

Clinician Self-Disclosure or Clinician Self-Concealment? Lesbian, Gay and Bisexual
Mental Health Practitioners' Experiences of Therapeutic Relationships.

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Abstract

Previous research exploring therapist self disclosure (TSD) indicates that when therapeutically relevant and used sparingly it can have a beneficial effect for the client, particularly when the client is a member of a stigmatised population. There are several limitations to the current literature including the failure to consider contextual variables that may influence the decision making process behind TSD and its impact. The quantitative methodology has mostly utilised analogue designs which may fail to capture the complexity of the topic when applied to clinical practice. There is a dearth of literature exploring the experience of disclosing from the perspective of the clinician. The current study sought to bridge this gap by utilising a qualitative methodology, Interpretative Phenomenological Analysis (IPA), to explore the experiences of lesbian, gay and bisexual (LGB) mental health practitioners disclosing sexual orientation to clients.

Eight self identifying LGB clinicians within Leicester Partnership Trust with experiences of disclosing sexual orientation to clients were interviewed for this study. Analysis revealed five super-ordinate themes; a) not just another disclosure b) reaching a make or break disclosure decision c) the experience of disclosing d) the enhancing effects of disclosure and e) the cost of concealment. Each super-ordinate theme contained three sub-ordinate themes. Overall the analysis revealed that disclosing sexuality is a complex, risky and meaning laden experience that requires careful consideration of the potential costs and benefits to the client, clinician and relationship. When a considered disclosure was made the participants experienced enhancing effects. A negative impact was experienced when they felt the need to conceal their sexual orientation. Clearly a complex process, disclosures of this nature were usually infrequent and done with the best interests of the clients and relationship in mind. Strengths and weaknesses of the study and suggestions for further research are discussed.

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Section A.

Literature Review

What is the effect of therapist self disclosure on the client, therapeutic relationship and psychotherapeutic outcome?

Abstract

The usefulness and appropriateness of therapist self disclosure (TSD) to the therapeutic process and outcome has been debated for many years. TSD has been defined in the research literature in many different ways. In common is the idea that a TSD occurs when a therapist verbally reveals something about him/ herself that would not otherwise be known by the client. TSD is an intervention used infrequently, serving to model appropriate client behaviours, increase similarity between clinician and client, promote universality, give encouragement, build rapport and offer alternatives. Previous reviews have revealed that TSD can be beneficial and needs to be researched and is a viable counsellor behaviour that needs to be researched and closely scrutinised. It has now been almost two decades since the last systematic TSD review was conducted and therefore an updated review of the topic could provide a valuable addition to the literature. The current review aims to systematically examine and critique the literature pertaining to the effects of therapist self disclosure published since this time.

The search strategy revealed eight suitable articles. The reviewed articles consist of; three examining the effect of different types of disclosures and their impact on observer ratings along different dependent variables, one examining the impact of congruency of TSD and four examining the effect of client and therapist characteristics on different dependent variables, with some cross over between investigations. Although comparison of contrasting methodologies is problematic, some conclusions can be drawn from the literature reviewed here. Taken together, the findings globally suggest that TSD can be beneficial to the therapeutic relationship and therapeutic outcome, with some limitations. Strengths and limitations of the reviewed articles are discussed, in addition to ideas for further research.

Introduction

A hotly debated topic for many years within the discipline of psychology is the usefulness and appropriateness of therapist self disclosure (TSD) to the therapeutic process and outcome. Emerging as a research interest during the 1970s as a function of exploring 'what works in therapy', therapists' intentional decisions to share personal information with clients remains a complex area of clinical practice (Bridges, 2001). Within mental health practice, TSD has traditionally been discouraged (Knox & Hill, 2003). However, during the 1970s, and as mental health care and society more widely changed over time, researchers and clinicians began to focus on the potential benefits of TSD. They started to challenge the long held assumption that TSD was inherently detrimental and something to be avoided (Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001).

