation status.
Participants have engaged in a certain amount of training regarding LGB-affirmative therapy. This amount is difficult to quantify given that formal training in this area was largely unavailable before the 1980’s and thus many of the most experienced affirmative therapists would have created learning experiences rather than participated as students. Some key factors were, however, identified including: any combination of completion of formal trainings (i.e. classes or workshops) specific to LGB-affirmative therapy (not included as a topic covered under a broader area such as multicultural counseling), engagement in LGB scholarship (either the study or authorship of), and receipt of mentorship/supervision around provision of affirmative therapy.

Participants consider LGB-affirmative therapy to be one of their main (i.e. top three) foci in counseling.

Participants have seen at least 20 clients addressing sexual orientation issues in any way during therapy and have acquired a minimum of 50 hours of direct client contact with these clients. Additionally, participants have had the experience of addressing SO identity in some way with clients which may include helping clients broadly or specifically discuss their SO identity, helping the client with issues related to coming out, and/or helping the client explore ways that their SO identity intersects with other identities they may hold.
Participants are currently providing psychotherapy services to at least one client addressing sexual orientation in some way. These criteria were assessed using a brief telephone interview (see Appendix E) explained later in this section.

Potential participants (therapists known to provide LGB-affirmative services) were identified through recommendations made by my dissertation committee, recommendations made by personal sources, internet searches, contact with LGBT-resource centers, listings in the phone book, and a "snowball" technique entailing asking participants if they would be willing to suggest other therapists as potential participants. I recruited three participants through information in a local LGBT resource center newsletter, three through recommendations made by a member of my dissertation committee, two through personal recommendations, and one through an internet search.

In the discussion of participant recruitment, it's important to note the geographic area and political climate where this recruitment took place. Again, I sought participants residing within approximately 90 miles from me in order to facilitate in-person interviews and to promote a relatively homogenous sample regarding geographic and sociopolitical climate. I centered my efforts on and successfully recruited from mid-sized Southwest Michigan cities such as Battle Creek, St. Joseph, Kalamazoo, Lansing, and Grand Rapids. Based on census information, in the year 2000 these towns had approximate populations of 53,000; 62,000; 77,000; 119,000; and 198,000 respectively. With the exception of Battle Creek, a city very close in proximity to Kalamazoo and thus sharing many of Kalamazoo's listed resources, all towns shared similar numbers of LGBT resources. For example, at the time of recruitment, Kalamazoo and Grand Rapids had freestanding
LGBT community resource centers (i.e. not affiliated with a university, college, or other community resources), Lansing had an LGBT resource center connected with Michigan State University, and St. Joseph had an LGBT resource center connected with its YWCA (Young Women’s Christian Association). Lansing had a local ordinance prohibiting discrimination based on sexual orientation; Grand Rapids had one in place prohibiting both sexual orientation and gender identity discrimination (J. D. Kaplan, personal communication, March 19, 2008). Of these two cities, only Lansing had a legal remedy in place in case of ordinance violation (Kaplan). It should be noted that the area of Michigan where recruitment took place, particularly the Grand Rapids locale, is the founding center for the Christian Reform Church. This church is based on Calvinist principles of religious piety and the sovereignty of God and openly devalues same gendered partnerships (Christian Reformed Church, 2008). The large presence of the church in Southwestern Michigan and its anti-gay stance clearly influences ways that various communities operate both socially and legally. As Walker and Prince (2010) stated, “Collectively, the institutions of politics and religion permeate our everyday lives and can powerfully influence attitudes towards LGBT individuals.” (p. 3).

All of the cities I recruited from also shared a statewide sociopolitical climate towards LGBT issues. In 2004, Michigan’s constitution was amended to reflect a position stating that the legal sanction of a union between two people can only occur between males and females. This amendment acted to constitutionally define marriage, placing additional legal obstacles to those with same-gendered partners wishing to marry (Lambda Legal, 2008). Although no official legal ban exists in Michigan barring LGBT persons from adopting; a judge may still deny parental privileges based solely on sexual
orientation (Triangle Foundation, 2008). According to information from the Triangle Foundation (an LGBT rights organization specific to Michigan), LGBT parents are commonly denied parental rights based on their sexual orientation and/or gender identity. Counter to Michigan's general lack of legal support for LGBT rights, the state's governor, Jennifer Granholm, has issued an executive order banning sexual orientation and gender identity discrimination in state workplaces although the enforceability of such an order is questionable (J. D. Kaplan, personal communication, March 19, 2008).

Potential participants were initially contacted through one of three types of cover letters (Appendices A-C) informing them of how I came across their contact information as well as a written invitation (Appendix D) outlining the study and the criteria for participation. Additionally, the invitation explained that, in the spirit of capturing a diverse sample of therapists with respect to factors such as gender, sexual orientation, and race, it would be possible that some therapists indicating interest would not be chosen to participate although this did not actually occur.

A total of 23 letters/invitations were sent out to potential participants. I received two written responses indicating that the therapists did not meet criteria and received phone contact from two therapists who indicated interest but did not ultimately meet criteria for the study. One therapist indicated interest and met criteria for the study but did not return a consent form and nine therapists did not respond. All potential participants were sent an initial letter and one follow-up letter (Appendix K) two weeks later if they did not respond to the first. Potential participants who responded to the research invitation were briefly assessed (see Appendix E) for set criteria by means of a statement read to them by phone. Potential participants were instructed to respond to the statement
indicating that they either did or did not meet the listed criteria. Information from the brief assessment was not recorded, as informed consent was not yet acquired.

Potential participants who did meet criteria were informed of such and sent a packet containing two copies of a consent form (Appendix F), a demographic questionnaire (Appendix G), and a postage-paid envelope to return completed materials in. The questionnaire was aimed at capturing potential participants’ identifying information in order to describe them in the study and to achieve diversity regarding factors such as race, gender, and sexual orientation. The packet also contained a brief letter of instruction regarding the materials (Appendix L). The consent form outlined the purpose and plan for the study as well as potential risks and benefits of participation. When consent forms were not returned within two weeks of sending, one reminder letter (Appendix M) was sent to the potential participant. Despite attempts at gaining greater diversity regarding gender and race (by sending invitations to potential participants with traditionally “male” first names and asking multiple sources if they knew of any male affirmative therapists and/or affirmative therapists of color), most participants in my study were female and all identified as White.

The final pool of nine participants consisted of four lesbian-identified females, two heterosexual ally-identified females, one bisexual-identified female, and two gay-identified males. Participants in this study were affirmative therapists practicing in midsized cities in Southwest Michigan. Eight of the nine therapists identified at least ten years of practice focusing on affirmative therapy and six identified at least 14 years. Three participants were licensed at the doctoral level and six at the master’s level. One participant was in his late 20’s and the rest ranged in age from early 40’s to early 60’s.
Six participants indicated receiving little/no LGB-specific training and little/no exposure to LGB identity models in their graduate programs while one participant described receipt of a significant amount of both in her doctoral-level graduate program. The most common forms of LGB-specific training experienced by participants were engagement in independent readings/self-study, contact with other affirmative peers/professionals, conference attendance, and supervision specific to affirmative therapy. Five participants indicated some form of exposure to LGB identity models in their training and these five also reported therapeutic use of the models. Brief identifying information (with pseudonyms) regarding each participant follows:

- Michael: White male in his late twenties who identifies as gay. Michael is licensed at the master's level, reports one year of practice focusing on affirmative therapy and has seen 20-40 clients addressing sexual orientation in therapy (four to five currently). Michael has had exposure to LGB identity theory/models in his training and uses LGB identity models in his work (identified Cass Model). Michael identified that his main theoretical orientations are acceptance and commitment therapy (ACT) and motivational interviewing.

- Judith: White female in her late fifties who identifies as lesbian. Judith is licensed at the master's level, reports 14 years of practice focusing on affirmative therapy and has seen 40-60 clients addressing sexual orientation in therapy (two to three currently). Judith has not had exposure to LGB identity theory/models in her training and does not use LGB
identity models in her work. Judith identified that her main theoretical orientations are humanistic, eclectic, and spiritually-focused.

- Elizabeth: White female in her late forties who identifies as lesbian. Elizabeth is licensed at the master’s level, reports 18 years of practice focusing on affirmative therapy and has seen 60-80 clients addressing sexual orientation in therapy (four to five currently). Elizabeth has had exposure to LGB identity theory/models in her training and does use LGB identity models in her work. Elizabeth cited use of the “Falco” Model of Lesbian Identity. Upon investigation of this model, I believe Elizabeth was referring to Kristine Falco’s (1991) book, *Psychotherapy with Lesbian Clients*, which included a chapter on lesbian identity development. In that chapter, Falco reviewed three developmental models of LGB identity: Coleman’s (1981/1982) *Developmental Stages of the Coming Out Process*, Cass’ (1979) *Model of Homosexual Identity Development*, and Lewis’ (1984), *The Coming Out Process for Lesbians*. Elizabeth identified that her main theoretical orientation is cognitive-behavioral.

- Linda: White female in her early fifties who identifies as bisexual. Linda is licensed at the master’s level, reports 10 years of practice focusing on affirmative therapy and has seen 40-60 clients addressing sexual orientation in therapy (four to five currently). Linda has not had exposure to LGB identity theory/models in her training and does not use LGB identity models in her work. Linda identified that her main theoretical orientation is Jungian.
• Anne: White female in her early fifties who identifies as a heterosexual ally. Anne is licensed at the doctoral level, reports 14 years of practice focusing on affirmative therapy and has seen 20-40 clients addressing sexual orientation in therapy (two to three currently). Anne has had exposure to LGB identity theory/models in her training and does use LGB identity models in her work (identified Cass Model). Anne identified that her main theoretical orientations are eclectic, developmentally-focused, and psychodynamic.

• Betsy: White female in her early fifties who identifies as a heterosexual ally. Betsy is licensed at the master’s level, reports 10 years of practice focusing on affirmative therapy and has seen 20-40 clients addressing sexual orientation in therapy (four to five currently). Betsy has not had exposure to LGB identity theory/models in her training and does not use LGB identity models in her work. Betsy identified that her main theoretical orientation is psychodynamic.

• Daniel: White male in his early fifties who identifies as gay. Daniel is licensed at the master’s level, reports 21 years of practice focusing on affirmative therapy and has seen 20-40 clients addressing sexual orientation in therapy (four to five currently). Daniel has not had exposure to LGB identity theory/models in his training and does not use LGB identity models in his work. Daniel identified that his main theoretical orientation is cognitive-behavioral.
- Susan: White female in her early sixties who identifies as lesbian. Susan is licensed at the doctoral level, reports 20 years of practice focusing on affirmative therapy and has seen more than 100 clients addressing sexual orientation in therapy (more than ten currently). Susan has had exposure to LGB identity theory/models in her training and does use LGB identity models in her work (identified Cass and Coleman Models). Susan identified that her main theoretical orientation is relational.

- Robin: White female in her early forties who identifies as lesbian. Robin is licensed at the doctoral level, reports 16 years of practice focusing on affirmative therapy and has seen more than 100 clients addressing sexual orientation in therapy (more than ten currently). Robin has had exposure to LGB identity theory/models in her training and does use LGB identity models in her work (identified Cass, Troiden, and McCarn and Fassinger Models). Robin identified that her main theoretical orientation is relational.

**Step 5: Collection of data**

Giorgi and Giorgi (2003) explained that a benefit of phenomenology is the illumination of the lived experiences of participants, greater than what they themselves can provide because they are living the experience and are thus too close to it for full examination. They added that retrospective recounting is usually the most effective way to glean information about the lived experiences of participants as this allows participants some distance from the experience itself, which promotes their ability to analyze and explore. Researcher-conducted interviews with participants are one of the most common
means of gathering this data. The researcher plays an important role in the interview process by keeping the participant’s focus on the phenomenon which is consistent with an important aspect of phenomenology: the directing of consciousness toward some direction or object (Giorgi and Giorgi). Another important role of the researcher is the promotion of an egalitarian relationship with participants so that power differences are minimized and participants feel able to challenge the researcher if necessary. If participants feel too intimidated to question the researcher, the rigor of the study is compromised (Suzuki, Ahluwalia, Arora, and Mattis, J. S., 2007 citing Hall and Callery, 2001).

Polkinghorne (1989) indicated that phenomenology data collection involves interviewing participants who have experienced the relevant phenomenon so they may provide descriptions of the experience in their own words. The interviewer seeks clarification from the participant where needed and as the interview progresses, information may become richer through questions promoting self-reflection. As discussed previously in this chapter, skilled psychotherapists possess natural as well as learned qualities that promote their effectiveness as interviewers. In the case of this study, I (an arguably skilled psychotherapist) interviewed other skilled psychotherapists and it was my perception that participants were able to deeply explore the phenomena. This perception was based on participants engaging in the following during interviews: offering responses that showed insight into their work, returning to prior questions to offer additional information, pausing to reflect, and a fluid exchange of responses.

During interviews with participants and over the course of this study, it was very important to me to provide participants with a sense of safety and to invite correction
regarding my interpretations. These aims mirrored an important aspect of working with clients in therapy and similar counseling techniques were used. For example, as both interviewer and therapist I rely on statements like, “please let me know if this isn’t accurate” to reflect what I’ve heard and to make sure I’ve heard correctly. These invitations for correction were interwoven throughout the interview process and it was my perception that therapists had no difficulty clarifying their perspective when needed. It is my assertion that the combination of skill-sets between participants and myself as interviewer added to the trustworthiness of the data by facilitating in-depth exploration of the phenomena and promoting accurate interpretation of participants’ words.

This aspect of phenomenological research spoke to what Creswell (1998) described as a kind of reciprocal interaction between researcher and participant where each brings a key piece of understanding to the phenomena; each dependent on the other and in trusting communication with each other. Giorgi and Giorgi (2003) explained this reciprocity is one of the benefits of phenomenology, allowing for the illumination of experiences that could not be achieved by the experiencers themselves due to the myopic view we naturally have of our own lives. As Creswell explained, it is this aspect of relative intimacy between researcher and participant that adds to the veracity of the data.

Participants were each interviewed twice: once in-person (see Appendix H for interview protocol) and once by phone (see Appendix J for protocol). Interviews were audio-recorded using a primary digital recorder and backup cassette recorder. All in-person interviews were between 60 to 90 minutes in length while phone interviews were between 20 to 45 minutes in length. All in-person interviews took place in private locations, most often the therapist’s office. The initial interview protocol was constructed
to arrive at a set of questions that would best facilitate in-depth exploration of the phenomena. Questions were constructed broadly to allow for a fluid and meaning-rich exchange between me and participants. Several drafts of potential questions were reviewed with my advisor with edits made based on his feedback. Questions were reevaluated by me and my advisor after the first two in-person interviews to assess whether they sufficiently arrived at rich data (it was assessed that they did and no changes were made).

After assessment that the interview protocol worked sufficiently to arrive at the information sought; the remaining participants were interviewed. After each interview, I took notes on my reactions to the interview for later use regarding examination of my potential biases. Audio-recordings (either tape or electronic format) were stored in my secure home office until transcripts were made of each recording at which point recordings were destroyed. The second interview protocol was created similarly, although the intention of that interview was inviting correction where necessary in addition to furthering exploration of the phenomena.

The process of transcribing completed interviews was interwoven throughout the interview period. All interviews were transcribed verbatim by me and any potentially identifying information was removed. Transcripts were saved in rich text format and uploaded into the qualitative software program, MAXQDA 2007. Transcripts and related documents were stored on a password protected computer and hard copies of transcripts and all other documents related to the project were kept in a secure home office.
Step 6: Analysis of data

After initial interviews were completed I transcribed each of them word for word in order to allow for rigorous examination of each participant’s data as recommended by Colaizzi (1978) and Creswell (1998). The transcription process itself furthered my immersion in the data, as I listened to small segments of interviews multiple times and verbalized them aloud to be captured by voice-recognition software (Dragon Naturally Speaking V.10). I then listened to the segments again to ensure that as much as possible, every word was captured accurately. Any potentially identifying information (names, agencies, locales) was removed from each transcript. Transcripts were next saved in “rich text” format and imported into the qualitative analysis program, MAXQDA 2007.

At this early stage of analysis, I first read through all of the transcripts and electronically (through my analysis software) highlighted any statements that I perceived to be salient to the examined phenomena. These statements included participants’ descriptions of their journeys as affirmative therapists, descriptions of their practice of affirmative therapy, and descriptions of ways that they addressed SO identity with clients. After this initial round of highlighting, I then went back to these statements to begin a process of data organization that included construction of “codes” and “subcodes” that represented what was highlighted. Codes might be conceptualized as the core concept of highlighted data, while subcodes were specific descriptors under that core concept. Each code was represented by a different color that allowed for better visualization of the data. This visualization assisted with further organization of the codes/subcodes into broader “themes” emanating from the data. As an example of how data was organized, a section of Betsy’s first interview reads as follows:
Well some of it's that nonverbal discomfort that you can sense when they're getting close to something that's, you know you're getting too close or they're stepping around an area that they don't want to walk in yet, you know they start squirming and looking you know (makes expression indicating anxiety) and it's like okay we'll let that sit for a little while you know, over there.

This segment of data was organized under the code, *attending to catalysts and cautions regarding broaching the topic of SO identity* which was later placed under the theme, *specific strategies used when addressing sexual orientation identity in therapy*. In the final presentation of results, I referred to the codes as “subthemes” and used details from what I categorized as “subcodes” to illustrate the subtheme. This change in terminology was made to best fit the two main categories of organization: the broader “themes” and the more specific, “subthemes” which I assessed as better descriptors than “codes”.

Every transcript was analyzed in this way with a continual editing process to arrive at the most concise and best fitting set of themes and subthemes which were continually “tested” by referring back to the data to check whether the subtheme still fit the data and/or whether there was salient data not captured by a subtheme. At the end of this process, six main themes were identified: *addressing identity* (11 codes, 46 subcodes), *therapists’ reflections on affirmative therapy* (15 codes, nine subcodes), *training around provision of affirmative therapy* (10 codes, 13 subcodes), *path to becoming an affirmative therapist* (five codes), *participant identity* (three codes), and *follow up* (five codes, one subcode). See Appendix Q for list of codes and corresponding definitions.

Merrick (1999, citing Lincoln and Guba, 1985) discussed use of external auditing to promote qualitative rigor and this step was integrated into my analysis process. One primary external auditor (not otherwise connected with the study) provided integral
feedback regarding the analysis process. This auditor met previously set criteria which included: status as a graduate-level student, faculty member, or licensed therapist; having some experience with LGB scholarship (either through self-study or contribution to/authorship of at least one paper on LGB issues); and either completion of a course on qualitative research methods and/or contribution/authorship to/of a paper using qualitative research methods. My auditor was a White lesbian-identified counseling psychology doctoral student who is a published author of LGBT scholarship and had numerous experiences with qualitative data. These qualities positioned my auditor to better understand the background and context of this study which helped her in identifying areas of the data analysis that seemed inaccurate or unclear. It should be noted that my chair, a seasoned LGB scholar, also brought an auditor's perspective through extensive review of every aspect of this study. Although he also provided feedback regarding data analysis and organization, any specific reference to an “auditor” in this study is referring to the external auditor.

Mainly, my auditor provided feedback on accuracy of analysis and how the themes/codes/subcodes were constructed. After an initial round of my own editing process, the auditor was supplied with a complete list of themes, codes, and subcodes (and their definitions); two randomly chosen transcripts; and the journaling I did regarding my reactions to the two transcript interviews. She provided feedback on the following areas: the understandability of the themes/codes/subcodes (i.e. did definitions fit and make sense?), redundancy (i.e did themes/codes/subcodes overlap?), and accuracy (i.e. did themes/codes/subcodes match the raw data?). She was also instructed to consider
my reaction notes and whether she detected any areas of researcher bias in the transcripts or the analysis.

Although I did not integrate every item of feedback provided by my auditor, her notes helped me clarify definitions, eliminate redundancy, and maintain a sense of being “on track” regarding accuracy. An example of feedback that was integrated includes the auditor noting that the code, *LGB Research, Scholarship, and Education* did not make sense under the theme, *Addressing Identity/ Therapeutic Use of Identity Models*. As I reflected on this feedback I agreed that use of the models for scholarship was not really something done in therapy and I changed the title of the theme to, *Addressing Identity/Use and Function of Identity Models* to better encompass the functions discussed in the study. An example of a piece of feedback that was not integrated was the auditor’s note that a part of one therapist’s transcript seemed to be related to assessment and she suggested that I recode that section. Upon review, I did not agree and found no evidence of the therapist engaging in assessment in that piece of their interview, but rather they were normalizing the client’s experience. By each piece of feedback provided by my auditor I made a notation regarding whether the feedback was integrated or not and reasons for each. This process was also less formally done with the auditing provided my chair; by each of his suggestions I made note whether it was integrated or whether we needed to discuss it further.

After going through every point of feedback provided by my auditor and noting how changes either were or were not integrated; a third transcript was selected and given to her for review. This transcript was selected randomly from two identified for their representation of codes occurring less frequently than in the prior two transcripts. This
selection was aimed at providing the auditor with exposure to the greatest possible
variety of codes within her reviewed transcripts. Based on feedback provided after the
third transcript was submitted, I assessed that current themes/codes/subcodes were
understandable, concise, and accurate; and that they fit the raw data. Narrative synopses
were created for each interview including an overview of themes/subthemes gleaned
from that particular interview as well as across participants.

Reflecting back on my relationship to the data, I recognize that my personal style
of analysis was to immerse myself deeply in the words on the page and create a very
detailed list of codes and subcodes. This “up close” or “micro” relationship to the data
allowed me to then “pull away” from the data for a more “macro” view that allowed for
identification of the broader themes. Next, I was able to use this visual examination to
identify connective elements across participants to construct an initial draft of the study’s
essence (included in the synopses, see Appendix P). This essence is considered the apex
of the phenomenological study (Colaizzi, 1978; Creswell, 1998; Polkinghorne, 1989).
Creswell (1998) explained, “The phenomenological report ends with the reader
understanding better the essential, invariant structure (or essence) of the experience,
recognizing that a single unifying meaning of the experience exists.” (p. 55)

Step 7: Data verification (member checking)

One of the final steps in the data analysis process (Colaizzi, 1978; Merrick, 1999)
is a verification step known as “member checking” or allowing the participants
themselves to review the researcher’s analyses for accuracy. Each participant was sent
their narrative synopsis along with a summarization of the themes/codes/subcodes found
most frequently in their interview, themes/subthemes found most frequently across all
nine participants, and an initial draft of the essence of the study. These synopses (see Appendix P) were sent with a letter of instruction (Appendix N) explaining that participants would be contacted within two weeks to schedule a follow-up interview by phone. The purpose of providing participants with these synopses was to facilitate further thinking on the phenomena and invite correction where necessary.

After it was assessed that participants had reviewed their synopsis, I interviewed them by phone and asked them to provide feedback (see second interview protocol, Appendix J) regarding accuracy of my interpretations, any corrections or additions they would like to make, and how well the core essence of the study fit their perspective. These interviews were conducted between May 2009 and July 2009 (four to nine months after respective initial interviews took place). The interviews were between 20 and 30 minutes in duration and were audio-recorded, transcribed, and uploaded into the analysis software as previous interviews had been. Just as with first interviews, second interviews were reviewed for salient statements and these statements were coded and later organized into themes. A relatively small amount of new themes/subthemes were created based on data emerging from second interviews and a shorter process of editing and “testing” against the data took place. In a few cases, participants added information to their interviews based on themes/subthemes discussed across participants. For example, Anne indicated in her second interview that she had forgotten to mention the influence of working with a number of gay-identified male clients on her path to becoming an affirmative therapist. Some participants made minor clarifications and/or gave additional information regarding the analysis of their data. All participants agreed with the essence of the study as fitting with their perspectives.
Step 8: Additional analysis

After member checks were complete, minor adjustments were made to themes/subthemes as reflective of feedback provided by the participants. Additionally, my research advisor provided ongoing feedback regarding the analysis and how the results could best be integrated into the dissertation with the aim of communicating to an audience of fellow scholars/practitioners. For example, based on ongoing feedback from my advisor, certain themes were re-titled to best capture the data that fell under those themes and subthemes were sometimes merged with others to best organize the data and communicate the results. The study’s essence was revised by providing richer explanation. The core meaning was unchanged but the essence was broadened to reflect examination of themes that traversed all participants. These themes are presented in the next Chapter, Results.

Review of the Study’s Rigor

Although some scholars have called for the field of qualitative research to reclaim more quantitative terms such as “validity” (see Merrick, 1999) regarding data verification, most qualitative studies have adopted terminology such as “rigor” and “trustworthiness” rather than “validity” and “reliability”. In this section, aspects of this study’s rigor are highlighted including my positionality and background as an LGBT scholar, researcher, and affirmative therapist; my immersion in the data; my documentation of personal reactions related to the study; use of salient literature review; provision of a detailed description of participants; provision of participants’ direct words; use of both external and internal auditors; and use of participant “member-checking”.
Creswell (1998) explained that the promotion of rigor occurs as an ongoing process throughout all aspects of one’s qualitative study. He pointed to some specific means of promoting rigor such as the positionality of the researcher, the researcher’s ability to examine their own reactions to their study, the research serving the community it is studying, and the research giving voice to its participants. Regarding my positionality as this study’s primary researcher, I drew from multiple elements including: my history of relationship with LGBT people and various LGBT communities; my nine years of master’s and doctoral-level clinical training and work experience; and my specific training on LGBT counseling issues.

The social positioning of the researcher has also been discussed by Morrow (2007) as a means of promoting transparency and making the researcher’s relative privileges known. I wished to be very cognizant of my place as a heterosexual-ally researcher who must recognize the ill effects of societal heterosexism and acknowledge the ways I am privileged as a result of this heterosexism. Throughout this study, I continually acknowledged my positionality as a heterosexual-ally therapist and researcher through journaling. Exploration through journaling was also used to explore my reactions and potential biases after each interview was completed. It was my hope to use my social positioning as a researcher and clinician to advance the field of LGB scholarship and improve therapy services for LGB persons.

Merrick (1999, citing Lincoln and Guba, 1985), explained that the researcher’s extended immersion in their data promotes its trustworthiness. This study was completed over a roughly two and a half-year period supported by several additional years of background study. I spent approximately one year gathering, transcribing, and analyzing
my data which immersed me in and connected me to the words of participants. This study’s rigor was also promoted by engagement in a thorough review of related scholarship/literature as well as examination of my own philosophical foundation regarding research. These examinations provide triangulation and context for the data. Specific areas of literature explored in Chapter Two were LGB models of identity, LGB affirmative therapy, and the use of LGB identity models in therapy. Other means of promoting veracity included my deep immersion in the data by performing all of my own transcription/analysis and my attention to facilitating participants’ exploration of the phenomena of addressing SO identity in therapy and practical use of LGB models of identity.

