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The lived experiences of queer identified couple/ marriage and family therapists : a qualitative study

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THE LIVED EXPERIENCES OF QUEER IDENTIFIED COUPLE/MARRIAGE AND FAMILY THERAPISTS: A QUALITATIVE STUDY

by

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PH.D. THESIS

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To my mother, Donna Krum
You have shown me how to truly be strong

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ABSTRACT

In the history of this country queer-identified individuals have faced discrimination and harassment in their places of school and work for many years. Research has found that exposure to these experiences can have a negative impact on mental health. Prior to this study, no data were available as to whether or not queer-identified Couple and Family Therapists (C/MFTs) also have faced discrimination and harassment within the field of C/MFT. This study explored the lived experiences of queer-identified C/MFTs in an attempt to identify what unique struggles this population faces, and if these struggles include coping with discrimination and harassment. Participants identified concerns over inadequate training and resources, issues related to self-disclosure, the role of being a spokesperson for the queer community, the role that context plays with regard to their experiences, the strengths of being a queer-identified C/MFT, and the relationship that the American Association of Marriage and Family Therapy (AAMFT) has had with queer-identified C/MFTs and the queer community in general. Finally, participants were asked to give words of advice to other therapists based on their own experiences. The results of the study suggest that queer-identified C/MFTs find their sexual orientation as a strength; it not only benefits their clinical work, but can enable a sense of empowerment in advocating for the rights of their community.

PUBLIC ABSTRACT

In the history of this country queer-identified individuals have faced discrimination and harassment in their places of school and work for many years. Research has shown that these experiences can cause significant mental distress. The purpose of this study was to explore the lived experiences of queer-identified Couple/Marriage and Family Therapists (C/MFTs) and highlights the needs of this unique population. Participants revealed that they did in fact have unique needs that other, straight identified therapists, may not require, and expressed their desire for an increase in resources to help them navigate these needs. Even though the study identifies the struggles that queer-identified C/MFTs face, it also reveals the strengths that are inherent to this unique population.

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CHAPTER I: INTRODUCTION

Problem Statement

According to a Gallup Poll (2012), about 3.4% of adults in the United States identify as lesbian, gay, bisexual, or transgender (LGBT) (Gates & Newport, 2015). There are about 2 million adults who are currently in a same sex relationship, with 780,000 of those individuals being married to a spouse of the same sex (Gates & Newport). While these numbers are on the rise, it is likely that they are low. Respondents of the survey may not have answered truthfully for fear of repercussions of being identified as LGBT or queer. Even though laws and public opinion have started to shift, there are still risks to being 'outed' as queer (Duffy, 2014; Goldberg, Hittson, Hu, & Duffy, 2014). (Throughout this dissertation, I will use the term *queer* when describing an individual who identifies as non-heterosexual. The use of the terms lesbian, gay, bisexual and transgender, or the acronym LGBT will be used when directly citing literature or when directly quoting participants. An in depth explanation of the term *queer* will be defined in a subsequent paragraph.)

In recent years, research has begun to focus on the queer community. In the past five years, a handful of studies have examined the prevalence rate of discrimination faced by queer-identified individuals within their workplace due to their sexual orientation and/or gender expression (Goldberg et al., 2014; Sears & Mallory, 2014). As of 2012, nearly half of the country lived in states with little to no protection from discrimination based on a person's sexual orientation (Hunt, 2012). Currently, there is no federal law protecting the queer community from workplace discrimination. At the time of this writing, 20 states still had no statewide laws barring discrimination in workplace and

hiring practices; of the 30 remaining states, the laws vary from full protection of all employees against discrimination on the basis of sexual orientation and gender identity (18 states), full protection against discrimination on the basis of sexual orientation (3 states), protection of public employees against protection on the basis of sexual orientation and gender identity (6 states), and protection of public employees against discrimination on the basis of sexual orientation (3 states) (www.hrc.org). According to a United States Senate hearing in 2012, "Nearly 42 percent of lesbian, gay, and bisexual people had experienced employment discrimination at some point in their lives" (Goldberg et al, p. 19-12). Discrimination takes many different forms, including harassment which is the most widely reported (Sears & Mallory, 2011), promotions being denied or individuals being fired (Herek, 2009), being exposed to derogatory comments (Human Rights Campaign, 2009), and not being hired for positions for which they are qualified (Goldberg et al.).

The impacts of the exposure to discrimination have been found to be detrimental to the physical and physiological health of those who are being oppressed (Sears & Mallory, 2014). Researchers are beginning to explore just how impactful this is on the queer community. The federal government is even stepping in to acknowledge the damaging effects of discrimination based on sexual orientation. The United States Department of Health and Human Services has recognized the "ill effects of a homophobic social environment" (Sears & Mallory, p. 40-17).

While these studies (and more) have explored the prevalence and impact of discriminatory practices in the work place, at the time of this writing, no studies have been published examining whether or not these same experiences are occurring with

regard to queer identified therapists within the Couple/Marriage and Family Therapy field. Given the percentage of Americans who identify as queer, it is likely that there are a number of Couple/Marriage and Family Therapists (C/MFTs) that identify as queer. The Bureau of Labor Statistics (2015) estimates that as of May 2014, there were approximately 30,150 practicing C/MFTs in the United States. If one assumes that the demographic make up the field mirrors that of the general population, then 3.4% of C/MFTs, or approximately 1,025 of C/MFTs would identify as queer. Given the rate of discrimination that the queer community faces in general, it is worth investigating whether or not these same discriminatory practices are being mirrored within the field of Couple/Marriage and Family Therapy. For queer-identified therapists, this could be happening within several systems, including training, supervisor-supervisee relationships, peer relationships, and client-therapist relationships. Furthermore, given that research has highlighted the negative impact that discrimination has on individuals, it is important to explore if these same are occurring with the Couple/Marriage and Family Therapy community.

Purpose of the Study

Several studies have been done focusing on queer oppression, homophobia, and heteronormativity in educational and work settings (Dessel, Goodman, & Woodford, 2016; Goldberg et al, 2014; Sears & Mallory, 2014), but this literature does not include the educational and clinical practices of queer clinicians, specifically Couple/Marriage and Family Therapists (C/MFT). Although it may be easy to speculate what the experiences of this population might be, speaking for a community that has traditionally been marginalized, without input from said community, could serve to further oppress

this population. Therefore, the best way to understand this population is to use mechanisms that allow their voices to be heard (Mertens, 2009).

The aim of this study is to understand the experiences of this unique population. More specially, the goal is to identify the thoughts, feelings and actions of queer C/MFTs and explore how these experiences impact their clinical work. By attempting to understand this community, the hope is to be able to highlight strengths that this population might possess, and how these strengths help them manage through their day-to-day lives. This could especially be important if this study identifies that queer C/MFTs have unique needs, or are in any way oppressed within the field of Couple/Marriage and Family Therapy. Highlighting the strengths that some queer identified C/MFTs have used to overcome difficult experiences may benefit others who face similar situations.

A second aim of this study is to discover how queer C/MFTs view the Association of Marriage and Family Therapy (AAMFT) and the organization's stances on issues that are pertinent to the queer community, especially queer C/MFTs. The AAMFT is the professional organization that sets the Code of Ethics for C/MFTs, as well as the standards for education and supervision, and represents the position of the field on issues such as conversion /reparative therapy, anti-discrimination policies and laws, and same sex marriage. Understanding how queer C/MFTs perceive the association is important because of the power that this organization holds with regards to shaping the future of the field of Couple/Marriage and Family Therapy, not just in clinical practice, but in training programs and licensure as well.

Research Questions

The overarching research question of this study is, what are the lived experiences of queer identified C/MFTs within the therapeutic context? The research questions below were constructed with the purpose of the study and the overarching research question in mind. They use the researcher's personal experiences with this unique population, and are developed from the existing literature that discusses the queer community in general (and not queer C/MFTs specifically since the literature on this specific subset of the queer community is sparse.)

The research questions for this study are as follows:

- What are the lived experiences, struggles, stressors, etc. of being a queer-identified therapist?
- What are some strengths that queer-identified C/MFTs have in dealing with their sexual orientation?
- How does the AAMFT and its COAMFTE accredited programs view the queer community?
- How does the sexual orientation of queer-identified therapists impact the therapeutic relationships of with their clients?

Definition of Terms

There are two terms that will be used throughout this paper that are worth defining. For the scope of this paper, the terms Queer and Therapist will be defined as the following:

Queer

Throughout this dissertation, the term queer will be used to describe those individuals who do not identify as heterosexual. The term queer was chosen over other popular terms because it can encompass a larger population. (Some members of the queer community do not label themselves as lesbian, gay, bisexual or transgender.) While the term queer generally encompasses those that do not identify as cisgender, for the purpose of this dissertation, the term will only be used to describe sexual orientation, thus exclude transgender persons (as represented by the T in LGBT . While this is a limitation of this study, the study of the lived experiences of the transgender community is still in its infancy, and there is not enough literature to include in this study. While there may be references using lesbian, gay, bisexual, and transgender (LGBT), this term will only be used when directly citing from a source that uses this term. Throughout the literature, the terms queer and LGBT have been used interchangeably. Furthermore, while some of the literature uses the overarching phrase of LGBT, most of the studies do not include transgender participants in their study; the phrase is more often used to categorize gays and lesbians, and occasionally bisexuals. For the purpose of this dissertation, queer-identified C/MFTs include those therapists who identify as non-heterosexual or cis-LGB.

Therapist

The term therapist is used to describe any mental health practitioner that is either a graduate of a C/MFT program or is a licensed MFT and practices couple and family therapy. Because one of the foci of this study is to investigate the relationship of queer-identified therapists with their professional organization (AAMFT) and COAMFTE

accredited training programs within the field of C/MFT, the focus of this study was narrowed to this population of therapists.

Couple/Marriage and Family Therapy

The phrase Couple/Marriage and Family Therapy (C/MFT) will be used throughout the dissertation. This phrase was chosen over Marriage and Family Therapy and Couple and Family Therapy because different accredited programs choose to identify as either one or the other. The combined phrase was used to incorporate participants regardless of the name of their training programs.

Self of the Researcher

Notes from personal reflections of a therapist in training:

> As I was finishing up a session with a family, during the cleanup, the young daughter picked up a ball and tossed it into the toy bin. I commented on her athletic ability and stated that she should play softball. The mother's face became distorted and she gasped, explaining that there was no way she would let her daughter play softball. The mother exclaimed that if her daughter played softball, she would turn out gay, and that there was no way she was going to have a gay daughter. I struggled to find words, not knowing the best way to proceed. Do I challenge the mother on this? Do I bring it up in the next session? What happens if she finds out I'm gay? Will it ruin our therapeutic relationship? Is it even ethical for me to bring it up?

As a queer-identified therapist, there were, and still are, countless incidences in which my identity as a queer person impacts my clinical experiences, both in the therapy

room and in the academic settings. My interests in this topic stem from these experiences, and the experiences of my queer-identified peers. It is from a place of curiosity and pain that I seek to explore and understand the experiences of other C/MFTs who also identify as queer.

Along with this genuine curiosity, I have a passion for the equal rights of the queer community. I have experienced oppression in my own life, and have friends and colleagues experiencing oppression in their professional and personal lives as well. By exploring and highlighting inequalities that impact this community, light can be shed which can lead to change. In other words, the best way to bring about equality is to first shine light on inequality. I have advocated for queer rights in other areas of my life, and view this study as an opportunity to explore whether there is a need for advocating for queer rights within the C/MFT community.

Conceptual Framework

This study is being conducted through the lens of transformative research. Mertens (2009) discusses the primary assumptions of this framework. Transformative research "places central importance on the lives and experiences of communities that are pushed to society's margins" (p. 48). It aims to shine light on the oppressive nature that society has on marginalized populations, and does so by engaging the voices of members of these populations that have long been ignored and/or excluded (Mertens). Transformative research has its roots in social constructionism, and places values on the realities of the oppressed. While it brings focus to the oppression that occurs to non-dominant groups, transformative research also places an emphasis on identifying and

highlighting the strength and resiliency that these groups have had to muster in order to survive in society (Mertens).

This framework fits with this proposed study in several ways. As was stated above, the queer community has been oppressed and still faces discrimination in all areas of their lives, especially in the work place. This study aims to identify if this is occurring within the field of Couple/Marriage and Family Therapy, and is attempting to do so by engaging the voices of those that live the day-to-day experiences of queer-identified C/MFTs. Given the lack of research exploring these experiences, an argument could be made that the field of Couple/Marriage and Family Therapy is continuing to exclude the voices of a potentially oppressed population; a population that has a history of being oppressed by the very field in which they work. The treatment of the queer community by mental health practitioners throughout history could be categorized, at times, as unethical (Miller, 2006). Furthermore, this proposed study fits with the transformative framework in that is seeks to highlight the strengths and resiliencies of this population. This lens will be applied to the study using a phenomenological approach (which will be discussed in further detail in Chapter 3).

CHAPTER II: LITERATURE REVIEW

After a thorough review of the literature, it became apparent that there was a dearth of literature regarding the experiences of queer-identified therapists. There was, however, ample research on the overall daily life experiences of queer-identified individuals. As was stated in the previous chapter, most of the research with regards to queer individuals does not make the distinction between queer and lesbian, gay, bisexual and transgender (LGBT) and use the term interchangeably. Furthermore, while some of the literature cited below includes the term transgender in their studies, most did not evaluate the experiences of the transgender community. In those studies that did separate gender identity and sexual orientation, I am only using the parts of the studies that focused on the individual's sexual orientation. The following chapter details the literature found on the experiences of queer individuals, and concludes with a description of the relationship between the queer community and the American Association of Marriage and Family Therapy (AAMFT).

Lived Experiences of the Queer Community

Heteronormativity/Heterosexism

One of the common themes found while reviewing the literature was the socially constructed idea that heterosexual behavior is the most socially accepted behavior; in other words, a prevalence of heterosexism and heteronormativity. Heterosexism is the idea that heterosexual behavior and attractions are the norm, and that those who do not identify as heterosexual are abnormal (Nadal, 2013). Heteronormativity is the assumption that "others are heterosexual when their sexual orientation has never been announced or discussed" (Nadal, p. 59). An example of heteronormativity would be assuming that

when an individual is referencing their spouse, they are describing a person that is of the opposite sex. Heterosexism and heteronormativity occur in all aspects of society in which queer-identified people are ignored or discriminated against, while their heterosexual counterparts are celebrated (Nadal; Walls, 2008).

Heterosexism and heteronormativity can be experienced either directly or indirectly (Nadal, 2013; Silverschanz et al., 2008). A direct expression of heterosexism could be the blatant harassment of queer individuals; a situation "in which an individual is directly targeted for her or his sexual orientation" (Nadal, p. 29). The intent may not be to harm the individual, but openly reflects the heterosexist bias of the one making the claim (Nadal; Silverschanz et al.). Examples of this could be reflected in the laws and policies that prohibit marriage between same sex partners. "Even though the intention may not be malicious or overtly homophobic in nature, such behavior may indicate one's heterosexist biases" (Nadal, pp. 28-29).

Heterosexism and heteronormativity can also occur indirectly. "Ambient (or indirect heterosexism) is unique in that it describes instances in which an enactor may reveal heterosexual biases without being conscious of any wrongdoing on her or his part" (Nadal, 2013). Silverschanz et al. (2008) argue that these indirect incidences of heterosexism and heteronormativity are more common. Examples of indirect heterosexism could include the use of gay jokes or by using terms that are used to define the queer community as a way to infer that others are weak or less than (Nadal; Silverschanz et al.). Examples of indirect heteronormativity are the "subtle slights and indignities, such as the treatment of same-sex sexuality as invisible" (Silverschanz et al., p. 179). Another form of indirect heterosexism is the denial by the dominant culture that

heterosexism and heteronormativity exist (Nadal). Denying their existence invalidates the experiences of the queer community, while at the same time ignoring a prevalent form of discrimination.

Language

Language is something that all individuals encounter on a day-to-day basis. Individuals experience it in face-to-face contact with other individuals, and are bombarded with it in the media as well. For queer-identified individuals, language can either be a tool that empowers them, or another mechanism in which the queer community as a whole is disempowered. The following paragraphs describe the impact that language has on the queer community, and specifically looks at the way media and religion use language as a means of disempowering the queer community.

Language is used in two ways to devalue the queer community. The first is the use of language to further promote heterosexuality as the norm (Nadal, 2013). This ties into the previous section, which outlines the heterosexist and heteronormative nature of society. One example of this could be in the naming of certain organizations or business. If something is advertised as a marriage clinic in a state that does not allow same-sex marriage, this can further the assumption that only heterosexual marriages are the norm, or that homosexuality is unacceptable (Nadal). Another example could be statements made by individuals such as "homosexuality is wrong" or "I'm praying for your gay soul". "Such statements or behaviors may not intentionally or consciously be verbalized to upset or hurt the recipient" (Nadal, p. 67), however, they often do cause pain, discomfort, or even fear.

The second is the use of derogatory language "with the intention of bullying or teasing" (Nadal, 2013, p. 56). Examples of this would be using homophobic and/or gay bashing slurs to intimidate or purposefully offend an assumed queer individual. Such language is spoken in schools, public places, in the media, and in churches, and is often ignored or deemed acceptable by a passerby.

Media. Media are used as a prevalent way to disseminate a message to society. With regards to the queer community, this message is often inaccurate and/or harmful (Nadal, 2013). In recent years, there has been an increase in the number of queer characters portrayed on television and in movies; however, heterosexuality is more widely portrayed and normalized. When queer characters are portrayed in the media, they are often times eroticized and portrayed in a demeaning way (Nadal). An example of this would be the sexualization of lesbians and bisexuals (Nadal). It is not uncommon for queer women to be portrayed in mainstream media as sexual objects that are the desire of heterosexual males. This reflects a culture in which heterosexual males believe that queer women are available for their pleasure, and that queer women just need to *fixed* by a strong, straight man (Herek, Cogan, & Gillis, 2002).

Religion. Images of Christian fundamentalists holding up signs covered with homophobic slurs have been played and replayed in the media. While the intent of these extremists is to hurt or offend the queer community (Nadal, 2013), not all religious groups who find sin within the queer community are intentionally aiming to offend. Different than other minorities who face discrimination, public disgust and discrimination toward the queer community is, for the most part, deemed acceptable as long as these

beliefs stem from religious tenets (Nadal et al., 2011; Nadal). This is exhibited in the Religious Freedom Bills that have been proposed (and passed) in some states.

Harassment

While heterosexism, heteronormativity, and the use of language to demean a population are all considered harassment, members of the queer community are also faced with others modes of harassment and discrimination, in all systems of their lives, some of which can have deadly outcomes. A study conducted by Herek and colleagues (2002) discovered that 94% of the participants (all of which identified as queer) had been victimized, with one-third of those respondents directly linking that victimization to their sexual orientation. Other, more recent studies have shown similar results, in which the majority of respondents reported microaggressions, harassment, and discrimination in their daily lives (Nadal, 2013). "Although all of these statistics are already significant, they may be even higher because LGBT people tend not to report instances of discrimination" (Nadal, p. 17). In the following paragraphs, an exploration of the literature will outline the various systems in which queer individuals face harassment, as well as the prevalence of hate crimes committed against this population.

Abuse aimed at the queer community can, and does, happen in all areas of society (Herek et al., 2002; Nadal, 2013; Silverschanz et al., 2008). Research has shown that many queer individuals have faced an alarming rate of harassment in their educational settings (Nadal; Silverschanz et al.). Queer individuals also face harassment at home, in their places of work, as well as queer establishments (Herek et al.; Nadal; Nadal et al., 2011; Silverschanz et al.) One study found that queer individuals are at risk of being outed and attacked when seen entering or leaving a queer establishment, such as

a gay bar (Herek et al.). Their study found that "although gay venues are often sites of attacks, being identified as a gay or bisexual in any public setting carries a risk" (p. 326).

