EXPERIENCES OF MIDDLE-AGED LESBIANS IN THERAPY: A FOCUS ON PERCEIVED SATISFACTION AND PRECURSORS OF RESILIENCE

By

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ABSTRACT

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There is a gap in research focused on satisfaction in therapy as reported by middle-aged lesbians. This study is relevant as middle-aged lesbians are at risk of experiencing further incidents of discrimination based on their sexual orientation compared to their heterosexual counterparts. Middle-aged lesbians are also likely to experience internalized heterosexism, deleterious mental health problems and barriers to mental health services influenced by heterosexism. Thus, it is imperative for family therapists to understand the life experiences of middle-aged lesbians, as well as the factors that lead to their satisfaction in therapy. This qualitative study utilized a descriptive phenomenological methodology to understand the life experiences of a sample of middle-aged lesbians, with a particular emphasis on the components of the therapeutic process that led to their satisfaction in therapy. Data were collected from seven Caucasian lesbian women, ages 40 to 64-years-old. All participants had been in therapy with different therapists for at least three months at the time of recruitment. In-depth interviews explored past experiences of discrimination and heterosexism, their coming out process, the components of therapy that led to their satisfaction with the therapeutic process, and the impact therapy had on participants with regards to increasing their sense of resilience. Implications for clinical practice and research are discussed.

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This dissertation is dedicated to Helen, my Great Aunt Leona, my Grandparents Donibel & Wayne, and Héctor & Elena. Thank you for believing in me and helping me to discover my truth.

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CHAPTER ONE

INTRODUCTION

Important legal protections and societal shifts in the levels of acceptance towards sexual and gender minorities have occurred in the United States within the past twenty years. The Pew Research Center recently reported that 63% of the United States (U.S.) population thinks that same-sex sexual orientation should be accepted by society (2015). This sentiment was reflected in three recent legal protections put in place for lesbian, gay, and bisexual (LGB) populations.[1] First, the Michael Shepard Act was enacted in 2010 to expand the Federal Hate Crimes Law to include crimes committed based on the victim's actual or perceived sexual orientation, gender identity, or disability. In 2010, the U.S. Military repealed the *Don't Ask Don't Tell* policy, which prohibited active LGB armed forces service members from disclosing their sexual minority status. This change in policy was expanded to include transgender service members in 2016. Third, the United States Supreme Court legalized same-sex marriage in 2015.

Despite these important advances, multiple expressions of oppression towards LGB populations continue to be pervasive throughout the US. For example, twenty-eight states do not have laws to protect LGB individuals from discriminatory practices associated with employment, housing, and public accommodation (Movement Advancement Project, 2016). To illustrate, when a same-sex couple gets married, their relationship is legally recognized according to federal legislation but they may not be protected from discrimination from state and local laws. Thus, LGB individuals who live in states without anti-discriminatory laws may be denied services from public accommodations, lose their employment, or be evicted from their rental

[1] *Whereas research focused on the transgender population is scarce, due to the focus of this study, the literature review will be primarily centered on LGB populations.*

homes after coming out once they marry. Failure to enact legislation aimed at prohibiting discrimination based on sexual orientation and gender identity leads to practices at state and local levels that continue to perpetuate oppressive practices, heterosexism, and violence towards LGB populations.

Middle-Aged Lesbians

The steady increase of life expectancy in the United States has led to a reconceptualization of aging (Sanderson & Scherbov, 2013). Women are living longer than past generations and live an average of five years longer than men (Arias, 2014; Sanderson & Scherbov, 2013). Despite these trends, research focused on middle-aged lesbians remains scarce (Fredriksen-Goldsen, Kim, et al., 2014; Jenkins, Edmundson, Averett, & Yoon, 2014). Although a number of studies have focused on middle-aged lesbians ages 40-50-years-old, the majority of these investigations have not included significant numbers of middle-aged lesbians older than 50 years of age (Jenkins, et al., 2014; Lewis, Milletich, Derlega & Padilla, 2014; Newcomb & Mustanski, 2010; Szymanski & Henrichs-Beck, 2014).

Research focused on the mental health needs of middle aged lesbians remains scarce (Serovich, Craft, Toviessi, Gangamma, McDowell, et al., 2008), particularly as it refers to the level of satisfaction in therapy, the therapeutic precursors of satisfaction in therapy, and the characteristics of the therapeutic process that are likely to enhance the individual's expressions of resilience. This investigation will seek to offer a contribution to reduce these gaps in the existing literature.

PURPOSE OF THE STUDY AND RESEARCH QUESTIONS

This investigation was informed by my life experiences as a middle-aged lesbian, the struggles I have experienced in a heterosexist society, and my own sense of resilience. As a

middle-aged lesbian and clinician committed to serving sexual and gender minority populations, I have experienced increasing frustration with the scarcity of resources available for clinicians committed to helping middle-aged lesbians. My hope is that this investigation will offer a contribution towards decreasing this gap in the literature and supporting the efforts of mental health clinicians working with this population.

The purpose of this investigation was threefold. First, to learn about the participants' perceived level of satisfaction in therapy. Second, to identify the precursors of the therapeutic process associated with such level of satisfaction. Finally, to identify the ways in which the participants' experiences in therapy helped to support their expressions of resilience at multiple levels (e.g., individual, relational, etc.). Whereas learning about the participants' coming out process was not a core research question, a brief exploration of these experiences was included in the interviews with participants to inform the data collection process.

Because the primary goal of this study was to provide relevant implications for couple and family therapy practice, a purposive sampling design targeted middle-aged lesbians (ages 40-64) who had been actively engaged in therapy for at least three months and reported moderate to high levels of satisfaction in therapy at the time of the recruitment. Further, this investigation was informed by a descriptive phenomenological approach (Porter, 1998), which seeks to attain a deep understanding of the life experiences of research participants. The following research questions guided the investigation:

1. What were the participants' levels of satisfaction in therapy?
2. Which were the characteristics of the therapeutic process associated with the participants' satisfaction in therapy?

3. What were the participants' expressions of resilience at multiple levels (e.g., individual, relational, etc.)?
4. In which ways did the therapeutic process enhance the participants' expressions of resilience?

It is important to clarify that this study constitutes the initial step of a broader program of research focused on identifying precursors and barriers to promoting satisfaction and resilience in therapy as it refers to middle-aged lesbians. However, due to the scope of the study, the investigation was limited to primarily documenting satisfactory experiences of middle-aged lesbians in therapy. We expect to extend this line of research in future studies by investigating factors associated with barriers to treatment and unsuccessful experiences in therapy.

SIGNIFICANCE OF THE STUDY

This investigation is relevant because there is a gap in the literature focused on the mental health needs of middle-aged lesbians, as well as best practices to address their needs in therapeutic settings. These considerations are discussed in more detail in chapter two. Prior to further elaboration on these issues, a brief reflection on the oppressive nature of heterosexism is warranted based on the focus of this investigation.

Heterosexism

Heterosexism, also referred to as homophobia and homonegativity, has been defined as the assumption that opposite-sex attraction should be the normative sexual orientation (Frost & Meyer, 2009). Heterosexism encompasses direct or indirect expressions of rejection and exclusion towards LGB individuals (Averett, Yoon, & Jenkins, 2013; Frost & Meyer, 2009). Heterosexism has multiple negative effects on the psychological, physical, financial, and spiritual health of sexual minorities (Frost & Meyer, 2009; Henning-Smith, Gonzales, &

Shippee, 2015; Lewis, et al., 2014; Mason, Lewis, Winstead, & Derlega, 2015; Mereish & Poteat, 2015; Mohr, 2015; Schmitt, Branscombe, Postmes, & Garcia, 2014; Szymanski & Henrichs-Beck, 2014). Some of these deleterious consequences include psychological distress (e.g., depression, negative view of self), financial difficulties, physical problems, social distress (e.g., lack of supportive others, relational difficulties), and a variety of co-morbid disorders (e.g., anxiety and drug dependence) (Frost & Meyer, 2009; Henning-Smith, et al., 2015; Lewis, et al., 2014; Mason, et al., 2015; Mereish & Poteat, 2015; Mohr, 2015; Newcomb & Mustanski, 2010; Schmitt, et al., 2014; Szymanski & Henrichs-Beck, 2014).

Internalized heterosexism Internalized heterosexism, internalized homophobia, or internalized homonegativity refer to the process by which LGB individuals incorporate negative views about their own sexual orientation (Frost & Meyer, 2009). The development of this internalizing process is complex, particularly because the experiences of discrimination and prejudice that sexual minorities experience in everyday life increase the possibility that they will feel constrained from discussing or disclosing their sexual orientation to others. The resulting experience of isolation may subsequently lead to a sense of shame or self-rejection (Mason, et al., 2015). At its core, the concept of internalized heterosexism is the acceptance by sexual minorities that same-sex orientation is non-normative and unhealthy, compared to an opposite-sex orientation. Thus, the resulting sense of self-rejection and shame can lead towards self-concealment of same-sex orientation. Self-concealment behaviors have been associated with negative health outcomes including psychological distress, depression, anxiety, somatic symptoms, negative health behaviors, and social isolation (Fredriksen-Goldsen, Kim, Shiu, & Emlet, 2014; Frost & Meyer, 2009; Henning-Smith, et al., 2015; Lewis, et al., 2014; Mason, et

al., 2015; Mereish & Poteat, 2015; Mohr, 2015; Pinel, 1999; Newcomb & Mustanski, 2010; Schmitt, et al., 2014; Szymanski & Henrichs-Beck, 2014).

Mason et al. (2015) examined the ways by which feeling the need to hide one's sexual orientation affects LGB individuals, as well as their interpersonal relationships. These researchers found that higher levels of social constraints in disclosing sexual minority identity were related to higher stigma consciousness—the belief that individuals will be rejected and discriminated against by others. In turn, higher stigma consciousness was associated with an increased sense of internalized heterosexism (Mason et al., 2015). Schmitt et al. (2014) documented the fact that individuals who concealed their identity over long periods of time reported higher levels of anxiety and social isolation. These researchers concluded that when sexual minorities felt free to discuss their identities, their levels of stigma consciousness and internalized heterosexism were likely to decrease with an associated increase in the sense of belonging and social connection (Mason et al., 2015; Pinel, 1999; Schmitt et al., 2014). Thus, social support and connectedness act as buffers against the effects of heterosexism and internalized heterosexism in the lives of sexual minorities (Mason et al., 2015).

GUIDING THEORETICAL FRAMEWORKS

This study was grounded in four theoretical frameworks. The common factors theory refers to the study of "dimensions of the treatment setting that include client, therapist, relationship, expectancy, and treatment variables that are not specific to a particular model" (Sprenkle & Blow, 2004, p. 119). The common factors approach was highly relevant for this investigation as it provided a guide to identify the components of therapy associated with treatment satisfaction and effectiveness that are shared among various treatment approaches

(Frank & Frank, 1993; Laska, Gurman, & Wampold, 2013; Sprenkle & Blow, 2004; Wampold, 2001).

Resilience theory was also a guiding theory as this framework focuses on identifying the individual and contextual characteristics in the lives of individuals associated with their capacity to adapt successfully to challenges that threaten their ability to function and develop (Lehavot, 2012; Masten, 2016, 2001). Ecological Systems Theory (Bronfenbrenner, 1979) assists researchers by providing a comprehensive guide to understanding the participants' life experiences as embedded in multiple systems (e.g., individual, family, societal). Finally, Relational Cultural Theory (Jordan, 2010; Miller & Stiver, 1997) addresses the importance of growth-fostering relationships in the development of individual identity and sense of self.

Common Factors Theory

Common factors theory has been highly influential in the couple and family therapy field (Davis, Lebow, & Sprenkle, 2012; Sprenkle & Blow, 2004). Essentially, this theory refers to those elements and processes of therapy that lead to treatment satisfaction and effectiveness and that are shared among various treatment approaches (Assay & Lambert, 1999; Laska, Gurman, & Wampold, 2013; Sprenkle & Blow, 2004). However, whereas common factors theory has been widely disseminated in the family therapy field, its application in research focused on mental health practice with middle-aged lesbians has been minimal. Addressing this gap in research is of critical importance due to the documented association between common factors and successful treatment outcomes.

Specific components integrate common factors theory. First, successful treatment is closely related to *clients' attributes,* such as personal characteristics, level of motivation, commitment to change, and additional individual resources. Next, *the therapist* is identified as a

critical component in successful therapeutic outcomes (Assay & Lambert, 1999; Frank & Frank, 1993; Sprenkle & Blow, 2004; Wampold, 2015). Despite this intuitive knowledge, empirical research focused on therapists' competency remains limited, particularly as it refers to mental health practice with LGB populations.

The therapeutic relationship is equally important for successful therapy. Even if clients and therapists possess considerable individual strengths and resources, the nature and quality of the therapeutic relationship is essential for promoting therapeutic change. An additional component refers to *expectancy* and credibility of treatment. Empirical studies focused on examining hope among middle-aged lesbians in therapy remain minimal. Finally, *non-specific treatment variables* constitute important common factors such as the therapist's ability to promote changes in the clients' patterns of interactions (i.e., behavioral regulation), facilitating clients' new perspectives on interactional processes and life experiences (i.e., cognitive mastery), and helping clients gain mastery with regards to regulating emotions with self and others (i.e., emotional experiencing). Common factors theory was highly relevant for this investigation based on its strong potential to explain the participants' level of satisfaction in therapy, as well as its potential to identify key precursors of resilience in the lives of participants.

Resilience Theory

Resilience is understood as the individual's capacity to generate resources aimed at overcoming adversity (APA, 2016; Helton & Keller, 2010). The definition of resilience has been expanded to encompass a dynamic concept that incorporates multiple systems (e.g., biological, social, familial, cultural factors), expanding a notion that solely focuses on the individual (Lehavot, 2012; Masten, 2016, 2001).

The study of resilience is particularly important when exploring the life experiences of individuals exposed to oppression and discrimination (Unger, 2003). Although resilience is essential to understanding the life experiences of sexual minorities, a significant gap in research remains with regards to the experiences of resilience associated with middle-aged lesbians (Averett & Jenkins, 2012; Robinson-Wood & Weber, 2016; Pachankis & Goldfried, 2013).

This theory was particularly relevant to this investigation as a guide for exploring expressions of resilience in the lives of participants at multiple levels (e.g., individual, relational, etc.). A focus on resilience was also relevant as the study sought to identify the ways in which the therapeutic process was conducive towards supporting the participants' expressions of resilience. This theory will be presented in more detail in chapter two.

Ecological Systems Theory

Ecological systems theory (Bronfenbrenner, 1979) provides a framework for understanding how people are influenced and interact with multiple systems in their lives. The theory identifies specific sub-systems that are interconnected and that directly or indirectly influence individuals. For middle-aged lesbians, the microsystem refers to individuals and systems that have a direct impact on their lives (e.g., intimate partners, family members, close friends). Mesosystems refer to interactions between microsystems. For example, the effect that friendships have on family relationships. Exosystems refer to indirect influences on women (e.g., how the work environment of one member of a couple influences the other member). Macrosystems refer to the broader societal and cultural factors that have a direct or indirect impact on individuals. For example, state laws that do not prevent discrimination in the workplace related to sexual orientation. Finally, the chronosystem refers to the importance of considering the influence of time when analyzing various subsystems. For instance, as older

lesbians mature, their coping mechanisms and capacity to manage heterosexism is likely to change. This framework was relevant for this study because the therapeutic relationship becomes a critical element of the microsystem in the lives of lesbians engaged in therapy. In addition, the therapeutic experience is expected to become a source of support for women as they interact with multiple systems in their lives.

Relational-Cultural Theory

Relational-cultural theory (RCT) (Jordan, 2010; Miller & Stiver, 1997) highlights the importance of growth-fostering relationships in the development of individual identity and sense of self. Thus, successful development is not solely an individual process, but the result of supportive and growth-fostering relationships. The premises established by RCT also indicate how individuals can effectively cope with discriminatory practices and ideologies. For example, empirical findings indicate that being a member of a supportive community buffers the negative experiences of heterosexism by offering a protective sense of psychological well-being while maintaining the individual's ability to establish healthy relationships with others (Mason, et al., 2015). According to RCT premises, the well-being of individuals is closely determined by the quality of social groups and communities to which they belong. This perspective challenges a deficit-based depiction of groups or individuals that are historically portrayed by some segments of society as inherently flawed (Jordan, 2010; Miller & Stiver, 1997).

This theory was relevant for the current investigation because it highlights the protective factors associated with the identity development of middle-aged lesbian women. It also offers a plausible explanation for barriers to identity development, such as internalized heterosexism. It is expected that the therapeutic relationship will constitute a source of support for women as they engage in growth-fostering relationships aimed at supporting the permanent process of identity

development, particularly when this occurs within contexts that are likely to be characterized by heterosexist expectations and norms. Table 1 presents the research questions, as well as associated guiding theories and research goals.

Table 1: Research Questions, Theories, and Goals

Research Questions	Guiding Theory	Research Goals
What is the participants' level of perceived satisfaction in therapy?	N/A	Aim is to identify the participants' level of satisfaction in therapy.
Which are the characteristics of the therapeutic process associated with the participants' perceived level of satisfaction in therapy?	Common Factors	Aim is to identify the components and processes of the therapeutic process associated with satisfaction in therapy.
What are the participants' expressions of resilience at multiple levels?	Resilience Ecological Systems	Aim is to identify the participants' expressions of resilience as expressed in multiple systems in their lives (e.g., micro- and mesosystems). Aim is to gain insight about relationships in the lives of participants that are conducive towards their expressions of resilience (e.g., relationships in micro- and mesosystems).
In which ways has the therapeutic process enhanced the participants' expressions of resilience?	Common Factors Resilience Ecological Systems Relational Cultural Theory	Aim is to identify the components and processes of the therapeutic process associated with the participants' expressions of resilience at multiple levels (e.g., micro- and mesosystems). Aim is to identify the components and processes of the therapeutic process that are supportive of the participants' expressions of resilience as referred to issues of identity development as middle-aged lesbians.

CHAPTER TWO

LITERATURE REVIEW

In this chapter, complementary literature is presented to expand the phenomena under study. The areas of scholarship addressed below expand the overview of the guiding frameworks.

Lesbians

In this study, lesbians refer to sexual minority women who are romantically or sexually attracted to other women and may identify as lesbian, gay, questioning or unsure, queer or any other non-heterosexual identity (GLAAD, 2016). Population estimates indicate that about 6.6% of women between the ages of 40-64 in the US self-identify as lesbian (Gates, 2014).