As suggested by McLeod (2001, citing Elliott, Fischer, and Rennie, 1999) regarding the promotion of rigor in qualitative study, detailed descriptions of participants have been provided to allow the reader to make their own judgments regarding their trustworthiness as sources of data. Multiple examples from the raw data (direct quotes from participants) have been given to support the analyses and allow readers the opportunity to construct alternate interpretations (McLeod). Additionally, it is my assertion that the results have been presented understandably as derived from the words of participants and that they provide useful information for researchers and practitioners (McLeod). As explained earlier in this chapter, the perspectives of an external auditor, my research chair, and participants themselves were sought at multiple points throughout the analysis process to maintain a sense of being “on track” regarding accuracy of data interpretations.
Lastly, it is my assertion that this study fulfilled one of Creswell’s (1998) criteria for qualitative rigor in that it acted to benefit its participants not only indirectly (through results that will hopefully benefit the field of affirmative therapy) but directly, in that participants described multiple positive effects related to taking part in the study. This kind of symbiotic relationship between researcher and participant is perhaps the ultimate aim of qualitative research. The majority of participants described feeling a sense of connection with other therapists that was both validating and reassuring (reading the themes that other participants endorsed provided a sense of being similar to those therapists and “on track” regarding their own work). Additionally, the majority of participants described an increased self-awareness as a result of discussing their work in-depth with a fellow-therapist and researcher. Although not cited by the majority, four therapists also described a sense of feeling valued for their work through the experience of speaking with a researcher who communicated an interest in what they do.
CHAPTER IV
RESULTS

This chapter begins with a presentation of contextual material for better understanding the results found in this study. This material includes information about the participants and their selection, their experiences with developmental models of LGB identity, and ways that the resulting major themes in this study were constructed. Next, the results are presented in a table format which is followed by in-depth explanation of the results.

Context and Background Regarding the Results

Between August 2008 and late July 2009, I interviewed nine participants who identified as “affirmative therapists” (see Chapter Three for full description of this definition and related criteria). Each therapist was interviewed twice; once in person followed by a shorter, second interview by phone. All therapists presented with varying backgrounds and experiences but all were able to richly explore the phenomena of addressing sexual orientation identity with clients in therapy. Five of the therapists had experienced some form of exposure to LGB identity models in their training and used these models in some capacity in their work with sexual minority clients, which they were able to explore and articulate. Information shared by these therapists regarding their work was used to identify salient themes related to the research questions and then finally, an overarching essence of the study.
In selecting therapists for this study, I purposely did not require that therapists had experienced prior exposure to LGB models of identity development. This was in part because I did not equate exposure to LGB identity models with meeting criteria to be considered an affirmation therapist. The five therapists who indicated prior exposure to LGB models of identity in their training gained this exposure through four identified sources: masters or doctoral-level coursework, independent study, conferences, and contact with peers and professionals. These therapists all described using developmental models of LGB identity to some degree in their affirmative work with clients.

Therapists who reported exposure to developmental models of LGB identity described a variety of experiences regarding the depth of this exposure, how they accessed this exposure, and how they integrated the information gleaned from these models into therapy. As explained in the previous paragraph, therapists accessed exposure to these models from multiple sources including coursework and conferences. Some therapists, however, seemed to have a more current relationship to the models as evidenced by their ability to name models and cite specifics regarding stages in a particular model. Other therapists knew that they had gained exposure to developmental models of LGB identity at some point in their training but could not name a particular model. In other words, therapists’ abilities to discuss and critique nuanced aspects of these models seemed heavily influenced by how recent their exposure was and how much study they had done regarding a particular model.

Despite differences regarding ability to provide detail regarding knowledge of developmental models of LGB identity development, all five therapists who had gained some exposure to them presented with a decent understanding of the unifying principles
of sexual minority identity development. These principles can generally be described as including the following: that sexual minority identity is one formed over time, influenced by multiple factors including beliefs about sexual minority persons, and can be described as a stage-like progression with aspects of final stages including the development of an integrated, positive sense of self regarding SO identity. Michael and Anne identified use of the Cass (1979) model; Susan was unable to name a particular model but confirmed exposure to Cass (1979) and Coleman (1981/1982) models when she heard their names cited by me in the interview; Robin identified Cass (1979), McCarn and Fassinger (1996), and Troiden (1989) regarding identity models. Elizabeth reported use of the “Falco” model of lesbian identity. Upon investigation, I believe Elizabeth was referring to Kristine Falco’s (1991) book, *Psychotherapy with Lesbian Clients*, which included a chapter on lesbian identity development. In that chapter, Falco reviewed three developmental models of LGB identity: Coleman’s (1981/1982) *Developmental Stages of the Coming Out Process*, Cass’ (1979) *Model of Homosexual Identity Development*, and Lewis’ (1984), *The Coming Out Process for Lesbians*.

Throughout this chapter, multiple themes regarding therapeutic attention to sexual orientation (SO) identity and related use of LGB identity models are identified and explored. With few noted exceptions, these themes were common to all participants. Under the “umbrella” of a particular theme, subthemes or more specific aspects of the broader theme are also reviewed. These subthemes were identified as experienced by the majority of therapists. Some themes explored in this chapter are more contextual in nature and may not speak directly to addressing SO identity, but are inextricably connected to it. For example, the first theme reviewed is, *Arrival at Identity as an*
Affirmative Therapist. This theme provides the reader with a contextual background regarding how these participants came to identify themselves not only as therapists but as affirmative therapists. This background allows the reader to both better understand the participants and more critically review information provided by them. Another theme, Specific Strategies Used in the Practice of Affirmative Therapy, is relevant because it speaks to the general practice of affirmative therapy which is, at times, very difficult to separate from specific attention to SO identity. The difficulties encountered regarding separately defining general aspects of affirmative practice from specific work on SO identity will be reviewed later in this chapter and further discussed in Chapter Five. This chapter culminates with the presentation of the unifying phenomenon which expounds on common themes in the creation of a narrative of participants’ collective experience.

Note: Regarding participant quotes and use of “therapist” vs. “participant”, it should be noted that where all-capital words were used in a quote (example: CITY), information was removed to preserve confidentiality; “therapist” and “participant” were used interchangeably to refer to those therapists who participated in this study.
## Results Presented in Table Format

### Table 1
Themes, Subthemes, and Sample Statements

<table>
<thead>
<tr>
<th>Theme</th>
<th>Associated Subthemes</th>
<th>Sample Statement</th>
</tr>
</thead>
</table>
| Arrival at identity as an affirmative therapist.  
*Specific professional experiences (such as a relationship with an LGB coworker).  
*Being identified as affirmative by others (e.g. supervisors, peers).  
*Addressing a community need for affirmative therapy. | From my own personal journey I remember the depression years and the struggles and you know, ‘why am I like this?’ and this sort of thing and I can relate to where a lot of the clients are coming from and I’ve had clients who have come in who have had therapists in the past who never really quite understood... (Personal identification as a sexual minority) |
| Specific strategies used in the practice of affirmative therapy  
*Definition:* Therapists’ identified techniques cited as integral to providing affirmative therapy in a general sense. | *Use of validation and acceptance.  
*Therapists’ use of their own SO identities.  
*Displaying and providing LGBT-related materials. | I shared with her a couple of movies that might be good for her to watch and, you know, gave her some reading and you know that kind of stuff, that I feel like that’s a really important part of this process because I can say that but if you can read a book, you can see a handout, or you can watch a movie it’s like Ah! I’m not alone! (Displaying and providing LGBT-related materials.) |
| Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy  
*Definition:* Therapists’ identified techniques aimed at promoting the client’s development of a healthy, integrated, positive SO identity and constructing a life authentic to that identity. | *Assessing SO identity in therapy.  
*Allowing the client to lead the way in work on SO identity.  
*Attending to the client’s chronological age and corresponding development.  
*Attending to catalysts and cautions regarding broaching the topic of SO identity.  
*Addressing family-of-origin and romantic relationship issues | I think it’s [addressing SO identity] on an as-needed basis and sometimes that’s something that comes out in the early stages of therapy right away and sometimes it’s something that clients aren’t ready to address until mid or later stages of therapy so I really try to tailor that to an individual’s sense of readiness in terms of when they want to address that, if they want to address it. (Allowing the client to lead the way in work on SO identity.) |
Table 1-Continued

<table>
<thead>
<tr>
<th>Theme</th>
<th>Study Results Associated Subthemes</th>
<th>Sample Statement</th>
</tr>
</thead>
</table>
| Main therapeutic functions of developmental models of LGB identity: Providing hope and conceptualization | *Providing hope.  
*Assisting with client conceptualization.                                                                 | It [an unspecified model of lesbian identity development] helped me to place where I felt I was on that continuum and what I remember being especially poignant about learning this model was realizing that this, I think there were five stages of her model, and that this fifth stage was this place where you actually are proud and happy about your own development and so I was very encouraged by that at that time; that this was a stage that could be attained. (Providing hope.) |
| Therapists' recognition/identification of models' limitations         | *Models as linear and limited.  
*Models as clinical and depersonalizing.  
*Models used inflexibly without attention to context.                                                                 | Well I mean I’m sure these models are helpful in the sense that they, people have researched them out and have found them to be useful information in working with clients. I’m just saying my own personal style is with any therapeutic approach, it’s less clinical and more, oh I don’t know what’s the word I would use, human [researcher responds, ‘yeah, organic?’] Yes, more organic, perfect word. (Models as clinical and depersonalizing.) |
| Positive aspects of research participation                            | *Fellowship with other affirmative therapists.  
*Increased self-awareness.                                                                 | It [participation in the study] made me, you know, think more about, you know, what underlies the actions that I take as a therapist and that’s always good for me as a therapist. And you know the other is just always wanting to improve the way that I relate to anybody that walks through my office and one of the ways to do that is to think about what I would want from my own experience and that just prompted me to think about it in that way. (Increased self-awareness.) |
Main Themes Identified in this Study

Four themes common to all participants were identified: Arrival at Identity as an Affirmative Therapist, Specific Strategies Used in the Practice of Affirmative Therapy, Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy, and Positive Aspects of Research Participation. Additionally, two themes common to the five participants who had exposure to LGB models of identity development were identified: Two Main Therapeutic Functions of Developmental Models of LGB Identity: Providing Hope and Conceptualization and Therapists’ Recognition/identification of Models’ Limitations. Because practical application of developmental models of LGB identity was central to my study, it seemed important that I not exclude these themes because they weren’t experienced by all nine therapists. Under the identified themes of the study, central “subthemes” were also identified. These subthemes were noted if they were experienced by five or more therapists with the exception of the themes specific to therapeutic use of the developmental models of LGB identity; those subthemes were noted if they were experienced by three or more therapists. These subthemes provide detail regarding how the major themes were experienced by the therapists.

Arrival at identity as an affirmative therapist

Therapists described affinities for a variety of theoretical orientations but all shared a commitment to the practice of affirmative therapy and an identity as an “affirmative therapist”. All therapists discussed influential factors on their development of identity as affirmative including their personal identification as a sexual minority, specific experiences in their professional life, being identified as affirmative by others,
and addressing a community need for affirmative therapy. It should be noted that any reference to “affirmative identity” implies identity as an affirmative therapist.

**Personal identification as a sexual minority**

Seven participants held minority sexual orientation identities and discussed the importance of their own identities in shaping their development as affirmative therapists. One aspect of this development was recognition of an ability to empathically connect with identity-related struggles that clients brought to therapy. Another aspect that therapists described was a natural flow to identifying as affirmative based simply on identifying as lesbian, gay, or bisexual themselves and easily gravitating towards an affirmative identity without any necessary forethought.

Some sexual minority therapists described feeling able to deeply understand and relate to aspects of their sexual minority clients’ stories. For these therapists, this ability to understand sexual minority clients’ lives promoted both their professional confidence and their professional identity as affirmative. This was highlighted by both Judith and Daniel. Judith reflected on coming through her own struggle with identity as a lesbian woman and realizing as a therapist, “Who would be the better person to really, really be there for somebody going through the struggle?” She added, “So I thought that myself being from that background [lesbian-identified], being that's intrinsically who I am, that would help other people to come and know who they are.” Daniel recounted his experiences struggling with and then coming into acceptance of his identity as a gay man and how these experiences promoted his ability to understand and empathize with sexual minority clients. He explained:

> From my own personal journey I remember the depression years and the struggles and you know, ‘why am I like this?’ and this sort of thing and I
can relate to where a lot of the clients are coming from and I’ve had clients who have come in who have had therapists in the past who never really quite understood...

Linda broadened this idea to using her own identity as a bisexual woman to better attune her to general issues of sexuality in her clients’ lives. Linda explained that this attunement was not just with sexual minority clients, but that this population especially needed compassion and understanding. Linda described how her life experiences both in the “heterosexual” world of a legally-sanctioned marriage with children and in her current long-term partnership with a woman made her more aware in her work as an affirmative therapist. This awareness allowed her greater ability to provide the compassion and understanding needed by sexual minority clients and promoted her development of an affirmative identity. Linda explained:

I think that progression for me especially walking both sides of the world has just made me have more of an open ear for that in my practice because I really feel like sexual orientation and sexual identification, issues around sexuality get missed a lot of times in therapy because people don’t ask those questions or aren’t presenting that as something that’s a healthy aspect of an individual rather than you know the traditional model has been pathology regarding homosexuality for years.

Some sexual minority therapists also responded to the question of how they arrived at an affirmative identity with a little bemusement, as if there really could be no other option. Susan put it clearly with her statement:

I identify as a lesbian and it has made that work, there’s a natural flow to that work just because I’m pretty willing to be out with clients that need me to be out. So I’m not so sure anything led me to it except myself.

*Specific experiences in their professional life*

Six therapists shared how certain professional experiences promoted their identity as affirmative. These experiences included relationships with sexual minority clients or
coworkers, exposure to a clinical issue that helped reframe attitudes about sexual minority identity, and gaining LGBT-specific training in a doctoral program.

For some therapists, contact with sexual minority clients and coworkers allowed them to build relationships with sexual minority persons and emphasized the need for affirmative therapy services. This contact played a key role in their development of an affirmative identity. Elizabeth explained:

[I] had the opportunity at that time to work with a lot of gay men in particular and found that work very rewarding and so wanted to carry it over into my practice and so that's initially how I started was with an interest in working with people affected by HIV and AIDS and then it seemed like sort of a natural process from that to open up my practice as well to LGBT and at the time in the community it felt like there were very few people who were offering those services and I felt that those were very important services to be offered.

For Anne, her relationship with a coworker humanized minority SO identity. Anne recounted how she hadn't had much, if any, exposure to sexual minority persons growing up and that for her, this relationship was pivotal. She explained:

Growing up I was not exposed at all to much diversity and so when I first came to CITY and that was more than 24 years ago now I noticed this, a woman with whom I worked using such care with her use of the language. I started listening much more closely and later when she came to trust me she came out and I think that was the beginning of me just identifying that anyone with a different orientation was just a person, a person and then, well it made every difference.

This contact and humanizing experience worked to promote a transition to identifying as affirmative.

For Judith, exposure to a clinical issue was pivotal to her assumption of an affirmative identity. Judith gained experience working with a group of teen-aged males who had perpetrated sexual violence on others. She described how connecting with this group of young men helped her reframe aspects of her own identity as a lesbian woman
as well as how she could influence others in her role as a therapist. Judith described her realization, stating:

> You know there are all kinds of disabilities here on this earth there are all kinds of things that people have, you know being gay is not a disability. I just became more aware of my influence in working with others how potentially that could help save somebody else.

Here, Judith identified two aspects of her clinical experiences that influenced her development of an affirmative identity: seeing other people’s lives in such a way that it helped her achieve greater acceptance of her own SO identity and recognizing that she had an ability to help those who are struggling in some way.

For one therapist in particular, accessing LGBT-specific training during her doctoral program created an environment where development of an affirmative identity occurred simultaneous to development of an identity as a therapist. In other words, there was no time during Robin’s existence as a therapist when she didn’t identify explicitly as affirmative. Robin explained:

> My doctoral training was the closest you could come I think to having a specialty training in LGBT issues. I got to do almost every section of my training that I wanted to have LGB stuff as the content, I got to do that for my dissertation, for my comps, for my clinical work, for you know my outreach work, for my professional organization development. I felt like I had a whole doctoral program that was counseling psych but it was also, it was you know LGBT stuff from beginning to end.

**Being identified as affirmative by others**

Another main factor in promoting some therapists’ development as affirmative was being identified by others as such. Six therapists described a progression of becoming known for their expertise and skill working with sexual minority clients and subsequently receiving more LGBT client referrals. This process seemed to perpetuate itself in that as therapists received sexual minority client referrals, they became
increasingly skilled and comfortable in their affirmative work which increased sexual minority referrals. This increase in both comfort/skill level and referrals acted to deepen their identities as affirmative.

Judith described the significance of having a mentoring supervisor recognize her skills working with sexual minority clients. She explained:

I think he [her supervisor] was recognizing in me an ability of mine to relate to gays and lesbians and transgendered people. He told me way before that I could have a job with him someday and he said you would be so good in my agency working with gays and lesbians. While that isn't what I do exclusively, but I do, I mean I get a lot of referrals from other counselors there.

Robin spoke about clients self-referring to her based on word-of-mouth and her visibility as an openly lesbian pastoral counselor. She explained:

People find you. I mean on campus, they find you so I already had [researcher asks, ‘they find you because they know that you’re an out lesbian and that you’re therefore safe to talk about sexual orientation stuff?] Yes and on top of that you’re at a church and you’re an out lesbian. If you’re there and they’ve heard about you and you aren’t (laughs) dead yet, they might be able to come there and discuss the intersection of faith and their sexual orientation.

Addressing a community need for affirmative therapy

For five participants, a significant aspect of their development as affirmative therapists was identifying a community need for their services. This need was discovered through clients directly expressing that they wished there were affirmative therapy services available, therapists observing a lack of affirmative services, and therapists hearing recounts of negative client experiences.

For Michael, an influence on identifying as affirmative was having clients express the need for affirmative therapy. Michael recounted, “Through my casework I was coming into contact with clients who needed counseling who were wondering, ‘Where
can I go?" Elizabeth identified that an influencing factor was her own observation of a lack of affirmative therapy services. She explained, "At the time in the community it felt like there were very few people who were offering those services and I felt that those were very important services to be offered."

The main factor for the five therapists identifying a community need was hearing about sexual minority clients' negative experiences with other therapists. Hearing these stories produced in participating therapists a sense of anger and determination to make a difference for these clients. This determination worked to solidify an identity as affirmative. Michael recounted:

I had a client who was referred to me who had seen another therapist in town who openly says that sexuality is a specialty area and was telling my client that, that he was gay and that he was, that he had a small brain because he was gay and that his brain was more like a female brain and that he was overly feminine so he would have a difficult time finding a partner (laughing)...

Michael described hearing this experience as so ridiculous it was funny to him, but also discussed the gravity of a situation where clients are clearly being given such faulty and damaging information. For Michael, hearing about his client's negative experiences with therapy clearly not affirmative inspired the development of an affirmative identity and professional practice. This inspiration was also felt by Robin who stated:

It's always felt like a real commitment to sort of, it's a network model but unfortunately under the oppression level that's still in CITY, it's an underground railroad network model, really feeling hugely committed to being part of something that is still oppressed here, is still sometimes coming up against people who've really recently had conversion therapy right across town or horrible experiences with mental health services really nearby and really in recent times.

Daniel recounted a similar experience:
I’ve had clients who have come in who have had therapists in the past who never really quite understood or you know I had one client one time say his former therapist asked ‘And when did you choose to be gay?’ You know and it’s just like they, she didn’t understand where he was coming from at all and so I can relate to it and so I figure I have a better understanding than probably a lot of the other therapists.

**Specific strategies used in the practice of affirmative therapy**

Although the practice of affirmative therapy could be considered a corollary topic in this study, I quickly realized how interconnected general affirmative therapy was to specific work on SO identity. It could certainly be argued that attending to SO identity in therapy is itself a specific strategy used in affirmative practice. This theme, however, was included as separate from specific work on SO identity for the primary reason of understanding the overall context of affirmative therapy in which SO identity-specific attention is embedded. One way of understanding this “interconnected but separate” quality might be to see this theme as the larger category of “bird” while attention to SO identity is a smaller, more specific category, “eagle”. All eagles are birds but not all birds are eagles. Any attention to SO identity could be considered a part of affirmative therapy but not every part of affirmative therapy directly addresses SO identity.

Under this theme, the main strategies cited by therapists as integral aspects of providing affirmative therapy in a general sense are explored. All nine participants shared specific techniques or key elements regarding their general practice of affirmative therapy. Although certainly not exhaustive regarding what is known regarding affirmative interventions nor regarding those used by participating therapists, three main strategies were identified: use of validation and acceptance, therapists’ use of their own SO identities, and displaying and providing LGBT-related materials.
Use of validation and acceptance

The primary therapeutic strategy identified by seven therapists was the use of validation and acceptance regarding any and all aspects of the client’s sexual orientation. Validation and acceptance are difficult to operationally separate, as the two concepts rely on each other. These therapists tended to describe validation as the embrace of those aspects of their sexual minority clients’ lives that are likely to be devalued in a heterosexist environment. When this validation is communicated, it works to simultaneously convey to the client that they are approved of, normal, and worthwhile, i.e. that they are accepted (Merriam-Webster, 2010). These therapists described ways of communicating validation and acceptance that included taking time to focus on the client’s partner, making sure to use appropriate language when referring to client’s loved ones, refraining from judgment, and allowing the client space to be wherever they may be developmentally.

For Linda, validation and acceptance were communicated through her choice of language, through her general presence with the client, and through her emphasis on empowering the client. She expressed, “So for me it’s languaging [sic], it’s acknowledgment, it’s affirming that as a positive identity versus something that is hidden or shameful.” Linda also described the importance of validating the client through empowerment, stating:

My own belief around therapy is that my role is much more as a midwife and if I let, that my presence and my affirmation can help people move themselves through and then they feel like it’s more theirs than mine and that’s important to me.
Linda described how her general caring presence with her sexual minority clients conveyed a sense of both validation (i.e. recognizing clients’ worth and legitimacy) and acceptance (fully embracing who they are as sexual minority beings).

For Susan, an essential aspect of affirmative therapy is communication of acceptance of the client’s developmental space, wherever that may be. By example, she explained that some clients are concerned about how their SO identity affects others and some aren’t:

Neither is right or wrong and that’s the other piece, it’s really important in affirming work that it’s not about right or wrong it’s about different. It’s each person is unique and each person does their own process, there isn’t a process. You do your process.

Here, Susan is explaining that her clients present with a variety of responses regarding how their SO identity affects those around them and that whatever their response is, it is a valid one (i.e. it is legitimate, it is right for them) and it is one she will accept.

Susan went on to describe the importance of validating and accepting the client’s life by using words that give meaning and respect to the client’s relationships while honoring that the client may never wish to adopt a sexual minority label. She recalled an experience with an older female client who had been partnered with another woman for many years but never identified as lesbian. She recounted how important it was for her to honor the intimacy of their relationship, stating:

I may even teach it that way [communicating to the client the significance of intimacy] and talk about how deep this relationship really was and how hard it might have been to find a place for people not just now that people don’t understand, family members don’t understand but how hard it was really in their whole life nobody understood. But never naming it, but it’s just as affirming because what we’re affirming is the context.
**Therapists’ use of their own sexual orientation identities**

Another key element of providing affirmative therapy identified by six therapists was allowing experiences of their own sexual orientation identities (lesbian, gay, bisexual, or heterosexual ally) to inform the therapy process. This was achieved in a variety of ways including modeling a sense of joy and satisfaction related to one’s minority SO identity, normalizing aspects of SO identity through personal examples, and using one’s SO identity experiences to intuitively connect with subtle issues the client may not be verbalizing. Again, these were strategies that were described as part of a general approach to affirmative therapy rather than specifically addressing SO identity.

For Judith, an essential aspect of affirmative therapy was bringing her own sense of happiness and satisfaction related to her identity as a lesbian woman into the therapy experience. Judith described wanting to model a sense of hope for clients either directly, by sharing aspects of her life, or indirectly, just by being herself in the therapy relationship. Judith explained:

> I will bring up my life experiences and not just focus on them exclusively but knowing that I have gotten through certain processes myself it just helps me, I think it helps people to see they must see some kind of gleam in my eye or color in my cheeks or when I'm talking, I mean I know that, that I am, I mean I'm just so happy in my life, my relationship with my partner. I hope that that radiates in my sessions. I hope that I can instill that sense of acceptance of who I am and deep affection for myself because I care about myself, I care about my identity, I care about who I am and what I'm becoming and I couldn't do that if I didn't share with my clients who I am to an extent. I don't think I could, I don't think I could be there with them.

Daniel described how he selectively shared his identity as a gay man with clients in order to normalize aspects of their identity development. He recounted:

> Sometimes I do [share my identity] and you know I’ll say I remember those years when I didn’t want to tell or sometimes I tell when I came out
to my parents and I’ll share the story about how I always thought that mom and dad never knew and when I came out to them, ‘We’ve known for years!’ You know, this sort of stuff you know.

Anne shared how she used her identity as a heterosexual ally to connect with a mother she knew personally, who was coming to her out of fear that her daughter might hold a lesbian identity. Anne described how she helped normalize the daughter’s potential identity by explaining to the mother, “I said straight up I mean I believe in my lifetime there will be enough biologic you know scientific data that will absolutely, empirically prove that this is a biological thing it’s not a choice and she was surprised, she was surprised.” Although a solely biological explanation of SO identity isn’t espoused in any of the literature reviewed for this study; this explanation is often used to combat homophobic attacks on minority sexual orientation identity.

Some therapists described using their SO identity to intuitively “get” aspects of the client’s story that might be related to SO identity but perhaps not verbalized by the client. Susan explained:

I can meet you [the client] where you are. I know and because I think I have lived in those time periods it’s pretty easy for me to get it, like I know it and it’s pretty easy for me to be with someone who’s 18 and struggling with their parents and trying to figure out how to manage that and talk with them about being gay, that’s pretty easy.

This was also true for Daniel who explained:

Being a gay man myself I can kind of sometimes and I don’t know if this is clinically appropriate but sometimes I can kind of jump ahead because I can, I can sometimes tell where they’re going and it may help them to talk about what’s going on like whether it’s coming out to your parents or you know to your coworker or whoever.
Displaying and providing LGBT-related materials

The display and provision of LGBT-related materials in the therapy space was also a key strategy in the practice of affirmative therapy. Six therapists discussed the importance of having LGBT-related books visible on their shelves and having easy access to print and other media resources for clients’ benefit. These factors were discussed in terms of providing a place where clients could visibly see these resources which was ultimately affirming to them, regardless of whether clients explored them. Therapists also discussed the utility of using resources that clients could take with them to explore on their own. Linda described how sharing LGBT-related materials with a particular client helped ease their sense of isolation:

I shared with her a couple of movies that might be good for her to watch and, you know, gave her some reading and you know that kind of stuff, that I feel like that’s a really important part of this process because I can say that but if you can read a book, you can see a handout, or you can watch a movie it’s like Ah! I’m not alone!

Specific strategies used when addressing sexual orientation identity in therapy

In addition to strategies identified in the practice of affirmative therapy, all therapists identified several strategies specific to addressing SO identity with their clients. These were described as techniques aimed at promoting the client’s development of a healthy, integrated, positive SO identity and constructing a life authentic to that identity. Therapists discussed several main strategies used when working on SO identity with clients: assessing sexual orientation identity in therapy, allowing the client to lead the way in work on sexual orientation identity, attending to the client’s chronological age and corresponding development, attending to catalysts and cautions regarding broaching the
topic of sexual orientation identity, and addressing family-of-origin and romantic relationship issues.

**Assessing for sexual orientation identity-related issues in therapy**

Before therapists engaged in therapeutic work attentive to SO identity, all nine described the importance of assessing for SO identity issues. This assessment seemed aimed more at triggering awareness in the therapist that SO identity should be addressed with their client rather than assessing level of SO identity development. This assessment was achieved in a variety of ways including asking about SO identity on intake (pre-therapy information gathering) forms or during intake interview, attending to LGB-related names or topics introduced in therapy by either the therapist or the client, and asking the client directly about SO identity.

