

Sexual Orientation Microaggressions: The Experience of Lesbian, Gay, Bisexual, and Queer Clients in Psychotherapy

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Psychological research has shown the detrimental effects that overt heterosexism have on lesbian, gay, bisexual, and queer (LGBQ) clients and on the psychotherapeutic relationship. However, the effects of subtle forms of discrimination, specifically sexual orientation microaggressions, have on LGBQ clients and the therapeutic relationship have not been addressed. This study used qualitative methodology to explore the phenomenon of sexual orientation microaggressions with 16 self-identified LGBQ psychotherapy clients. Results of this study support the existence of sexual orientation microaggressions within the therapeutic environment and provide a descriptive account of 7 sexual orientation microaggression themes, channels of microaggression communication, and the impact microaggressions have on therapy and clients.

Keywords: sexual orientation microaggressions; psychotherapy with lesbian, gay, bisexual, and queer clients; covert heterosexism

The United States has become increasingly accepting of lesbian, gay, bisexual, and queer (LGBQ) individuals, and psychotherapy has undergone dramatic changes resulting in improved attitudes toward LGBQ clients, increased training opportunities on LGBQ issues, and a growth of LGBQ-focused psychotherapy literature. Although the trend is for greater affirmation, practitioners offer a mixed level of responsiveness to LGBQ clients and issues. On one hand, exemplary practices have been accounted for in which practitioners working with LGBQ clients expressed positive therapeutic experiences during assessment, intervention, and process (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991); practitioners and practitioners in training exhibit greater interest in furthering their knowledge and insight pertaining to affirmative practices with LGBQ clients (Dillon et al., 2004), and there is an increase in the use of gay-affirmative approaches in therapy (Kilgore, Sideman, Amin, Baca, & Bohanske, 2005).

On the other hand, it remains the case that LGBQ clients continue to report considerable discrimination and hostility during the therapeutic process (Bowers, Plummer, & Minichiello, 2005; Greene, 2007) and that negative therapist variables such as bias and ignorance is present within many aspects of psychotherapy (i.e., intervention and assessment) (Garnets et al., 1991). LGBQ clients have detailed unhelpful therapy experiences during the course of therapy when their therapist exhibited unsupportive and dissatisfying reactions to their sexual orientation (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). Overt forms of discriminatory

practices, such as the practice of conversion or reparative therapies, have declined (Friedman & Lilling, 1996), yet considering the continued biased and unhelpful treatment experienced by LGBQ clients (Liddle, 1996), it is possible that overt forms of heterosexism have been replaced with more subtle forms of heterosexism (Bowers et al., 2005).

Subtle and covert forms of heterosexism within the therapy environment could potentially come across in the form of microaggressions. Microaggressions are communications of prejudice and discrimination expressed through seemingly meaningless and unhelpful tactics. They may be delivered in the form of snubs, dismissive looks, gestures, and tones (Constantine, 2007; Constantine & Sue, 2007; Sue, Capodilupo, et al., 2007). The intention of a microaggression is to deliver a hidden denigrating, hostile, or negative message about a person or a group (Sue, Capodilupo, et al., 2007). For example, Sue and colleagues (Sue, Bucceri, Lin, Nadal, & Torino, 2007) note the use of “color-blindness” of White individuals making statements such as, “I don’t see color.” Overtly, this attitude appears to be a harmless statement, and potentially a possible admission of universal acceptance of others. However, the omission of seeing one’s race or ethnicity suggests an invisibility of ethnic minorities and denies the racial realities of ethnic minorities.

The subtle nature of a singular microaggression makes deciphering a microaggressive attack challenging. In fact, a microaggression is not identified by the occurrence of a singular event, but rather it is a product of the accumulation and regularity of small injustices that promote an environment of hostility and confusion to the target of the aggression (Solórzano, Ceja, & Yosso, 2000; Sue, 2010a). Further complicating the identification of microaggressions is that they are often unconsciously communicated by well-meaning and kindhearted individuals, and can be easily explained away through nonbiased and valid reasons (Sue, Capodilupo, et al., 2007). For instance, asking an Asian American individual, “Where are you from?” is seemingly safe and shows

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interest and curiosity; however, the effect of repeated exposure to such questions causes many U.S.-born Asian Americans to feel demeaned and like a “perpetual outsider” or foreigner (Sue, Bucceri, et al., 2007).

The manifestation, process, and impact of microaggressions differ from other forms of traditional discriminatory practices in a number of ways. First, traditional practices of discrimination are often overt, conscious and deliberate acts delivered to purposely cause harm or oppress a target (Sue, 2010a). This includes individual, institutionalized, and cultural practices of discrimination. Traditional forms of discrimination are easily identifiable, for instance, the use of epithets, hate crimes, and sexual harassment clearly communicate derogatory messages. Visual cues such as swastikas, hanging nooses, and angry protestors outside of LGBTQ events provide evidence of bias and prejudice. Additionally, there is legal and civil recourse available to those who experience traditional discriminatory practices that negatively affect their employment, housing, or educational opportunities. Overt and obvious discrimination and bigotry are generally thought to be easier for minority individuals to deal with as there is little confusion to the message being delivered, and minority individuals are then able to activate coping strategies or seek rectification (Hodson, Dovidio, & Gaertner, 2010).

Unlike traditional practices of discrimination, covert bias and microaggressions are often delivered by good-intentioned and well-meaning individuals who unconsciously hold biases and prejudice. Mental health practitioners who disagree with heterosexism are not immune to societal or psychological stigmatization of LGBTQ individuals and may unintentionally perpetuate biased views in their work with LGBTQ clients (Barrett & McWhirter, 2002; Bowers et al., 2005). The invisibility of covert heterosexism pushes recognition of biased views outside of immediate awareness, consequently disabling mental health professionals’ ability to address or confront microaggressions.

Contrasted to the clear message of hate, anger, intolerance, and repulsion delivered through traditional discrimination, microaggression messages are hidden and imbedded within content, syntax, and context. Through nebulous verbal, nonverbal, or environmental means, microaggressions communicate that marginalized groups are not welcome, intellectually inferior, and deviants (Sue, 2010a, 2010b). After a microaggressive incident, the recipient of the microaggression is left feeling powerless, invisible, pressured to represent one’s group, and may experience a loss of integrity (Sue, Capodilupo, & Holder, 2008). The consequences of microaggressions survive past the actual acts themselves, leaving in their wake an environment of confusion, hostility, anger, and damaged self-esteem, which are emotional and psychological wounds not quickly resolved (Sue, 2010b; Sue, Capodilupo, et al., 2007).

