Lesbian, Gay and Bisexual Clients' Experiences of Discussing Sexual Identity in Therapy

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: 

Dated: 15/11/2013

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ABSTRACT

The current study explores lesbian, gay and bisexual (LGB) individuals' experiences of discussing sexual identity in therapy. Current literature indicate that the absence of sexual identity issues being identified and discussed could be a significant barrier to effective therapy with LGB clients. However, little research has explored how sexual identity is conceptualized in therapy by LGB clients and their therapists, and how this influences their therapeutic outcomes. Using interpretative phenomenological analysis (IPA), LGB clients' experiences of discussing sexual identity in therapy was investigated. Results clustered into three overarching themes: *1.* Sexual identity as self in the making; *2*. Sexual identity as a barrier; and *3*. Sexual identity as increased awareness of oppression. Discussion of sexual identity is important for LGB clients in therapy, regardless of whether it is the main focus of their presenting issues. These discussions help them explore their sexual identity formation processes, which result in a stronger sense of identity due to a better understanding of sexual identity as an aspect of themselves. LGB clients who lack such opportunities to discuss sexual identity in therapy experience heteronormative assumptions and biases from their therapists, which increased their awareness of themselves as individuals of sexual minority and empathy towards others under oppression. The current study concludes that therapists should remain open-minded and explorative when helping LGB clients discuss their sexual identities in therapy, but always in context to their presenting issues so that conceptualizations and sense-making of sexual identity is centred in the clients' subjective experiences.

1 – BACKGROUND

1.1 Counselling Psychology: An Overview

The American Psychological Association (APA) describes counselling psychology as a subspecialty of psychology that focuses on normal development as well as issues with psychological discourses, to facilitate emotional and physical wellbeing of clients with culturally sensitive practices, and takes a preventative approach in interventions (APA, 2013). In New Zealand, the Institute of Counselling Psychology established in 2003 defines the role of counselling psychologists as to "enable and empower clients experiencing typical and atypical problems of living to enhance their personal, social, educational and vocational functioning" (NZPS, 2013). Developed within the framework of existential phenomenology with influences from humanistic approaches and values such as those proposed by Carl Rogers, counselling psychology acknowledges the subjective life-worlds of self and others, and also the intersubjective nature of psychotherapy (Brown & Corne, 2004). The engagement with the clients' subjective experiences, values and beliefs and quality of the therapeutic relationship are important (Woolfe, Strawbridge, Douglas & Dryden, 2010), and so is the social context within which the client's self is constructed (Wampold, Ahn & Coleman, 2001). Woolfe (1990) identified counselling psychology as distinctive from other psychologies due to its questioning of the medical model in favour of a more existential or humanistic value base. While counselling psychologists do not engage in any one particular therapeutic style, a commitment to lifespan development and cultural diversity is central to the field. In short, counselling psychology is concerned with areas of human functioning that include a person's inner life, social functioning and systemic factors impacting on their wellbeing (Manthei, Stanley & Gibson, 2004).

1.2 Counselling Psychology and Sexuality

In therapeutic processes, counselling psychologists usually acknowledge themselves as an active participant who brings in their own attitudes and values. They are especially aware of the theories, research and practices pertaining to issues of diversity (Cooper, Frewin, Gardiner, O'Connell & Stanley, 2002). Counselling psychologists' values and political views towards sexual minorities are therefore

highlighted due to the field's postmodern assessment on the influence of cultural ideologies and social relationships on mental health (Strawbridge & Woolfe, 2010). Asta and Vacha-Haase (2013) have found that counselling psychologists have a general desire and interest concerning social justice issues, and this is partly influenced by a continued understanding of their current professional roles. Given the continuation of both oppression and acceptance in current societal shifts towards same-sex relationships, counselling psychologists have been instrumental in creating and furthering the sexual minority research literature. Most literature in counselling psychology on therapy with LGB clients have focused on the effects of anti-LGB stigma, since they are internalized, expressed and experienced by LGB individuals (Croteau, Bieschke, Fassinger & Manning, 2008). A leading article in an issue dedicated to sexual minority issues in *The Journal of Counselling Psychology*, Moradi, Mohr, Worthington and Fassinger (2009) proposed that sexuality and sexual identity are worthy of study in counselling psychology because increasing diversities of experiences reported within LGB populations could provide potential alternative explanatory factors for presenting issues in therapy, other than apparent sexual minority effects. With regards to the significance of subjectivity in counselling psychology, Mohr (2002) argues that current sexual orientation biases in therapy are not merely due to issues in therapists' attitudes, but rather as the result of heterosexual therapists' attempt to maintain and express heterosexual identities as a way of contributing to a coherent and positive sense of self in themselves. Furthermore, Worthington and Mohr (2002) discussed that the level of sexual identity achievement and awareness in heterosexual therapists has been found to influence the depth of engagement one is able to form with LGB clients to explore aspects of their sexuality and interpersonal issues related to their sexual identity. This includes desirable counsellor characteristics such as the ability to recognize sexual transference and countertransference, preventing sexual values from influencing their work, and being comfortable with sexually-related material (Worthington, Savoy, Dillon & Vernaglia, 2002).

1.3 Sexual Identity Development Theories

Over the decades, social discourses have influenced both therapists' and clients' perceptions towards sexuality and conceptualizations of mental health issues. Homosexuality was first condemned as sodomy from Genesis 19:1-8 and criminalized in England in the 1500's as punishable by hanging. In 1791, Europe began decriminalizing sodomy post-revolution in France partly contingent to the Enlightenment process to protect private spheres from state intrusion. Medical fields first became interested in the studies of sexuality when those suspected of public and anal sex were required medical examinations to check for insanity. Although pathologizing, sexual deviancy also became a legal matter due to concerns of the innocence of the accused. Neuropsychiatry's concerns of same-sex attraction as congenital or hereditary brought about the notion of 'sexual inversion' that dominated medical thinking into the 20th century. In 1905, Freud brought forth several theories on homosexuality: while he believed ecological and traumatic factors impacted on the development of innate, biological instincts, he perceived homosexuality as a symptom of psychic conflict. With bisexuality, his view was constitutional: where there in every individual existed a masculine/active and feminine/passive tendencies, and in addition, one's anatomical sex should dictate consistent sexual satisfaction with the opposite sex (Freud, 1953). Homosexuality was thus presented on developmental arrests as an alternative to religion's theory of immorality and psychiatry's pathogenic medicalization. Thus, both the essentialist notion of sexuality – a fixed and stable phenomenon fundamental to the self – and social-constructivist perspective on sexual identity – an arbitrary construct that is fluid and changeable across contexts – have shaped psychological theories of sexual orientation. Changes to the official perspectives on homosexuality in the DSM mean that therapeutic approaches to LGB clients vary depending on which formulations are accepted (Pachankis & Goldfried, 2004).

Until recently, sexual identity development and its contribution to ego-identity in the LGB population have not been closely investigated. Sexual identity has been defined as a process of self-definition more broadly as a sexual being (Worthington, Savoy, Dillon & Vernaglia, 2002). Sexual identity development commonly refers to the process in which an individual comes to conceive and

present themselves as lesbian, gay or bisexual (Diamond, 2006). Specifically, Yarhouse (2012) discusses that sexual identity appears to entail a cohort of psychosocial concepts, including: 1) *biological sex* as male or female, 2) *gender identity*, or one's psychological sense of being male or female, 3) *sex role*, or one's adherence to social expectations of one's sex, 4) *sexual orientation*, the direction and experience of one's sexual attraction, and perhaps as more recently proposed, 5) *valuative framework*, or one's intention of what to do with their sexual desires with considerations to their values and belief systems.

Erikson's (1950) psychosocial stages of development first offers a theory for how ego-identity develops, namely "the accrued experience of the ego's ability to integrate identifications with the vicissitudes of the libido, with the aptitudes developed out of endowment, and with the opportunities offered in social roles". His proposal of the stage *Identity* vs. *Confusion*, occurring around age 13 to 19, involves exploration and developments of one's sexual identity and gender roles. Marcia (1996) expanded upon Erikson's developmental theory through an identity status approach, where she added one's attitudes towards sex roles and beliefs about personal sexuality as extra criteria to the consideration of an individual's identity exploration stage. Schiedel and Marcia (1985) suggested that sex roles are used by adolescents as a kind of ready-made identity that is used as support while they experiment with other aspects of identity. They further suggest that outcomes are one of four ego-identity statuses: *Achievement*, where the person has passed through exploration and made self-chosen commitments; *Moratorium*, as in a state of exploration; *Foreclosure*, where commitments commonly parrot parental positions and did not pass exploration; or *Diffusion*, a lack commitment and concern over lack of direction.

Homosexual identity developmental theories are similar to the stages described by Marcia (1996). The Cass model (1979) of homosexual identity development proposes that identity is shaped by comparison of consistencies or inconsistencies between how an individual believes others perceive them and their self-perception. Cass (1979) commented that "stability and change in human behaviour are dependent on the congruency or incongruency that exist within an individual's interpersonal environment". Cass (1979) therefore theorized that there are six stages an individual goes through to acquire a homosexual identity, including *confusion, comparison, tolerance, acceptance, pride* and *synthesis* of self-identity.