Michael described his process of assessing SO and gender identity at intake:

I assess sexuality in the initial assessment. [researcher: Tell me about that.] You know on our intake forms we ask sexual orientation and also gender. So from there if it’s flagged then it’s you know explored...[researcher: and the options, when you ask about sexual orientation, is you know, “questioning” one?] Gay, lesbian, heterosexual, bi-attractional, bisexual, transgender, questioning is on there as well, gender is male, female, transgender. [researcher: Okay depending on you know the information you get from that you have maybe a jumping off point?] I typically will ask clients if they do check that they’re heterosexual okay so you identify as heterosexual so your partners are primarily you know the opposite sex? And then off that if someone’s gay I like to know what their primary partners are; some people identify as gay and they’re having sex with both men and women so...

Here we see ways that specific questions on an intake form can help with opening a discussion of SO identity and allow the therapist to approach the topic with the client.

Elizabeth described how she assesses for SO identity issues in the initial history-gathering phase of therapy. She explained that because she works in a private practice
setting, she does not use a standard intake form but rather relies on verbal history taking. She explained:

There are times when in the history taking when issues will arise. In other words, I will ask clients to tell me more about you know like as they're, I'm doing the history taking and they are describing certain events oftentimes in going back to where symptoms began sometimes it seems to be related to say puberty for somebody who is starting the coming-out process or you know how those areas are related in their teenage years and so oftentimes as part of the history taking I will ask, you know tell me about your relationships and what your relationships have been like or tell me about so there are some times in the information-gathering stage where I will begin to get a sense of somebody's identity and so if anything in particular begins to stand out then I may ask at that time is that something you want to work on together or is that something you'd like to take a look at?

Here Elizabeth is describing how her early history-gathering process allows her to assess for SO identity-related issues and ask the client about whether bringing those issue into therapy is something they want to do.

Some therapists identified ways that as they work with a client in therapy they may assess for SO identity issues by mentioning names of sexual minority entertainers, discussing their own sexual minority family members, or bringing up a certain political topic and using this material to invite information from their client. Certain therapists mentioned being attuned to similar material introduced into therapy by the client. For example, Anne described assessing for SO identity-related issues by attending to political topics brought up by her client. She explained:

It [assessing for SO identity issues] has to do with those moments of subjective discontinuity when a person is really struggling or oftentimes too when someone just chooses to bring up something that's happening politically because oftentimes those are very important moments. I think of them as almost gestures you know where someone is making a gesture in a different direction and whenever I see that I'm kind of going hmm, they're thinking, they're paying attention they're waking up. Parts of them are waking up. [researcher: And so when parts are waking up, that seems
like for you a therapeutic invitation to address identity?] Definitely, definitely.

For Judith, introducing material about others seemed to feel more therapeutic than disclosing her own identity. Judith also described benefits of sharing her identity as a lesbian woman with clients, but here she is discussing early relationships with clients where personal disclosure may have been perceived as threatening to the client. In the following example she described disclosing to a client that she has a sexual minority cousin in order to observe the client’s reaction and assess for issues related to SO identity:

I think that I probably would preface it something like I think I’ve mentioned something before to kids that I have a cousin who’s gay, which I do. I’ve done that before but I usually don’t come out with who I am. I might do it on the QT [on the quiet] type of thing.

Susan described that when clients tell her they’ve been to a certain entertainment venue known to be associated with the LGB community she uses this information as assessment. She explained that, for her, clients rely on this method of bringing SO identity into therapy quite often and it is her job to pick up on the information and use it therapeutically. She stated:

[She will pay attention to] the identification of places or [researcher: you mean literally?] Yeah, places that they might have been hanging out. Like at the NIGHTCLUB, somebody says I’ve been to the NIGHTCLUB. You know there isn’t any reason to tell me you’ve been to the NIGHTCLUB to do something I mean and everybody at the NIGHTCLUB is certainly not, or performing there is not gay or lesbian but it still gives some information about that.

Certain therapists described their practice of asking clients about SO identity directly. For Linda, she related this practice to her own experiences as a bisexual woman as well as her context of working in private practice. Linda shared a belief that certain
aspects of clients’ lives where they have experienced shame, like SO identity, require a kind of directness that can be experienced as validating. She also described how working in a private practice setting seems to allow her more freedom in this area:

I think [I’m more direct] because of my own sexuality and my own exploration in that area [sexuality]. I’m a pretty direct therapist so I always ask about sexual orientation, I always ask about substance abuse, I always ask about spirituality. I ask about some of the nontraditional routes that people ask about because those are just parts of who we are and what people bring in so...[researcher: Have you always done that?] I think I’ve gotten stronger in that probably the last ten years, you know I’ve been in private practice for 14 years now and I’m not in an agency where I have to be careful.

Allowing the client to lead the way in work on sexual orientation identity

Although some therapists described addressing SO identity before the client may bring up the topic, all identified the importance of allowing clients to lead the process of therapeutic work on SO identity. The described significance of this aspect of work on SO identity was connected to recognition of clients’ vulnerabilities as they explored the possibility they may hold an oppressed identity, wanting to promote the clients’ autonomy and empowerment, and preserving/promoting a sense of trust in the therapy relationship. Based on the frequency of this theme occurring in the study and all nine therapists’ expressed enthusiasm for the importance of this theme, it became the most significant theme of the study.

Allowing the client to “take the lead” throughout the psychotherapy process is consistent with humanistic principles of providing good therapy (Rogers, 1940; Raskin and Rogers, 2000) and with those aspects of affirmative therapy related to validating and empowering the client. In this case, however, this theme is specific to participating therapists’ attention to SO identity. For Elizabeth, allowing the client to lead the process
of addressing their SO identity served to promote the likelihood that the topic would be
broached only when client was truly ready. She explained:

I think it’s [addressing SO identity] on an as-needed basis and sometimes
that’s something that comes out in the early stages of therapy right away
and sometimes it’s something that clients aren’t ready to address until mid
or later stages of therapy so I really try to tailor that to an individual’s
sense of readiness in terms of when they want to address that, if they want
to address it.

Elizabeth went on to explain: “…so it’s [SO Identity] addressed only if it’s an issue and
my preference is always for it to be addressed by the client, not by me if there is an issue
that seems to be identity-related that’s causing symptoms or causing difficulty in
functioning…”

For Judith, allowing the client to lead the process of addressing SO identity in
therapy helped create an essential atmosphere of trust; an atmosphere that would be
violated if she addressed the issue before the client was ready. She explained:

I would not ask a person about their sexual orientation, I would not come
out and say well, have you ever thought you were gay? I would never say
that, I think that would just be an extreme turnoff to somebody; I think
that they have to kind of like enlist your trust and be able to tell you first.

Some therapists discussed this issue in terms of being careful not to influence a
client’s process of SO identity development by discussing their own. With some humor,
Robin recounted how she had to monitor her enthusiasm for her lesbian identity so that
she didn’t diminish her client’s lead in their own SO id process, recounting:

I think because earlier the hottest and newest topic in terms of forming my
own identity was coming to that place of, okay, I’m a lesbian and also
what does that mean and how does that you know get integrated into
everything else? It had the good effect of making me brave to do some
things and raise some questions places but probably clinically there was
some times of overemphasis or assumed enthusiasm that like everyone
else’s level of priority of this identity question you know, if it isn’t on
their top priority list, it ought to be because you know, if you haven’t
looked at it and you haven’t gotten where you feel better about yourself or you’re still feeling pretty oppressed or not feeling good about yourself as a result of this identity well we can sure fix that!

Here, Robin related how, for her, her SO identity was a very salient (if not the most salient) aspect of her overall world and how, if not careful, discussion of her SO identity could have disrupted key aspects of the client’s SO identity development process.

Similarly, Linda explained how she is mindful of her decision to disclose her identity as a bisexual woman to a client, stating:

I want to choose my words carefully there, I probably I only reveal my story if it’s going to enhance the affirmation, not if it’s going to I mean I know this is typical but in any way that’s going to take away from, like I would never disclose my own orientation if someone was in the process of exploring theirs, initially. Because I’ve watched people, I mean people really hang onto therapists’ words, and so I would be very affirming of that experience of being gay or lesbian but I wouldn’t, I probably wouldn’t put my own orientation in it until that had become a little more solidified in their own minds. [Researcher asks, because you wouldn’t want them to perhaps miss a step in their own journey? to which Linda replies, yes.]

**Attending to the client's chronological age and corresponding development when working on sexual orientation identity**

Eight therapists identified that a central element of addressing SO identity with clients was considering their client’s age and the general aspects of development corresponding to that age. Attending to these factors helped therapists assess the client holistically and allowed them to adjust their SO identity-specific interventions to better fit their clients. Some therapists described shifting the language they used related to SO identity to better suit the client’s age in order to facilitate the flow of addressing SO identity in therapy and promote the therapeutic alliance. For example, one therapist described how being more flexible in her SO identity-related language (i.e. not discussing the client’s identity as if it has been solidified) helps her younger clients feel safer in the
therapeutic relationship. In addition to adjustments made regarding language, some therapists also discussed changes in their conceptualization of SO identity development based on their client's age. For example, one therapist discussed her tendency to view her younger clients' SO identities as more fluid than older clients.

Both Susan and Robin cited examples of how they adjust the way they talk about SO identity to better fit the client's age and general development. For example, Robin explained that whenever SO identity is an issue to be addressed in therapy, she believes it is essential that she discusses aspects of her own SO identity. The ways that she does this, however, are influenced by the client's age and development. Robin explained, "I will adjust that [how she discloses her own identity] according to age group, sometimes when people are pretty young in their questioning the words they're ready for or the concepts they're ready for, I'm as gentle as possible." Robin added that it has been her assessment that younger clients are frequently less aware of others' issues generally and identity-related issues specifically and thus she still makes the choice to disclose her own SO identity but would do it in a more subtle way than she might with an older adult person.

Susan discussed how the client's age influenced her SO identity-related word choices, stating:

I do it [address identity] differently with different people. Young people use, I would probably use the word 'gay' more with women, with young people, than 'lesbian'. Not that they don't know what a lesbian is but they talk about being gay or they talk about being queer and they're gay and queer. If somebody is 60 and talks about having been in a relationship for 15 years and that person's ill and family has come for them; I don't use any of those words because none of those words fit. The relationship is what we just talk about, what it was like to live in such a close intimate relationship and not feel now that you can participate with the family or figure out how to stay connected.
Susan expounded on the connection between the client’s age and language she chooses when addressing SO identity in therapy. She explained:

Well I think we are talking about identity but identity, if someone today is 60 and their partner maybe was 72 and the partner has a disease and the family has come for the partner; these women might, until I hear from the client their own language of their identification, they identify, it’s still really probable they identify personally as a couple in their own home in their very own private life but wouldn’t identify outside that, maybe have one other couple as friends, might have known them and so I don’t use the word, I don’t say ‘lesbian’, I don’t say anything. Because those words can be off-putting if they’ve not used them and yet at the same time the affirming piece is to identify their relationship and their commitment and their intimacy and their concerns and even their love although love is something I’m really cautious about using that word, intimacy is a stronger word for me. It says more than love.

Judith discussed stylistic changes specific to addressing SO identity that she might make according to a client’s age. She explained that when working with adolescent clients around issues of SO identity she is much more direct, as it is her experience that this style helps to engage them. Judith explained:

You kind of got to be frank, you’ve got to get them right while they’re there because if the kid’s even willing to consider coming in for counseling you’ve kind of got to grab it while you can because a lot of teenagers won’t come in for counseling.

Michael also discussed an SO identity-related therapeutic adjustment related to the client’s age. He discussed how he is much more cognizant of honoring the validation adult clients may experience from identifying as gay or lesbian and conversely, his adolescent and young-adult clients may resist adopting a label at all. Michael explained:

With my older clients they tend to really grab onto that gay identity or whatever it is you know what I’m saying. Some of my younger clients are like look I don’t want to be gay I don’t want to be bi I want to be you know whoever I want to be me. I have a name I’m just a human being.
Attending to catalysts and cautions regarding broaching the topic of sexual orientation identity

All nine therapists discussed ways that they attended to cues from clients to either address SO identity with them (a catalyst) or back off from the topic (a caution). Catalysts included the therapist’s intuitive sense of SO identity saliency for the client while cautions included the therapist’s observation of discomfort in their client and making assumptions about how the client may or may not identify. Other catalysts and cautions are reviewed in the remainder of this section.

Some therapists identified that an important factor in deciding whether to address SO identity is their client’s non-verbal communication. This communication might include the client's body language/posture, what is not being said in a session, a noticed hesitation, muscle agitation, or facial displays of emotions such as disgust or shame. Some therapists described using their observations of clients’ non-verbal communication to delay addressing SO identity as potentially threatening to the client while others discussed use of non-verbal cues to alert them to the necessity of addressing potentially SO-related issues with the client. Betsy described how she might use her sense of a client’s non-verbal communication to attune her to the necessity of temporarily holding off the topic of SO identity. She explained:

Well some of it’s that nonverbal discomfort that you can sense when they’re getting close to something that’s, you know you’re getting too close or they’re stepping around an area that they don’t want to walk in yet, you know they start squirming and looking you know (makes expression indicating anxiety) and it’s like okay we’ll let that sit for a little while you know, over there.
In another example of using non-verbal communication as a cue, Susan described using what she deemed “missing” information in a client’s story to prompt her to address SO identity as a salient issue for the client. She explained:

As you listen even in the very first portion of somebody’s first hour and you hear, I mean there’s so many cues. I, if you hear only pronouns and you’re not hearing he or she, or whatever and at that point I might and usually I’m very direct and I might say, ‘tell me more about your partner’ and then almost always people will tell me about their partner.

Missing information was also salient for Linda who stated, “It’s about what’s not being said in a session too. I guess that’s vague but if someone’s coming in and not talking about their partner or not talking about their relationships or not talking about being sexual.”

Some therapists also cited client’s verbal content as significant regarding the decision to address SO identity. Examples of verbal content included the client’s initiation of discussion around SO identity, how many times a client has referenced something perceived to be connected to SO identity, or the client’s inflection when discussing SO identity-related material. Elizabeth described paying attention to her client’s verbal “signals” to let her know that approaching the topic of SO identity would be therapeutic. These signals took the form of the client’s choice of topic or particular questions voiced by the client. She explained:

When the client begins giving signals or indications verbally that they’re ready for that [talking about SO identity]. In other words, if a client starts referring to issues around their identity or discussing problems that appear to be arising directly out of that. Again that’s usually based on disclosure of the client and things that help me to know, that indicate a readiness is when they are beginning to ask particular questions or make observations and so by taking their lead typically is when those things would be addressed, when they come in, you know ‘I’ve been thinking a lot about this’ or ‘I’ve been wondering about that’ or you know ‘this happened this week and it made me think about that’.
Jeff described his experience relying on clients’ verbal content to address SO identity if that is an issue they are directly talking about. He explained, “My experience has been that most clients that come in if they wanted to discuss it they bring it right up. I don’t feel like I have to dig I mean very seldom do I feel like I have to dig.”

Use of their intuitive sense regarding SO identity saliency for the client was also cited as a catalyst for addressing the topic in therapy. Therapists described paying attention to overt and covert cues that might indicate saliency but also using their own insight and knowledge perhaps less connected to rational evidence. Describing the ways that she assesses whether to address SO identity with her clients, Linda described use of her own “intuitive process” to inform her decision. She explained that she uses her observation of a client’s discomfort as well as her intuitive sense to decide whether SO identity might be an issue to address. Linda explained:

> Like there’s a lot of times when I just have a sense that that’s an issue. I worked in a clinic with another therapist and we’d often do supervision and I’d say, ‘You know I think you’re working with a gay client there.’ And she’d say, ‘No, no.’, you know when we’re doing supervision and she’d come back and she’d say, ‘That person was gay. How did you know that?’

Betsy described this intuitive sense as “reading between the lines” of what her clients are saying. She explained that many clients will not come in directly stating that SO identity is something they want to discuss in therapy, stating:

> Not so much [clients talking about SO identity] well here’s my life and here’s how I learned to identify with ‘blah’ because most people don’t come in able to do that but just talking about whatever it is they brought in, you know, to the room and using that one filter of how do they see themselves and how do they conceptualize who they are in what they’re telling me you know not literally, but the subtext, the stuff that you get between the lines.
Although some therapists indicated comfort using their intuitive sense as a catalyst to address SO identity with clients, some also described being cautious around making assumptions about their clients’ SO identities and/or its associated saliency. Assumptions were described as potentially ill-informed assessments based on information such as style of dress or physical mannerism. Some therapists described ways that they avoided bringing up the topic of SO identity with clients if they thought they might be making an assumption rather than using information like the client’s verbal content or their own intuition.

Robin discussed this issue in the context of assuming that just because a client may be openly discussing certain behaviors, the therapist shouldn’t assume they are identifying in a particular way or that any SO identity is necessarily salient to that client. She explained:

If people [clients] are really seeming to come from that context where identity itself, they don’t necessarily see sexual orientation as an identity or anything that they have to label in any way and sometimes depending on how already articulate and politically active they are you know they might throw my storybook right back in my face and be like, ‘You know this is, this is some oppressive junk that you know happened 30 years ago and this was really nice but you know it’s 2008, and take your old, you know, dusty lesbian politics and you know leave them off of my life.’ And you only need one of those to like (laughs) remind you to you know check before you make assumptions.

*Addressing family-of-origin and romantic relationship issues as they relate to sexual orientation identity*

All nine therapists identified multiple strategies related to addressing family-of-origin and romantic relationship issues in the context of SO identity. Addressing these issues included working with family members of sexual minority persons to better understand aspects of SO identity so that they could ultimately respond more
empathically to the sexual minority person (thus in some cases the client was not a sexual minority person but the family member), helping clients manage SO identity-related conflicts in their family relationships, facilitating exploration of the ways that issues related to SO identity affect romantic relationships, helping clients with transition out of heterosexual relationships, and helping clients develop and maintain healthy romantic relationships.

Some therapists emphasizing the importance of romantic relationship-oriented work with sexual minority clients did not categorize this work as specific to SO identity. However, in discussing these issues with my advisor, it was agreed that the kinds of transitional issues discussed by some therapists (supporting clients as they navigated transition out of heterosexual relationships for example) were definitely connected to SO identity development according to the literature. For example, in Coleman’s (1981/1982) Developmental Stages of the Coming-Out Process, the fifth and final stage (Integration) is characterized by an adoption of a sexual minority identity inclusive of both public and private aspects of self. It could certainly be posed that the sexual minority clients who may acknowledge realization and adoption of a sexual minority identity and who may have quite positive feelings about that identity are still dealing with identity development issues as they build a non-heterosexual romantic partnership. These issues could be viewed as “stage five” issues through the lens of Coleman’s model. We also see the connection between romantic relationship building and SO identity development in Troiden’s (1989) Formation of Homosexual Identities Model where characteristics of his fourth and final stage (Commitment) include romantic relationship development with same-gendered others. The therapists who cited attention to their clients’ romantic
relationships as important described related strategies in numerous ways that were centered on helping their clients develop and maintain healthy romantic relationships which thus promoted the latter-stage work of their SO identity development.

Helping family members understand aspects of SO identity was key for Susan who worked for a time in a college counseling center. She described a situation where same-gendered sexual behaviors occurring on an athletic team were discovered and caused alarm for numerous parents. She described working with these parents on better understanding these behaviors as they related to SO identity in order to reduce fear and misunderstanding; increase empathic, rational response; and ultimately help the students. She stated, “It [the situation and the intervention] didn’t turn out perfectly for everyone but it turned out positively for most of them where parents had more language that they could talk with their student.”

Increasing parents’ understanding and empathy was also cited by Robin as a central aspect of working on SO identity in therapy. She described a particular instance when she worked with a parent on understanding their child’s behaviors from an SO identity-related perspective. For Robin, it was important that she provide the parent with information about SO identity development so that the parent could contextually understand that what their child was doing was not necessarily willful engagement in “dangerous” behavior, but was actually adaptive. Robin recounted how the parent asked her:

You know like what about all this has to be so overt like I love this person and I want to be there and I want to understand this and but you know this is so overt and loud and scary to me and like you know we have to have you know pictures and clothes I consider almost cross-dressed and you know out public displays of affection on National Coming-out Day you
know pictures in the paper and you know why does it have to be this way and isn’t this a little too much and isn’t this dangerous?

From a therapeutic perspective, Robin saw her job as hearing and validating the parent for caring enough about her child to seek help and then helping her understand SO identity in a way that helped her to make sense of the behaviors so she could better connect with her child. Robin explained that she told the parent:

This is really important to get to sort of this place that it might go overboard for a little while, it might result in you know painting your house rainbow colors or you know something that you’re going to find too loud but in order to come out of this level of oppression and internally horrible stuff coming to this really buoyant place where everything is loud is part of it and it won’t probably stay that way but you have to get it how dark it is before that and then how like people sometimes literally felt like they went from death to life.

Anne also recounted her experience helping a mother understand SO identity so that the mother’s irrational fear was reduced and she may better respond to her daughter’s needs. Anne recalled that this mother came into therapy reporting a fairly homophobic reaction to the suspicion that her daughter might identify as lesbian. Anne explained that her goal with this woman was to challenge her erroneous beliefs with some education regarding SO identity development. In this case, Anne focused on the biological aspects of SO identity development as the most effective route to challenging the mother’s homophobia. Anne explained, “I said straight up I mean I believe in my lifetime there will be enough biologic you know scientific data that will absolutely, empirically prove that this is a biological thing it’s not a choice and she was surprised, she was surprised.” For Anne, this explanation seemed to help reduce the mother’s anxiety and fear related to the possibility that her daughter might not be heterosexual, which could then work towards promoting the mother’s acceptance of her daughter.
For some therapists, family-of-origin issues were discussed mainly in terms of ruptures in family relationships as connected to the client’s SO identity. Examples of these kinds of ruptures might include clients disclosing their SO identity to one parent and not the other and how this creates a triangulating tension between the parents, dealing with threats or verbal hostility from family members regarding the client’s SO identity, or navigating SO identity management in different family settings where the client feels less accepted. For these therapists, addressing SO identity-related family ruptures included helping the client navigate the complicated and sometimes painful path between development of a positive SO identity and maintenance of close relationships with family-of-origin members.

Daniel explained how in his work attending to family issues related to SO identity it is important for him to help the client explore their experiences around disclosure of their identity to family members (particularly parents or other primary caregivers). Daniel described helping clients who had not openly discussed their SO identity with parents explore the variety of outcomes they might experience if they did disclose. He also discussed his role as a kind of “reality check” for clients who may have been in cohabitating same-gendered relationships spanning several years and various locations who believe their parents have no idea about their SO identity. Daniel explained:

I’ll ask but it’s not all the time because it depends on the person, but how long they’ve been out. You know are they out to their family? I mean I’ve had couples who, you know, their parents think they’re just roommates so then we’ll explore those issues, explore the issue do you really think that they don’t have a clue?

For Betsy, it was important to help clients understand the ways that their SO identity-related behaviors may be contextually healthy but might produce tension in their
family-of-origin relationships. For example, as many sexual minority clients progress in their SO identity development, they experience what is commonly referred to as the “pride” stage (taken from Cass, 1979). In this stage of LGB identity development, clients are less concerned with acceptance from society and may experience a new, joyful energy as they feel free to be more openly “out”. One therapist described this stage as moving from death to life. For Betsy, it became important to help the client embrace this identity-related energy while helping them understand how the new behaviors associated with this stage might affect family members. She explained:

Sometimes I feel like I’m in the role of just holding onto the reins and trying to get them to slow down a little bit because they’re just, you know running off almost helter-skelter and not thinking about consequences and, slow the heck down you know, just because you’re so happy doesn’t mean your mom is.

Regarding attention to the romantic relationships of sexual minority clients, Daniel recalled his work with a male couple of 15 years. He described the couple as “very closeted” regarding their identity statuses with their families-of-origin and their employers. For Daniel, it was essential in his work with both men to address how their individual SO identities affected them in their partnership and how they might jointly create a positive identity as a gay couple. Daniel spent time listening to the ways SO identity affected this couple on a day-to-day basis and integrating this information into the therapy. Daniel explained:

Sometimes I’ll ask but it’s not all the time because it depends on the person but how long they’ve been out. You know are they out to their family? I mean I’ve had couples who, you know, their parents think they’re just roommates so then we’ll explore those issues.

Daniel went on to describe helping the couple explore their relationship, asking questions about each person’s definition of intimate partnership in order to validate the relationship.
and promote a sense of unified identity as a couple. For example, Daniel asked the couple, “What makes you, what makes your relationship special you know, what is it that you do with each other or for each other that seems to make this relationship a relationship and not just roommates?” For Daniel, helping this couple explore these kinds of questions facilitated their individual exploration of identity and promoted the creation of a positive identity as a couple.

Linda also described in her work with sexual minority couples the importance of addressing SO identity both individually and collectively. She explained that she believed it was important to help sexual minority couples “develop as strong of a community as they can” so that they could better honor and validate their own relationship. For Linda, this connection to community seemed to be part of helping two sexual minority individuals form a unified, positive identity as a couple. She explained, “The more we bring our relationships out into the present and out of this hidden realm, the more conscious we can be in our relationship.” Linda also explained the significance of addressing the way(s) that individual SO identity can affect the partnership of a sexual minority couple. She stated:

Often when I’m working with couples there’ll be one person who’s more comfortable being out than the other and so how do we create, keep working on affirming both people’s experience? Perhaps the fear in the person on the one side and the person on the other side is saying I want us to be more out in the world and then how do you, you know not necessarily come out if you’re not ready to do that, but how do you find other allies, support, advocates for you in this community that can support you in being in this relationship?

Several therapists identified that central elements of their affirmative work included being sure to actively affirm not only the client but their partner as well, helping the client understand the dynamics of an abusive relationship, helping the client cope
with the loss of a relationship, promoting the client’s communication with their partner, and helping the client manage the daily issues arising in their romantic relationship. In discussing what is central to her idea of affirmative practice, Linda explained:

Another place that I didn’t talk about though that I feel is really really important is when I work with gay or lesbian couples I feel like that’s a whole different area of affirmation. But how do I as a practitioner affirm their relationship and how do I encourage them to get support and develop support in their lives for affirming that relationship and I think that’s a really another important piece.

For Linda, inclusion of the client’s partner in her scope of affirmation was vital to her sense of what is therapeutic. The client’s partner does not need to be present in the therapy to be affirmed, as Linda described how simply asking the client about their partner acted as a way of affirming their relationship. Although not cited as specific to promoting a healthy SO identity, this kind of affirmation of the client’s romantic partner works to promote the latter-stage SO identity work discussed in the opening of this theme.

For Daniel, relationship issues comprised the bulk of therapeutic topic in his affirmative practice. He stated, “Actually most of the gay clients I have are not even around identity issues it’s more in relationship issues, about how to act and/or react in a relationship.” He went on to discuss his work with a lesbian-identified woman struggling with her intimate relationship. Daniel explained:

I’m working with a young woman now who’s, she’s probably a LATE TWENTIES lesbian, she’s out to her family, she’s out at work but she’s in this awful relationship and my focus is to help her to take a look at what is, what constitutes a healthy relationship. You know, is abuse tolerated? You know, how much of this, how much of this are you going to take?

Throughout his interview Daniel highlighted several issues important to his affirmative work: helping his client understand what might be a cycle of abuse occurring in her
relationship, exploring the daily issues that arise in an intimate relationship, and possibly helping a client move towards ending a hopeless relationship.