Given that harassment and abuse can occur at any given place, it is not all that surprising that the harassment and abuse can come from a variety of different people. It is not uncommon for queer-identified individuals to face harassment from their own family members, including parents, siblings, and members of the extended family (Herek et al., 2002; Nadal, 2013; Silverschanz et al., 2008). Studies have also shown that harassment by coworkers is also fairly common (Herek et al.; Nadal). Finally, harassment occurs at the hands of strangers; individuals that have had no prior relationship with the queer individual (Nadal, Nadal et al., Silverschanz et al.).

Legal. It can be argued that the legal system actively works to discriminate against the queer community in two ways. The first includes the laws and policies that are in place to block some of the basic civil rights of the queer community (Nadal, 2013; Nadal et al., 2011). Some of these basic civil rights are marriage and equal employment opportunities (Nadal). As was discussed in chapter one, it is still legal for employees to be fired for identifying as queer in several states throughout the United States.

The other way in which the legal system is discriminating against, and in some cases harassing, the queer community, is with regards to the classification and prosecution of hate crimes (Nadal, 2013). Even though the federal government has passed legislation that includes sexual orientation as a protected class against hate crimes, several state and local jurisdictions do not recognize hate crimes based on a person's sexual orientation (Gay, Lesbian, and Straight Education Network, 2010). "Furthermore, because of the heterosexism that is often pervasive within the criminal justice system,

hate crimes toward LGBT people may not be labeled as such" (Nadal, p. 26). Studies have shown that in some instances, the queer victims of harassment are blamed because if they had been straight, this experience would not have occurred (Herek et al., 2002; Lyons, 2006; Nadal; Silverschanz et al., 2008). In other words, it is not uncommon for queer people to be blamed for the discrimination that they are encountering due to the assumption that the queer individual should have either looked less queer, or should have chosen a different lifestyle. This is commonly called blaming the victim.

Hate crimes. As was stated earlier, many queer-identified individuals face harassment in their lives due to their sexual orientation. At times, these incidents of harassment can escalate, resulting in attacks against individuals and their property (Herek et al., 2002; Herek, 2009). These attacks ranged in seriousness from verbal assaults (which was described in a previous section) (Nadal, 2013; Silverschanz et al., 2008), to vandalism, to sexual and physical assaults which sometimes result in the death of the queer victim (Herek et al.). Participants in one study described how they had their personal property vandalized, stolen, or destroyed as a result of a hate crime committed against them due to their sexual orientation (Herek et al.; Nadal). Many queer women have experienced sexual harassment and/or assault due to their sexual orientation. In one study, "several women described incidents in which a male acquaintance or friend sexually assaulted them…Many reported that their attacker seemed to be trying to prove that the woman was actually bisexual or simply needed the right man in order to become heterosexual" (Herek et al., p. 328). With regards to physical assaults, it is not uncommon to hear stories about queer individuals who have been beaten out of fear and hatred due to their sexual orientation, with some of the beatings resulting in the death of the victim

(Herek et al.). While all of these incidents vary in severity, research has shown that any form of harassment or hate crime committed against a queer-identified individual can have an extreme amount of fear associated with the experience (Herek et al.). This fear can have a detrimental impact on the individual.

Impact

Numerous studies have highlighted the negative impact that heterosexism, discrimination, and harassment has on the mental health of those who are being subjected to it (Herek et al., 2002; Nadal et al., 2011; Nadal, 2013). "There is also empirical support for negative consequences associated with experiences of sexual-minority stress in the workplace" (Silverschanz et al., 2008, p. 180). These negative consequences can include not only poorer work performance, but also can result in mental health distress. Furthermore, studies have shown that individuals who have had the experiences outlined above, can develop significant mental health impairments as a result, including episodes of depression, anxiety, substance abuse, eating disorders, self-harming behaviors, and suicidal thoughts and actions (Nadal et al.; Nadal; Silverschanz et al.).

AAMFT and the Queer Community

Since its creation, the American Association of Marriage and Family Therapy (AAMFT) has had a difficult relationship with the queer community. Mental health practitioners, in general, have a history of mistreatment of those that do not identify as heterosexual (Miller, 2006). It was not until 1973 that homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders as a mental illness (American Psychiatric Association, 1973). The AAMFT was an active participant in this history of this mistreatment.

In more recent years, the AAMFT has struggled with its role in the changing political climate in which the queer community has begun to gain power and a voice. The AAMFT was one of the last professional mental health organizations to come out against the practice of reparative therapy (a therapy in which the goal is to change a person's sexual orientation from homosexual to heterosexual), which has been proven to be extremely harmful to individuals (McGeorge, Carlson, & Toomey, 2015). It was not until 2009 that the AAMFT board of directors released the following statement:

> From time to time, AAMFT receives questions about a practice known as reparative or conversion therapy, which is aimed at changing a person's sexual orientation. As stated in previous AAMFT policy, the association does not consider homosexuality a disorder that requires treatment, and as such, we see no basis for such therapy. AAMFT expects its members to practice based on the best research and clinical evidence available.

While this statement argues that sexual orientation is no longer considered a mental health disorder that requires treatment, it does not condone the practice of reparative therapy. It does not highlight the harm that has been found in conducting reparative therapy, nor does it state that this practice is unethical.

The association's stance of trying to avoid the politics of a situation with regards to the queer community has had even more recent occurrences. When in 2015 the state of Indiana passed a law that would allow businesses to deny services to a queer person because it goes against the proprietors' religious beliefs, the AAMFT released a very neutral statement that did not outright condemn this law as unethical, nor did it come out in support of the law.

While the relationship between the queer community and the AAMFT has been difficult, there has been an effort made by the AAMFT to increase cultural competencies, especially with regards to the queer community. In the current edition of the Code of Ethics, discrimination against individuals based on their sexual orientation and gender identity is clearly stated as unethical. Furthermore, the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) has included sexual orientation in their expectations of teaching cultural competency (Carlson, McGeorge, & Toomey, 2013). While these steps have been taken, research shows that change is slow to come. In a recent study, researchers found that graduates from a COAMFTE accredited programs reported that they did not receive sufficient training with regards to working with individuals that do not identify as heterosexual (Carlson, McGeorge, & Toomey). This highlights that change is happening, but it is happening at a very slow rate.

Relation to Queer-Identified C/MFTs

As was stated earlier, there is currently no literature examining the lived-experiences of queer C/MFTs within the therapeutic setting. Given that the literature shows that queer individuals are subjected to heterosexism, heteronormativity, harassment, legal restrictions, and hate crimes in their lives, and given that the impact of these experiences usually has a detrimental impact on the mental health of those experiencing them, it is worth exploring whether or not these same experiences are occurring to C/MFTs in their professional and personal lives. If these experiences are occurring, it is worth investigating what, if any, impact they are having on queer-identified C/MFTs. If these experiences are not occurring, it is worth investigating what

is different about the AAMFT community from society in general. Based on the review of the literature, and the aim of this study, the following research questions are posed:

- What are the lived experiences, struggles, stressors, etc. of being a queer-identified therapist?
- What are some strengths that queer-identified C/MFTs have in dealing with their sexual orientation?
- How does the AAMFT and its COAMFTE accredited programs view the queer community?
- How does the sexual orientation of queer-identified therapists impact the therapeutic relationships of with their clients?

CHAPTER III: METHODOLOGY

Phenomenological Research

Phenomenology is a method of qualitative research that explores the experiences of its participants (Dahl & Boss, 2005, Gale & Dolbin-MacNab, 2014; Mertens, 2009). More specifically, phenomenological research done through the lens of a transformative framework attempts to not only explore the experiences of its participants, which are frequently from a marginalized and silenced population, but to use the study to give a voice to those that have been kept voiceless (Mertens). Phenomenological research seeks to highlight the strengths and resiliency of the population that is being studied in order to shine a light on how these individuals have been able to overcome the obstacles that they are faced with. (Mertens).

Phenomenological research does not seek to find the truth. In fact, because phenomenology is steeped in social constructionist theory, to a phenomenological researcher, there is no one truth (Dahl & Boss, 2005). The aim of a phenomenological study is not to discover whose experience of an event is the most accurate, but instead, it is to discover what the unique experiences are, how the past has shaped these experiences, and how these experiences might shape the future. Phenomenological research seeks to elicit stories from the participants, and to find meanings in these stories; it "does not need to 'smooth out' discrepancies or inconsistencies, but rather looks for meaning within them" (Dahl & Boss, p. 70).

The goal of phenomenological research is not to find the correct way to handle unique situations. The goal of phenomenological research is to start a conversation; a conversation that shines a light onto experiences that others may not know are occurring.

Phenomenological research does not seek to explore the effectiveness of specific approaches participants may have used to cope with difficult experiences. Phenomenological research does not aim to generalize the findings to every person of the population being studied. Readers of this study can decide for themselves if the study is applicable to them, as qualitative research is not inherently generalizable (Dahl & Boss, 2005).

Recruitment

Recruitment for this study took place in three stages. The first stage consisted of the creation of a short online survey. This survey was created and distributed using the UIowa Qualtrics system. This survey included the following questions (and can also be found in Appendix A):

1) Are you currently a student or a graduate of a COAMFTE accredited program?
   a. Yes
   b. No
2) Are you currently or have you previously been a practicing Couple/Marriage and Family Therapist (C/MFT)?
   a. Yes
   b. No
3) With regards to your sexual orientation, how do you self-identify? (For example: gay, straight, lesbian, queer, bisexual, pansexual, etc.)
   a. _____

4) Would you be willing to be contacted to be interviewed as a part of a study exploring the unique experiences of self-identified queer Couple and Family Therapists? This study would consist of one 60-minute interview via Skype with the possibility of a follow-up interview. If so, please include your email address.

   a. Yes. My email address is_____

   b. No.

5) For more information, questions, concerns, etc., please contact Trae Yeckly at tracie-krum@uiowa.edu.

The survey was emailed to the directors of 104 COAMFTE accredited programs in Couple/Marriage and Family Therapy. This email contained a brief description of the study, a link to this survey, and request that the directors forward the email to their current students, as well as to any alumni listservs.

The second stage of recruitment involved a review of the responses to the surveys. This review highlighted contact information of individuals who were interested in participating in the interview, as well as helped to determine inclusion criteria (which will be discussed in a subsequent paragraph).

During the third stage of recruitment I made contact with the prospective participants. I emailed individuals who had indicated on their surveys that they were current students or graduates of COAMFTE accredited programs, that they had experience as a practicing C/MFT, that they identified as queer (as defined in Chapter 1), and were willing to be contacted to participate in the interview. The email to the prospective participants included a more detailed explanation of the study, including the

time commitment (one 60-minute interview, an option for a follow up interview, and the opportunity to member check the transcriptions which may also take some time). It also included a letter of informed consent which included a description of the possible consequences of the study (such as the possibility of a breach of confidentiality, or the possibility of stressful emotions being evoked as a result of some of the questions and/or answers, etc.), as well as the steps that I would be taking to protect confidentiality (the use of pseudonyms, digital recordings and transcripts be stored in a locked filing cabinet, and all electronic files being stored in a secured file on a computer that requires a password to access the contents of the computer). Finally, the email outlined how the data would be analyzed (which will be discussed in subsequent paragraphs of this chapter).

Sample Size

The desired minimum sample size for this study was ten participants. This number was chosen based on numerous considerations. First, I was attempting to develop a rich description of the participants' experiences, and having a minimum sample size of ten allowed me the time and space to develop this richness. By choosing a smaller sample size, I was seeking depth in order to develop a detailed description. "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information richness of the cases selected" (Patton, 2002, p. 254) than with the number of participants. Due to the small sample size, I was able to become immersed in the data and was able to have "prolonged and substantial engagement" (Mertens, 2009) in the process. Mertens argues that credibility of the study is strengthened when Iis allowed sufficient time to reach saturation, which was easily reached with this sample size. Second, the use of purposeful sampling tends to yield smaller sample sizes (Patton). The goal of

purposeful sampling is to seek participants that fit a specific requirement, in this study, C/MFTs that identified as queer. As was argued in chapter one, the approximate number of queer-identified C/MFTs is about 1025. Given that the target population is fairly small, aiming for a sample size of ten is feasible.

Participants

Inclusion Criteria

The inclusion criteria for this study were as follows: participants must be a student or graduate of a COAMFTE accredited master's or doctoral C/MFT program; they must have clinical experience as a C/MFT, must speak English fluently, and they must self-identify as 'queer', as defined in Chapter One as any individual that identifies as a sexual minority. This includes, but is not limited to, those who identify as gay, lesbian, homosexual, bisexual, pansexual, and queer. C/MFTs face unique clinical situations that their colleagues with other professional identities might not face when working with couples and families. Participants must have clinical experience because the purpose of this study was to explore those experiences through the eyes of queer therapists. Participants must be fluent in English because I does not fluently speak any other language, and meanings and experiences could be misrepresented through translations. Finally, the reason that participants must identify as queer is that this study aims to explore what it is like for queer therapists in this field, and seeks to give them a voice of their own.

Exclusion Criteria

Exclusion criteria for this study were as follows: potential participants that were fellow colleagues of mine including current students in my program, mental health

practitioners that do not identify as a C/MFT, and potential participants that reside outside of the United States or Canada. I made the decision to exclude my current peers because of the potential for boundary issues. Because the peers have background knowledge of the importance of this study, I did not want my peers to be put in a position that would put pressure on them to give answers that I may be hoping for. I chose to exclude those practitioners from outside of the United States and Canada because different countries have different laws and social norms with regards to the queer community. I did not want to endanger anyone if they were practicing in a country in which they could be jailed by their responses. I chose to include Canada because they are the only other country affiliated with AAMFT and their accredited training programs are also accredited by the COAMFTE.

Respondents

A total of 104 emails were sent to the directors of COAMFTE accredited programs within the United States and Canada. A list of COAMFTE programs was compiled based on data found on the American Association of Marriage and Family Therapy's website. The 104 programs were selected because they met the inclusion criteria. 17 respondents completed the survey. All 17 respondents were sent the follow up email that was previously described. Of the 17 original respondents, 12 responded to the email stating that they were interested in participating in the study. Of those 12, 11 went on to schedule interviews, with 10 completing the interviews. Therefore this study consisted of a sample size of 10. An in depth description of the respondents, including demographic data are discussed at the start of Chapter 4.

Data Collection

Once I identified participants who were interested in participating in the study and had met the inclusion criteria, contact was made with those participants via email. Participants were asked for verbal consent, and once that was obtained, an interview was scheduled. The interviews ranged in time from 30 minutes to 53 minutes. All participants were given the opportunity to request a follow up interview within three months of the initial interview. None of the participants requested a follow up interview.

Interview

I conducted all interviews. Because the interviews took place via Skype, the participant had the choice as to where they wished to have the interview take place. Because of confidentiality concerns, I encouraged the participants to choose a place that allowed them privacy so that they could speak freely without fear of others overhearing their responses. Because of the sensitive nature of the questions being asked, I did everything in their power to protect confidentiality.

The interview began with another overview of the study, including the possible risks and the potential time commitment. I again asked the participants if they would like to continue in the study, and reminded them that they were free to withdraw from the study at any time. Once the participants agreed, I asked them to choose a pseudonym. I asked the participant a series of demographic questions (see Appendix B).

Once the demographic data were obtained, I utilized a semi-structured, open-ended interview format. There were a total of 6 questions that are listed below (and can be found in Appendix C.)

1. What is it like being a (insert participants chosen term of sexual orientation) therapist?
2. Can you tell me about a time or an experience in which you felt you were treated differently, or discriminated against within the therapeutic context due to your sexual orientation?
3. Can you tell me about a time or an experience in which you felt your sexual orientation was a strength or helped you with regards to your therapeutic and/or academic work?
4. How do you view AAMFT's relationship with the queer community? Did your education from a COAMFTE accredited program influence this view?
5. What is something you think others should know about your experiences as a (insert participants chosen term of sexual orientation) therapist?
6. Is there anything that I didn't ask that you think should be included in this interview?

These questions were the basis of the interviews. All participants were asked these six questions during the interview. Different follow up questions were asked depending on the answers given by the participants. The interviews lasted on average about 45 minutes. The audio of the interview was digitally recorded on an electronic recording device. I also took notes during the interview, highlighting specific quotes and/or corresponding body language. Once the interview was complete, I journaled her initial reactions, thoughts, and impressions of the interview. All notes and the electronic recording device were stored in a locked filing cabinet in my home office.

Data Analysis

Researcher Bias

One way in which researcher bias was controlled for was through the use of outside coders to spot-check the data. While I was the sole transcriber and coder of the interviews (which will be outlined in subsequent paragraphs), I also employed two outsider coders to implement a form of investigator triangulation. The two outside coders were chosen because of their familiarity with qualitative data analysis. Both identify as cis-gender Caucasian male; one identifies as heterosexual and the sexual orientation of the other is unknown. They are both doctoral students in the same department as myself, but are students in a different program. I have conducted research with both outside coders. Both had some familiarity with the design and the premise of this study. Employing investigator triangulation was done to help increase the rigor of the study (Patton, 2002). A description of how the outside coders randomly checked the data will be described shortly.

Another way I attempted to control for researcher bias was to acknowledge my personal experiences and how they might impact the interpretation of the data. I identify as a queer C/MFT. It is because of my own personal experiences that my interest in studying the queer community, especially queer therapists, developed. Wondering if others had similar experiences, and curiosity about how others handled situations unique to the queer community within the therapeutic context, inspired me to explore the literature. The lack of literature within this area is what inspired me to conduct this study. Because I identify as a member of the population that is being studied, it is important to

not only acknowledge this position, but to also acknowledge the impact that this might have on the study.

Phenomenological research does not come from the stance of an objective researcher; in fact, it embraces the notion of researcher subjectivity and views it as a strength (Dahl & Boss, 2005; Mertens, 2009). My experiences, both past and present, shaped the questions being asked, and shaped the way the data were interpreted. In order to make sure that my experience did not overshadow the experiences of the participants, I had to engage in "a continuing and explicit process of self-reflexivity and self-questioning" (Dahl & Boss, p. 67). I kept a researcher journal, in which I explored my thoughts and feelings with regards to interviews and data analysis. I also utilized member checks throughout the process of obtaining and analyzing data, which will be explained in subsequent paragraphs. Implementing these procedures that have just been described helps to strengthen the trustworthiness of this study.

Transcription

All recordings of the interviews were transcribed by me. This allowed me to become immersed in the data (Dahl & Boss, 2005). I transcribed the entire interview (Mertens, 2009), including place holders (such as *um* or *like*), long pauses, and emotional reactions (such as crying or laughing). I also reviewed her handwritten notes that were created while the interview was taking place. This allowed me to make note of any relevant movement or body language that may have been present during interview. Once the transcription was completed, I mailed the completed text to the participant for their review. This was done to ensure that I correctly transcribed the interview, as well as to give the participant a chance to edit the contents of the transcription. This was the process

of member checking. This process consisted of the sending the participant a transcript of their interview, and asking them to check it for inaccuracies. The participant also had the opportunity to redact any part of the transcription that they wished to be excluded from the content, and offer any clarifying feedback if they feel that their responses given during the interview were not accurate. Participants were then offered a follow up interview if they wished to further clarify or further answer any of the questions. None of the participants requested a follow-up interview.

Coding.