Sue and colleagues (Sue, 2010a; Sue, Capodilupo, et al., 2007) describe three forms of microaggressions: microassaults, microinsults, and microinvalidations. *Microassaults* are conscious and deliberate forms of discriminatory practice, biased attitudes or behaviors that are intended to harm or oppress a marginalized group (Sue, Capodilupo, et al., 2007). Microassaults most closely compare with *old-fashioned* discrimination (Sue, Capodilupo, et al., 2007; Sue, Nadal, et al., 2008), including acts such as name-calling, avoidant behavior, and intentional discriminatory actions; however, the conditions in which microassaults are expressed differentiate them from traditional forms of discrimination. Perpe-

trators of microassaults require a degree of protection that is present under three conditions: (a) anonymity—the perpetrator’s identity will not be linked to his or her actions or role, (b) safety—the perpetrator believes he or she is in the company of others who share their biases and feels more free to express offensive beliefs and attitudes, and (c) control—an individual may conceal his or her biased beliefs and attitudes, but in a situation in which they feel out of control, their biases are overtly expressed (Sue, 2010a).

Microinsults are laden with demeaning and insulting properties. Snubs, gestures, and verbal slights, typically outside of one’s awareness, communicate rudeness and insensitivity to a marginalized group (Sue, 2010a; Sue, Capodilupo, et al., 2007). For example, telling a Black man, “You speak so well”, sends the underlying message that Blacks are intellectually inferior and that it is unusual for a Black man to be articulate (Sue, Capodilupo, & Holder, 2008). Finally, the purpose of *microinvalidations* is to “exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of certain groups” (Sue, 2010a, p. 37). Sue (2010a) provided an example of someone assuming a woman is lesbian because of the perceived lack of effort the woman put into her appearance, which communicates the message that lesbians are not concerned with being attractive or are less attractive than heterosexual women. Microinsults and microinvalidations are considered to be more dangerous than microassaults, as the first and second are often acts committed outside of an individual’s awareness. However, it is suggested that microinvalidations are the most dangerous microaggression because they deny the reality of other groups and impose an alternate and oppressive reality on marginalized groups (Sue, 2010a).

Microaggression research has focused primarily on the experiences of persons of color, specifically racial microaggressions experienced by African and Asian Americans. Racial microaggression research has demonstrated the pervasive existence of racial microaggressions and the detrimental effects racial microaggressions have on the therapeutic relationship, quality of treatment, and psychological well-being of clients. Not only do racial microaggressions disrupt the therapeutic environment, they are potentially harmful to the psyche of clients who participate in therapy. Clients of color who are exposed to racial microaggressions may prematurely terminate therapy, view their therapists as less multiculturally competent, feel misunderstood by their therapists, and have stronger feelings of frustration and anger (Constantine, 2007; Constantine & Sue, 2007; Sue, Capodilupo, et al., 2007).

Microaggression researchers assume that the phenomenon of microaggressions does not exist solely within communities of color; hypothesizing that “sexual orientation microaggressions” (Sue, 2010a, 2010b; Sue & Capodilupo, 2007) may have a powerful and devastating impact on the lives and therapeutic experiences of LGBTQ persons (Sue & Capodilupo, 2007; Sue, Capodilupo, et al., 2007). Considering that LGBTQ clients tend to have high rates of mental health service utilization (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Haldeman, 2001), and the knowledge that covert forms of bias exists outside of practitioners’ awareness (Bowers et al., 2005), greater examination of sexual orientation microaggressions is needed for the provision of affirmative and competent psychotherapy practice. Conceptual works (Nadal, Rivera, & Corpus, 2010; Sue, 2010a; Sue & Capodilupo, 2007) suggest several sexual orientation microaggression themes

(i.e., second-class citizen, assumption of abnormality, denial of heterosexism, endorsement of heteronormative culture, and assumption of universal LGBT experience); however, such themes are not empirically based. The purpose of this study was to expand the concept of microaggressions to sexual orientation and to explore themes, experiences, and the impact of sexual orientation microaggressions in psychotherapy. This investigation offers a descriptive account of such a phenomenon, reveals sexual orientation microaggression channels of communication, and details the impact of sexual orientation microaggressions on LGBQ clients and the therapeutic environment.

Method

Participants

Participants in this study were 16 self-identified LGBQ individuals. A summary of participant demographics with pseudonyms is provided in Table 1. Participants ranged in age from 20 to 47, and the average age was 26.25. There were nine females and seven males. Participants racially self-identified as White (13 participants), Hispanic/Latino (two participants), and Black (one participant). To ensure anonymity of the participants, some ethnic identifiers were purposely excluded from Table 1. Participants were highly educated as all were working toward college and professional degrees or held a college degree. The number of therapists participants had seen in their lifetime ranged from 1 to 13 therapists.

Procedure

This study drew participants from a large, comprehensive university in the southeastern United States. Participants were recruited through the campus LGBT center and website, local LGBTQ-oriented listservs, and the primary investigator solicited participants during a campus LGBT center student meeting. Recruitment announcements asked for LGBQ individuals to volunteer to participate in small focus groups designed to obtain their

input about their counseling experiences. All participants completed a phone screening prior to joining the focus groups. To be included in the study, potential research participants had to identify as LGBQ, and had at least one 50- to 60-min session with a mental health professional (psychologist, licensed counselor, social worker, marriage and family therapist, or a psychiatrist). Each participant received a monetary inducement of \$20, and light refreshments were served.

Data Collection

Two small self-contained focus groups facilitated by the primary investigator were used as the primary mode of data collection for this study. Self-contained focus groups are commonly used as the primary method of inquiry and data collection in both LGBQ and racial microaggression literature. Additionally, when sensitive issues are explored, such as therapy experiences or sexual orientation, focus groups promote engaged conversations of a shared experience, fostering greater discussion and disclosure regarding the sensitive issue (Frith, 2000). Focus groups are advantageous over other forms of data collection, as focus groups provide a more naturalistic environment in which participants are influenced by one another, possibly resulting in the creation of a synergistic atmosphere in which shared beliefs and experiences may emerge (Litosseliti, 2003). The memories elicited from hearing other participants' experiences and nonverbal encouragers between focus group participants assisted in constructing a more complete picture of the range and types of microaggressions experienced by LGBQ psychotherapy clients.