Judith also discussed the significance of helping clients manage relationship issues in her affirmative practice. She recalled how she often discovers in therapy with sexual minority clients that relationship problems may not be the presenting issue but then take a central role in therapy. Judith recounted her work with a particular client: “She came in and the reason she came in is because she was talking about her MEDICAL ISSUE, but that wasn’t the problem; the problem was her and PARTNER.” Judith explained that at that point in the therapy, that the focus became helping the client explore her wants and needs in the context of her intimate relationship. Again, with both Daniel and Judith, their attendance to their clients’ romantic relationships helped clients build positive lives around their SO identity.

Another way that some therapists described working with clients to build lives around their SO identity was helping them transition out of heterosexual romantic relationships. Linda, Elizabeth, and Judith all identified that a key element of practicing affirmative therapy was helping their clients who may have been in heterosexual relationships end these relationships or explore the possibility of doing so. In some cases, these issues involved the need to address parenting responsibility and/or manage a previous partner’s negative feelings about the ending of a relationship. Elizabeth explained:

People will come to me who have realized maybe midlife or in their 20’s say that they’re beginning to come out to themselves and they may be married and so their biggest concern is how to work through issues in unwinding their marriage and taking care of their families and it’s not about huge concern that they’re gay it’s about how do they make these life transitions in a caring way so that they can be authentic to themselves.
Elizabeth went on to state:

A recent client that I have been working with is someone who realized in her mid-20’s after being married and having two children that she is a lesbian and her marriage had been really pretty dead for a long time and so what she has been working on doing is navigating her way out of her marriage and exploring who she is in relationship to another woman.

For Elizabeth, an essential aspect of her affirmative work was displayed here: supporting her client as they navigated multiple changes related to ending a marriage, building a new romantic relationship, and parenting their children.

Judith recounted the affirmative therapy she provided to a female client who realized mid-therapy that she identified as lesbian and subsequently ended her heterosexual marriage. Judith described the complicated issues and mixed feelings she had in helping this client with her transition. She explained:

Within four months she left her relationship with her husband and she came out and she is now divorced and living the life that she, hard life because she doesn't have anybody but she’s realizing, she has a gay aunt she has other people in her life who can support her. Anyway that was one of my, I'd say, biggest accomplishments was to know that somebody was close to leaving their husband and recognize who they were. Not that I want people to break up over it but how can you not when you realize that you're in a marriage where you're not able to be who you want to be?

Judith described positive feelings in helping this woman find an authentic self but also recognized the hardships the client faced in making this transition.

Linda described a similar situation in therapy where she worked with a male client who was just beginning to explore areas of his life related to SO identity. This exploration coincided with the ending of his heterosexual marriage and Linda explained the necessity of integrating all of these elements into her delivery of affirmative therapy. She explained:
The man that I spoke about, I mean he is just getting a divorce now and is you know adamant that he’s not a gay man and yet everything in his life is pointing to that really being a place that he’s on the edge of exploring and I, my role is just to keep normalizing that whatever experience he’s having is probably leading him into the places in himself that he might not know yet.

Main therapeutic functions of developmental models of LGB identity:
Providing hope and conceptualization

In discussion of use of LGB models of identity in therapy, two main functions of the models were identified by the five therapists who had experience with the models: providing clients with a sense of hope and assisting therapists with multiple facets of client conceptualization.

Providing hope

Four therapists reflected on identity models' utility in providing clients with a sense of hope and possibility for the future. In general, these therapists appeared to be focusing on providing this sense of hope through discussion of aspects of the developmental models of LGB identity with their clients, particularly illustrating latter stages of development. One therapist discussed how her exposure to developmental models of LGB identity development infused her with hope regarding her own SO identity which she was then able to model vicariously for her clients. Hope was also provided through use of the models to normalize aspects of SO identity development which worked to decrease the client's sense of isolation in their experience. One therapist explained how exposing her clients to literature related to SO identity development acted to communicate hope by placing a sense of value on the information. Her message to clients was that the scholarship was created by those who took the courage and time to do so, that the scholarship is valuable, and thus the client is valuable.
Elizabeth explained that exposure to a model of lesbian identity development gave her a sense of hope not only for clients but for herself. She explained:

It [an unspecified model of lesbian identity development] helped me to place where I felt I was on that continuum and what I remember being especially poignant about learning this model was realizing that this, I think there were five stages of her model, and that this fifth stage was this place where you actually are proud and happy about your own development and so I was very encouraged by that at that time; that this was a stage that could be attained.

For Elizabeth, contact with this model first functioned to help her in her own identity development and later influenced her work providing affirmative therapy, helping her communicate this hopefulness to clients. Elizabeth illustrated the way she shared this sense of hope with clients stating, “This [SO identity development] is really really hard right now but here’s what you have to look forward to. You know this does get better and here are some of the ways that it can get better and here is, you know also to instill hope.”

Robin reflected that she uses LGB models of identity development in therapy particularly when she detects a sense of isolation, loneliness, and fear related her client’s SO identity development. She explained:

Probably one of the bigger things that’ll sort of trigger that [use of LGB models of identity development in therapy] is no matter whether people are just clarifying and coming to identity or they kind of have been for a while, when they’re doing the like ‘I’m feeling really isolated in my experience’ thing, you know, and they’re talking about how they don’t know if anybody else feels the way they do or they don’t know if anybody else looks at themselves the way they do, whatever, that seems like an opportune moment to say well you don’t have to define it the same way but you might find community at least by reading if not in person, by knowing that the experience you’re having for some people is labeled something and that label may include actually an identity that goes with the label and may come to them by some process of development which could be conceptualized various different ways but you know people do tell their stories about it and they do sort of have a progression and you might find yourself having a path or a story that you are supported in or find community in by knowing other people stories.
Anne explained that the mere act of putting one’s theory regarding positive SO identity development into the public realm acted to communicate hope to clients. She explained that whenever she shared aspects of SO identity-related literature with clients, this was instilling hope. Anne stated:

That anybody would have the courage to put their own belief system out in such a public viable way I mean that’s an act of courage and it doesn’t matter if someone does that physically in writing. I mean it has to do with, are they going to face themselves with honesty and take risks even when they’re afraid?

**Assisting with client conceptualization**

Another main therapeutic function of LGB models of identity cited by three therapists was assisting with client conceptualization. In general, client conceptualization is influenced by therapists’ theoretical orientations and certainly not limited to a client’s SO identity. For this theme, however, conceptualization focused on how these therapists think about their clients generally and specifically in the context of the client’s SO identity. For example, client conceptualization might include thinking about the broader ways a client may have coped with long-term oppression and invalidation regarding SO identity and specifically, how they are coping with these issues in their workplace.

Conceptualization, particularly as discussed by these therapists is closely linked with the therapist’s assessment of the client’s SO identity development. For example, in order to generally form a concept of the client’s SO identity, a therapist may need to simultaneously “assess” or assign an importance to (Merriam-Webster, 2010) how that identity has developed and shaped the client’s current functioning. In other words, the ways that therapists think about or conceptualize the client includes making assessments regarding the client’s development.
Some therapists described how developmental models of LGB identity provide them with a framework to assist them with conceptualizing their client’s SO identity development which ultimately helps them in choosing appropriate strategies to meet their client’s identity-related needs. The models outline specific behavioral and emotional markers regarding SO identity development that might include being confused, making contact with other sexual minority persons, and feeling proud. Therapists described how knowledge of these markers helped them conceptualize and assess aspects of their clients’ SO identity development.

Michael described how knowledge of LGB identity models, the Cass (1979) Model particularly, helps him in his immediate client conceptualization regarding SO identity. Regarding why he uses the Cass model more than any other, Michael explained that it was connected to its usefulness regarding client conceptualization. He explained, “Yeah, they [other LGB identity models] all seem similar in some ways, so the Cass model I think is laid out a little bit more, it’s a better fit for me to kind of like conceptualize the process in my mind.” Michael went on to further describe his thought process regarding use of the Cass model to conceptualize aspects of his clients’ SO identity development explaining:

I guess that in my mind I’m conceptualizing okay where is the client at? [researcher asks, ‘you do that right from the beginning?’] Yeah, where’s the client at? I mean the Cass model is helpful for that and, are they at confusion, are they at acceptance, are they at synthesis, on that spectrum…

Michael also described how the Cass (1979) model provides a kind of lingering influence independent of directly showing the client the model or regularly reviewing it himself. Michael explained, “I mean I don’t sit with a client and say, oh you’re in the confusion stage, I mean that’s ridiculous, so it’s not, it’s more for my benefit to help me
gauge, okay, where is this person at?” This kind of influence was also described by Elizabeth and Susan. Elizabeth described how she has internalized information from the models but, like Michael, wouldn’t show the information to a client or even think of herself as directly applying a stage-theory of LGB identity development to her clients. She explained:

In terms of working with actual models where that’s concerned I think that again for me, that those models have become part of my repertoire, but an internal part so that I’m not consciously applying models. I think that they’ve sort of been taken in as a part of who I am as a therapist but I really work on tailoring my work to the individual development of the person and where they are so I don’t think of myself as consciously identifying where they are in particular stages. I’m thinking of where they are in their own stages.

Elizabeth went on to provide more detail about how she uses developmental models of LGB identity when conceptualizing her client’s SO identity. She explained:

One thing that I really like to do is to illustrate somebody’s progress and so when somebody mentions a way that they have mastered a new set of skills one of my favorite things is to say, ‘Gosh, I wish I would’ve had a video of you today saying this so that I could have shown this to you six months ago and so just to really mark as we go the fact that wow you can do this now. You would have never been able to do that when we met and look at what you’ve done.’ And to really reinforce that progress and so and to mark it in that way versus saying you know, ‘Wow I think you’ve reached Falco’s third stage.’ [Researcher asks, ‘I see so it’s almost like using each client’s journey as its own developmental model?’] Exactly, I mean I’m aware of those stages in my mind. [Researcher asks, ‘Right, so it (the model) informs you kind of off the page?’] Yes [Researcher asks, ‘And helps you to then illustrate to the client look at the way that you’re developing and growing?’] Yeah.

Of the therapists who reported use of developmental models of LGB identity in therapy, Michael most clearly articulated ways that he linked client conceptualization to intervention. Michael described multiple examples of this link between conceptualization of the client’s SO identity development and choosing a particular
intervention. Michael described using Cass’ (1979) model to help identify clients in first stages of SO identity development, characterized by clients’ first awareness of ways that a sexual minority identity may apply to them. He explained, “And if they’re at confusion [Cass’ first stage of minority SO identity development] what’s popping up sometimes, I do help clients explore how has heterosexual privilege affected your ability to kind of feel comfortable in the community, you know, what does that mean?” In this example, Michael may be referring more to Cass’ (1979) stage two (Identity Comparison)-related tasks but he is clearly linking his conceptualization of the client’s SO identity with his choice of therapeutic strategies centering on providing the client with education regarding the effects of societal heterosexism. Michael also highlighted that the Cass model was useful for him particularly in being mindful of clients in earlier stages of SO identity development because of his own perception as someone in a later stage of development. Michael stressed that he wanted to be mindful of choosing a strategy more appropriate for his client rather than one influenced by his own SO identity development.

Michael also explained how he might recognize someone in Cass’ (1979) last stage of SO identity development, characterized by deep acceptance of one’s minority SO identity and feelings of connection to the world overall including both heterosexual and sexual minority others. This stage is also characterized by the possibility that a particular event in the life of a sexual minority person might bring their SO identity to the forefront of their awareness, as Michael touches on. He explained:

Obviously someone who’s in the synthesis stage probably doesn’t have a whole lot of issues around their sexuality, or they may. There may still be some stuff that pops up for them they may be well, they may be well integrated with their sexuality in the community and have a partner. There may be some stuff that pops up still about you know ideas or thoughts that from your past in regards to family you know, or there may be some
(pause) yeah, there may be some stuff that’s still kind of hanging out there, you know cut offs from the past.

Michael went on to explain how, even in later stages of SO identity development, negative beliefs about SO identity may arise. Michael described how he targets these dysfunctional beliefs fueled by “cut offs from the past” with cognitive strategies aimed at challenging those beliefs.

**Therapists’ recognition/identification of models’ limitations**

The five therapists in this study who did use LGB models of identity in their work with clients all acknowledged and identified some central limitations to the models including the models’ tendency to present SO identity development as too simplistic and linear and the models being perceived by some therapists as clinical and depersonalizing. Additionally, some therapists described a critique that related more to how the models might be used rather than the models themselves. These therapists explained a perception that information presented in the models may be adhered to inflexibly which could potentially impede the process of therapy or worse, harm the client.

**Models as linear and limited**

Four therapists reflected that, in reality, SO identity development does not progress in the neatly defined stages that might be implied in most developmental models of LGB identity. In addition to the question of linearity, therapists identified models’ failure to account for the ways that lifespan issues intersect with and influence SO identity. Therapists explained that many of the nuances of SO identity development that they had either personally experienced or witnessed in their clients’ experiences are not accounted for in the models.
For Michael, his experience working with multiple sexual minority persons in therapy allowed him to observe that their SO identity did not follow the stage-like progression outlined in most LGB identity models. Michael reflected that at times his clients seemed to skip forward in stages of SO identity development and at other times return to earlier stages. Michael explained:

I’ve seen other [LGB] models that have been structured similar to the Cass model and some of them, I just, I think the stages are fine, it’s a natural progression. Some people I don’t think that people move through those like that, you know, I mean sometimes people do you know sometimes people move through those, sometimes people jump, sometimes people regress.

Michael also succinctly explained, “Clients experience shit that’s not on there [reflected in the models]. You know and whatever that is, that people are where they’re at.” With that brief statement Michael described how some of the nuances of SO identity development are not reflected in existing LGB identity models and that this absence shouldn’t devalue the client’s unique experience of SO identity development.

Susan also reflected on her own SO identity development and how it did not seem linear. She explained, “I’ve been through six steps 24 times, you know, I mean really. What I know is each person’s process is their own and then it may skip a step or it may do a step twice.” Here Susan identified a critique of LGB identity models similar to Michael’s. Although both Susan and Michael found the models useful for client conceptualization, they recognized that SO identity development occurred in a non-linear fashion not reflected in the models.

In addition to concerns about linearity, this theme also reflected on inherent limits in stage-models of LGB identity. By “inherent”, I mean that the very nature of a progressive model of development (i.e. presence of clearly defined stages, limited in
length in order to be understandable and publishable in a journal or book chapter) prohibits its ability to fully address the variety of factors influencing SO identity development. For example, Robin discussed how lifespan issues influence SO identity development in ways not shown in the models. Robin shared how her own lifespan development, specifically reaching self-identified limits regarding fertility brought up aspects of her own SO identity she thought were settled. Robin went on to explain how facing a perceived finality that she will not bear children brought up numerous thoughts about the role heterosexism has played in her life and how this experience pushed her to revisit earlier places in her SO identity development. She linked these aspects of her own SO identity development to what she felt was missing and/or could be revised regarding existing models. She explained:

You know that idea that you revisit stuff and you revisit it at various points in the lifespan and that it's not about having regressed but you come around and there it is again and that spiraling up? You are developing, you aren't in the same place but you are coming by some of the same scenery and it may look for while like oh here we are again.

Here, Robin illustrated how aspects of SO identity development are influenced by other developmental issues and later in the interview she suggested that a “helix” model where development is portrayed as more of a spiral (rather than a linear progression) may be more appropriate.

_Models as clinical and depersonalizing_

Three therapists explained that they limited their therapeutic use of LGB models of identity development based on a perception that they seemed clinical and depersonalizing. It should be mentioned that one therapist voicing this criticism did not use LGB models of identity in her work at all, connected to this critique. For these three
therapists, there were multiple concerns related to using developmental models of LGB
development in therapy. One concern was that any direct use (i.e. showing a model to a
client) would impart an idea that aspects of clients’ lives could be categorized, which
would seem invalidating. Susan voiced this concern, stating:

I don’t use the models, I don’t, I would not ever find myself saying to a
client, ‘well you know this is really the third stage and you’ve got a
couple, you know you’re in the third of six stages and you’ve made these
stages kind of predictably’ and I would never, never, never say that to a
client in that way like they are, I don’t know some test tube. [researcher
asks, ‘it sounds very clinical to you?’ ] It sounds clinical, but it sounds
depersonalizing. It’s like all of their most personal, intimate, terrifying
feelings now fit into a grid? That doesn’t fill your soul to me.

At other times in the interview, Susan acknowledged that, as an affirmative therapist, she
benefits from knowledge gleaned from the models, but also feels some conflict related to
use of this type of scholarship which feels at times contradictory to her more relational
style of therapy.

Susan went on to describe her experience of tension between LGB identity
research and affirmative practice more in-depth. She explained:

Even if I were to use a theoretical model I would say it more this way:
what we know about this is it’s a transition and it kind of has starts and
stops and there’ll be times when you’ll doubt and times when you won’t
and times when you think you are so sure and then not so much. I might
say that, but I would never refer to it as a theory because our work isn’t,
our work is relational. It’s not, that would just make it formal or would
just take away from what we know about this is: What we know, not we
may, what we know. It’s always, I use that inconclusively as part of how I
explain things because it has many meanings, it could mean to them, well,
what we, the scholars, know. They don’t know there are scholars. They
don’t even know anybody researches this. They don’t care really. But
they do care that I get it or that they’re safe, or that the panics of coming
back off that choice has intrusive thoughts of suicide or intrusive thoughts
of, I mean they have, those are the things they have to know that I get it.
Here, Susan seemed to be describing an emphasis on being present with her client and communicating a deep sense of understanding to them; an understanding that from her perspective could be impeded by both thinking about the client too clinically and/or using techniques that felt too academic and depersonalized.

Linda, who denied use LGB models of identity in her work, acknowledged some feelings of bias in what might be described as her choice not to integrate these models into her practice. She hypothesized that a likely reason she has avoided use of LGB models of identity in her work is their association with the “study” of sexual minority persons, a population with a history of being pathologized by researchers. Linda explained:

There are times, I mean if I’m working with a parent, I’ll use a developmental model, you know, I’ll use a developmental model for child growth and things like that so I mean there are places where I do that. [researcher asks, ‘and why would you do that with a parent?’] I think probably for the same reasons you’re talking about in the other area, I mean it normalizes a child’s behavior and so I think I use those models but I don’t, I’m just watching my own bias come up here. There’s some, I don’t know, there’s something in this for me that I’d have to sit with longer but there’s something in here about, there’s some bias for me of homosexuality having been studied initially as pathology and so we’re going to study it and use this model to understand the self and somehow for me that creates a little bit of separation.

Here, Linda acknowledged some of her own bias in relying on other kinds of developmental models to normalize a client’s behavior.

The ambivalence expressed by Linda was continued in her second interview where she returned to the finding that she perceived LGB models of identity as overly clinical. She explained:

Well I mean I’m sure these models are helpful in the sense that they, people have researched them out and have found them to be useful information in working with clients. I’m just saying my own personal style
is with any therapeutic approach, it’s less clinical and more, oh I don’t know what’s the word I would use, human [researcher responds, ‘yeah, organic?’] Yes, more organic, perfect word.

Here Linda seemed to be acknowledging that LGB identity models are useful to some therapists and although she understands their utility she is still resistant to using them herself based on her perception of them as clinical.

Models used inflexibly without attention to context

Another critique cited by three therapists was that LGB models of identity have the potential to be misused by therapists if they adhere to them inflexibly and without attention to contextual factors regarding SO identity. Some therapists explained that overreliance on LGB identity models may allow for important information to be missed while other aspects of a client's SO identity development (such as deciding against coming out at work) might be mistakenly viewed as dysfunctional from certain models’ perspectives. For example, the most widely used model (Cass, 1979) as reflected both in the literature and in this study generally purports that a sexual minority person who isn’t “out” at work would be considered less mature in their SO identity development than one who is.

Michael explained that his concern regarding therapeutic misuse of developmental models of LGB identity is that therapists might over-focus on developmental markers cited in the models. For example (based on Michael’s interview), a therapist using the Cass (1979) model might be overly focused on looking for signs of confusion with their clients who may be beginning to explore their SO identity for the first time. In Michael’s experience, not all clients experience this kind of confusion, even if they are in early stages of SO identity exploration. If a therapist were too focused on
one aspect of SO identity development based on a model’s content, it could at least stall the process of therapy or even worse, harm the client. Michael expressed:

I think that it’s easy to get caught up in looking for those things [specific developmental markers of SO id development] when you’re given a model like that to look for that stuff in a client and you can lose what you’re looking for. Those things there can be stuff lost if you’re using that to guide you and use that as a measuring tool for someone’s development. I think that that’s personally that’s dangerous you know, I don’t know that I would ever use any instrument like that because you can’t generalize to an entire [population], do you know what I mean?

This perception was also shared by Robin who explained that certain populations of sexual minority persons might be particularly misunderstood if assessed through the lens of existing models. For example, Robin discussed her experience with older adult lesbian women, explaining, “How mismeasured and misconstrued their [older adult lesbian women] experiences would be if we just went with this straight, you know, application of the kind of original ways that Cass or others were coming across.” Robin explained that for these women, their ability to openly disclose their SO identity was greatly limited and how, if they were judged by this measure of identity development, they would wrongly be labeled as “less” developed.

**Positive aspects of research participation**

All nine therapists discussed experiencing their participation in this study as positive. This positive experience seemed connected to participants seeing themselves as similar to other affirmative therapists, experiencing greater self-awareness regarding their work, and experiencing their work as valued. Some participants shared that they felt their work as affirmative therapists was validated by participating in this study.
**Fellowship with other affirmative therapists**

After all first interviews were completed, therapists were sent early-draft summaries of findings from their interview as well as a drafted synopsis of findings from all other participants. This information allowed therapists the chance to review the accuracy of interpretations gleaned from their interview; but it also gave therapists a chance to read about other participants' experiences. Eight therapists expressed a sense of validation in seeing similarities between themselves and other participants. These similarities seemed to create a sense of fellowship with other affirmative therapists even though identities of all therapists were kept confidential. Some therapists described this sense of fellowship and similarity as affirming in that it instilled a sense of connection with other therapists and a sense of being “on track” regarding therapeutic interventions as well as provided encouragement to continue providing affirmative services.

Michael explained a sense of validation in reading about other therapists’ experiences as similar to his:

I thought it was cool that there are, you know, a lot of the numbers or at least half if there were nine of us that were kind of in line with some of the things that I had said [researcher asks, ‘did that feel validating in some way?’] Yeah I guess, I mean it was kind of cool to see that like people were kind of using, doing affirmative therapy or had some like, oh I can’t think of the word, some kind of similar process to kind of approaching LGBT or not T, but LGB clients. So yeah I thought that was cool and yeah I suppose on some level it is validating to see that they’re also doing those things.

This sense of validation from similarity to other therapists was also reflected by Linda, Betsy, and Judith. Linda explained, “I mean actually it felt like a lot of the same or similar to what I was thinking; the same in terms of the experience as well so I guess it felt affirming to me to read.” Betsy stated:
I went down to all the other therapist things and I found myself checking, did I say this, did they say, you know am I in common with them and I felt relieved, I really did, okay I’m not so, sometimes I really do feel like I’m sort of flying by the seat of my pants in some ways. Well, I don’t know, or you could call it intuitive. I’m not sure how to frame that, and it was nice to know that I’m sort of in line with kind of what other people are thinking or experiencing.

For Betsy, there was not only a sense of connection to other therapists but also a described sense of relief in seeing that her affirmative interventions were mirrored in other therapists’ interventions as well. Later in her second interview, Betsy added that she felt a sense of validation in seeing that, as a heterosexual-ally affirmative therapist, her interventions were similar to those described by sexual minority therapists. She explained, “Well they [affirmative interventions described] were very similar. You know it was interesting, they were very similar experiences...you know most of your participants are GLBT and actually I didn’t see that much difference.” Here, Betsy is describing a slight sense of insecurity regarding identifying as a heterosexual-ally and wondering if her lack of identification as a sexual minority prohibits her from providing quality affirmative services. Seeing that her services were comparable to those provided by sexual minority therapists offered her reassurance and a sense of validation.

Judith described how reading about others’ work produced a sense of camaraderie and fellowship that has inspired her through tough economic conditions that have limited the amount of services she is able to provide. Judith explained, “I just became more aware of the issues I face are the same issues they face and when I read it, it just gave me more of a desire to keep on going with it [providing affirmative therapy]. I haven’t been doing as much therapy due to the economy lately but it sure is necessary.”
**Increased self-awareness**

Six therapists reported that taking part in the research which required thinking deeply and critically about their work increased their self-awareness. In general, a therapist’s self-awareness is an essential component of providing good therapy in that it allows for therapists to monitor their own presence, reactions, and effectiveness of their interventions while working with clients. Some therapists expressed throughout the interview process that this was the first time they had really had to articulate what it is they actually do when providing affirmative therapy. Although some therapists indicated that this articulation was sometimes difficult, they also found that engaging in the challenge of verbally describing what usually remained unspoken was powerful and worked to shine light on their process of providing affirmative therapy.

Linda explained that participating in the study promoted self-exploration of the ways she engaged clients in therapy. She explained:

> It [participation in the study] made me, you know, think more about, you know, what underlies the actions that I take as a therapist and that’s always good for me as a therapist. And you know the other is just always wanting to improve the way that I relate to anybody that walks through my office and one of the ways to do that is to think about what I would want from my own experience and that just prompted me to think about it in that way.

Here, Linda described the benefits of more critically thinking about ways that she chooses her therapeutic interventions. She also explained that this kind of critical thinking allowed her to see her work more through her clients’ eyes which helped her be a more effective and empathic therapist.
Anne was more abstract in her description of the link between participation in this study and increased self-awareness as an affirmative therapist. She described how seeing other therapists articulate their work made her more aware of her own. She explained:

It was actually almost comforting to see that other therapists are and it’s not just aware, it’s that they, it seemed to me that it was an ongoing, and struggle I think would be too strong a word but just a challenge of one’s own values and you know for me the whole consciousness matters more than anything because you know for me that’s the consciousness of any sort of struggle is really I think the only protection that I feel I have in terms of making you know an error and so I rely on the awareness of colleagues you know to help me with that too.

Here Anne describes therapists’ awareness as “consciousness” and that it is this consciousness regarding therapeutic work that promotes the integrity of that work.

**The Essence of the Study**

This chapter culminates with the presentation of this study’s “essence” which is considered the apex of the phenomenological study (Colaizzi, 1978; Creswell, 1998; Polkinghorne, 1989). As Creswell (1998) and other scholars of qualitative research have explained, the crux of the phenomenological study is the construction of a unifying phenomenon that ties together the richly described participant-experiences that have been captured throughout the course of the study. The essence of this study (Affirmative Therapists’ Collective Experience Addressing Sexual Orientation Identity with Clients and Using Developmental Models of LGB Identity in Therapy) follows:

The nine therapists interviewed for this study all shared a passion for the practice of affirmative therapy that transcended theoretical orientation. Therapists held a variety of sexual orientation identities but all shared a common identity as an “affirmative
Therapists described several influential factors regarding their development of this identity including personal identification as a sexual minority, specific professional experiences, being identified as affirmative by others, and addressing a community need for affirmative therapy. All therapists identified key strategies used in their practice of affirmative therapy; the three main strategies being ample use of validation and acceptance (embracing those aspects of their sexual minority clients’ lives that are likely to be devalued in a heterosexist environment), use of their own SO identities in therapy (through positive modeling, normalizing, and using their experiences to intuitively connect with the client), and displaying and providing LGBT-related materials (making sure clients can easily view and access materials related to sexual minority issues).