TSD has been defined in the research literature in many different ways. Disclosures which are non-verbal, i.e. based on dress, surroundings and physical characteristics of the therapist, are not generally included in these definitions because they are qualitatively different to verbalised self disclosures as they do not require the purposeful sharing of personal information (Norcross, 2002). In common is the idea that a TSD occurs when a therapist verbally reveals something about him/ herself that would not otherwise be known by the client (Hill & Knox, 2001). McCarthy and Betz (1978) differentiated between self disclosing statements (statements that refer to personal experiences of the therapist), and self involving statements (statements that refer to the therapist's personal response to the client). Disclosures of counter transference and immediacy statements have also been differentiated in the literature (Hill & Knox,

2001). It is also commonly recognised that a therapist revealing personal information about her/himself to the client can involve some risk and vulnerability (Bridges, 2001). For example, an intentional sharing of personal information or views can leave the therapist feeling exposed to the scrutiny of the client (Bridges, 2001).

Theoretical Background

Differing Schools of Thought - When is TSD Appropriate or Useful?

The traditional psychoanalytic stance on the usefulness of TSD lies on one end of a continuum and does not advocate its use. For this orientation, the therapist should act as a ‘mirror’ to the client, reflecting back only what the client has presented the therapist with (Norcross, 2002). Here, self-disclosure on behalf of the therapist is viewed as unethical and incorrect (Hansen, 2005) and a mistake often made by novice therapists attempting to ease resistance (Myers & Hayes, 2006). Central to this argument is the need for therapist neutrality in order to uncover, interpret and resolve transference; the unconscious part of the client-therapist relationship which emerges as a result of the clients’ unresolved issues (Goldstein, 1997). TSD has been traditionally viewed as resulting from countertransference; the therapists’ own unresolved, unconscious issues and as such has been viewed as non-useful if not unethical to reveal within the therapeutic relationship (Mallow, 1998). In more contemporary analytic literature TSD has provided rich debate around its’ potential usefulness and the near impossibility of revealing nothing of ones’ self throughout treatment has been recognised (Mallow, 1998). As such the traditional assumptions have been questioned and the debate around TSD can best be considered as having evolved in favour of a more flexible and less dichotomous perception of its potential usefulness to the therapeutic process (Meissner,

2002; Gediman, 2006; Tsai, Plummer, Kanter, Newring & Kohlenberg, 2010). Authors have expressed the usefulness of recognising and revealing countertransference responses as a therapeutic tool to aid understanding of the clients' unconscious and emotional processes (Mallow, 1998). Countertransference has also been considered as the therapists' response to the clients' interactional patterns; therapists' disclosure of their subjective experience of being with the client can therefore be beneficial therapeutically (Cerney, 1985; Mallow, 1998; Peterson, 2002). More contemporary authors have argued for compatibility of neutrality *and* self disclosure to bridge the gap between these two dichotomous positions (Meissner, 2002). This has led to the argument for the potential usefulness of TSD when approached from the principle of mental, rather than behavioural, neutrality so that any TSD is based on the ongoing clinical experience of what may be "facilitative of both the analytic process and the therapeutic benefit of the client" (Meissner, 2002, pg. 5).

On the other end of the continuum lies the humanistic approach whereby TSD is both expected and desirable as a means of exhibiting congruence and as an essential aspect of the therapeutic relationship (Rogers, 1951, cited in Norcross, 2002). Similarly, feminist theory advocates the use of TSD and suggests that it can serve several therapeutic goals including addressing the issue of power imbalance between client and therapist and enabling clients to make an informed choice when choosing a therapist (Enns, 1997). Multicultural theory also advocates the use of self disclosure, particularly when working with clients of different socio-cultural backgrounds and alternative lifestyles to the therapist as a means of proving themselves trustworthy (Norcross, 2002).

Use of Therapist Disclosure in Psychotherapy

In a summary of the literature pertaining to the use of TSD, Hill and Knox (2001) found that TSD is an intervention used infrequently. Examining research which utilised a number of different sources (including judges coding disclosure behaviour, clients and therapists) to evaluate disclosure behaviour in individual therapy sessions, they concluded that TSD accounted for between 1-13% of all interventions, with an average of 3.5% across studies. Research utilising a survey methodology suggests that therapists/ counsellors use a significantly greater frequency of positive versus negative self involving statements during sessions (Robitscheck & McCarthy, 1991). Disclosure of information regarding professional qualifications and experience are most common and disclosures of sexual practices and beliefs least common (Edwards & Murdock, 1994). Therapists are also more likely to make disclosures to clients with high ego strength disorders (i.e. anxiety and mood disorders, PTSD and adjustment disorders) (Simone, McCarthy & Skay, 1998). Research that has focussed on the reasons why therapists disclose to clients suggests that TSDs serve, from the perspective of the clinician, to model appropriate client behaviours, increase similarity between clinician and client, promote universality, give encouragement, build rapport and offer alternatives (Edwards & Murdock, 1994; Simone, McCarthy & Skay, 1998).