One focus group was composed of five participants, whereas the other held 11 participants. Prior to beginning the focus groups, each participant signed a consent form and completed a demographic form. The focus groups lasted from 90 to 120 min and were digitally audio recorded. To encourage open discussion and to assist in data triangulation, two process observers (one in each focus group) who identified as lesbian or queer also participated in the focus groups. The observers were selected because of their previous professional, clinical, and research experience working

Table 1
Participant Demographics

Pseudonym	Gender	Sexual orientation	Age	Race/ethnicity	Number of therapists in lifetime	Number of therapy sessions in lifetime
Adam	Male	Gay	47	White-Eastern European descent	8	Incomplete response
Bethany	Female	Queer	27	White	4	30
Courtney	Male	Gay	47	White-European	13	>1,000
Debbie	Female	Queer	29	White	3	>30
Evon	Female	Bisexual	25	White-Caucasian	1	Incomplete response
Felicia	Female	Queer	22	Hispanic/Latino-South American	1	>20
Gabriella	Female	Bisexual	28	White-Caucasian	3	3
Hines	Male	Queer	20	Black-African American	1	3
Iris	Female	Bisexual/Queer	20	White-Western European/Native American	8	>90
Johnson	Male	Gay	22	White-Western European	3	12
Kristopher	Male	Gay	21	White	2	~42
Lamar	Male	Gay	23	White	4	20-30
Marissa	Female	Lesbian/Queer	20	White-European	3	20-25
Nolen	Male	Gay	28	Hispanic/Latino-North American	2	~30
Olivia	Female	Bisexual	21	White-WASP	5	Incomplete response
Phoenix	Female	Lesbian	20	White-American/European	5	>20

with LGBQ individuals; they were assigned to their respective focus group on the basis of their availability. Observers were present in the focus groups for two reasons. Observation is a method of data collection that can provide additional insights into the investigation. The observational notes of the observers were compared with the investigator notes and incorporated into the research. Second, an observer identifying as LGBQ reflects an attempt to recreate the atmosphere constructed in previous microaggression research. Racial microaggression research (i.e., Constantine, 2007; Constantine & Sue 2007; Sue, Bucceri, et al., 2007) operated from the assumption that maximized group comfort and sharing could be obtained from matching the race of the moderator and focus group participants. As the primary investigator identified as a heterosexual ally, it was hoped that the presence of a LGBQ-identified observer would help facilitate the open discourse that was reportedly present in racial microaggression studies. The observers' role was described to the participants, and the observers introduced themselves to the participants, and shared background information regarding their professional status and LGBQ identity.

Focus group questions were formulated from a review of empirical and theoretical literature pertaining to microaggressions, LGBQ psychotherapy clients, and heterosexism within the therapy environment. The script used in this study was adapted from the script and questions used by Sue and colleagues' (Sue, Bucceri, et al., 2007) study of racial microaggressions and Litosseliti's (2003) examples of stages for focus groups. The interview questions used are available in the Appendix.

Psychological Phenomenology

Due to the lack of psychological research investigating the microaggressive experiences of LGBQ therapy clients, and because qualitative inquiry can produce new forms of knowing (Morgan, 1997), the use of qualitative inquiry was essential for this study. Psychological phenomenology was well suited for this examination given that the central purpose of phenomenology is to "determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it" (Moustakas, 1994, p. 13).

Methods for Data Analysis and Synthesis

Preliminary data analysis was independently completed by the primary researcher. Responsibilities of the second researcher included providing feedback on the analysis, psychologically transformed labels, and complementarity of themes with transcribed statements. The analysis of this investigation was derived from the guidelines of Moustakas (1994) and the "Duquesne method," which involved (a) collecting verbal protocols that described the experience, (b) reading them through carefully to get a sense of the whole, (c) extracting significant statements, (d) eliminating irrelevant repetition, (e) identifying central themes, and (f) integrating these meanings into a single description (Creswell, 1998).

The collection of verbal data from the focus groups began the process of exploring LGBQ psychotherapy clients' lived experiences of microaggressions. After the data were collected and transcribed, it was read in its entirety multiple times to gain a sense of the experiences of participants as a whole.

Following a full depiction of participant experiences, the data were reduced into significant statements and descriptions that formed meaningful units. Creating units of meaning was done by reading and rereading the transcripts more slowly, and acknowledging a series of meaningful statements or shared ideas. Using the guidelines of the van Kaam method of phenomenological analysis (cited in Moustakas, 1994), statements that did not meet the following criteria were eliminated from the study: (a) statements that contained a moment of the experience that was sufficient for understanding it and (b) statements that could be abstracted and labeled.

Meaningful units were then clustered together into central themes, and the essence of the phenomenon was described using the participants' language. Participants' language was then transformed into psychologically sensitive expressions (Giorgi, 2006); for example, the description of an experience that conveyed subtle discrimination was transformed into the psychological label of a *microaggression*. Completing the data analysis involved providing both a textual description (description of the participant's experience) and structural description (context in which microaggressions take place) from the synthesized and transformed data (Creswell, 1998; Creswell, Hanson, Clark, & Morales, 2007).

Trustworthiness. Trustworthiness of any form of qualitative inquiry can be compromised by the subjectivity of the researcher (Huberman & Miles, 1994; Maxwell, 1996; Morrow, 2005). Validity checks were used at all stages of this study to maintain the integrity of the findings. The primary researcher used an outlined reflexivity approach throughout the study to aid in continual cultural self-exploration and to explore bias and the potential for subjectivity (see Langdrige, 2007). The use of *epoché*, considering all material as fresh and as seen for the first time (Moustakas, 1994), assisted in the perseverance of researcher objectivity. Imaginative variation involves changing aspects of the description to determine whether the interpreted or transformed description of the phenomenon correctly reflects the description given by participants (Giorgi, 2006; Moustakas, 1994). Imaginative variation was used to check the appropriateness of psychologically transformed statements.

Written notes and feedback from the investigators and process observers provided data triangulation. Debriefing between the observers and the primary investigator occurred immediately after data collection concluded. Several questions were explored in the debriefing including the following: (a) What were the most important themes or ideas discussed? (b) did the facilitator or participants engage in any microaggressive acts (as previously defined in microaggression literature) during the focus groups? and (c) what were the initial feelings and comments about the discussion? The observational notes were later used in the data analysis to aid in the identification and confirmation of themes, provide validation of the focus group format, and highlight the emotional reactions of participants. Post data analysis participant feedback also provided a level of triangulation.

Researchers' Backgrounds, Experiences, and Biases

The primary investigator is a self-identified African American, heterosexual, female ally, who is professionally and personally interested in the lived experiences of LGBQ individuals and is seeking to better understand the existence of microaggressions.

The data for this study were collected while the primary investigator was a counseling psychology doctoral candidate and was used for her dissertation. Professionally, the researcher has clinical experience working with LGBQ individuals and groups as well as experience teaching and researching LGBQ-related issues. Personal interest in this topic stems from the researcher's pursuit of social justice and desire to improve the quality of clinical services provided to historically marginalized groups.