In addition to general affirmative practice, all therapists identified key strategies specific to addressing SO identity with their clients. These strategies were aimed at promoting the client’s development of a healthy, integrated, positive SO identity and constructing a life around that identity. Four main strategies were identified: allowing the client to lead the process of addressing identity, attending to the client’s chronological age and corresponding development (age-influenced stylistic adjustments made regarding how SO identity is addressed), attending to catalysts and cautions regarding broaching the topic of SO identity (cues from clients to either address or back off from the topic), and addressing family-of-origin and romantic relationship issues (helping clients manage SO identity-related disruptions in their family relationships and develop and maintain healthy romantic relationships, etc).

The strategy, “allowing the client to lead the process of addressing identity” became the most significant strategy found in this study based on its frequency of
occurrence and all nine therapists’ expressed enthusiasm for its importance regarding therapeutic attention to SO identity. This importance was connected to recognition of clients’ vulnerabilities as they explore the possibility they may hold an oppressed identity, therapists’ wish to promote their clients’ autonomy and empowerment, and preserving/promoting a sense of trust in the therapy relationship.

Five of the nine therapists in this study had some form of exposure to LGB models of identity in their training and used these models to some degree in their affirmative work with clients. These therapists described a variety of experiences regarding the depth and quality of their exposure and how they integrated the information gleaned from these models into therapy. They identified two main therapeutic functions of developmental models of LGB identity: promoting a sense of hope (particularly through illustration of models’ latter stages of development) and assisting with multiple facets of client conceptualization (through models’ descriptions of specific behavioral and emotional markers of SO identity development). These therapists all acknowledged and identified some central limitations to the models including their tendency to present SO identity development as too simplistic and linear, the perception of the models as clinical and depersonalizing, and their potential to be used inflexibly without attention to context.

Therapists described a range of positive reactions to participating in this study. These reactions seemed mainly connected to feeling validated for their affirmative work. Therapists also described how reading the summary of themes from other participants sparked a sense of fellowship with other therapists and of being “on track” regarding their own work. An additional benefit of research participation described by therapists was
gaining an increased awareness of their work through articulating their own processes regarding affirmative therapy and ways that they address SO identity with their clients.
CHAPTER V

DISCUSSION

The purpose of this chapter is the provision of the following as related to this study: brief overview of results, review of results in the context of existing scholarship and research questions, implications for affirmative practice and scholarship, limitations and future directions, and conclusion.

Brief Overview of Results

Four themes common to all nine participants were identified in this study: Arrival at Identity as an Affirmative Therapist, Specific Strategies Used in the Practice of Affirmative Therapy, Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy, and Positive Aspects of Research Participation. Additionally, two themes common to the five participants who had exposure to LGB models of identity development were identified: Main Therapeutic Functions of Developmental Models of LGB Identity: Instilling Hope and Conceptualization and Therapists’ Recognition/identification of Models’ Limitations. The results of the study culminated in an overarching essence that unified the perspectives of all nine participants with the aim of expressing their experience of the study’s phenomena. Details regarding these themes and the study’s essence can be found under the first bolded heading of Chapter Four, Main Themes Identified in this Study.
Review of Results in the Context of Existing Scholarship and Research Questions

As discussed more completely in Chapter Three, this study focused on two main research questions:

- Do LGB-affirmative therapists use developmental models of LGB-identity in therapy and if so, how?

- How do LGB-affirmative therapists address SO identity more generally with clients?

This section is comprised of two subsections, each of which includes a review of results most pertinent to these questions presented in the contexts of two main areas of literature: (a) LGB identity models and their practical applications in therapy and (b) affirmative therapy. Within these subsections ways that results are supported by the literature are first discussed, followed by a review of results’ divergences from the literature. The overall intention of discussing the results in this way is to provide the reader with a wider context of how the results fit within existing scholarship as well as how they may have “missed the mark” set by the literature and/or pushed the edges of existing scholarship.

Results in relation to the literature on developmental models of LGB identity and their practical applications

Results presented in this section are those related to literature on developmental models of LGB identity and their applications in therapeutic work. Before explaining the themes most relevant to this area of literature, some information is provided regarding the therapists who endorsed these themes and how the themes address the research questions. Five of the nine therapists who participated in this study indicated having some form of exposure to LGB models of identity in their training and used these models to some
degree in their affirmative work with clients. Thus, for these therapists, an integral (and obvious) link to their practical use of the models was gaining prior exposure to them.

This information answered the question, “Do LGB-affirmative therapists use developmental models of LGB-identity in therapy?” Based on information gleaned from these therapists, the answer appeared to be, “Yes, if they have any knowledge of the models.” The therapists who had exposure to developmental models of LGB identity reported most familiarity with the Cass (1979) Model of Homosexual Identity Formation (four out of five therapists reported some exposure to and/or use of this model) which was consistent with the popularity of this model and its representation in the literature. Other models identified by one therapist each were Troiden’s Model of Homosexual Identity Formation (1989, 1993), Coleman’s Stages of the Coming Out Process (1981/1982), and McCarn and Fassinger’s (1996) Model of Lesbian Identity Formation.

The two themes from this study that stood out in relation to literature on developmental models of LGB identity and their practical applications were: Main Therapeutic Functions of Developmental Models of LGB Identity: Providing Hope and Conceptualization and Therapists’ Recognition/identification of Models’ Limitations. These themes addressed the second part of the first research question: How do therapists practically apply developmental models of LGB identity to their work with clients? In the following two subsections, these themes are explicated including ways they were supported by the literature. The third subsection is devoted to ways that these themes diverged from the literature.
Main therapeutic functions of developmental models of LGB identity: providing hope and conceptualization

The first of the two main themes related to therapeutic application of developmental models of LGB identity encompassed the specific ways that these models were applied in some therapists’ affirmative work. Two main therapeutic functions of the models were identified; the first being use of the models to provide clients with a sense of hope and possibility for the future. In general, therapists provided this hope through discussion of aspects of the models that conveyed a sense of positivity regarding minority SO identity development, particularly the latter stages of development. For example, Elizabeth recalled how she was infused with hope when, early in her own identity development as a lesbian woman, she attended a conference where she learned about LGB identity models. She saw from these models that there was light at the end of the more difficult early work of SO identity development, work that she was immersed in at the time. Later, as an affirmative therapist, Elizabeth explained how she conveyed this sense of hope to her clients, illustrating this “light” for them. This hope was also provided through use of the models to normalize aspects of SO identity development which decreased clients’ feelings of isolation in their experiences.

Use of developmental models of LGB identity to normalize aspects of minority SO identity development has been discussed and/or illustrated in a few sources of literature. Although McCarn and Fassinger (1996) did not specifically highlight “normalization” as a way their model might be used in therapy, I believe they illustrated use of their model to normalize a client’s experience through presentation of several case studies. In their presented case, “Carla”, the authors described a way of normalizing her experience through increasing her understanding of her SO identity development. They
explained, “In fact, sharing the model with Carla may help her to understand the process she is moving through…” (p. 528). Kort (2008) also illustrated use of LGB identity models to normalize the client’s experience through multiple case studies. Ritter & Terndrup (2002) suggested use of developmental models of LGB identity to “destigmatize” (p. 169) what the client is experiencing in relation to their minority SO identity, which is a kind of normalization of the client’s experience.

The second main therapeutic function of the models as described by some therapists was assisting with client conceptualization which, for this study, included the variety of ways that therapists think about their clients as connected to SO identity. These therapists described how developmental models of LGB identity provided them with a framework that assisted them with conceptualizing their client’s SO identity development which ultimately helped them in choosing appropriate affirmative interventions to meet their client’s identity-related needs.

Ways that certain therapists in this study described use of developmental models of LGB identity to assist with client conceptualization and choice of intervention were consistent with work by Ritter and Terndrup (2002), Israel (2004), Kort (2008), Perez and Amadio (2004), McCarn and Fassinger (1996), Matthews (2008), Chernin and Johnson (2003), and Croteau and Thiel (1993). For example, Ritter and Terndrup highlighted behavioral aspects of various stages of LGB identity development (gleaned from Cass, 1979; Troiden, 1979; Grace, 1979; and Coleman, 1981/1982 models) to highlight developmentally appropriate therapeutic interventions. Israel explained, “The various models of sexual orientation may help counselors conceptualize their clients and can provide clients with tools for understanding themselves.” (p. 349)
Therapists' recognition/identification of models' limitations

The second theme related to therapeutic application of developmental models of LGB identity captured the critiques that some therapists associated with the models. Three main critiques emerged from their data: models as linear and limited, models as clinical and depersonalizing, and models as potentially used inflexibly without attention to context. The first of these critiques related to the models themselves while the second and third also touched on the question of how these therapists applied (or didn’t apply) these models in their work.

The first of the three main critiques identified by some therapists addressed the way that SO identity development has been portrayed as a linear progression in most models of LGB identity. Some therapists questioned the validity of this kind of linear depiction of SO identity development. In addition to the issue of linearity, certain therapists identified models’ failure to account for the ways that lifespan issues intersect with and influence SO identity. Some therapists explained that many of the nuances of SO identity development that they had either personally experienced or witnessed in their clients’ experiences are not accounted for in the models.

Therapists’ critiques related to linearity were consistent with numerous sources in the literature including some of the models’ own creators. For example, Eli Coleman (1981/1982) wrote in his discussion section that many LGB persons do not follow a precise, stage-like progression in their SO identity development and that sexuality exists on more of a continuum. Taking a retrospective look at his own model, Troiden (1993) explained that his model “describes only general patterns encountered by committed homosexuals.” (p. 194) Troiden added,
Homosexual identity formation is not conceptualized here as a linear, step-by-step process in which one stage precedes another and one necessarily builds on another, with fluctuations written off as developmental regressions. Instead, the process of homosexual identity formation is likened to a horizontal spiral, like a spring lying on its side...progress through the stages occurs in back-and-forth, up-and-down ways; the characteristics of stages overlap and recur in somewhat different ways for different people. (p. 195).

Other authors have provided critique explicit to models' linearity including Cox and Gallois (1996), Ritter and Terndrup (2002), and Fassinger and Arseneau (2007). Diamond (2006) and McCarn and Fassinger (1996) expanded on the critique of linearity and addressed a lack of acknowledgement in the models of the ways that physical/emotional attractions can be fluid throughout the SO identity development process, even after identity has "formed".

The second critique identified by some therapists in this study related to their perception that the models seemed clinical and depersonalizing. Certain therapists explained that they limited therapeutic use of LGB models of identity development based on this perception. In fact, one therapist (Linda) stated that she didn't use LGB models of identity at all based on this critique. She hypothesized that a reason she has likely avoided use of LGB models of identity in her work is their association with the "study" of sexual minority persons, a population with a history of being pathologized by researchers. Linda also explained that her concern with direct use of LGB identity models in therapy was that it didn't fit her conceptualization of her own work as less clinically-focused and more "organic". This area of critique was not well reflected in the literature and is discussed more under the "divergences" subsection which follows.

The third main critique cited by some therapists was that LGB models of identity have the potential to be clinically misused if practitioners adhere to them inflexibly and
without attention to contextual factors regarding SO identity. Some therapists explained that overreliance on LGB identity models may allow for important information to be missed while other aspects of a client's SO identity development (such as deciding against coming out at work) might be mistakenly viewed as dysfunctional from certain models' perspectives. For example, the most widely used model (Cass, 1979) as reflected both in the literature and in this study generally purports that a sexual minority person who isn’t “out” at work would be considered less mature in their SO identity development than one who is. What is missed in this assumption, however, are the contextual factors such as safety and culture that may inhibit a sexual minority person from being fully out in all spheres of their life.

Concerns voiced by certain therapists regarding possible therapeutic over-adherence to information presented in developmental models of LGB identity were shared by authors such as Broido (2000) who advocated for therapists to be flexible in their view of SO identity development. Coleman (1981/1982) proposed that therapists should not follow rigid patterns in conceptualizing SO identity or using developmental models of LGB identity. Fassinger and Arseneau (2007) provided one of the most complete explanations for this critique, explaining that SO identity-related models are bound by temporal limits, need to be consistently updated, and thus shouldn’t be used in a lock-step fashion. A quick overview of existing models highlights this point; there is an approximate ten year gap between the two most recent models reviewed (McCarn & Fassinger, 1996 and Fassinger & Arseneau, 2007). Additionally, more than 30 years have passed since the creation of the (still) most-cited model (Cass, 1979).
Results as divergent from the literature on developmental models of LGB identity and their practical applications

Several key differences between relevant results and the literature regarding developmental models of LGB identity and their practical applications now follow. The first relates to therapists’ description of using the models in therapy to not only normalize aspects of clients’ SO identity development but to provide clients with hope. This kind of use was not overtly represented in reviewed literature and therefore stands out as a relatively unexplored intervention related to the models. Although use of the models to normalize the client’s experience has certainly been described in the literature (Kort, 2008; McCarn & Fassinger, 1996; Ritter & Terndrup, 2002), some therapists in this study clearly took normalization a step further into the realm of hopefulness.

The second key difference between results and the literature on developmental models of LGB identity and their practical applications related to the critique cited by some therapists that developmental models of LGB identity come across as clinical and depersonalizing. This finding was only somewhat reflected in literature reviewed for this study. I believe Cox and Gallois (1996) touched on this critique in their work applying social identity theory to models of LGB identity development. Although the authors did not use the word, “clinical” to describe existing models, they inferred a kind of clinical and depersonalized approach to LGB identity as reflected in existing sexual minority identity models. This critique appeared rooted in the assertion that existing models take an overly individualistic approach to minority SO identity development; an approach influenced by oppressive social forces. It appeared that Cox and Gallois were linking this history of individualism and lack of attention to social influences on SO identity to a depersonalized approach to SO identity.
The third key difference speaks to the attention that some authors in the literature have given to critique of validity issues and research methodology used in the creation of developmental models of LGB identity (see Cass, 1984b; McCarn & Fassinger, 1996). Not surprisingly, therapists in this study did not mention concern with issues related to sampling or methodological soundness of research on developmental models of LGB identity. Usually, these kinds of critiques come from scholars who are well-trained in research methodology and focusing a very critical eye on the research. The therapists interviewed for this study all likely had some training in research methodology as part of their masters programs but most were more than ten years distant from this training. Additionally, all participating therapists functioned as fulltime practitioners (none reported current contributions to scholarship or research) and were more concerned with whether a piece of literature was useful to them in their daily practice than soundness of methodology.

Results in relation to the literature on LGB- affirmative therapy

Results presented in this section are those related to literature on affirmative therapy. The two themes from this study that stood out in relation to this area of scholarship were: Specific Strategies Used in the Practice of Affirmative Therapy and Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy. Before discussing these themes I want to note that in the literature, the topic of affirmative therapy is not generally addressed independently from therapeutic attention to SO identity. Because of this study’s focus on ways that therapists address SO identity, specific strategies in this aim were distinguished and reflected in the theme, Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy. This strategy
most clearly addresses the question of how therapists attend to SO identity in their work with clients. As in the previous section, the following two subsections explain these themes including ways they were supported by the literature. The first subsection which follows explains the strategies related to the general practice of affirmative therapy; the second explains strategies used as specific to addressing SO identity. The third subsection is devoted to ways that these themes diverge from the literature.

Specific strategies used in the practice of affirmative therapy

The first theme reviewed in relation to literature on affirmative therapy is Specific Strategies Used in the Practice of Affirmative Therapy. This theme captured the strategies cited by therapists as integral to providing affirmative therapy in a general sense (as opposed to specifically focusing on SO identity). All participating therapists shared specific strategies regarding the practice of affirmative therapy and three main techniques were identified: use of validation and acceptance, use of their own SO identities in their therapeutic work, and displaying and providing LGBT-related materials.

The first key strategy related to the practice of affirmative therapy as identified by some therapists was provision of validation and acceptance. Before explaining this strategy, it should be noted that multiple affirmative therapy interventions ultimately validate the client, but here validation and/or acceptance were explicitly cited by both participating therapists and sources in the literature as central to affirmative work. Additionally, I wish to note that validation and acceptance are difficult to operationally separate, as the two concepts consistently intersect. For example, it’s quite difficult to validate someone without first accepting them; conversely, the act of acceptance is a kind of validation.
Some therapists described validation as the embrace of those aspects of their sexual minority clients' lives likely to be devalued in a heterosexist environment which was consistent with the Merriam-Webster (2010) definition of “validate”: “to recognize, establish, or illustrate the worthiness or legitimacy of”. These therapists described how, when this validation is communicated, it works to simultaneously convey a sense of deep acceptance to their clients. Ways that therapists described “acceptance” in their affirmative work matched Merriam-Webster's (2010) definition of “accept”: “to receive willingly” and “to give admittance or approval to.” Some therapists described how they communicated validation and acceptance by taking time to focus on clients’ partners, making sure to use appropriate language when referring to clients’ loved ones, refraining from judgment, and allowing the client developmental autonomy.

Use of validation and acceptance as a key aspect of affirmative therapy was consistent with Malyon’s (1982) stance that a minority SO identity is to be “valued and facilitated” (p. 62) by the therapist. Another pioneer of affirmative therapy, Don Clark (1987), advocated for therapists to respond to their clients’ same-sex thoughts, feelings, and behaviors with acceptance and affirmation. Acceptance was also a key theme in Croteau and Thiel’s (1993) article on affirmative career counseling where the authors advocated for counselors to create an office space that actively communicated acceptance towards LGB issues. Fassinger (1991) discussed the necessity of validation when practicing affirmative therapy. She explained that therapists “Should deliberately create a gay affirmative approach that validates a gay sexual orientation...” (p. 170). Validation of clients’ relationship choices was also cited as a central aspect of affirmative therapy in one of the few empirical studies on the topic (Lebolt, 1999).
The second key strategy identified by some therapists in this study regarding their affirmative work was allowing experiences of their own SO identities (lesbian, gay, bisexual, or heterosexual ally) to inform the therapy process. This was achieved in a variety of ways including modeling a sense of joy and satisfaction related to one’s minority SO identity, normalizing aspects of SO identity through personal examples, and using one’s SO identity experiences to intuitively connect with subtle issues the client may not be verbalizing.

Therapists’ use of their own SO identities to inform their affirmative practice was consistent with material presented in the chapter, *Lesbian and Gay Affirmative Psychotherapy: Defining the Domain* (Milton, Coyle, & Legg, 2002). In this chapter, the authors cited therapists’ willingness to discuss their own SO identity as an essential component of affirmative therapy. They explained that the therapists’ willingness to disclose aspects of their own minority SO identity worked to communicate a sense of safety to the client. Therapists’ unwillingness to examine and/or discuss their own SO identity was described by Kort (2008) as a clear impediment to provision of affirmative therapy. In a qualitative study by Pixton (2003), it was identified that sexual minority clients felt it important that therapists positively represent “their own sexuality group” (p. 214), meaning that sexual minority therapists model a healthy sense of their SO identity and heterosexual therapists actively model an identity as an ally. Additionally, therapists’ recognition of the therapeutic relevance of their own SO identities was identified by ALGBTIC (2010) as a core competency in the provision of affirmative services.

The display and provision of LGBT-related materials in the therapy space was the third key affirmative strategy cited by some therapists who discussed the importance of
having LGBT-related books visible on their shelves and having easy access to print and other media resources for clients. These factors were discussed in terms of providing a place where clients could visibly see these resources which was ultimately affirming to them, regardless of whether clients explored them. Certain therapists also discussed the importance of having affirmative resources like DVDs that clients could take with them to explore on their own.

Providing and displaying LGBT-related materials as an affirmative strategy was mirrored in the literature by several sources. Croteau and Thiel (1993) highlighted this strategy in their article on ways career counselors can be more affirming. The authors explained that counselors can convey a sense of acceptance regarding minority SO identity through use of non-heterosexist office forms and visible display of LGBT materials like posters and books. More than other sources, the authors linked the visibility of such materials to the provision of hope which, in some cases, facilitated the client’s later exploration of SO identity. Chernin and Johnson (2003) advocated for therapists providing and displaying LGBT-related materials as well as using non-heterosexist office forms in their chapter, Creating the Foundation for Affirmative Psychotherapy. Attention to heterosexist language on office forms was also cited by Milton, Coyle, and Legg (2002) and Kort (2008) as an important aspect of affirmative therapy. Fassinger (1991) cited bibliotherapy as a useful affirmative strategy to counteract the lack of LGB representation in the media.

**Specific strategies used when addressing sexual orientation identity in therapy**

The second theme reviewed in relation to literature on affirmative therapy is Specific Strategies Used When Addressing Sexual Orientation Identity in Therapy. This
theme spoke to the strategies aimed at promoting the client’s development of a healthy, integrated, positive SO identity and constructing a life authentic to that identity. Information presented under this theme responded to the question of how therapists address SO identity more generally with clients. All participating therapists shared strategies specific to their work on SO identity and five main techniques were identified: assessing SO identity-related issues in therapy, allowing the client to lead the way in work on SO identity, attending to the client’s chronological age and corresponding development when working on SO identity, attending to catalysts and cautions regarding broaching the topic of SO identity, and addressing SO identity in relation to family-of-origin and romantic relationship issues.

The first of the five main strategies specific to addressing SO identity was assessing for SO identity issues. This strategy was cited by all nine therapists as a central aspect of work on SO identity and was achieved in a variety of ways including asking about SO identity on intake (pre-therapy information gathering) forms or during intake interview, attending to LGB-related names or topics introduced in therapy by either the therapist or the client, and asking the client directly about SO identity.

Although multiple sources in the literature have definitely included assessment as key to an affirmative approach (see Browning, Reynolds & Dworkin, 1991; Buhrke & Douce, 1991; Chernin & Johnson, 2003; Kort, 2008; Matthews, 2007; Pope & Barret, 2002; Ritter & Terndrup, 2002; Shannon & Woods, 1991), this subtheme was mainly explored as divergent from the literature. This was primarily related to the ways that therapists in this study discussed assessment throughout the therapy process rather than just in the beginning stages, as has mainly been reflected in the literature. Additionally,
therapists discussed ways that assessment occurred before the client has identified as a sexual minority or even acknowledged SO identity questioning which also diverged from the literature.

The second main SO identity-specific strategy reviewed here is allowing the client to lead in the process of work on SO identity which was strongly endorsed by all therapists in this study. Therapists' described enthusiasm for this strategy seemed connected to recognizing clients' vulnerabilities as they explore their SO identity, wanting to promote the clients' autonomy and empowerment, and preserving/promoting a sense of trust in the therapy relationship. Therapists shared several key ways that they allow clients to take the lead including being very mindful of how, when, and if they disclose their own SO identity as gay, lesbian, bisexual, or heterosexual ally and relying on the client to raise the subject of SO identity rather than the therapist doing so. Based on this strategy's frequency and all nine therapists' support of its centrality to work on SO identity, it took the role as arguably the most important strategy discussed by therapists in this study.

The strategy of allowing the client to lead the way in addressing SO identity in therapy is another that was mainly discussed as divergent from the literature. Although it is unlikely that a source in the body of affirmative literature reviewed for this study would promote an overtly directive approach with clients (for example, a therapist advising that a client present as "out" at work), few sources specified the importance of a non-directive approach as suggested by therapists in this study. Malyon (1982) did explain that the first phase of affirmative therapy "must be concerned with promoting trust and establishing the responsibilities of both client and therapist." He went on to
explain, “Most often, a non-directive or client-centered approach can achieve this.” (p. 63). Eubanks-Carter, Burckell, and Goldfried (2005) touched on the importance of allowing the client to lead the process of addressing SO identity in their article on therapeutic effectiveness with LGB clients. The authors stressed that therapists shouldn’t assume that SO identity is necessarily going to be a topic for therapy with LGB clients, explaining, “Having a therapist who focuses on sexual orientation when it is not relevant can be just as frustrating as having a therapist who ignores sexual orientation altogether.” (p. 10).

The third main element of addressing SO identity with clients as described by almost all therapists was considering their client’s age and general aspects of development that correspond to that age. Attending to these factors helped therapists assess the client holistically and allowed them to adjust their SO identity-specific interventions to better fit their clients. Certain therapists described shifting the language they used related to SO identity to better suit the client’s age in order to facilitate the flow of addressing SO identity in therapy and promote the therapeutic alliance. For example, some therapists described how more flexibility in their SO identity-related language and conceptualization helped younger clients feel safe in the therapeutic relationship.

Attention to the client’s age in the context of SO identity was relatively well-reflected in the literature. Logan and Barret (2005) presented multiple competencies that related to attention to the sexual minority client’s age in relation to their SO identity. One example of such a competency was therapists’ knowledge that developmental tasks for sexual minority adolescents are often complicated by their experience of SO identity (for example, presence of suicidal ideation is a relatively frequent occurrence in LGBT
youth). Chernin and Johnson (2003) included “youth” and “elderly” (p. 22) as subpopulations of sexual minorities requiring special understanding. Specific to working with lesbian clients, Browning et al. (1991) discussed the importance of attending to the client’s age when addressing SO identity. They explained that coming out may be more difficult for younger lesbian women based on heightened dependence on others and lack of access to a lesbian community. The authors made some specific therapeutic suggestions based on the client’s age including helping younger clients navigate the decision to come out to family and the provision of resources to help younger clients and their parents. Suggestions for work with older lesbian women included helping them become aware of heterosexist and discriminatory environments and directly advocating for the client. Ritter and Terndrup (2002) wrote chapters on SO identity development for both adolescent and older adult sexual minority persons. The authors interwove therapeutic suggestions throughout these chapters including the necessity of linking sexual minority youth with a community of LGBT others to offset aspects of internalized heterosexism.

The fourth strategy, which was identified by all nine therapists as key to addressing SO identity is attention to clients’ cues to either broach the topic of SO identity with them (a catalyst) or back off from the topic (a caution). Catalysts included the therapist’s intuitive sense of SO identity saliency for the client while cautions included the therapist’s observation of discomfort in their client and refrain from potentially faulty assumptions regarding a client’s SO identity (such as assuming a client’s SO identity based on style of dress). The discussion of catalysts and cautions in
work specific to SO identity was not overtly represented in the literature and is discussed under divergences from the literature.

The last of the five main strategies related to addressing SO identity was attention to family-of-origin and romantic relationship issues which was identified as important by all nine therapists. Addressing these issues included working with family members of sexual minority persons to better understand aspects of SO identity so that they could ultimately respond more empathically to the sexual minority person (thus in some cases the client was not a sexual minority person but the family member), helping clients manage SO identity-related conflicts in their family relationships, helping clients with transition out of heterosexual relationships, and helping clients develop and maintain healthy romantic relationships.

men. In a similar article on affirmative therapy for lesbian women, Browning, Reynolds, and Dworkin (1991) called for therapists’ awareness of issues specific to lesbian couples including lack of representation of long-term relationships, lack of legal rights, and negative expectations related to the relationship (citing Berzon, 1988).

Results as divergent from the literature on LGB-affirmative therapy

There were several noted differences between the literature on affirmative therapy and the relevant results described by therapists. The primary difference relates to addressing heterosexism as a key aspect of affirmative therapy. In one of the first published treatises on affirmative therapy, Clark (1987) explained that a central element of affirmative therapy was helping clients to recognize and challenge both internal and external homophobia and heterosexism. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) identified that addressing heterosexism with clients is a core competency of affirmative therapy (2010). The American Psychological Association (APA, 2000) emphasized the need for those working with sexual minority clients to have an understanding of the ways that heterosexism has affected the client. Ritter and Terndrup (2002) wrote that a variety of theoretical approaches may be effective regarding provision of affirmative therapy as long as key elements are interwoven such as the exploration of the effects of heterosexism on the client. Kitzinger and Coyle (2002) strongly advocated for addressing heterosexism to be a central therapeutic task when working with sexual minority clients. Shannon and Woods (1991) explained that affirmative therapists should help clients identify and fight heterosexism and learn coping skills to address the stress associated with this fight. They
explained that this task is linked with helping the client form a positive SO identity and
greater connection to both sense of self and relationship to the world.