Individuals with multiple stigmatized identities of gender identity, gender expression, and sexual orientation are at higher risk for experiencing discrimination and prejudice compared to their heterosexual counterparts (Meyer, 2003; Pinel, 1999). Middle-aged lesbians who are members of multiple stigmatized minority groups (e.g., ethnic minorities and low socioeconomic status) and who have experienced higher incidents of discrimination and heterosexism are likely to experience cumulative life challenges (Frost, Meyer, & Hammack, 2015; Warner, 2008). For example, it has been documented that lesbians exposed to chronic stressors are at risk of experiencing difficulty trusting others, lack of social support, internalized homophobia, negative body image, eating disorders, emotional dysregulation, depression, anxiety, shame, substance abuse, relationship difficulties, maladaptive coping behaviors, and insecure attachments, (Bayer, 2014; Fingerhut, Peplau & Gable, 2010; Lewis et al., 2014; Meyer, 2003; Szymanski & Henrichs-Beck, 2014).

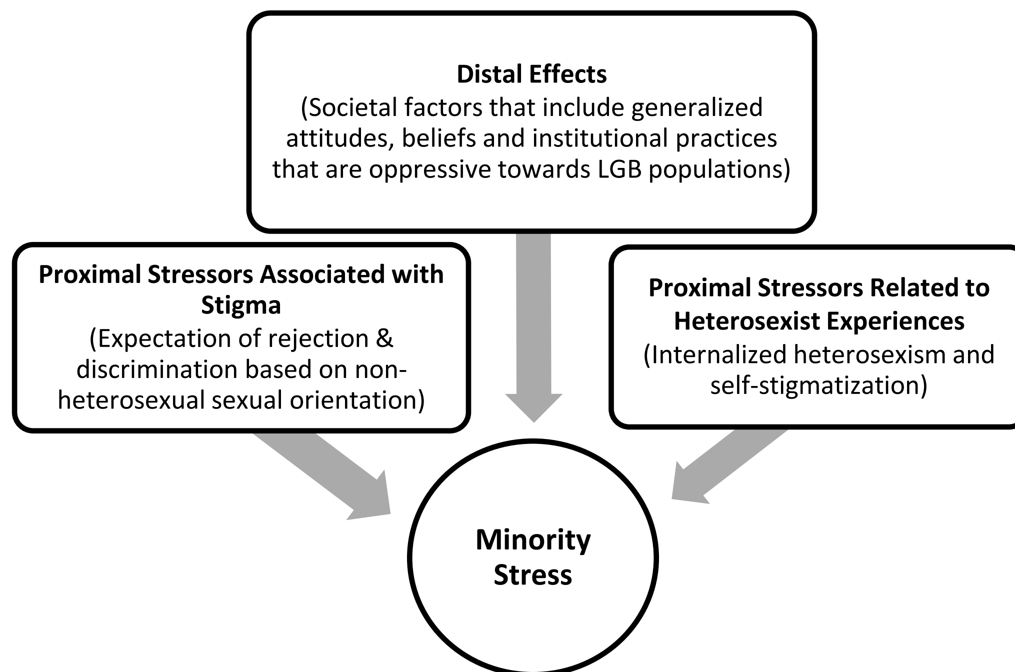
Multicultural-feminist perspectives are useful for understanding the impact of multiple expressions of oppression, particularly because these theories emphasize the role of cumulative

adversity on individuals (Szymanski & Henrichs-Beck, 2014; Warner, 2008). For instance, middle-aged lesbians may experience sexism, ageism, heterosexism, and internalized heterosexism (Szymanski & Henrichs-Beck, 2014). Further, research has documented that middle-aged lesbians who have experienced greater incidents of discrimination have higher levels of internalized heterosexism (Szymanski & Henrichs-Beck, 2014). Lesbians without alternatives to cope with these stressors are at an increased risk for experiencing negative outcomes such as poor physical and mental health, relationship problems, social isolation, and maladaptive coping strategies (Cohen & Byers, 2015; Fingerhut, Peplau, Ghavami, 2005; Lewis et al., 2014).

Heterosexism in the United States

In the US, sexual minorities experience more incidents of discrimination, including physical and sexual assaults, than heterosexual individuals (Hatzenbuehler, 2009). Frost and Meyer (2009) have conceptualized the heterosexism experienced by sexual minorities as a form of chronic minority stress with distal and proximal effects. Distal effects are related to societal factors and include generalized attitudes, beliefs, and institutional practices that are oppressive towards LGB populations. Proximal effects refer to expressions of oppression within the individual and include internalized heterosexism and self-stigmatizing effects, which are particularly detrimental for sexual minorities. Frost and Meyer's model is depicted in Figure 1.

Figure 1: Minority Stress Model (adapted from Frost & Meyer, 2009)



Internalized heterosexism is one of the key precursors of minority stress and a predictor of stress associated with oppressive contexts and discriminatory practices against sexual minorities (Meyer, 2003). This form of oppression can negatively impact the individual's feelings about their sexual identity with deleterious effects such as increased levels of shame, self-rejection, fear, concealment, and rejection of other sexual minority individuals (Bayer, 2014; Henning-Smith, Gonzales, & Shippee, 2015; Frost & Meyer, 2009; Lewis et al., 2014; Rosario, et al., 2006).

Effects of heterosexism on middle-aged lesbians Heterosexism, also referred to as homophobia and homonegativity, encompasses the beliefs and assumptions that heterosexuality is the normative sexual orientation and non-heterosexual orientations are considered defective or unnatural (Frost & Meyer, 2009). The effects of heterosexism and internalized heterosexism on

middle-aged lesbians include significant risks for physical and mental health (Averett & Jenkins, 2012; Meyer, 2003; Robinson-Wood & Weber, 2016; Sagie, 2015). In addition, middle-aged lesbians are at higher risk of chronic substance use disorders than their heterosexual counterparts, as drug abuse and dependence can be used as a coping mechanism to deal with prolonged stressors and discrimination (Hatzenbuehler, 2009; Meyer, 2003).

Internalized Heterosexism in Middle-Aged Lesbians Middle-aged lesbians who have struggled to cope with oppressive contexts over long periods of time are likely to experience the cumulative impact of multiple stressors such as frequent heterosexist incidents, lack of support from sexual minority peers, rejection from family members and friends, lack of connection with the LGB community, social constraints related to discussing sexual minority issues, feelings of shame or negativity about the non-heterosexual orientation, and the need to conceal one's sexual identity from others (Bayer, 2014; Fingerhut, Peplau, & Ghavami, 2005; Frost & Meyer, 2009; Kaysen, Bulesza, Balsam, Rhew, Blayney, et al., 2014; Lehavot, 2012; Lewis et al., 2014; Larson, et al., 2015; Mason, et al., 2015; Rosario, et al., 2006; Schmitt, et al., 2014; Szymanski & Henrichs-Beck, 2014).

For middle-aged lesbians, the effort of concealment over time can impose a particularly deleterious burden (Bayer, 2014; Kaysen, et al., 2014; Larson, et al., 2015; Mason, et al., 2015). Schmitt et al. (2014) documented that chronic efforts to conceal were associated with social isolation and mental health disorders (Bayer, 2014; Kaysen et al., 2014; Larson et al., 2015; Mason et al., 2015). Minority stress has also been documented to be associated with numerous negative social and health effects for middle-aged lesbians (Bayer, 2014; Frost & Meyer, 2009; Lehavot, 2012; Lewis et al., 2014; Rosario, et al., 2006). Empirical studies indicate that middle-aged lesbians are likely to be secretive about their sexual identity, receive less support from both

the heterosexual and the non-heterosexual community, and are more vulnerable to experiencing intense levels of stigma, depression, shame, anxiety and internalized heterosexism (Bayer, 2014; Fingerhut, Peplau, & Ghavami, 2005; Szymanski & Henrichs-Beck, 2014).

Psychological and physical health Numerous studies have documented that middle-aged lesbians face higher risks for psychological problems and psychopathology than their heterosexual counterparts (Bayer, 2014; Fingerhut, Peplau & Gable, 2010; Frost & Meyer, 2009; Henning-Smith, Gonzales, & Shippee, 2015; Lewis et al., 2014; Meyer, 2003; Lewis et al., 2014; Mason et al., 2015; Mereish & Poteat, 2015; Mohr, 2015; Schmitt, Branscombe, Postmes, & Garcia, 2014; Szymanski & Henrichs-Beck, 2014). Middle-aged lesbians are also at high risk for experiencing internalizing psychological symptoms and disorders such as depression, anxiety, low self-esteem, negative beliefs about self and others, psychological distress, suicidality, social isolation, internalized heterosexism, and a negative view of self (Hatzenbuehler, 2009; Kaysen, et al., Szymanski & Owens, 2008). Efforts to conceal one's sexual orientation can increase the negative view of self as a middle-aged lesbian, which can result in hypervigilance and fear that others will discover the stigmatized identity (Henning-Smith, Gonzales, & Shippee, 2015; Pinel,1999). Fears of rejection experienced by middle-aged lesbians are not unfounded. Sexual minorities are twice as likely to experience discrimination and victimization than members of the heterosexual population (Meyer, 2003; Potok, 2011).

Sexual Identity Development

A brief discussion on sexual identity development is warranted as developmental issues and aging represent core issues in this study. Sexual identity development constitutes a key human developmental milestone and the process for non-heterosexual individuals varies for each person as it is significantly influenced by the context in which individuals live. Many of the

current models of sexual identity development for non-heterosexual individuals are predominantly essentialist in nature with an influence of social constructivism theoretical perspectives. Essentialist perspectives highlight the need to understand the essence of a life experience or a specific aspect of human experience (DeLamater & Hyde, 1998). Social constructivism states that our understanding of reality is derived from our interactions with others and the resulting exchanges of meaning. Thus, our understanding of life experiences can be constantly questioned and modified (Berger & Luckmann, 1967).

According to essentialist and social constructivism perspectives, sexual identity development is not a linear process with discrete beginning and end points. Rather, sexual identity is a changing and fluid process that allows for multiple phases and identity perspectives informed by social and cultural interactions (Rosario, Schrimshaw, Hunter, & Braun, 2006). Among the existing sexual identity development models, the stage-based framework proposed by Cass (1979, 1996) has been widely accepted. This model is described below.

Cass model of sexual identity development The sexual identity development model proposed by Cass (1979, 1996) postulates the existence of a pre-stage phase, where individuals usually hold the belief that they should be heterosexual as a result of accepting the social expectation that heterosexuality is the preferred sexual orientation. Thus, same-sex orientation is conceptualized as an undesirable orientation. The next stage of the Cass model is known as *identity confusion*, which refers to an initial awareness of same-sex sexual desires and behaviors, and active questioning of the previously assumed heterosexual orientation. Prominent emotions during this stage may include confusion, self-rejection, and distress.

An individual begins to identify with a non-heterosexual identity during the next stage, known as *identity comparison.* In this phase, individuals notice differences between themselves

and those with a heterosexual orientation. Salient emotions during this stage may involve sadness, fear, loneliness, and apprehension. In the next stage, *identity tolerance*, individuals may acknowledge that a non-heterosexual sexual identity is preferred and efforts to connect with non-heterosexual communities and/or individuals to ameliorate the sense of isolation and loneliness may begin. At the next stage, *identity acceptance,* individuals begin to accept and feel positively about sexual identity rather than just acknowledging it. Key activities at this stage may involve increased contact with non-heterosexual individuals, communities, and activities. Individuals may also disclose their identities to trusted others.

As individuals move to the next stage, *identity pride*, there is an increased need to disclose sexual identities in a celebratory manner. Additional experiences may include increased involvement with the non-heterosexual community and engagement in social activism. In the final stage, *identity synthesis*, the non-heterosexual identity becomes an aspect of the individual's self rather than the main identity (Cass, 1979, 1996). Whereas Cass's model continues to be regarded as a widely accepted sexual identity model, our understanding of the applicability of this and similar models for middle-aged women continues to be scarce, particularly as it refers to how these phases align (or not) in the face of discrimination.

Resilience

Resilience is understood as the individual's capacity to generate resources aimed at overcoming adversity (APA, 2016; Helton & Keller, 2010). The definition of resilience has been expanded as a dynamic concept that incorporates individual and contextual components (e.g., biological, social, familial, cultural factors) (Lehavot, 2012; Masten, 2016).

Masten (2016, 2001) emphasizes that the dynamic nature of resilience across time is highly dependent on the interactions that an individual has with multiple systems. For example, interactions with a therapist who affirms and supports middle-aged lesbian clients can facilitate

growth and resilience whereas connections with religions that embrace deficit-based views of same-sex orientations can be detrimental to resilience. Thus, rather than an individual trait, resilience must be understood as a phenomenon highly dependent on individual resources and systemic influences (Masten, 2016, 2001).

The study of resilience is particularly important when exploring the life experiences of individuals exposed to multiple expressions of oppression (Unger, 2003). Lehavot's (2012) coping model is particularly relevant as this framework proposes that coping strategies vary according to the ways in which they are utilized. For example, problem-focused coping behaviors are action-oriented and seek to improve situations that create stress. These behaviors can include planning a strategy to approach a problem, gather information about alternatives to cope with challenges, and set in motion a series of alternative plans to overcome difficulties. These adaptive coping strategies have been found effective for dealing with chronic stress (Lehavot, 2012). Within the set of coping strategies, emotion-focused strategies are used to manage the emotional distress resulting from challenging situations (Lehavot, 2012). In contrast to non-adaptive coping strategies related to emotions such as denial, active strategies include recognition of distress and the need to engage in emotional regulation and help-seeking behaviors (Lehavot, 2012).

The study of resilience with the population under study is of critical importance as coping strategies of middle-aged lesbians may include both adaptive and maladaptive behaviors (Lehavot, 2012). Some examples of maladaptive coping strategies may include substance use or abuse, gambling, risky sexual practices, concealment of same-gender orientation, avoiding associations with other middle-aged lesbians or the LGB community, and denying one's sexual identity (Lehavot, 2012; Kaysen et al., 2014; Meyer 2003; Szymanski & Owens, 2008).

Research also indicates that when middle-aged lesbians feel less socially constrained to discuss their stressors and difficulties, they tend to embrace behaviors that constitute precursors of resilience such as establishing new supportive social connections or remaining engaged in the LGB community (Bayer, 2014; Larson, et al., 2015; Mason et al., 2015; Schmitt, et al., 2014; Szymanski & Kashubeck-West, 2008). Although resilience is essential to understanding the life experiences of sexual minorities, there remains a significant gap in research with regards to resilience as experienced by middle-age lesbians (Averett & Jenkins, 2012; Robinson-Wood & Weber, 2016; Pachankis & Goldfried, 2013). This investigation sought to offer a contribution to address this gap in knowledge.

Mental Health Research Focused on Middle-Aged Lesbians

Mental health research focused on middle-aged lesbians remains scarce (Johnson, 2012; Pachankis & Goldfried, 2013). A recent search focused on "middle-age lesbians" from 2000-2016 in relevant mental health journals resulted in 81 articles. However, only eight articles were explicitly focused on this population, with the remainder of studies reporting aggregated lesbian samples that did not consider age as a central focus. The lack of emphasis on middle-aged lesbians constitutes a clear gap in research and documented clinical practice.

In the next section, an overview of research on middle-aged women and mental health is presented, followed by a brief summary of the limited available literature on mental health practice with middle-aged lesbians.

Middle-aged women and mental health There is a popular perception that middle-age is characterized by multiple challenges such as the so called "midlife crisis" (Degges-White & Myers, 2006; McQuaide, 1996; Piran, 2016). As it refers to women, some common stereotypes portray middle-aged women as unhappy, frustrated, unattractive, asexual, and menopausal

(Degges-White & Myers, 2006; McQuaide, 1996; Piran, 2016). Research on the lives of middle-aged women has frequently focused on issues related to reproductive aspects such as menopause and the empty nest syndrome (McQuaide, 1996). Whereas such studies provide a better understanding of some life experiences of middle-aged women, they may also reinforce negative stereotypes by inferring that women's lives are only meaningful if they are active in their role as parents (Piran, 2016). In fact, studies have confirmed that when women have meaningful relationships and activities that are separate from their roles as mothers, their levels of distress during midlife decrease compared to women whose identities are primarily connected to their roles as parents (Borzumato-Gainey, Kennedy, McCabe, & Degges-White, 2009; McQuaide, 1996; Siegel & Mathews, 2015).

Research has also confirmed that supportive and satisfying relationships for middle-aged women have an important connection to their levels of life satisfaction, self-concept, and self-esteem (Borzumato-Gainey et al., 2009). In fact, empirical studies indicate that middle-age is experienced by many women as a period of intense productivity, deeper psychological insight, increased self-awareness, and a sense of satisfaction with self-defined gender roles and expectations (Degges-White & Myers, 2006; McQuaide, 1996; Piran, 2016). In contrast, middle age can be a particularly phase in the lives of women if they experience a lack of resources, chronic adversity, and limited social support networks. These women are particularly vulnerable to economic adversity, stressful life events, unemployment, fears of aging and death, substance abuse, and social isolation (Jacobs, 2008; Siegel & Mathews, 2015).

The negative mental health impact for women experiencing contextual adversity and social isolation can be highly detrimental. For example, middle-aged women experiencing anxiety are also at an increased risk for depressive disorders (Kravitz, Schott, Joffe, Cyranowski,

& Bromberger, 2014). In fact, whereas depression rates for women are generally higher than for men, the highest rates of depression for women correspond to those ages 40-59 (Pratt & Brody, 2014). For middle-aged women with a family history of depression, their risk of experiencing clinical levels of depression is increased by 250% compared to their counterparts without such family background (Colvin, Richardson, Cyranowski, Youk, & Bromberger, 2014).

Engagement in mental health services Middle-aged women engage in mental health services more often than men (Ghesquiere, 2013; Vogel, Wester, & Larson, 2007). However, important factors may inhibit their help-seeking behaviors with regards to accessing adequate mental health services (Ghesquiere, 2013; Goncalves, Coelho, & Byrne, 2014). Studies have documented help-seeking barriers such as financial constraints (Ghesquiere, 2013, Kitchen Andren, et al., 2013; Vogel et al., 2007), concerns about adequacy of treatment (Vogel), desire to overcome symptoms without formal treatment (Goncalves et al., 2014; Helton & Keller, 2010; Kitchen Andren, et al., 2013), fear of self-disclosure (Vogel), and stigma (Ghesquiere, 2013; Helton & Keller, 2010; Kitchen Andren, et al., 2013).

With regards to precursors to engaging in mental health services, research indicates that middle-aged women approach treatment options by discussing concerns with people they trust. Additional precursors include addressing their mental health concerns by making lifestyle changes, engaging in new activities, or reading self-help materials (Helton & Keller, 2010; Kitchen Andren, et al., 2013). In rural communities, anonymity is particularly important for middle-aged women seeking mental health services (Helton & Keller, 2010; Kitchen Andren, et al., 2013). It is common for rural middle-aged women to first seek help from their primary care physician or clergy member and follow their recommendations prior to seeking out professional mental health services (Kitchen Andren, et al., 2013).