The coinvestigator identifies as a Latino, heterosexual, male ally. He is interested in multicultural competence and interested in extending the concept of microaggressions to the LGBQ realm. The coinvestigator was the dissertation chair and advisor for this research. Professionally, the coinvestigator has extensive clinical experience working with LGBQ clients.

As the researchers are an intricate part in the conduction of any research, it is important that the assumptions of the researchers are made explicit at the outset of the study. Three primary assumptions were made regarding this study: (a) Personal accounts of LGBQ therapy clients' experiences would produce descriptive accounts of microaggressions; (b) channels of sexual orientation microaggression communication would be revealed through participant narratives; and (c) if sexual orientation microaggressions were present, then they would have an impact on research participants.

Results

Study results support the existence of sexual orientation microaggressions within the individual therapy environment. The following section outlines seven sexual orientation microaggression themes, channels of sexual orientation microaggression communication, and the impact sexual orientation microaggressions have on the therapeutic environment and LGBQ psychotherapy clients. By way of "thick description" (Denzin, 2001), in this section we use the participants' language to provide an understanding of participants' experience of sexual orientation microaggressions and the context in which the microaggressions occurred.

Sexual Orientation Microaggression Themes

Seven themes emerged that represent microaggressions experienced by LGBQ individuals in psychotherapy. Of note, some of the participant's statements express microaggressions that could fit into more than one theme; therefore, some themes are interrelated. Each microaggressive theme is illustrated by narrative examples gathered from the transcripts. A summary of sexual orientation microaggression themes, examples of microaggressions, and their underlying messages are presented in Table 2.

Theme 1: Assumption that sexual orientation is the cause of all presenting issues. One of the overarching findings of this study was participants' descriptions of the subtle techniques therapists used to infer that participants' sexual orientation was the cause of all of their presenting issues. Participants discussed presenting in therapy for treatment of issues unrelated to their sexual orientation such as academic issues, depression, anxiety, homesickness, and trauma. Yet, regardless of clients' presenting issues or symptomatology, sexual orientation remained a therapeutic topic. Therapists frequently brought up participants' sexual orientation at inappropriate times or in abrupt, rudimentary ways as described by one participant:

I would be talking about my stress and anxiety and how I am freaking about schoolwork and everything has to be perfect and perfectionism and so on and so forth because I am already perfectionistic and get all into a whirlwind of stress. And then, I would be in the middle of conversing about this and I would get a question like, "So how does your family feel about you being gay?" And I was like, "they aren't really pleased, but anyway, back to what I was talking about five seconds earlier." (Kristopher)

Another participant shared his reaction to his sexual orientation being regarded as the focus on treatment:

... something wasn't right that somebody could take a little tiny piece of the big intake picture that had nothing whatsoever to do with why I wanted to see a counselor. And say, "Well no no no, the problem isn't the [description of abuse] and all this history that you are carrying with you, the problem is that you are gay." (Courtney)

Theme 2: Avoidance and minimizing of sexual orientation. LGBQ participants described the process of issues pertaining to sexual orientation being avoided and minimized and that therapists were unaware of how sexual orientation could have an impact on their presenting issues. Iris shared her experience, "Probably the most subtle discrimination would be silence . . ." Participants also described silencing and avoidance of sexual orientation as an active and conscious effort made by therapists:

He [the therapist] wouldn't talk about it, "I'm not ready to deal with this abuse stuff, but I will talk to you about this relationship I am having some trouble with," and he wouldn't talk about it [same-sex relationship]. (Debbie)

Active avoidance of LGBQ issues was reflected in therapists' evasion of using LGBQ terminology. A subconversation between two members highlighted the evasive efforts therapists used to circumvent discussing same-sex relationships, which included refusal to use the word *gay*, referring to intimate partners using nongendered pronouns such as *they* or *them*, and referring to sexual orientation as a "choice" or "lifestyle."

Therapists' seemingly used kind and supportive methods to minimize and inadequately address sexual orientation issues by delivering statements such as, "You don't need to worry about that [LGBQ identity] right now" and "Experimentation is normal." Marissa described her experience of minimization when her therapist stated, "That I didn't need to worry that I was gay because I probably wasn't because it is perfectly normal to like to cuddle and kiss girls and that doesn't make you gay."

Therapists' lack of empathy in understanding the effect sexual orientation had on presenting issues was especially salient in issues surrounding coming out. Therapists tended to focus on the freeing and accepting components associated with coming out, yet failed to recognize pain, internalized heterosexism, and rejection that can also be associated with coming out. A 47-year-old gay male participant described his therapist's reaction to him being outed:

When I came out, I got outed accidentally to my mom, it's a long story but I told my therapist about it and he said, "Well good!" You know, obviously I had been crying before I even went in his office. I don't think heterosexual people know what an impact coming out can have. It can be freeing in one way and at the same time be very frightening. (Courtney)

Table 2
Sexual Orientation Microaggressions in Psychotherapy

Theme	Microaggression	Message
Assumption that sexual orientation is the cause of all presenting issues	A therapist says to a client, "I know what the problem is, you are gay."	Your sexual orientation is the problem.
	When a client discusses academic issues, a therapist interjects, "What do you think this issue has to do with your sexuality?"	Your sexual orientation needs to be treated.
Avoidance and minimizing of sexual orientation	A therapist avoids using LGBQ terminology.	Issues related to your sexual orientation are not important to talk about.
	A therapist tells a client, "You don't have to worry about that [sexual orientation] right now, let's talk about this other issue."	You should feel uncomfortable talking about your sexual orientation.
	When a client is accidentally outed, a therapist responds, "Good, it's about time."	You make me uncomfortable.
Attempts to overidentify with LGBQ clients	A therapist makes frequent references to distant family members who are LGBQ.	Coming out is not a big deal.
	A therapist tries to befriend LGBQ clients or frequently engages in small talk.	I understand your issues because I know someone who is LGBQ.
	A therapist changes the way he or she speaks or changes physical posture to appear more comfortable with LGBQ individuals.	I am not homophobic because I know someone who is LGBQ.
Making stereotypical assumptions about LGBQ clients	A gay male client describes his weekend and the therapist says, "You were in a hardware store?!"	You are an oddity, and I am "cool" because I work with you.
	A therapist tells an attractive lesbian woman, "You don't look like a lesbian."	All LGBQ people are alike.
Expressions of heteronormative bias	A LGBQ client notices that a therapist's office only displays heterosexual books and pamphlets.	I don't need to make an effort to get to know you as an individual.
	After a client discloses their sexual orientation, a therapist states, "I am not gay!"	You are abnormal.
Assumption that LGBQ individuals need psychotherapeutic treatment	A therapist encourages a client to stay in treatment against the client's wishes.	You need to change or conform.
	When a client is being referred, the referring therapist states, "It doesn't matter who you see as long as you're seeing someone."	It is insulting for you to think I am gay.
Warnings about the dangers of identifying as LGBQ	A therapist asks a client, "Are you sure you want to enter this lifestyle?" or "Have you really thought this through?"	You are incapable of making rational decisions.
	When a client discusses experiencing discrimination, the therapist says, "This lifestyle brings certain problems with it."	Any problems you face are your own fault for choosing an LGBQ identity.
		Systemic oppression does not exist.