The research literature has also examined TSD as a function of therapist theoretical orientation. Feminist therapists appear more willing to share salient aspects of their personal background than psychoanalytic/dynamic and other therapists. Humanistic-experiential therapists report disclosing more often than psychoanalytic therapists and marriage/family therapists are more likely to disclose personal information than clinical social workers (Simi & Mahalik, 1997; Edwards & Murdock, 1994; Jeffrey & Austin,

2007). No differences have been reported in therapist ethnicity and amount of disclosure (Edwards & Murdock, 1994). One study has reported that for male therapists, as experience increases self reference decreases (Robitscheck & McCarthy, 1991). Therapist theoretical orientation therefore appears to be a better predictor of self disclosing behaviour than demographic variables.

Previous Research Reviews

A review search revealed five previous relevant reviews (Strassberg, Roback, D'Antonio & Gabel, 1977; Watkins, 1990; Hill & Knox, 2001; Fisher, 2004; Henretty & Levitt, *in press*). One of these focussed specifically on the ethical issues surrounding therapist disclosure of sexual attraction to a client (Fisher, 2004). Strassberg et al's (1977) more general review examined the previous two decades of research to provide an in-depth review of the theory and empirical findings from the clinical literature. Hill and Knox's (2001) review comments on many pieces of research from the 1970s to time of print. Henretty & Levitt's (*in press*) article similarly summarises TSD research from the 1970s to date. However, none of these reviews were conducted in a systematic manner as no information is provided which would allow replication.

Watkins' (1990) systematic research review, however, did report on methods used to select the literature, facilitating replication. TSD literature published between 1970 and 1988 was reviewed. In it he grouped together studies which focussed on (i) positive disclosure, negative disclosure and self involving statements as counsellor self disclosure variables (ii) similarity/ dissimilarity and intimacy as counsellor self disclosure variables (iii) mediating variables in counsellor self disclosure. He concluded

that self disclosure is a “viable counsellor behaviour that needs to be researched and closely scrutinised” (pp. 497). Ten recommendations for future research were provided, including moving the research away from analogue studies into the field, investigate TSD in regard to subject and counsellor race and ethnic origin, study the effects of TSD beyond the initial interview and develop research on TSD in a manner that is consistent with theory and teaching on TSD.

It has now been almost two decades since Watkins’ (1990) review was conducted. As noted by the Psychopathology Committee of the Group for the Advancement of Psychiatry (2001), the way in which mental health care is delivered changes over time in line with societal changes and therefore an updated review of the topic could provide a valuable addition to the literature.

Aims

The current review aims to systematically examine and critique the literature pertaining to the effects of therapist self disclosure published since the time of Watkins’ (1990) paper. By doing so, the review aims to provide an overview of recent research into the area, explore whether the research recommendations have been taken forward and establish the effects of therapist self disclosure in recent research.

Method

A systematic review of the literature pertaining to the effects of therapist self disclosure was conducted using the databases PsychInfo, PsychArticles, Medline and Embase. Appropriate search terms, identified through the review literature, were entered into the individual databases. The search terms were *therapist self disclosure*, *counsellor/counselor self disclosure*, *therapy outcome*, *therapist/counsellor/counselor characteristics*, *client characteristics* and *therapeutic relationship*. The terms were combined to identify all related articles. This search revealed relatively few research articles (78) and time was therefore spent reading through references of reviews, and hand-searching journal articles to elucidate any further articles. The following limitations were set on each database:

- Articles must be published between 1990-2010
- Articles must be written in English
- Articles must be based on data from a human population
- Articles must be peer reviewed

Any articles published prior to 1990 were omitted as the current review was concerned only with recent research. Including articles published before 1990 would also be potentially replicating the information available in previous reviews. All reviews, single case observations, theoretical and purely discursive pieces were removed. Studies that utilised groups as participants were also excluded to maintain internal validity. The identified articles were initially screened for relevance by reading through the journal titles and abstracts and, where insufficient information was available, the article in its entirety was retrieved. A total of 23 articles were identified for possible inclusion and were collated using an online reference management database (Refworks). At this stage

eight articles were identified as utilising qualitative methodology. In order to replicate and update Watkins' (1990) review concerning the quantitative literature these articles were omitted.