An alternative model was proposed by Troiden (1989) which conceptualizes identity formation as taking place against a backdrop of stigma, where themes present in homosexual's lives are clustered around certain developmental phases in life. The model's emphasis is on sensitization, or a 'pre-homosexual' phase where before puberty, affective, cognitive and behavioural experiences are seen as paramount to the interpretation and meanings the individual later on attach to adopt a gay or lesbian identity. While the stage of *Identity Confusion* is also present in Troiden's model, the next stage of *Identity Assumption* includes both tolerance and acceptance of a possibility of homosexual identity, as the individual experiences sexual and emotional experiences with others of the same sex, and prepare to as confront affiliated social stigma and challenges. Finally, the last stage of *Commitment* requires from the individual an internal sense of security and satisfaction from the fusion of emotionality and sexuality with a same-sex individual into a significant whole as a source able to provide happiness and love in life. At this stage, the individual may also choose to hide or express their new chosen identity, integrating one's public image and private self. Weinberg, Williams and Pryor (1994) began theorizing a framework in attempt to capture common experiences of bisexual individuals. Stages are similar to homosexual identity development, including *Initial Confusion* of attraction and sexual orientations; *Finding and Applying a label* to selves as bisexual after exploration; *Settling into a new identity*; and it is theorized that *Continued Uncertainty* is sustained throughout the life of a bisexual person due to minimal accurate information available in society, which result in fear of judgment and misunderstanding of fluidity of attraction in these individuals. While not exclusive to the bisexual population, polyamory – the practice, desire or acceptance of having more than one intimate relationship at a time consensually – poses further challenges to the notion of monogamy as an ideal sexual and emotional form of love in society.

1.4 Changing Therapeutic Approaches towards LGB Clients

With regards to the significance of developmental considerations in counselling psychology, sexual identity developmental theories should in theory influence therapists' conceptualizations and therapeutic approaches to LGB clients' presenting issues in therapy. The American Psychiatric Asscociation (APA) found

that currently in therapy, psychologists vary widely in therapy in their adherence to a standard of unbiased practice with gays and lesbians (Garnets et. al., 1991). Despite the de-pathologization of homosexuality in the mental health profession, many therapists report feeling uncertain of how to approach LGB clients (Lawver, 2012). Many therapists who do take on LGB clients do not perceive sexual identity as relevant to the therapeutic process (Barlett, King & Phillips, 2001). Barlett, King and Phillips (2001) have even suggested that therapists should explain their theoretical approach to homosexuality or bisexuality prior to starting therapy to obtain the client's consent.

LGB identities require a client to confront or deny something that they have discovered or created within themselves (Langdridge, 2007). How therapists help clients to face this process of identity formation can impact on the client's life-worlds powerfully and directly. If there is negative prejudice associated with the client's sexual identity, it can be internalized and turned against the self, even without an external aggressor (Langdridge, 2007). Gay-affirmative therapies (GAT) therefore seek to provide a direct corrective to homonegativity. GAT was defined by Malyon (1982) as an affirmative therapists "challenging oppression in self & others, being familiar with & able to respond to issues presented by gay clients, and developing competence in using a range of therapeutic interventions, together with an awareness & acceptance of personal limitations in working with this client group". GAT represents a special range of psychological knowledge which challenges pathologization of homosexuality, rather than an independent system of psychotherapy (Davies & Neal, 1996). Two distinct approaches to gay-affirmative therapy have been developing: one is an *ethically* affirmative therapy, where LGB identities are valued equally with heterosexual identities; the other is a stronger *LGB affirmative* therapy, where therapists encourage elements in the expression of LGB identities and use positive affirmation to ameliorate the effects of heterosexism. While the former emphasizes methods of interpretation such as hermeneutics that allow therapists to see beyond the surface meaning of clients' narratives, the latter asks therapists to directly challenge negative self-attributions in LGB clients and encourage positive sexual identities (Ritter & Terndrup, 2002). Although with either approach therapists are supporting clients' inner experiences, the latter requires a more activist stance from the therapist's to reduce feelings and negative connotations of cultural stigma. This has significant implications for counselling psychologists

because the latter approach may seem at odds with counselling psychology's therapeutic neutrality in existential & humanistic psychotherapeutic practice. In addition, GAT has been criticized of bringing premature foreclosure to the sexual identity work with an LGB client by restricting their power to work through and create their own meanings with the therapeutic relationship (du Plock, 1997; Goldenberg, 2000; Cross, 2001).

While many sexual identity developmental models acknowledge that identity is acquired through both stability and changes that occur through interactions with an individual's contextual environments, whether a person ever really experiences or achieves a stage of identity synthesis is has been called into question (Yarhouse, Tan & Pawlowski, 2005). Sexual identity does not only involve recognizing and accepting same-sex attraction, but also reconsidering and rediscovering other-sex attraction to maintain long-term identity. In other words, sexual questioning may not end at one's identification as lesbian, gay or bisexual, but instead continues as the individual's experiences expand in emotional relationships, social networks or ideological beliefs (Yarhouse, 2012). Some therapists may believe that encouraging patients to accept and be proud with their identity is affirming, but this may not be helpful for clients who are questioning or in conflict over their sexual identity. On the other hand, it could also be difficult for therapists to know where to 'meet' clients who are currently struggling with their sexuality. These issues open an area for on-going discussion on whether there is a theoretical incompatibility between LGB affirmative practices and more existential or humanistic approaches.

1.5 Summary

Sexual identity development, including model formation and heterosexual identity development, as well as clinical judgments and attitudes towards LGB clients are emerging areas in the field of counselling psychology. Counselling psychologists have been urged to shape and contribute to public policies regarding sexual minority issues (Moradi, Mohr, Worthington & Fassinger, 2009), however, current fragmentations in LGB affirmative approaches reflect a need for more understanding in theories of sexual identity development. Shifting social concepts towards homosexuality and same-sex relationships require therapists to have greater understandings of how their values and therapeutic approaches impact on their LGB

clients in the therapeutic relationship, particularly pertaining to issues regarding clients' sense of selfhood, sexual identity, behaviours and relationships. The next chapter presents existing research and literature on how sexual identity is understood to play a role in the conceptualization of LGB clients' mental health issues, and how it may be influenced by both the client and therapist.

2 – LITERATURE REVIEW

This literature review identifies themes in the current literature concerning sexual identity in therapy with LGB clients. These include: LGB client's experience of mental health services; issues relating to sexual identity in therapeutic relationships, as conceived by both clients and therapists; and finally, issues with training and education in psychology on dealing sexual minority clients.

2.1 LGB Clients' Experience of Mental Health in New Zealand

In New Zealand, same-sex marriage was legalized as of August 19th, 2013. While many social discourses towards homosexuality currently exist, historically heteronormativity – the assumption that heterosexuality is inherently superior to other sexual orientations (Tilsen & Nylund, 2010) – has been used against the passing of the Civil Unions Bill via the notion of 'natural law', or the fact that children cannot be a direct consequence of same-sex relationships. Despite the fact that homosexuality was officially removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1973 by the APA, homonegative discourses are still dominant and widely prevalent in New Zealand (Semp, 2006). LGB clients who used mental health services claim their sexual identities are pathologized, implicated in their mental health problem, or completely ignored (Adams, Dickinson, & Asiasiga, 2010). Semp (2006) found that a 'silence' is being maintained around sexuality by mental health practitioners, many of whom perceive their LGB clients to be too 'fragile' to discuss their sexual identity and only raising the topic of sexuality with them ambiguously.

A New Zealand study by Birkenhead and Rands (2012) found that many LGB clients continue to report high rates of dissatisfaction with mental health services due to heterosexual bias and discrimination, and many conceal their sexual identity because of shame or embarrassment. As a result, many LGB clients in New Zealand continue to fear and hide their sexual orientation despite wanting to be asked about their sexuality (Birkenhead & Rands, 2012). LGB clients feel providers lack understanding of their needs and they do not have the opportunity in therapy to discuss their issues relating to gender and sexuality even if they want to (Adams, Dickinson, & Asiasiga, 2010). It is perhaps no surprise that LGB clients have

continued to use therapy at a greater rate than their heterosexual counterparts (Liddle, 1996; Bieshieke, Perez & Blasko, 2007). There is robust evidence that New Zealand non-heterosexual populations are more at risk of suicide and mental health problems than the heterosexual population (Fergusson, Horwood, Ridder, & Beautrais, 2005; Welch, Collings & Howden-Chapman, 2000). Increased risk of major depression, anxiety, substance abuse, multiple disorders and suicidal ideation are all characteristics associated with LGB individuals (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003). It seems that the absence and lack of sexual identity issues being identified and discussed are significant barriers to effective mental health treatment for LGB individuals.

2.2 Concept of Sexual Identity in Therapeutic Relationships

2.2.1 Client Perspectives

Many therapeutic issues in LGB therapies regard topics concerning clients' feelings relating to identity and sexual orientation, such as internalized homophobia; negative self-criticism and non-acceptance of self; over-identification with positive or negative stereotypes; effects of childhood abuse; and painful coming-out processes (Cheng, 2003). Pachankis and Goldfried, (2004) noted that it is difficult for LGB clients to discuss their sexual identity, because issues such as internalized homophobia affect the degree to which LGB clients can be open about their sexual identity. LGB individuals tend to have smaller social circles, which also makes privacy and coming out exceptionally difficult to deal with (Pachankis & Goldfried, 2004). They may also feel that if others know their true identity they would be rejected (Haldeman, 2010). Therefore, even once their sexual identities are disclosed, clients feel they would have to deal with the unpredictability of responses from therapists (Semp, 2006).

Despite these difficulties, LGB clients do not want avoidance of negativity towards homosexuality from the therapist, as this indicates lack of depth in engaging with negative perceptions related to the acceptance of LGB culture, and shows that the therapist is unable to challenge the client's interpersonal issues (Grove & Blasby, 2009). Additionally, LGB clients want a therapeutic relationship in which their therapist is comfortable when discussing issues relating to sexuality, so they could explore previous unexplored areas of sexuality in a safe and open space (Pixton,

2003). For some clients, it is important to identify their sexual orientation as ambiguous in order to develop authenticity in therapy since sexual identity is not always clear-cut (Ohnstad, 2009). As Arseneau and Fassinger (2006) described, clients would sometimes 'rather get wet than be under the umbrella' of sexual labels and terminologies.