Note. LGBQ = lesbian, gay, bisexual, queer.

Theme 3: Attempts to overidentify with LGBQ clients. In an effort to demonstrate comfort, affirmation, or denial of heterosexism, LGBQ clients reported that therapists attempted to overidentify with clients. Overidentification included assumed similarity between therapist and client, gross displays of posturing to reflect comfort and likeness, and prematurely associating with clients when such familiarity was yet to exist for the client. Participants cited numerous occasions of therapists relating their personal heterosexual experiences to the experiences of their LGBQ clients:

But I had a couple of counselors who almost seemed like they had to make a point from time to time to mention something about a family situation or a comparison about something that I was going through. And, I don't think and I am not saying this to defend them, never came across like it was intentional or trying to make a point, but it was more like my life should be the same as theirs' kind of thing. (Adam)

Several LGBQ clients indicated that their therapists changed their demeanor and behaviors to exhibit understanding and accep-

tance. This ranged from changes in vocal tones and facial expressions to posture realignment. Such posturing was likely intended to convey acceptance, yet when alignment was displayed prematurely or when familiarity between client and therapist was not established, therapists operated from their perspective of the client's experiences or needs, and lost the perspective of the actual client, which resulted in a therapeutic disconnection. The following quotes shed additional light on the efforts made by therapists to attempt to identify with clients or to overly show support:

And one time I just casually mentioned that I had a crush on a TA and she [therapist] was like, "Oh, what's his name?" and I was like, "Victoria." She got really excited. Like it was this big deal you know. That I'm bisexual. Like, I don't know. It was like she welcomed me to like the open-minded tribe. (Olivia)

... "[Therapist asking] do you have a boyfriend?" "[client responding] No, I don't, I'm gay." And then he started to tell me about the one lesbian he knew. His total demeanor changed. Like he just moved in his little rolly chair and he just like sat back and relaxed. Were you

trying to, "Oh, you're a girl, let me talk all sweet to you? Oh, you're gay, ok, awesome, I can chill out now?" It was really weird that he was like, "Oh cool, so I can act cool around you, I can act like a dude and you won't mind." (Phoenix)

Theme 4: Making stereotypical assumptions about LGBQ clients. Participants' statements identified covert messages that demonstrated stereotypical beliefs about LGBQ individuals. A range of stereotypical assumptions made by therapists were disclosed with many focusing on appearance, particularly with female participants. Participants commented that therapists stated, "You are too pretty to be gay" and "You look too heteronormative."

Stereotypical suppositions also occurred in therapists' assumptions of (a) romantic relationships, "I think a lot of therapists bring up codependence right away when you're a lesbian"; (b) promiscuity in gay male relationships; and (c) quality of family relationships, "I remember part of the conversation being, I couldn't tell you specifically, but it was, 'Of course I have a bad relationship with my family, all gay people have a bad relationship with their family.'"

Another common assumption was that LGBQ clients have undergone religious conflict or that they were currently engaged in a tumultuous religious experience, and LGBQ clients must make a choice between their religion and sexual orientation. Participants expressed that their therapists disagreed with religious doctrine that judge and condemn LGBQ individuals and would make statements such as, "Well, maybe you should think about just not being a Christian anymore." Although participants interpreted such remarks as coming from a place of support for the LGBQ client, such statements left LGBQ clients questioning their religious beliefs and feeling unheard by their therapists as expressed by a participant, "You are really just still oppressing the way that I identify and the way that I experience the rest of my life because you are saying I have to choose."

Theme 5: Expressions of heteronormative bias. LGBQ clients were sensitive to the fact that as a component of being genuine, heterosexual identifying therapists may disclose their heterosexuality through displayed pictures or personal disclosures; however, participants reported feeling stifled when heterosexuality was communicated as being the norm and superior way of being and when LGBQ orientations were viewed as abnormal or inferior. Unanimously, participants reported the expressions of heteronormative bias in the pronouns and descriptive labels used by therapists: "Do you have a boyfriend?"; "Do you have a girlfriend?"; and "Are you married?" Therapists' assertions of their own sexual orientation alluded to the supremacy of heterosexuality. One participant recalled his former therapist's statement of, "Well, I am not gay!" in which the delivery and punctuation were out of context.

Heterosexuality as the norm was also promoted in recommendations and suggestions given to LGBQ individuals from their therapists, including bibliotherapy, pamphlets and brochures, and by viewing the books located in therapists' offices and waiting rooms. These resources were typically exclusive to heterosexual individuals and couples and ignored LGBQ issues and individuals.

Theme 6: Assumption that LGBQ individuals need psychotherapeutic treatment. LGBQ clients indicated that their therapists' actions were directed under the assumption that LGBQ individuals are flawed and abnormal individuals who need to be in

psychotherapeutic treatment. This assumption was expressed to clients when they felt pressured by their therapists to remain in psychotherapy when clients felt that they were ready to terminate. In cases in which LGBQ clients were referred to therapy by parents or guardians, therapists' continued treatment of high-functioning individuals who expressed little interest in continuing psychotherapy conveyed therapists' assumption of LGBQ individuals need for counseling services based primarily on their sexual orientation.

Similar sentiments were repeated when clients reported feeling pressured to follow recommendations and treatment plans with which they disagreed. After coming out to her therapist, Marissa expressed feeling as if she was "battling" with her therapist regarding her need for therapy and medication:

Because of that [a previous experience with a different therapist], that actually kept me from coming out to the very last possible second to my therapist, and when I did, the reaction that she had was the exact reason that I had tried to hold that back. Because I really feel like I lost a lot of credibility because I felt like every time I went to see her, it was a fight. Like, I mean basically we had a fight, and, "No, you just need to take drugs," and I am like, "No, I really don't, I just need to talk and get things straightened out." And as soon as I told her, like she asked me how my boyfriend was, and I told her that I had left him for my best friend [a female], all of a sudden, it's like I lost so much credibility. Like all the ground that I gained in that battle had been lost. And so it began all over again.