Efficacious therapeutic approaches for middle-aged women Studies have documented that the most effective approach for middle-aged women experiencing clinical depression and anxiety consists of integrating medication and psychotherapy (Pratt & Brody, 2014; Siegel & Mathews, 2015). Whereas research indicates that middle-aged women are receptive to receiving psychotherapy and pharmacological treatment, studies also indicate women's preference for psychotherapy alone (Kitchen Andren, et al., 2013). With regards to treatment modalities, cognitive behavioral therapy has been shown to be effective for the treatment of anxiety disorders with this population (Siegel & Mathews, 2015). Interpersonal and psychodynamic therapies are also particularly effective when distress is related to issues of changing identities and aging (Siegel & Mathews, 2015). Mindfulness-Based Stress Reduction (MBSR) has shown strong promise for middle-aged women experiencing internalizing problems (Frisvold, Lindquist, & McAlpine, 2012). Additional approaches with positive effects include those focused on the body and movement, such as Neuromuscular Integrative Action (Switzman, Barton & Koehn, 2011) and Developmental Theory of Embodiment (Piran, 2016). Alternative approaches have also been documented to improve mental health, including yoga, physical exercise, art, and expressive writing (Annesi & Westcott, 2005; Cummings, Hayes, Saint & Park, 2014; Kitchen Andren, et al., 2013).

Mental health services for middle-aged lesbians In addition to the inherent stressors of midlife, middle-aged lesbians need to cope with living in contexts characterized by heterosexism and homophobia. In fact, lesbians and gay men are twice as likely than heterosexual women and men to be diagnosed with a mental health disorder (Meyer, 2003). Middle-aged lesbians are also more likely to engage in individual mental health services, rather than couple or family therapy (Burckell & Goldfried, 2006; Johnson, 2012; Pachankis & Goldfried, 2013).

Mental health professionals in several fields, including couple and family therapy, have recognized the urgent need to develop standards of practice informed by a keen understanding of the impact of oppression and discrimination on these populations (Johnson, 2012). Further, there is acknowledgement that the clinical and empirical literature focused on mental health services for middle-aged lesbians remains seriously underdeveloped (McGeorge & Carlson, 2011).

A promising mental health services approach has been proposed by McGeorge and Carlson (2011). In essence, these authors emphasize the need for heterosexual therapists to develop competencies to work with LGB clients by embracing an LGB affirmative approach. According to this approach, they outline three areas that therapists should constantly monitor when engaging in services with LGB clients. The first step consists of active exploration and monitoring of heteronormative assumptions about interpersonal and intimate relationships. That is, therapists must constantly reflect on what they consider "normative" and "healthy" in couple relationships (McGeorge & Carlson, 2011). The second step is to explore heterosexual privileges by acknowledging ways that the therapist benefits from identifying as a heterosexual individual. Thus, therapists are encouraged to reflect on questions such as "In which ways has my involvement in heterosexual relationships been encouraged, rewarded, acknowledged, and supported by my family, friends, and the larger society?" and "Have I ever feared that I could be harmed based solely on my heterosexuality?" (McGeorge & Carlson, 2011, p. 19). The final step is for therapists to explore the development of their own heterosexual identity. For example, therapists are encouraged to engage in critical thinking about their sexual identity development by answering questions such as "How do I describe my sexual identity? How do I explain that I came to self-identify as heterosexual?" (McGeorge & Carlson, 2011, p. 20).

The aforementioned model can facilitate a process of critical self-examination for heterosexual therapists when becoming LGB affirmative therapists (Burckell & Goldfried, 2006; Shelton & Delgado-Romero, 2011). In fact, LGB clients have indicated that important characteristics associated with their willingness to engage in therapy refer to the need for therapists to have explored their own feelings, beliefs and biases associated with non-heterosexual orientations (Brooks, Inman, Klinger, Malouf & Kaduvettoor, 2010; Shelton & Delgado-Romero, 2011). Additional therapists' qualities that facilitate therapeutic engagement of LGB clients refer to therapists having some experience working with LGB clients, conveying an understanding of what LGB clients are likely to experience in homophobic contexts, and providing a safe space for LGB clients to explore their sexuality and relationships without judgment (Burckell & Goldfried, 2006).

In contrast, characteristics that detract LGB clients from engaging in therapy refer to therapists' discomfort with LGB clients, lack of awareness about LGB issues, the use of heterocentric language, and an overemphasis on sexual identity over other identities (Burckell & Goldfried, 2006). In fact, some studies have documented that therapists who have not engaged in self-reflection of values, beliefs, and assumptions about LGB clients may inadvertently engage in microaggressions or the "communication of prejudice and discrimination expressed through seemingly meaningless and harmless tactics" (Shelton & Delgado-Romero, 2011, p. 210). Whereas there is increasing recognition of the high need to develop lines of research focused on improving mental health practices with middle-aged lesbians, the existing empirical studies on this topic remain scarce. Thus, the current study seeks to offer a contribution towards addressing this gap in knowledge and research.

Clinical Practice and Research in the CFT Field Focused on LGB Populations and Middle-Aged Lesbians

Research and practice in the CFT field focused on LGB populations have considerably expanded in the last decade (Addison & Coolhart, 2015; Hartwell, Serovich, Grafsky, & Kerr, 2012; Lebow, 2015). A recent search of refereed articles in family therapy journals focused on LGB issues for the years 2000-2016 resulted in 403 publications. These articles addressed a variety of topics relevant to practice and research with LGB populations such as training and supervision (Edwards, Robertson, Smith & O'Brien, 2014; McGeorge, Carlson, & Toomey, 2015b; McGeorge & Carlson, 2016), gay affirmative therapy (Pachankis & Goldfried, 2013), relationship satisfaction (Belous & Wampler, 2016; Knoble & Linville, 2012) criticisms of conversion therapy approaches (Flentje, Heck & Cochran, 2013; McGeorge, Carlson & Toomey, 2015a; Serovich et al., 2008; Walker, 2013), resilience (Kwon, 2013), and best clinical practices for heterosexual therapists working with LGB populations (Bernstein, 2000; McGeorge & Carlson, 2011; Walker, 2013).

Clinical practice It is likely that the majority of CFTs will work with LGB individuals and families at some point in their clinical career. Therefore, there is a high need for high quality empirical research to inform clinical practice, as well as clear ethical standards supportive of LGB rights (Green, Murphy, Blumer, & Palmanteer, 2009). In general, the mental health field has challenged discriminatory and iatrogenic approaches such as conversion therapy, originally based on the belief that same-sex orientation can be "repaired or cured" through conversion or reorientation therapy (Serovich et al., 2008). To date, major mental health professional organizations have openly challenged these approaches as harmful and unethical. Examples of professions embracing this stance are the American Counseling Association, the AAMFT, the

American Medical Association, the National Association of Social Workers, and the American Psychological Association (AAMFT, 2009; Anton, 2010; Davie, Genel, Howe, Karlan, Kennedy, et al., 1996; Human Rights Campaign, 2015; Whitman, Glosoff, Kocet, & Tarvyda, 2013).

However, whereas the American Association for Marriage and Family Therapy (AAMFT) has required compliance with ethical standards for CFTs working with LGB populations (AAMFT, 2015), empirical and objective data describing the level of competence of family therapists working with LGB populations remains inconclusive. For example, a survey of 526 AAMFT clinical members conducted in 1996 found that almost half of the respondents reported that they did not consider themselves competent to work with clients who self-identified as lesbian or gay (Doherty & Simmons). Whereas most recent reports indicate therapists' increased sense of competence in clinical work with LGB clients (Green et al., 2009), rigorous studies documenting the quality of clinical practice from the perspective of LGB clients remain limited (Green et al.).

Therapists who feel supported by their supervisors and are encouraged to develop awareness of their personal biases towards LGB individuals will be better prepared to provide higher quality services to these populations (Cowie & Rivers, 2000; Eubanks-Carter, Burkell, & Goldfried, 2005). As Eubanks-Carter et al. (2005) have stated, "our LGB clients are not only gay, lesbian and bisexual men and women; they are members of families, professions, and communities. Our goal is to affirm not only their sexual orientation, but their entire identity" (p. 9). Unfortunately, research aimed at informing clinical practice with middle-aged lesbians in the CFT field remains underdeveloped (Serovich et al., 2008).

CHAPTER THREE

METHODS AND PROCEDURES

The purpose of this investigation was threefold. First, to learn about the participants' perceived level of satisfaction in therapy. Second, to identify the precursors of the therapeutic process associated with such level of satisfaction. Finally, to identify the ways in which the participants' experiences in therapy helped to support their expressions of resilience at multiple levels (e.g., individual, relational, etc.). Whereas learning about the participants' coming out process was not a core research question, a brief exploration of these experiences was included in the interviews with participants to inform the data collection process.

Because a key goal of this study was to provide relevant implications for couple and family therapy practice, a purposeful sampling approach was implemented. Specifically, I recruited middle-aged lesbian women (ages 40-64) who were actively engaged in therapy for at least three months, and who had reported moderate to high levels of satisfaction in therapy at the time of the screening.

This investigation was informed by a descriptive phenomenological approach (Porter, 1998), as this methodology assists researchers seeking to reach a deep understanding of the life experiences of research participants. This study involved two face-to-face in-depth exploratory interviews with seven middle-aged lesbians. After the initial face-to-face in-depth interview, the content was examined by the investigator to identify relevant emerging themes. These data helped to inform subsequent interviews, with the third interview having a specific focus on participants reviewing the accuracy of final selected themes. This investigation followed the tenets of the phenomenological tradition described by Husserl (1962, 1970) by implementing methodological procedures as proposed by Porter (1994, 1995, 1998).

A Descriptive Phenomenological Approach

Qualitative studies have significantly expanded the understanding of the impact of heterosexism on the lives of sexual minorities in the contexts of discrimination (Platt & Lenzen, 2013), gay identity development (Paul & Frieden, 2008), and religion (Barton, 2010). However, empirical data focused on how heterosexism impacts middle-aged women continues to be scarce (Averett & Jenkins, 2012). Further, empirical literature describing the most effective alternatives for therapists to support middle-aged lesbian clients as they cope with oppression remains limited (Green et al., 2009; Hash & Rogers, 2013; Johnson, 2012; Johnson & Fluty, 2016; Pachankis & Goldfried, 2013). The current investigation sought to offer a relevant contribution to the field by using a phenomenological approach focused on providing detailed descriptions by the research participants as it refers to their satisfaction in therapy, the factors that led to this level of satisfaction, and how therapy enhance their sense of resilience.

Patton (2002) emphasized that researchers using the phenomenological approach should prioritize participants' reflections through in-depth interviews with the goal of identifying a critical life experience and focus on "how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others" (p. 104). Thus, the interviews conducted in this study sought to facilitate an in-depth reflection by participants related to: (a) their level of satisfaction in therapy, (b) precursors to such level of satisfaction, and (c) the ways in which the therapeutic process enhanced the participants' sense of resilience.

To reach this goal, the first wave of interviews initiated with a series of grand tour questions asked to participants, with probes on selected sub-themes as well as participant's feedback. The flow and structure of the second interviews were determined according to each participant's individual responses provided in the first interview. In the phenomenological

approach, an in-depth understanding of the participants' life experiences is the priority, rather than attempting to obtain data aimed at reaching generalizability of findings to the larger population (Patton, 2002; Porter 1998; Unger, 2003).

Bracketing Bracketing is an important component of phenomenological research and refers to identifying the ways in which the researcher engages in the process of investigation, as well as to monitoring personal biases that may impact the research process. It is expected that this process of self-examination and introspection will allow researchers to purposefully monitor their biases through the course of the investigation (Marshall & Rossman, 2011). As a middle-aged lesbian, several of the themes reported by the participants of the study resonated with my life experiences. Thus, in close consultation with my dissertation director, I engaged in a permanent process of reflexivity aimed at identifying my reactions and biases related to the subject matter.

Sites

Participants were recruited through two mental health practices in Michigan, with a specific focus on serving the LGB populations. Clinicians affiliated with these practices agreed to refer participants who met the selection criteria for this study. These practices provide individual, group, family, and couple therapy to the surrounding communities. Three referrals from one mental health practice completed all the interviews within six weeks of initial contact. Four participants from another mental health practice completed all three interviews within four weeks of initial contact.

Participants

A key characteristic of phenomenological studies refers to clearly defining the phenomenon under study and ensuring that participants share common life experiences (Porter,

1998). With regards to inclusionary criteria, all participants met the following requirements: (a) self-identified as lesbian, (b) between the ages of 40 and 64 years old, (c) spoke English as primary language, (d) provided consent to participate, (e) were actively engaged in mental health services for at least three months prior to recruitment, and (f) reported moderate to high levels of satisfaction in therapy. Exclusion criteria consisted of: (a) engaged in mental health services due to severe mental health disorders (e.g., psychosis), (b) mandated to engage in mental health services due to court proceedings, (c) engaged in mental health services for less than three months, and (d) reported low levels of satisfaction in therapy (or lack thereof).

Due to the nature of descriptive phenomenological studies, low sample sizes are highly recommended in order to ensure depth of description of the participants' life experiences (Porter, 1998). All participants were compensated with a $30 gift card for each of the first two interviews. This investigation followed all regulations and recommendations required by the Michigan State University Institutional Review Board.

Procedures

Recruitment and data collection Due to the nature of this study, the main recruitment strategy consisted of direct referrals by clinicians serving LGB populations in clinical settings. Upon receiving names and contact information of potential participants from mental health practitioners, the principal investigator conducted a brief screening interview by phone to ensure eligibility criteria. Once inclusion criteria were confirmed, the principal investigator arranged logistics with each participant and conducted the interviews at the location of their choice. Participants were offered the choice to be interviewed at their home, at the principal investigator's office, at one of the participating sites, or at a public location. The majority of the interviews were completed at the participants' homes and the rest at my clinic office or at public

cafes. The confidentiality of all participants was protected by following all regulations and recommendations established by Michigan State University's IRB. Participants' names were replaced with pseudonyms.

The participants' demographic information is presented in Table 2 and Table 3 provides an overview of each participant. All seven participants had been or were engaged in individual therapy at the time of recruitment. The participants sought therapy for major depressive, anxiety, posttraumatic stress, and panic disorders; some participants were living with more than one mental health disorder. Information about the therapeutic characteristics are presented in Table 4. At the first interview, the principal investigator initiated the interview by explaining the purpose of the study to each participant, explaining the consent process, and obtaining signed consent. After signing consent, participants were paid a compensation and received a copy of the signed consent form. Next, participants completed a short demographic questionnaire and the interviews started after obtaining approval from participants to be audio recorded. Participants were assured that they were not obligated to answer any questions they did not feel comfortable responding. Participants were also assured that they could stop the interview at any moment without fear of repercussions. A sample of the consent form is included in Appendix A.

Table 2: Participant Characteristics

100% Euro-American Middle-Aged Lesbians (n = 7)			
Age	43-64 years	M=57.3 years	
Education	High School: 1	College: 3	Graduate: 3
Income	$12,000-71,000	M=$33,771	
Employment	Full Time: 3	Retired: 1	SSD: 3
Relationship Status	Single: 2	Committed: 3	Separated: 2
Living	Alone: 3	Partner: 2	Family: 2
Previously Married to Man	6	M=20 years	
Children	No: 3	Yes: 4	
Time Out	3-10 years: 2	11-30 years: 3	>30 years: 2

Table 3: Individual Participant Information

Domain	**Beth**	**Sue**	**Melanie**	**Britt**	**Robin**	**Jo**	**Sharon**
Age	60	61	43	64	59	55	59
Annual Income	32K	71K	33K	12K	12K	55K	25K
Education	MA	MS	MA	MA	HS	BS	BN
Previous Marriage to Man	31 yrs	31 yrs	14 yrs	23 yrs	17 yrs	N/A	3 yrs
Living w/	Self	Wife	Family	Wife	Self	Self	Family
Employed	Disabled	FT	FT	Retired	Disabled	FT	Disabled
Years Out	3	5	12	22	27	37	42
Length of Therapy	>10 yrs	3 mo	>5 yrs	6 mo	3 yrs	3 mo	4 yrs
Therapy Satisfaction Level	High	High	High	Moderate	Moderate	Moderate	High

Table 4: Characteristics of Therapy

Reasons for Therapy	# of Participants	Length of Therapy	# of Participants	Level of Satisfaction	# of Participants
Depression	5	<1 year	3	High	4
Co-Occurring Disorders	5	1-4 years	2	Moderate	3
Coming Out	4	5-9 years	1		
Trauma	3	>10 years	1		
Anxiety	3				
End of Relationship	2				

Interviews. The initial interview began by building rapport and providing an overview of the study and research implications for enhancing clinical practice. To promote rapport, participants were asked to describe their experience of coming out. Next, women were asked to reflect on their level of satisfaction in therapy and the factors associated with such level of satisfaction. Participants were also asked to reflect on expressions of resilience in their lives with regards to being a middle-aged lesbian. The ecological framework was used to explore expressions of resilience at multiple levels. Finally, participants reflected on the ways in which the therapeutic experience had contributed towards their expressions of resilience.

According to the descriptive phenomenological approach (Porter, 1998), initial interviews were analyzed for relevant themes and subsequent interviews were designed to expand on details addressed by participants in the initial interviews. According to Porter (1998), second interviews allow participants to reflect on the feedback provided in the initial interviews and confirm, revise, or disconfirm their initial narratives. Finally, third interviews were conducted after themes of the second round of interviews were identified, with the goal of identifying final themes that best described the life experiences of participants (Porter, 1998).

The researcher engaged in careful journaling to track her reactions and emerging biases during the data collection and preliminary analytical process (Patton, 2002; Porter 1998). Each participant was offered a guide for community resources during the initial interview. The electronic files of audio recordings, demographic information forms, interview guides, notes, and memos were kept in a password-protected computer of the principal investigator. Paper copies of consent forms and demographic information of participants were kept in a locked cabinet in a research laboratory at MSU with restricted access.

Data Analysis

Each interview was transcribed verbatim and coded using the NVivo 11 Pro qualitative software analysis by QSR International (Bazeley & Richards, 2000). The principal investigator conducted a broad identification of themes to prepare the second interview and the final member checking interview. Detailed idea-by-idea coding in NVivo software was conducted after all 18 interviews were complete. Each individual idea was the unit of analysis in this study and was categorized as either irrelevant data, life-world data, or lived experience data (Porter, 1994, 1998). Information not directly related to the scope of this study was considered irrelevant data and was not be included in analyses.

Life-world data. Life-world data refers to life experiences occurring in the participants' context for which they do not have direct control over (Porter, 1998). For example, being discriminated against (Porter, 1995) constitutes an experience that occurs to individuals and are dependent on actions from people in their environment. According to Porter (1995), *elements* are the most basic units of analysis of life-world context. For example, a statement by a participant indicating "my father always rejected my sexual orientation" represents a clear example of life-world data. Common elements were clustered into *descriptors*. Common

descriptors were categorized as *life-world features,* which represent the broadest level of life-world data.