The remaining fifteen articles were further screened using a data extraction tool (Appendix C). The data extraction tool facilitated assessment of the quality of each article and its relevance to the review. Quality of the article was rated according to its sampling procedures, methodology and analysis. The relevance of each article to the review was rated according to its aims and adherence to exploring the effects of TSD on domains including the therapeutic relationship, client and/or therapist.

Results

Of the articles initially identified from the database search, fifteen were scrutinized for possible inclusion in this review using a data extraction tool. Following this procedure eight articles were deemed appropriate for inclusion. The remaining seven articles were excluded because they were not relevant to this review (i.e. not examining the effects of TSD, utilising groups, exploring career counselling rather than mental health or were position pieces as opposed to research articles). Due to the small pool of relevant, available articles, some research rated as being of poorer quality (for example, those using purely questionnaire methods) were included where they added significantly to the evidence base by examining the effects of TSD on client, therapist or therapeutic relationship.

The articles reviewed utilised the terms therapist and counsellor. For the purpose of clarity this review will use the term therapist to describe both. The articles broadly cover the effect of different types, frequency and intimacy of TSDs on therapy outcome, perceptions of the therapist and likelihood to engage in therapy. Ethnicity of therapist and participant were also utilised as variables and the studies made use of clinical and non-clinical populations. The reviewed articles consist of; three examining the effect of different types of disclosures and their impact on observer ratings along different dependent variables, one examining the impact of congruency of TSD and four examining the effect of client and therapist characteristics on different dependent variables. It should be noted that there was some cross over between studies regarding focus of the study i.e. where some focussed on specific types of disclosure they also explored variables included in other studies. While it would have been preferable to focus more exclusively on one element (i.e. specific effect on the therapeutic relationship *or* therapy outcome) omitting this data from the small pool of relevant data retrieved through the search strategy would mean losing information potentially important to the topic of this review. The reviewed articles are summarised in Table 1 (see Appendix D for a more detailed summary of reviewed articles). For the purpose of clarity, the articles will be grouped and evaluated as follows; effect of different types and frequency of disclosures, effect of congruency of disclosures, effect of client and therapist characteristics.

Table 1. Summary of reviewed articles

Grouping	Authors
<i>Effect of Type and Frequency of Disclosure</i>	<ol style="list-style-type: none"> 1. Myers & Hayes (2006) 2. Barrett & Berman (2001) 3. Goodyear & Schumate (1996)
<i>Effect of Congruency of TSD</i>	<ol style="list-style-type: none"> 4. Nyman and Daugherty (2001)
<i>Effect of Client/ Therapist Characteristics/ Demographics on TSD</i>	<ol style="list-style-type: none"> 5. Kim, Hill, Gelso, Goates, Assay and Harbin (2003) 6. Cashwell, Shcherbakova and Cashwell (2003) 7. Kelly & Rodriguez (2007) 8. Gregory, Pomerantz, Ptitbone and Segrist (2008)

Effect of Type and Frequency of Disclosure

One study examined how observer perception of therapists and sessions were affected by general TSD and counter-transference disclosures in comparison to no disclosures. The role of the working alliance (WA) and previous experience of therapy on perception was also explored (Myers & Hayes, 2006). An undergraduate student population (n=224) viewed one of three videos in which the WA was depicted as either positive or negative and in which the type of TSD was manipulated to show either general, counter-transference or no disclosure. The dependent variable was participant ratings on several questionnaires relating to the therapists' perceived performance. It was found that perception of the therapist and session was affected by the WA. When the WA was positive, the general self-disclosure condition was rated more expert and in depth than both the counter-transference and no disclosure conditions. When the WA was negative the no disclosure condition was rated as more expert, indicating a mediating effect of WA on perceived helpfulness/ appropriateness of TSD. In addition, participants with previous experience of therapy rated the counter-transference

condition as more expert and in depth. It was concluded that self-disclosure may be problematic when the WA is negative but beneficial when the WA is positive, genuine and humane.

There are several limitations to this study. Generalisability was limited by the analogue design and the fact that the data analysed were captured from a simulated segment of a single therapy session. The brief simulated segment could be argued as unlikely to be representative of the complex and fluid nature of the therapy process. Generalisability is further limited due to all of the depicted therapists being white and the majority (90%) of participants also being of European American ethnicity. In addition, this study did not explore the therapist's potentially differing views of the WA. Limitations notwithstanding, the study highlights the importance of the therapist's need to be mindful of whether and what to disclose. Exploring potential mediating factors such as the WA is in line with the recommendations of Watkins' (1990) review.