Theme 7: Warnings about the dangers of identifying as LGBQ. Participants expressed feeling as if their therapists felt it was his or her responsibility to warn them of the inherent dangers associated with an LGBQ identity. Therapists often took an expert stance on LGBQ issues and felt it necessary to provide LGBQ individuals with knowledge regarding entering and maintaining an LGBQ identity. This came across in the form of questioning, "Are you sure you know what you are getting into?" Warnings were more direct in statements such as, "Well, you should expect those sorts of things to happen with this lifestyle" and "Well, if you are going to be gay, you have to expect to come up against these certain conflicts against your religious family and other people in your religion."

Channels of Communication

This study revealed that sexual orientation microaggression communication is multidimensional within the individual therapy environment. Sexual orientation microaggression channels of communication are consistent with previous microaggression research reports of verbal, behavioral, and environmental microaggression interactions or exchanges (Sue, Capodilupo, & Holder, 2008). Verbally, microaggressions were delivered in direct and indirect comments made by therapists to clients. For example, participants reported being told by therapists, "Well, you are not actually queer" and "Have you thought this [being gay] through?"

Nonverbal and behavioral sexual orientation microaggression incidents are derogatory messages that are communicated to LGBQ psychotherapy clients through a therapist's body language, cues, and physical action and inaction. For example, participants reported nonverbal messages of silence, "He wouldn't talk about it [my same-sex relationship]." Behavioral incidents also included

therapists changing their physical demeanor or posture in response to clients disclosing their LGBQ sexual orientation status.

Finally, environmental microaggressions are delivered through physical surroundings that represent a microaggression/microaggressive event (Sue, Capodilupo, & Holder, 2008). For example, one participant reported, "All of the information you get, pamphlets and things, seem to be geared towards that [heterosexuality] as well." Environmental microaggressions also derived from seeing therapists' family pictures in their offices and the types of books maintained on therapists' bookshelves. Participants stated the belief that therapists should not have to conceal their personal lives; however, they noted that seeing such items made them aware that they were different from their (assumed) heterosexual therapists, and often LGBQ clients felt more guarded during initial visits.

Overwhelmingly, examples provided by participants suggest that verbal, nonverbal, and behavioral sexual orientation microaggressions were communicated unconsciously and without ill-intent by their therapists. One participant stated, "It [sexual orientation microaggressions] is pretty pervasive I think, but I don't think it is malicious, it's just they don't know."

Impact of Sexual Orientation Microaggressions

The presence of sexual orientation microaggressions within the individual therapeutic environment had a negative impact on the therapeutic process. Confirmation of this finding came in the form of participants' emotive reactions, attitudinal changes regarding therapy and therapists, and diminished help-seeking behaviors.

Affective consequences of sexual orientation microaggressions included clients feeling uncomfortable, confused, powerless, invisible, rejected, and forced or manipulated to comply with treatment. Participants felt invalidated, unaffirmed, frustrated, and angry when their sexual orientation and issues pertaining to sexuality were ignored, avoided, overrepresented in treatment, or pathologized. Clients felt as if their therapists could not understand their presenting problems or the sexual reality of LGBQ individuals. An example is noted in one participant's comment, "And the person [therapist] just didn't really listen to me. Like they didn't believe that what I was saying was my actual experience."

Clients' active participation in the therapeutic process was compromised when clients experienced sexual orientation microaggressions that left them feeling misunderstood and invalidated. Participants withheld information, failed to discuss their sexual orientation or issues relevant to sexual orientation, and felt the need to be deceptive to get their needs met. Fear of being seen as abnormal or different had a suppressive and muting affect on some participants' disclosure of their sexual orientation to their therapists. In line with this theme, a 28-year-old bisexual female participant stated:

I didn't really have an open dialogue about my sexuality when I had some therapy sessions. I mean it was kind of clear that she thought it was the norm from her saying like . . . "Yeah, you never really told me like do you have a boyfriend" . . . I wasn't really out at the time to anybody . . . I didn't really feel like talking about it anyways, and definitely didn't want to talk about it because I would know how she would feel. And then also, she already made it seem like kind of the normal thing to have a boyfriend drop me off. Well maybe I don't. But I don't want to, we just got along really well, so didn't want to be like,

oh you think it's wrong. Alright, well I am just not going to talk about it. (Gabiella)

Clients' were left feeling doubtful about the effectiveness of therapy, the therapists' abilities, and the therapists' investment into the therapeutic process when therapists minimized their sexual reality. Johnson, a 22-year-old gay male, shared the manner in which minimizing sexual orientation affected his therapeutic experience:

Like that was one of the things I wanted to talk about because for me, my issues interfacing with my family and my friends on a completely truthful level was sexuality based. So I needed to tell her that. But to have it brushed aside seemed stupid . . . seemed kind of, to be dismissive about it when I would bring it up as an issue seems pointless because, you know at the same time we talk about you don't want people to talk about "my gay friend" and that be the first thing, your sexuality really is an overriding thing that really influences how you understand the world.

Sexual orientation microaggressions have an enduring psychological impact on LGBQ clients. The anger, frustration, and helplessness participants expressed while telling their stories during the focus groups substantiates the prolonged effect sexual orientation microaggressions have on the psyche of LGBQ individuals. Such emotive experiences altered their view of therapy in such a way that prolonged or prevented clients from returning to therapy.

Discussion

Psychologists aspire to provide ethical and competent services to their clients with a special emphasis on attending to services provided to members of vulnerable populations. Over the last several decades, psychologists have been able to attend to the issues of overt prejudice and discrimination. However, as this study demonstrates, it is much more difficult to address the covert discrimination that may occur in the therapy relationship. When clients in this study were asked about their relationships with their therapists, they were able to relate stories that, when analyzed, revealed consistent themes related to the experience of microaggressions. In the section that follows, we focus on aspects of the results that merit further discussion.

Microaggression Taxonomy

The experiences of sexual orientation microaggressions expressed by LGBQ participants in this study fit within the previously articulated microaggression taxonomy: microassaults, microinsults, and microinvalidations. The following is a description of sexual orientation microaggressions fit within the taxonomy.