Interestingly, a study by Mair (2003) found that while some clients do not believe they need to talk about their sexual identities in therapy, at the same time they feel frustrated that their therapists did not help them explore what being lesbian, gay or bisexual means, even when sexual orientation was not the main issue. Thus, LGB clients who do not seem 'ready' to discuss sexuality may in fact be assessing the heteronormative environment and their therapists' willingness to discuss sexuality in general (Semp, 2006). Ideally, therapist and client should be on the same wavelength so there is instant empathy, and that the client does not have to explain too much in regards to their sexuality (Malley & Tasker, 2007). While some heterosexual therapists may be tempted to refer LGB clients to LGB therapists under the assumption that they could provide more competent care, this may not necessarily be the case because LGB therapists hold different beliefs over social aspects of LGB lifestyles, and would judge clients' behaviours as healthy or unhealthy ultimately on the meaning it has for themselves and their client (Jones, Botsko & Gorman, 2003).

Grove and Blasby (2009) commented that LGB clients want their sexuality to be treated as one aspect of themselves and their relationships, but not over-emphasized by therapists. In addition, it is important that therapists can support their exploration of sexual identity as well as other subject positions that may be at a tangent, such as religious beliefs (Lebolt, 1999). Milton, Coyle and Legg (2005) suggested allowing LGB clients to talk freely or even negatively about their experiences of sexual identity formation processes can help them develop more realistic ideas of a sense of self. However, this may require therapists to be aware of discrepancies between their imagined and actual experiences of their LGB clients, since it is easy for therapists make conceptualizations contingent on 'dealing with LGB identities' and attribute clients' problems to their sexual orientation (King, 2003).

In summary, there are barriers to LGB clients disclosing or discussing their sexual identities in therapy, although there are uncertainties over whether the client

or therapist should dictate the significance of sexual identity in the presenting therapeutic issue. Furthermore, while LGB clients want their sexual identities to be discussed in an open-minded way and without preconceptions, it may be difficult for therapist to discuss sexual identities with LGB clients without implicating it in their presenting issues.

2.2.2 Therapist Perspectives

Semp's (2006) research identified that currently therapists are perceived as the ones who should have the initiative to help clients explore their sexuality, since they assess what is important in treatment and have a responsibility for minimizing harm to others. However, many therapists currently feel difficult to approach the subject of working with LGB clients openly and honestly (Logan & Barret, 2006). These are perhaps in part due to the fact that recognizing and owning homophobia is a threatening process to society as a whole, and therefore often side-stepped by therapists in therapy (Mair, 2003). Landridge (2007) noted the importance for therapists to be aware of their own issues since their own fears towards sexual minority issues will reinforce clients' fears, concerns or negative views of themselves.

Commonly, discomfort in the therapist leads to over-compensation through being overly positive clients or not daring to challenge client issues related to gay culture (Eubanks-Carter, Burckell & Goldfried, 2005). The subjectivities of therapists can thus be projected onto clients if the therapist is not mindful of empathically understanding meanings of their clients within a phenomenological framework. These include values or identities that therapists may hold at different times of their lives that may be at a tangent with LGB sexuality (Bieschke et. al., 2000). As clients discuss their sexual identity in relationships to others as well as the wider society, their use and understanding of sexual identity terms have diverse contexts, reasons and meanings (Semp, 2006). Therapists who lack familiarity and understanding of the nature and meaning of LGB lifestyles encounter difficulties when clients need to discuss sexual material (Milton, Coyle & Legg, 2009). Therefore, therapists may need to have adequate knowledge not only pertaining to LGB issues, but also in how they have valued and held their own sexual identities as the norm.

Sexual identity and feelings towards sexuality are on-going negotiations between client and therapists as concepts of individual versus collective meanings of emotion (Livingstone, 2010). Moon (2010) found that while in therapy, some therapists come to feel that current understandings of relationships between sexual feelings and sexual identity are not an adequate portrayal of their social or sexual experiences, and experience new meanings of their feelings towards gender and sexual attraction as their LGB clients narrate their subjective experiences via socially organized emotional concepts. The current DSM-V adopts the term *gender dysphoria*, synonymous with gender identity disorder, to describe individuals who are discontent with the sex and gender they were assigned at birth (APA, 2013). Although this description places more emphasis on the individual's subjective experiences, therapists may still be unaware of how pathological views of homosexuality continues to influence their thoughts, feelings, and behaviours in subtle ways (Eubanks-Carter, Burckell & Goldfried, 2005). Langdridge (2007) has cautioned that while most LGB clients will embrace a fixed notion of sexual identity, therapists need to recognize and value this position equally with more dynamic notions of sexual identity, especially when challenging the need for a fixed and stable identity.

In summary, therapists' discomfort, lack of knowledge and limited facilities to describe experiences of sexuality may be limiting in terms of helping LGB clients explore their sexual identities and the meanings they have in their presenting issues and their lives.

2.3 Need For Research & Training

In addition to the pathologization of LGB identities, there are serious concerns over the training of psychologists to engage with this client population. While the current status quo is that therapists should determine if their client's sexual identity is relevant to their presenting problems and to what degree it impacts their current situation (Pachankis & Goldfried, 2004), this seems to contrast with training which assumes clients will set their own agenda on the process. Training psychologists have also reported feeling their heterosexual and gender privileges contribute to personal insecurities and anxiety that they are not able to be effective in collaborating with LGB clients, despite wanting to actively work to end oppression

in social justice issues (Asta & Vacha-Haase, 2013; DiStefano et al, 2000; Ji, 2007; Russell, 2011). As a result therapists may sometimes feel they are stepping over boundaries when raising topics of sexual identity with LGB clients and thus remain dormant in a therapeutic relationship in which they perceive clients are offered the active subject position to disclose if they wish (Semp, 2006). Although there is substantial research and literature on beneficial elements to LGB therapy which focus on therapist characteristics and practices (Israel et. al., 2008; Liddle, 1997), sex, gender and sexuality are rarely addressed in training, and therapists do recognize this trend (Moon, 2010). Therapists feel limited in their understanding of emotions related to same-sex identities, since most therapeutic training courses are embedded within heteronormative structures (Singh & Shelton, 2010).

These issues are reflected in a significant gap in counselling psychologists' cultural competency to working with sexual minority groups. Asta and Vacha-Haase (2013) stressed there seems to be issues with integrating social justice elements into professional work for training counselling psychologists. Birkenhead and Rands (2012) found that many New Zealand clinicians reported not having undertaken or been provided training on sexual orientation and identity, though nearly all would like to. A lack of specific input in gay-affirmative attitudes of staff and research interests has historically resulted in American psychology students learning from their own informal sources and feeling ill prepared to work with gay or lesbian clients (Buhrke, 1989). Phillips and Fischer (1998) have suggested that a lack of specific training is harmful to this client group since the therapist would lack of critical knowledge on the analysis of psychological theories pertaining to sexual identities. Conversely, McLean and Marini (2008) found that therapists who have multicultural competence are able to establish safety in therapy sessions to allow clients of sexual minority to feel comfortable in expressing their experiences. Adequate training in the knowledge and skills required for dealing with clients of sexual minority is therefore a priority issue for training therapists.

However, there is a current need for more research on the integration of knowledge, skills and values of therapists with regards to the outcomes of LGB therapy, at both macro and micro levels (Harrison, 2000). A content analysis conducted by Singh and Shelton (2010) on the qualitative studies concerning therapies with LGB clients revealed only twelve qualitative articles have been published in the last decade in four journals, all of which belonged to either ACA or

APA. Majority of studies on the development of LGB therapeutic interventions were purely empirical and did not explore the development of interventions or the treatment experiences of the clients (Singh & Shelton, 2010). This is concerning because empirically supported therapies have traditionally been developed and tested on heterosexual individuals then applied to sexual minority populations (Martell, Botzer, Williams & Yoshimoto, 2003). There is a great disparity between the number of LGB individuals seeking treatment and currently published qualitative research concerning this population, and the lack of qualitative literature on LGB clients' therapeutic experiences and experiences could limit the extent to which in-depth understanding of their treatment outcomes can be claimed (Greene, 2007). Perhaps more importantly, the absence of LGB issues in mainstream psychology may send an erroneous message that as a marginalized group, LGB individuals are not as worthy of study considerations as heterosexual clients (Greene, 2007).

Systematic reviews have highlighted the importance for training psychologists to develop cultural awareness, sensitivity and confidence in discussing issues of sexuality with clients (King, Semlyn, Killaspy, Nazareth, & Osborn, 2007). Even with multi-cultural courses increasing in graduate training programs (Ponterotto, 1998), graduates and professional practitioners continue to report inadequate educational training in providing services to LGB clients (Israel & Hackett, 2004; Bidell, Ragen, Broach & Carrillo, 2007). Despite strong heteronormative influences, there seems to be no clear answer currently on how to change the academic curriculum within the counselling psychology field (Asta & Vacha-Haase, 2013). The effects of a potential lack of unified approach towards sexual minority groups in New Zealand may continue to reflect dissatisfaction with mental health services expressed by LGB individuals.

2.4 Conclusion

LGB individuals in New Zealand and overseas continue to report a high rate of dissatisfaction with mental health services due to heterosexual bias and discrimination. LGB clients who conceal their sexual orientation or identity are likely to experience discrepancies between their true selves and the image they present to others, resulting in a sense of inauthenticity (Pachankis & Goldfried, 2004), and this is likely to reflect a poor therapeutic relationship (Galgut, 1999).

Therapists therefore are in an unique and privileged position to directly have an impact on the world of LGB individuals. While sexual identity appears to be important for LGB clients to explore in therapy, there is little research particularly of qualitative nature that has investigated how it affects their therapeutic experiences and outcome, as well as how this experience is affected by the therapist's competency in dealing with clients of sexual minority. The conceptualization of sexual identity in LGB therapies and how it can help LGB clients explore their presenting issues in a meaningful way create an area for exploration and make the focus of this current research project.