Lived-Experience Data*.* Lived-experience data refers to narratives describing "the way that the informant makes sense of his [her] experiences" (Bordere, 2003, p. 27). Porter (1994) suggests analyzing experience by grouping data into three levels. *Intentions* represent the most basic unit of lived experience data and indicate the participants' responses to specific life experiences. For example, "I sought support from my friends when my parents criticized me for my sexual orientation," illustrates a participant's specific intention to act in the face of family rejection. Once initial intentions are identified, similar intentions are grouped into *component phenomena*, with *phenomenon of the lived experience* being categorized as the broadest category of lived-experience data.

Filling out

Filling out refers to the process of reintegrating bracketed material into the analytical process (Porter, 1998). This process is completed by maintaining a dialogue with colleagues, particularly as emerging findings are identified in an effort to identify biases in the categorization of data (Sharp, 2003). In addition, I maintained a journal to track my reactions to the research process and engaged in several conversations with my dissertation director to discuss all emerging themes in the investigation.

Trustworthiness of the Data

Trustworthiness of the data in qualitative research refers to demonstrating that findings are credible, transferable, dependable, and confirmable (Lincoln & Guba, 1985; Morrow, 2005). If data accurately describes the essence of the phenomena under study, findings can be

considered credible (Baker et al., 1992; Lincoln & Guba, 1985). By implementing multiple interviews with participants, the credibility of data in this study was enhanced (Porter, 1994).

Transferability requires researchers to achieve a "degree of similarity between sending and receiving contexts" (Lincoln & Guba, 1985, p. 316). I used journaling to write detailed descriptions of the contexts in which meanings were created by participants, as well as to track my personal reactions and experiences throughout all research activities.

Finally, dependability and confirmability are interrelated concepts and refer to the assurance that research findings are reasonable and a result of implementing adequate methodology. To this end, I shared copies of the transcribed interviews and coded transcripts with my dissertation director to enhance the rigor of the study. In addition, I kept an audit trail (Rodgers & Cowles, 1993) with methodological and analytical notes throughout the investigation.

CHAPTER IV

RESULTS

Seven middle-aged women self-identified as lesbian discussed their experiences in therapy and characteristics of this process that led to their satisfaction in therapy. Women also described how therapy helped them increase their sense of resilience. These conversations were informed by a rapport building section of the interview in which women described their coming out experiences. All participants confirmed that it was helpful to have time between interviews to reflect about challenging topics, as well as having an opportunity to expand on their narratives. For one participant, this approach was especially helpful and gave her the opportunity to request that a ten-minute segment of her second interview be omitted because she felt too vulnerable with the content. This portion of the interview was deleted from the transcript and not used in the data analysis.

Second and third interviews were structured around the emerging themes that were identified in the initial interviews. This facilitated a process in which participants were active in reviewing for accuracy the initial analysis conducted by the principal investigator. By following this methodology, fidelity to the descriptive phenomenological approach (Porter, 1998) was maintained throughout the collection and analysis of the data concerning the participants' lived experiences and the contexts in which they occurred. Whereas an interview guide was used in the first interview, the participants' narratives were used to guide subsequent interviews.

The analysis of the data began with the identification of individual ideas categorized as irrelevant, life-world, or lived-experience data. Data identified as irrelevant were not included in the data analysis. Life-world data resulted in 171 original elements, which were categorized into descriptors and six life-world features. The final selected features of the life-world context were:

(a) *experiencing heterosexism and discrimination*, (b) *experiencing changing social views about LGB populations*, (c) *recognizing how trauma affected me* (d) *therapy makes me feel stronger*, (e) *feeling understood by my therapist*, and (f) *feeling fearful*.

Analysis of lived experience data generated 384 intentions, which were categorized in five final phenomena: (a) *coming out*, (b) *embracing therapy to deal with adversity*, (c) *taking action in therapy*, (d) *reaching out thanks to therapy*, and (e) *becoming a political activist.* Appendices D and E present the outlines for the life-world and lived-experience data.

Life-World Context

Porter (1995) describes the life-world context as the social environment in which a person's experiences are embedded. The participants in this study were situated in diverse life-world contexts in which they reported a range of experiences of feeling supported, isolated, and rejected by others. They described how their experiences with their families of origin, partners, colleagues and friends had positive and negative impacts on their sexual identity development. All participants reported experiencing heterosexism at some point in their lives. Within a continuum of experiences, participants elaborated on experiencing discrimination and harassment, with negative impacts at a personal level such as internalized heterosexism and a permanent sense of stigma.

Participants also reflected about the changes they have witnessed with the passage of time in the United States pertaining to societal acceptance of LGB populations. The participants who had been out longer identified these changes more readily than those who had been out for shorter periods. While discussing the gradual acceptance of LGB individuals, some participants expressed the wish to provide a positive representation of lesbians and to serve as mentors for LGB youth who are coming out. This desire was particularly prevalent in participants who had

been out longer than twenty years. Participants who had been out less than ten years reported being most affected by experiences of heterosexism and discrimination than women who had been out longer. These participants also expressed higher levels of stress associated with their sexual orientation than women who had been out longer than ten years.

An area that participants discussed in depth referred to how trauma has affected their self-concepts as individuals, women, and lesbians. Some participants described the experiences of trauma without using the term "trauma" and others used the term quite comfortably. What was evident from the interviews was that the experiences of trauma inhibited participants from not only exploring their sexual identity development as lesbians but also from exploring their identity as women. The impact that trauma has had on their ability to trust, regulate their emotions, and seek support from others was clear in the way they described the details of positive and negative experiences with partners, friends, family members, and their therapists.

With regards to their experiences in therapy, emotional safety was central to the development of trust with their therapist and resulting satisfaction in therapy. The participants also identified components of therapeutic process that led to their satisfaction in therapy and increased their sense of resilience. Women also reflected on the therapeutic techniques and approaches that were helpful to them and the therapists' characteristics that facilitated or inhibited positive outcomes. Throughout the interviews, participants talked about their daily life struggles and their ability to overcome adversity with the support of others. All women reflected on key precursors for their sense of resilience and spoke with pride about their accomplishments in their personal relationships, careers, therapy, and in their process of growth as middle-aged lesbians.

Some participants mentioned that even though it was useful to have a therapist with whom they could process their experience, limiting therapy to generating insights of their experiences was not enough to help them cope with daily challenges. Thus, being able to develop clear goals, plans for treatment, and monitor progress were essential to enhance the impact of therapy. In addition, knowing that their therapists were accessible between sessions was of critical importance to many participants as they could rely on them during crises.

The participants also emphasized their fears about the current presidential administration. These fears were expressed as disbelief, anger, or a resolute commitment to embrace political advocacy. Most participants spoke about their fear that the current administration could rescind federal protections for the LGB community and the need for continued vigilance and advocacy for maintaining these legal protections.

Next, the following life-world features will be described: (a) *experiencing heterosexism and discrimination*, (b) *experiencing changing social views about LGB populations,* (c) *recognizing how trauma affected me*, (d) *therapy makes me feel stronger*, (e) *feeling understood by my therapist,* and (f) *feeling fearful*.

Experiencing Heterosexism and Discrimination

The participants in this study differed with regards to how they reported their experiences of heterosexism and discrimination. For example, Sharon has been out for 42 years, Jo for 37, and Robin for 27 years. These women provided minimal reports on discrimination. Sharon did not speak about difficulties related to internalized heterosexism and Jo mentioned it once. Robin talked about how internalized heterosexism was not an issue for her but that early childhood sexual trauma had inhibited her sexual identity development. The remaining four participants spoke about their experiences with heterosexism and discrimination throughout their lives in

very descriptive and frequently in emotionally moving ways. The range of experiences associated with heterosexism and discrimination varied from becoming aware of internalized heterosexism to witnessing how others were oppressed by heterosexist behaviors.

Understanding how internalized heterosexism affects me**.** Participants described how they were aware early in their lives that internalized heterosexism had affected how free they felt to explore their sexuality. However, women were less clear about how they came to embrace heterosexist expectations and values. Beth, age 60 and out for three years, spoke about her awareness of internalized heterosexism as she explored her sexuality as a teenager:

> I don't remember anybody telling me it was wrong to be a lesbian or gay or whatever...It must just be ingrained in you or something because I felt guilty! I felt really guilty for having my first sexual experience be with a girl. I felt a lot of shame about that.

Melanie, 43 years old, and out for about ten years, described her experience in high school:

> I've had crushes (on females) since I was a kid. I didn't know anybody like that but there were others who got beat up for that. Seeing kids getting beat up in high school for those kinds of things (same-sex attraction)I think really shut me down.

Sue is 61 years old and has been out for five years. She had been a military service member for more than 30 years and talked about how her own exploration of her sexual identity was affected early in her career by witnessing discrimination against a fellow military service member:

> One of the first people I met in the military was someone who was booted out for being gay. It was during the witch-hunt days. So, the message was very loud and clear: Don't

> think about it. Don't do anything. Don't go down that road (makes eye contact with interviewer and shakes head slightly).

Heterosexist expectations and beliefs affected participants in oppressive ways. Britt, 64 years old and out for 22 years, was especially illustrative in describing how she experienced this pressure:

> And it was all inside--all my anxiety about who I was supposed to be in the world…and all of the pressure I felt in order to conform to all of these roles that were imposed upon me…I felt like all of the things that I had been pretending to be in order to fit in and to be the good daughter and the good wife and the good mother and the good sister...all those things were indoctrinated onto me throughout my childhood and my youth…I just always felt everything inside right here (touches sternum area)…like this unbearable pressure!

Jo, 55 years old and out for 37 years, made two statements about her experiences with internalized heterosexism that were qualitatively different than the other participants' statements. She mentioned overhearing her parents talk about her sexual orientation when she was young:

> When I was 15, I overheard my parents say something about me as a homosexual but I just put that word away. I don't think I allowed it to apply to me. I think I knew I was gay before school, you know, probably at 4 or 5 years old. But I didn't have language for it. It wasn't about acceptance or denial.

Being impacted by heterosexism and discrimination**.** All participants talked about the effects they experienced from witnessing and experiencing discrimination resulting from heterosexism. Jo described hearing about others being bullied and harassed for being gay from her childhood to the present, "I heard that regularly growing up…'gay, dyke, faggot', all the

negative cuss words and slurs that people got and are still getting." Sharon spoke about how her strong sense of self was impacted by heterosexism:

> Everybody who comes out has [experienced discrimination or heterosexism] at some point. But it's been mostly manageable. I was seventeen and the president of my church's youth group, I was very active. Then I came out and the church had a special election and elected a new president because I was a lesbian. Later, my brother-in-law said all I needed was a good f*** (sexual act with a man). But I had a strong sense of myself ever since I was young that shielded me from those things.

Family members who used derogatory terms about lesbians seemed to create the most distress for participants. Britt spoke of her experiences of harassment by her relatives:

> My sister would tell me, 'Poor persecuted dyke, I feel so sorry for you. You're persecuted because you're a lesbian.' She told me I was a pervert and some of my nephews were very nasty and called me a 'fucking dyke' and, you know, they were very nasty people.

Beth also spoke of a painful experience of heterosexism and vandalism from a previous close friend that happened after she came out three years ago:

> My friend doesn't want her children to see me since I came out. I was like a grandma to them. It's crushing me…(cries). She and her boyfriend vandalized my house three times. The first time they put words like 'faggot' all over my house, the second time there more anti-gay words on my windows. And the third time, they took a knife and went right through some canvasses I had painted for the local LGB art gallery.

Beth's experiences with heterosexism from previous friends and her church were intense and left her feeling lost as a result of being rejected by her church:

Sometimes I don't know where I belong…(cries). I think a lot of what this feeling has to do with my church right now. I've been in the church all my life. And they don't want me there … I love God and I think my faith's stronger because I have to hold onto it.

Whereas these experiences had negative effects on the lives of these participants, some participants talked about how these experiences also increased their resilience to manage further oppression. In thinking of the pain that they experienced, they talked about how important it has been for them to contribute towards a more accepting society where their younger counterparts might have an easier time than they did. Some of these goals may be related to the developmental milestone of wanting to contribute to the next generation, however, what has influenced this motivation for these participants are their own experiences with heterosexism and discrimination.

Experiencing Changing Social Views About LGB Populations

Experiencing a more supportive society**.** Participants spoke about how the societal acceptance towards LGB individuals has changed during their lifetimes. Jo, who came out in late adolescence, compared the attitudes towards therapy when she was a teenager in 1976 to today's attitude:

> I was born in '61 and by the time I was 15 and struggling--I mean…I don't think it was commonplace for middle-class working family kids to go to therapy. I'm very, very, thrilled to see how kids have it easier in certain respects…that it's not a word they're afraid to say out loud--being gay or lesbian, you know? The prospect of coming out now, I don't know if it's any easier but I think it's more visible so that has to make it better.

Melanie described how the church she attends has begun to incorporate diversity education events focused on LGB awareness:

> Two summers ago, one of the Sunday school leaders who was very progressive did an LGB awareness event. That was really helpful. I felt much more a part of the church. I felt like I had allies…I felt more comfortable with that. Feeling that I was accepted by the church, I think, made me feel more positive about being a lesbian. I started going to church every Sunday. I was a little bit more involved.

Sue spoke about the passage of the national marriage equality act as a sign of societal acceptance of the LGB population:

> My partner, a lifelong lesbian, didn't think she'd ever be able to get married. So, when they passed marriage equality, not the brief time they did, but when the supreme court ruled in June, she was in tears. She said, 'For the first time in my life I feel like, you know, a full-fledged citizen in the United States.' That was a pretty powerful day.

Feeling like a mentor for the younger generation. Some participants expressed how important it was for them to act as a mentor for younger LGB generations. Sharon talked about how she came to realize that her daughter, who had come out as a teenager, viewed her as a mentor for her role as a lesbian mother:

> I took my daughter to protests and demonstrations, and to the lesbian and gay March on Washington in '83. She was a toddler, little enough to carry on my shoulders. When she says, 'I want to be the same kind of mother you were' it's hard for me to take in because honestly, my goal as a parent was that her therapy bills would be less than mine. And to hear that she considers it to be such a resounding success, it's like, 'really?' (laughs)

Melanie's home has become a haven for her 17-year-old daughter's LGB friends. She says, "My daughter's LGB friends come over when she's not here just to hang out and relax. It's kind of cool to have them here and for them to feel this is a safe place." Her daughter tells Melanie that when she is older, she hopes to be just as "welcoming and cool" of a mom as Melanie is.

Recognizing How Trauma Affected Me

Trauma affecting my sexuality with others. Jo expressed the belief that sexual trauma is common in the LGB population and therefore, therapists must be competent in treating middle-aged lesbian clients with histories of sexual trauma. In this study, three participants had histories of repeated sexual assault from childhood to adulthood and five had histories of physical or emotional trauma from childhood and adulthood.

Robin, a childhood survivor of sexual exploitation, sexual assault, and physical assault, found out as an adult that her mother had also been sexually abused as a child. She reflected:

> I came across a photo and on the front, it said, 'to my little princess' and it was a picture of my mom when she was a child with this man. There was a picture of me professionally taken when I was five. If anybody ever wants to know if a child was molested, look at the eyes. It's in the eyes. And I knew what my eyes looked like after I experienced that. And I was looking at my mother's picture. My mother had the same look in her eyes.

Beth described how her exploration of her sexual identity was affected by the sexual trauma she experienced from her older brother:

> I was raped by my brother when I was thirteen and so I believe that it made it impossible for me to really embrace any kind of sexuality. I talked to my mom and she did not want to hear that…my oldest brother is the golden child so she dismissed it. And all of it went right back down into me and I suppressed it all. I didn't think about the rape or my sexuality anymore.

Trauma affecting my ability to connect with others. Beth, who has a history of childhood sexual trauma, recounts how her trauma was reactivated by an unwanted kiss on the cheek at her church:

> I told him not to kiss me on the cheek like he usually did but he did it anyway. I looked back at the pastor's wife and she could tell that I was freaking out. So, the pastor's wife was right there for me. She always was. She could see that it was traumatic for me. And it was hard to come back to church after that. It took me a couple of weeks.

Melanie talked about how her experience with trauma has made it hard for her to engage with others:

> I had depression from childhood trauma. My dad died and I lived with my mom but she wasn't there. I raised my two siblings from age thirteen on. So, I think that contributes to that depression, panic, and anxiety. It had gotten so bad that I couldn't get out of bed. I couldn't go to work. I couldn't drive. It was terrible.

Whereas the participants who experienced trauma in their lives described how it has affected their view of themselves and their relationships, they pointed out that their ways of living with trauma have increased their sense of resilience. An example of this refers to embracing resilience by engaging in therapy.

Therapy Makes Me Feel Stronger

The relationship with my therapist helps me to be accountable. The women in this study experienced traumatic assaults or losses but they recognized that they were challenged by their therapist to remain accountable for their emotional health. Britt experienced the loss of her 15-year-old son when he refused to have contact with her after she came out. After twelve years without contact from her son, she explained how her psychiatrist met with her for a few sessions when her therapist was not available:

> I just totally broke down and cried like a baby. She just let me cry and she looked at me and said, 'You can't let him ruin your life. He is hurting you and there doesn't seem to be anything you can do. But you can stop letting him ruin your life.' That was a really powerful statement for me. I kept seeing the desperation in her face and hearing this woman's words. A few years later, I realized she was right and that I couldn't continue to cry and cry for days and days every holiday or on his birthday. And finally, I guess I just made a commitment to myself to stop doing that.

Another example of how the therapeutic relationship increased accountability refers to Melanie and her experience with a Dialectical Behavioral Therapy (DBT) skills group:

> I worked with them for about three years. I worked that full program. It was really rough at first and then I came through it with flying colors. I did the advanced group with no problem and that's what eventually gave me the courage to say, 'I want a divorce. I'm done.' And not to let him manipulate me or talk me back into any of that.

In Melanie's case, the group gave her the confidence to leave an unhealthy relationship where she felt trapped. She came out shortly after the divorce and stated that 'Now I just touch base with my therapist as needed…I'm doing alright."

Feeling positively about my sexual orientation. Participants expressed positivity about their identities as lesbians many times throughout the interviews. Britt, for example, described her sense of excitement as she was coming out, “I wanted to tell the whole world! (loud sing-song falsetto voice) I'm a lesbian!” Sharon smiled widely and laughed when she said, “I'm a lesbian. I've always been a lesbian”. Beth described her experience:

> Because of her [therapist], dealing with my being a lesbian was amazing. Because she told me about the spectrum…she helped me understand and accept the fact that I am a lesbian. And it’s okay…I am probably more authentic and happier now than I’ve ever been in my life. And here I am, 60 years old. So, I think it’s cool! (smiles proudly)

Self-acceptance for their sexual identity was evident in the ways participants talked about identifying as lesbians and experiencing a liberating feeling of being able to live their lives “out and loud.” Thus, therapy for these women was affirmative and empowering, albeit difficult for most.