Microassaults. Microassaults within this study were most readily delivered verbally to participants. Therapists working with LGBQ clients used direct statements that suggested a conscious awareness of bias and negative attitudes. This was prevalent in the theme of therapists working from the assumption that sexual orientation was the cause of all presenting issues (Theme 1). A therapist stating to a client, "I know what the problem is, you are gay" shows a clear and reckless abandonment of guidelines and best practices and shows disrespect and possible hostility toward LGBQ individuals. The distinguishing feature between sexual orientation microassaults and traditional forms of sexual prejudice

and discrimination is the context in which sexual orientation microaggressions are presented. Although the therapist may have not been treating a like-minded client, several clients involuntarily presented for treatment at the insistence of parents who, similarly to their therapist, believed that sexual orientation was a presenting concern. As biases and negative attitudes went unchallenged by the referral source, therapists were provided with a sense of safety that allowed such remarks to be made.

Additionally, other remarks appeared to surface at times when therapists appeared frustrated with their LGBQ client or the progress being made in therapy. In these moments, a therapist's usual control was abandoned to reveal statements that acknowledged biased attitudes. This was exhibited in the assumption that LGBQ individuals need psychotherapeutic treatment (Theme 6) in that therapists pushed for clients to stay in treatment for longer than was perceived necessary by clients. Such microassaults have the underlying message that LGBQ individuals are internally flawed, and their sexual orientation is a problem that needs to be treated.

Although sexual orientation microassaults are overt and more easily identifiable than other forms of sexual orientation microaggressions, they are still difficult to challenge within the therapeutic context. Any group or individual can deliver microaggressions; however, the greatest harm comes when messages are transmitted from those who hold power to those who are disempowered (Sue, Capodilupo, & Holder., 2008). Therefore, the inherent power imbalance between therapist and client makes the occurrence of microaggressions, even microassaults, difficult to challenge.

Microinsults. Microinsults, subtle expressions of rudeness and insensitivity (Sue, Capodilupo, et al., 2007), were present in overidentification efforts (Theme 3) and stereotypical presumptions (Theme 4) made by therapists. The communication of microinsults may likely be a common occurrence for therapists who are attempting to be responsive and affirmative. The intent of therapists who communicate similarities between the therapist and LGBQ client, or understanding of the LGBQ community as a whole, is to connect with LGBQ clients and exhibit safety. As such, realigning body language or sharing personal experiences of therapists' relationships with other LGBQ individuals is not directly aggressive. However, when such communications are conveyed in an environment in which familiarity between therapist and client has not been reached, and when assumptions made about the LGBQ community are not the experience held by the individual client, the impact is the creation of a therapeutic environment that is neither inviting nor safe. So much so, LGBQ clients are left feeling misunderstood, stereotyped, and put down—the emotive reactions of experiencing an attack.

Microinvalidations. Sexual orientation microaggressions in the psychotherapeutic environment dismiss, ignore, remove, and invalidate the sexual reality and experience of LGBQ clients. Avoidance of sexual orientation (Theme 2), expressions of heteronormative bias (Theme 5), and warnings made to LGBQ clients (Theme 7) communicate that the experiences of LGBQ clients are not valid, unimportant, and erroneous. The unconscious transmission of microinvalidations by therapists convey the message that the LGBQ client is the problem or that difficulties experienced are the fault of the LGBQ client; "blaming the victim" (Constantine & Sue, 2007). When therapists use sexual orientation microaggressions that neglect to account for the presence of societal oppression and discrimination, they deliver the message that clients should

expect certain difficulties and are at fault for not adequately preparing themselves for the hardships they will likely face. Such communications have personal and environmental consequences. Erroneously blaming clients can foster internalized homophobia and shift the focus in therapy to issues that ignore the presenting needs of LGBQ clients.

Invisibility and Sexual Orientation Microaggressions

Targets of racial microaggressions can attest that a perpetrator's subtle discriminatory practices were based on ones' perceived racial identity, yet even with this knowledge, after a microaggressive experience, targets are left feeling confused or in a "catch-22" situation (Sue, 2010a; Sue, Capodilupo, et al., 2007). The invisibility of sexual orientation does not provide LGBQ clients with the same luxury of correlating feelings of confusion or invalidation to the behaviors or actions of another. LGBQ clients must decipher whether an actual microaggression occurred, whether it was based on their sexual orientation, and then cope with the emotive consequences. The invisibility of sexual orientation microaggressions creates a therapeutic environment that diminishes the quality of therapy. When sexual orientation microaggressions occur, LGBQ clients are forced to internally process the experience, which is ultimately distracting from the therapeutic goals.

Responding to either conscious or unconscious communications of sexual orientation microaggressions, LGBQ clients may refrain or postpone coming out to their therapists for fear that the relationship will detrimentally change or that they may be judged by their therapists. Such an environment forces LGBQ clients to hide an aspect of their identity; their sexual orientation remains invisible while the distress associated with dealing with perceived stigma may increase in visibility.

When sexual orientation microaggressions are used to silence sexual orientation and to keep sexual orientation invisible, internalized homophobia is promulgated. Speight (2007) argued that internalized oppression (i.e., internalized homophobia) is a damaging psychological injury that is more destructive than external oppressive events. Most identity theories express the importance of overcoming internalized homophobia to develop a healthy LGBQ identity. Sexual orientation microaggression messages from therapists carry the message that LGBQ individuals and same/both-sex attractions are wrong, abnormal, or inferior as compared with heterosexuals and heterosexuality and that therapists are uncomfortable and uneducated in LGBQ issues. Such messages may lead LGBQ clients to refrain from discussing issues related to their sexual orientation in a meaningful way, and thus fail to challenge internalized homophobia.

The indoctrination of heterosexism and invisibility of sexual orientation places well-intentioned therapists in a position to unconsciously communicate sexual orientation microaggressions to LGBQ clients. In fact, most participants described having strong therapeutic alliances with their therapists and believed that their therapists genuinely cared for their well-being, yet acknowledged that subtle discrimination was present in the therapy room. The hidden nature of sexual orientation microaggressions and inherent client-therapist power deferential makes it difficult to decipher microaggressive events from acceptable practice, which may force LGBQ clients to question their own interpretation of events. LGBQ clients were left feeling pulled to minimize or rationalize

microaggressions in hopes of rectifying therapeutic failures or to rescue therapists from uncomfortable feelings triggered by the presence of sexual orientation microaggressions. At other times, LGBQ clients ignored the occurrence of sexual orientation microaggressions. However, the more common reaction to sexual orientation microaggressions was inaction due to LGBQ participants feeling blindsided and unprepared to make any response. Inaction, ignoring, or minimizing the existence and impact of sexual orientation microaggression or sexual orientation can create a psychological and emotional scar that no well-intentioned therapists would want to inflict on a client.