2.5 Objective of Current Study

The objective of the current study is to explore the phenomenon of discussing sexual identities from LGB clients' perspectives. In particular, the researcher will examine how sexual identity is approached and conceptualized in the therapeutic relationship, and how it influences the therapeutic outcomes for these clients. In particular, how therapists' attitudes and competency affect the clients' feelings and conceptualization towards their sexual identities will be investigated. Findings from the current study will provide insights into how counselling psychologists can deal with LGB clients and issues with sexual minorities more coherently and effectively.

3 – METHODS & METHODOLOGY

3.1 Methodological Approach: Interpretative Phenomenological Analysis (IPA)

IPA is a qualitative method of analysis that is theoretically rooted in phenomenology and symbolic interactionism (Smith, 1996). Phenomenological psychology concerns an individual's subjective perceptions and how they ascribe meaning to their experiences, rather than an attempt to produce an objective statement (Smith, Jarman & Osborn, 1999). Symbolic interactionism is influenced by phenomenology and also argues that meanings an individual ascribes to experiences are obtained through a process of interpretation and social interactions (Denzin, 1995). IPA originated from an attempt to explicate the significant connection between discourse analysis and social-cognition in individuals that could contribute to understanding of health psychology (Smith, 1996). Discourse analysis is concerned with cognitive attitudes, beliefs and intentions, and assume that people draw on pre-existing social discourses in their verbal statements (Potter & Wetherell, 1995). Therefore, IPA researchers are concerned with reading and analysis of qualitative texts, since verbal expressions are assumed to be heavily context-driven and shifts in social discourses mean individuals' underlying cognitions are also affected (Smith, 1996).

An aim of IPA is therefore to develop interpretative analysis that positions participants' descriptions in relation to wider social, cultural and even theoretical contexts (Larkin, Watts & Clifton, 2006). IPA explores in detail how participants makes sense of their personal and social worlds, and assumes there is a chain of connection between an individual's words, cognitive and emotional states, but recognizes that people may struggle to express their thoughts and affect (Cassidy, Reynolds, Naylor & De Souza, 2011). The researcher therefore has to interpret participants' mental and emotional states from what they have said, and attend to the mental processes of participants in cognitive, linguistic, affective and physical ways (Larkin, Watts & Clifton, 2006). IPA researchers therefore have two aims: the first is to understand and describe participants' life-worlds, and produce a third-person, psychologically-informed description to get as close to the participant's perception as possible (Larkin, Watts & Clifton, 2006). The second aim is to develop an overt,

interpretative analysis in a more speculative fashion, where the researcher must think about 'what it means' for participants to have made their claims, feelings and concerns in the particular situation (Larkin, Watts & Clifton, 2006). Reflections made upon the object of study from the perspective of participants' engagement with it can therefore be used to contribute to current understanding of how the object can be understood and enacted.

IPA is suited to the current study because the objective of understanding how sexual identity affects LGB clients in therapy concerns with individuals' mental processes from both clinical and social-cognitive paradigms. While IPA's phenomenological approach aligns with the conceptual foundation of counselling psychology towards interventions, particular attention will be paid to the therapeutic relationship, which is acknowledged as a symbolic interaction that can be explored for how participants' perceptions and understanding of sexuality is received and responded to by their therapists. IPA allows the researcher to capture LGB clients' sense-making processes while remaining empathic to their narrative experiences, and endeavour to understand the point of view of the participants and what it is like to take their side in the therapy room. In addition, the researcher asks critical questions of the texts to see if there are processes that the participants were unaware of, such as underlying feelings or beliefs 'leaking' from the texts that was not intended (Smith & Osborn, 2007). This is important as it enables the therapeutic relationship to be examined not only within a clinical context, but also taking into account how it might be impacted by homonegative discourses that are outside the therapy room

3.2 Methods

3.2.1 Recruitment Process

IPA studies use purposive sampling and seek a small and fairly homogenous sample for whom the research question will be significant, since the aim of the approach is to detail understanding of a particular group rather than producing empirical generalizability (Smith & Osborn, 2007). Smaller samples also allow for richer and deeper analysis of texts without drawing away from the participants' original meanings (Smith, Flowers & Larkin, 2009).

For this research project, posters advertising the study were produced and placed in health clinic waiting rooms around Auckland, disseminated through LGB

community centres such as Rainbow Youth and through community websites with the organizations' consent. These areas were appropriate as they allowed the researcher to target the intended sample group of LGB individuals from a wide range of age groups and backgrounds, who may have been through therapy. The advertised participant criteria were volunteering individuals who self-identified as lesbian, gay or bisexual, aged between 20 to 55, and have had counselling within the last 3 years. Selection of the participants was on a first-come, first-served basis, and extra volunteers were thanked for their interest and time in making contact. There were no incentives for participating in the study. The first five volunteers were emailed by the researcher thanking them for their interest in the study, and provided a Participant Information Sheet detailing the purpose of the study and the interview structure. Participants were given the opportunity before the interview to ask any questions or concerns they have, and were given a copy of the Consent Form that outlined their privacy and confidentiality rights to read before signing at the start of the interview process.

3.2.2 Data Collection

Semi-structured interview is the exemplary method for IPA (Smith & Osborn, 2007). This form of interviewing allows both the researcher and participant to engage in dialogue where initial interview questions can be modified pertaining to the participants' responses, and the researcher can follow areas of interest and importance as they arise. In this relationship, the participant is perceived as the experiential expert on the subject and allowed maximum opportunity to tell their story (Smith & Osborn, 2007). The participant can also introduce issues the researcher has not thought of and share their experiences in these areas more closely.

The researcher employed the technique of funnelling to set the interview questions. The researcher began the interview with a broad question such as "Could you describe to me your experience with therapy?" This allows participants to give their own views before being directed into more particular concerns of the study, such as "Did you and your therapist discuss your sexual identity in therapy?" and "How did you feel about your therapist's understanding of you as a lesbian/gay/bisexual client?". An interview that successfully acquires responses from both general and more specific levels of questioning indicates seamless engagement

of the participant on the topic, rather than being forced to enter the life world of the researcher (Smith & Osborn, 2007). The interviews lasted on average an hour, and were audio-recorded with the participants' consent. At the end of the interview, participants were informed that they may change or omit anything they have said before a specific date. However, no participant did so. The data were transcribed verbatim by the researcher.

3.2.3 Data Analysis

Analysis in IPA are presented in resulting themes that concern more with the meaning and complexity of the content from participants' texts, rather than the frequency they appear (Smith & Osborn, 2007). The participants' story can either represent a piece of their identity, or the researcher can make suggestions about constructs and beliefs that manifested from the participants' psychological worlds (Smith, 2003). Rigour is obtained through a sustained engagement with the texts and a process of interpretation by the researcher, as meanings of the participants' mental and social worlds are not transparently available (Smith & Osborn, 2007). The current study employs the method of analysis outlined by Smith and Obsborn (2007) which includes 4 steps:

Step 1. *Looking for Themes in the First Case.* The initial process of theming is close to free textual analysis where similarities and differences, contradictions and new insights are found. Then, themes move to a higher level of abstraction and may invoke more psychological terminology. The researcher finds expressions which are at a level high enough to allow theoretical connections within and across cases to be made, but are still grounded in the particularity of the study's topic.

Step 2. *Connecting the Themes.* Emerging themes are listed chronologically and connections are inspected. Theoretical or analytical ordering is explicated as the researcher attempts to make sense of the connections between the themes. Themes are now either clustered together, or emerge as superordinate concepts. A table of themes, ordered coherently, is produced. Clusters capture most strongly the participant's concerns on the topic and now have titles.

Step 3. *Continuing the Analysis with Other Cases.* Once step 2 is done, the researcher can either use themes from the first interview to help orient subsequent analysis, or work on the second interview from scratch, as long as this pattern is repeated with other transcripts. For the current study, the former approach was taken.

Step 4. *Writing Up.* The final stage is concerned with translating themes into a narrative account and outlining the meanings inherent in the participants' experiences. Themes are explained, illustrated and nuanced. The table of themes is the basis for the form of narrative argument that supports the case, with verbatim extracts from the transcripts. The Results section can either contain emergent thematic analysis with a separation Discussion section that links the analyses to extant literature; or, links to the literature can be discussed as each superordinate theme is presented in a single Results and Discussion section. The current study adopts the presentation style of the former.

4 – RESULTS

This chapter first provides a demographic description of the participants, then presents three superordinate themes that resulted from the data which capture the lived experience of LGB clients discussing sexual identity in therapy.

4.1 Participants

Five participants were recruited for the current study, and pseudonyms have been used to ensure their anonymity. Participants were aged 27.4 years on average, and included two lesbian females (Elle and Nina), one gay male (Blake), one bisexual female (Lena) and one bisexual male (Tristan). On average they began therapy on two and a half years ago, and all initially sought therapy due to relationship issues except Lena, who began therapy to deal with her history of trauma and abuse. Three had sought therapy through GPs or other medical services, and two began their therapy through work supervision.

4.2 Themes

Participants were encouraged to talk as widely as possible about their experiences of discussing sexual identity in therapy. Their experiences clustered into three superordinate themes which captured how participants conceptualized their sexual identities in therapy, as well as how it was influenced by their therapists. The themes contain shared experiences and beliefs that were emotionally emphasized by participants across the data set, and more varied and detailed experiences are narrated with subthemes:

Theme 1 – Sexual Identity as Self in the Making

Subtheme 1.1 In relation to presenting issue

Subtheme 1.2 Open exploration

Subtheme 1.3 Development of Identity

Theme 2 – Sexual Identity as a Barrier

Subtheme 2.1 Countering Heteronormativity

Subtheme 2.2 Alienation as a Continual Outcome

Theme 3 – Sexual Identity as Increased Awareness of Oppression

The following sections describe each superordinate theme and subthemes in detail.