Therapy makes me hopeful. Therapy promoted a sense of hope for participants, as Sharon expressed:

> So he [therapist]…had this belief in me. 'Of course, there is recovery for you, available for you if you have that in you. And we're going to find it.' Just a real optimism and belief. You know, so that was the most important thing I think I've ever gotten.

Beth seemed surprised about her therapist’s investment in her emotional well-being:

> She's like an angel to me! She comes wherever I’m at, it seems like! For the first year and a half, she came to my house twice a week and I’d have two-hour sessions. I’d never had a therapist do that. And I said to her, ‘what are you doing?’ and she said ‘I believe

that if you need therapy and it doesn’t matter how long we have to do it, we will get there.

Britt talked about how her therapist created a sense of hope by creating a safe place for her to talk about issues related to her sexual orientation:

> Then she said, 'like I have gay clients and lesbian clients.' So she kind of opened the door to letting me know it was okay to say what I wanted to say. She kind of made me aware that yes, it's hard to do and hard to admit for some people but that, you know, that this was a safe place for me to go ahead and express that.

Feeling Understood by my Therapist

My therapist understands my life challenges and strengths. Participants emphasized how important was for them that their therapists understood what they were going through and helped them to manage adversity. According to Sharon, without a therapeutic relationship, the techniques “hold no water.” Without understanding the nuances of their lives, “the therapeutic relationship will be weak.”…Beth reflected on these issues:

> She [therapist] helped me separate myself from my family because it was abusive and I didn't need to be in that environment…It's how she talks to me and the interaction we have, you know? And I really think it's important that a therapist understands and shows support in a lot of things, but in that area especially, when you're coming out. It's just a good relationship. And I think that's important. I would think that would be the goal. Because you want people to talk. You can't get better without getting it out.

Whereas four participants reported high satisfaction with therapy, three were moderately satisfied. Jo described how she perceived her therapist’s sensitivity towards LGB issues:

> I'm not her usual client. I don't know if she's had any (lesbian clients) …It doesn't feel like it. But it's not that I feel in any way discriminated against by her, I just feel like she really doesn't have a grasp of, you know, what it's like for me as an older lesbian dealing with a breakup.

My therapist is comfortable working with LGB populations. When Beth was asked how comfortable her therapist was with LGB clients, she did not hesitate. "I know that I'm safe with her and that she is not going to tell me not to be gay." Britt was also positive about her therapist's level of comfort with having her as a lesbian client:

> It was great to come out to my therapist first! The funny thing is that she was very intuitive about it. I suppose I skirted the issue a lot, you know? Pardon the pun! (laughs) But eventually she just said, 'You know, a lot a people…find it helpful to talk about things even though they're afraid…like I have gay clients and lesbian clients.' So she kind of opened the door to letting me know it was okay to say what I wanted to say.

Some participants said it was important to them to find an LGB therapist based on their prior experiences with heterosexual therapists. Jo said that before finding her current therapist, she experienced dissatisfaction in therapy with a therapist who did not have awareness of LBG issues. She stated:

> I think [in the future] I will specifically seek out lesbian therapists…I just think I'll be more likely…it's more comfortable, it's more relevant. Sometimes I had to educate my therapist. It's kind of like dating someone much younger or much older and you have these generational differences.

Other participants stated that as long as the therapist was familiar and comfortable with the LGB community, it didn’t matter to them if they were not from the LGB community. Sharon shared her thoughts on this issue:

> I had a long-term therapist who was a middle-aged lesbian like me. And it was helpful to know that I didn't have to explain those things, that she would get what I'm talking about when I'm talking about the community...but to me it was worth it to explain those things because my [heterosexual] therapist was always open to learning about that. And he took what I said as, 'Ok, I believe you that that's how it is.' So, to me, the willingness to listen to the client about what it's like and be able to empathize? That is just as important as just having knowledge of [the LGB community].

Authenticity, validation, and knowledge are important therapist qualities that participants identified as factors that helped them improve their level of satisfaction with therapy. Whereas these experiences have been empowering, participants also reflected about larger systems that increased the sense of fear and uncertainty in their lives.

Feeling Fearful

In addition to reflecting on their experiences in therapy, participants spontaneously addressed the impact on their lives resulting from the 2016 presidential election outcome.

Fearing that I will experience more heterosexism and discrimination. Sue provided a detailed reflection of her fears associated with the current political climate in the US:

> The day of the election, I was all happy. And the day after? I was terrified to have the contractors who were working on our kitchen in my house. Because I didn't know who these men were, who they voted for, what they really believed. I was in tears all day. All day. And at one point I heard some of the guys saying, 'we better wrap this up early so we

can go out and celebrate Trump's victory'. I was beside myself. Here I was, alone in this house with these guys. Oh, it was just awful. And it was the first time in my life I felt so isolated and vulnerable. Um...It just was awful!

Sharon also expressed her fears:

I'm afraid that we'll lose all we've fought and won. You know, look at...the president… he who shall not be named. 45? I'm really afraid. I have to tell you, that fear plays a big part in my depression right now.

Jo began to express fears of further discrimination and heterosexism about retirement plans:

I'm getting to where I can start to think about retiring and where I want to go and what I want to do. And I just want to be somewhere safe. I think the climate of our country in the last month has proven that there are a lot more bigots and hatred than one thought. We knew it was there but it's much worse than we thought. And who knows what four years of that, eight years ... Who knows what will prosper?

Fearing that my legal rights will disappear. Particularly concerning for women was the fear of possibly losing the legal rights that have recently been won for LGB equality. Beth voiced her concerns:

That's where I have a problem with the Trump thing. I'm still struggling with it because I looked at it like, 'You voted for Trump. You voted against me.' Because this is affecting my life. You know? Whether you think it or not…it could affect my life.

Sue expressed:

> That's why it's terrifying all the way we've come knowing that...(grimaces)...(laughs). He who shall remain unnamed. Given all the advances that have come of late... I mean, are we going to go back to the DSM-III where homosexuality is a mental diagnosis? ...Scary.

Lived Experiences of Middle-Aged Lesbians in Therapy

With regards to lived-experience data, participants first reflected on their coming out process. Next, women reflected about their experiences in therapy. Finally, participants discussed their emerging identities as political activists. Lived-experience data were organized in five phenomena: (a) *coming out*, (b) *embracing therapy to deal with adversity*, (c) *taking action in therapy*, (d) *reaching out thanks to therapy*, and, (e) *becoming a political activist*.

Coming Out

Feeling afraid of coming out. Some participants expressed fear of acknowledging they were lesbians and fear about coming out to family members, male partners, friends, therapists, or at church. Britt talked about her fear of coming out to her therapist, “I was still afraid in therapy, I was afraid of coming out and not being accepted.” Melanie was married when she began the coming out process and she described how she overcame her fear:

> I wanted to talk to somebody about these feelings I was having. But I didn't know how to say what I wanted to say without sounding like an idiot. So, I left and I came back the next day and said that I wondered if there was anybody at the center that was married and who also had these feelings towards women. And there was a woman there who had also been married and had come out so I’ve been with her for years now.

Her persistence in seeking help speaks to the level of distress she felt about not knowing how to live her life as a lesbian. This sentiment was expressed by Beth who said: “I was so depressed, I was suicidal. I didn’t want to be doing those things with my husband, the things that

other people like. And then I was done.' Britt also expressed, "I was at the point where if I didn't say something, I was going to explode."

Struggling with my sexual identity. The participants who struggled the most with their sexual identity were the two women who came out in the past five years and had been married to men. At the time of the interviews, Beth had been out for three years and Sue had been out for five years. Beth's struggles with her sexual identity were connected to the unresolved traumas of sexual assault by her older brother, the physical abuse by her mother, the impacts of bipolar disorder, and the lack of support from her family, friends, and church. She described her experience:

> I went home to my family but it was just horrible for me. I hadn't come out yet. So, I was getting a lot of grief, I mean, a lot of crap from getting divorced. My medicine was doing well in managing my disorder. But I was still having all this stuff from my family that would pour me into the suicidal ideation…I didn't want to live. And once I came out and accepted it, that all changed. I was able to cope better because I wasn't holding all that stuff in, you know? I could be myself.

Sue's struggles with her sexual identity were different in that she had a supportive family and husband, no history of trauma or mental health disorders, and a career in the military. She talked about her struggles in the context of her attraction to another woman:

> I saw her again and I was oddly attracted to her and that just kind of puzzled me because it was like, I'd been married for twenty-six years then. I couldn't relate to that. You know? It was like 'What does that mean?' I didn't understand these feelings I was having. I realized that this was about me. It wasn't about her. It was about me and who I wanted to be for the rest of my life and that I needed to do something about that.

Discovering my strength and coming out. Britt, Beth, Melanie, and Sue came out after the age of 40. Sharon and Jo came out in their late teens and Robin came out when she was 32 years old. Regardless of their age when they came out, all the participants remembered the experiences well. Britt says that she had known her whole life that she was more attracted to women than to men but she had decided to marry a man. In describing her experience with coming out, she says:

> Even though I was married to a man and had kids, I decided that at this age the feelings that I had been fighting off and saying no to my whole life--very consciously saying no--I decided that I was either going to embrace those feelings now or let them go forever. So, I decided that I was going to come out. So, I came out first to my therapist, then to people at school, and then to my husband and kids. After coming out and telling all these tales and finally rejecting this stuff that I had allowed to be layered and plastered on top of me, and finally busting that shit out, changed my whole life! It changed my outlook on everything. Like, for the first time, um, I felt real.

Jo talked about her coming out experience as a gradual process:

> I guess it's kind of a layered thing, you know, first you come out to your friends and all is well, you know, because we were young and played softball, and everybody was coming out. Um...and then I think I was about 30 when I got my first really serious girlfriend and I came out to my family. And then I was probably closer to 40 before I was out everywhere...you know, at work and everywhere and then...Out of the closet!

Melanie decided she wanted to divorce her husband and come out after she kissed a woman for the first time:

> I just decided after I kissed her one day, 'Yep. I'm done. I want a divorce.' There was no doubt about it. Nope. Done…(laughs) That kiss was important. Because I felt things. I didn't feel, like, stiff. It came natural. If felt good, like, you know...is it fireworks? Yes!! It is true!! I got it!! And the first time I had sex I was like, 'Oh!!' Like, a new light came on!! (laughs) 'There is more to this!!' Cause before I'd be like, 'Oh, sex, okay, whatever, really?' I mean I cried for years because I felt so yucky and used and dirty and 'Ew! Why do people do this?' You want to make a baby? I'm good. But, ew, no!! It was not fun for me. No, no, no. No. (laughs) But now? I've had a couple of different partners. Uh, yeah, I'm good. I'm very happy. Yeah. Got it! (laughs) Very, very different perspective.

Beth also talked about how liberating her coming out experience was when she was 57 years old, "I came out three years ago and it was very freeing. I felt...I felt...it was exciting! And I was joyful!"

In addition to the intentionality embedded in their coming out process, all of the participants reported the beneficial impact of their experiences in therapy, although participants differed on their level of overall satisfaction. The next section will describe how the participants' experiences in therapy helped them deal with adversity.

Embracing Therapy to Deal with Adversity

Embracing coping techniques. The act of learning coping techniques to face adversity was a highly relevant experience for women in this study. Sharon, who struggles with depression, believes that learning coping techniques has been vitally important:

> Being willing to be say 'this isn't going to be the one and only answer'. There are lots of approaches that I can take and need to take. I think that has been a strength of mine to be

open and seeking. You know, if I just went to the therapist I had right now and that was the only thing I was counting on to get me through this depression, I'd be dead.

Sue talked about a technique that resonated with her:

> The thing that she [therapist] helped me with at that particular time in the beginning, was that I had to email her every night three things that I felt good about doing for myself. She said, 'The more specific you are, the more you begin to feel and own your accomplishments." She would just jot a succinct short reply saying, 'You need to be more specific' or 'Great job.' But that really helped. And we did that for about two or three weeks.

Sue liked this technique so much that she continued to use it in her journaling after her therapy had ended. Jo mentioned that she sought therapy for a breakup:

> …[My current therapist] gave me some coping skills that were desperately needed at the time. That helped me put things in a perspective or give me a position to reflect or act upon things differently than a knee-jerk reaction.

The process of trying, practicing and learning effective coping skills also increased their sense of resilience and self-efficacy. As participants explored how they dealt with adversity in therapy, they examined how therapy helped them cope with fear and insecurity in their lives.

Letting go of fear and insecurity. Most participants spoke about coping skills learned in therapy to help them cope with adversity. For example, Melanie elaborated on the ways she manages her emotions, "Sometimes I just have an emotional reaction whether it's rational or not. But to back up and think, 'what are the facts?' seems to influence me greatly." Sharon talked specifically about Dialectical Behavioral Therapy techniques that were relevant to her:

> It really is that relationship, the therapeutic relationship is as important as any technique. I wasn't the typical DBT client. I don't have borderline personality or anything but that approach has resonated with me. And I have also gone to therapists who are really into techniques. 'Let's try this next time. We'll learn how to do...' It's all techniques and they're not effective if there's no true connection, right?

Moving away from unhealthy behaviors. Participants were open about the various unhealthy behaviors they had engaged in as a way to cope with emotional distress, as well as how therapy helped them to change them. Beth reflected on how she has been able to modify her negative self-talk, “I'm very content. I have a tendency--USED (emphasized) to have a tendency! (laughs) It's so hard to reframe it! (laughs) Alright, so I used to be like, if you got close to me? Uh, I would run. I couldn't handle it. So, running meant eventually I would move [homes].”

Britt described how her awareness of unhealthy behaviors in relation to her siblings motivated her to make changes that were healthy for her:

> I basically just wrote them off. I don't communicate with them hardly at all anymore. Because that's healthier for me. You know, I used to go every holiday just beating myself up for that. About how horrible these relationships are and they should be better. And it was all my fault and finally I was like, 'No. No, it's not. Not my fault.'

The act of embracing therapy to deal with adversity for these women was an act of both awareness and action. When they realized that therapy could help them, they became actively involved in the therapeutic process. Some were more engaged in therapy than others but none of the participants considered that therapy was unhelpful. A key action that participants embraced in therapy referred to becoming vulnerable and putting in the effort to make therapy work.

Taking Action in Therapy

Being vulnerable. Participants discussed their willingness to make themselves vulnerable to their therapists so that they could deal with the issues that brought them to therapy. The majority of participants referred to how helpful was for them to become vulnerable in therapy. Beth spoke highly of her therapist, calling her an "angel" at one point because her therapist invested so much time and energy in her process:

> I think just being able to be totally honest how I feel. …Knowing it's safe for me to do that.…. I've had a lot of therapists. And I have never had this experience before. I have never been able to reveal things about myself, I mean, totally. And it always felt like I wasn't getting anywhere. So, this experience has been a lot different.

Making therapy work. Participants disclosed what they tried to make therapy work for them. Melanie affirmed:

> I think with her [therapist], as I've grown, I realize I'm not any good for anybody if I don't take care of myself. It's really starting to turn around to where I am taking care of myself. I am going to bed on time. I am eating. I am realizing where my limits are, if I can't do something, you know, I need to take a break and that's okay. She's helped me recognize where those limits are, create some boundaries and not feel bad that I have those boundaries. Which is huge.

One woman in the study highlighted the critical role she had in extending the benefits of therapy by being proactive after reaching an understanding of her situation. Britt said:

> I think for the most part my experiences were opportunities for me at the time to open the faucet and just let things pour out. But usually what happened after I was done purging, I

was like, 'well, now what?' There never seemed to be any 'what'. There never seemed to have been any goals that were set up or met. And so, I just stopped going.

Whereas the majority of women experienced embracing vulnerability as a growth-producing experience, one participant reported an unethical experience with a former therapist who she saw prior to her current therapist. Sharon said:

> When I finally decided that I needed to deal with some trauma around sexual assault, I told my male therapist about a time that I was raped. I had my keys in the door and was trying hard to get into my apartment because some guy was stalking me. I got inside, locked the door and all the locks with the deadbolts and stuff, and left my keys hanging from the outside of the door. So, he got in and I was raped. So I was telling this guy [therapist] about it and he says, 'Well, do you think you left the keys there on purpose, subconsciously?' And, you know? I quit thinking about dealing with the rapes and sexual assault for probably twenty years. I didn't talk to anybody. I took that so hard. I felt like he was right…that I-I must have wanted it.

Robin said that she has had many therapists but when she began to put more effort into making therapy work, she experienced growth:

> I had not mourned any of what I had gone through in my childhood but until I had a safe place, I couldn't release that. Crying isn't something I do very often but she [therapist] told me, ‘It does not mean that you are weak if you cry. It's alright to cry and mourn your childhood.’ That was the biggest thing that helped me decide to let it go, knowing that it was safe for me. So, I had a safe place to cry with her. That was everything.

Beth said that therapy has worked for her because of her relationship with her therapist but also because of her own efforts. She said:

> I think cause I'm willing to talk and am willing to do the hard work, you know, feel those feelings about things that I had to keep tabling and tabling. I do that because I want to grow. I want to keep moving forward.

Britt also talked about her commitment to therapy and how she has experienced growth from her work during therapy:

> I had an openness to the therapeutic process. I always believed in it. For me, it was important to being committed to taking a certain amount of time out every week or every two weeks just for myself. I sort of started doing some mandalas and I really enjoyed that. I started mixing it with writing, with journaling…I had kind of a book where I kept my drawings and my things that I was writing about. That was really helpful not only in the short-term, but later when I would go back and look at it, I thought, 'Oh wow. I remember feeling that way.' But I remembered feeling why I felt that way and realized that I really feel a lot better than that now. I look back on therapy and I can say, 'yes, it did help. I can see that'.

Reaching Out Thanks to Therapy

Asking for help when I need it. Participants described how therapy has helped them to seek help from others, including their therapists, as Sue expressed:

> She [therapist] was very accessible. When I felt that I needed to see her, you know, she'd respond as quickly as she could. It was very easy. She never made me feel like I was putting her out and she always was present and gave me 100% of her attention.

Beth similarly described how important was for her therapist to respond when she reached out for help:

> One training was about abuse and it got into the incest and it hit me…they had to take me out of the room because I was traumatized, I could not even think. When I got home, I immediately called my therapist and she came to my house the next day to help me.

Melanie talked about how she felt empowered to seek help for her daughter:

> When I was looking for a therapist for my daughter just this last year, one of the requirements was that I would ask on the phone whether services were LGB-friendly or -knowledgeable or -supportive or something along those lines. That was important to me and it was important to her too because she's up and back like I was, questioning.

The act of seeking an LGB-friendly therapist for her daughter was significant for Melanie because of previous experiences with therapists who did not want to work with her on sexual identity issues or refused services to her. The rest of participants also described how important it was to be able contact their therapist outside of their appointments. For example, Sharon expressed:

> What I learned from my therapist is how many ways you can approach therapy and heal. He mentioned things about spirituality and it made me think. And I ended up seeking out resources and started going to these meetings at church and now that's my community and they are there to support me. It's wonderful and has really helped a lot. I started meditating because he [therapist] shared his experiences about meditating. I discovered that meditating and mindfulness is just the number one way to work with me. So, having his support helped me with finding groups and community.