Barrett and Berman (2001) manipulated the number of self disclosures made by a therapist over four sessions. The number of disclosures was increased with one client and decreased with another in a clinical sample of thirty six clients at a university counselling centre. Several likert type scales were utilised to measure the dependent variables of symptom distress and liking of therapist. It was found that participants in the increased disclosure condition reported lower symptom distress and greater liking for their therapist. No effect of TSD on frequency or intimacy of client disclosures was found. However, as nearly all TSDs were judged to be in response to similar client disclosure, generalisability of the findings is restricted to reciprocal TSDs.

A particular strength of this study is that by utilising a clinical sample its findings are more readily applicable to clinical practice. A further strength is that, in line with Watkins' (1990) recommendations, the study explores the effects of TSD beyond the initial interview stage. There were, however, several limitations. The authors do not indicate how participant suitability for the study was determined, introducing the possibility of sampling bias. However, inclusion and exclusion criteria were reported. In addition, the clients and therapists were around the same age limiting generalisability to therapist – client relationships where the age gap is minimal. It is possible, and worth further exploration, that larger age differences between therapist and client could yield different results. Also, the study does not address the possible differences in types of disclosures (i.e. factual information versus personal thoughts or feelings).

The final study utilised a sample of 120 licensed mental health professionals (60 female and 60 male) who responded to simulated 8.5 minute segments of therapy sessions in which the client disclosed sexual attraction to the therapist. Likert-type scales rating perceived expertness, attractiveness and trustworthiness of the depicted clinician were utilised (Goodyear & Schumate, 1996). The response of the therapist was manipulated to either disclose similar sexual attraction or be non-committal regarding their feelings. The self-disclosing condition was rated as less therapeutic for the client and the mental health practitioner was rated as less expert but more attractive. No significant effect of condition on rating of the therapists' trustworthiness was found. The generalisability of these results is, however, limited by the analogue design, although the use of mental health professionals as observers does move the study somewhat into the field as a progression from purely non-clinical or student samples. Generalisability is further limited by the fact that all participants were from the greater Los Angeles area and were

majority white and non-Hispanic (92.5%). As highlighted by Watkins (1990), further exploration of ethnicity as a mediating factor on the effect of TSD is needed to draw firmer conclusions here.

A particular strength of this investigation is that it addresses a specific type of disclosure which remains ethically dubious but is nonetheless a probable situation to be encountered by therapists at some point during their career. One limitation is that the authors did not indicate how participants were assigned to conditions. Also, participants were provided with background information regarding the clients' recent experience of divorce which may have influenced their ratings, detracting from the validity of these results.

In summary, it appears that a higher frequency of TSD can serve to reduce symptom severity and increase liking for the therapist. WA is a potentially powerful mediating factor on the effect that TSD has on the client, as is previous experience of therapy. TSD of sexual attraction to a client remains an ethically difficult area for mental health professionals but such disclosures do not negatively affect observer ratings of therapist trustworthiness.

Effect of Congruency of TSD

Nyman and Daugherty (2001) examined the relationship between the congruence of therapist self disclosure of a religious coping strategy (prayer) and observer perceptions of a therapist. Vignettes were manipulated so that the TSD was either congruent or incongruent with the client disclosure. A student population (n=67) was utilised as raters. It was found that participants in the congruent disclosure condition had a more

favourable perception of the therapist. Participants across the two conditions did not differ significantly on ratings of trustworthiness or expertness but did on ratings of attractiveness (i.e. friendly, likeable, sociable and warm). Participants were significantly more likely to choose to see the therapist depicted in the congruent condition for personal therapy. It was concluded that the congruence of TSD may play a role in determining the effect of self disclosure on the therapeutic relationship.

Exploring disclosure congruence as a mediating factor on the effect of TSD is a strength of this investigation and is in line with previous recommendations for future research (Watkins, 1990). Several methodological limitations include the use of a non-clinical, ethnically homogenous sample limiting generalisability beyond this population. The small sample size may have affected results, and the authors did not indicate that a power analysis had been conducted to establish effect size. Like other studies utilising a university sample population, the degree of education and socio-economic status may also limit the generalisability of results to highly educated individuals. It is also possible that the findings might not be replicated with populations from different ethnic and/or religious backgrounds, further limiting generalisability. In addition, by using written vignettes the investigation does not control for clinician technique as a possible mediating factor as the participants may have pictured the disclosure happening in a multitude of ways, potentially affecting results.