Theme 1 – Sexual Identity as Self in the Making

Out of the five participants, two reported positive therapeutic outcomes as a result of discussing their sexual identities in therapy. These participants discussed sexual identities specifically in context to their presenting issues with their therapists. Their discussions included exploring their sexual identity formation processes and how it played a significant role for their present selves. As an outcome, these participants conceptualized their sexual identities as important and necessary towards a more positive sense of self.

1.1. In Relation to Presenting Issue

Lena initially sought therapy through work supervision to deal with the effects of her traumatic and abusive past. She described the nature of her discussion:

> *We talked quite openly about sexual orientation in our working context, um, around the discussion of what our teaching programs do and how it can be more inclusive, and do I need to claim my identity in a classroom – is it useful for me to claim that I'm bisexual when I'm in a homophobic class? So that's some of the anxiety I've been unpacking and even in therapy it's been more around being bisexual.*

For Lena, discussions around her sexual identity were specific and in context with her presenting issue around work performance. Similarly, Tristan's experience of discussing his sexual identity was also in context to the role it played in his presenting issue of depression:

> *We started talking about the dark things that was going through my head, and stuff I was experiencing down in Dunedin… I was this whole other person down there, and that's when the whole sexual conversation started up, and we discussed the relationships I was having down there. She obviously picked up on the things that I did that I regretted when I was down there, and the conversation pretty much started from there in terms of my sexual orientation and preferences.*

Tristan's sexual identity was discussed since it was perceived to be a significant contributing factor to his presenting issue in the context of depression. It was

important for Tristan that his sexual identity was not discussed as a point of interest on its own:

> *Never at one point would we just focus on sexuality. She never sort of stepped out of the zone just to talk about my sexual feelings or stuff like that, ever. I think that made me more comfortable with her as well, because I knew she wasn't focusing on one thing.*

It was important to Tristan that her therapist did not implicate his sexual identity as a main cause or concern to his presenting issue, but rather treated his sexual identity as a part of himself, which helped him feel comfortable that she had this understanding.

1.2. Open Exploration

Both Lena and Tristan described their therapists' approach in discussing their sexual identities as open-minded and non-judgmental. Tristan described his therapist's approach in discussing sexual identity with him:

> *There was always a balance. The conversation would start off with how my week sort of went, then she'd remind me of a conversation we had previously that was about my sexuality… She would pick a topic and then it would lead to another, and if there was an issue linked between the two, we'd work on finding out how I could overcome it, so at least I wouldn't blame it on one particular item. Because I was blaming it on the freedom that I had to maintain my sexuality, she wanted to work through that and make me realize what I did was the best thing for me. But there was never an urge from her to push me in one direction, it was always an open discussion and then I would come to my own conclusion.*

It was significant to Tristan that his therapist allowed him to draw his own conclusion on how his sexual identity had played a role in his presenting issue, and as a result he came to perceive that it was one of many contextual factors in his problematic life from the past, rather than the main issue.

Similarly, Lena expressed how an open exploration helped her reflect on her sexual identity formation process where she was going through a phase of sexual experimentation:

> *Lot of my experimentation phase was – and we talked a lot about this in therapy – me breaking lots of boxes was actually what allowed me to survive.*

> *Um, because it allowed me to really break away from the dynamics of my family and figure out my own identity, and finding a lot of like strong social and political changes. So it was allowing me to figure out why I was doing that stuff, and having those conversations around me figuring out, 'Ok yea, actually with the sexual experimentation there was a lot around regaining power.'*

Lena was able to discuss and explore her sexual identity as contingent with other parts of herself, including her social and political identities. In this way, she was beginning to understand her selfhood more wholly, and her sexual identity was conceptualized as an important factor in the making of her broader sense of identity. Lena also emphasized the importance of her therapist in allowing her to come to her own conclusions:

> *I really appreciated in her that she hasn't gone that kind of causal link of 'because this happened to you that happened' because that would also shadow like some of the question of my identity, and whether it is sexual orientation or political identity, or any parts of my identity. So I found that quite useful. And then, um, not kind of stigmatizing it, you know, not going 'That's what it was,' and more going 'Well, those are the things that you've learn from there and that's quite a powerful transition.'*

In Lena's experience, an open-minded exploration with her therapist on her sexual identity formation process helped her to conceptualize her sexual identity as a positive and even protective factor in her struggle with a traumatic past.

1.3. Development of Identity

Discussion of sexual identity resulted in stronger and more positive senses of identities for these two participants. Lena's therapist had encouraged her to be clear in how she felt about her bisexual identity:

> *Having been abused I think when I was quite young, there were questions around was I attracted to women as well because of my abuse. And we, yea, it was just her checking in about that, whether I had that process clear in myself that I wasn't reacting to something but that was actually who I was and me being okay with it… she was also checking in with the process of how much I had actually processed that piece of info, like were there subconscious reactions, or had I actually analysed it and made it quite conscious for myself.*

As a result of acknowledging her sexual attraction, Lena consequently became more confident and comfortable with who she is as a bisexual woman:

> *I think it's definitely clarified for me in terms of my sexual identity so while I hadn't used it hugely to work with my sexual orientation, um, I'd become a lot stronger in my identity and a lot happier, and um, while working through other areas of my life…in that sense, while it wasn't the prime focus of my therapy, you know just being clearer and stronger in myself has helped that part of my identity as well. I'm also not needing people in society to actually recognize me or accept me, it's like I don't actually need that approval.*

Similarly, Tristan became a lot more confident and proud of his bisexuality, and felt a positive change from who he was before therapy:

> *At the start when I started seeing her, I was always you know, I'd blame myself for everything that went wrong in my life at the time… but then I understood the situation that I went through, and I realized that it had actually made me a stronger person. So she made me realize that, and made me more confident in myself and who I am. I can easily talk to my friends about my sexuality now and that doesn't bother me at all, before it would have like, explaining to someone that I was bi, explaining that I was, you know, having relationships with guys as well, it made me too uncomfortable. Now I don't care. Now I certainly can if I'm seeing someone. I can openly say, 'Yup, I'm seeing them' and I don't feel any shame in it.*

It appears that talking about his sexual identity formation process had helped him remove feelings of shame associated with his sexual orientation and preferences, because Tristan had learnt to no longer perceive it as a source of his problems or a negative part of himself. Nevertheless, both participants expressed different conclusions in regards to their sexual identity development. Lena described herself as in a continual process of exploration:

> *[My sexual identity] is very fluid. I'm finding trans-men very attractive at the moment, so it's even broader than the male-female spectrum. It's actually also transgender people, especially transgender men. I find them really hot, I'm not sure what it is, but yea. And so I think bisexual actually probably doesn't sum it up properly. I think it's an easy label for people to go, 'Oh, ok, you're not into one or the other. You're into both.' Um, and then there might be other labels that are coming out that might identify better.*

Lena expressed feeling that bisexual as a term is not adequate enough to capture her sexual identity experiences fully, and acknowledged her sexual attraction to others as fluid. Tristan also identifies his sexual preferences and identity as fluid and changeable. However, as a result of discussing his sexual identity in therapy, he came away with a clearer and firmer belief in which orientation he wants:

> *I definitely switch it on and off. Like, personally I don't know how I do it, but I do decide whether I want to be with a girl or I wanna be with a guy. Like this time I decided that I was gonna go for a girl cos I'm wanting to have the whole, you know, ideal family and all that. I know I can have that with a guy as well, but I still feel like I'd be looked down upon even though it's such a normal norm now... so I did enjoy myself with the guys, but now that's all finished, you know, I'm in a happy place again. But those feelings can be switched on though.*

Tristan was able to offer a grounded reason for his choice of sexual preference and having distinct phases of being attracted to one gender or the other. In contrast, Lena expressed a desire to be open to attractions towards other sexual and gender identities.

Theme 2 – Sexual Identity as a Barrier

Three participants experienced negative therapeutic outcomes due lack of opportunities to discuss sexual identity or same-sex relationship issues in-depth or meaningfully with their therapists. These participants felt that being gay or lesbian was a barrier as they had to help bridge the gap in their therapists' lack of knowledge on sexual minority issues, as well as battle against heteronormative assumptions made in the therapeutic relationship. As a result, participants felt a sense of alienation in having to resolve their presenting issues on their own, and felt stuck, alone and even conceptualized their sexual identity as the source of their therapeutic problem.

2.1. Countering Heteronormativity

Participants consistently expressed frustration and disappointment in feeling that their therapists had inherent heteronormative biases in therapy. Elle described an experience where she felt her sexual identity was being implicated as a major concern:

> *It was sort of the way she wanted to use the concept of my sexuality, wasn't really um, in line with what I was there for I guess. She was, um – because a large part of what we talked about was, um, self-esteem and stuff like that, so she sort of decided that I wasn't very good with self-esteem I guess, um, so she was like, 'How do you feel about identifying with your sexuality?' I said, 'I don't mind. I don't have a problem with it' and she was quite surprised by that, yea. So she obviously wanted to take something down a particularly track there, but it didn't quite go along.*

In this experience, Elle was made very aware that her sexual identity was a primary focus for her therapist, and that it had taken significance over the presenting issue that she wanted to discuss. As a result, she felt that her sexual identity was a barrier to the practical discussion of resolving her presenting issue that she had anticipated. Blake also described experiences where he could not discuss his presenting issue due to his therapist's heteronormative assumptions:

> *It sounds silly but it was heterosexual focused, despite the fact that she knew I was talking about my male partner and that we were having issues there. Half the time she'd say something and my relationship is actually not like that. I'm in an adult, open relationship, and she's talking about couple's counselling for that. There were some of those preconcept notions of what should a relationship be, and it almost felt like she was trying to put some of that onto me. She said, 'You might want to think about a monogamous relationship because of the fact that, you know, open relationships don't really work.' and it's like, Oh my god, that's not helpful. Think about what you're saying and what impact it actually has, rather than taking, nearing on heterosexual assumptions.*

Blake expressed a strong sense of shock and disappointment that his therapist could not discuss his same-sex relationship issue with him, but instead imparted her heterosexual preference and values in her client. Another participant, Nina, also experienced her therapist's lack of understanding of same-sex relationships and lifestyles as obstructive to resolving her presenting issue. However, this seemed to be expected for Nina as a client of sexual minority:

> *You sort of you sort of get used to the boundaries of the heteronormative society so um, and I mean in any case there's stuff that is sort of unique to your own, um, situation. But I wasn't totally surprised or anything, but it did make it a bit – I guess having to rehash things that for me were so um, just*

normal or sort of taken for granted. Having to rehash those were a little bit, um, I guess added an uncomfortable element to the situation where I couldn't just say something and she'd totally intuited it. I had to further explain it was a bit sort of frustrating I guess in the experience, yea.