Once the interviews had been transcribed, the data analysis process begun. "Phenomenological analysis seeks to grasp and elucidate the meaning, structure, and essences of the lived experience of a phenomenon for a person or group of people" (Patton, 2002, p. 482). This analysis included several phases. The first phase of phenomenological data analysis was becoming aware of one's own biases and how this might impact the interpretation of the data. This was described in the previous section. The next phase involved bracketing out the data (Douglass & Moustakas, 1985; Patton). Bracketing entailed a dissection of the transcripts. Key phrases and statements were identified and extracted from the transcriptions. A word or short phrase that described the statements was used to label the extracts (Douglass & Moustakas; Patton). This required that I become immersed in the data. In order to achieve this immersion, the transcripts were reviewed multiple times. I took an initial pass at the transcriptions in order to become familiar with them. The second pass served as a review; it allowed me to become part of the material. The third and subsequent passes had the purpose of bracketing. By

reviewing the transcriptions in depth numerous times, I became immersed in the data (Dahl & Boss, 2005; Patton, 2002; Mertens, 2009).

After bracketing, the phrases and statements that had been identified were analyzed, and themes began to emerge (Douglass & Moustakas, 1985; Patton, 2002). These themes create codes, and the transcriptions were coded. It was after the transcriptions had been coded that I utilized a form of investigator triangulation. I de-identified the transcripts and randomly selected one page from each participant's transcript. (The transcripts were on average 10 pages in length.) These pages were delivered to the two outside coders who were not associated with the study that were employed to spot-check the data. I also included a list of the codes that had emerged from the data. I instructed the outside coders to code the pages that were delivered to them and then compared these codes to my own coding. One of the coders wondered if the theme of self-disclosure was too broad and encompassed too much of the material. The coders and I engaged in a discussion about how the other themes played out throughout the rest of the dissertation since the coders only had access to a small sample of the transcripts. The coders agreed that the codes that were already established accurately reflected the content of the transcripts.

After this had been completed, integration of the data occurred. I reviewed all the coded data, as well as the original transcripts, and searched for patterns and commonalities, as well as differences (Douglass & Moustakas, 1985; Patton, 2002). These are the results of the study. "What emerges is a depictions of the experience and a portrayal of the individuals who participated in the study" (Patton, p. 487).

Trustworthiness and Credibility.

Trustworthiness is defined in the literature as "the degree to which its process and conclusions are rigorous" (Gale & Dolbin-Macnab, 2014, p. 255). Credibility is often associated with trustworthiness and "asks if the research findings are credibly drawn from the original data" (Gale & Doblin-Macnab, p. 255). There are several ways in which I attempted to strengthen the trustworthiness and credibility of this study. The literature states that one way to demonstrate trustworthiness is through the use of thick and rich descriptions of the experiences of the participants (Gale & Doblin-Macnab). In the following chapters, I will provide detailed direct quotes from the participants and thorough portrayals to provide a thick and rich description. Utilizing external audits and discussing the study with disinterested individuals is another way that the trustworthiness and credibility of a study can be strengthened (Gale & Doblin-Macnab; Mertens, 2009). I utilized investigator triangulation as was explained in a previous paragraph. Member checking is another way to ensure trustworthiness and credibility (Gale & Macnab; Mertens). I utilized member checking of the transcripts as was described in a previous section of this chapter. Finally, being aware of how my past and present experiences can influence the interpretation of the data and self-reflection of researcher bias is key to demonstrating trustworthiness and credibility (Gale & Doblin-Macnab; Mertens). In the discussion section of chapter five, I will integrate my reactions and experiences into the discussion of the results. This will allow the reader to take into consideration how my experiences may have influenced the study.

CHAPTER IV: FINDINGS

This study explored the lived experiences of queer-identified Couple/Marriage and Family Therapists (C/MFTs) via Skype interviews with 10 participants, and keeping a research journal. The goal of this study was to identify the thoughts, feelings, and actions of queer C/MFTs and to investigate if these experiences impact their clinical practices.

Through conducting the interviews, transcribing, coding, and discussing the data, I became immersed in the material and developed a full understanding of the data. Through this process, six themes emerged: training, self-disclosure, spokesperson, context, strengths, and the relationship with the American Association of Marriage and Family Therapy (AAMFT). Each theme will be discussed and described via general descriptions and quotes, including subsequent subthemes attached to them. Prior to the introduction of the themes, an in-depth description of the ten participants is required in order to give their voice to their stories.

Participants

Prior to the interview, all participants were asked to choose a pseudonym. This was done to help protect their identity. Participants are referred to via their pseudonym throughout the dissertation. After a brief overview of their demographics, information will be provided for each participant.

All of the interviews took place online via Skype. Each participant was asked to choose a safe and confidential place to conduct the interview. All ten participants chose to conduct the interviews in their homes. Participants ranged in age from the low-twenties to the low-sixties. Nine of the ten participants identified as cis-gendered female, with one

participant identifying their gender as androgynous. All identified their preferred pronouns as female pronouns. All but one participant was trained in a public, state funded university, with one being trained in a privately funded training program. Seven identified as Caucasian, one as Middle Eastern, one as Vietnamese-American, and one as mixed race. Three of the participants identified as bisexual/queer, three as queer, one as bisexual, one as lesbian, one as lesbian/queer, and one as gay/gray-a. Years of experience ranged from one-half year to 15 years. Clinical settings for the participants were diverse, with all participants having experience in at least two different types of clinical settings. Nine of the participants were located throughout the United States and one was from Canada. Six of the participants were currently in a romantic relationship, with four identifying as single. (See Table 1 found at the end of this chapter.)

As was stated earlier, a total of 12 individuals responded to the follow up email, expressing their interest in participating in the study. Both of these individuals identified as male and both identified as gay. It is unclear as to why these two individuals decided not to participate in the study.

Natalie is a 38-year-old cis-gendered female. She identifies as lesbian/queer. She chooses to use the term lesbian when identifying her sexual orientation to heterosexuals, and the term queer when identifying her sexual orientation to other members of the queer community. She has 15 total years of clinical experience, with 10 of the years occurring after she received a master's degree in Marriage and Family Therapy. She has practiced therapy in a wide array of settings, including agencies, wilderness, residential, private practice, and hospitals. She obtained her master's degree from a public university, and went on to obtain a Psychology Doctorate from a public university years after she had

obtained her master's. She has practiced in several geographical locations, including the West Coast, the Midwest, and the East Coast. She identifies her race/ethnicity as Caucasian and is currently partnered.

Sara is a 25-year-old cis-gendered female. She identifies her sexual orientation as bisexual. She has been a practicing C/MFT for 5 years. She has practiced in an outpatient clinic and at a university clinic. She received her master's degree from a public institution, and is currently a doctoral student at a public institution. Geographically, she has practiced in the South, the East Coast, and the West. She identifies as Vietnamese American. She is currently not partnered. She practices from a Narrative and Experiential lens.

Nana is a 61-year-old female. She identifies her sexual orientation as lesbian. She has been a practicing C/MFT for 12 years. Clinical settings have included agency work and private practice. She received her training from a public institution. Geographically, she has practiced in the West. She identifies her race/ethnicity as Caucasian. She is currently partnered. She practices from a Trauma Informed lens, and Attachment Theory lens, and from the Experiential model.

Maggie is a 35-year-old female. She identifies as bisexual/queer. She has been a practicing C/MFT for approximately 6 months. Clinical settings have included an LGBT Clinic, and a university clinic. She is receiving her master's training from a public institution. She has practiced in the Midwest. She identifies her race/ethnicity as Caucasian. She is currently partnered.

Avery is a 23-year-old androgynous individual. She identifies her sexual orientation as Gay/Gray-A (Gray-A being defined as 'a-sexual' by the participant).

Clinical settings include agency work, private practice, and university clinics. She received her master's degree from a public institution and is currently a doctoral student in Couple/Marriage and Family Therapy at a public institution. Geographically, she has practiced on the East Coast and in the West. She identifies her race/ethnicity as Caucasian. She is currently not partnered. She practices from a Narrative and a Strategic lens.

Stella is a 45-year-old female. She identifies her sexual orientation as queer. She has been practicing for 5 years. Clinical settings have included agency and private practice. She received her training from a private institution. Geographically, she has practiced in Canada. She identifies her race/ethnicity as mixed. She is not currently partnered. She practices from an Emotion-Focused lens and a Cognitive-Behavioral lens.

Amanda is a 25-year-old female. She identifies as bisexual/queer. She has been practicing for 1 year. Clinical settings include a university clinic and school-based therapy. She received her master's degree from a public institution. She has practiced solely in the West. She identifies her race/ethnicity as Caucasian. She is currently partnered. She practices from a Narrative lens and from and Internal Family Systems lens.

Elynn is a 29-year-old female. She identifies her sexual orientation as bisexual/queer. She has been a practicing C/MFT from 7 years. Clinical settings include agency and an LGBT practice. She received her master's degree from a public institution. She has solely practiced in the Midwest. She identifies her race/ethnicity as Caucasian. She is not partnered. She practices from and Emotion-Focused lens, and uses a lot of psychoeducation in her clinical practices.

Cheryl is a 31-year-old female. She identifies her sexual orientation as queer. She has been a practicing C/MFT for 6 years. Clinical settings have included residential treatment, community center, agency, and group private practice. She received her master's degree from a public institution. She has practiced solely in the West. She identifies her race/ethnicity as Caucasian. She is currently partnered. She practices Dialectical Behavioral Therapy, Cognitive Behavior Therapy, and approaches therapy from an Attachment Theory lens.

Atiyeh is a 26-year-old female. She identifies her sexual orientation as queer. She has been a practicing C/MFT for 1 year. Clinical settings include a university clinic and a community center. She received her master's degree from a public institution. She has practiced solely in the West. She identifies as Middle Eastern. She is currently partnered. She practices therapy from a Narrative lens.

Each participant was interviewed once, and a plethora of data were collected. Due to amount of data that were gathered by conducting qualitative interviews, I chose to focus mostly on the data that answered the research questions mentioned in Chapters one and three. I have chosen several quotes that represent each of the themes and subthemes that emerged from the interviews. At the end of the interviews, each participant was asked to give some advice, words of wisdom, or mention something that they wished their colleague would know about being a queer C/MFT. The last section of this chapter is words of advice from the participants.

Training

Through review of the transcripts, patterns and similarities emerged. It was from these patterns and similarities in the participants' responses that themes were identified.

Training concerns was one of the main themes that emerged from the data. These concerns centered around two issues: training concerns for working with queer clients, and training concerns for being a queer therapist navigating the world of Couple/Marriage and Family Therapy.

Lack of Training

Throughout the interviews, the majority of the participants discussed their work within the queer community. Each participant was asked to describe how their clinical training programs prepared them to work with the population to which they belong. Several participants commented on the training, or lack thereof, with regards to working with members of the queer community. Two participants described the altogether lack of academic training they received on queer issues.

> We had this gender and ethnicity class that did not include sexual orientation as a topic. So it was a human development class that did not include the human diversity including human sexual orientation or gender identity. (Natalie)

> It was missing. And I mean I sought it out on my own, but I still talk to some members of my cohort from grad school, and they don't know how to provide affirmative therapy for queer people. They think that providing affirmative therapy means like not judging people for being queer. It is nice not to judge people for being queer, but it doesn't make you someone who can provide therapy. And it sort of pisses me off to think about it because I'm pretty sure one of my instructors identified as queer!... It's just missing. It's like an undiscussed thing in that program. (Elynn)

While some of the participants expressed frustration with the near absence of training on queer issues, one participant described her academic training as 'hit or miss.'

> In terms of knowledge about queer issues, I don't know, it was really hit and miss. I would say it was adequate. We did talk about queer issues including trans issues, which was really good, and in the diversity class that we took, they actually had like a trans person step in to talk about trans issues, which I thought was really awesome. In our Family Life Cycle class, we spent like a day talking about, 'oh, and here's how it might look different if you're queer.' I mean, that was a little, I don't know, that bothered me a bit. But at least queer people were brought up! (Amanda)

Several other participants commented on the lack of training integrated throughout the course of their programs, but that will be discussed under the Integration of Concepts category.

One participant discussed that the lack of clinical training went further than the classroom. Natalie, a therapist who worked primarily with the queer community while in private practice, was asked if she felt she was appropriately trained for working with the queer community.

> It didn't feel like I was. I didn't have an opportunity in the program to train with queer clients or really in a queer context, and I think to be able to work with special populations you need to be able to have that kind of training with really structured supervision. So in that way, no. (Natalie)

Like Elynn commented above, Maggie had sought out information on the queer community on her own. This led her to passionately describe her frustration and fear with regards to the lack of training. When she was asked if she felt her training program had prepared her for working with queer clients, she emphatically answered the following:

> No! When we're dealing with an 80 percent suicide attempt rate on trans kids, no. There is simply not being enough done. (Maggie).

Possible Dangers and Ethical Concerns. Therapists hold a great deal of power within the therapeutic context. Sara points out that, "I have inevitable power in that relationship, and I can do more damage to a client than just anyone walking down the street." Nearly half of the participants expressed concern over the possible repercussions of sending therapists out into their communities that are inadequately trained to work with this population. Two participants described incidences when either classmates, or conference attendees held outdated views on the queer community and the ethical concerns that those views impose.

> It's very scary sometimes to hear people who attend and say comments that I'm like, 'whoa! You're providing therapy?! You just said that?!" (Elynn)

Maggie elaborated on this concern by discussing how it might interfere with the therapeutic relationship.

> By continuing to believe that it's a queer lifestyle, it's a choice, it's all sorts of things; they're going to bring that into the therapy space. And their patients are

going to feel that, and they're not going to open up, and they could lose people and that's dangerous. That is flatly dangerous

A great deal of the participants described their own process of being a client in therapy, and how that shapes their view of the therapeutic process. One participant described how this had led to experience first-hand as a client, and as a therapist, the potential danger imposed by non-affirming therapy.

I love therapy. I've gone to therapists for years and years and years, and I believe in it, but it's also something that can kill. It can do so much damage and it's terrifying, and there's a part of me that feels like I'm a part of the system that is so horrid…I mean, people can come to a therapist in a place of questioning, and be told that they're wrong or that it'll change. I remember I had a colleague, and I'm still sickened by the situation, but my colleague had a teenager that identified as bisexual, and their family was not very accepting and did not know. And this colleague came into the workroom and was like, 'well you know, I'm going to have a really rough session.' And I'm like, 'Oh, why?' And my colleague was like, 'well my client is going to come out to their parents,' and I was like, 'oh, that sounds really difficult.' And my colleague stated, 'well yeah, they have to tell their parents. They deserve to know.' And I replied, 'well, what are you going to do if the teenager doesn't want to say it?' And my colleague responded with, 'well what do you mean?' And I said, 'a lot of people freeze. I remember when I came out, I didn't say any words, like at all. A lot of people have the exact same situation, and so what's your backup plan?' And my colleague responded, 'there

> isn't. Their parents deserve to know.' And exactly what I said happened, and the client said nothing. And my colleague came out for the teenager, my colleague outed the teenager to the family, in session. And I just remember thinking that my colleague doesn't even know how they will be a story in that client's life, for the rest of their life. And I mean, I hope that in that situation it's just like a bad coming out story where people laugh at it, but a lot of times it's not. And this can get to be a point where there are so many non-affirmative things said to you that you feel wrong, and that there's no way to be right. (Avery)

One participant was in a unique position in that she was also an instructor at a clinical training program. She discussed her struggles of with navigating a mostly homogenous (with regards to both sexual orientation and race and ethnicity) faculty and student population and the resistance she met when she attempted to integrate more training on queer issues. She described her ethical concerns regarding her students.

> So I'm dealing with students who like don't get it. I've gotten questions from student therapists that are like, 'well I don't give this gay client to a gay therapist because the gay therapist will make the client gay, but I can make the client straight.' And I'm like, 'No!', but in reality I'm like, 'let's talk about that.' You know, but I feel like if I blatantly call out those students, I don't feel like I have the support of the faculty…So I'm trying to navigate all of that, because I feel like as a person who is a part of the LGBT community, I feel a responsibility to not release therapists who are going to do harm to the community. But then I know

that I can't do exactly what I want without the professional repercussions of it if I don't have the full support of the faculty.

Lack of Resources

With a conversation regarding the lack of training inevitably came a conversation about the lack of resources, both regards to appropriate supervision and literature. One participant eloquently described a response that was commonly discussed among the participants when a request for resources was made by the queer clinicians.

> I think the response I got a lot of the time if I were to ask about queer representation in something in class, a lot of times the answer I would get was, 'you should do that study,' or 'you should explore that topic' or 'see if you could find anything.' Sometimes that was frustrating because I just wanted it to already be there. (Atiyeh)

Lack of supervisors and academics. Another similarity among the majority of the participants was the heteronormativity of the faculty in their clinical training programs, and lack of queer supervisors in both their training programs and postgraduate clinical work. When asked if this impacted their clinical work in any way, 3 participants answered in the affirmative.

> I don't know what my clinical work would be like had I had a supervisor who was queer. So I don't know. I was in a supervision class, and we had to do a genogram for our supervisors and all the supervisors we had over our careers, and my colleague, who is also queer, was like, 'yeah, you know, I had these supervisors who identified as gay, it was like this for me.' And I was like, 'oh, wait, I've never had that.' He was like, 'that's so sad.' And I was like, 'it is sad.' I think it would be nice. I think it

would make things, I don't know, I feel like I could have more nuanced conversations, and maybe understand myself and my patients better. I mean, I've had very supportive, I've had great supervising experiences, but you know, sometimes there are just certain conversations that you can't have with people who are not like you. (Natalie)

Nana described an incident in which a client's parent had made a comment about being grateful that their child's therapist was not queer, and how she sought supervision to figure out how to best handle this situation. Her description highlights how even with the best of intentions, some heterosexual supervisors may not know what is best for their queer supervisees.

I talked to my supervisor about that she was sort of saying, 'hmmm, I don't know what we should do about that.' I think my supervisor processed it with the director first, who was a man, and I think his question to her was, 'Why wouldn't a therapist want to disclose a sexual orientation?', not understanding the potential safety piece of that. So then she came back to me and said that he said that and that we still weren't quite sure about what to do. (Nana)

One participant described the positive impact it had on her confidence as a therapist and as an academic to see a queer person in a position of power. She described her thoughts about having a queer professor in her first semester of graduate school, which highlights the positive impact that might occur for queer clinicians if they see a great number queer faculty and supervisors.

> I had an adjunct professor who was queer, but not in our core faculty. That was big. I don't know what about having her my first term was just like a big, I don't know, for me. It felt like there's a possibility that I could do this work if somebody like her is telling that this is part of our history and it's been happening for years and we just don't hear about queer therapists, but they're there. So I think that speaks a lot to the message it sent to the student body in any identity. (Atiyeh).

Lack of literature. Participants briefly touched upon their frustration with the lack of literature found with regards to working with queer clients, and being a queer clinician. Stella discussed her frustration with the lack of queer literature found within the journals of our profession.

> It's like, you know, virtually no queer content. It's clearly not a giant priority that I saw, that I noticed. I see a lot in other [professional journals], but since they're the main published journals of our profession, it's notable, right? (Stella)

Two participants echoed this frustration both with regards to class material and to research.

> As a student, I was really upset that I couldn't find more queer research and it wasn't talked about enough for me, and still isn't. (Natalie)

> I had a lot of problems with the class material in relationship to queer issues. I have been fairly vocal about that in this program. (Amanda)

Integration of Concepts

As was stated previously, the majority of participants were not satisfied with the level of training they received in working with the queer community. For most of the participants, what little training they did receive, was through the use of 'gay days'. Five of the participants discussed their frustrations with gay days, and their desire to have queer issues integrated throughout the literature. The idea of integration of concepts came up numerous times, and participants highlighted that clients' sexual orientation is just one aspect of their identity.

> I felt like the program's approach to integrating gay topics was to have gay day and you know, I see that happening in lots of places where multicultural competencies are not infused in core values of an organization, and so at the time they had gay a day and thought that was good enough, and then gay things were never ever talked about ever again (Natalie).