Therapist Authenticity and Sexual Orientation Microaggressions

Sexual orientation microaggressions will happen in the psychotherapeutic environment. The question is what the therapist can do once the microaggression has occurred. The answer to this question is not easy as the importance of context and client–therapist variables are at play. Sexual orientation microaggressions can arise when therapists outwardly discuss sexual orientation, attend to presenting issues other than sexual orientation, or attempt to normalize LGBQ clients' experiences. Presented with such a paradoxical dilemma, well-intentioned therapists may be left feeling powerless and helpless in responding appropriately to the needs of LGBQ clients. Such feelings can be minimized by attending to the therapeutic context. Sexual orientation microaggressions are unconsciously expressed when statements or behaviors are inconsistent with the context of clients' presenting issues, treatment goals, and acclimation to therapy. Therefore, therapists should not refrain from discussions for fear of articulating a sexual orientation microaggression, but should instead evaluate the context for their statements, suggestions, or interventions.

A nondefensive and transparent approach best supports confrontation of sexual orientation microaggressions. The innocuous nature of microaggressions lends nicely to explanations such as, "That's not what I meant" and "You are taking what I said/did the wrong way." Therapists are wise to avoid using such statements, and instead focus on creating an atmosphere that allows for processing the impact that sexual orientation microaggressions have on clients, the therapeutic relationship, or therapy environment.

As heterosexism plagues even those with good intentions, therapists can accept the high likelihood that they do in fact hold some heterosexist or biased views even if it is not in their immediate awareness. Admission of heterosexism can actually be an asset for continued growth and rapport when working with LGBQ clients as expressed by Berkowitz (2005), "Accepting that I am unintentionally homophobic has allowed me to be more compassionate with myself when I make mistakes or express prejudices and to also be more open to feedback that will help me correct them" (pp. 29–30).

Limitations

Although this study detailed the sexual orientation microaggression experiences of 16 LGBQ psychotherapy clients, several limitations exist. Most participants assumed that their therapist was heterosexual; yet, this may not have been the case. Considering the assumed heterosexual identity of therapists, this study may or may

not accurately reflect sexual orientation microaggressions that exist in therapeutic environments with LGBQ-identified therapists.

Although the researcher attempted to elicit feedback from the 12 research participants who agreed to be contacted post data analysis, only one participant provided feedback on the study results. This study is limited in not having a fuller account of the participants' perception of the data analysis. In addition, the variability in size (5 vs. 11) of focus groups presents potential limitations. Willingness to share, opportunity to participate, and degree of responsibility were likely affected by group size.

Care should be taken in generalizing the results from this qualitative study of 16 highly educated and predominantly White (81%) individuals residing in the *Southeast United States. The experience of LGBQ individuals without collegiate educational attainment, ethnic minorities, and individuals living in other geographical locations may offer a different experience of microaggressions. Additionally, this study did not assess when psychotherapy experiences were completed and was reliant on participants' memory of therapy experiences; therefore, fallacies of retrospective reporting may exist (i.e., forgetting, over/underreporting) (Brewin, Andrews, & Gotlib, 1993; Hardt & Rutter, 2004).

Finally, this research is based on the analysis of researchers who identify as heterosexual allies. The principal investigator's identity as an "outsider" is a strength for this study as membership in a particular culture may inadvertently cause the researcher to focus on his or her reality of the experience and may underrepresent the experience as expressed by the research participants (Yeh & Inman, 2007). However, the researcher's identity also served as a hindrance for this study. Feedback from one of the focus group process observers indicated one incident of the researcher using a sexual orientation microaggression. Participants in the second focus group engaged in a prolonged discussion about their disdain for therapists who use words such as *partner* when addressing relationships and stated their preference for the terms *girlfriend/boyfriend*. Following this discussion, the researcher used the label *significant other* to describe romantic relationships. This event and other sexual orientation microaggression incidents, which the researcher is unaware of, may have impacted the integrity of the data collection.

Conclusion

The power of sexual orientation microaggressions rest in their ability to stealthily debilitate the therapeutic environment for the purpose of continued indoctrination of systemic oppression. Correctly recognizing and labeling the confusion, resentment, and silence sexual orientation microaggressions leave in their wake is not an easy task for clients or therapists. However, acknowledgement of the existence of sexual orientation microaggressions and taking the risk to challenge microaggressions can set a therapeutic tone to foster enhanced conversations regarding power, privilege, and sexuality, likely improving the quality of the therapeutic relationship. As multiculturalism and qualitative research methodologies are designated as the fourth and fifth forces of psychology, psychology and counseling are primed to develop and use clinical interventions and research methodologies that disarm the power of sexual orientation microaggressions and truly encourage the growth and prosperity of LGBQ clients.

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Appendix

Interview Questions

Opening Statement

1. At this time, we would like each of you to say your first name, your major or occupation and why you are interested in participating in this study.

General Questions

1. Please give us a general description about what your experience in therapy was like. Do not feel that you have to share why or the reasons you entered therapy.
2. Gay men, lesbian women, and bisexual and queer individuals often have experiences in which they are subtly invalidated, discriminated against, and made to feel uncomfortable because of their sexual identity. In thinking about your therapy experiences, could you describe a situation in which you feel you were subtly discriminated against because of your sexual orientation?

Interview Questions

1. Did you disclose your sexual identity/orientation to your therapist? Why or why not?
2. Think of some of the stereotypes that exist about gay men, lesbian women and bisexual and queer individuals. Has a therapists ever expressed their stereotypical beliefs about you?
3. Were there any experiences in counseling in which you felt that your therapist did not understand the impact of your sexual identity on your presenting issue or concerns?
4. What are some subtle ways that therapists treated you differently because of your sexual identity?
5. What has a therapist done or said to invalidate your experiences of being discriminated against?
6. Describe a situation in which you felt uncomfortable, insulted, or disrespected by a comment made by your therapist that had homophobic overtones.
7. In what ways have therapists made you feel “put down” because of your sexual orientation?
8. How has a therapist subtly expressed that “heterosexuality is the norm”?
9. In what subtle ways has a therapist expressed that they think you are a second-class citizen or inferior to heterosexual individuals?
10. Has a therapist suggested or made you feel like you “do not belong here” because of your sexual identity?

Transition Questions/Statements

1. We want to hear as many stories as possible. Even if you think your experience is just like everyone else’s, don’t just say, I agree. We want to hear your story, because there’s always something unique in each person’s own experiences.
2. What are some of the ways that you dealt with these experiences?

Ending Questions

1. How do you think subtle forms of heterosexism and/or homophobia impacted the overall quality of your counseling experience?
 2. What do you think the overall impact of your experiences has been on your lives?
 3. So today, you shared several experiences of subtle discrimination. Some of you said . . .
 4. What are some themes you heard from one another’s experience?
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