Nina described having 'gotten used to' heteronormative assumptions in society, however for her it was still frustrating and disappointing that a corrective experience did not occur in therapy with her therapist. This consequently added difficulties for Nina in explaining her presenting issue to her therapist who could not seem to grasp her struggles.

In addition to heteronormative biases in therapy, participants also had to compensate for the lack of their therapists' knowledge on sexual minority issues. Blake described his experience of seeing two heterosexual counsellors:

They had very, very limited knowledge levels around, around sexuality and gender identity stuff. So one of the counsellors, the male one that I sought through uni, I literally had to explain everything. It was like doing a professional development session with him, two sessions around crash course in what is sexuality… I had to direct them to kind of primer papers and research papers around gender and sexuality, which was like, 'This is terrible. Why am I telling you how to do your job?'… That was so unhelpful to me because I had to then kind of hold my stuff to one side and jump into professional mode.

Blake took on the role of educating his therapist as a gay client when he realized his therapist lacked knowledge on sexual minorities. Elle had a similar experience where she felt she had to step up her role of being a lesbian to clarify for her therapist issues pertaining to same-sex relationships:

We were talking about issues with, um, with the ex-girlfriend and it sort of being I guess like the concept of um, sort of a homosexual relationship having differences to, you know, the usual heterosexual relationship. Um, yea, I guess she was – there were instances where um, she was perhaps talking about something that was more traditional. And um, what I was – what I had dealt with was something that was um, sort of different and very particular to same-sex relationship. So there were instances um, I sort of did feel like I was getting to the end of her knowledge of that sort of thing. She perhaps didn't train in those things. So there was a sort of a, sort of a

teaching experience, I guess, where I'd become the one who sort of was handling the situation.

For both participants, their therapists' lack of knowledge on sexual minority issues made the participants feel that as members of sexual minority they are expected to explain their differences to others because LGB lifestyles are not mainstream.

2.2. Alienation as a Continual Outcome

Participants felt a sense of alienation when their therapists either side-stepped or could not seem to understand the significance of their sexual identities. Participants felt they were stuck or alone with their presenting issues, and some resorted to trying to resolve it on their own.

Nina expressed her disappointment that her therapist had side-stepped her sexual identity, which she perceived to be important to her therapeutic experience. As a consequence, she felt that she 'never got anything out of therapy' and thus resorted to try to analyse her problem on her own:

I think a lot of what I brought upon myself was really rooted in issues – cos I said I was cool about my sexual identity, but when I started I was closeted to 90% of my friends and family, and I knew I've got to step back and look at that. What I think I want is the ability to step back and look at that objectively with my therapist to understand it – I feel like I can do that now, like I can look objectively and see what was wrong with the situation, but that's all on me. That's thanks to nobody. Like if I had a therapist who could help me understand, um, the way my brain worked, why I let myself do certain things, I would feel a lot better about it, instead of having to spend hundreds and hundreds of hours personally analysing my own past.

Blake reported a similar experience in resolving his sexual identity related issue on his own due to the therapist's incompetence:

I was using sex as self-harm and I was suicidal as well. And so when it got to the really bad point it was like, 'I really need to see someone again just to off-load some of this stuff,' try and figure out how to sort it out. It just ended up being professional development for him pretty much, rather than actually counselling help for me… It was almost completely away from my issues into my career aspiration, which was completely disconnected to what I was

doing counselling for. I kind of got to the point where I went, 'Fuck it, I just have to do this,' so I did a bit of reading myself, came out, got to an alright place and sorted it out.

In this case, Blake described how his therapist's side-stepping of the main issue he wanted to discuss led to a feeling of loneliness associated with coming out, could have been potentially dangerous to Blake while he was suicidal. Elle shared with these two participants the experience of resolving her issue in private when her therapist side-stepped discussing her same-sex relationship issues:

The aspects of the relationship that I went there to talk about were tied into the fact that it was a same-sex relationship, but I hadn't been able to discuss those aspects of it before, and I still couldn't properly in therapy because obviously there were sort of limits to what she knew. So that's possibly why I was having such trouble with it, and I think it was a sort of realisation of that while I was there, that I sort of didn't want to bring it up in the session. So that was sort of a private revelation I guess in the, um, sessions, but not so at the end of the day discussed – more because like it wasn't a line of questioning that was ever offered and I didn't sort of think it would be.

In therapy, Elle had realized her therapist's limits and unwillingness to discuss same-sex relationships and decided not to raise the topic with her. On reflection, she realized that the lack of this discussion was a main reason for why she was still having difficulties with her presenting issue of anger and isolation, and in addition, she began to have doubts that there was something 'uncommon' with her relationship:

The main reason I sort of sought out therapy in the first place was being very overwhelmed and isolated in my anger and depression. I felt that I had something to do with not having been able to talk about my sexual identity, I guess... The therapist sort of lacking in what she was wanting to talk about, sort of made me realize that what I wanted to talk about wasn't like a common universal sort of thing, like a common way of understanding how, um, perhaps how issues with relationships are understood in terms of emotions and behaviours and stuff like that, and that wasn't exactly what had happened with me...

The lack of opportunity to discuss her sexual identity and same-sex issues in therapy made Elle feel that her sexual identity played a bigger part in her relationship issue

than she had originally believed. This idea that her sexual identity may actually be the main source of her presenting issue marks a stark contrast to Lena and Tristan's experiences where their came to conceptualize their sexual identities as an important part of their personal development.

Theme 3 – Sexual Identity as Increased Awareness of Oppression

For some participants in the current study, a lack of opportunity to discuss their sexual identities in therapy increased their awareness of their status as individuals of sexual minority. Due to their therapists' lack of awareness to understand or empathize with their struggles, these participants felt a moral sense of responsibility in terms of having an awareness of how others in similar minority positions may also experience misunderstanding or oppression.

Lena described an instance when she felt she was not being heard emotionally by her therapist as she tried to discuss her abusive past in relation to the dominance of heterosexism:

> *It was really hard, and she just kept telling me that I was doing really well and I was like, 'This is not helpful, you're telling me that I'm doing really well, I'm here in this room, there's obviously a reason.' And, um, I mean that could relate really strongly to my – I was going to move forward my conversation around sexual orientation, probably that same therapist wouldn't have been able to um, hold that conversation either because she was very blind to many power dynamics and not having much awareness herself around herself, actually. Like what part did she have in the room, how did she impact me.*

Lena felt that her therapist's lack of awareness around social power dynamics meant that the significance of her sexual identity could not be recognized and therefore discussed meaningfully. She later commented on her reflections that as a result of seeking therapy, she became more aware of the importance of her sexual identity:

> *Until I got to about 27, that was when I said, 'Ok, maybe I can [try therapy]', and I think as a teenager I had such a different identity to everyone else, um, that was a real fear that they would force me not to have that identity anymore, whereas now as an adult woman I can go, 'Actually this is who I*

am, and you as a therapist don't fit with me' so I can move on. So I think that's quite an important reflection to have.

Nina also expressed her thoughts on her therapist's lack of awareness on the struggles that that clients of sexual minority are likely to have gone through:

> *You don't want a therapist to raise assumptions, but knowing where I've been because of, I don't know, people with like homosexual identities, knowing that at some stage I would have had to come out, that would have put stressed on me… It was never talked about like when I came out or how I felt about it or any of that. Um, so she's going through my entire history but, not any of that stuff that led to where I was today in regards to my sexual identity. It was all about family and how I felt at times, and very much personal without touching on sexual identity.*

On reflection, Nina spoke of her perceived importance of a sense of awareness of others' struggles:

> *If you are in any type of minority, you're forced to step back and look at your position, especially when it's something like sexuality where you actually actively have to choose – not that it's a choice – but you have to choose to belong to that community, you have to look really carefully in your own obstacles in life and your own personal experience… if you faced difficulties in your life it would be much easier to be empathetic with other situations. So I'm hard-core left-wing because I find it very easy to put myself in the shoes of any other group of society facing any adversity*.

Here, Nina expressed that she perceives her own experiences as important because she could empathize with other minorities in a way she felt that her therapist could not. Similar to Nina, Blake also ties his sexual identity into his political value stance and defined his sexual identity as a gay man as of moral significance:

> *It is quite a big part of whom I am because it dictates a lot of things in society. My sexuality means a lot to me of course because, I recognize that people have actually died just being what I am. And because of who I am, I'm now another part of the minority group and that means a lot especially politically, you know.*

In addition, Blake spoke passionately about being able to now use his understanding of the significance of sexual identity to help others:

> *I can now recognize what it's like to be in the position of some of the young people I work with, and say, 'You know, it's alright. You can be who you are, it's fine.' A lot of the thing we find is that it's our stories that give them the most. It's when we say, "I'm gay and I'm still here, I'm fine, I'm still a functioning person' that they go 'Oh shit. Actually I don't have to be a giant queen, if I want to be I can, but I don't have to be.' And so you know being able to use my sexuality for the good of mankind, that kind of idea is also really cool.*

As a result of negative therapeutic experiences, participants experienced an increased awareness and moral sense of responsibility to help ameliorate the lack of empathy and struggles against heteronormativity that others might be experiencing.