> I don't like the idea of like, ok, this is the diversity section or the diversity specific session. I think diversity should be in everything we do. I don't like centralizing it. It gets tiring when you see like an issue come out, like 'this issue of this month is about diversity! Next issue we're going to forget about diversity.' So that's really frustrating. (Sara)

> I think that a lot of times you have the gay day or the gay guy, but yeah, that's not encapsulating much of the real experience. That would be great if they could have intersectional folks (folks who could speak about more than just one aspect of

their identity) coming to talk about the work they're doing, and having that reflected in the faculty. (Atiyeh)

I mean, mainly I think it would be really cool to have like queer issues integrated throughout curriculum. In terms of like, it's not like this chapter in week seven that we read and then you know all about queer people. It's like if queer issues were just integrated throughout courses, I think that would really shift how we talk about queer issues. (Amanda).

For one participant, even though gay day was a thing in some of her courses, queer issues were not discussed in all of her courses. When that was brought to the attention of the faculty, they encouraged her to present on queer issues.

We arranged a gay presentation for that class. So then I became the thing that I had always criticized because I was like, here, we're having a gay day now. But at least I brought in there. (Natalie)

Not all of the participants had issues with the lack of integration. Cheryl described how her program infused queer issues throughout her clinical training program and highlighted that as a strength of her program.

I think our program did a good job integrating that at a lot of levels. They would integrate it into case examples and stuff. It wasn't like a heteronormative program. I think it was pretty integrated throughout. (Cheryl)

Self-Disclosure

Even though it was not directly asked about in all of the interviews, every participant mentioned the issue of self-disclosure. The conversation generally centered on whether or not self-disclose one's own sexual orientation and to what extent, both with clients and with their peers and colleagues. For one participant in particular, the issue of self-disclosure was something that she had been pondering for quite some time, and she was frustrated by the lack of literature on the subject. Like other queer therapists, she consulted with colleagues and peers about the best approach.

> This is my own curiosity because I've heard of a therapist, he's gay, and he gets very uncomfortable if he's working with homophobic clients. He would do things like put the rainbow flag to gay up his office, so that people would like know; and I'm more like I'm not going to let anyone know and then one day I'm going to pop it on them, and if they don't like me, then they can leave, but I like them to get to know me as a person and see them squirm when they realize. Then they leave and I'm like, 'okay, now I know what you are like.' And there have been some instances where they change their mind. But for him, he's like, 'this is who I am, get it out of the way.' So I'm interested in how other therapists do it. Do they prefer that method of 'boom, here I am,' or more like my sneak attack? (Sara)

The responses from the participants showed a spectrum of self-disclosure, with one participants commenting that they tend not to explicitly self-disclose to their clients.

> I feel like it doesn't happen very directly. I think that sometimes people will be talking about the community or resources available and I think sometimes the way

I talk about it might imply that I know about it on a first hand basis, but I don't think I really ever just come out and say it outright.

For the majority of the participants, their stance on self-disclosure was more neutral. Two participants commented that they would self-disclose to certain clients depending on what was occurring in sessions.

Maybe you have a sixth sense and you don't come out if it's not going to be useful or relevant. So that's sort of been my process with clients. Because I don't have short hair, I really pass for straight probably all of the time. And so I don't ever come out with clients unless I think it's going to be really important or helpful. (Nana)

So if I think it's important to the therapeutic relationship, then I might ask some questions about 'what would it mean for you if my identity is gay? What would it mean for you if I identify as a heterosexual? What are the ways in which I seem gay or straight to you? What brought these questions up? Does it feel important to you?' So I try to stay focused on clinical relevance, and certainly if I think it's clinically relevant, I'd be happy to talk about my identity with clients and the meaning of that. But I want to tread lightly because I think I have some clients, particularly, I'm thinking of a few lesbian-identified clients for whom I think it would be a struggle to learn that I am not a lesbian. And so I try to tread carefully around that and just talk maybe about shared experiences and do they have a sense that I can understand them. Do they have a sense that I can relate to that part

> of their identity, and if so, how is that helpful and meaningful and would that go away if they learned something else about me? (Elynn)

One participant described how her preferred method of self-disclosure was to be out, but that it was not always an option given the context. Natalie described that in certain hospital settings, it was considered more professional to not discuss her sexual orientation.

> So I worked with one family of two moms and their kid, and I worked with a teenager who identified as queer, but I was never encouraged to disclose my own identity or to bring that to bear on our work together. (Natalie).

She went on to discuss the differences in her work in the medical setting versus her work in private practice where she catered to the queer community.

> You know, it didn't say it [that I was queer] on my website at the time, but I was pretty explicit in everything I did. You know people in private practice, because especially with couples, they are shopping for you, and people used to call and screen me and you know, if they don't like that you work with gay people at all, they're probably not going to lie you for being gay so they're probably not going to pick you…That was the most comfortable for me because I could be incredibly transparent. (Natalie)

One participant described the hypocrisy she felt when she opted to self-disclose to a client, compared to her heterosexual counterpart.

> It's always been frustrating for me, especially because so many parts of who I am are under the guise of like this is self-disclosure; this is too much information. Whereas I had co-therapy cases where my male co-therapist said, 'oh, me and my wife' and no one ever questions him. But if I ever say 'oh me and my girlfriend' then its like, 'why did you self-disclose?' (Avery)

Struggles Related to Self-Disclosure

Within the discussion of self-disclosure, several participants discussed their struggles with navigating how, when, and to what extent do they disclose their orientation.

> In the therapy room, it's been kind of interesting navigating disclosure. Fortunately I haven't had a client yet that was like homophobic or biphobic or anything like that, so that's something that I haven't encountered yet that will be interesting when it does. (Amanda)

Amanda touched upon a point that many participants mentioned. Several struggled with how they respond, or would respond, to a homophobic comment made in sessions. Amanda went on to discuss how she struggles with navigating the line between advocating for herself and her community while simultaneously not passing judgment on her clients.

> I think it's a real struggle, because, you know, in my day-to-day personal life I really don't have a problem calling people out, like I'm on top of that. But for some reason, I had a really hard time figuring how to incorporate that into the therapist relationship and trying to validate people's experiences and people's

> pain without validating the oppressive beliefs that they have. So I don't know if I have a great answer because it's something that I'm still kind of struggling with and working on. (Amanda)

Nana, when discussing the situation described earlier when a client's parent made a comment assuming that she was a heterosexual and had expressed concern over his child being seen by a queer therapist, described how she sought supervision on how to best proceed. During the conversation with the supervisor, the discussion of whether it was ethical or not to remain closeted to this client came about.

> And then she (the supervisor) went on to say that she thought that perhaps we could have some ethical problems if I just proceeded without informing him or doing something different, and at the same time, the agency couldn't require me to disclose my sexual orientation. (Nana)

Nana went on to describe how they came up with a solution of having her meet with the client's parent, and inform him that she could not say that she was a heterosexual, thus in a way disclosing her sexual orientation without having to explicitly disclose her sexual orientation.

Nana was not the only participant to describe a time when she struggled with relinquishing the power of whether or not to self-disclose at the request. Atiyeh described a similar incident and the feelings she had afterwards.

> There's been a time when my sexuality was of interest to a client, and to me it felt like an invasion of my privacy. And I feel like I just felt uncomfortable with the way that it became present in the room. I think clients have made assumptions

> about my sexual orientation, and that then part of the learning curve for me is deciding what to do when those assumptions come up. How do I handle how much I want to focus on the therapeutic relationship and then how much I want to kind of move on? (Atiyeh)

She went on to describe a time when she felt pressured to disclose. She described the sense of disempowerment she felt after disclosing and related it to not feeling like she had control over what parts of her personal life she wanted to share with her clients.

> I felt more uncomfortable afterwards. I felt like I regretted saying it just because I wanted to keep more; I wanted to feel like I had ownership of what I shared, and I didn't feel like I really had it in that situation. (Atiyeh)

Safety Concerns

One of the key components that emerged when discussing whether or not to disclose to clients and/or colleagues was the idea of safety. Participants would consider the safety risks to both themselves and others before disclosing their sexual orientation. This looked different for certain participants.

Safety concerns with clients. When discussing the incident she had had with her client's parent with regards to her sexual orientation, Nana outlined the safety precautions she took when she informed him that she could not say she was a heterosexual therapist, highlighting the safety concern that other participants felt with regards to homophobic clients.

> It was kind of scary because I didn't have any experience with coming out and having it be a negative thing. And I wasn't really coming out to him, although I kind of fully was. So ambiguous that it seemed like I kind of was. So it was a little

> scary and then, yeah, it was one of those anxious 'this is going to be a hard thing' moments…So we planned a meeting where I would sit where he was closest to the door because I thought it was a pretty weird situation. (Nana)

Physical safety was not the only concern. In describing the situation in which she regretted coming out to a client, Atiyeh addressed concerns for her emotional and mental well-being.

> It was a situation where I could have either exposed myself and come out to a client who I didn't feel comfortable at all coming out to, or I could have denied my relationship with my partner really specifically and a really specific instance, and I felt like so much about how I feel about not hiding who I am was a factor in that. And so even like weighing the decision, I had a really hard time with when do I want to be comfortable and say that's not your business, and when does my background of feeling like I'll never say this person isn't my person. So I came out and said this person was my partner, and that was like the queer side of me saying this is really important, but then the therapeutic side of me felt like I didn't want to do that. So I felt like I was in a double bind (Atiyeh)

When discussing self-disclosure with other clients in her agency work, Nana discussed the safety concern of causing harm to the client or to their therapeutic relationship.

> Like if I need to make some reference about family or my experience, I might be super vague because I don't want to deal with it, or make them uncomfortable, or put an unneeded burden on them that isn't appropriate. (Nana)

By being vague, Nana was not only be cautious to not cause harm to her clients, but also related it to keeping the clinical room a safe place for herself with regards to potential client reactions.

Not all of the participants were as worried about their physical or emotional safety; or if they were, they did not let it impact the way they dealt with self-disclosure, especially with regards to homophobic clients.

> I don't believe in staying quiet and just letting that pass without stating. If they have those beliefs, if they are genuinely homophobic and they don't want to work on it, and have to talk about it, and I have called it to their attention, it's not my job as a therapist to proselytize, but you know, I'm not going to be completely passive. (Maggie)

Safety concerns with colleagues. Participants were not only concerned about the potential dangers of self-disclosure with clients, but of the potential dangers with their colleagues. One participant described a particular incident in which a colleague reactive in a negative and inappropriate way to her sexual orientation.

> I would say there was one particular person that I had issues. He was just saying how he believed it's a disease and all this stuff and said something like 'I don't think that you should be a therapist and that's my opinion' so that, there was times like that that's been an issue.

Two of the participants described ways in which they navigated their work environments in order to maintain a level of safety. One participant has decided that she waits until the issue comes up and then weighs the options.

> In collegial relationships, I kind of wait until some question comes up about my personal life and then think twice about it sometimes. Coming out in a conversation is kind of co-dependent; I hope it's not going to be too hard for them. (Nana)

One of the participants described how she likes to disclose early on with her colleagues.

> So it's always been my safety strategy to disclose my identity early in relationships with other people, and the onus of the burden is on them to either like it or not like it and do something about it; but they can never say I didn't tell them. As soon as you come out to other people in however way you do that, you know, you get to know where everybody stands really quick. I feel like if I disclose early then it keeps me out of situations where people can misconstrue information or I don't know, if they decide to make the dynamic dangerous or uncomfortable, the burden is on them to really go out of their way. They can't pin it on me for being gay. I think that's where I came up with that strategy of being just really out, and trying to be out early and quickly so I could put the onus on everybody else, so if they don't like me, it's their problem; it's not because I didn't tell them. (Natalie)

Passing

Most of the participants interviewed would describe themselves as *passing*, meaning that most people might assume that they were heterosexual. Nana described the almost shock when her supervisor discovered that she identified as queer in the situation with the homophobic parent of a client described earlier.

> Because I don't have short hair, I really pass for straight probably all of the time. We called in the supervisor and she said, 'yeah, I can see how no one would notice that about you because I remember thinking kind of huh, when I heard that.' (Nana)

Another participant discussed how others perceived her because of her long hair and feminine traits.

> Like some of my colleagues were like, 'oh, you know, but you're so feminine!' And I'm like, 'that has nothing to do with it.' And then I got my haircut, and they were like, 'oh, well now we know.' And I'm like, 'No! That doesn't make me. Just because I got my haircut doesn't mean anything!' (Sara)

Invisibility of bisexuals. The participants that identified as bisexual commented on the feeling of invisibility that they felt, not only in the field of Couple/Marriage and Family Therapy, but also in the queer community and among their colleagues.

> I notice that because I'm bi, I feel like when people that when I am with people who are heterosexual, they just try and like to pretend that I'm heterosexual, and they just never talk about it. (Sara)

> My sexuality is invisible. Because I married a dude, everybody assumes I'm straight. And because I don't share this straight identity or this straight experience, nobody asks about my experiences. They just assume. I just blend and that gets really frustrating sometimes. I mean, sometimes it's fine, but sometimes it gets really frustrating because it's not easy to have gone through that process, and I really don't want to blend. (Maggie)

> My experience more often than not is that it doesn't occur to people that I may not be straight. And that feels bad. It is sometimes difficult to identify as bisexual because it seems that identity, it doesn't occur to people. My clients assume I'm either a lesbian or straight, and have made comments occasionally, that sort of make me feel an experience of invisibility like with my clients. I have queer couples who have said, 'Oh, we've been talking at home and trying to guess whether you're gay or straight.' So occasionally I feel really highly aware of that dynamic. (Elynn)

Navigating Communities

Another theme that emerged with regards to self-disclosure was the struggles of navigating both the queer community and the straight community. Some of the participants described the steps they took to ensure that their presences in these communities would have a minimal impact on their therapeutic relationships.

Navigating Queer Communities. The queer community tends to be small and people within the queer community tend to know the other people in their community. Most of the participants reported that they worked in some way with the queer

community. They discussed how being a queer therapist has helped them relate to their clients, but that they run the risks of running into clients or forming dual relationships with clients. Two participants discussed the struggles of navigating the same community in which they work. Nana and Stella who both work with primarily queer clients within their private practices discussed how they handle working with and being part of the queer community.

> That's really challenging. I cannot go to a gay function in town without seeing at least one previous client and try to just observe the 'don't acknowledge clients unless they acknowledge me' piece; although that's a little bit of an oversimplification in a small community because there are some people that I know that they're really going to take it the wrong way if I don't smile and say hi. So I just try to balance what I know about the person, but I can't go watch the local lesbian choir concert or a basketball game or something without problem passing or seeing bunches of previous clients in some settings. (Nana).

> A lot of the clients who come to see me are people who are like, 'Oh, I'm coming to see you because we share similar politics,' or are explicitly queer identified as opposed to maybe LGBT identified. It's already smaller, so there's a lot of overlap that I negotiate in my practice, and so usually I start by talking about the potential for overlap in a small, shared community. With some people I know right away what our overlap is, you know they've been in my workshops, or I recognize them from events, or you know, like a friend of a friend of a friend, but sometimes it's less clear, but it often reveals itself down the road. So in that way I

> come out like, ‘we’re part of the same community’; people have to make a decision about whether they are comfortable, over feeling super anonymous, and everybody has a different comfort level with that. I have a whole spiel. (Stella)

One participant, Elynn, who also primarily works with members of the queer community, described how her fear of running into clients at queer events has kept her from engaging in queer activities around the city.

> I have struggled individually with sort of committing myself to go places where I know I’m likely to run into clients. And it’s a balance that I’m still trying to find. I am somewhat introverted anyway, so seeing clients all day can be sometimes the most interaction that I really want in that day. So it’s easy for me to convince myself not to go out. And another contributing reason is like, ‘oh, I’m just going to see a bunch of clients at this queer dance party, I’ll just stay in.’ And I’ve been struggling against that because it really impacts me. I moved to the city 2 ½ years ago, and it took me some time to get used to the city, and lately I’ve been sort of intentional about trying to develop my social network a little bit more because I tend to work and then hang out alone. So, I have to ask myself the question, like ‘is that a good reason not to attend events where I might be able to make friends and expand my social network?’ So I’m trying to be a little braver about that, and so far it’s going fine, I haven’t seen clients at the places I’ve gone. But I know it’s likely and I have to get used to that fact. (Elynn)

Navigating Straight Communities. Some of the participants also discussed navigating being queer in a heterosexual society. One participant discussed how she explained to another straight colleague how she acts differently when out in public with female partners.

> I remember there was this one women, I can't remember what the question was, but there was some small group discussion happening, and I mentioned something about, 'well when I'm with a male partner, I hold hands in public all the time, but when I'm with a female partner, I usually like, we don't hold hands' and that was like, there was a couple of people at the table that were just like really shocked by it, by me saying that, and like they told me later it was kind of an interesting eye opener for them. (Amanda)

Nana discussed how her comfort level of being out in town has changed as her career has progressed.

> You know there's one thing I think about more in the community, you know, I've been in my relationship almost 20 years and there was a time when if we were walking downtown we were always holding hands, and such. And perhaps now that doesn't happen as often, and I think I kind of think about that maybe a bit more in that I wouldn't purposely do that, or I might, you know, maybe I'm thinking about passing just a tiny bit more, because now that I've had so many clients and I have more clients and such. Maybe I think about the risk of someone seeing that or knowing that could be out there. I think that's gone through my mind a time or two, just being out in the city community. It's pretty minimal

compared to what I think what a lot of people are experiencing, but it's been a thought a time or two.

Role as a Spokesperson

A theme that arose was considered both a strength and a struggle among several of the participants as this feeling of needing to be a spokesperson for the queer community, especially within their clinical training programs.

> And so I felt like I had to be aggressively gay. I felt like I had to be professionally gay. I felt like I had to always be on the gay soapbox. In retrospect I think that was a part of my age, and sort of my own personal development, but I also think because I was younger, I was totally willing to take on any battle that came my way, and I was like, 'sure! If you're going to exclude me, I will include myself!' (Natalie)

> So I felt like sometimes my role was to point out when I bumped up against things, and when other people did. Which can be energizing or exhausting, depending on what the situations is. (Atiyeh)

> I'm going to keep fighting as hard as possible so that no one in this room, or that comes after me, has to fight again. And that's always how I feel about this. But there are times when I'm just tired and I don't want to have to fight constantly. But then I feel very activist-y, of like, I have privilege in places that people don't and I need to make sure that I keep my strength up. And it's just a lot more work

than I feel a lot of other clinicians have. And if AAMFT did a better job, I don't think that would be the case. (Avery)

What about the Queer Kids?

A phrase that was uttered by two participants, with a 3rd articulating something similar was the phrase, 'What about the queer kids?' Six of the participants commented feeling like they had to take it upon themselves to highlight the lack of attention paid to queer issues in therapy, especially within the academic setting.

I would just like throw out just a little something, 'what about the queer folks?' (Stella)

And another kind of academic experience is years ago, a gay colleague of mine and I took the clinical supervision training together. And there was something said that I thought shouldn't be let slide, that I thought somebody needed to include the same sex couple orientation piece about, and I did that. I made some statement. My colleague came up to me during the break and said, thank you for bringing that up. I feel like I always have to be the person who says what about the queer issues.' (Nana)

Some of the participants described the feelings of displeasure they perceived were coming from their peers and professors because of their continual acknowledgement of the lack of queer issues being presented.