Although four therapists did appear to use an affirmative strategy of directly
focusing on the challenge of heterosexism, this was definitely not cited by the majority of
therapists as a central aspect of their affirmative work. One might argue that any therapy
affirming sexual minority identity is challenging heterosexism but for this study I looked
more at the overt challenge of heterosexism and it was my interpretation that the
literature was also referring to this kind of intervention. In the literature, it appeared that
addressing heterosexism as an affirmative strategy involved bringing heterosexism into
client awareness and helping them to challenge it. This strategy did appear consistent
with ways that the four therapists in this study described addressing heterosexism. For
example, Michael explained how he linked his assessment of his client’s SO identity
development to his choice to address heterosexism with them. He explained, “…and if
they’re at confusion [the first stage of Cass’ (1979) model] what’s popping up sometimes
I do help clients explore how has heterosexual privilege affected your ability to kind of
feel comfortable in the community, you know, what does that mean?” That a majority of
therapists who participated in this study did not describe overtly addressing heterosexism
does not mean that more therapists did not actively address this social justice issue with
their clients in therapy. It could have been the case that because I didn’t directly ask
about this strategy, it wasn’t mentioned. This direct challenge of heterosexism was likely
the most significant affirmative strategy described in the literature that was not reflected
by a majority of therapists in this study.
The second noted difference between the literature and reviewed results relates to therapists’ identified affirmative strategy of using their own SO identities (lesbian, gay, bisexual, or heterosexual ally) to inform their work. The depth and complexity that some therapists in this study described regarding use of their own SO identities to enrich their affirmative practice was not mirrored in the literature. In one of only a few empirical studies regarding provision of affirmative therapy (Lebolt, 1999), it was identified by presumably sexual minority clients (the sample was not fully described) that it was important to them that sexual minority therapists model healthy ways of coping in their provision of affirmative therapy and that clients wished to “idealize” (p. 362) their gay therapists (I interpreted this to mean that the clients wanted to know their therapist’s SO identity and more importantly, ways that their therapist had overcome obstacles and thrived). Lebolt’s study didn’t, however, provide detail regarding how therapists actually engaged in positive modeling or integrated their own SO identities into their affirmative work. In other studies of affirmative practice (see Milton, Coyle, & Legg, 2002; Pixton, 2003) therapists’ self-disclosure regarding their SO identities and the modeling of healthy SO identity development are mentioned, but again, little detail is provided regarding how these processes occur. Some sources specific to LGB-affirmative therapy explained that affirmative therapists should engage in a certain amount of self-introspection regarding personal SO identity and attitudes towards sexual minority persons (APA, 2000; Browning, Reynolds, & Dworkin, 1991; Clark, 1987; Perez & Amadio, 2004; Shannon & Woods, 1991) but these sources did not specifically discuss ways that therapists might use their SO identities to inform their affirmative work. Several sources have linked therapists’ level of SO identity commitment to perceived self-efficacy regarding
affirmative therapy (see Dillon, Worthington, Soth-McNett, & Schwartz, 2008; Matthews, Selvidge, & Fisher, 2005) but again, these sources did not elaborate on how therapists link their committed identities to their work.

A third noted difference between the literature on affirmative therapy and the relevant results of this study relates to therapists’ use of assessment and their attention to catalysts and cautions in their SO identity-specific work. These two strategies are highlighted together here because they are closely related. For example, therapists’ assessment that SO identity should be addressed with a client might include multiple catalysts like what the client is bringing into the therapy discussion.

Some therapists identified methods of assessment that were reflected in the literature such as asking about SO identity on intake forms, but much of what therapists discussed regarding assessment described doing so throughout the therapy process and delved quite deeply into the process (rather than occurrence) of assessing. This means of assessing addresses the clients who are perhaps so early in their SO identity development that they are not ready to endorse a label as LGB on an intake form. Some sources in the LGBT literature tended to address SO identity assessment only briefly. Matthews (2007) wrote, “Effective assessment begins with openness during intake to a wide range of possibilities with respect to sexual orientation.” (p. 211) but did not detail how this assessment would take place. In their chapter on counseling gay men, Pope and Barret (2002) asserted that therapists need to assess for client’s identity development regarding sexual orientation but little information was provided on how therapists actually engaged in this assessment. Other sources addressed SO identity assessment more richly, but only in regards to clients who have already put SO identity “on the table”. Shannon and
Woods (1991) provided details regarding ways of assessing more complex issues related to SO identity development such as therapeutic exploration of the age that a client first became aware that they were different from other males. Similarly, Browning, Reynolds and Dworkin’s (1991) article on affirmative therapy for lesbian women addressed more nuanced aspects of SO identity development and Kort (2008) explained the importance of assessing a client’s “stage of coming out” (p. 26). The sources that more richly explored SO identity assessment assume the client has already addressed SO identity in some way. Some authors discussed assessment mainly in relation to diagnosis, with an emphasis on not mistaking aspects of SO identity development for pathology (see Buhrke & Douce, 1991; Kort, 2008; Ritter & Terndrup, 2002) while others seemed mainly focused on attention to heterosexist bias in psychological testing instruments (see Chernin & Johnson, 2003; Matthews, 2007).

Therapists in this study appeared to illuminate an aspect of SO identity-related assessment heretofore little explored: the sometimes delicate process of assessing whether SO identity should be brought into the therapy room or put off. When therapists sensed the topic should and could be broached, this was a “catalyst”; signs from the client that the topic should be held off were categorized as “cautions”. This process was reflected in the strategy, attending to catalysts and cautions regarding broaching the topic of SO identity. This strategy brought to light a complex, interactional process between the therapist and client and none of the literature reviewed for this study spoke to such a process.

The last noted difference between the literature and results reviewed here is therapists’ identification that perhaps the most vital aspect of work on SO identity is
allowing clients to take the lead in the process. Allowing the client to take the lead in therapy is certainly a key aspect of multiple theoretical orientations including humanistic or “Rogerian” (Rogers, 1940) approaches, problem-solving approaches (Egan, 2002), and relational approaches (DeYoung, 2003). However, this specific strategy has been far less explored in LGBT-affirmative literature.

**Implications for Practice and Training**

This section highlights implications for practice and training as derived from the three main areas of results from this study: general affirmative practice, specific attention to SO identity in therapy, and the practical application of developmental models of LGB identity. Additionally, an implication related to therapists’ demographic information is included.

This study provided an empirical examination of the practice of affirmative therapy of which there are astoundingly few (Bieschke, Perez, & DeBord, 2007). Findings from this study shed light on areas of affirmative practice explored very little in the literature (empirical or otherwise). Although this study’s focus was not on general affirmative practice, it was found that general affirmative practice was so entwined with specific attention to SO identity that it would have been impossible not to produce results speaking to the practice of affirmative therapy and three main strategies were identified. The one that most diverged from the literature regarding depth of the topic (and thus most clearly advancing the existing body of affirmative scholarship) was therapists’ use of their own SO identities (lesbian, gay, bisexual, or heterosexual ally) to inform the therapeutic process. Therapists described ways that they integrated their SO identities
into their affirmative work including modeling a sense of joy and satisfaction related to their minority SO identity, normalizing aspects of SO identity through personal examples, and using their SO identity experiences to intuitively connect with subtle issues the client may not be verbalizing.

The detailed descriptions provided by therapists regarding the strategy of using their SO identities to inform their work not only provides information regarding affirmative practice but speaks to a growing edge in affirmative training. This strategy supports the importance of therapist training programs’ inclusion of self-exploration regarding SO identity in their curricula. A recent study examining trainees’ experiences of what best facilitated their growth around LGB issues suggested that self-exploration is best facilitated over time in environments that promote the personal growth of the therapist (Grove, 2009). Additionally, literature on more cutting-edge aspects of affirmative therapy such as addressing internalized heterosexism has identified that a central aspect of training in this area is the promotion of therapists’ self-awareness through exercises like journaling; exercises that can only take place over time (Kashubeck-West, Szymanski, & Meyer, 2008). One possibility for facilitating the deeper-level self-exploration needed to train therapists on LGBT issues is a multiple-week class specific to LGBT counseling and my hope is that more graduate programs in psychology will regularly offer (if not require) this kind of class. These kinds of self-exploration opportunities in affirmative training would promote the likelihood that more therapists could draw from their own experiences around SO identity to inform their work.
Although therapists in this study did provide much needed information on ways that affirmative therapy is enacted generally, they also brought to light the importance of training specific to affirmative therapy. The majority of therapists who took part in this study described receipt of little to no affirmative training in their graduate programs and although they all sought training elsewhere, their experiences reflected some deficits in relying on sources of training such as contact with colleagues or supervision. One area where these deficits may have played a role was in therapists’ lack of attention to racial or socioeconomic factors as intersecting with SO identity. Although therapists discussed other intersecting factors such as the client’s age and religion, therapists did not mention attention to the client’s race or socioeconomic status which was likely influenced by the predominance of private practice settings in this study, where most clients are White and middle class. It is also possible that lack of attention to race and culture as intersecting with SO identity was equally influenced by a dearth of competent affirmative training where attention to identity intersections would be highlighted.

Another area where a training deficit was evident was in therapists’ lack of exposure to what are inarguably some of the best means of training around minority SO identity: developmental models of LGB identity. Few therapists were able to specifically cite models they had encountered or delve very deeply into the content of the models. It should be noted, however, that even with this limited exposure to the models, the critiques that therapists associated with them were consistent with critiques that are reflected in the general literature which underscores the need for scholars to attend to critiques related to models’ linearity and over-simplification of SO identity development. It is also important to note that participating therapists would quite possibly disagree with
this categorization of lack of exposure to developmental models of LGB identity as a training deficit. One therapist described an intentional avoidance of the models based on her view of them as clinical and depersonalizing. Other therapists who did use the models appeared to do so in a way that addressed their concerns with them as both overly-linear and clinical (i.e. not using the models directly with clients) which is an adaptation that could be linked to therapists’ high level of experience.

The multiple deficits in therapists’ affirmative training pointed to a need for more comprehensive efforts in areas of training and competency. In some cases, therapists described these deficits themselves and in other cases the deficits were apparent based on incongruence between what therapists reported as affirmative practice and what is reflected in the literature as affirmative practice. Affirmative therapy as a subspecialty of psychotherapy interventions could be considered fairly new (roughly 25 years old) and early literature described it more as a general approach than a theoretical orientation (see Malyon, 1982). However, it should be noted that pioneering authors like Malyon (1982) and Gonsiorek (1982) who advocated for such a stance were rooted in their own theoretical perspectives and may have had difficulty envisioning affirmative therapy as indeed a much-needed “prescription” for how to provide competent psychotherapy to sexual minorities. Other therapy approaches have been extensively documented and even “manualized” (i.e. standardized to a degree) in order to promote competent delivery of the therapy (see multiple manuals on Cognitive-Behavior Therapy [CBT], Dialectical Behavior Therapy [DBT], Acceptance and Commitment Therapy [ACT], etc). This kind of attention to competent delivery of therapy has allowed for greater empirical study of treatment approaches like CBT and DBT which have become some of the most
empirically supported in the field of psychotherapy (Feigenbaum, 2007; National Alliance on Mental Illness, 2010; Powers, 1999; Rathus & Miller, 2002.) Calls for more empirical support of affirmative therapy have not been answered and this may be connected to lack of clarity and precision related to its constitution. Thus, greater attention to both the practice of affirmative therapy and its empirical support are needed. Additionally, we need better ways to assess that affirmative therapists are adequately trained which could be promoted by research-driven attention to graduate programming and curricula content.

Therapists in this study provided rich information that went beyond general affirmative practice into specific exploration of attending to SO identity in therapy. Although the topic of therapeutic attendance to SO identity is reflected in the literature in multiple ways, empirical investigation of how therapists specifically attend to SO identity in their work has been missing. Therapists illuminated ways that they promote their clients' development of a healthy and positive minority SO identity. One of the most significant strategies employed by therapists in this aim was allowing the client to lead the way in work on SO identity. This strategy, although well represented in general psychotherapy literature, is reflected in just a few sources specific to affirmative therapy. Strategies like this one can potentially provide affirmative practitioners and those providing affirmative training with information beyond the "it's okay to be gay" basics as called for by Bieschke, Perez, and DeBord (2007, p. 3).

The final area of results reviewed here brings to light therapists’ practical application of developmental models of LGB identity in their work. The applied use of these models has not been empirically explored despite the models’ significant role in
scholarship and training related to affirmative therapy. Therapists revealed some key ways that they practically applied these models including using the models to provide clients with a sense of hope and possibility. This strategy was little reflected in reviewed literature and has great potential to be integrated into more cutting-edge training material on affirmative therapy. The potential benefits of linking developmental models of LGB identity with provision of hope may be supported by a recent study (Moe, Dupuy, & Laux, 2008) showing that more advanced SO identity development was associated with the presence of hope. The study didn’t address the question of whether provision of hope could advance SO identity development but it appears a likely possibility that therapists who can convey a sense of hopefulness regarding minority sexual identity to clients may help them in their development of a positive SO identity.

In addition to implications derived from the three main areas of results, demographic information from therapists produced an implication related to practice and training. Therapists discussed a sense of isolation from each other and a perceived distance from existing scholarship on LGBT issues. Clearly, this sense of isolation can be exacerbated by practicing in settings and geographic areas that limit one’s contact with affirmative peers, research, and scholarship. Two factors were at play here for the majority of therapists: they practiced in private settings and these settings were located in southwest Michigan. Private practice settings often have limited personnel and financial resources that constrain therapists’ time and access to current research and training on LGBT issues. For example, personal subscription to online databases/scholarly journals and membership in professional organizations is often perceived as cost-prohibitive to
therapists and this barrier was mentioned by one privately-practicing female therapist who stated:

Well part of the problem when you graduate at the doctoral level is you lose your library privileges and in loss of library privileges you lose access to a variety of journals, I mean you can subscribe but they're very expensive and that's prohibitive really. I mean if there's a reason there's an article or two we would be willing to pay for but then you have to research it in a very different way and then I think it's time consuming in a way that isn't really conducive to private practice.

The private-practice setting also limited some therapists' contact with other affirmative peers. In many private practices, therapists operate in relative isolation and are not afforded the same “in the hallway” consultations that group practices, community agencies, or other counseling centers allow. These isolating factors were likely compounded by the geographical setting that all therapists operated in (mid-sized cities in southwest Michigan). As discussed in Chapter Three (Step 4, identification and recruitment of appropriate participants), geographic locale has an influence on the ways and means of affirmative practice. Trainings and resources specific to practice with LGBT clients are occasionally available in southwest Michigan but the opportunities related to affirmative therapy are clearly less available here than they are in areas with more thriving LGBT communities (like San Francisco and New York). Much of the literature on LGBT training has centered on what is provided in psychology graduate programs (see Grove, 2009; Kashubeck-West, Szymanski, & Meyer, 2008; Miville et al. 2009; Walker & Prince, 2010). Chernin and Johnson (2003) briefly mentioned workshops/seminars and communication with colleagues as means of accessing affirmative training but there remains a clear need for more specific suggestions targeting some of the day-to-day barriers therapists in this study discussed regarding training. One
suggestion might be exploring the effectiveness of social networking sites like Facebook regarding the organization of peer-supervision meetings for affirmative therapists.

Limitations and Future Directions

As with all studies, this one has multiple limits that warrant discussion. It should be noted that almost every limitation could also be posited as a strength but the focus of this section is exploration of ways that future studies might expand on information gleaned from this study. Areas of limitation explored in this section include those related to phenomenological study, diversity of participants in this study, specific constructs of this study such as inclusion criteria, the data gathering and analysis process of this study, and the general process and outcome of therapy. Suggestions related to these limitations are interwoven throughout.

The first limitation examined here relates to use of a phenomenological research method. As with any phenomenological study, the results are best understood in the context of a small number of participants and are unable to be generalized to a larger population. Future studies may want to use other qualitative methods like consensual qualitative research or grounded theory in order to gather a broader range of information. Quantitative methods may also be drawn upon to provide information generalizeable to others.

Another limitation more directly related to this study is lack of diversity among the nine therapists who participated. These therapists were relatively diverse regarding SO identity but they lacked diversity regarding race, gender, age, level of experience, and practice setting. All participants were White, seven were female, seven were over the age
of 50 or turned 50 during their participation, eight would be considered highly experienced therapists reporting ten years or more of practice focusing on affirmative therapy, and six worked as private practitioners. Additionally, all participants practiced in the southwest Michigan area with seven practicing in one local city and two in a city very close by.

Although the areas of homogeneity mentioned in the last paragraph have benefits regarding the commonality of experience across participants, a more diverse sample could have yielded richer information. For example, because training opportunities are usually greater in settings like community mental health sites, group practices, and university counseling centers, the fact that most of the study’s participants practiced privately may have limited their access to training specific to affirmative therapy. Additionally, because most of the participants were over the age of 50, there was an inherent cohort effect regarding the training they received (or didn’t receive) during their graduate programs and how long it had been since they had that training. Attention to issues of SO identity in psychology graduate programs is a relatively recent phenomenon and thus; if participants received this training during the eighties and nineties, the likelihood of accessing training specific to affirmative therapy and/or LGB identity was modest at best. Regarding therapists’ distance from the bulk of their training, statements about their recollection of the models or how long it had been since they’d fully reviewed them seemed to support that this distance played a part in their difficulty articulating what drew them to a particular model. Again, this homogeneity regarding participants’ ages, types of practice, and locations may have provided some advantage in greater ability to contextualize results but this possible cohort effect may have negatively impacted
participants' abilities to explore the material presented to them around practical use of LGB identity models in therapy.

The next area of limitation explored here relates to ways that participating criteria were set. As explained in Chapter Four (see *Therapeutic use of LGB Models of Identity Development: Exposure Equals Utilization*), I purposely did not require that therapists had experienced prior exposure to LGB models of identity development. This was in part because I did not equate exposure to LGB identity models with meeting criteria to be considered an affirmation therapist. In retrospect, my failure to include prior exposure to LGB identity models as part of participating criteria likely limited the ability of most participating therapists to delve very deeply into one of the main topics of this study: how do therapists use developmental models of LGB identity in their practice?

Most participants received little to no exposure to LGB-specific issues including models of identity development during their graduate training and only a few gained exposure to LGB models of identity development after completion of their graduate training. Thus, although all of the participants identified as affirmative and met criteria for the study, four had no exposure to these models and did not use them in their therapy. Additionally, I now realize that simply having some exposure to these models does not necessarily correlate to understanding the model or being able to articulate reasons for using a model in therapy. The five therapists who did have exposure to LGB identity models described a variety of experiences regarding the depth of this exposure, how they accessed this exposure, and how they integrated the information gleaned from these models into therapy. For example, some therapists seemed to have a more current relationship to the models as evidenced by their ability to name models and cite specifics
regarding stages in a particular model while others could not name a particular model. Therapists’ abilities to discuss and critique nuanced aspects of these models seemed heavily influenced by how recent their exposure was and how much study they had done regarding a particular model. Additional criteria around level of exposure to and understanding of developmental models of LGB identity may have been helpful (although this heightened criteria may have also made recruitment very difficult).

Several limitations relate to the data gathering and analysis processes. Initial in-person interviews with participants all lasted approximately an hour but rarely took the 90 minutes allotted for the interview. Second interviews were significantly shorter and were conducted by phone. It was my perception that rich material sought through these interviews was successfully gathered but there are some limitations to note regarding their length. Firstly, I spent roughly one face-to-face hour with each participant which is considered a relatively limited period of time for in-depth qualitative exploration. It is possible that the shorter-than-allotted times for both first and second interviews were related to flaws in the interview questions or interviewing technique. For example, there were several points during the interview process where I recall making the choice not to delve deeper into what I perceived to be incongruence in a therapist’s information. What drove this choice was likely my background as a therapist and not wishing to “challenge” the client (or in this case, the participant) as this might disrupt the connection between us. In retrospect, my interviews may have benefited from a more “research-driven” eye where I returned to questions more persistently than I would as a therapist. The use of focus groups (multiple participants meeting together to be interviewed) may have allowed for deeper exploration of the research questions as therapists may have felt some
comfort with probing each other about issues and adding relevant information based on what was being brought up in the group. Additionally, all participants were given the opportunity to provide correction and add information through a "member-checking" process [see Chapter Three, Step 7, data verification (member checking)] but this step occurred roughly half-way through the analysis process and multiple changes were made in the realm of data analysis post-member check. This aspect of rigor may have been strengthened by the addition of another member-checking step closer to the completion of data analysis.

The last area of limitation explored here relates to the process and outcome of therapy. Therapists, more than any other field, are exposed to a certain amount of self-reflection and self-exploration in their training. Thus, therapists are likely able to have an open discussion of their own work. However, all therapists have "blind-spots" (aspects of their work with clients where information may be overlooked or misinterpreted) and all therapists are subject to human fallibilities. Therefore, reliance on therapist self-report has limitations. This may be addressed through an external source viewing the therapist's work and adding this perspective to the data. Additionally, the perspective of the client was missing from this study. In the future, it will be necessary to gain the client's vital perspective on efficacy of affirmative/SO identity-related strategies. Lastly, this study did not speak to any aspect of outcome regarding the process of affirmative therapy. Although strategies were identified which were not previously examined in empirical study, we do not have any information regarding how use of these strategies might affect the outcome of therapy.
Conclusion and Reflections

The material shared by therapists in this study addressed existing gaps in the literature regarding empirical study of affirmative therapy and work on SO identity. Therapists shared candid detail regarding their experiences providing affirmative therapy, specifically attending to SO identity with their clients, and practically applying developmental models of LGB identity. From these details, numerous strategies were identified which will hopefully shed light for readers on multiple “how” questions related to work on SO identity. For example, therapists shared actual, “nuts and bolts” techniques connected to these strategies, not just abstract ideas. It is my hope that this kind of candid information from therapists working “in the trenches” will help bridge existing gaps between research and practice.

Illumination of these more nuanced techniques may also help advance LGBT-related training. Better LGBT-related training in psychology graduate programs and through post-graduate workshops could help reduce therapeutic missteps that commonly occur with sexual minority clients. For example, it has been contended that therapists’ avoidance of SO identity issues is a common error made by mental health professionals (Perez & Amadio, 2004, citing Gonsiorek, 1993a) and conversely; some therapists may over-focus on achieving a resolution of sexual identity, especially with younger clients (Perez & Amadio). Greater exploration of specific strategies used in affirmative practice generally and attending to SO identity specifically could help therapists-in-training (and more advanced therapists with little affirmative experience) be better prepared for work with sexual minority clients.
This study also produced results that speak to the beneficial power of research and particularly, qualitative research. The way research is conducted can promote its potential to benefit a range of recipients that include not only “the usual” audience of scholars/practitioners but also clients, and the participants themselves. Therapists in this study supported qualitative research’s potential to have an immediately positive and empowering effect on participants. All therapists described ways that they felt their participation directly benefited them including feeling more connected to other affirmative therapists and increasing their self-awareness regarding their work. Some therapists also discussed feeling appreciated by having a researcher take an interest in their work. What therapists shared regarding their experience of participation in this study supports claims by authors such as Gamson (2000) that qualitative methods are optimal for LGB research. Gamson stated, “Qualitative methods, with their focus on meaning creation and the experiences of everyday life, fit especially well with movement goals of visibility, cultural challenge, and self-determination.” (p. 348). Research that invites the participant to deeply explore aspects of their experience and communicates a sense of value for this experience thus becomes a kind of therapy for the participant.

Specific to my own growing edges as an LGBT scholar/researcher and affirmative practitioner, the therapists in this study brought to light the complexity involved in separating general affirmative practice from specific attention to SO identity development. For example, when this study was early in conception I tended to view therapist attention to SO identity as distinct from general affirmative therapy. This complex and, at times, false distinction was also reflected by therapists who tended to describe aspects of latter-stage SO identity development such as romantic relationship-
building as general affirmative therapy work rather than as related to SO identity. Through discussions with my research chair, I began to understand that constructing a life authentic to one’s SO identity was identity-work. I now have a deepened understanding of the interconnection between attention to SO identity and affirmative therapy that I believe will contribute to my future efforts regarding affirmative research and engaging in affirmative practice.

My role as a researcher in this study also raised multiple questions for me regarding social justice and ways that I might be more proactive regarding the challenge of heterosexism and the promotion of civil rights for sexual minorities. I believe that as a researcher I am obligated to address issues of social justice and it is my assertion that providing better quality affirmative services to sexual minority and questioning persons is in service of social justice. This study was aimed at the “micro” level, examining the work of nine affirmatively-identified therapists practicing in Southwest Michigan. I drew on my background as a therapist and scholar to draw information from these therapists with the aim of advancing the field of affirmative therapy. I believe that the process of sharing this information and examining their work in context also had a directly beneficial effect on these therapists. It is my hope that this study contributes to therapists being better equipped to work with LGBT clients in such a way that these clients can develop a positive sense of self and thrive in/challenge the status quo of heterosexism, homophobia, and gender oppression. This hope takes on heightened relevance in light of information related to the negative experiences of LGBT and questioning youth in schools (Birkett, Espelage, & Koenig, 2009). For example, it has been reported that over 90% of LGBT youth sometimes or frequently hear homophobic remarks in their school
(words such as "faggot", "dyke", or "queer") and sometimes these remarks come from faculty or school staff. Sadly, LGBT youth are almost twice as likely as their non-gay peers to be threatened with or injured by a weapon at school and this kind of harassment is linked to greater risk of suicidal behavior (Suicide Reference Library, 2006). Affirmative therapists can potentially counter the devastating effects of this kind of hostile environment and help their clients develop a positive, resilient minority SO identity. Although I believe that this study did speak to issues of social justice, it is my aim to take my future research to a more “macro” level, examining social policy and ways that heterosexism may be interrupted institutionally and societally.

Lastly, my experiences with participating therapists had a directly beneficial effect on me aside from helping me to complete my dissertation. I had the opportunity to meet with nine therapists committed to their work and who deeply cared about the lives of LGBT people. These therapists gave of their time generously and shared aspects of their work that helped me better understand my own work as a therapist. These therapists’ commitment to affirmative work also helped me forge a new resolve to focus more on affirmative therapy in future research and in my practice as a therapist. I am deeply grateful for the time I spent with each of these therapists and I will remember them long after this study has been completed.
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Appendix A

Referral Cover Letter
I was referred to you by ________ as someone who might be interested in participating in a study I am conducting. This study is a qualitative investigation of LGB-affirmative therapists’ use of developmental models of LGB identity in therapy and how they address sexual identity more generally. This study is aimed at advancing the field of LGB psychology including LGB-affirmative therapy and LGB-identity scholarship. Along with this cover letter is an invitation outlining criteria for participation in the study and providing more information about the study.

Some brief background information about me as a researcher and therapist:

- I identify as a heterosexual ally and have been engaged in social justice work emphasizing LGBT issues since 1999.
- I began WMU’s doctoral program in counseling psychology in 2003 and have focused my research interests mainly on LGBT identity, work on racism for White LGBT psychology professionals, and the impact of the discussion of race in supervision.
- I hold the license of Limited Licensed Psychologist and currently work as a therapist practicing Dialectical Behavior Therapy for Interact of Michigan.