Seeking affirmation from my therapist. Participants talked about how their experiences in therapy helped them feel more comfortable seeking affirmation from their therapists. Some of

the examples included checking with their therapists about their changing perspectives about themselves as healthy middle-aged lesbians, about their social interactions, and about their therapist's support for them.

Beth started relying less on her therapist as she became more comfortable in her life. Whereas this seems like a simple observation, it is much more complicated for Beth. Her history with trauma and oppression has affected her ability to trust others and to understand her own motivations, values, and self-worth. She did not say, "She's very supportive" as if describing a single event. She said, "*I know* she's very supportive', implying an internalized trust that her therapist will be there to support her. For Beth, this statement encompasses the lengthy, yet successful healing process that she has undertaken with a therapist who has worked hard to earn her trust over the past few years.

Sharon described how validation and affirmation from her former therapist was important to help her engage in the therapeutic process:

> The thing that he did that allowed me to put my defenses down and believe that it was worth being invested in the therapeutic process, was the fact that he validated me…he heard me, he appreciated me, he truly liked me…I felt liked, I felt heard, and he had this belief in me. 'Of course, there is recovery for you, available for you if you have that in you. And we're going to find it.' Just a real optimism and belief. You know, so that was the most important thing I think I've ever gotten.

Sue discussed how her therapist helped her affirm the new knowledge about her changing perceptions of self after coming out and the LGB community:

> My therapist was great about dissecting and putting things into perspective. I mean, I know about male-female relationships. But this was whole new territory. You know?

> And I was like, 'What is normal in these circumstances?' So, she was great at giving me perspective and it helped to know that she's in the [LGB] community herself.

Seeking resources from the LGB community. For some participants, becoming involved and seeking resources from the LGB community was an important precursor of their sexual identity development and healing process. Some, like, Beth, experienced not only a safe community but a broader understanding of the LGB culture. She affirmed:

> I had these preconceived ideas about what it meant to be gay or what I was going to see and 'why do you hang out in bars?' And then I found out because I went! And when people say, 'why do you hang out in the bar,' now I can say to them, 'Well, that's where my community is'. It's like my church…it's sacred and it's safe

For Britt, becoming involved in the lesbian community was an important step for her as a newly-out lesbian. She described the progression of her involvement in the LGB community:

> I started getting real excited about being out in the lesbian community…When I first came out I was very active in the lesbian and gay community…I ended up being the chair of the pride festival. I think it was two years that I did that. I made it happen, basically, the pride festival for the little town.

For these participants, therapy helped them reach out to others when they needed support and this practice became an integral part of their growth.

Becoming a Political Activist

In addition to reflecting on their experiences in therapy, women reflected on their own process of growth as political activists. The participants reflected on these experiences as well as how they gradually embraced this identity throughout their lives.

Helping others understand our strengths as lesbians. Two participants were very vocal about representing a positive model of being a lesbian at their workplaces. Jo works in government and most of her colleagues are men. She described how she felt about being openly lesbian in her role as an elected official:

> I decided that I would be out and I wouldn't, in any way, pretend to be in the closet for any of them. I wasn't trying to push it in their faces. But I wanted people to realize that not only did I have a vast knowledge of what they needed to know but they also needed to know that they were taking this advice from a lesbian. And that was important to me, especially in a male-dominated arena.

As she described her job and her struggle to achieve the promotions she has earned, it became clear that her goal was not to have admiration or attention but to dispel negative stereotypes of lesbians. This goal tied in with her hope to help the next generation of LGB youth so that their lives would be easier.

Melanie was in the midst of dealing with a complaint filed by her colleague who claimed she was uncomfortable because Melanie was acting affectionately towards a female colleague. She was not out at work and felt that being out would jeopardize her job. She struggled with dealing with the discrimination and with presenting a positive and strong image of a lesbian to the community. In trying to find some peace, she thought about a lesbian role model at her workplace:

> There was a supervisor that I worked with ten or fifteen years back who was out and proud. I've been thinking a lot about her. And there were some staff who would give her flak and if it phased her, she didn't show it outwardly. You know, I thought, that really takes a strong person. She's kind of a mentor, you know? That really has given me the

courage to just drop it and move on. Because I am who I am and that's not going to change. So, what does it matter if somebody doesn't like it? It's your job, you know what you're doing, you know? Stop second-guessing yourself!

Challenging oppression by fighting for myself and others. Some of the participants talked about how they fought oppression in their daily lives for themselves and others. Britt, when describing her relationship with her family of origin during the holiday season, said:

> You know, for a lot of people, it's (the holidays) a positive time and a good time. And they have a lot of great memories and photographs and babies being born and all this happy horseshit. And uh, it wasn't that for me! (laughs) It never was that for me! Even before I came out it was always a struggle because I was the black sheep. I was the one that was always arguing and disagreeing and being the liberal in the face of the conservatives. I didn't fit! I did not fit.

Even though she describes her interactions with her family members as conflictual, she continues to engage in being the "liberal in the face of the conservatives." The struggle she is faced with in her family situation seems to be one of trying to find a place in her family where she can 'fit,' while openly 'arguing and disagreeing' with family members with conservative orientations. This conflict was mentioned often by Britt and was eventually resolved as she became more comfortable with her own identity as a middle-aged lesbian.

Sue links her struggles with the stigma she felt about her mother's illness, as she discussed:

> Coming out as a lesbian wasn't difficult. Far more difficult is me coming out of the closet about my mother who was mentally ill. Nobody knew. It took me a long time to process this but I wrote…about how high school wasn't good for me, that my mother was an

> institutionalized schizophrenic and that basically coming out as a lesbian was easier than coming out with a parent that's mentally ill. And then at the end I just said I was tired of living in closets.

Becoming an activist for LGB rights. Some of the participants reflected about becoming activists by providing a positive role model for other lesbians or engaging in lesbian feminist culture. Jo expressed her thoughts about being a positive role model:

> Being a role model or helping the next generation is important to me. I like to make it easy for the next guy. That's really, really a big deal to me. And I totally know I did with (the neighbor girl) who has been out since she was fifteen. She's about 23 and it's great. She lives down the street and you'll see her with young ladies across the street so it's nice.

Sharon elaborated on these issues and emphasized the importance of becoming aware of lesbian feminism when she was a young woman:

> I had never heard of feminism or lesbian feminists at that point so I just didn't really know that it existed. And then, I discovered lesbian feminism (laughs), and, so, no looking back! I am and have been an activist since then.

CHAPTER V

DISCUSSION

This study described the life experiences of seven middle-aged lesbians who reflected about their coming out experiences, their perceived satisfaction in therapy, the precursors associated with their reported levels of satisfaction in therapy, and the ways in which therapy enhanced their sense of resilience.

The investigation followed the descriptive phenomenological approach (Porter, 1998) and resulted in fourteen in-depth interviews and seven brief interviews. Life-world data resulted in five features: *(a) experiencing heterosexism and discrimination, (b) experiencing changing social views about LGB populations, (c) recognizing how trauma affected me, (d) therapy makes me feel stronger, (e) feeling understood by my therapist, and (f) feeling fearful*. Lived experience data resulted in five final phenomena: *(a) coming out, (b) embracing therapy to deal with adversity, (c) taking action in therapy, (d) therapy helping me to reach out, and (e) becoming a political activist.* In the following section, research findings will be discussed according to the existing literature, followed by reflections on clinical implications, limitations of the study, and suggestions for future research.

Life-World Experiences of Middle-Aged Lesbians in Therapy

Experiencing Heterosexism and Discrimination

Sexual identity development. All participants discussed experiences associated with heterosexism and discrimination. Sexual identity development provides a useful framework to understand how these experiences have affected research participants. Briefly, the Cass model of sexual identity development (1979, 1996) describes the stages of sexual identity development from the pre-stage phase to the final identity synthesis. At each of these stages, the perceptions,

feelings and actions gradually change from a refusal to allow awareness of a sexual identity other than heterosexual, to the integration of the same-sex orientation as a core identity along with other identities (e.g., mother, advocate, etc.).

Because social interactions and life experiences influence understanding of meaning (Berger & Luckmann, 1967; DeLamater & Hyde, 1998), the experiences of heterosexism and discrimination present unique challenges to individuals who are in different stages of sexual identity development. For example, both Beth and Britt talked about how devastating was for them to experience the rejection from close friends and family members when they were at the beginning stages of their sexual identity development. In contrast, Jo and Sharon reported that even though they experienced distress from discrimination or heterosexism at their workplaces and church, the distress was not particularly deleterious. Thus, participants' experiences of distress associated with discrimination varied according to stages of sexual identity development. That is, current results appear to indicate that the level of distress resulting from heterosexism or discrimination may be, at least in part, associated with the participant's stage of sexual identity development, with less distress likely to be experienced by women who have reached the more advanced stages of sexual identity development. For example, women in this study who reported higher levels of distress from their experiences with heterosexism and discrimination had been out for shorter periods of time.

Further, according to participants' narratives, women most affected by discrimination were likely to experience higher levels of stigma constraint and internalized heterosexism, which has numerous negative effects on physical and mental health (Frost & Meyer, 2009; Henning-Smith et al., 2015; Lewis et al., 2014; Mason et al, 2015; Mereish & Poteat, 2015; Mohr, 2015; Schmitt et al, 2014; Szymanski & Henrichs-Beck, 2014). Research supports that feeling less

constrained in discussing stressors related to being a middle-aged lesbian increases the likelihood to engage in growth-producing behaviors, such as seeking support from others or connecting with the LGB community (Bayer, 2014; Larson et al. 2015; Mason et al., 2015).

Finally, some participants also reported a strong sense of self and pride about their sexual orientation, which is characteristic of the final stage of sexual identity (identity integration) (Cass, 1996). The benefits of this level of satisfaction indicate an increased sense of resilience and capacity to cope with heterosexism and discrimination in effective and healthy ways (Mason, et al, 2015; Pinel, 1999; Schmitt et al., 2014). Women reported adaptive coping skills such as learning emotional regulation skills and implementing strategies to deal with chronic stress (Lehavot, 2012).

Minority stress model. Frost and Meyer's (2009) minority stress model provides a lens useful to understand the experiences of heterosexism and discrimination of research participants. Briefly, minority stress is conceptualized as a chronic stressor with distal and proximal effects. Distal effects encompass societal factors such as generalized attitudes and stereotypes, institutional practices, and negative beliefs about LGB populations. Proximal effects include internalized heterosexism and self-stigmatization (Frost & Meyer, 2009).

In this study, none of the participants reported experiencing heterosexism in the form of physical assaults although five women were aware of hate/bias crimes in the form of physical assaults against others. The women in this study talked about distal effects of minority stress in the contexts of institutional heterosexism and discrimination associated with religion, the legal system, and the healthcare system. All participants expressed anxiety about heterosexist beliefs portrayed in the current presidential administration and political system. When reflecting about discriminatory experiences in their churches, work place, or health care settings; women

described these experiences in ways that conveyed distress, but also as opportunities to engage in activism aimed at changing institutionalized heterosexism.

Proximal effects for participants seemed to be more challenging to manage as they frequently resulted in self-stigmatization and internalized heterosexism. The belief that a heterosexual identity is the ideal sexual orientation was evident among participants, based on their reports describing attempts to meet expectations of heterosexuality when they were younger. Six of the seven participants in this study had been married to men and described how this was a significant heterosexist expectation in their families and communities that they had internalized, which indicates a significant level of internalized heterosexism as previously reported in the literature (Fredriksen-Goldsen et al., 2014; Frost & Meyer, 2009; Henning-Smith, et al., 2015; Lewis, et al., 2014; Mason et al., 2015; Pinel, 1999; Schmitt et al., 2014; Szymanski & Henrichs-Beck, 2014).

Some of the participants also reported struggling with stigmatized beliefs about their identities as lesbians. That is, they reported feeling as if something was wrong with them because they were lesbians. These beliefs stemmed from experiences with their families, communities, religion, and the greater society. Overall, the effects of heterosexism affected all aspects of the participants' lives, confirming theories describing the extensive negative impact that discrimination and heterosexism have in the lives of members of oppressed and marginalized populations (Cohen & Byers, 2015; Frost & Meyer, 2009; Henning-Smith, et al., 2015; Lewis, et al., 2014; Mason, et al., 2015; Mereish & Poteat, 2015; Mohr, 2015; Newcomb & Mustanski, 2010; Schmitt, et al., 2014; Szymanski & Henrichs-Beck, 2014).

Experiencing Changing Social Views About LGB Populations

Ecological systems theory. As participants recalled their own experiences of sexual identity development and heterosexism, they talked about how societal acceptance towards same-sex orientation and LGB populations has changed over time. In their narratives, women talked about how they have experienced an increased sense of hope by society's decrease in heterosexist beliefs and the increase in societal acceptance towards LGB individuals. Some women reported positive changes in their churches, families, mental health care settings, and worksites in the form of acceptance and respect towards LGB communities.

The Ecological Systems Theory (Bronfenbrenner, 1979) provides a framework for understanding how individuals and families are influenced by different systems in their lives. The microsystems of these participants include family members, close friends, and intimate partners. The acceptance or rejection by family members had powerful effects on the participants as it influenced their level of internalized heterosexism or self-acceptance. Mesosystems refer to interactions among microsystems. This level of analysis is useful as for example, Jo talked about how her family's acceptance and caring towards her partner had a positive effect on the way she interacted with her family. Exosystems are indirect influences that a system has on an individual. For example, the participants talked about how experiences of support towards their partners through their social networks had a positive impact on their own well-being. The macrosystem refers to contextual factors that influence individuals. Thus, participants talked about the highly positive impact of the passage of the national same-sex marriage law.

Chronosystems incorporates the influence of time on various subsystems impacting participants. In this study, some participants reflected about the considerable changes of societal attitudes about LGB populations across generations. The experiences of the participants who

came out as younger lesbians were qualitatively different than the participants who recently came out. Specifically, older women reported the widespread anti-lesbian climate characteristic of several decades ago. By reflecting on these issues, participants expressed relief that younger generations of lesbians are less likely to encounter the level of heterosexism that older generations experienced. In essence, attention to the different levels of eco-systems in the lives of women as postulated in Ecological Systems Theory, was a very useful approach when analyzing the participants' life experiences (Bronfenbrenner, 1979)

Recognizing the Impact of Trauma

In this study, five of the seven participants reported experiences of physical, sexual, or emotional trauma in their lives. These participants talked about how trauma negatively influenced their sexual identity development and their ability to emotionally connect with others. For example, women who were sexually assaulted as children felt that their sexual identity development had been stalled at that point. They did not allow themselves to act on any sexual exploration and avoided thinking about sexual issues until they were older and processed the trauma with their therapists. They disclosed that their ability to trust others had been damaged to the point where they did not seek support from anyone until they were much older. Participants exposed to severe trauma reported considerable challenges trusting others and some even attempted suicide. Common among these participants were diagnoses associated with mood disorders, anxiety, and posttraumatic stress disorder. Women affected by trauma also reported maladaptive coping behaviors such as social withdrawal, eating problems, and substance use. Overall, these findings confirm the multiple negative consequences of trauma and how for LGB individuals, trauma has a distinctive layer of complexity due to the intense discrimination they experience based on heterosexism and oppression at multiple levels (Bayer, 2014; Fingerhut et

al., 2010; Hatzenbuehler, 2009; Lewis et al., 2014; Meyer, 2003; Szymanski & Henrichs-Beck, 2014).

Therapy Makes Me Feel Stronger: The Benefits of Therapy

Common factors. Understanding what has worked in therapy for this sample of middle-aged lesbians can be accomplished by using common factors theory as a frame of reference. According to common factors theory, key components of therapy associated with positive outcomes refer related to the client's resources, the role of the therapist, the quality of the therapeutic relationship, expectancy for positive outcomes, credibility of treatment, and non-specific treatment variables (Frank & Frank, 1993; Laska, Gurman, & Wampold, 2013; Sprenkle & Blow, 2004; Wampold, 2001).

Participants in this study identified key characteristics of the therapeutic process that were particularly relevant. Specifically, the majority of participants identified the relationship with their therapist as a main motivator for becoming accountable for their process of change in therapy, despite how challenging this process was at the outset. For example, Britt became more accountable for her own mental health by listening to her therapist point out how damaging it was for her to hold on to the hope that her son, who had refused to have contact with her for more than a decade, would change his mind and accept her sexual orientation. Britt was eventually able to process the pain of her son's rejection. Beth reported that she was able to learn and use adaptive coping skills because of her therapist's encouragement. Both Jo and Melanie credited the supportive therapeutic relationship as helping them to feel confident and strong enough to create healthy boundaries and to explore their sexual identity.

Participants felt positively about their sexual orientation and increased their understanding of human sexuality by their work in therapy and the connections they had with

their therapists. Women reported that these insights led them to experience higher levels of self-acceptance and lower levels of internalized heterosexism. In sum, common factors theory is highly relevant to current findings, particularly as it refers to the important role that participants attributed to the nature and quality of the therapeutic relationship, their own attributes as clients, and the hope they had in the therapeutic process (Frank & Frank, 1993; Laska, Gurman, & Wampold, 2013; Sprenkle & Blow, 2004; Wampold, 2001).

Relational-cultural theory. Closely related to common factors theory, relational-cultural theory (Jordan, 2010; Miller & Stiver, 1997) is an appropriate framework to understand the benefits of therapy reported by women in this study. In essence, the theory's major premise refers to the critical influence that growth-fostering relationships can have against oppressive experiences such as heterosexism and discrimination.

Participants in this study emphasized how important it was for them to have an authentic, empathic, and understanding relationship with their therapists. Although this is an element of common factors theory, participants expressed that therapy allowed them to break through the social isolation they were experiencing as a result of the oppressive nature of heterosexism, and that it was key for participants that their therapists helped them to see heterosexism through a lens of oppression. Some participants even reported that the relationship with their therapists was one of the few relationships they had that helped them to recognize the oppressive effects of heterosexism in the lives of LGB individuals. This is a key aspect of relational-cultural theory as the framework states the key role that fostering supportive social relationships has for coping against oppression and discrimination (Jordan, 2010; Miller & Stiver, 1997).

Feeling Understood by My Therapist

Relational-cultural, common factors, and resilience theories. Relational-cultural, common factors and resilience theories are useful for explaining the participants' sense that their therapists understood them. According to relational-cultural theory, the relationship between the participant and the therapist was the agency for positive change. Specifically, participants indicated that their therapists understood their issues well enough to be effective. Some of the issues that these middle-aged lesbians were experiencing were break-ups, experiences of heterosexism at work, managing mood disorders, and dealing with trauma. These reports coincide with the critical role that relational-cultural theory attributes to the nature of the therapeutic relationship (Jordan, 2010; Mereish & Poteat, 2015; Miller & Stiver, 1997).