It's been interesting. I'm, as far as I'm aware, the only LGBT person in my program, in my cohort at least, and so I end up going 'well what about the queer

kids?' a lot and that gets really old. He (a professor) gets a little bit tired, I think, of me going 'but what about the queer kids?' My classmates I think are really sick of me being on a soapbox, but if they would actually open their minds, I wouldn't have to be on the soapbox all the time! (Maggie)

I would say that sometimes I got the feeling, and this was more kind of a general feeling, less than like something explicitly being said, but that because I was pretty vocal about being frustrated about a lot of the class material, there were times when I wondered if because I was openly identifying as queer, and I was having a lot things to say about the lack of queer or just accurate queer representation in a lot of the literature, that if I was at times taken less seriously because it was so personal. (Amanda)

Specialization in Queer Topics

The majority of the participants identified that they have worked with queer clients, with four participants stating that at one point in the career, they either currently or previously worked with primarily queer clients.

I really love to work with the LGBTQ population. (Nana)

When I was in private practice, it was my practice; it was my professional identity, and it was how I carved out my practice. I specialized in the queer community. (Natalie)

> When I got out of grad school, I had always known that I wanted to work with the queer community, and then when I started to do a little research about where support exist, I noticed that there are not very many couple therapists who specialize in queer couples. I found a lot of therapists in the city, a lot is a relative term, who said that they specialize in queer individuals, but not same-sex couples, so I was trying to find a niche there. And I think I did. (Elynn).

Several of the participants described how their academic work also focused on queer issues and queer topics.

> People in academia, people who are out, are like professionally gay and all of their work has to do with being queer. (Natalie)

One participant discussed how she feels her research is not taken as seriously as others because it is perceived as a personal issue.

> I also specialize in LGBT issues and they're really important to me and I do a lot of research in it. Then I have it qualified as like, 'oh, you're a one trick pony, like this is all you think about.' And it's not treated as like, 'oh, you have a specialty and that's great!' I see other people, like there's someone in my program right now who specializes in trauma, and I don't see it treated the same way. I just always see the LGBT issues being treated as like, 'oh, that's cute but like stop it.' And people I feel like often think, 'oh you're just in gay things because you are gay.' And it's like, no! I mean, maybe there was some part of me that knew that I

was gay, and like that's why I was interested, but I was interested in this way before it became a personal issue. (Avery)

Being an Appropriate Spokesperson

While several of the participants discussed feeling like they had to be a spokesperson for the queer community, two participants described times when inappropriate spokespersons were brought into their respective training programs and the impact that it had on them and their classmates. They emphasized the importance of getting accurate information out to their colleagues, while at the same time, the importance of not bringing someone in to represent a community that is potentially harmful to said community.

> We had a person who came in to do the day on queer issues. He was a white, cis gay dude who basically said, 'actually I only know how to work with cis gay dudes in terms of sex therapy, and I don't know anything about the other population groups.' And in fact, he kept refusing to use the word *cis* and just kept saying gay and in terms of anatomy and kept like equating gay men with having two penises. I like raised my hand 4 times and was like, 'I think you mean like cis gay men,' and he just would not accept it. So then he started talking about sex therapy with queer women and said, 'I don't know anything about how queer women have sex.' And we were like well why is he here doing this talk on queer sex. Then he decided to talk about trans sexuality too and like didn't know anything about it. So he would actually say these really offensive things. He said, 'I don't know anything about how trans people have sex, but I do know it's really,

> really complicated.' Like that was all he said about transsexuality. It was so bad that it was almost funny. (Amanda)

Amanda went on to describe the frustration she felt when she approached her faculty about this particular guest speaker and found out that in every single cohort prior to hers that had had an outspoken queer person, that that person had complained about this presenter. She described the disbelief she felt that her faculty would knowingly continue to bring in someone to represent the queer community that had offended so many of their queer students. The other participant echoed the need for bringing in appropriate speakers.

> I think with all of the critique I would have, it would just be bringing people who represent whatever population you're talking about in, so they can share their background and not just bringing in a person of color to talk about racism, but somebody who is actually really well trained in the area. (Atiyeh).

Context

Context was a factor for most of the participants, and it impacted several aspects of their experiences of being a queer therapist, including safety, out-ness, and comfort. For Natalie, who has experience working in a wide array of settings with different types of coworkers, context determined a lot of things.

> It depends on the context for me. In my current work in hospitals, my sexual orientation identity is, like I know it's important but for everyone I interact with, I believe they just assume I'm straight, or I believe they assume that it's kind of irrelevant as a variable. It's not; it's always relevant. But, I would suggest that I

> often feel in hospitals that, you know, I work in pediatric hospitals, and I've been doing that for the past 3 or 4 years, I feel like I need to really keep my sexual orientation really on the down low. When I was in private practice, it was my practice. I specialized in the queer community. I had tons of trans people in my practice and I'd say that more than half of the couples that I worked with were queer. But, in pediatrics, in those medical settings, it's really a different bag of tricks. (Natalie)

One participant described how the context of her clinical training program changed from cohort to cohort, and how that was disconcerting to her.

> I did have quite a few queer classmates in my year. However, the year above me there were no, at least out, queer folks. And the year below me, there was only one out queer person. And so like I felt really about my cohort, like there's a lot of queer people which is really cool. But then when I looked like immediately on either side of me, I thought that maybe my cohort was a fluke and it's not usually like this. So that was concerning for me. (Amanda)

Location of Programs and Practices

Three of the participants had experience working in different parts of the country, and all three discussed how their location affected their experiences.

> So yeah, that's had an impact on me. You know, working in one part of the West is a very different creature actually than working in another part of the West. Just because it's all called the West doesn't mean that it's all culturally similar…And then in the Midwest where I just didn't feel like cultural concerns were even

valued, it was easy to be out with my colleagues, but it was harder to be the full scope of myself with patients. (Natalie)

It took me awhile. I think, with people in the West realized that they were only okay with me if they forget that I'm gay. I had a lot of good allies there, so it helped. I think that in the West I was able to work at an affirmative agency in my practice, I put myself out as an affirmative clinician, and the West is just more diverse and also less impoverished. So I didn't work with people who didn't understand what preferred gender pronouns are. (Avery)

So in the West, there are so many resources here. It's like resource galore. The only thing they are missing is cultural diversity. In the town on the East Coast, where my previous school is at, there are just not many people there at all. The only LGBT people, most of them were on campus. So there was a haven on campus. But as soon as you get off of campus, it's the rural mountains and small towns. So that was very different. (Sara)

Support Systems

Three participants explicitly discussed the sense of empowerment they felt being surrounded by supportive faculty, supervisors, coworkers, and cohort mates.

I feel like I'm part of a larger community of queer identified therapists. I was lucky in the fact that I was one of I think 5 folks in my cohort who identified as queer, which I know is kind of an anomaly. So for me in my training, I felt like, at least among my cohort, like part of a community…I felt like I had this team that

was collaborating with me on it. It was in my practicum group, and one of my practicum members identified as queer, so I also felt like, 'ok, this isn't just me dealing with things,' which was really helpful. Being able to identify with other folks who shared similar experiences and I learned a lot from them. So that was meaningful. (Atiyeh).

I think it honestly has to do with the people that are there. I think all of the people that work there (where I work) are just genuinely pretty open-minded and accepting. So it just comes about naturally. (Cheryl)

I feel like me and some other folks in the program who identify as queer as well kind of had similar reactions to things, like I think we had a lot of really good conversations and discussions that maybe wouldn't have happened if we hadn't already had that background knowledge or background experience. (Amanda)

Isolation

While some of the participants discussed the strengths of working in a supportive environment, others discussed feeling isolated, and the negative impact it had on their experiences. Sara discussed the difficulties she has faced by being one of the few academics at her current location that focuses on queer issues.

I'm like 1 of 2 people who are interested in any kind of trans or sexual minority issues. It's been harder, even though this department is in a more open city, it's actually been harder for me to navigate all of these issues, because I'm in a

department that's not as diverse, or not as, I don't want to say supportive or not supportive, but not as openly affirmative as my doctoral program was. (Sara)

Elynn, a therapist that works primarily with queer couples, expressed her frustration with being the only queer C/MFT in her practice, and feeling cutoff from other practicing queer C/MFTs.

> Sometimes I feel like I exist in a vacuum, like I'm the only MFT in my practice so I'm working with other affirming therapists, but they don't know a systems background. Then I have this other consultation group with MFTs who don't know how to work with queer people, so I feel like why in this city am I not able to locate folks I can consult with who like have this intersection of both. (Elynn)

She went on to discuss looking to her professional organization for a way to connect with other queer C/MFTs, but that it is nearly impossible due to the way the American Association of Marriage and Family Therapy is organized.

> I think there was something about dividing. The only division that exists is by geography. Like where does that leave the queer affirming therapists from like the South? You know? Not that' there's not affirming people somewhere in the South. (Elynn)

Strengths of Being a Queer Therapist

All of the participants were asked what, if any, were the strengths of being a queer-identified C/MFT. Every single participant identified strengths that were related to their sexual orientation, especially with regards to their clinical work. The sense of passion and pride that all of the participants spoke about as their strengths, was inspiring.

> I think the process in and off itself of being queer involves a lot of introspection. If you can question your orientation, you can question who you are as a person. When I talk to someone queer, I'm almost positive that they understand how to do good introspective work. (Avery)

> What it means is that I am being myself as a therapist. And what's that like is that it allows me to maintain my selfhood, like in the work that I do; which I think is the way in which we are the most effective as therapists. When we work from a genuine, honest place, it has all the benefits of being able to be yourself. (Stella)

> I always feel like being queer is a strength. It's never not. Even when I'm in a hospital where I feel like I need to be really quiet about that, I still feel like it's a strength. You know, I have a lot of other sort of majority identities. You know I'm white, nobody ever mistakes me for anything other than white. I can polish up my language in such a way that I can be read as not just well educated, but upper class, even though that's not my economic background; and like I'm able bodied. I've got a lot of privilege. I'm pretty clear that there aren't a lot of other windows for me into minority experiences, but this window of being queer for me is very helpful, and I feel like I've been able to sue it as a point of self-reflection. (Natalie)

Drawing on Personal Experiences

Nearly all of the participants discussed how their queer identity helped them in their work with queer clients. Participants shared that their own personal experiences,

especially with the coming out process, was an invaluable asset to help their clients who might be going through that same process.

> This is what I told my classmates. Because I had to go through this process of figuring out what I was when I was a teenager, and that was the 90s and people weren't talking about it yet, and so I had no idea what was going on inside of me and I was pretty much alone in the process and because I did that, because all queer kids have done that, we have a certain strength and flexibility that can be tapped into to understand other peoples' issues. That, you know, is pretty unique. Going through the dark and coming out the other side you have seen the dark and you know how it can be, and you know how lonely you can feel and how wrong you can feel, and how many other different emotions can be laid there. At the same time, you've come out the other side, you know, like, 'oh, right, I can actually still cope. Cool.' (Maggie)

> I think it's a resource for some people, especially with coming out issues that they can kind of see and meet with a person who is taking it all in stride. I feel like it (coming out) has been kind of a safe and positive and empowering process for me, so I hope I can sort of embody that or convey that to someone who's struggling so much with acceptance with their family, with their spirituality, with their colleagues, and I hope it's a resource. (Nana)

Joining with Clients. One way in which the experiences of the participants helped to strengthen their relationship with their queer clients was their ability to use their experiences to join with their queer-identified clients.

> I think for queer clients, it's clearly been a strong benefit. They feel like they can be themselves, and not feel like they have to hid parts of themselves; but also I think lots of queer folks have the experience of going into therapy or many other spaces and having to explain themselves in ways that are hurtful. I hear from a lot of straight therapists, 'but we ask everybody lots of questions all of the time.' And that's true, and I ask my queer clients the same kinds of questions that straight therapists would ask, but I think it feels really different coming from a queer therapist; where it doesn't feel like an interrogation. It doesn't feel like that person is starting from zero. It feels like a genuine curiosity about trying to understand better an individual's experience. It no longer feels like you're trying to explain a whole world or community to begin with. So in those ways, being a queer therapist, that's my experience of it; it's awesome! (Stella)

> I felt like they (my clients) had to do less work as clients. And I understood more. I have a client right now who is trans-identified. They are just really uncomfortable with a lot of it. And they talk about the idea of passing and things like that. I feel like it's really helpful in those settings because I understand the ambiguity of it and understand the importance and unimportance of language. It just feels like a different experience for them because they're not talking to a cis person; they're talking to someone who they don't have to explain the importance

of passing or the uncomfortability of going into female sections of stores or trying to figure out how to convert sizes and things like that. And so I think that helps me a lot because I get a lot of joining down, quickly. (Avery)

I can think of one example that was a real positive example. I was working with a teen who felt like they didn't know anybody else who identified as queer, or LGBT. They didn't have any examples of what that looked like, and they kept saying, 'you can't be it until you see it' and we had a really positive relationship, and I just kept hearing this theme of like, 'there's nobody around me, and I have nobody I can relate to about it, and it's not that people are negative about queer issues around me, it's just that I don't see it anywhere.' And so I felt like that was a time I could say, 'well I'm here' and I think the way I phrased it was 'I identify as queer, but I know that what you need is a friend or somebody in your personal life and that my goal for you is to plug you into those resources through some other activities and ideas I had for her clubs and groups and stuff like that. But I think in that moment, they appreciated knowing that there was one person. (Atiyeh)

Different Lens

Not only did the participants view their queer identity as being a strength in working with the queer community, several of them empathized the profound effect it has on their work with all of their clients, including heterosexual clients. Many of the participants described having a different view of the world that was shaped by their experiences of being queer. Many of them credited this view to helping them create a

unique lens in which they see their clients, and discuss the positive impact that has on the lives of their clients.

> I feel that being bi has made me a lot more open, which then influences who I am as a therapist. Maybe I say that because whenever I'm in a practicum working with other therapists, sometimes I feel like they get very thrown off by identities, like certain kinds of different identities. Not only in terms of sexual identity, but any other things in their lives that they kind of just don't understand why that person is that way. And for me, it's kind of like, well, people are different, and so I couldn't really get that (if I weren't bi). (Sara)

> It's also a strength in that I think even in my work with straight clients and straight couples and families. I think I come in with different sets of assumptions and maybe, I'm curious in ways and ask questions. I remember once, I had this couple and she was the bread earner and he was out of work and had been for a long time, and there was a dynamic there for sure, and I had to check, like is this still a thing? Like is it still a thing to be super gendered in a straight world? I think that allowed to me to kind of approach it with different kinds of assumptions and to ask different kinds of questions. It allowed them to sort of fill in what their experience of it was, without me coming at it with the assumption that this how it is, or how it should be. So I think that's something that I can bring a little bit of different kind of nuanced way of thinking. (Stella)

> I think people with a queer identity have a really special lens through which they view others, and I think we come in with fewer assumptions and more openness, and I think that to me is a privilege about being a queer therapist. I think it really allows me to understand, and this might be bigger than just my sexual identity, but it allows me to understand how many possibilities there are for healthy, successful relationships. Like I see a lot of couples, and I don't have a picture in my head of how a relationship is supposed to go. I've had relationships that feel heterosexual, and I've had relationships that feel way more queer, and I have had relationships that feel kind of traditional in terms of gender roles, and some that feel so not traditional. I think my queerness allows me to be open to so many additional possibilities for what a healthy relationship looks like. (Elynn)

AAMFT Relationship with the Queer Community

Because the American Association of Marriage and Family Therapy (AAMFT) is the professional organization of the field of Couple/Marriage and Family Therapy, and because it is responsible for setting the Code of Ethics of the field and for setting the tone of the field of Couple/Marriage and Family Therapy, it was important to ask each of the individuals to describe their views and relationships with the AAMFT. Two of the participants, Nana and Cheryl, reported that they do not have much of an opinion on the AAMFT as they are not really involved with the professional organization. Nana went on to state that she has never really been too involved with the organization.

> I think I was usually pretty oblivious to issues at the national level. (Nana)

Other participants, who have deeper connections and involvement with the AAMFT, had a more critical view of the organization.

> I never really benefited from it (the AAMFT), or I felt like I did not benefit from it. I say overall, I've never been impressed with the AAMFT's relationship with the queer community. (Natalie)

> If it's not important to AAMFT, it doesn't have to be important to the programs that are teaching clinicians. (Avery)

> I would say the fact that I don't know anything about AAMFT's relationship with the queer community is indicative of AAMFT's relationship with the queer community. (Elynn).

Lack of Progress/Remaining Neutral

One of the biggest concerns that a number of the participants had with regards to the AAMFT is the lack of progress that the organization has made with regards their stance on queer issues. Four of the participants commented explicitly that they felt that the AAMFT is one of the least progressive mental health organizations and that they attempt to remain neutral on a range of queer issues, which in turn, halts progress.

> I want to talk to other therapist about queer people and queer clients and queer relationships, and I haven't seen any opportunities to do that through the AAMFT. (Elynn)

Well, I mean it seems like they're at least paying some kind of lip service to it (queer issues), but I don't know how genuine it is. (Amanda)

It's like diversity, diversity. They're just throwing in these buzzwords so that it sounds good. They're doing it so much that it's like now you're just overcompensating for the way, but I think that they're trying in a way that is not, like it doesn't actually create any specific ways of how we should do this, and how we should integrate this. And I get really peeved when they use the word diversity so generally and broadly that you're not really talking about any particular needs of any population; you're just like, diversity, because it's vague. (Avery)

I feel like the AAMFT is pretending to walk a line to say, 'well we are apolitical,' but you're never apolitical. That's not how life works. So you know, I just think that the AAMFT is not willing to take a strong position to say that they will put human rights and human dignity first, and make that a core value, and I think it extends beyond just our treatment of queer people. I think the AAMFT is overwhelmingly and unapologetically white, and they've made very little effort to recruit and retain diverse talent, people representing all forms of human diversity. And for those reasons I think the AAMFT really fails its membership and really fails society, and really fails in its mission, so it failed me. (Natalie).

Influence of Religion

Several of the participants commented on the perception that the AAMFT caters to its religious constituents, stating that their hesitation to make progress comes from their fear of offending the religious sector of the organization; in other words, they would rather upset the queer community than upset the religious community. Some of the participants also commented that it is this catering to the religious members of the organization that has limited the amount of literature published on queer issues, and the attempted apolitical stance on other queer issues.

> I think there's a stigma (to being queer), but I think it comes more from a religious place, and an experiential place, than it does from a scholarly place. (Maggie)

> Well, it doesn't seem like they (AAMFT) do that much (relate to the queer community). Word on the street is that there's a pretty strong religious contingent that directs research focus and the interests of the organization in a way that in fact doesn't make space for research and stuff on the topic. (Stella)

> I've had the experience that the organization really prefers to cater to a very straight and very religious demographic and by religious, I mean people who use religious arguments to say that gay people are not acceptable in society. (Natalie)

> I feel like AAMFT has been the slowest out of all the mental health professions to openly affirm LGBTQ individuals and families. I feel like it is part of the

religious factor with them; that they are afraid of losing that part of the organization. And I think, I feel like it's such an either/or; we need a both/and. We need everyone to be on the same page. It's not religion versus sexuality or gender identity. That's not the right way to think about it. (Sara)

Advice

At the end of each of the interviews, the participants were asked to share some words of advice based on their experiences as queer therapists to either future queer therapists, current queer therapists, or their straight colleagues. Two participants offered words of advice to their colleagues.

Don't assume. I mean it really comes down to that. Don't assume. We look at each other and we assume all sorts of things, all of the time, and we don't know. And it's just don't assume; don't assume things about people. I mean I know it's human to do, but we can also then stop and think and analyze the assumptions that we've made. People get lost when we label them. And people are so interesting and have such amazing stories, they shouldn't get lost. (Maggie)

The thing that I wished people understood the most, in my personal life and this question is privilege. I think that it is really easy for people to talk to me of, well like, 'just don't let it get to you' or ' don't think about this' like 'you don't have to know the answers, like you don't need a label' and not realizing how that' always of me. And that's always something that people are putting on me, if I'm not putting them on myself. (Avery)

Two participants offered words of advice to queer individuals who are considering a career as a therapist. Both of them emphasized the importance of choosing an affirmative program.