Effect of Client Characteristics/ Demographics on TSD

Four of the eight studies explored the effect of client characteristics on TSD. Two examined the role of client ethnicity.

Kim, Hill, Gelso, Goates, Assay and Harbin (2003) explored how Asian-American participants reacted to counsellor disclosures during one session. They examined the immediacy effects of the type and intimacy of the disclosure utilising sixty two Asian American university students and observer ratings. Utilising several likert type scales of participant perception of the therapist, relationship and helpfulness of disclosures as the dependent variables, they manipulated the amount of personal information disclosed by the therapist. It was found that the disclosure condition (high versus low) did not predict session outcome. Disclosures of reassurance/approval and strategies used by the therapist to overcome difficult situations were used more frequently than other types of disclosure. Participants rated disclosures of strategies as more helpful than approval/reassurance. In addition, the intimacy of the disclosures was related to helpfulness, although the vast majority of the disclosures were judged to be of medium intimacy, limiting comparison across intimacy levels.

A particular strength of this investigation is that, in line with previous research recommendations (Watkins, 1990) it uses a non-white ethnic population and examines adherence to cultural values as a potential mediating factor in the effect of TSD. Several limitations to the investigation were apparent, including the questionable soundness of one of the scales used as a dependent variable; a single item measure that had not been used before. The data were collected during only one (initial) session and therefore may differ from data collected from later sessions or ongoing sessions. Participants were also paid for their participation and results may have differed for clients genuinely seeking counselling without the prospect of payment. The generalisability of these results is further limited by the small sample size.

Cashwell, Shcherbakova and Cashwell (2003) explored the influence of client and therapist ethnicity on client preferences for TSD among a sample of African-American and Caucasian university students (n=411). It was found that respondent ethnicity affected preferences for certain types of information about the therapist. African-American participants reported a significantly stronger preference for TSDs relating to personal feelings, sexual issues, professional issues and success/ failure than Caucasian participants. Both African-American and Caucasian participants indicated stronger preference for TSD when the therapist was identified as being of a different ethnicity to the participant. A real strength of this study is that it explores client preferences for disclosure, an area that has received little attention in the literature. It highlights the potential for TSD to be utilised by mental health professionals of any ethnicity to enhance the therapeutic relationship and engagement. In addition, it adds to our knowledge regarding cross-cultural counselling and indicates potential avenues to enhance therapeutic engagement. However, the use of a non-clinical student sample limits the generalisability of results and further exploration is clearly required.

Another study investigated the links between self reported TSD and clients' initial symptom levels, the working alliance (WA) and symptom change (Kelly & Rodriguez, 2007). It was found that, contrary to their hypotheses, therapists disclosed significantly more to clients with lower initial symptomatology. TSD was not significantly related to WA scores and self-disclosure scores were not significantly correlated with symptom change. It was concluded that more TSD does not result in better therapy outcome. However, only amount of TSD was investigated, as opposed to timing, congruency or intimacy of the TSD. One limitation of this article is that the authors did not report the type of correlational analysis utilised. Selection bias may have been introduced in the

recruitment stage of the research as the therapists used in the study were asked to select their own sample and the dependent variable of therapist self reports was not validated. In addition, clients were recruited at different stages of therapy and were paid for their participation which could have impacted on results. However, the investigation does utilise a clinical sample and its results are therefore more readily applicable to the clinical field.

The effect of client characteristic of religiosity (high versus low) and TSD of religious affiliation at the onset of therapy was investigated by Gregory, Pomerantz, Ptitbone and Segrist (2008). They found that across both levels of religiosity, participants were more likely to see psychologists who described themselves as having an affiliation to a major religion as opposed to describing themselves as atheist. The particular religion of the psychologist was significant for the high religiosity participants and non-significant for low religiosity participants. This suggests that therapist disclosure of personal religious background at the outset of therapy may have a significant effect on the likelihood that a prospective client would choose to see the therapist. By exploring religiosity as a potential mediating factor Gregory and Pomerantz et al (2008) are advancing our understanding as suggested by Watkins (1990). However, the analogue design and study vignettes may not accurately reflect how the therapist in real clinical situations would make such a disclosure. A further limitation of the investigation is that their sample consisted of a majority female, European-American participants thereby limiting generalisability beyond this group.