5 – DISCUSSION

This chapter provides a discussion of results from the current study and makes links to the literature on sexual identity in therapeutic relationships narrated in Chapter Two. Participants' experiences of discussing sexual identity in therapy and how this was influenced by their therapists' approaches and characteristics are discussed, as well as its influence on their therapeutic outcomes.

5.1 Significance of Sexual identity for LGB clients

All participants in the current study expressed that their sexual identities were an important aspect in their presenting issues, even if it was not the main focus or the reason they initially sought therapy. Participants who experienced meaningful discussions of their sexual identities with their therapists came to conceptualize their sexual identities as a natural and necessary part of their growth, and by exploring the functions and meanings of their sexual identities, participants were able to resolve their presenting issues as well as gain better understanding of a sense of who they are. For Tristan and Lena, exploring their sexual identities in context of their presenting issues helped them reflect in detail their sexual identity formation processes. As outlined in Chapter One, Weinberg, Williams and Pryor (1994) theorized that bisexual individuals experience the final stages of sexual identity development as *Settling into a new identity* and *Continued Uncertainty*, which involves continual misunderstanding and fear of judgment from others of the fluidity of their attraction. In accordance with this model, while both participants have come to accept their bisexual attractions, they still needed to explore the meaning of adopting this sexual identity. As the results showed, these participants came to very different conclusions: while Tristan was happy having completed the exploration and come to a satisfactory stage in feeling settled to have relationships with females, Lena continues to experience and discover new sensations of being attracted to transgendered people. This suggests that sexual identities may hold unique meanings and serve different functions to different individuals. Semp (2006) commented that the use and understanding of sexual identity terms have diverse contexts, reasons and meanings to sexual minority individuals. Thus, rather than attempting to ensure clients have achieved finite *synthesis* as proposed by Cass (1979), it is perhaps more

important that LGB individuals feel they have the freedom to define how their sexual identities play a role in their lives and personal growth.

Some participants experienced less desirable therapeutic outcomes where they felt their sexual identities and aspects related to their presenting problems could not be discussed in therapy. They felt that sexual identity became accentuated as a part of themselves but in a broader sociological context. These participants felt they carried within them an identity of cultural significance, and through re-experiencing heteronormative biases in therapy, they were able to connect with a moral sense of responsibility and empathy towards others of minority groups. However, while these participants may have been able to express their pride in their awareness and the ability to help ameliorate oppression in society, their presenting issues and difficulties tied to their own sexual identities remained unexplored in therapy. In Troiden's (1989) model of sexual identity development, the last stage of *Commitment* describes individuals choosing to integrate their public selves with private selves to form an internal sense of security and satisfaction. The lack of opportunity for these participants to discuss what their sexual identities mean to them in more private and personal contexts in therapy may therefore prevent meaningful and healthful psychological development. As a result, participants came to feel more aware of themselves as part of a minority in the public arena.

5.2 Therapists' Influence on Sexual Identity in Therapy

Therapists' therapeutic approaches and attitudes towards clients' sexual identities in the current study impacted on how the participants conceptualized their sexual identities in relation to their presenting issues. Langdridge (2007) has noted that LGB identities require clients to confront or deny what they have discovered within themselves, thus therapists' ill-equipped approach can impact on the clients' life-worlds negatively. Participants who experienced their therapists' attitudes as open-minded and non-judgmental in exploring their sexual identities came to a more positive understanding of their sexual identities in themselves as well as in relation to their presenting issues. Conversely, participants who perceived their therapists to have inherent heteronormative biases or lack awareness addressing their biases conceptualized their sexual identities as a barrier or source of problem in their presenting issues. Heteronormative bias seemed to extend to clients' perception of

their therapists' level of comfort with non-heterosexual lifestyles as well as their clients being in a stage of exploring what their sexual identities mean to them. Therefore, when these therapists were perceived to lack the ability to or emotional competence to explore sexual identities without preconceptions or being influenced by their own values, participants were unable to work on their presenting issues in which sexual identities were strongly tied to.

Semp (2006) discussed that LGB clients who do not seem 'ready' to discuss sexuality-related material may actually to assess the heteronormative environment. Participants in the current study were sensitive in assessing their therapists' acceptance and stance towards homosexuality in therapy. The level of empathy perceived by the participants from their therapists affected how easy participants found it to discuss same-sex issues openly with them. Participants also found it difficult to believe that their therapists could truly understand the struggles they described on both cognitive and emotional levels if they perceive that the therapist has not examined their own feelings of oppression or experiences of being a minority in some way. Therefore, LGB clients' perceptions of their therapists' level of experience and knowledge on sexual minority issues also seemed to influence their willingness to discuss sexual identity. Singh and Shelton (2010) have found that training psychologists expressed feelings of anxiety that heterosexually-based educational programs make them feel ill-prepared for working with clients of sexual minority orientation. This perhaps emphasizes need in training programs to ensure that therapists not only have adequate knowledge relating to sexual minority issues, but are also able to get across empathy and genuineness to LGB clients in a way that fosters an open and nurturing connection.

Mohr (2002) argued that sexual orientation biases in therapy may be the result of therapists needing to express heterosexual identities in order to maintain a coherent sense of self in themselves. Results from the current study showed that LGB clients may in fact be 'handling' their therapists' discomfort with their unfamiliarity with LGB identities by needing to take on a teaching position in therapy. This issue of parentification whereby clients need to educate and explain their phenomenon to therapists reflect a lack of understanding of LGB issues in the psychology and counselling professions (Igartua & Des Rosiers, 2004). Thus, the therapists' lack of knowledge on LGB issues may not just be an issue of

unprofessionalism, but also puts LGB clients at risk of feeling self-conscious of how their sexual identities could make others uncomfortable when therapists are not honest or upfront about their lack of understanding. It is not unlikely that minority clients who had to take on an educating role feel objectified as they have become learning opportunities or challenges for their therapists. This reinforces their experiences of heteronormativity, which in itself reflects a possible need for transformation in therapeutic approaches towards sexual minority issues in the counselling profession.

5.3 Sexual Identity in Therapeutic Relationships

As reflected in the literature, while some clients do not think sexual identity needs to be discussed in therapy, they feel frustrated that their therapists cannot help them explore what being homosexual means (Haldeman, 2010; Mair, 2003). Results from the current study showed that while participants do believe that their sexual identities were a significant aspect of their presenting issues, not all were ready to discuss it in therapy. Lawver (2012) has noted that sex can be a potent topic for both client and therapist, and sexuality-related material in clients' narratives are often manifestations of underlying, internal issues that address fear, anxiety or loss in the client. Opportunities to discuss sexual identity are therefore paramount for LGB clients, and consequently, feelings of alienation and aloneness can result in LGB clients if they feel that the significance of their sexual identity cannot be understood or are misunderstood by their therapists. For some participants, the topic of their sexual identities was either side-stepped altogether, or made a central focus of investigation that was outside the context of their presenting issues. In the current study, Blake made a particular personal example of alienation leading to potential fatal consequences if the client is psychologically vulnerable and are put at risk of feeling they are alone in the painful processes of coming out or figuring out their sexual identities. This participant commented that sexual identity should be raised by the therapist as an offer of opportunity for LGB clients to speak about the subject that they may find difficult. However, another participant, Elle, voiced that sexual identity is a topic that is intensely personal, one could feel 'hunted' when asked about it. Therapists should allow clients to raise it themselves in time. While both participants' comments reflect the potential effect of internalized homophobia in

therapeutic relationships, Elle was having difficulties talking about her sexual identity. Her therapist did not offer an opportunity to discuss it thus she never had the chance to 'talk properly' and did not resolve her presenting issue. This study confirms Lawver's (2012) suggestions that in raising the topic of sexual identity with LGB clients, therapist may need to approach it as a checkpoint for getting into deeper issues that the client needs to address, such as their level of emotional attachments as well as the depth of their relationships.

5.4 Implications For Practice

Counselling psychology has a commitment to lifespan development and cultural diversity and encouraging clients to engage with their subjective experiences, values and beliefs (NZPS, 2013). Results from the current study show that sexual identity formation processes are important for LGB clients regardless of whether or not sexual identity is a main focus in their presenting issues. Therefore, in additional to their knowledge in developmental psychology, counselling psychologists should be familiar with at least a basic understanding of sexual identity developmental theory. Yet these diverse experiences of sexual attraction and meanings of sexual identities such as those the current study has explored also requires counselling psychologists to remain open-minded and non-judgmental towards LGB clients. It is paramount for therapists to foster a welcoming space for discussing sexuality-related material to explore both positive and negative meanings of sexual identities with the client, regardless of the therapist's approach.

Additionally, it may be useful for training programs to help counselling psychologists recognize that heteronormativity as a powerful psychosocial influence on both clients' and therapists' understanding of sexual identity and selfhood. Broido (2000) identified that current boundaries between heterosexuality and homosexuality seem fixed and impermeable. From a Queer Theory perspective, all knowledge relating to sex, gender and sexuality is subordinate to the institutionalization of heteronormative ways of understanding oneself.