> I mean in a therapy program, I would say that it is most useful to be in a place where you can bring what you need as a lens to bear on the material that you're going to get, without feeling too limited by that. And so when I talk to people who are interested in this kind of work, I often tell them that being in a room full of therapists is like having a room full of people who are very interested in people, who are very interested in like how people are affected by things, who are generally fairly committed to helping, or wanting people to feel okay and to understand why they do or they don't. They may or may not know anything about your politics or your sexuality, so to be able to walk in the space that's created by that genuine curiosity and love of people, just to bring your own experience and to create space for it. You need to be able to be in a place where you can kind of come at it from that direction. (Stella)

> I guess I would say to be really intentional about choosing a program that's really inclusive and supportive. I guess depending on where you were working, it might be more of an issue, but if you were to have clients, because I remember that was a concern of mine when I was still in the program and then a little bit at my first job, getting clients who were homophobic, and being concerned about how to handle that. It hasn't come up very often, and especially not recently, but I think

to be aware that that could happen, and to get a lot of supervision around working with those clients. (Cheryl)

One of the participants took a social constructionist approach to the words of advice and emphasized that her experiences were created by her societal contexts.

I guess what I come back to that is knowing that it's different for everybody and I think that it's hard to isolate just what my experiences were like as a queer therapist. So I think that it's just part of the mix that I am that kind of shaped my experience. But it's hard to me to really distinguish that from all of these other experiences. And also, I can't speak for everybody else, but that's just for me. (Atiyeh).

The remaining five participants offered words of advice based on their experiences to queer therapists who are currently practicing. Two of the five emphasized the importance of coming out.

Maybe I did it (coming out) at the right time when I felt like I had enough support, so maybe my advice then would be like obviously you have to seek support. I think your training plays a big part of it. You have to find an affirmative training place and I think your supervisor has to be affirmative. I think you should just, like don't wait until they find out. (Sara)

I think as much as it feels safe, I would just encourage people to come out and be vocal about their experiences because I feel like the program became better due to

all the loud queer people in my cohort. Know that hearing those experiences, even though it's not our job as queer people to like educate everyone, as comfortable and safe as it is, you need to vocalize. It can be really beneficial for folks. (Amanda)

The other three participants emphasized the strength of being a queer therapist and the need that there is for queer mental health practitioners.

I mean use your experiences to understand your clients. Like don't leave your identity at the door because it's so valuable. That doesn't mean that you have to disclose it, but keep it. You know, and use it and allow it to be part of the lens through which you view each client, regardless of their identity. Because I think people with a queer identity have a really special lens through which they view others. I think we come in with fewer assumptions and more openness, and I think that to me is privilege about being a queer therapist. (Elynn)

I feel like being queer identified and being a mental health professional is a contribution and I would want people to know that that has so much value; that we're resources and have a lot to offer to the profession and to society and to the public. There's a ton of overlap with the straight world, but there is also a margin that's a world of our own, and has value; it doesn't conform to the straight norms, and doesn't mean that it isn't any less awesome. (Natalie)

I would encourage queer people who want to be service providers and be in mental health and counseling to do it, because I think there's really a need. I don't

> know the statistics now because I'm not that academically oriented, but if the coming out process or being queer is still one of the highest risks for suicide for young people, that's terrible. We need to keep trying to change the world, and having more queer identified therapists certainly would help. The more they feel safe to disclose and to help others, the more we have accessible people in the community for people to talk to on top of the *it gets better* movement. I think the more people feel safe and okay, the fewer mental health issues will come out of just discovering you're not straight. (Nana)

Summary of Chapter

Although each participant had a unique story to tell, all the participants shared certain similarities with each other. They highlighted the importance of proper training with regards to working with the queer community, and the importance of integrating queer issues throughout the literature. The theme of self-disclosure was touched upon by every one of the participants. Each participant described at least one instance or experience in which they struggled with, or were concerned about, the issue of disclosing their sexual orientation, especially to their clients. Another theme that emerged was the issue of being made a spokesperson for the queer community. For some, this experience was invigorating and beneficial, and for others it was exhausting and felt very othering. Context was a key component in the number of positive experiences that the participants encountered in both their academic and clinical work. Those participants who felt isolated and unsupported were more likely to have fewer positive experiences than those who felt supported and surrounded by other queer clinicians, supervisors, and faculty members. One theme in which all of the participants spoke about with great passion was

the strength they found in being a queer-identified therapist, and the positive impact that it had had on their clinical work. Finally, the participants' opinion of the AAMFT seemed to depend on the participants' level of academic interests. Those who had sought education past the master's degree, and those who had recently just graduated tended to have a stronger opinion about the national organization than those who had been out of the academic setting for quite some time. With that being said, all participants commented to some degree about the weak relationship that the AAMFT has with the queer community.

Table 1: Description of Participants

	Natalie	**Sara**	**Nana**	**Maggie**	**Avery**
Pronouns	She/Her/Hers	She/Her/Hers	She/Her/Hers	She/Her/Hers	She/Her/Hers
Age	38	25	61	35	23
Sexual Orientation	Lesbian/Queer	Bisexual	Lesbian	Bi/Queer	Gay, Gray-A
Gender	Cis gender Female	Cis gender Female	Female	Female	Androgynous
Clinical Setting	Agency, Wilderness, Residential, Private Practice, Hospitals	Outpatient Clinic, University Clinic	Private Practice, Agency	University Clinic, LGBT Clinic	Agency, Private Practice, University Clinic
Years	15 total (10 post M. Ed.)	5	12	½	3
Educational Setting	Public	Public	Public	Public	Public
Race/Ethnicity	Caucasian	Vietnamese American	Caucasian	Caucasian	Caucasian
Location	West, Midwest, East Coast	South, East Coast, West	West	Midwest	West, East Coast
Partnered	Yes	No	Yes	Yes	No

	Stella	**Amanda**	**Elynn**	**Cheryl**	**Atiyeh**
Pronouns	She/Her/Hers	She/Her/Hers	She/Her/Hers	She/Her/Hers	She/Her/Hers
Age	45	25	29	31	26
Sexual Orientation	Queer	Bisexual/Queer	Bisexual/Queer	Queer	Queer
Gender	Female	Female	Female	Female	Female
Clinical Setting	Agency, Private Practice	University Clinic, School-Based	Agency, LGBT Practice	Residential, Agency, Group Private Practice, Community Center	University Clinic, Community Center
Years	5	1	7	6	1
Educational Setting	Private	Public	Public	Public	Public
Race/Ethnicity	Mixed	Caucasian	Caucasian	Caucasian	Middle Eastern
Location	Canada	West	Midwest	West	West
Partnered	No	Yes	No	Yes	Yes

CHAPTER V: DISCUSSIONS AND CONCLUSIONS

Overview

The purpose of this study was to examine the unique experiences of queer-identified Couple/Marriage and Family Therapists (C/MFTs). More specifically, the goal of this study was to identify the thoughts, feelings, and actions of queer C/MFTs and to explore if these experiences impact their clinical work. I strived to achieve this goal by conducting interviews with ten participants.

Before diving into the discussion of the themes found within the data, it is important to acknowledge my own reactions, responses, and emotions that I experienced while conducting this study. As a queer-identified C/MFT, it is important that I take into consideration my own experiences as they undoubtedly shaped the lens through which I conducted the interviews and viewed the data. As a queer-identified C/MFT, I found it easy to relate to my participants; and as an individual that some would consider to be easily identifiable as queer, I believe it allowed my participants to be more comfortable with me about their experiences as opposed to doing the interviews with someone whose sexual orientation might be a mystery. I found that some of the experiences of the participants were similar to my own experiences. This created a sense of comfort for me and a sense of community. It helped to validate my reasons for wanting to conduct this study. It was also extremely helpful to hear from participants whose experiences were different from mine. At times, I struggled with my reactions to certain issues, such as self-disclosure; but I developed a deeper understanding of why people approach the revelation of their identity in different ways. Throughout this process, there were two distinct moments in which I was overcome by emotions. While transcribing and coding

the data, I experienced a sense of pride and joy as every single participant described their sexual identity as a strength, and spoke with such passion. It was inspiring to hear the different stories of how their sexual orientation has helped them to become better therapists and better people. I was also overcome with great sadness and concern as I heard stories of discrimination and overt homophobia, especially with regards to religion and the Association of Marriage and Family Therapy (AAMFT). Because of my experiences and reactions, I found it very helpful to keep a researcher journal, and to process some of my reactions with my peers. The following section will discuss the results of the study, comparing it to the literature (where it is existent), and to my own experiences, observations and research journal.

Discussion

Six major themes emerged from the study: (1) training, (2) self-disclosure, (3) role as a spokesperson, (4) context, (5) strengths of being a queer-identified therapist, and (6) AAMFT relationship with the queer community. Each theme had a set of subthemes. Within the theme of (1) training, three subthemes emerged: (1A) lack of training, which included the subcategory of (a) possible dangers and ethical concerns; (1B) lack of resources, which included the subcategories of (a) lack of supervisors and academics, and (b) lack of literature; and (1C) integration of concepts. Within the theme of (2) self-disclosure, four subthemes emerged: (2A) struggles related to self-disclosure; (2B) safety concerns, which included the subcategories of (a) safety concerns with clients, and (b) safety concerns with colleagues; the subtheme of (2C) passing, which included the subcategory of (a) invisibility of bisexuals. The theme of (3) role as a spokesperson and three subthemes emerged: (3A) what about the queer kids; (3B) specialization in queer

topics; and (3C) being an appropriate spokesperson. Within the theme of (4) context, three subthemes emerged: (4A) location of programs and practices; (4B) support systems; and (4C) isolation. In the fifth theme, (5) strengths of being a queer therapist, two subthemes emerged: (5A) drawing on personal experiences, which included the subcategory of (a) joining with clients; and the subtheme of (5B) different lens. Within the theme of the (6) AAMFT relationship with the queer community, two subthemes emerged: (6A) lack of progress/remaining neutral; and (6B) influence of religion.

Training

The subthemes and subcategories that emerged highlighted the concerns that the participants had about their clinical training programs. All but two of the participants commented that their programs lacked adequate training in working with queer clients. One of the participants who felt adequately trained was the only one that commented that her training program integrated queer issues throughout the curriculum. The concerns that were raised by participants included, but were not limited to, lack of training, and the potential dangers that can arise due to the lack of training, lack of resources, including access to queer supervisors and queer literature, and concerns about the lack of integration of queer concepts throughout their training programs.

Lack of Training. Most of the participants had strong opinions about the level of training they and their colleagues had received with regards to working adequately with the queer community, describing it as lacking. This was surprising as the lack of training was described by participants from different locations and different training programs. The participants found this troubling. They described the fears and concerns of what might happen if therapists, regardless of sexual orientation, are working with any

population that they are not properly trained to work with. This experience of inadequate training is consistent with the literature that is available on the lack of frequency and magnitude of training in affirmative therapy within Couple/Marriage and Family therapy training programs (Carlson & McGeorge, 2012; Godfrey, Haddock, Fisher, & Lund, 2006; Rock, Carlson, & McGeorge, 2010). One such study investigated the level of training that 190 students from COAMFTE accredited Couple/Marriage and Family Therapy training programs had received with regard to working with queer clients. Of those 190 respondents, 60.5% reported that they had not received any training on affirmative therapy, and 62.6% reported that they had not received any training on queer identity development models (Rock et al., 2010).

This finding is extremely important because it highlights the need for better training of C/MFTs. The AAMFT Code of Ethics requires that practitioners maintain a certain level of competency. It is difficult to maintain this level of competency working with the queer community when therapists are not trained to work with this specific population.

This subtheme that emerged did not surprise me. As a graduate of a COAMFTE accredited master's degree program, and as a clinician who has worked extensively with the queer community, it was easy to relate to the participants on this particular issue. While I received some training with regard to working with the queer community, I felt it was lacking in some areas, especially with regard to being trained as an affirmative therapist. What was fascinating to me was that this seemed to be a problem regardless of the training program and the location.

Possible Dangers and Ethical Concerns. The eight participants that expressed concern over the lack of proper training discussed the possible repercussions for sending improperly trained therapists into practice. This is consistent with the literature that highlights the direct correlation between the number of hours spent training on queer/affirmative therapy issues and the level of competence perceived in the ability to work effectively with the queer community (Rock et al., 2010). Possible repercussions of not having adequate training for C/MFTs, according to the participants, included therapists being ill-equipped to handle the unique struggles of this population, feeling uncomfortable with the topic of sexuality and creating a space in which a client feels that they are not safe to discuss their orientation, and not knowing how to navigate their religious beliefs when working with queer clients.

This finding highlights the power inherent in therapy and the potential harm that can, arise and in some instances has arisen due to inadequate training. These are struggles unique to the queer community that untrained clinicians may either minimize or fail to recognize in sessions. Other clinicians may be all together uncomfortable with queer issues and refuse to acknowledge them in session. This can create a space where a client feels as if they are unable to be fully present and honest in session, or worse, that their sexual orientation is something to hide and is something to be a shamed of. While there is a paucity of literature on this particular topic with regard to the client-therapist relationship, Long and Grote (2012) discuss how the same issue may occur in the supervisor-supervisee relationship, and how this can create an instance in which the queer supervisee receives the message that it is not permissible to bring up any issue of sexual orientation. Through isomorphism, the queer supervisee may mimic this pattern of

communication with their queer clients. Killmer and Cook (2014) argue negative patterns of interaction that occur between the supervisor and therapist may be re-enacted between the therapist and the client.

Finally, and potentially the most dangerous, is when clinicians assert their religious freedom and refuse to see queer clients, or worse, terminate with a client after the revelation of the client's sexual minority status, or the concern that therapist would engage in conversion therapy with their queer clients.. Conversion therapy, the attempt to change a client's sexual orientation from queer to heterosexual, has been found to be dangerous and can cause significant harm to the client (Cramer, Golom, Lopresto, & Kirkley, 2008; Green, 2003; Shildo & Schroeder, 2001). In fact, four states, California, Oregon, Illinois, and New Jersey, and the District of Columbia, have banned the use of conversion therapy with minors because of the harm that it has caused (www.lgbtqmap.org). A study conducted by McGeorge, Carlson, & Toomey (2015) found that nearly 20% of their respondents believed it was ethical to practice conversion therapy, with 3.5% reporting that they had practiced conversion therapy at some point during their careers. This highlights that the concerns presented by the participants that their peers might engage in conversion therapy were valid. Given the data, there could be approximately the same amount of queer-identified C/MFTs as there are of C/MFTs that have practiced conversion therapy (about 3.5%). While the initial reaction to this statistic could be overwhelmingly disheartening, Rosik (2003) argues that not all clinicians who practice conversion therapy do so because they believe homosexuality to be an abomination. Rosik argues that providing conversion therapy offers a unique service to certain clients that are experiencing a clinical problem in being unhappy with their sexual

orientation and having a strong desire to change it. While Rosik makes a compelling argument, it is easy to critique it. Green (2003), in a response to Rosik, highlights that by offering conversion therapy, Rosik is implicitly telling his clients that he has a problem with homosexuality and therefore would make those queer clients who wish to remain queer feel as if they were not welcomed in his practice. I would take this argument further and add that there are other ways to approach working with someone who is struggling with their sexual orientation other than trying to change it. A therapist could explore from where these feelings of shame and this desire to change originate, and help the client work through them. Sessions could focus on dealing with depression, anxiety, or familial issues that may arise due to the client's sexual orientation, and highlight ways in which their sexual orientation can, and will be, a strength for them.

Lack of resources. Several of the participants stated that their lack of training was in part due to the lack of resources made available. These resources included both exposure to queer supervisors and faculty, as well as the lack of literature found in the prominent journals of our field, textbooks, and other training materials with regard to either working with or identifying as part of the queer community.

Lack of supervisors and academics. Some of the participants experienced supervisors who lacked a general understanding of some of the struggles and unique situations faced by queer therapists. Supervisors were either surprised by the sexual orientation of the participant, or were unsure how a participant should handle a situation, such as self-disclosure. This problem may stem from an array of different issues, such as the lack of training of supervisors and the possibility that queer clinicians may be more informed of queer issues than their supervisors. This second part is consistent with the

literature on queer supervision (Long & Grote, 2012). It parallels the experience of most the participants, as well as my own, that were encouraged to seek out information on their own on queer issues by their faculty and supervisors. By having a greater knowledge of the material, one has to wonder to what benefits can a queer therapist gain from seeking supervision about queer related issues from a supervisor who is unfamiliar with queer issues or is improperly trained.

This also highlights the lack of queer supervisors that are employed within in our field. Queer therapists are more likely to benefit from seeking supervision from someone who understands the struggles that accompany navigating the world of C/MFT as a queer person. This is consistent with what Long and Grote (2012) have argued. They state that it is more likely that a queer clinician would prefer to work with a queer supervisor. They highlight the supervisors' ability to be a model for what it means to be an *out* therapist, and the supervisors' firsthand understanding of the complexities of being queer in this profession (Long & Grote). While it appears that there is an inherent strength for queer C/MFTs to have supervision with a queer supervisor, only one of the participants did have that experience. This information is a bit troublesome and highlights the need for a greater number of queer-identified AAMFT approved supervisors in COAMFTE accredited training programs. This could increase the comfort of queer C/MFTs and the knowledge of queer issues for all C/MFTs regardless of sexual orientation.

Lack of literature. The majority of participants expressed frustration at the heteronormative nature of the literature within the field of Couple/Marriage and Family Therapy that was used in their training programs. Participants commented that most of the theoretical models and approaches to therapy focused on heterosexual, cis-gendered,

monogamous couples and families, and generally tended to exclude any mention of queer couples and families. This is consistent to what Rock, Carlson, & McGeorge found in their 2010 study, namely that most of the literature excludes a conversation about how to work from an affirmative standpoint when addressing issues such as homophobia and heterosexism. Again, this finding raises the question of how can practitioners abide by the Code of Ethics, which requires them to be competent if the literature excludes working with queer couples and families? It is difficult to train clinicians to work effectively and safely with unique populations without literature to aid in and support training.

A number of participants also highlighted the lack of queer research that was made readily available to them in their training programs through the use of journal articles and conferences. While there has been an uptick in the amount of scholarly articles published in the journals of the profession, the number is relatively small compared to other topics. For those articles that are published, a number of them are not based on empirical research. Participants commented that it seemed as if most articles published on queer issues would be published in special edition issues, with a return to heteronormative publications the following issues. Two of the participants commented on the lack of queer topics being presented at the annual AAMFT conferences. This is consistent with what McGeorge and Carlson (2012) describe. They highlight that the number of presentations and posters is shockingly low, and the number has not increased much over time. I had similar experiences at the annual AAMFT conference, and part of a conversation with other members of the Queer Caucus discussing the frustration felt by the queer constituents of the American Association of Marriage and Family Therapy

(AAMFT). This lack of research and scholarly work is highly important as it relates back to the greater theme of training. As a field that is becoming more reliant on empirically based research (COAMFTE, 2015), one could make the argument that it is difficult to train clinicians on queer issues without empirically based queer research.

Some of the participants highlighted the complete lack of literature with regards to queer C/MFTs. This sparked feelings of frustration and at times, a sense of loss, as the most common response for questions regarding issues relating to training as a therapist is 'to look it up'. Queer C/MFTs do not have the opportunity to scour the literature in hopes of finding guidance on how to best proceed as a queer C/MFT. Questions remain unanswered and queer C/MFTs may be left feeling as if their experiences and struggles are not a valued component of their field of study. This lack of literature was one of the driving forces as to why I chose to do this study. After going through my own struggles as a queer-identified C/MFT, I wanted to help to create a body of literature so that future queer-identified C/MFTs do not have to go through some of the same struggles that myself and the participants have experienced.