According to common factors theory, the role of their therapists was essential to promote a process of change. In fact, feeling understood and accepted by their therapists was stated as an essential component of therapy and an effective precursor of change. Some participants also talked about their therapists' sense of humor and how critical their therapists were in helping them identify their own strengths. Thus, as stated in common factors theory, therapists were key in the process of change reported by participants (Assay & Lambert, 1999; Davis, Lebow & Sprenkle, 2012; Laska, Gurman, & Wampold, 2013).

Resilience theory is also useful to examine the critical role of therapists in successful experiences in therapy. Because resilience is dependent upon social interactions, each session has the potential to facilitate or diminish growth and resilience for the client (Masten, 2016). However, difficult interactions can be buffered by a strong therapeutic alliance in which the client feels emotionally safe, understood, accepted, heard, and validated (Brukell & Goldfried, 2006; Kwon, 2013; McGeorge & Carlson, 2011). For the participants in this study, learning how

to work through differences with their therapists was a powerful way to increase the belief that their therapist understood them as middle-aged lesbians, as well as the fact that conflict can be successfully managed in relationships characterized by trust.

Feeling Fearful

Minority stress model. The minority stress model posits that oppression associated with socio-economic and political contexts constitutes a distal expression of minority stress, whereas proximal stressors include internalized heterosexism and expectations of rejection based on non-heterosexual orientations (Frost & Meyer, 2009). This model provides an appropriate framework to examine the sense of oppression and fear reported by women in this study.

Participants consistently reported fears about being a sexual minority in the current political and social climate. This fear has increased by the concern that recent laws providing legal rights and protections for LGB populations may be repealed by the current administration. This fear has led Jo, Britt, and Sharon, who have been out for more than 20 years; to start considering moving out of the country should this occur. Others, like Beth, Melanie, Robin, and Sue, who have been out for less than 10 years, expressed fear and dismay but without elaborating on plans to leave the country.

According to the minority stress model (Frost & Meyer, 2009), it may be possible that because Jo, Britt, and Sharon have been out longer, they have had more extensive exposure to the deleterious consequences of prolonged exposure to oppressive contexts. These participants were also vocal about other expressions of oppression that they associate with the current administration, particularly as it refers to targeting of racial, religious, and immigrant minorities. This level of awareness highlights key premises of oppression towards minority status as postulated by the minority stress model (Frost & Meyer, 2009). Further, older participants were

more reflective of challenges experienced by aging lesbians, for example, the fear of having to move to assisted living facilities where staff may hold heterosexist beliefs. This fear coincides with the literature on middle-aged women that indicates an increased vulnerability for older women as it refers to economic adversity, fears of aging, and limited social support (Jacobs, 2008; Siegel & Mathews, 2015).

Lived Experiences of Middle-Aged Lesbians: Coming Out and Satisfaction in Therapy

Coming Out

Sexual identity development. Participants were asked about their coming out experiences. Due to the prominence participants gave to this topic during the initial interviews, this topic was included as a major theme of lived-experience data. Participants varied in age with regards to the timing when they came out. Whereas some women reported that their families were not happy about their orientation, family members eventually supported them the best way they could. Others experienced open rejection by family members, which often resulted in the loss of family relationships.

For some participants, distal effects of minority stress (e.g., heterosexism in institutions and communities), had a major role in deterring them from exploring their sexual identity and fully engaging in their coming out process. These women lived heterosexual lives for many years until they were able to identify their fears associated with exploring their sexual identity and were willing to explore them. These participants reported various negative effects resulting from living as heterosexual women, which included chronic depression and anxiety, and a decreased sense of self. According to sexual identity development, concealing or hiding a stigmatized identity over time, is frequently associated with deleterious health and mental health consequences (Kravitz, et al., 2014; Schmitt et al., 2014).

In line with the sexual identity model proposed by Cass (1996), the middle-aged women in this study described the process of sexual identity development as beginning internally and "moving outside of themselves" as they progressed through the stages. Despite the awareness of being attracted to women at a young age, participants struggled with identifying themselves as lesbians (pre-stage phase). Participants also talked about the confusion they felt about not feeling like they fit with their peers who were enjoying heterosexual relationships (identity confusion and identity comparison). Women also experienced challenges with naming their orientations because they did not identify with a "homosexual" identity, which they considered a clinical and somewhat derogatory term. They preferred to use the terms lesbian or bisexual to describe their orientation rather than homosexual (identity tolerance).

As women became more comfortable identifying themselves as lesbian or bisexual, they felt conflicted about coming out to others. They expressed fears about the proximal effects of minority stress (Frost & Meyer, 2009), such as being rejected by their families-of-origin, children, spouses, friends, church families, and social groups. Some sought support from friends they knew who were lesbians or who were not heterosexist, therapists who advertised themselves as lesbian-friendly, pastors they trusted, support groups, services from LGB community centers, or their adult daughters (identity acceptance).

As the participants continued to feel supported and affirmed for their non-heterosexual orientations, the need to tell others and celebrate their coming out became more pressing (identity pride). Thus, the act of coming out was described as liberating, life-changing, joyous, exciting, and something that allowed the participants to be fully present in their lives (identity pride). Acclimating to the excitement of coming out and realizing that their sexual identity was just one aspect of their personhood was described by the participants as a gradual process

(identity synthesis). As Jo says, “we cut the grass, we go to work, we struggle with finances…just like anyone else. We’re just people.” Overall, the participants’ experiences were consistent with the sequential phases proposed in sexual identity development proposed by Cass (1996).

Embracing Therapy to Deal with Adversity

Common factors. Participants in this study talked about how they were able to make a commitment to therapy to help them cope with the adversity they were facing in their lives. Common factors theory has identified the role of clients’ personal characteristics as a key element for success in therapy (Assay & Lambert, 1999; Davis, Lebow & Sprenkle, 2012; Laska, Gurman, & Wampold, 2013).

The task of letting go of their fears and insecurity in therapy was viewed as a process that was accomplished within the therapeutic relationship. The belief that they would experience growth from the therapeutic relationship helped them to feel safe and make the commitment to therapy. The participants also spoke about their own personal qualities, which were important to experience success in therapy. Among these were their belief that therapy would help, their commitment to keep motivated to remain in therapy, and their intentionality in learning coping techniques. The majority of participants expressed that they learned how to live with their distress and fears, and eventually overcame these feelings. In essence, the participants’ personal resources and strengths were key precursors for the reported success in therapy, a key factor identified in common factors theory (Assay & Lambert, 1999; Davis, Lebow & Sprenkle, 2012; Laska, Gurman, & Wampold, 2013).

Taking Action in Therapy

Common factors and resilience theories. The intentionality demonstrated by women in therapy aligns with premises of common factors and resilience theories, which highlight the key factor that individuals' personal strengths have with regards to successful processes of change (Assay & Lambert, 1999; Frank & Frank, 1993; Levahot, 2012; Masten, 2016, 2001; Sprenkle & Blow, 2004; Wampold, 2013). Among the most salient participants' attributes were their commitment to be vulnerable by working on difficult issues and feelings, their motivation to learn about and engage in self-care, and their belief that therapists were invested in their therapeutic process. Some of the participants have overcome experiences that were cruel and unfathomable to many. When I asked them if they wanted to stop or take a break, they said that telling their stories made them stronger. Thus, the act of telling their stories was a clear demonstration of resilience of these participants.

Common factors and resilience theory also align with the premises of descriptive phenomenology (Porter, 1998), which refers to the need to identify the core intentions of people about their life experiences, as well as how individuals become active agents of change for improving their lives. Thus, women in this study reported taking responsibility for examining and discarding irrational or unfounded fears, working towards decreasing their sense of insecurity, becoming accountable for maladaptive behaviors, changing negative self-talk, and implementing positive changes in their lives and in their relationships with others. Women also learned to manage their symptoms of anxiety, depression, and trauma. The time and energy the participants invested in learning these techniques allowed them to develop healthy and adaptive coping skills that increased their sense of resilience (Kaysen et al, 2014; Lehavot, 2012; Szymanski & Henrichs-Beck; 2014; Szymanski & Owens, 2008).

Participants also reflected how their hard work in therapy gradually resulted in key achievements such as becoming aware that there was nothing wrong with them, accepting that they were worthy of love and dignity, being able to withstand intense challenges, and owning the right to belong to a larger community. These revelations happened more quickly for some participants than others, but all refer to the sense of empowerment women experienced by discovering these truths about themselves and the success they accomplished in the context of therapy. Further, the participants' sense of resilience extended to various dimensions of their lives, particularly because they had become aware of their capacity to overcome adversity. These findings are aligned with the concept of resilience proposed by Masten (2014), which highlights the key role of individuals' personal resources and strengths for overcoming adversity.

Reaching Out Thanks to Therapy

Resilience theory**.** Resilience theory provides a framework to understand how individuals adapt to adversity and become more resourceful in the process (Masten, 2016; Unger, 2003). Resilience is also understood as a process that is dependent on the interactions between individuals and the key systems impacting their lives (Masten, 2016).

The participants described multiple expressions of resilience amid challenges and struggles to cope with intense adversity. They talked about how therapy strengthened their capacity to recognize when they need help and how to reach out to others. This expression of resilience was a difficult lesson for some participants as it requires trusting others and being vulnerable. Thus, reaching out to their therapists for help was easier when participants believed that their therapists would be there for them, that they would respond appropriately, and that they would be able to help. This finding coincides with resilience premises as presented by Levahot

(2012) and Masten (2016, 2001) who emphasize that supportive and affirmative relationships can foster resilience.

Expressions of resilience also included advocating for themselves and fully engaging in treatment for mental health disorders. These achievements were highly relevant for participants as many of them have focused their lives on prioritizing taking care of others. Therefore, asking for help when they needed it and speaking assertively, as well as committing to therapy, were clear expressions of resilience for these women. The women in this study also talked about the importance of examining with the help of their therapists, beliefs and behaviors that were conducive towards supportive and meaningful relationships, or unsupportive relationships that put them at risk for unhealthy habits (e.g., drug use). This constitutes an expression of resilience as women were active in reaching out for help or connection with others, but were proactive to ensure with their therapists that the changes were adaptive. Many women reported that they engaged in the process of living healthy lives by making a small change, checking with their therapists to confirm it was the right move, and proceeding to the next change until they felt confident in their own judgment that their behaviors were healthy or adaptive. By engaging in this slow process, participants reported feeling more confident in the choices with regards to their relationships with others and themselves. These expressions of resilience go in line with core indicators of resilience previously reported in the literature (Helton & Keller, 2010; Lehavot, 2012; Masten, 2016, 2001; Unger, 2003).

Ecological systems and relational-cultural theories. According to Ecological theory (Bronfenbrenner, 1979), it is notable that the therapeutic relationship for participants became a highly important microsystem and reaching outside of this microsystem was challenging for participants. However, women talked about how as they became more comfortable asking their

therapists for help, their level of comfort in asking others for help increased. Some women became involved in social groups after reaching out for support, others sought help from formal social service agency support groups, churches, friends, or family members. For others, their therapists connected them to lesbian community resources, which helped them become active in LGB communities.

Coinciding with relational-cultural theory (Jordan, 2010; Mason, et al., 2015; Miller & Stiver, 1997), participants described how connecting to LGB communities felt safe to them. This finding is relevant as relational-cultural theory highlights the critical role of community belonging to fighting oppression and discrimination (Mason, et al., 2015). Thus, the experience of joining LGB communities allowed women to learn about the broader LGB culture, find useful resources, and become involved in volunteering, social outings, art performances and exhibitions, and pride festivals. A particular highlight for participants referred to their involvement with LGB community centers as this level of networking provided them with a strong source of social support.

Becoming A Political Activist

Sexual identity development, resilience theory, and minority stress model. For all participants, becoming political activists became a natural reaction to fighting oppression, challenging stereotypes about lesbians, and advocating for LGB rights. These experiences constitute expressions of personal growth as described in resilience theory (Unger, 2003) and the minority stress model (Mason et al., 2015; Pinel, 1999; Schmitt et al., 2014). It also illustrates participants at the stage of identity pride and identity synthesis, according to Cass's sexual identity development model (1996).

The concrete expressions of political activism reported by women included traveling to protests at state and federal capitols, living open lives as lesbians in their personal life routines and the workplace, online activities through social media, contacting representatives and congress members, being out to friends and families, and talking about issues of heterosexism with various social groups.

Participants also explained how important it was for them to dispel negative stereotypes about lesbians and to present a positive role model of middle-aged lesbians for younger lesbians. They accomplished this by being open about their sexual orientation, emphasizing commonalities between themselves and heterosexual middle-aged women, engaging in larger community and neighborhood events with their partners, and confronting heterosexism in healthy ways. The capacity to become agents of change was particularly characteristic of lesbians who had been out longer than ten years and coincided with the identity synthesis stage as proposed by Cass's (1996). Thus, a highly relevant finding from this investigation refers to the fact that political activism in these women was also closely related to their own process of sexual identity development.

Finally, all the participants expressed that by engaging in this investigation, they consider that they were making a positive difference by increasing the public's understanding of issues impacting middle-aged lesbians, challenging negative stereotypes, and helping to improve mental health services for this population. This sense of contributing to the well-being of communities is a key characteristic of the minority stress model (Bayer, 2014; Fingerhut, Peplau, & Ghavami, 2005; Meyer, 2003; Szymanski & Henrichs-Beck, 2014).

CLINICAL IMPLICATIONS

Current findings have relevant implications for family therapy practice with middle-aged lesbian clients. Above all, data clearly indicated the importance of therapists to establish strong therapeutic relationships with their clients. To develop a strong therapeutic relationship, clinicians must attend to issues of joining with clients by providing a safe and private environment for therapy, engaging in active listening, validating client concerns, identifying client strengths, being authentic and empathic, and instilling hope for positive outcomes.

Clinicians also need to have familiarity with key issues impacting the lives of middle-aged lesbians and be knowledgeable of local LGB resources. Participants also expressed how critically important was for them for therapists to openly state their commitment to work with LGB populations. Whereas heterosexual therapists can be effective in therapy with LGB clients, clinicians from the LGB community are more likely to have inherent resources and personal growth experiences associated with detailed knowledge of lesbian culture, personal experiences with the coming out process, and deep awareness of heterosexism. For example, clients talked about how their LGB therapists talked at ease about their clients' sexual identity, an issue that heterosexual therapists may struggle to address and may silently discourage.

Therapists should also be cognizant of the sources of stress for middle-aged lesbians. That is, middle-aged lesbians requesting therapy are very likely to experience distal and proximal stress resulting from their sexual minority status. Some of these experiences are likely to include experiences of discrimination and heterosexism, conflicts with sexual identity development, social isolation, lack of familial or peer support, and financial hardships. Thus, clinicians must be familiar with this range of potential presenting problems and equipped with effective interventions to address them.

Current findings also highlight the relevance for family therapists to complete LGB affirmative training as a core competency for working with middle-aged lesbians (Johnson, 2012; McGeorge & Carlson, 2011). Specifically, participants mentioned that they felt it was necessary for all clinicians to examine the biases, privileges, stereotypes, and assumptions they hold with regards to clients of various sexual orientations, gender expressions, races, abilities, ages, SES, ethnicity, and languages. Britt recommended that clinicians carefully analyze these issues by asking themselves the following questions:

> How do I really feel about different cultures, religions, people of color, people of various orientations? How do I react to them in the real world, not what I put on paper, but in the store, the restaurant, in the therapy office? Why do I feel that way and what do I need to do to change that?

An additional clinical implication from this study refers to the need to understand common interpersonal dynamics in same-sex relationships, the nature and consequences of childhood sexual trauma and other forms of child abuse and neglect, intimate partner violence, and common mental health problems experienced by middle-aged lesbians (e.g., depression, anxiety). Further, because research indicates that middle-aged lesbians are more likely to seek individual mental health services than couple or family therapy (Burckell & Goldfried, 2006; Johnson 2012; Pachankis & Goldfried, 2013), clinicians are likely to begin working with an individual middle-age lesbian client. Once trust and a strong therapeutic relationship are established, therapy can become relational in nature by expanding to couple or family therapy.

In closing, Sharon provided sound advice for clinicians working with middle-aged lesbians: “Be with her on her own journey but do not lead her journey.” Thus, clinicians should provide support, guidance and techniques to promote healing and growth. However, according to

Sharon and other participants, clients must assume responsibility for their own process of change, which will eventually lead them to successfully complete therapy and use the lessons learned in therapy as they become resilient individuals in their daily lives.

LIMITATIONS AND STRENGTHS OF THE STUDY

This study has important limitations that must be acknowledged. First, this investigation consisted of a small sample size and utilized a qualitative methodology. Thus, current findings are not generalizable to the larger population of middle-aged lesbians. In addition, the sampling criteria inevitably led to sampling bias. That is, this study only included Caucasian middle-aged lesbians who had come out and were moderately to highly satisfied with their most recent therapeutic experiences. Thus, findings are not applicable to middle-aged lesbians of color, who have not come out, or who have not experienced satisfaction in therapy.

Despite these limitations, this investigation constitutes a relevant contribution to the field as studies focused on the life experiences of middle-aged lesbians in therapy are scarce. Data are relevant as all participants indicated a desire to offer a contribution towards improving quality of mental health services for middle-aged lesbians. Finally, the multiple interview nature of the study offered the possibility to clearly identify specific components of therapy that were associated with the participants' satisfaction in therapy.

FUTURE RESEARCH

Findings from this study confirm the need for research focused on the mental health needs of middle-aged lesbians. First, six participants in this study reported major depressive and anxiety disorders and five women reported histories of interpersonal and familial trauma from childhood and adulthood. These preliminary findings indicate the importance of investigating the

prevalence of these mental health problems among middle-aged lesbians, as well as the need to investigate the most effective alternatives to provide them with the services they need.

In addition, future research is needed focused on extending the identification of common factors as key precursors of change for middle-aged lesbians in therapy. In this study, participants reported several components identified as key components in common factors theory, such as the role of therapists, the women's personal resources, and the nature of the therapeutic relationships. Thus, it is relevant to promote studies aimed at identifying common factors that account for positive outcomes with this population.

Third, it is critical to expand this line of research to include middle-aged lesbians who have had unsuccessful therapeutic experiences. Examining the factors leading to unsuccessful experiences in therapy could provide valuable insights that would be instrumental for clinicians in their work with this population. Likewise, identifying barriers that prevent middle-aged lesbians from engaging in effective therapy is a needed area of research.

Participants in this study also reported their preference for engaging in individual psychotherapy. Research focused on investigating this tendency might prove beneficial for the field of couple and family therapy as there is a need to examine when extending therapy to couple and family therapy processes would be beneficial, or not. In addition, group therapy interventions may have the potential for positive outcomes as well as decreasing isolation in this population.

Finally, there is a need for research aimed at refining the LGB affirmative approach to address the needs of middle-aged lesbians in therapy, particularly because this line of research inquiry remains seriously underdeveloped.