Thank you for your consideration,

Victoria Cane
Appendix B

General Cover Letter
Dear ________,

I found your name through an internet search for LGB-affirmative therapists and am hoping you might be interested in participating in a study I am conducting. This study is a qualitative investigation of LGB-affirmative therapists’ use of developmental models of LGB identity in therapy and how they address sexual identity more generally. This study is aimed at advancing the field of LGB psychology including LGB-affirmative therapy and LGB-identity scholarship. Along with this cover letter is an invitation outlining criteria for participation in the study and providing more information about the study.

Some brief background information about me as a researcher and therapist:

- I identify as a heterosexual ally and have been engaged in social justice work emphasizing LGBT issues since 1999.
- I began WMU’s doctoral program in counseling psychology in 2003 and have focused my research interests mainly on LGBT identity, work on racism for White LGBT psychology professionals, and the impact of the discussion of race in supervision.
- I hold the license of Limited Licensed Psychologist and currently work as a therapist practicing Dialectical Behavior Therapy for Interact of Michigan.

Thank you for your consideration,

Victoria Cane
Appendix C

Agency Cover Letter
Dear ________,

DATE

Through contact with your agency, I was informed that you currently provide LGB-affirmative treatment. I am hoping you might be interested in participating in a study I am conducting. This study is a qualitative investigation of LGB-affirmative therapists’ use of developmental models of LGB identity in therapy and how they address sexual identity more generally. This study is aimed at advancing the field of LGB psychology including LGB-affirmative therapy and LGB-identity scholarship. Along with this cover letter is an invitation outlining criteria for participation in the study and providing more information about the study.

Some brief background information about me as a researcher and therapist:

- I identify as a heterosexual ally and have been engaged in social justice work emphasizing LGBT issues since 1999.
- I began WMU’s doctoral program in counseling psychology in 2003 and have focused my research interests mainly on LGBT identity, work on racism for White LGBT psychology professionals, and the impact of the discussion of race in supervision.
- I hold the license of Limited Licensed Psychologist and currently work as a therapist practicing Dialectical Behavior Therapy for Interact of Michigan.

Thank you for your consideration,

Victoria Cane
Appendix D

Invitation to Participate in a Qualitative Research Study
You are being invited to participate in the dissertation research of Victoria Cane entitled, “LGB-affirmative Therapists’ Use of Developmental Models of LGB-identity in Therapy: A Phenomenological Investigation.” The purpose of this study is to gain a better understanding of ways in which LGB-identity models are used in therapeutic work with clients as well as ways that sexual orientation identity is therapeutically addressed more generally.

- Criteria to be eligible for participation:
  - Therapists are licensed to practice therapy in Michigan at the masters or doctoral level.
  - Therapists identify and meet criteria as LGB affirmative (view minority sexual orientation as a healthy, valid, and positive sexual orientation status and have acquired a sufficient amount of training on LGB-affirmative treatment through any combination of formal classes, presentations, supervision, and independent study).
  - Therapists consider LGB-affirmative therapy among their top three areas of focus in counseling.
  - Therapists have seen at least 20 clients addressing sexual orientation in any way in therapy and have accumulated at least 50 contact hours with these clients.
  - Therapists have had the experience of addressing sexual orientation identity with clients in therapy.
  - Therapists are currently providing therapy services to at least one client addressing sexual orientation in any way.

- Your participation would include one face-to-face interview at a private location deemed convenient for you and the researcher and one telephone interview. The first interview will last approximately 60 minutes (and no longer than 90). The second interview would be conducted by phone, lasting approximately 30 minutes (no longer than 45) and would take place approximately three to six months after the initial interview.

- Upon receiving your contact information, you will be sent a study participation packet with more information about the study including an informed consent document and a demographic questionnaire. In the spirit of gaining a diverse sample of affirmative therapists regarding factors such as gender, sexual orientation, and race, I will purposefully select eight to ten participants from the pool of potential participants. Any therapists not chosen to participate will be informed via mail and/or email.

- You may choose to withdraw from the study at any point.
• Your participation may help to advance the practice of affirmative treatment for sexual minority persons.

• One participant (out of approximately 10) will be chosen randomly to receive a $50 gift certificate for Amazon or Barnes and Noble (their choice).

If you have interest in participating, please complete the contact information on the second page and return in the stamped envelope provided. Please contact Victoria Cane at victoria.cane@wmich.edu 269/598-5861 if you have any questions.

Thank you,
Victoria Cane, M.A, L.L.P, Doctoral Student
James Croteau, Ph.D., Professor
Appendix E

Initial Assessment Protocol
Initial Assessment Protocol

Potential participants will first be contacted through a cover letter informing them of how I came across their contact information (either through someone’s recommendation or through my own searches using internet and other resources) as well as a written invitation outlining the study and criteria for participation. Interested and qualifying participants are asked to return a brief form to me via mail in a stamped and addressed envelope included in their invitation materials. After I receive this form, I plan on having a brief phone conversation with them to ensure that they understand and meet all of the criteria for my study. Information gleaned from this brief assessment interview would not be recorded, as informed consent would not yet have been acquired. Participants will be instructed to listen to the specific criteria qualifying them for the study and to inform me whether they meet or do not meet the criteria. Below is the scripted protocol for this conversation. It is intended as a guide and will not be used as a strict template for the interview:

Hello, my name is Victoria Cane and I received your indication of interest for participation in my dissertation research on LGB-affirmative therapist’s use of developmental models of LGB-identity in therapy. Thank you for your response. Before I take any further steps, I wanted to make sure that you understand and meet criteria for participation.
I will read a statement listing the criteria to you. Please let me know if there is any part of the information that does not apply to you.

I am licensed therapist at either the master’s or doctoral level practicing in Michigan. I identify as an LGB-affirmative therapist and consider affirmative therapy to be one of my main (at least top 3) areas of focus in counseling work. I have engaged in numerous training experiences around affirmative therapy including any combination of classes, workshops, and/or trainings specific to affirmative therapy; self-study of the literature which may include my own contributions to the literature; and receipt of supervision and/or mentorship around provision of affirmative therapy. I have seen at least 20 clients addressing sexual orientation with me in individual therapy and have amassed at least 50 client-contact hours with these clients. I have had the experience of addressing sexual orientation identity with a client. I am currently seeing at least one client addressing sexual orientation with me in therapy.

Did all aspects of this statement apply to you?
If yes, inform them that they meet all criteria for participation and ask them if they are still interested in receiving further information. If so, thank them and let them know a packet will be sent to them immediately and that an interview would be scheduled after packet materials are completed and returned. If not, thank them for their time.
Appendix F

Consent to Participate Form
You have been invited to participate in a research project entitled, “LGB-affirmative Therapists’ Use of Developmental Models of LGB-identity in Therapy: A Phenomenological Investigation.” This study is part of the dissertation of student-investigator, Victoria Cane, doctoral candidate in counseling psychology. The purpose of this study is to gain a better understanding of ways in which developmental models of LGB-identity are incorporated into therapeutic work in order to advance the study of both LGB-affirmative therapy and LGB identity.

If you meet eligibility requirements and agree to participate, I ask that you take part in an in-person interview session which will last approximately 60 minutes (and no longer than 90 minutes) as well as a follow-up interview conducted by phone and lasting approximately 30 minutes (no longer than 45 minutes). The follow-up interview will occur approximately three to six months after the initial interview. The interviews will be conducted by Victoria Cane, student-investigator, at a private location deemed convenient for both you and the student-investigator. The interviews will be audio-taped to ensure accurate recording of your responses. In the first interview, you will be asked to respond to a series of general questions regarding your experiences with use of LGB-identity models in psychotherapy. The second interview will focus on checking the accuracy of interpretations made regarding your data, facilitating a deeper discussion of the questions based on other participants’ responses, and allowing you to add any information you choose.

Your participation in this study is completely voluntary. You may cease participation at any time before or during the study by simply informing the student-investigator of your desire to discontinue. The interview will then be terminated immediately without prejudice or penalty to you.

Over the course of this study, the strictest measures will be taken to protect participants’ confidentiality. Your name will not appear on any papers where your responses are recorded, as the forms will all be coded with a number and pseudonyms will be used. The student and principle investigators will each maintain a separate master list with the names of participants and the corresponding code numbers/pseudonyms which will be
destroyed at the study’s end. Recordings will be electronically stored on a password-protected computer accessed only by the student and principle investigators and will be erased at the study’s end. Backup recordings made on standard audiotape will be stored in a secure location in the principle investigator’s office and destroyed at study’s end. All other documentation related to the study such as consent forms will be retained for a period of at least three years in a locked file in the principle investigator’s office.

The potential benefits of participation include having the opportunity to discuss your experiences with providing affirmative therapy as well as exploring how you use LGB-identity models in your therapeutic work with clients. Participation may result in gaining a better understanding of your work as an affirmative therapist which may benefit both you and your clients. Findings from this study will be available on dissertation databases and may be submitted to peer-reviewed journals for wider publication. Participation may also have multiple positive implications regarding the field of affirmative therapy and counseling more generally. There is very little empirical data on affirmative therapy and this study may help others in their pursuit of LGB-affirmative training. Results from this study may also indicate where work needs to be done on LGB models of identity as well as new ways of integrating existing information into counseling. Additionally, LGB clients may be better served in therapy through information revealed in this study.

Although there are minimal risks associated with participation in this study, a potential risk is that you may feel uncomfortable sharing your experiences with provision of affirmative therapy and using LGB-identity models. There are also the potential risks connected to the time commitment and inconvenience of the interviews associated with this study. You are encouraged to keep a copy of this consent, as it indicates your consent to participate in the study. Should your participation in these interviews raise any concerns you would like to address, please bring them to the student-researcher’s attention (Victoria Cane at 269/598-5861 victoria.cane@wmich.edu). You may also contact the principle investigator (Dr. James Croteau at 269/387-5111 james.croteau@wmich.edu) and/or the Human Subjects Institutional Review Board (HSIRB) chair at (269) 387-8293 or the Vice President of Research at (269) 387-8298 if questions or problems arise during the course of the study.

This consent document has been approved for use for one year by the HSIRB as indicated by the stamped date and signature of the board chair in the upper right corner of this form. Do not participate if the stamped date is more than one year old or if the date is omitted.

Your signature below indicates that you have read and/or have had explained to you the purpose and requirements of the study and that you agree to participate.

______________________________   ________________________
Signature of participant        Date
Appendix G

Demographic Form
Demographic Form

Western Michigan University
Department of Counselor Education and Counseling Psychology
Principal Investigator: Dr. James Croteau, Ph.D.
Dissertation Author: Victoria Cane, M.A, L.L.P
Faculty Advisor: Dr. James Croteau, Ph.D.

Pseudonym, if any, you would like to choose for the study (if left blank one will be chosen for you)

____________________________________________________________________________________

Age: __________________________________________

Gender: (please circle):
  a. Female
  b. Male
  c. Transgender
  d. Other ________________________________

Is there any information not included in the above choices you would like to add?

____________________________________________________________________________________

____________________________________________________________________________________

Race: (please circle):
  a. American Indian or Alaskan Native
  b. Asian or Pacific Islander
  c. African American/Black
  d. Latino(a)
  e. Caucasian/White
  f. Biracial/Multiracial
  g. Other ________________________________

Is there any information not included in the above choices you would like to add?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Primary Sexual Orientation: (please circle):
   a. Gay
   b. Lesbian
   c. Bisexual
   d. Queer
   e. Heterosexual
   f. Other _______________________

   Is there any information not included in the above choices you would like to add?
   __________________________________________________________
   __________________________________________________________
   _______________________

Highest degree held: _______________________

Program & University Highest Degree Attained
   From: _______________________

License Held to Practice Therapy in Michigan: (please circle):
   a. Limited Licensed Psychologist
   b. Licensed Psychologist
   c. Limited Licensed Professional Counselor
   d. Licensed Professional Counselor
   e. Limited Licensed Master’s Social Worker
   f. Licensed Master’s Social Worker
   g. Other _______________________

   Is there any information not included in the above choices you would like to add?
   __________________________________________________________
   __________________________________________________________
   _______________________

Courses/training you have taken specific to LGB counseling: _______________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   _______________________

Years of Experience Practicing Affirmative Therapy as a Major Treatment Focus: ______________________
Approximate Number of Clients who have Addressed Sexual Orientation with You in Individual Therapy (please circle):
   a. 20-40
   b. 40-60
   c. 60-80
   d. 80-100
   e. More than 100
Is there any information not included in the above choices you would like to add?

__________________________
__________________________

Number of Clients Currently Addressing Sexual Orientation with You in Individual Therapy (please circle):
   a. 1
   b. 2-3
   c. 4-5
   d. 6-8
   e. 8-10
   f. More than 10
Is there any information not included in the above choices you would like to add?

__________________________

Thank you for your time in completing this questionnaire
Please complete the following information and return in the stamped envelope provided.

Name ________________________________

Address ____________________________________________

_____________________________________

E-mail ________________________________

Telephone Number _______________________

Best way and time to reach you:

_____________________________________

_____________________________________

Thank you,

Victoria Cane
2020 Grand Ave.
Kalamazoo, MI 49006
victoria.cane@wmich.edu (269)598-5861
Appendix H

First Interview Protocol
First Interview Protocol

Pre-Interview Procedures: I will likely be meeting participants in this study for the first time at the initial interview. A short time (likely about 5 minutes) will be spent on introductions and establishing basic rapport as well as getting situated in the room and setting up recording equipment. Before the interview begins, I will review participants’ signed consent forms with them, remind them that they may choose not to answer any questions and that they may voluntarily end their participation in the study at any time. I will gain a verbal consent confirming their signed consent for participation before beginning. The protocol questions are designed to ensure that I attend to all pertinent issues, but they are intended to be a guide rather than a strict template. I will use the questions to guide participants in exploring the phenomena but participants will be allowed freedom in providing whatever information they feel important. The major questions are designated by bold italic type while potential follow-up questions are in regular type. The first two questions are intended to gain contextual information regarding the background of participants and their experiences around provision of affirmative therapy. Questions three through five are focused on the specific phenomena of using LGB-identity models in therapy as well as more general ways of therapeutically addressing sexual orientation identity. The interview will end with thanks given to the participant and a reminder that after initial analyses are made; synopses of these will be sent to the participants for their review before the second interview as well as thematic information gathered from analyzing other participants’ data. I will remind participants that second interviews will take place by phone at a mutually convenient time approximately three to six months after the first interview.

1. **As you know, I am interested in learning about LGB-affirmative therapists’ experiences with using LGB identity models in treatment and around addressing sexual orientation identity generally. I would first like to understand a bit more about your training and work as an affirmative therapist. What led you to identify as an LGB-affirmative therapist?**
   a. What kind of training have you had around provision of affirmative therapy (i.e: formal trainings, independent readings, supervision, etc).
   b. How much was LGB identity addressed in your training (describe)?
   c. Were any LGB identity models incorporated into your training and if so, please describe which ones and how they were used?
   d. How long have you been doing affirmative therapy/how long has it been one of your main treatment specialties?

2. **Now I'd like to get a sense of your work as a therapist. Can you start by telling me about your general approach to affirmative counseling (central aspects, etc)?**
   a. What is your main theoretical orientation?
   b. Do you think your theoretical orientation integrates well w/ affirmative therapy?
      i. If so, how?
      ii. If not, what adjustments have you had to make?
3. Please tell me about how you address identity in treatment.
   a. When do you generally address this topic?
   b. What are things you look for regarding when to broach the topic of identity?
   c. Are there any therapeutic factors you are particularly cautious about when addressing identity with clients? How about any factors that indicate to you it's an opportune time to address identity?

4. How do you incorporate LGB models of identity into your work with clients?
   a. Are there particular ways you present this information to clients?
   b. Which models do you most use and why?
   c. What suggestions, if any, might you have regarding the need for revising existing models or creating new ones?

5. Being sure not to use any information that could potentially identify any client, could you provide some case-based examples of ways that you use the identity models in treatment?
   a. Are there any ways you address sexual orientation identity generally that have not been discussed here?

As the interview comes to an end, I thank them again for their time and remind them that I will be contacting them either by email or phone within the next three to six months to set up our second interview which will take place by phone and occur within that same time period (three to six months after the first interview). I will also remind them that I will be sending them a synopses of my interpretations regarding their interview in the form of a narrative summary for the purposes of allowing them to review the data for accuracy, provide corrections if necessary, and possibly assist with delving deeper into exploration of the phenomenon. This exploration will also be assisted by provision of general themes gathered from other participants' data.
Appendix I

Data Coding Sheet
**Data Coding Sheet**

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Appendix J

Second Interview Protocol
Second Interview Protocol

This interview is designed to expand on information gleaned from the first interview as well as to assess accuracy of analysis. It will take place by phone at an arranged time approximately six to nine months after the first interview. The interview will begin with greetings and confirmation that the participant received materials sent to them (a summarization of findings from their previous interview, synopses of themes found across all participants, as well as the “essence” or core idea of the study) and reviewed them. If they did not review them, the student researcher would ask them if they could please take approximately 10-15 minutes to do so and call them back. The student researcher will remind participants that the conversation is being recorded as part of the data, that they may choose not to answer any questions, and that they may end their participation in the interview at any time. The protocol questions are designed to deepen exploration of the phenomenon, invite any corrections regarding the student researcher’s interpretations, and assess whether the essence of the study fits the participant’s perspective. As with the first interview, the student researcher will use her counseling skills in her efforts to elicit and understand the participant’s experience. The second interview questions are intended to be a guide rather than a strict template. The interview will end with thanks given to the participant and a reminder that participants will be sent a final summary of analysis after the study is complete (approximately one year after their first interview). It would also be explained that after all interviews are completed, the winner of the participation incentive (a $50 gift certificate) will also be randomly chosen, the incentive will be sent to them, and other participants would be informed that this selection has taken place.

1. I would like to begin our 2nd interview by again thanking you for participation in my study. The purpose of this interview is to openly invite you to correct me if there is anything you believe I may have gotten wrong regarding the summary of your narrative, corresponding themes, and core essence of the study. I would also like to invite you to add anything that you think is relevant regarding the topic. Are there any corrections you would like to make regarding my summarization and analysis?

2. What was your reaction to reviewing themes noted from other participants? Did this review touch on anything new regarding your work with sexual orientation identity?

3. Did participation in this study spark any new ideas or thoughts regarding your approach to affirmative therapy generally and sexual orientation identity particularly?

4. Does the essence of the study fit your perspective and if so, how? If not, what changes would you make?

5. Regarding our discussion overall, is there anything that you would like to add?
Appendix K

Follow-up Letter
Dear __________,

I recently sent you a packet containing information on my dissertation study, *LGB-affirmative Therapists' Use of Developmental Models of LGB-identity in Therapy: A Phenomenological Investigation*, as well as an invitation for participation. I am hoping you received this information. If so, please take a moment to consider participating. If you are interested, please return the information sheet included in your materials by (2 weeks later). If you did not receive the packet, please contact me by phone 269/598-5861 or email victoria.cane@wmich.edu and I will send you one immediately.

Thank you for your time,

Victoria Cane
Appendix L

Instructions for Participants
Hello!

Thank you for your show of interest in my study. Enclosed in this packet are two copies of a consent form, a demographic questionnaire, and a postage-paid envelope.

Provided you are still interested in being a participant in my study, please return to me in the envelope:

- One signed copy of the consent form. Please keep the other copy for your records.
- The completed demographic questionnaire.

Please complete these items and return them by (2 weeks later).

After I receive your information, I will contact you promptly by phone or email to arrange a time and place to interview you.

Thank you for your time,

Victoria Cane
Appendix M

Reminder to Return Materials
Dear ___________,

I recently sent you a packet containing materials for participating in my dissertation study, *LGB-affirmative Therapists' Use of Developmental Models of LGB-identity in Therapy: A Phenomenological Investigation*. I am hoping you received this information. If so, please take a moment to complete the items and return them to me in the postage-paid envelope by (1 week later). If you are still interested in participating and did not receive the packet, please contact me by phone 269/598-5861 or email victoria.cane@wmich.edu and I will send you one immediately.

Thank you for your time,

Victoria Cane
Appendix N

Instructions Included with Synopses
Dear ___________.

Enclosed you will find a synopsis of themes I found from our interview on DATE. I plan on contacting you sometime over the next 2 weeks to schedule our 2nd interview which will take place by phone. Before we meet by phone, I would like you to take a few moments to review the themes from our interview for accuracy as well as anything of significance you believe I may have missed.

I am also sending a summary of themes gathered across all participants as well as the "essence" or core idea of the study. I encourage you to review these themes as a whole in order to further your thinking on the subject before our phone interview and to let me know whether the essence found in the study fits your perspective. It may be helpful to note any key thoughts you have on the subject before we speak. Additionally, I may ask a few follow-up questions to clarify aspects of your first interview. The second interview will not be longer than 30 minutes in duration.

Thank you for your time,

Victoria Cane
Appendix O

Check-in with Participants
Hi __________.

I wanted to let you know that all first interviews are completed and coded and I am now in the process of revising my codes before I send them to participants for review. Sometime over the next six weeks, you will be receiving in the mail a synopsis of the codes I created from your interview as well as a synopsis of the main codes I created from all other interviews. Within two weeks of receiving these, I will contact you either by email or phone to schedule our second interview which will be conducted by phone. I ask that you review the codes from your interview for accuracy and take note of anything you think I should correct or revise as it is very important to me that I correctly capture your voice. The collective list of codes from all participants are sent for your review to inspire further thought regarding the studied phenomenon of addressing sexual orientation identity in therapy and therapeutic use of sexual orientation identity models. As a reminder, if you wish to withdraw from further participation in this study, you may do so without penalty.

I look forward to speaking with you again.

Victoria Cane
Appendix P

Sample of a Participant Synopsis
Participant 9, “Robin”:

Demographic descriptors used for the study: “Robin” (R) is a White female doctoral level therapist in her early forties who identifies as lesbian. R reports 16 years of affirmative therapy as a main focus of her work and has seen more than 100 clients addressing sexual orientation in therapy. R has had exposure to lgb models of identity in her training.

R discusses the factors in her life that led her to become an affirmative therapist including specific training and professional experiences, identification of a community need for affirmative therapists, her own identity as a lesbian woman, and being identified as affirmative by others. R recounts aspects of her personal journey regarding sexual orientation identity (SO id) and how her identity intersected w/ and was positively influenced by her training/professional experiences. Additionally, R describes how her SO id has had positive impacts on her training and professional life.

R indicates that her lgb-specific training has included significant exposure to lgb issues and identity theory/models in her doctoral program. Additionally, R describes training through lgb-specific courses, engaging in/authoring lgb-research and providing lgb-specific education and training, contact w/ other professionals and peers, and independent readings/self-study. R explains that she was able to gain a significant amount of training and exposure to lgb issues in her doctoral program mainly because she continually brought up the need for such training. Regarding exposure to lgb models of identity, R recalls Cass as the main model reviewed as well as the Troiden Model and the McCarn and Fassinger Model. R describes some barriers to lgb training including providers of lgb training failing to offer counterpoints to aspects of lgb identity models and her own distance from professional activities and scholarship related to affirmative therapy.

R describes that a key element of affirmative therapy is use of her own identity as a lesbian woman although she adds that it is important to allow the client’s own identity to develop unhindered by her personal story. R indicates that before sharing her SO id w/ the client, she first assesses whether or not this disclosure would impede therapy in any way. R explains that in general, she does not automatically share her SO id status unless the client is overtly presenting w/ issues related to SO id. R explains that when clients are coming in w/ SO id-related issues she believes it is essential to the therapeutic process to share her own SO id. Other key aspects of affirmative therapy described by R include: displaying and providing lgb-related materials, modeling a sense of pride in her own SO id and displaying a commitment to lgb-related social justice issues and community, and normalizing the client’s SO id-related experiences.

Regarding the specific work of addressing SO id w/ the client, R explains that she pays attention to the client’s age regarding how she addresses SO id w/ them. R explains that how she presents developmental information to clients (particularly regarding presentation of an identity model) depends on her assessment of their thinking and information-processing style as well as their ability to emotionally process the information. R describes that presenting narrative “coming out” stories to clients is one way to share developmental information w/ them. R expresses that another important
aspect of identity work w/ clients is attending to the ways SO id intersects w/ relationship and family issues. R expresses that therapists should avoid assumptions about the client’s life or what they want to address in therapy and explains her perception that SO id is generally less of an issue for clients now than in the past. R adds that it is important for therapists to allow for ambiguity regarding SO id, an example being clients rejecting any SO id label. R explains one area of caution in how she approaches SO id in therapy is a client’s lack of support system. R explains that one cue she uses to address SO id in therapy is her own assessment that doing so is relevant to the client’s progress. Other ways that R describes assessing for identity issues include paying attention to lgb-related names or topics the client brings up.

Specific to therapeutic use of lgb id models, R explains that she tends to utilize the McCarn and Fassinger model most often. She explains that SO id models help both the client and the therapist explore and understand the different facets of SO id and may help promote understanding for the client’s family and loved ones. Another function of lgb identity models cited by R is providing hope and decreasing a sense of isolation for the client. R critiques existing lgb models of identity as outdated and overly linear in their depiction of SO id development. She describes how lgb models may be dangerous if overused. In terms of suggestions for future lgb identity scholarship, R mentions the Keegan model of identity conceptualization and how newer lgb identity models might benefit from the flexibility of the Keegan model.

**Primary themes gleaned from R’s interview:**
The most frequent themes in R’s interview (occurring 7x) related to mention of the Cass Model of Homosexual Identity Development. Other themes occurring multiple times in R’s interview included: *using lgb models of identity in therapy to help both the client and the therapist explore and understand the different facets of SO id (5x); *paying attention to the client’s age when addressing SO id in therapy (2x); *allowing for client’s ambiguity regarding SO id (2x); *mention of the McCarn and Fassinger Model of Lesbian Identity (3x); *mention of the Cass Model of Homosexual Identity Development (7x); *presentation of narrative “coming out” stories to clients as a way to share developmental information w/ them (2x); therapist assessing the client’s thinking style and ability to emotionally process information before presenting them w/ material such as lgb models of identity (4x); *the critique of lgb models of identity as overly linear in conceptualization of SO id development (3x); *therapist addressing SO id only when relevant to the client’s progress (2x); *the importance of refraining from assumptions about the client’s life or what they want to address in therapy (3x); *using caution when working on SO id w/ clients who have little support in their lives (2x); *the therapist using their SO id to inform their affirmative work while letting the client’s story be their own (5x); *therapist sharing their SO id w/ their clients only when it has been assessed that it would not impede therapy (2x) but immediately if SO is an issue the client is presenting w/ (3x); *therapist experiences significant training on lgb issues in their doctoral program (3x); *therapist experiencing significant exposure to lgb identity theory/models in their doctoral program (2x); *therapist encountering barriers regarding lgb-specific training (3x); *therapist gaining lgb training from independent readings; *the influence of specific training/professional experiences (2x), being identified as
affirmative by others (2x), and own SO id (2x) on participant’s path to becoming an affirmative therapist; * therapist discussing aspects of their personal SO id journey (5x); the positive influence of therapist’s SO id on their training/professional life (2x); and the positive influence of therapist’s training on their SO id (3x).

**Primary themes represented across the study sample of 9 therapists:**

One of the overarching themes apparent across participants is the use of their own identities as sexual minorities or allies in their work as affirmative therapists. Seven participants described aspects of their SO id (lesbian, gay, bisexual, or heterosexual ally) development journeys and all seven sexual minority-identified participants cited their SO ids as influential regarding their identities as affirmative therapists. A majority of participants (6) also cited that being identified as affirmative by others (in terms of referrals and professional life), specific experiences in their clinical practice and/or training (6), and identifying a community need (5) were influential to their identities as affirmative therapists.