Integration of Concepts. Nine of the ten participants had the experience that when queer issues were brought up in their training, it was through the use of a 'gay day.' What this meant was that queer issues were treated as a separate entity that received a limited amount of time and energy, and were rarely integrated throughout the course. This approach mirrors what is described by some as a well-intentioned approach that believes that multicultural issues can be taught in summarized lectures and chapters (Addison & Coolhart, 2015). But as the participants pointed out, this approach is not

sufficient. Nearly all of the participants expressed a desire to have queer issues integrated throughout the entirety of their training program.

Integrating concepts may also help to alleviate some of the feelings of otherness that queer-identified C/MFTs have experienced, and which some of the participants described. Sitting in a class and listening to a professor or supervisor discuss common presenting issues for couples and families, and only describing heterosexual couples and families, may make queer students feel as if their identity is invisible. Adding a special day to discuss queer issues separate from the rest of the discussion can make queer-identified C/MFTs feel as if their identity is somehow less than, or so odd that it cannot be integrated into the core material. Either way, it can have an othering effect on the queer-identified C/MFT. Again, at the time of this writing, this is the only study that has examined this experience thus far.

Self-Disclosure

Self-disclosure was the one theme that had the most divergence among the participants. Use of self-disclosure fell into one of three categories: to self- disclose, not to self-disclose, and a self-disclosure only in certain situations and with certain clients. The reasons for disclosing or not disclosing varied among participants, with some finding strength in disclosing and others feeling as if they were revealing too much of themselves to their clients if they chose to disclose. The most common type of disclosure occurred when participants worked with other queer clients.

The literature on self-disclosure is sparse but growing and is consistent with the findings of this dissertation. Studies have found that there are inherent strengths to self-disclosure. Jeffery and Tweed, 2015) conducted a study in which clinicians described that

self-disclosure had a powerful effect on their clients. They described how their clients felt a sense of relief after the therapist made the disclosure; it helped to make the invisible nature of human sexuality visible, and created a space for the topic to be explored (Jeffery & Tweed). Other studies have found that most queer clinicians are open to self-disclosing under certain and appropriate circumstances (Moore & Jenkins, 2012). Deciding whether to self-disclose or not can be complicated and requires a decision making process. Therapists take into consideration several factors when deciding whether to disclose or not. These factors include the therapists' own personal beliefs about self-disclosure, and weighing the perceived costs and benefits of self-disclosure (Jeffery & Tweed).

Self-disclosure was the most talked about issue within the study. As a queer-identified C/MFT, I have had to consider the use of self-disclosure within my own clinical settings. I came into this study with a strong opinion on the use of self-disclosure. As an individual that is identifiably queer, I believed that the best approach to self-disclosure was to be open and honest from the beginning. This would normalize queer identity and help to create a safe atmosphere for my queer clients. By being openly queer, I also believe that this could be beneficial to all clients, especially those who may harbor homophobic thoughts. Clients' thoughts and opinions on the queer community may be shaped by exposure to the queer community, and can help to alleviate some of the fear that homophobic individuals may poses. As I listened to the different views on self-disclosure of the participants, I became aware of the reactions I had, especially towards those participants who wished to keep their sexual orientation private. After these interviews, I would take time to evaluate what triggered these reactions and my thoughts

behind them. One of the most powerful things that came out of this study for me was her ability to acknowledge and accepts the different takes on self-disclosure. While being willing to self-disclose is a viable option for me, it is not for all queer-identified C/MFTs.

The discussion of self-disclosure is extremely important and contested. While it appears that there are inherent strengths of disclosure, there are also numerous safety concerns (which will be highlighted in subsequent paragraphs). It is important that this conversation continue and that the literature continues to grow on this topic. Queer C/MFTs can and will benefit from having access to the experiences of other queer C/MFTs through studies and presentations that can help them navigate the complicated decision making process that occurs when navigating the sticky world of self-disclosure.

Struggles related to self-disclosure. All of the participants had experienced some type of struggle with the issue of self-disclosure. Some of the participants struggled with the general concept of self-disclosure; more specifically when to self-disclose, and to what extent. This appears to be a common struggle for other queer therapists. Queer therapists factor in the potential harm that the disclosure process might have on themselves and their clients. They may take into consideration what potential impact the disclosure might have on the therapeutic relationship, and worry that the disclosure might place an undue burden on the client (Jeffery & Tweed, 2015). A few of the participants described how they sought supervision for this particular struggle, and that the responses were not always beneficial.

Another common struggle with regards to self-disclosure was feeling pressured not to disclose or to discuss one's own sexual orientation. For the participants, this pressure ranged from never being encouraged to self-disclose to being reprimanded for

self-disclosing. This highlights the hypocrisy of the therapy environment. According to the participants, heterosexual counterparts were rarely, if ever questioned when they mention their opposite sex partners. This highlights the discomfort with the queer community that some people in a position of power within the field of Couple/Marriage and Family Therapy hold. Incidences like these help to create an environment in which queer experiences are viewed as abnormal and inappropriate. For the participants that preferred to self-disclose but were pressured not to, a part of their identity was kept from being acknowledged in the therapy room. For some clinicians who conceal their sexual orientation, the impact of the concealment can have a negative impact. It can result in a sense of loss of part of themselves (Jeffery & Tweed, 2015).

Therapy is an intimate and intense relationship. This relationship is disproportionate in terms of power. Regardless of the approach, the therapist inherently holds the power of the relationship. Listening to the participants describe the struggles they faced and the fears they had with regards to self-disclosure also highlights how disempowered the therapist might feel in certain situations. As a member of a minority status, queer-identified C/MFTs already face instances of feeling disempowered by society. It makes sense that disclosure of sexual orientation can be both empowering and disempowering. I related to the participants that described the frustration they felt when they were encouraged or explicitly told not to disclose; I could empathize with their sense of disempowerment. I was taken aback listening to participants discuss the feelings of disempowerment when they felt that they did not have an option and had to disclose. For some, power lies in being able to decide for themselves what part of their personal identity they wish to share with others and what parts they want to keep private.

Safety concerns with clients. Another struggle that nearly all of the participants mentioned was how to handle homophobia and biphobia in sessions. This brought up the issue of safety for the therapists. Some of the participants had yet to face direct homophobia or biphobia in their sessions, but commented that they were aware that it could, and probably would happen at some point in their careers, and others had already had these experiences in their therapeutic work. Challenging homophobic and biphobic comments made by clients does not necessarily mean that therapists would be outed, but some expressed that that was a concern for them. Research has highlighted that it is the therapist's responsibility to take into consideration how clients might react, and that clinicians should take into account all of the potential risks and benefits to the client and the therapeutic relationship (Moore & Jenkins, 2012).

Most of the participants also wondered if coming out to these particular clients would change the clients' views on homosexuality if they knew that they had developed a close and valuable relationship with a member of the queer community. This highlights a personal and unique struggle that is faced by queer therapists; should they value the therapeutic relationship more or their commitment to social justice and their community? While most of the participants struggled with this question, there was one outlier. One participant described that she always chooses to challenge her clients when comments like that are made. She spoke passionately about her responsibility as a member of the queer community to challenge those who hold stigmatizing beliefs.

The overall consensus of the participants was that they felt as if they were in an either/or situation; they had to choose between the therapeutic relationship and their commitment to social justice for their community. This binary thinking seems odd for a

community that prides itself on thinking in more than just either/or terms. I would argue that there is more to it than just the two choices. Using the therapeutic relationship to challenge the client is an option. A therapist could explore with their clients what their views are on the queer community and where these views have stemmed from. This would allow the client a chance to feel heard and respected, and opens the door to a conversation in which the therapist may be able to explore with the client how these views may be harmful to them or others. A therapist can challenge a client in safe and respectful manner. The client may or may not change their view on the queer community, but it is then up to the client to decide if they would like to continue therapy.

Safety concerns with colleagues. The participants also described how they had to navigate self-disclosure of their sexual orientation with their colleagues. A number of the participants described experiences in which they dealt with some sort of negative experience by comments of their colleagues with regards to sexual orientation. This is consistent with the literature that highlights the high number of potential issues that queer individuals face in their work and school environments (Goldberg, Hittson, Hu & Duffy, 2014; Sears & Mallory, 2014). Where the experiences of the participants differ from the literature is that those participants that described negative experiences by comments of their colleagues, none of those experiences resulted in physical harassment, threats, loss of job or status. This finding is reassuring for queer-identified C/MFTs. While it may not be the experience of all queer-identified C/MFTs, these ten individuals have made it through their careers thus far, in what some consider to be a fairly conservative field, without having to face some the most damaging experiences of harassment that their queer peers may face in other fields. The most common negative experiences described

by the participants were the invisibility of queer issues, being held to different standards than their heterosexual counterparts, and comments made that worked to further stigmatize homosexuality. While these incidences can have a negative impact on a person's mental and emotional well-being (Sears & Mallory, 2014), one could argue that they are far less severe than those experiences faced by queer individuals in other careers. With that being said, one must caution that this study only describes the lives of ten queer therapists; this does not mean that other queer-identified C/MFTs are not experiencing other forms of harassment that make them feel unsafe.

It is interesting that even though none of the participants experienced extreme forms of harassment or discrimination, the participants were still cautious and safety was a concern of theirs. One has to wonder if the participants would have experienced more intense and severe forms of discrimination if they did not take these safety precautions, or if these safety precautions become part of the reality of the queer community regardless of the setting due to the past and present experiences of the community as a whole.

Passing. Some of the participants described themselves as easily identifiable as queer by either their appearance or by their marketing. Others discussed how they believed that they could be identified as heterosexual. Studies have shown that most clinicians feel that their clients read them as heterosexual (Moore & Jenkins, 2012). A few of the participants described experiences in which colleagues mentioned the length of their hair as they expressed shock in finding out that the participants identified as queer. For some, the idea of passing was frustrating. For others, it was almost refreshing. Some of the participants commented on how their queer clients might infer their sexual orientation. The participants described that some of their queer clients were able to pick

up on subtle clues, such as the way the participant spoke about queer issues, or how they spoke about the queer community and queer resources. This coincides with other studies that have highlighted that queer therapists tend to implicitly self-disclose their sexual orientation as opposed to an overt and explicit self-disclosure (Kronner & Northcut, 2015). This result highlights that it is impossible to compartmentalize your identities and to leave them outside of the therapy room. Even if a therapist can pass as heterosexual, their experiences shape the lens through which they see the world, and in turn, influences the way they work with their clients. As much as they might try, their clients may pick up on their sexual orientation, and wonder why the therapist is choosing to keep it a secret.

This particular finding was interesting for me. In my experience, I have both had the ability to pass as heterosexual and have been easily identified as queer. When I first reflected on this finding, I thought back to the days when I had longer hair and was easily mistaken for straight, which happened to be when I first started practicing as a C/MFT. At first thought, I did not think this particular finding was relevant because I had believed that none of my earlier clients identified as queer. The more I reflected, however, I realized that I may have had clients that identified as queer, but that never disclosed their sexual orientation to me. I was still fairly closeted at the time, and now I look back and wonder if my fear of disclosing my sexual orientation to not only my clients, but to other individuals in my life may have set a tone in the therapy room that it was not a safe place for my clients to discuss these things.

Invisibility of bisexuality. While the idea of passing or not passing was touched upon by all of the participants, those who identified as bisexual, which were four participants, expressed the greatest frustration at passing, and generally characterized part

of their experience as invisible. Little research has been done to explore the unique experiences of the bisexual community, but the research that has been done highlights that a common experience for members of the bisexual community is a sense that their identity is invisible or illegitimate (Hayfield, Clarke, & Halliwell, 2014; Ross, Dobinson, & Eady, 2010). This sense of invisibility was found both within the queer community and in the heterosexual community (Hayfield et al., 2014). While this study aims to explore the lived experiences of queer-identified C/MFTs, this finding highlights that these experiences will not all be the same for different member of the queer community. Bisexuals have a different set of struggles that may not occur to other members of the queer community, further isolating the bisexual community and working to further silence their voices.

Navigating communities. Because therapists have lives outside of the therapy room, they have to be cautious as how they navigate the world around them. For queer therapists, this is especially true. Queer therapists not only have to deal with the possibility of running into clients in public, especially their queer clients with whom they share a community, but they also have to deal with the possibility of being outed if seen at a queer function or with their partners.

Navigating queer communities. Participants discussed their experiences of learning how to navigate the queer community, especially for those participants who worked primarily with queer clients. This could pose the possibility of the occurrence of dual relationships. One participant described that she could not go to a queer event in town without running into a current or former client. Other participants had similar experiences and discussed how they best approached those situations. Participants who

worked primarily with queer clients tended to be very proactive and made it known to the client that there was the potential that they would not only see each other at queer events, but that there may be some overlap in their friends' groups. While there is limited research on the possibility of dual/multiple relationships within the queer community, some research has been done with therapists working in rural communities. This research supports an approach, in that the therapist would strive to insure that working with clients with whom they shares such a small community would not impair her personal judgment with said clients (Gonyea, Wright, & Earl-Kulosky, 2014). All of the participants that worked primarily with queer clients reported that they would discuss how they would respond to seeing the clients in public; which usually consisted of the standard of not acknowledging the client unless the client acknowledged the therapist first.

Therapists, regardless of their sexual orientation, run the risks of seeing clients in public. What makes this experience unique for queer-identified C/MFTs is the intimacy found within most queer communities. Queer communities tend to be smaller, and there tends to be a lot of overlap in the different relationships. It is my experience that members of the queer community utilize the same services (such as doctors and therapists) and frequent the same establishments and events (such as bars). This can make it difficult for therapist to navigate as their clients may have been referred to them via other clients, or that their clients may be a friend of a friend (one participant described how this was a common occurrence for her.) Again, this highlights the need for more resources that are specifically geared towards helping queer-identified therapists navigate these unique experiences. It is important that therapists learn how to appropriately

navigate the potential issues of dual relationships so that clients are not being exposed to improper and inappropriate therapeutic practices.

Navigating straight communities. One participant described that when she was younger, she would walk hand in hand with her partner while out in public. She commented that this does not happen as much anymore, and credited it to a concern of being seen by clients. Other participants described similar feelings of being cautious about their sexual orientation while out in public. If a queer therapist chooses to keep their sexual orientation private from their clients, they run the risks of being spotted at queer events or with their partners, which in turn, could out them to their colleagues and clients. One has to wonder what impact this may have on the therapeutic relationship. If a therapist feels as if they have to hide their sexual orientation in public for fear of offending clients, there could be the potential that the therapist begins to harbor some feelings of anger towards their clients. This could be amplified if the therapist is in a relationship and the partner becomes frustrated with having to keep their relationship closeted. On the other hand, if the therapist chooses to be out in public and is spotted, navigating how to handle that in session can be difficult. At the time of this writing, I could not find any literature on this particular struggle for queer-identified C/MFTs.

Role as a Spokesperson

Within the theme of the role as a spokesperson, three subthemes emerged: what about the queer kids, specialization in queer topics, and being an appropriate spokesperson.

What about the queer kids? One experience that a number of the participants shared was feeling responsible to point out where their training left out the experiences of

the queer community. A phrase that was repeated by a handful of the participants in some way was 'What about the queer kids and folks?' Several participants felt that it was their responsibility as a queer-identified person to highlight where the literature was lacking. Participants descried this experience as both invigorating and exhausting. At times, being the one on the soapbox could be frustrating and alienating. Some participants wondered if their peers and faculty members grew tired of them always bringing up queer issues. These results are similar to those found in studies that examined experiences of other minority student groups in clinical training programs (McDowell, 2004; McDowell, Brown, Cullen, & Duyn, 2013). Individuals that identify with minority populations tend to be aware of the needs of their communities, and tend to be attuned to when their community is being left out of the conversation.

This finding is extremely important in that it highlights the need for a safe community in which queer topics can be broached without fear of repercussions. This can be done by already including queer topics into training programs. This again ties back to the need for more literature. It should not always fall onto the queer 'kids' to have to highlight the where programs are failing the queer community. With more literature and more presentations on the subject, faculty and supervisors can be better equipped to bring this conversation into their training procedure.

Specialization in queer topics. Nearly all of the participants commented that they had focused on queer issues in some manner and at some point throughout their academic and clinical careers. For a few of the participants, being a member of the queer community inspired them to specialize in queer issues and in working with the queer population. These responses coincide with a study done on the experiences of low

socioeconomic status (SES) students in Couple/Marriage and Family Therapy training programs. McDowell and colleagues (2013), found that students from low SES had a yearning to give back to their communities.

The queer community faces higher levels of mental health distress than their heterosexual counterparts. As a field, we should be wanting to better serve this population. If research has shown that other minority populations who seek a career as a C/MFT want to give back to their community, one could hypothesize (and that hypothesis is supported by this study) that the same could be said for queer-identified C/MFTs. The field of Couple/Family Therapy should be actively recruiting individuals who wish to work with this unique and marginalized population, and it appears that their first line of recruitment should be within this very community, the queer community.

My coming out process started at the same time as my training as a C/MFT. As stated earlier, I was fairly closeted about my sexual orientation with my clients as well with some other individuals. While most of my colleagues knew that I identified as queer, I was still not completely comfortable in my identity to be out to everyone that I knew. I remember vividly having a conversation with a colleague as to why I was so hesitant to be so openly queer. I discussed how I just wanted to be a therapist that happened to be queer and not a queer therapist. I had similar experiences as my participants, in which they identified that most of the queer professionals that they knew were professionally queer. For me, the frustration of not being represented in the literature and the frustration of not having resources led me to change my stance, as I have focused my research and clinical work to queer issues. While this has been empowering for me, I can comprehend how this may be frustrating to others.

Being an appropriate spokesperson. While nearly all of the participants described one of their roles as being a spokesperson on behalf of the queer community, a number of participants highlighted the importance of being an appropriate spokesperson. A few participants had experiences in which members of the queer community were brought into lectures to speak on behalf of the queer community, but who ended up misrepresenting a vast majority of the community. These participants expressed feeling angry at the misrepresentation, and confusion that their training programs would continually invite someone to speak on behalf of a community in which they were so greatly misrepresenting. These misrepresentations could work to further stigmatize certain aspects of the queer community. This relates back to the lack of integration and intersectionality. Not all queer individuals have the same experiences. By bringing in one individual to speak on behalf of the entire community further works to silence the community. The queer community is a diverse and multifaceted community. If one individual stands up and teaches others that their experience is universal for all queer-identified individuals, clinicians may approach their clients from this assumption, which could in turn invalidate the lived experiences of their clients if the experiences of their client differs than that of the spokesperson. As such, one has to wonder what would constitute an 'appropriate spokesperson'; I would argue that it would be an individual that is willing to share their experiences, but make it clear that they are not speaking on behalf of the entire queer community.

Context

A few participants commented on the role that context played in their experiences. Context included, but was not limited to, work environment, timing,

location, and social support (location and social support will be described in the following subthemes). One participant described how her experience varied depending on the context of her work. In certain work settings, such as private practice, her identity as a queer individual had a greater role than in a hospital setting. This highlights that certain employment settings appear to be more comfortable with sexual minorities. This brings up the question as to which types of settings are more conducive to queer therapists, and what makes certain settings more queer friendly than others?

Another participant highlighted that the timing of her clinical training program proved to be beneficial. She commented that her cohort had an abnormally high number of queer individuals, but stated that the cohorts that were a year ahead of her and a year behind her only had one out queer individual, respectively. It is difficult to ascertain as to whether or not her cohort was the norm or if the other cohorts were the norm and there is currently no information made available about the number queer-identified C/MFTs or therapists in training. Other studies have highlighted the homogenous nature of the field of Couple/Marriage and Family Therapy, especially with regards to race and SES (McDowell, 2004; McDowell et al., 2013). It would be fascinating to explore how the demographic make up of clinical training programs, with regards to both the faculty and students, influences the level of satisfaction of clinical students with regard to their training as competent C/MFTs. In other words, are students who graduate from more diverse programs better trained to work with more diverse populations? Do students who come from cohorts with a greater number of queer-identified C/MFTs benefit from having colleagues who bring up the issue of 'what about the queer kids?'