SELF OF THE RESEARCHER ISSUES

Months before I was ready to interview participants for this project, my excitement about investigating the life experiences of middle-aged lesbians in therapy was hardly containable. However, I also had concerns. As a middle-aged lesbian myself, I worried that the experiences that participants would share with me would remind me of my own experiences. I was concerned about my ability to be an objective researcher without being cold and formal with participants. I worried that my own beliefs, assumptions, biases, and interpretations would damage the messages that my future participants tried to convey through me.

To deal with these concerns, I explored the possibility that I had not fully processed some of my own experiences with discrimination and heterosexism. I wrote. I talked with my partner. I began an audio journal. During this time of exploration, David Bowie, my role model as a younger woman, died. After his death, I found myself remembering my own experiences of discrimination as a young woman. I remembered how David Bowie's music and physical presence made me feel stronger despite the heterosexism that I experienced. When he died, it felt like I had lost a source of resilience and I again began to doubt my abilities as a researcher.

I spoke with a therapist who identified that by submitting to my fears that I would not be able to be objective and professional, I was sabotaging my dissertation. This made sense to me and so I began working with her on ways to remain engaged on my dissertation. I hurried along through the proposal, interviewing participants, transcribing, and the data analysis.

Through the interviews, I heard participants describe experiences of heterosexism that were like my own. It was difficult at times to remember that I was a researcher and not a clinician or a friend. I learned, through the process of recognizing when my responses to participants were not that of a researcher, how to manage the self-of-the-researcher issues. I

reminded myself that I needed to practice mindfulness and become completely present with the participants so that their voices and experiences could truly be heard. During the transcription of the interviews I allowed myself the luxury of processing feelings that I had set aside to be present with participants. I turned to writing once more and explored my feelings about the parts of the interviews that triggered a response. For the difficult interviews where participants described their traumatic experiences, pain, or losses, I allowed myself to experience sadness or anger for them as I transcribed these interviews. When my feelings of sadness or anger seemed to verge on sympathy, I reminded myself of their resilience and what they have been able to overcome in their lives without my sympathy.

This process of allowing myself the time to manage my feelings about the content of the interviews and self of the researcher issues became important for this project. It felt necessary so that I could be fully present with the participants. My participants' voices are strong in this study and I feel honored and grateful that they gave such a tremendous part of themselves. And I made it through despite myself.

APPENDICES

APPENDIX A

Study Consent Form

Experiences of Middle-Aged Lesbians in Therapy: A Focus on Perceived Satisfaction and Precursors of Resilience

Study Consent Form for Participants

Purpose of the Study:

We are conducting a research study to learn about your level of satisfaction in therapy as a middle-aged lesbian, as well as the characteristics of the therapeutic process associated with such level of satisfaction. We also want to learn about the ways in which therapy has supported your life experiences as a middle-aged lesbian. We expect that study findings will support mental health practitioners working with middle-aged lesbians by increasing the quality of the services they provide.

Participation in the Study Includes:

You are being asked to participate in two face-to-face individual interviews and a follow-up discussion. Each of the initial two interviews will take approximately 1 hour and the final interview will last approximately 15-30 minutes. To participate you must: (a) identify as a middle-aged lesbian (ages 40-65), (b) have been actively engaged in therapy for at least three months, and (c) consider that your experience in therapy has been moderately or highly satisfying. With regards to the questions you will be asked, I will ask you to report your level of satisfaction in therapy, the characteristics of therapy that you consider have led to such level of satisfaction, the ways in which you have overcome adversity as a middle-aged lesbian, and the ways in which therapy has allowed you to overcome such adversity.

As I explained to you in the initial phone call, this interview must be audiotaped to ensure that we accurately document your responses. By consenting to participate in the study, you are providing consent for me to audio-record your responses.

In addition to the interview, you will be asked to complete a questionnaire with some general questions about yourself. You will receive $30 for your participation in each of the initial two face-to-face interviews as compensation for your time and effort ($60 = total payment for two interviews). The third interview is generally brief (15-30 minutes) and can be conducted over the phone. I will not provide financial compensation for participation in the third interview due to the brevity of the interview.

This study will not provide you any form of mental health service. If you feel you are in need of mental health treatment, you are encouraged to contact your current therapist or your local community mental health agency. A hard copy of the Southeast Michigan Rainbow Resource Guide for Older Adults will be offered to you at the first interview.

Privacy and Confidentiality:

Your confidentiality will be protected to the maximum extent allowable by law. Confidentiality would not be maintained, however, if you report engaging in abuse of children, elderly adults, or if you report

intent to harm yourself or someone else. The only people with access to your research data will be Georgia Carpenter and Dr. Parra Cardona (her supervisor). In addition, the Michigan State University Human Subjects Protection Program may also have access to your data in the event of an audit. The audio recordings will be labeled with an ID number and will be temporarily linked to your name. However, we will delete the master list linking your ID number with your name as soon as the third interview is completed. Only Georgia Carpenter and Dr. Parra-Cardona will have access to the master list linking your name to your interview and questionnaire. Your contact information will be stored in a locked file cabinet in a research office with restricted access, as well as the researcher's password-protected computer. We will keep all data associated with this research project for three years after the project is closed, during which time it will be stored in a locked file in a research office with restricted access. The findings of this study will be described in the doctoral dissertation by Georgia Carpenter. When the results of this study are presented and published, pseudonyms will be used to ensure your anonymity.

Your Rights to Participate, Say No, or Withdraw:

Participation in this research study is completely voluntary. You may say no to participation or you may change your mind and decide to stop participating at any time with no negative consequences. You may also choose not to answer any question you do not want to answer. Your participation will have no effect on your ability to obtain services from your therapist or any other community mental health agency. Withdrawing from the study or not answering questions will not prevent you from receiving compensation for participating in the study.

Potential Risks and Benefits:

There is a risk that you might experience some discomfort as a result of your participation in this study. For instance, you might feel uncomfortable discussing challenges in your life. If you experience discomfort, you may always choose not to answer a question that makes you feel uncomfortable, take a break from answering questions, or stop participating in the study at any time without fear of negative consequences.

You may experience benefits from participating in this study. We expect that you may appreciate having the opportunity to talk about your experiences and provide feedback about what could be helpful to therapists committed to serving middle-aged lesbians. You may also experience relief by discussing past life experiences and explain the ways in which you have overcome past challenges. You might also experience satisfaction from knowing that your answers will help improve mental health services to other middle-aged lesbians.

Contact Information

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact either researcher listed below.

Georgia Carpenter, MA, LMFT
Researcher and Study Coordinator
Michigan State University
Human Development & Family Studies
408 Human Ecology Building

J. Rubén Parra-Cardona, Ph.D.
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Phone: (517) 432-2269

In addition, if you have any questions or concerns about your role and rights as a research participant or would like to obtain information, offer input, or would like to register a complain about this research study, you may contact, anonymously if you wish, the Michigan State University Research Protection Program at (517) 355-2180, FAX: (517) 432-4503, email irb@msu.edu, or regular mail at 202 Olds Hall, MSU, East Lansing, MI 48824.

Signed Consent:

Your signature below indicates your voluntary agreement to participate in this research study, which includes your authorization for me to audio-record your responses. Thank you for your time.

Signature: ____Date: ____________

You will be given a copy of this form to keep

APPENDIX B

IRB Exempt Status

MICHIGAN STATE UNIVERSITY

Initial IRB Application Approval

October 24, 2016

To: Jose Parra
3D Human Ecology

Re: **IRB#** 16-1352 Category: EXPEDITED 7
Approval Date: October 24, 2016
Expiration Date: October 23, 2017

Title: Experiences of Middle-Aged Lesbians in Therapy: A Focus on Perceived Satisfaction and Precursors of Resilience.

The Institutional Review Board has completed their review of your project. I am pleased to advise you that **your project has been approved**.

The committee has found that your research project is appropriate in design, protects the rights and welfare of human subjects, and meets the requirements of MSU's Federal Wide Assurance and the Federal Guidelines (45 CFR 46 and 21 CFR Part 50). The protection of human subjects in research is a partnership between the IRB and the investigators. We look forward to working with you as we both fulfill our responsibilities.

Renewals: IRB approval is valid until the expiration date listed above. If you are continuing your project, you must submit an ***Application for Renewal*** application at least one month before expiration. If the project is completed, please submit an ***Application for Permanent Closure***.

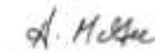
Revisions: The IRB must review any changes in the project, prior to initiation of the change. Please submit an ***Application for Revision*** to have your changes reviewed. If changes are made at the time of renewal, please include an ***Application for Revision*** with the renewal application.

Problems: If issues should arise during the conduct of the research, such as unanticipated problems, adverse events, or any problem that may increase the risk to the human subjects, notify the IRB office promptly. Forms are available to report these issues.

Please use the IRB number listed above on any forms submitted which relate to this project, or on any correspondence with the IRB office.

Good luck in your research. If we can be of further assistance, please contact us at 517-355-2180 or via email at IRB@msu.edu. Thank you for your cooperation.

Sincerely,



Harry McGee, MPH
SIRB Chair

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APPENDIX C

Interview Guide

Interview #1

Thank you for participating in this study. Basically, this study is focused on your level of satisfaction in therapy as a middle-age lesbian, as well as the characteristics of the therapeutic process associated with such level of satisfaction. We also want to learn about the ways in which therapy has supported your life experiences as a middle-aged lesbian. We expect that study findings will support mental health practitioners working with middle-aged lesbians by increasing the quality of the services they provide.

I will start this interview by asking you about your coming out process. I will then ask you questions about your satisfaction in therapy and the characteristics of therapy associated with your level of satisfaction. Finally, I will ask you about the ways in which you have overcome adversity in your life and how therapy has been helpful as you continue to overcome challenges in life. Your answers will allow me to understand what these experiences have been like for you and how we, as mental health practitioners, can offer high quality services to middle-aged lesbian women.

I truly want to understand your personal experiences as well as your thoughts, feelings, and meanings that you have about these experiences. Your story is unique and I'd like you to feel comfortable answering the questions in whatever way is best for you. This is not a test so there are no right or wrong answers. If a question is confusing, please let me know. Finally, if at any time you don't want to answer a question or you want to stop the interview, you have the right to do so. Just let me know and I will stop the interview.

Joining, Consent, and Payment

Please tell me about how you learned about this study (followed the participants' response by clearly detailing to participants how this research will assist clinicians in offering better services).

Proceed to sign the consent form and offer payment.

Interview

Grand Tour Question #1

Please describe your coming out experience.

Grand Tour Question #2

What is your level of satisfaction in therapy?

Grand Tour Question #3

What do you identify as the characteristics of therapy that have helped you the most?

Probes:

What is it about you that you consider has contributed towards your satisfaction in therapy?

What is it about the personal characteristics of your therapist that has been helpful?

What is it about the relationship you have established with your therapist that has been helpful?

Please tell me about how much you expected therapy to be useful before you started coming to therapy.

In which ways has therapy helped you to *change behaviors* you wanted to change prior to coming to therapy?

In which ways has therapy helped *you to think about your problems* in a more positive view?

In which was has therapy helped *you to manage your emotions* more effectively?

Grand Tour Question # 4

Please tell me about how you have overcome challenges in your life associated with being a middle-aged lesbian.

Probes:

What is it about you that has helped to overcome challenges associated with being a middle-aged lesbian?

What is it about how you have managed your relationships with people close to you that has helped you to overcome challenges associated with being a middle-aged lesbian?

With family members?
Close friends?

What is it about how you have managed your relationships with other people in your life that has helped you overcome challenges associated with being a middle-aged lesbian?

With neighbors
Friends
Co-workers
Others

Grand Tour Question #5

As you have reflected about the ways in which you have overcome challenges as middle-aged lesbian by focusing on yourself or others, has therapy been useful to help you with these experiences? If so, how?

NOTE: Focus on answers NOT addressed in response to Grand Tour Question 3

Grand Tour Question #6

What would be the main recommendations you would have for therapists serving middle-aged lesbians so they can be most helpful to their clients?

Closing Question

Is there anything else that I did not ask that you feel is important to include?

APPENDIX D

Outline of life-world data

First Draft

1. Recognizing how heterosexism affects me
    a. Seeing my heterosexual privilege when I lived as a straight married woman
    b. Understanding my internalized heterosexism
    c. Seeing heterosexist behaviors from others
    d. Realizing that some family members, friends and others no longer wanted contact with me because of my sexual identity
    e. Recognizing discrimination from my job or at my church
2. Experiencing changing social views
    a. Being a lesbian is not a mental disorder or a crime anymore
    b. Society is much more supportive than when I came out
    c. I can live openly easier now than I did ten or more years ago
    d. Laws have changed to protect me and my relationships or family.
3. Becoming aware of how trauma affected my sexual identity development
    a. Trauma made me fearful of exploring my sexuality with men or women
    b. Trauma made it difficult for me to be vulnerable with others
    c. Trauma made it hard to manage my emotions
4. Therapy helps me feel stronger
    a. Help me navigate this new territory
    b. My relationship with my therapist helps me stay accountable in therapy
    c. My feelings about other women are normal
    d. I can live out loud proudly
    e. I am not crazy or damaged
5. Feeling satisfied with therapy
    a. The therapeutic techniques apply to me
    b. My therapist accepts me
    c. Therapy helps me feel hopeful
    d. Therapy helps me feel self-confident
6. Feeling understood by my therapist
    a. My therapist understands issues for older lesbians
    b. My therapist understands me
    c. My therapist is comfortable and accepting working with LGB issues

Second Draft

1. Recognizing how heterosexism affects me
    a. Understanding my internalized heterosexism
    b. Seeing heterosexism behaviors from others
    c. Being impacted by heterosexism
2. Experiencing changing social views about LGB
    a. Society is much more supportive than when I came out
    b. Laws have changed to protect me and my relationships or family
3. Recognizing how trauma affected my sexual identity development
    a. Trauma made me fearful of exploring my sexuality with men or women
    b. Trauma made it difficult for me to be vulnerable with others
4. Therapy helps me feel stronger
    a. My relationship with my therapist helps me stay accountable in therapy
    b. I feel positive about my sexual orientation
    c. Therapy helps me feel hopeful
5. Feeling understood by my therapist
    a. My therapist understands me
    b. My therapist is comfortable working with LGB issues
6. Experiencing socio-political fears
    a. Fearing that legal rights and protections for me will disappear
    b. Fearing that I will experience more heterosexism

Third Draft

1. Experiencing heterosexism and discrimination
    a. Understanding how internalized heterosexism affects me
    b. Being impacted by heterosexism and discrimination
2. Experiencing changing social views about LGB populations
    a. Experiencing a more supportive society
    b. Feeling like a mentor for the younger generation
3. Recognizing how trauma affected me
    a. Trauma affecting my sexuality with others
    b. Trauma affecting my ability to connect with others
4. Therapy makes me feel stronger
    a. The relationship with my therapist helps me to be accountable
    b. Feeling positively about my sexual orientation
    c. Therapy makes me to be hopeful
5. Feeling understood by my therapist
    a. My therapist understands my life challenges and strengths
    b. My therapist is comfortable working with LGB populations
6. Feeling fearful
    a. Fearing that I will experience more heterosexism and discrimination
    b. Fearing that my legal rights will disappear

APPENDIX E

Outline of lived-experience data

First Draft

1. Coming out
    a. Being afraid to accept I was gay
        i. Feeling that part of me was dying if I didn’t come out
        ii. Feeling guilty about the pain I caused when I came out
    b. Feeling afraid to come out
        i. Feeling burdened by this big secret
        ii. Feeling unacceptable by my therapist
        iii. Losing my marriage to my male spouse
        iv. Losing custody of my kids
        v. Being cut from my family
        vi. Being rejected and alone
        vii. My church might expel me
        viii. I might lose my job
        ix. I’ll hurt others
    c. Struggles with sexual identity
        i. Trauma interferes with sexual identity development
        ii. Mental illness interferes with sexual identity development
        iii. Adjusting to unfamiliar social and relational roles
    d. Coming out later in life
        i. Creating new friends as an older lesbian
        ii. Dealing with the loss of old friends and male spouse
        iii. Helping my children adjust
        iv. Supporting myself financially
2. Discovering my strength
    a. Becoming an advocate for LGB rights
    b. Becoming a role model for younger LGB individuals
    c. Representing a positive view of a lesbian to others
    d. Feeling strong as a middle-aged lesbian
3. Using therapy to deal with adversity
    a. Learning therapeutic techniques
    b. Managing my emotions
    c. Letting go of insecurity
    d. Challenging negative beliefs about myself
    e. Taking steps to change unhealthy patterns
4. Taking action in therapy
    a. Feeling comfortable expressing my needs: Making myself vulnerable
    b. Being honest with my therapist and myself
    c. Making therapy work

5. Dealing with Socio-Political Concerns
    a. Fearing that legal rights and protections for me will disappear
    b. Fearing that I will experience more heterosexism, racism, ageism
    c. Wondering who will be there for me: Fears about retirement
6. Finding Support from Others
    a. Seeking affirmation and acceptance from therapist
    b. Finding safety to be myself with others
    c. Seeking resources from the LGB community
    d. Exploring churches and groups that are LGB-friendly
    e. Asking for help when I need it
7. Fighting the Effects of Oppression
    a. Understanding the intersectionality of stigmatized identities
        i. As a lesbian
        ii. As a woman
        iii. As an older person
        iv. As a person living with a disability
        v. As a family member of a person living with serious mental illness

Second Draft

1. Coming out
    a. Feeling afraid to come out
    b. Struggles with sexual identity
    c. Coming out later in life
2. Discovering my strength
    a. Becoming an advocate for LGBTQ rights
    b. Representing a positive view of a lesbian to others
3. Using therapy to deal with adversity
    a. Embracing coping techniques
    b. Letting go of insecurity
    c. Moving away from unhealthy behaviors
4. Taking action in therapy
    a. Making myself vulnerable
    b. Making therapy work
5. Becoming A Political Activist
    a. Engaging in advocacy events
6. Finding Support from Others
    a. Asking for help when I need it
    b. Seeking affirmation and acceptance from my therapist
    c. Seeking resources from the LGBTQ community
7. Fighting the Effects of Oppression
    a. Living as an out lesbian
    b. Challenging oppression
    c. Fighting for LGB equality

Third Draft

1. Coming out
    a. Feeling afraid to come out
    b. Struggling with my sexual identity
    c. Discovering my strength and coming out
2. Embracing therapy to deal with adversity
    a. Embracing coping techniques
    b. Letting go of fear and insecurity
    c. Moving away from unhealthy behaviors
3. Taking action in therapy
    a. Being vulnerable
    b. Making therapy work
4. Reaching out thanks to therapy
    a. Asking for help when I need it
    b. Seeking affirmation from my therapist
    c. Seeking resources from the LGB community
5. Becoming A Political Activist
    a. Helping others understand our strengths as lesbians
    b. Challenging oppression by fighting for me and others
    c. Becoming a political activist for LGB rights

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