A majority of participants indicated that key elements of their affirmative training have included: self-study through reading (8), contact with other peers/professionals (6), and supervision (5). Regarding training experienced during therapists’ graduate programs, the majority of participants had little or no training on lgb issues (5) and little or no exposure to lgb identity theory or models (5). Seven participants described specific graduate-level experiences as barriers to their training on lgb issues.

In terms of a general approach to affirmative therapy, the majority of participants (5) indicated some difficulty articulating their approach but were then able to do so. Participants (7) identified that validation and acceptance of the client (specific to their SO id) and use of the participant’s own sexual minority identity in therapy (6) were key elements. Specific to participants’ (6) use of their own identities as lgb or ally, it was identified as important to allow the client’s own identity develop unhindered by the therapist’s story. Other key elements included displaying and providing lgb materials (6), normalizing (5) the client’s SO id-related experiences, attending to relationship and family issues (5), and paying attention to/mirroring the client’s use of language (5).

Regarding addressing identity with clients in therapy, it was identified by eight participants that paying attention to the client’s age played a key role as did attending to ways that the client’s identity intersects and interacts with family/loved ones. It was also identified as key that therapists allow the client to lead the process of addressing identity (7) and help clients explore all aspects of their identities (5). Participants identified that both verbal readiness (6) and non-verbal communication (5) such as hesitations in speech were cues for them to address identity with clients. Five participants indicated that they address sexual orientation identity w/ clients beginning w/ the intake process.

Specific to therapeutic use of lgb identity models, it should be noted that five participants had received at least some exposure to the models in their training and utilized them either directly or indirectly in therapy. Of those five, four participants cited the Cass model as the one they were most familiar with and most exposed to. The main therapeutic
function of sexual minority identity models cited by participants (4) was providing hope/decreasing a sense of isolation for the client. Models were also cited as useful in conceptualizing, assessing, and identifying appropriate interventions (3). In terms of how therapists presented developmental information to clients, it was cited by four participants as important to first assess the client’s particular style of handling and processing information. Participants indicated several critiques of SO identity models including their lack of helpfulness to the therapy process (4), their danger if overused (3), and their overly linear description of identity development (3).

The essence of the phenomenon:
This study tells a story of the complexity and intricacy of minority sexual orientation identity development for clients. The most significant message gleaned from the therapists is the importance of honoring the client’s unique trajectory of identity development and allowing them to lead the process regarding addressing identity in therapy. It would seem that lgb models of identity can and do play a role in therapeutic work on identity but this role is clearly influenced by therapists’ exposure (or lack thereof) to the models in their training and fraught with critiques regarding the outdated nature of existing models and their failure to capture some of the more nuanced aspects of identity development. That being said, it did seem that the models were useful in providing a sense of hope to clients and in helping therapists with issues related to client conceptualization, assessment, and intervention.
Appendix Q

List of Codes and Corresponding Definitions
I. Addressing Identity
This category of codes refers to the multitude of ways that therapists specifically address SO id w/ their clients.

IA. Assessing Identity Issues
Therapists describe the variety of ways in which they detect whether SO id is a salient issue for their clients.

IA1. At Intake: All Aspects of History Taking
All aspects of intake assessment including forms and verbal interview.

IA2. Reaction to LGB-related Names, Topics Mentioned in Therapy
Therapists discuss assessing for id issues by mentioning names of lgb entertainers, discussing their own lgb family members, or bringing up a political topic. Therapists also pay attn. to lgb-related places/people that the client brings up.

IA3. Therapist Asking About Id Directly
Therapists describe how they will ask cits directly about SO id.

IB. Paying attention to the client's age
Therapists discuss the ways that the age of their client affects how they address identity w/ them. Examples including assessing that younger clt's may think differently about id and be more fluid in linking sexual beh. w/ id. Other examples include addressing id issues more directly w/ younger clts and being more careful to avoid labels related to SO id w/ older clients.

IC. Allowing the Client to Lead the Process
Therapists discuss the importance of allowing the client to control when and how id is brought up.

ID. Identity and family/loved ones
Therapists reflect on their work addressing SO id and how id relates to and intersects w/ the clt's identified family (including the client's partner and chosen, non-biologic family) and other persons the client may have a significant relationship w/ whom they do not consider "family". This code may also include therapists doing work w/ the family member of someone who identifies as lgbt and who may be struggling w/ their loved one's id in some way.
IE. Helping the Client Explore
Therapists discuss the importance of helping the client explore all aspects of their world in relation to SO identity. This exploration may include ways that either rejecting or endorsing an LGB id may affect them.

IF. Allowing for Ambiguity Regarding Identity
Therapists discuss the importance of allowing clients to reject SO identity labels even if they are comfortable w/ most other aspects of an LGB identity.

IG. SO ID More Process than Problem
Therapists reflect on their perception that relatively few clients come in struggling w/ SO id as a problem to be solved but more of an ongoing life-process issue and that this evolution is related to minority sexual identity being more accepted generally than in the past.

IH. Necessity of Expedition
Therapists indicate perception that addressing identity issues should be done sooner rather than later and that clts addressing SO identity in any way should be met w/ support and affirmation immediately whether or not they ultimately identify as a sexual minority.

II. Catalysts and Cautions
Therapists discuss specific aspects of their work that either prompt them to address SO id w/ their clients or signal that it may not be a good time to address SO id.

II1. Client’s Non-verbal Communication
Therapists reflect on paying attn. to their client’s non-verbal communication when deciding when to address SO id w/ them. Non-verbal communication may include the client’s body language/posture, what is NOT being said in a session, a clt's muscle agitation, and through clt's displayed emotions such as disgust, shame, or a noticed hesitation.

II2. Therapist’s Assessment of Clt. Security
Therapist reflects that one signal for her to address SO id w/ her clt. in therapy is her assessment that the clt. feels safe and secure in the therapeutic relationship.

II3. Anytime Anywhere
Therapists discuss ways that addressing sexual identity is interwoven throughout all aspects of therapy and that there are therefore no specific cues or catalysts to attend to.
II4. Client's Verbal Communication
Therapists reflect that catalysts for them to address SO id w/ their clients in therapy include the client's initiation of the topic in therapy as well as other aspects of verbal communication such as tracking how many times a client has said something or their inflection while saying it.

II5. Sense of ID Saliency
Therapists reflect that a catalyst for them to address SO id in therapy is their intuitive sense that SO id may be salient to the clt. even if the clt. is not disclosing this in therapy.

II6. Areas of Caution/What not to do
Therapists reflect on id-related issues that prompt them to "tread lightly" such as using an id label before the clt. is ready or working w/ a clt. who has a background of sexual trauma.

II6a. Making assumptions
Therapists reflect on the importance of avoiding assumptions about their clts, particularly that SO id is an issue. Other examples include avoidance of assumptions based on a clt's style of dress.

II6b. Clt. having little support in their lives
Therapist reflects on ways that she treads lightly w/ addressing SO id when she perceives that a clt. may have little support on their lives. Therapist explains that it may be dangerous for a clt to process an issue such as SO id w/ no social support other than the therapist to help them navigate their reactions.

II6c. Religion
Therapist discusses ways that fundamentalist religious beliefs make her cautious when addressing SO id.

II6d. Intense discomfort
Therapists reflect on their use of caution when addressing id w/ clts who appear v. uncomfortable. Examples include attending to id at a slower pace and assessing the clt's discomfort level as potentially therapy-destroying.

II6e. Avoiding Being Cautious as a Therapist
Therapists discuss ways that they may have been more cautious earlier in their careers but
are less so now and that this serves the therapy better.

II6f. Using an id label before the clt. does
Therapists discuss the importance of following the clt's lead regarding how and when to identify and what label to use (if any).

II6g. Clients In Early Stages of Identity Dx.
Therapist reflects that he uses more caution in addressing SO id w/ clts he assesses are at v. early stages of SO id dx. particularly b/c he himself is not and he believes it important to allow himself to become grounded in the clt's experience.

II6h. Sexual Abuse Histories
Therapists discuss treading very gently around id issues w/ clts who present w/ sexual trauma histories.

I. Therapeutic Explanation of Identity Development
Therapists explain the multiple ways that they may present/discuss identity development issues w/ clients including presenting identity models to clients directly or sources containing the coming out stories of other sexual minority persons.

IJ1. Using Client/Therapist Info to Illustrate Development
Using the client's own progress to illustrate the ways their SO id has developed. Some therapists described their identity work w/ other clients to illustrate SO developmental principles.

IJ2. Connecting the past to the present
Therapist explains the importance of helping clients explore the connections between significant events and relationships from their pasts to their present issues w/ SO id.

IJ3. Use of Coming Out Narratives
Therapists explain that they give clts "coming out" stories of lgbt individuals to allow clts to explore id and dx through their relationship to the stories. Additionally, clt's may gain a sense of validation and hope through these stories.

IJ4. Use of Didactic Materials
Therapists describe giving developmental information such as a coursepak, an article, or a book directly to the clt (or family members/loved ones of sexual minorities) for their review and to generate discussion of SO id.
IJ5. Discussing development generally (not using SO models)
Therapists explain that they might discuss SO id dx more generally w/ clients and may provide more general id dx material (not SO id models).

IJ6. Assessing the clt's ability to handle and process the info.
Therapists reflect on ways that they assess the thinking style of their clients before presenting and discussing certain developmental info such as SO id models in therapy. For example, one therapist reflects that clients who are seeking books, magazines, articles, and other sources related to identity seem best matched for being presented w/ id models as a learning tool. Additionally, therapists discuss their assessment of the clt's ability to sit w/ and cope w/ the information that they are given (i.e the therapist assessing that it may overwhelm the clt.).

IK. Use and Function of Identity Models
Therapists describe specific ways that they use identity models in therapy as well as broader uses of the models. An example of broader uses of the models includes helping with advancing lgb scholarship and research. Therapists explain that this aids in training a range of professionals on how to better serve lgb persons.

IK1. conceptualization, assessment, and intervention
Therapists explain that id models help them w/ assessment and conceptualization of their clt's id which ultimately helps them w/ choosing appropriate interventions. Additionally, some therapists discuss the ways that models help them w/ general conceptualization of sexual minority clients' identities but that they may never directly use any particular model.

IK2. Providing Hope/decreasing sense of isolation
Therapists reflect on identity models' utility in providing clts w/ a sense of hope and possibility for the future (particularly illustration of latter stages of development) as well as normalizing aspects of id dx and decreasing the clt's sense of isolation in their experience.

IK3. Exploration and Understanding
Therapists discuss the utility of SO developmental theory and info in helping clts to explore and understand the different facets of identity including decisions related to coming out. This assistance w/ understanding is not limited to sexual minority clts but also helps therapists promote understanding w/ the clt's family/loved ones. Additionally, therapists reflect on ways that models help them to understand group vs. individual aspects of SO identity development.
IK4. LGB Research, Scholarship, and Education
Therapists reflect on the utility of SO models in doing academic work or research, providing a language or template to frame from. Therapists also discuss the models' utility in educating health professionals about lgb id.

IK5. Specific Models Cited
Any specific developmental models cited as therapeutically used by therapists.

IK5a. Sexual Orientation Models
- Cass
- Coleman
- Troiden
- McCarn & Fassinger

IK5b. Other Developmental Models
- Jung
- feminist id model
- Keegan

IK6. Limits of/Suggestions for the Models
Any critiques or limitations expressed by therapists regarding id models as well as suggestions for the revision of existing models and/or creation of newer models and lgb scholarship generally.

IK6a. Overly Linear & Limited
Therapists reflect that actual identity development does not tend to occur in stage-like fashion and that any stage-like description of id falls short in some way. Therapists also reflect models' failure to account for the ways that lifespan issues intersect w/ and influence SO id. Additionally, therapists explain that models fail to capture the multitude of developmental issues clients experience regarding identity and the nuances of id.

IK6b. Clinical/Depersonalizing
Therapists reflect on models seeming too "clinical" and depersonalizing and thus, not therapeutically useful.

IK6c. Outdated
Models do not capture the ways that sexual orientation id has evolved over time including the aspect of not identifying w/ any sexual orientation label or changing one's identification multiple times over the lifespan.
IK6d. Over-reliance on the models
Therapist expresses that models can be dangerous if used in a way that is too lock-stepped and may allow for important information to be missed while other aspects of a client's id dx (such as deciding against coming out at work) is pathologized.

IK6e. Suggestions for LGB Models & scholarship
Therapists provide suggestions regarding revising existing SO id models or creating new ones as well as for lgb scholarship generally.

IK6e1. Integrating lgb scholarship into education
Therapist discusses the need for better integration of lgb training and scholarship into education. This training is not specific to models but clearly would include SO id models in it's scope.

IK6e2. Bridging gaps between research and practice
Therapists discuss the necessity of creating and deseminating research about id more freely, therapists accessing and utilizing the info, and scholarship reflecting more current concepts of id. Additionally, it is suggested that therapists do not simply accept research but rather examine it more critically.

II. Participant Identity
Any discussed aspects of participants' identity(ies) that seem salient to the studied phenomena.

IIA. Discussion of therapist's lgba identity journey
Therapists reflects on their journeys regarding their identities as lgb or ally including lifespan issues and the impact of heterosexism, coming out stories, and feelings about being politically active.

IIB. Pos. influence of SO id on training/professional life.
Therapists describe ways that their own SO id's positively influenced their professional life/training.

IIC. Pos. Influence of training/prof. life on Sexual Orientation Id
Therapists describe ways that their professional life/training positively influenced their own SO id'. Several examples include the ways that SO id models positively influenced therapists' SO id.
III. Training Around Provision of Affirmative Therapy
Any training therapists have experienced (either as trainer or trainee) regarding affirmative therapy including self-study, formal coursework, and conferences.

IIIA. Doctoral Level Training
Any doctoral level training specific to lgb issues/identity.

IIIA1. Significant training on LGB issues
Therapist encountering a significant amount of training specific to lgb issues/identity during her doctoral program.

IIIA2. Little or No Exposure to LGB Identity Theory or Models
Little/no exposure to lgb identity theory or models encountered during therapists' doctoral programs.

IIIA3. Little or No Training on LGB Issues
Little/no training specific to lgb issues/identity encountered during therapists' doctoral programs.

IIIA4. Significant Exposure to LGB Identity Theory or Models
Significant exposure to lgb identity theory or models encountered during therapist's doctoral program.

IIIA5. Some Exposure to LGB Identity Theory or Models
Some exposure to lgb identity theory or models encountered during therapists' doctoral programs.

IIIA6. Some Training on LGB Issues
Some training specific to lgb issues/identity encountered during therapists' doctoral programs.

IIIB. Master's Level Training
Any master's level training specific to lgb issues/identity.
III B1. Some Training on LGB Issues
Some training specific to lgb issues/identity encountered during therapists' master's programs.

III B2. Some Exposure to LGB Identity Theory or Models
Some exposure to lgb identity theory or models encountered during therapists' master's programs.

III B3. Little or No Exposure to LGB Identity Theory or Models
Little/no exposure to lgb identity theory or models encountered during therapists' master's programs.

III B4. Little or No Training on LGB Issues
Little/no training specific to lgb issues/identity encountered during therapists' master's programs.

III C. Specific Coursework
Any coursework specifically addressing lgbt issues/identity.

III D. Barriers to LGB Training
Therapists reflect on specific barriers they may have encountered regarding training on lgb issues including negative experiences. Examples include having material presented only briefly, no formal presentation of any material related to sexual orientation, advisors refusing to use the word "lesbian", receiving information that pathologizes lgb id, and lack of exposure to current research.

III E. Providing Training/Educating/Doing LGB Research
Therapists review ways they have engaged in providing training or less formal education around lgb issues or have engaged in research on lgb issues.

III F. Conferences/Workshops
Any conferences or workshops explicitly addressing lgb issues/identity.

III F1. Some Exposure to LGB Identity Theory or Models
Therapist reflects on gaining exposure to a particular SO id model through a conference training.
IIIG. Training Through Work
Any work-related training specifically addressing LGB issues/identity.

IIIH. Independent Readings/Self-Study
Any readings or other self-study (such as video) specifically addressing LGB issues/identity.

IIIH1. Some Exposure to LGB identity theory or models
Exposure to LGB identity theory/models through self-study/independent readings.

III. Contact With Other Professionals and Peers
Therapists describe a key part of their learning experiences related to affirmative therapy being contact with other peers/professionals doing affirmative work.

IIII1. Some Exposure to LGB identity theory or models
Exposure to LGB identity theory/models through contact with other professionals and peers.

IIII. Contact With Other Professionals and Peers
Therapists describe a key part of their learning experiences related to affirmative therapy being contact with other peers/professionals doing affirmative work.

IIII1. Some Exposure to LGB identity theory or models
Exposure to LGB identity theory/models through contact with other professionals and peers.

IIIIJ. Supervision
Therapists describe receiving training and exposure to LGB issues through work with supervisors.

IV. Path to Becoming an Affirmative Therapist
Therapists describe the paths that led them to identifying/becoming affirmative therapists.

IVA. Personal Identity as LGB
Therapists discuss the ways that their personal id's as LGB influenced their identification as affirmative therapists.

IVB. Being Identified by Others
Therapists describe how being id'd as LGB-affirmative by others (clients, peers, other professionals, etc) and associated referrals of sexual minority clients helped promote their own development as LGB-affirmative therapists.

IVC. Specific experiences in clinical practice and/or training
Therapists describe specific experiences encountered in their professional life or training that influenced their becoming affirmative therapists.
IVD. Identifying a Community Need for Affirmative Therapy
Therapists discuss ways that they identified a need for affirmative therapy in the community, most often by discussing negative experiences clients have had with non-affirmative therapists.

IVE. Personal life experiences
Therapists discuss personal life experiences influencing their identification as affirmative therapists such as family upbringing.

V. Therapists Reflections on Affirmative Therapy
This category encompasses a multitude of aspects of therapists' experiences providing affirmative therapy including what they believe are essential components of affirmative therapy and their challenges in doing affirmative therapy.

VA. Validation and Acceptance of SO
Therapists reflect on the necessity of validating those aspects of sexual minority clients' lives that are not likely to be validated in a heterosexist environment (for example, the client's choice of partner) as well as communicating an attitude of deep acceptance towards the client's SO id. (whatever this may be, including questioning or not using any self-identifying label) which decreases shame.

VB. Therapist Using own experience of LGBA identity
Therapists reflect on the ways that their own id informs them and is used as a therapeutic tool with the client. This may include openly sharing their id with the client. Examples include modeling skillful behavior and a sense of hope for clients. In the case of a particular ally therapist, modeling was facilitated by the therapist having her client meet with some of the therapist's lgb colleagues.

VB1. letting the client's story and progression be their own
Therapists discuss the importance of allowing the client's unique story and developmental pace to unfold without overly influencing them based on therapist's SO id. Some therapists explicitly state that they will not disclose their SO id until the client seems relatively sure of their own SO id.

VB2. assessing whether disclosure may impede therapy
Therapists reflect on their decision not to disclose their id as lgb or ally out of concern that this would hamper the client's therapeutic progress in some way. One therapist adds that she not only assesses for whether this would impede therapy but also whether it would actively benefit therapy (and if not, she may choose not to disclose).
VB3. Having pride in and commitment to one's own identity
LGB-id'd therapists discuss the importance of having pride in and commitment to one's own SO id in doing affirmative work.

VB4. Immediately if SO is an issue
Therapist reflects on her belief that it is essential that she comes out to clients immediately if sexual orientation is at all an issue based partially on her own experiences w/ feeling betrayed when others have not been open about their sexual orientation.

VB5. only if asked
Therapists reflect on instances when they would only share their id if asked directly by the clt.

VB6. Feeling safe w/ the client
LGB-id'd therapists reflect on the necessity of a sense of safety and trust in the relationship w/ the client before sharing personal info @ id.

VC. Normalizing the clt's SO experience(s)
Therapists reflect on the importance of normalizing the clt's SO-related experiences.

VD. Attending to relationship and family issues
Therapists reflect on the importance of attending to areas of relationship in sexual minority clients' lives whether it be through couples work or individually. This includes working w/ clts on transitioning out of heterosexual relationships.

VE. Examining & challenging beliefs and/or behaviors
Therapists reflect on the importance of helping clts. identify and challenge negative beliefs and/or behaviors related to sexual orientation. Examples include specific negative beliefs about other sexual minority people and avoidance behaviors related to those beliefs.

VF. Attention to Language
Mirroring the client's choice of language. For example, referring to a woman's partner as her wife if she has referred to her partner in that way. Following the client's lead regarding language. Paying attn. to the client's self-label of gay, lesbian, bisexual, or other.
VG. Displaying and providing LGB materials.
Therapists reflect on the importance of visibly showing lgb materials and making those materials available to clts.

VH. Teaching/Providing Information
Therapists reflect on the ways that they incorporate teaching into their affirmative work.

VI. Addressing injustice/taking part in community
Therapists reflect on the importance of being active in lgb-related social justice and community as well as addressing social justice issues such as heterosexism.

VJ. Affirmative to All
Therapists discuss the importance of being affirmative to all the clients they see (not just sexual minority clients) and that this place of affirmation is more of a general philosophy than a specific approach.

VK. Emphasis on Non-Pathological Approach to SO
Therapists discuss the importance of taking a non-pathological approach to SO in their affirmative work. Therapists explain that this means taking a more holistic view of clts rather than one based more on theory and the medical model of trying to "fix" something that is wrong. Some therapists indicate perception that use of id models in therapy seems overly clinical and pathologizing.

VL. Creating a Sense of Safety For the Client
Creating a safe enough environment for the client to begin to examine and explore their SO identity and rehearse SO identity-related behavioral changes in therapy.

VM. Helping the Client Find a Support System
Therapists reflect on the importance of helping clients (and their partners) access a support system around their SO id. Examples include referring clt's to an lgbt-specific group.

VN. The Challenges of Doing Affirmative Therapy
Therapists describe some specific challenges they have faced doing affirmative therapy.

VN1. Working w/ Adolescent Clients on Sexual Orientation
Therapists describe their challenges working w/ adolescent clts.
VN2. Boundary Issues
Therapist reflects on her experiences with client/therapist boundaries doing affirmative work and her perception that this has been more of a challenge in her affirmative work than other therapy. This therapist describes several instances where her boundaries felt violated and her reactions ranging from mildly irritated to feeling physically unsafe.

VN3. Small town therapy: everyone knows each other
Therapists discuss the challenges of doing sexual orientation work in a community where many people know each other.

VO. Difficulty Articulating Approach
Therapists describe or display a general difficulty identifying central aspects of affirmative therapy but are then able to do so.

VI. Follow Up
Codes derived from 2nd interview data

VIA. Agreement with Data Interpretations.
Therapists indicated overall agreement with researcher's interpretations regarding their data. Some therapists added information regarding their experiences and some clarified aspects of interpretations but none indicated disagreement with any presented interpretations.

VIA1. Adjustments/Clarifications/Reactions
Any adjustments or clarifications that therapists presented regarding the interpretation of their data. Additionally, one participant in particular expressed multiple reactions to the presentation of the data in her synopsis that was neither an adjustment nor a clarification but mainly centered on expressing a feeling of an emotional layer and the voice of the researcher missing from the synopsis.

VIB. Increased Awareness
Therapists discuss their reaction to have participated in the study as an increased awareness of their own work and how they do this work. Some therapists also reported an increased awareness of how new training experiences related to their affirmative work. Others mentioned a sparked interest in LGB identity models/scholarship and how they would like to either learn about certain models for the first time or update their existing body of knowledge regarding models or scholarship.
VIC. Importance of Peer Support
Therapists touch on the value that contact with other affirmative peers and professionals has for them. This may be existing peer support or the idea of peer support.

VID. Essence is a fit
Therapists are asked about their perception that the essence of the study fits their perspective and indicate that it does. Some therapists emphasize the piece that stands out for them is that regarding honoring each client's unique trajectory of identity development.

VIE. Sense of Validation/Affirmation
Therapists discuss their reaction of feeling validated and/or affirmed by reading about other affirmative therapists' experiences and methods and by participating in the study more generally. One therapist asked me about my reaction to my study and reflected that this was "hope engendering" for her. Some therapists also discuss feeling validated by reading the synopsis of their own work, as this seemed to bring into light that what they are doing is valuable and on-track.
Appendix R

Essence of the Study
Essence of the Study

Affirmative therapists’ collective experience addressing sexual orientation identity with clients and using developmental models of LGB identity in therapy

The nine therapists interviewed for this study all shared a passion for the practice of affirmative therapy that transcended theoretical orientation. Therapists held a variety of sexual orientation identities but all shared a common identity as an “affirmative therapist”. Therapists described several influential factors regarding their development of this identity including personal identification as a sexual minority, specific professional experiences, being identified as affirmative by others, and addressing a community need for affirmative therapy. All therapists identified key strategies used in their practice of affirmative therapy; the three main strategies being ample use of validation and acceptance (embracing those aspects of their sexual minority clients’ lives that are likely to be devalued in a heterosexist environment), use of their own SO identities in therapy (through positive modeling, normalizing, and using their experiences to intuitively connect with the client), and displaying and providing LGBT-related materials (making sure clients can easily view and access materials related to sexual minority issues).

In addition to general affirmative practice, all therapists identified key strategies specific to addressing SO identity with their clients. These strategies were aimed at promoting the client’s development of a healthy, integrated, positive SO identity and constructing a life around that identity. Four main strategies were identified: allowing the client to lead the process of addressing identity, attending to the client’s chronological age and corresponding development (age-influenced stylistic adjustments made regarding how SO identity is addressed), attending to catalysts and cautions regarding broaching
The topic of SO identity (cues from clients to either address or back off from the topic), and addressing family-of-origin and romantic relationship issues (helping clients manage SO identity-related disruptions in their family relationships and develop and maintain healthy romantic relationships, etc).

The strategy, “allowing the client to lead the process of addressing identity” became the most significant strategy found in this study based on its frequency of occurrence and all nine therapists’ expressed enthusiasm for its importance regarding therapeutic attention to SO identity. This importance was connected to recognition of clients’ vulnerabilities as they explore the possibility they may hold an oppressed identity, therapists’ wish to promote their clients’ autonomy and empowerment, and preserving/promoting a sense of trust in the therapy relationship.

Five of the nine therapists in this study had some form of exposure to LGB models of identity in their training and used these models to some degree in their affirmative work with clients. These therapists described a variety of experiences regarding the depth and quality of their exposure and how they integrated the information gleaned from these models into therapy. They identified two main therapeutic functions of developmental models of LGB identity: promoting a sense of hope (particularly through illustration of models’ latter stages of development) and assisting with multiple facets of client conceptualization (through models’ descriptions of specific behavioral and emotional markers of SO identity development). These therapists all acknowledged and identified some central limitations to the models including their tendency to present SO identity development as
too simplistic and linear, the perception of the models as clinical and depersonalizing, and their potential to be used inflexibly without attention to context.

Therapists described a range of positive reactions to participating in this study. These reactions seemed mainly connected to feeling validated for their affirmative work. Therapists also described how reading the summary of themes from other participants sparked a sense of fellowship with other therapists and of being “on track” regarding their own work. An additional benefit of research participation described by therapists was gaining an increased awareness of their work through articulating their own processes regarding affirmative therapy and ways that they address SO identity with their clients.
Appendix S

HSIRB Research Approval Letter
Date: July 14, 2008

To: James Croteau, Principal Investigator
   Victoria Cane, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 08-07-07

This letter will serve as confirmation that your research project entitled “LGB-affirmative Therapists’ Use of Developmental Models of LGB-identity in Therapy: A Phenomenological Investigation” has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: July 14, 2009