Location of programs and practices. Three of the participants had had the opportunity to practice in various geographical locations throughout the United States. All three highlighted that their geographical location influenced their experiences. Resources and diversity, or the lack thereof, was one of the reasons why location had such a huge impact. Participants highlighted that places with greater resources and greater diversity were generally more accepting than places that were lacking. These participants also commented that the political climate played a role. This makes sense since different cities and states have different laws regarding sexual orientation and identity (www.hrc.org). In locations where laws actively work to discriminate against the queer community, such as religious freedom bills that allow for business to deny goods and services to queer individuals, it is more likely that these laws would reflect the general attitudes of the people of that location, aiding in creating a negative experience for the queer therapists.

One way in which programs and practices that are located in more conservative areas can help to create a context in which their students and staff feel safe is to include policies that specifically discuss how they strive to make their place of work or school an open and affirming environment. This could include publicly coming out against 'religious freedom bill's', actively recruiting members of the queer community, and displaying queer friendly art that help to create an inclusive environment.

Support systems. A number of participants related some of their positive experiences to the sense of support they garnered from their faculty and peers in their training programs. Faculty support was essential in making the participants feel safe and accepted. Those participants who felt supported by their faculty were able to address

concerns with their faculty, and felt a sense of freedom to be themselves. They were able to pursue projects studying queer issues and to explore what it meant for them to be a queer therapist. Again, there is currently no literature examining the occurrence of this within the queer community of Couple/Marriage and Family Therapy, but other studies have had similar findings. In one study exploring the experiences of racial minorities in clinical training programs, McDowell (2004) found that participants found strength in the support they received from their faculty and supervisors when support was given.

Other participants described the support they felt from being surrounded by other queer students and colleagues in their work environment. This highlights the importance of recruiting and retaining a greater number of queer C/MFTs. McDowell (2004), makes a similar argument with regards to racial minorities. She found that students of color were able to utilize peer and faculty support as a resource. They were able to process experiences with those who had similar background and that it was vital in normalizing the individuals' perceptions and emotions (McDowell).

This is important in that it shows the positive impact that having other queer individuals around can have on the experiences of queer-identified C/MFTs. Again this highlights the need to actively recruit and retain not only queer students and therapists, but queer faculty and supervisors.

Isolation. While those participants that had a strong support system commented that it helped to create positive experiences for them, a few participants commented on the damaging effects that isolation could have in their experiences. For some participants, isolation meant being one of, if not the only, queer person in their work or school setting. This made it difficult for them to navigate certain struggles. One participant commented

in the interview that she was glad to partake in the study because it gave her a chance to talk to another queer therapist about things that she had not been able to process because she had no one to process it with.

When working in isolation, one has to wonder if it is reminiscent of the coming out process. When an individual is coming out, they are learning how to navigate the world around them as a queer individual. They may look to others queer individuals for guidance and support. When no one is around to offer this guidance and support, the individual may struggle and become distressed. The same could be argued for queer individuals trying to navigate a heterosexual work environment. As was highlighted throughout this study, queer-identified C/MFTs face unique struggles. Having the ability to consult with other queer colleagues and supervisors can help to make navigation of these struggles easier.

Strengths of Being a Queer Therapist

One of the goals of transformative research is to highlight the strengths and resiliency of the population being studied. This task was easily obtained in this study. Each of the participants experienced their sexual orientation as a strength within their clinical work, and all spoke about it with such passion and inspiration. For some of the participants the strengths came from having the ability to relate to their clients, and join with their clients, because of their own past experiences. Participants also identified strength in their ability to view the world around them, including their clients, in a different lens than their heterosexual counterparts.

Drawing on personal experiences. Some participants commented that their own personal experiences as a queer individual made them stronger therapists. One participant

highlighted that she found her strength as she struggled through the darkness of her coming out process, and shared that strength with her clients. Other participants also highlighted that given their own personal experiences, they have been able to be a source of support for their clients, and in some cases, foster a sense hope for their clients by being an example of someone who has gone through and has come out the other side. This ability to relate to the clients, and to discuss shared experiences can help to strengthen the therapeutic relationship. Clients may feel a sense of comradery with their therapists. They may get the sense that their therapist understands them better because they have similar experiences.

As I have matured as a person and as a clinician, I have become more comfortable with my sexual orientation and how it impacts my work. As was stated earlier, I am fairly out as a therapist and have seen the benefits it has had on my clinical work. I have had the experience of clients commenting that there are not a lot of queer role models, and that it was helpful to talk to someone who has gone through it. I have had clients ask me questions about my personal life because they have no one else to ask and they are looking for some guidance or validation. I was able to provide this guidance and validation because I had lived through similar experiences.

Joining with clients. Some participants shared that they felt they could join quicker and more effectively with their queer clients due to their shared sexuality. Participants remarked that some of their queer clients had to do less work in the therapeutic process because they did not have to educate the queer C/MFT on some of the nuances of the queer community or queer experiences. Having a queer therapist helped to create a space in which the client could truly be themselves without fear of how the

therapist might react to their sexual orientation. This is consistent with the literature that highlights that the use of self-disclosure can help to expedite the joining process and create a stronger therapeutic relationship between queer client and queer therapist (Kronner & Northcutt, 2015; Jeffery & Tweed, 2015). While having similar background can create a sense of shared experiences, it is important for the therapist to recognize that even if they are members of the same minority group, their experiences may be vastly different. It is important to not bring any assumptions into the therapy space even if both client and therapist identify as queer. Doing so could damage the therapeutic relationship.

Different lens. A vast number of participants described how their sexual orientation created a unique lens for them for the way that they view their clients and the world around them. One participant commented that she comes from a place of so much privilege, that her sexual identity is her one window into the experiences of those with less privilege. Others described how being a member of a community that does not adhere to societal norms, they have been given the freedom to develop their own constructs. These participants entered the therapeutic relationship with fewer assumptions and a willingness to accept the realities of their clients.

Having unique experiences creates a different lens through which an individual views the world. As queer-identified individuals living in a heterosexual society, it is not uncommon for queer individuals to have a different take on the world. Everywhere they look, queer individuals are exposed to a world that vastly different than theirs. They have had to learn how to navigate this heterosexual world through a queer lens. It is no wonder why a majority of the participants incorporated a postmodern approach into their therapeutic process. In postmodern approaches to therapy, the therapist understands that

different people have different constructs of realty based on their past experiences. Coming from a place of having a vastly different construct of reality, queer-identified C/MFTs are able to see that their clients have their own constructs of the world around them.

This particular finding shows one of the greatest strengths of the queer-identified C/MFT. Regardless of the sexual orientation of their clients, it appears that queer-identified C/MFTs have the ability to allow the space for the client's constructs to be explored. As a profession, we should be encouraging all clinicians to use their strengths in working with clients, and as such, should be encouraging our queer C/MFTs to openly explore how their sexual orientation and the experiences that have accompanied them through their life can have a positive impact on their work with all clients. In order to do this, a space must be created that is safe enough and accepting enough to do this exploration. Again, this can be achieved by an increase in literature, out faculty and supervisors, and by the support of heterosexual peers and colleagues.

AAMFT Relationship with the Queer Community

Every participant was asked about their experiences with the Association for Marriage and Family Therapy (AAMFT), and if those experiences influenced their interpretation of the AAMFT's relationship with the queer community. A handful of participants had little to no experiences with the AAMFT, and as such, did not have an opinion on its handling of queer issues. The remaining participants spoke passionately about their feelings of frustration with their professional organization. This frustration mainly centered around two main issues: the lack of progress being made by the AAMFT

with regards to queer issues, and the AAMFT's acceptance of influence by their religious constituents.

Lack of progress/remaining neutral. Several participants commented on the slow pace of change that the AAMFT is embracing. While they noted that the organization is starting to make some changes with regards to its stances on queer issues, the progress is excruciatingly slow. A few of the participants commented on the organization's stance on conversion therapy, and how the AAMFT was the last mental health professional organization to come out against conversion therapy. One participant highlighted that this did not seem to be enough as the AAMFT did not call for its members to refrain from practicing this harmful approach, but merely suggested that they practice from an evidenced based background. This is troublesome in that it the organization still allows its members to do potential harm to a vulnerable population. Several participants referred to an article published by McGeorge, Carlson, & Toomey (2015) in which they explored the beliefs held by family therapists about conversion therapy. This study found that nearly 20% of the participants found nothing wrong or unethical with practicing conversion therapy, and that 3.5% acknowledged that they had practiced conversion therapy. One participant described an incident where a fellow therapist was convinced that gay therapists should not work with gay clients for fear that it would turn the clients gay, but believed that as a heterosexual therapist, he could turn the clients straight. This highlights the need for the organization to take a stronger stance on issues, and to act on queer issues in a timely manner. The longer the association waits to condone such harmful practices in an outright manner, the more clients are being exposed to harmful practices, which is both unethical and inhumane. The field of

Couple/Marriage and Family therapy is graduating therapists from their training programs that believe that the best approach to working with queer clients is an approach that has been shown to cause significant distress, including suicide. At the time of this writing, there are no professional repercussions distributed from the AAMFT to therapists who practice conversion therapy, even though it has been outlawed for minors in a handful of states due to the harm that it causes. How can queer-identified C/MFTs ever feel comfortable working in this field if the AAMFT is not strong enough to stand up for its queer clients?

A few of the participants acknowledged that the association attempts to remain neutral on controversial topics. One participant characterized it as attempting to remain apolitical. The participant highlighted that this, of course, is in itself taking a stance. By attempting to remain neutral on issues such as *religious freedom laws*, the association is taking a stance that it does not feel it is important enough to come out against discriminatory action for the sake of their queer therapists, or more disturbingly, their queer clients. Other professional mental health associations have embraced the need to be vocal in this political discussion and have issued strongly worded statements coming out against religious freedom laws. The American Counseling Association (ACA) issued a statement in their May newsletter against a *religious freedom* bill in the Tennessee congress. On their website, ACA discusses that such bills that allow mental health professionals to refuse services to clients based on the counselor's religious beliefs is a direct attack on their code of ethics, is detrimental to the mental health of their clients, and is against federal law. They explicitly state that they oppose this bill (ACA, 2016). One has to wonder why the AAMFT is dragging its feet in attempt to remain apolitical,

instead of using its voice to empower its clinicians to stand up for the rights of their clients, as is being done in the ACA.

Influence of religion. Many of the participants commented on the AAMFT's relationship with the religious community. Most of these participants credited the AAMFT's lack of progress and attempts at staying neutral as a way to appease their religious constituents. One participant described how even though the AAMFT Code of Ethics has a non-discrimination clause that includes sexual orientation and gender identity, religious institutions are still allowed to use the codes of their parent institution, which often include statements and practices that queer-identified individuals may find discriminatory. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), which is a separate entity from the AAMFT, requires that its programs strive for diversity and inclusion, and that they must keep with the tenants of the AAMFT Code of Ethics (COAMFTE, 2014). The accreditation standards go on to highlight that not all training programs are housed in similar institutions, and the faith-based institutions can provide education that is congruent with their religious beliefs. For example, if a program is housed in an institution that has widely considered homosexuality a sin on par with that of child molesters and murders, C/MFTs that are trained in such programs can be taught these stigmatizing beliefs and encouraged to base their clinical practices off of them. It appears as if the association is more worried about losing its religious constituents as opposed to its queer constituents, which has tainted the way that the queer community views the professional organization that is supposed to represent their and their clients' best interests.

Limitations of the Study

While this study has laid the foundation for exploring the unique experiences of queer-identified C/MFTs, it is not without its limitations. The homogenous make up the participants could be considered a limitation. Seven of the ten participants identified as Caucasian, and none of the participants identified as male. This lack of male representation did not allow for the study to examine the similarities and differences faced by queer men and queer women. All attempts were made to include males in the study, and a few male-identified individuals responded to the initial survey, but none of them followed through. The gender makeup of the study, however, is fairly representative of the field of Couple/Marriage and Family Therapy. In a recent review of the demographics of COAMFTE Couple/Marriage and Family Therapy programs, the AAMFT (2015) found that female identified individuals outnumbered male identified individuals five to one. (These data did not include the number of individuals who identified as outside of the gender binary). While the lack of diversity may be considered a limitation, the aim of this study was not to generalize to the queer population as a whole, but to develop a rich description of these participants' experiences.

Another limitation of this study is sampling bias. All participants were self-selected to be in this study, which means that they were motivated and may have had an underlying reason for wanting to participate (as one participant highlighted). It is also unclear as to how many queer-identified C/MFTs actually had the ability to opt into the study. Invitations to participate in the study were sent to all of the accredited training programs, but there was no way to follow-up to determine if all of the programs forwarded the invitation to their students and alumni. The participants that opted to

partake in, and completed the study, were all out to some degree. Queer clinicians who have yet to make their sexual orientation known to their colleagues, supervisors, and/or faculty may have refrained from participating in the study due to fear of their sexual identity being revealed and the possible repercussions that may have occurred due to such a disclosure.

Recommendations for Future Research

Due to the scarcity of literature on the experiences and struggles of queer-identified C/MFTs, the recommendations for future research are limitless. I will, however, describe some areas that are deemed highly important and relevant to this study. The biggest struggle that the participants faced was the issue of self-disclosure. A future study could explore the different ways that queer C/MFTs handle self-disclosure of their sexual orientation, their reasons why, and reactions of their clients. This could create a body of literature that other queer-identified C/MFTs could use in making an informed decision about the best away to approach self-disclosure for themselves in training program and clinical practice.

Another area of future research could further explore what role context plays in queer-identified therapists' experiences. Research could specifically target on queer C/MFTs that are located in different geographical locations of the United States, and compare and contrast their experiences to gain a deeper understanding of the role context plays in setting the emotional tone of an experience. Research could also focus on exploring various clinical and academic settings, and how different institutions, such as religious training programs, medical settings, and social service agencies impact the experiences of queer C/MFTS.

Finally, research could explore the clients' perspective of queer-identified C/MFTs. Participants of this study highlighted that their sexual orientation was a strength to their therapeutic practices. The next step would be to investigate if clients agreed with their perception of it as a strength, and to what extent clients, especially queer clients, benefit from having a queer-identified C/MFT.

Clinical Implications

Given the results of this study, there is a clear need for an improvement in clinical training practices, especially with regards to queer issues that are relevant to both queer clinicians and queer clients. Carlson & McGeorge (2012) argue that COAMFTE accredited training programs need to embrace the concept of teaching affirmative therapy practices. This would ensure that a greater number of C/MFTs would be properly trained to work within the queer community, which would better allow the AAMFT to promote much needed services to a vulnerable population.

Another result of this study that could potentially have positive implications on clinical work is the discussion of sexuality and sexual orientation as a strength. This could impact both the therapists and the clients. Teaching therapists to use their identities as a strength can help to create a sense of confidence, as evidenced by the responses of the participants in this study. This could also include therapists using their own experiences as a way to join with, and to create a stronger therapeutic alliance with their clients. Stronger therapeutic relationships have been shown to be a greater indicator or therapeutic outcome than any other factor (Jeffery & Tweed, 2015). If therapists are trained that it is not only acceptable, but could be beneficial to use their own experiences to foster a deeper relationship with the clients, the benefits to the clients could be great.

Feeling isolated and the absence of literature to help answer some of the questions that are prominent to queer-identified C/MFTs can be a source of distress. This study begins to create a base of literature that is specifically geared at starting a conversation regarding some of the most asked questions. By having resources to explore how to best handle certain unique situations for this particular minority group, queer-identified C/MFTs may become more secure in their therapeutic approaches and practices.

This study also highlights the need for integration of queer topics throughout training programs. By integrating not only queer concepts, but other aspects of diverse identities as well, programs can train their clinicians to incorporate intersectionality work into their clinical practices. This may help to strengthen the therapeutic relationship as clients may feel that their therapist is able to work with all aspects of their identity.

Finally, this study outlines how the queer constituents of the AAMFT believe that the organization is failing them. Some offered suggestions for changes, such as incorporating more queer resources into training, research, and conferences. It appears as if the queer community (at least those represented in this study) is eager to share these concerns with their professional organization, in an attempt to strengthen the relationship between the queer community and the AAMFT. This could potentially lead to the organization's ability to attract and retain more queer clinicians and academicians, which in turn could provide much needed and improved services to queer-identified folks. This could help to continue to reduce the stigma attached to identifying as queer both within the field of Couple/Marriage and Family Therapy and the society at large.

Conclusion

In conclusion, the majority of participants had similar responses to the research questions, with only a few outlying responses. Those outliers were found in areas regarding the integration of queer topics throughout training programs and responses to self-disclosure. While different settings and locations created different experiences for the participants, an overall theme of the importance of context was found in all of the interviews. The strongest consensus among the participants was that their sexual orientation was a strength, in some manner, to their therapeutic work.

The results of this study could be beneficial for a number of reasons. The material in this study, especially the advice given by the participants, could be beneficial to queer individuals who are contemplating a career as a C/MFT. Practicing C/MFTs could find strength in knowing that their experiences and struggles may be similar to others, and could help to create a sense of community. Supervisors and faculty members could use the results of this study to gain a better understanding of the needs of this unique population. Finally, the AAFMT could use the results of this study, and others like it, to help them strengthen their relationship with the queer community.

One of the biggest concerns expressed by the participants was the lack of resources provided to them. One of the goals of this study was to help create a base of literature for this population in an attempt to begin a much-needed conversation. By accomplishing this goal, the hope it that other queer-identified C/MFTs will join this conversation, and create an invaluable loud, queer voice so that other queer-identified C/MFTs feel a sense of community and support.

APPENDIX A

Initial Survey

1) Are you currently a student or a graduate of a COAMFTE accredited program?
   a. Yes
   b. No
2) Are you currently or have you previously been a practicing Couple/Marriage and Family Therapist (C/MFT)?
   a. Yes
   b. No
3) With regards to your sexual orientation, how do you self-identify? (For example: gay, straight, lesbian, queer, bisexual, pansexual, etc.)
   a. _____
4) Would you be willing to be contacted to be interviewed as a part of a study exploring the unique experiences of self-identified queer Couple and Family Therapists? This study would consist of one 60-minute interview via Skype with the possibility of a followup interview. If so, please include your email address.
   a. Yes. My email address is_____
   b. No.

5) For more information, questions, concerns, etc., please contact Trae Yeckly at tracie-krum@uiowa.edu.

APPENDIX B

Demographic Questionnaire

Name:_____

Pseudonym:_____

Preferred Pronouns:_____

Age:_____

Sexual Orientation:_____

Gender:_____

Type(s) of Clinical Experience/Setting:_____

_____

Years of Clinical Experience:_____

In what type of educational setting did you receive your clinical training?

(For example: public, private, religious, online, etc.)

_____

Race/Ethnicity:_____

State in which you practice:_____

APPENDIX C

Semi-Structured Interview Questions

1. What is it like being a (insert participants chosen term of sexual orientation) therapist?

2. Can you tell me about a time or an experience in which you felt you were treated differently, or discriminated against within the therapeutic context due to your sexual orientation?

3. Can you tell me about a time or an experience in which you felt your sexual orientation was a strength or helped you with regards to your therapeutic and/or academic work?

4. How do you view AAMFT's relationship with the queer community? Did your education from a COAMFTE accredited program influence this view?

5. What is something you think others should know about your experiences as a (insert participants chosen term of sexual orientation) therapist?

6. Is there anything that I didn't ask that you think should be included in this interview?

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