Thus, if one steps back from the illogicality attributed to emotions and the way it is currently assigned to sex, gender and sexualized bodies, it would become apparent how it acts as social capital in the structure of identity (Moon, 2010). Therefore, it may be important for counselling psychologists in particular to reflect

on their own sexual identity acquisition, cognitively and emotionally, if they are to commit to an acceptance of culturally diverse experiences and meanings and acknowledge how heteronormativity has influenced their attitudes towards both heterosexual and non-heterosexual clients in therapy. Lastly, whether one choose to take a conscious, 'gay-affirmative' attitude to advocate for the eradication of homonegative biases or a neutral stance to help LGB clients explore whatever experiences relating to their sexual identities that emerge, therapists need to be specific in bringing sexual identities into the discussion in context with the client's presenting issue.

6 – CONCLUSION

6.1 The Current Study

Using IPA, the current study explored LGB clients' experiences of discussing sexual identity in therapy and how this affected their therapeutic outcomes. The current study has found that discussions of sexual identity is therapeutically significant for LGB clients in helping them make sense of their presenting issues, even when this was not the main presenting issue. Discussing sexual identity could help bring forward deeper psychological insights relating to both positive and negative associations with clients' sense of identity. Therefore, discussions of sexual identity with LGB clients may serve to explore their intrapersonal and interpersonal cognition, affect and behaviours, rather than focusing on their sexual orientation.

The current study has also found that heteronormativity permeates therapeutic relationships, and is consistent with current literature findings that homonegative discourse is prevalent in New Zealand mental health services. Considering most participants in the current study sought therapy for same-sex relationship issues, heteronormative assumptions may severely impact on clients' potential to form intimate relationships with their chosen partners. This also adds an extra challenge to the client for a strong and confident self-identity within the therapeutic relationship. Therefore, therapists are in a privileged position with a responsibility to directly provide corrective experiences to LGB individuals, particularly for counselling psychologists.

The current study also concludes that while an adequate knowledge of LGB issues and affirmative attitudes towards sexual minority clients are essential for therapists. For therapists, it is more important to be existential or exploratory in the therapeutic approach rather than having preconceptions of norms for experiences related to sexual minority identities, as this allows clients to explicate meaning of their sexual identity in context of their own presenting issues.

6.2 Limitations & Critique of Process

Several limitations exist in the current study. First, due to the scope of the current study as a Master's dissertation, word limitations meant the full richness of

themes and subthemes present in the original data could not be fully expressed, and only the most salient were selected for presentation. In addition, expenditure was limited and participants were restricted to those from the Auckland region. This may create sample bias where the results are not representative of LGB clients' experiences across New Zealand. Also, participants' age range was small – between 20's and 30's – despite advertisement for the current study allowing for a much wider age gap. This may also reduce the generalizability of results across age groups as clients from different generations may have more diverse therapeutic experiences due to the social changes in perspectives towards homosexuality and same-sex marriages. A further limitation of the current study is the variability of therapists the participants sought. As there was no way of ensuring the mode of practice or training background of the therapists, validity of the conclusions made in the current study in regards to therapist characteristics and therapeutic styles may be limited.

IPA requires the researcher of the current study to think beyond the participants' overt narratives into underlying affect and cognitions towards their therapists. Some participants at the time of the study were still in therapy or considering seeking further therapy. While participants provided rich insights into how LGB individuals experienced discussions of sexual identity in therapy, their perceptions towards their therapists may also have been influenced or hindered by potential unresolved psychological issues. Due to the current researcher being a counselling psychologist in training, there are limitations to the level of distinction between what might have been transference in the participants' narratives – whereby the therapist's intentions or approaches are misconstrued – and what might have been a genuine lack of therapeutic effectiveness in the therapists.

6.3 Recommendations for Future Research

Future research could compensate for limitations for the current study by exploring experiences of LGB clients whose therapists' therapeutic approaches and training backgrounds are known. In line with Moradi, Mohr, Worthington and Fassinger's (2009) recommendations, it would be constructive to investigate counselling psychologists' therapeutic approaches with LGB clients, in terms of how existential or humanistic approaches compare with stronger gay-affirmative approaches in influencing the conceptualization of sexual identity meanings in

therapy. In addition, more accurate capturing of LGB individuals' experiences of sexual attraction and the corresponding meanings they assign to their sexual identities could be an area for further research. More detailed investigation into the wide variety of feelings, thoughts and behaviours that may be previously unexplored due to socio-political oppression of same-sex relationships could shed light on how heteronormativity has limited ways of understanding oneself more broadly as a sexual being. These conceptualizations have implications for how gender dysphoria and mental health may be defined in the field of psychology.

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APPENDICES

Appendix A: Ethics Approval

11 June 2013

Caril Cowan
Faculty of Health and Environmental Sciences

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

A U T E C
S E C R E T A R I A T

Dear Caril

Re Ethics Application: **13/106 Lesbian, gay and bisexual clients' experience of discussing sexual identity in therapy.**

Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 10 June 2016.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online throughhttp://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 10 June 2016;
- A brief report on the status of the project using form EA3, which is available online throughhttp://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 10 June 2016 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Madeline Banda
Acting Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Sany Tsai aporia24@gmail.com

Appendix B: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

01/05/2013

Project Title

Lesbian, Gay and Bisexual (LGB) Clients' Experiences of Discussing Sexual Identity in Therapy

An Invitation

My name is Sandy Tsai and I would like to invite you to participate in my thesis study on LGB clients' experiences of therapy and counselling. This study is for partial completion of my Master degree in Counselling Psychology, and your participation is highly valued and appreciated. Your participation is voluntary and you may withdraw at any time prior to the completion of data collection. Also, you will be shown the interview transcript and have the opportunity to make changes or delete any segments you do not wish to be used.

What is the purpose of this research?

The purpose of this study is to explore the experiences of LGB clients who have been in therapy, and how – if any – discussions around sexual identity (such as homosexuality and bisexuality) was conducted with therapists. The study is also looking at whether clients felt understood by their therapists in terms of their sexual identity experiences.

How was I identified and why am I being invited to participate in this research?

You were identified and selected as a result of answering to the advertisement for this study either through the advertised poster, E newsletter or through word of mouth. You have also matched the participant criteria for the study as an individual self-identified as lesbian, gay or bisexual, aged between 20-55 and have had some form of therapy within the last 3 years.

What will happen in this research?

This study involves a one-on-one interview with me (a student researcher but not a trained counsellor), discussing your experience of therapy in particular around sexual identity, such as whether discussions on this topic occurred with the therapist at all, and how you felt about it as a result. The interview is expected to last around 1 hour, but may be more or less depending on the conversation. The interview will be audio- recorded and the content is only accessible to me and my thesis supervisor, Caril Cowan, and only used for the purpose of this study.

What are the discomforts and risks?

It is understandable that while talking about your therapeutic experience, some issues or memories would be triggered and perhaps stimulates an emotional response. You may decline to discuss any topic, answer any question or stop the interview at any time if you feel unsure or uncomfortable about what is being discussed. You do not have to disclose any personal

information that you do not wish to as it is important that this study does not cause you any anxiety or distress.

How will these discomforts and risks be alleviated?

If taking part in this study causes any anxiety or distress to you, the AUT Health, Counselling and Wellbeing Clinic offers confidential counselling support free of charge for up to 3 sessions. They can be contacted at AUT's city campus (09 921 9992) or North Shore campus (09 921 9998) for appointments. Please inform the centre that you are a participant of the current study.

What are the benefits?

By participating in this study, you have an opportunity to voice your opinions about therapy with LGB clients and to be heard and for this knowledge to be used to further the practice of counselling psychology. Your input will contribute to a better understanding of how psychologists and therapists in general can be better trained to work more sensitively to LGB individuals' needs, and also contribute to the general understanding of different sexual identities and experiences.

How will my privacy be protected?

Your privacy and confidentiality will be assured as only I (the researcher) and Caril Cowan (thesis supervisor) of this research have access to your data, which will be anonymous even at this stage. A Confidentiality Agreement will be shown to you and signed by both you and the researcher before the interview. You may choose a pseudonym to be used in the interview as well as throughout the study. In addition, your identity and information will not be discussed with anyone else. While the findings from this thesis may be referred to in future research, the raw data and any contact details will not be re-used for any subsequent work.

What are the costs of participating in this research?

This study requires around one hour of your time, and transport to the AUT psychology clinic for interview if applicable. Costs for transport can be reimbursed if necessary; please provide receipts or tickets from your transportation.

What opportunity do I have to consider this invitation?

You may consider this invitation and respond by June 16th, 2013 for participation.

How do I agree to participate in this research?

A Consent Form and Confidentiality Form will be emailed or posted to you to sign before the interview if you agree to participate in the study.

Will I receive feedback on the results of this research?

You may wish to receive feedback on the results of this study. A copy of the completed thesis will be emailed to you, and you may contact me for further discussions of interest.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project
Supervisor, Caril Cowan, *caril.cowan@aut.ac.nz*, 921 9999 ext 7730.

Concerns regarding the conduct of the research should be notified to the Acting Executive Secretary of
AUTEC, Madeline Banda, *ethics@aut.ac.nz* , 921 9999 ext 8316.

Whom do I contact for further information about this research?

Researcher Contact Details:
Sandy Tsai aporia24@gmail.com
021 167 4469

Project Supervisor Contact Details:
Caril Cowan
caril.cowan@aut.ac.nz
09 921 9999 ext7730

Approved by the Auckland University of Technology Ethics Committee on 11th June, 2013, AUTEC Reference number 13/106.

Appendix C: Consent Form

Consent Form

Project title: **Lesbian, Gay and Bisexual Clients' Experiences of Discussing Sexual Identity in Therapy**

Project Supervisor: **Caril Cowan**

Researcher: **Sandy Tsai**

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 01/05/2013.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio- taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature:

..... Participant's name: .....

Participant's Contact Details (if appropriate):

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Date:

Approved by the Auckland University of Technology Ethics Committee on 11th June, 2013 AUTEC Reference number 13/106.

Note: The Participant should retain a copy of this form.