Discussion

Research exploring TSD has made use of several methodologies including analogue studies and surveys and clinical and non-clinical populations to explore the effect of variables such as the WA, ethnicity, religiosity and previous experience of therapy in relation to TSD. Comparison of results utilising contrasting methodologies and sample populations is problematic because differing results could be explained in terms of such methodological differences. However, some conclusions can be drawn from the literature reviewed here. Taken together, the findings of this systematic review globally suggest that TSD can be beneficial to the therapeutic relationship and therapeutic outcome, with some limitations.

The research included in this review produced mixed results regarding the effect of increased frequency TSD. It was found that increased, reciprocal TSD can reduce symptom distress and increase liking of the therapist, thereby aiding engagement and potentially the working alliance (WA) (Barrett & Berman, 2001). However, increased frequency of TSD has also been shown not to lead to better therapeutic outcome (Kelly & Rodriguez, 2007). The different methodological designs could account for this discrepancy. The use of a clinical sample across studies makes explanation of these differing results more difficult, although the difference in the number of sessions for which the clients had been seen (four sessions versus ongoing therapy, respectively) could provide some explanation.

The research provided evidence of an interactive effect of the WA on TSD and indicates potentially beneficial effects of TSD when the WA is positive, and potentially

problematic effects when the WA is negative (Myers & Hayes, 2006). In contrast, another study indicated that TSD was not significantly related to the WA (Kelly & Rodriguez, 2007). These findings are particularly interesting given that previous studies suggest that most TSD occurs in the initial few sessions, presumably before a strong WA has been established. Paradoxically, previous survey investigations have indicated that TSD occurs as a means of increasing similarity between client and therapist, with the aim of improving the WA (Edwards & Murdock, 1994). The differing methodologies utilised between these two studies could account for the differing results.

A potentially beneficial effect of disclosing personal information about the therapist (e.g. religious background) at the outset of therapy has been found and suggests that clients who describe themselves as non-atheist would be more likely to engage in therapy with a therapist who is affiliated to a major religion (Gregory, Pomerantz, Ptitbone & Segrist, 2008). This could be an important factor in enhancing engagement with various religious populations, even when the reason for seeking therapy may not be related to religion.

Through exploring another specific type of disclosure, that of sexual attraction to the client, it has been shown that ratings of therapist expertness are adversely affected. This type of disclosure remains a contentious and under-explored area within psychology (Fisher, 2004). Feelings of attraction towards clients are not uncommon within the therapeutic relationship (Fisher, 2004) and further exploration of the topic could provide valuable information to aid preparation for such situations during therapists' training and ongoing development and supervision.

The congruence of the disclosure made by the therapist has also been shown to be an important mediating factor in determining the effect of TSD on the therapeutic relationship. Therapists who use disclosures that are congruent with the clients' own disclosures are rated more favourably by observers (Nyman & Daugherty, 2001) and support better therapeutic outcome (Barrett & Berman, 2001). However, most TSDs were reciprocal in nature and in line with prior client disclosure in one of these reviewed studies and more research is needed to examine more closely the effect of congruent versus incongruent disclosures.

In line with the recommendations made by Watkins in his 1990 review, more recent investigations have started to explore the effect of client and therapist ethnicity on TSD and its effect with specific populations. Results suggest that, among an Asian-American population, the amount of TSD does not predict session outcome, although the intimacy of disclosures appears related to its helpfulness (Kim & Hill et al, 2003). In addition, client and therapist ethnicity has been shown to influence preferences for certain types of information in cross cultural counselling (Cashwell, Shcherbakova & Cashwell, 2003).

Limitations and Future Research

The heterogeneous populations and methodologies reviewed makes synthesis and comparability of the findings difficult. In addition, the various studies explored different factors relevant to TSD and made use of a variety of measures to do so. Whilst it would have been preferable to limit the reviewed articles to certain methodologies, the paucity of recent, relevant research made this impossible.

Interestingly, very little published research has emerged since 1990, in comparison to Watkins' review. This may be due to the belief that all potential avenues relating to TSD have already been explored. However, this was not the conclusion drawn and is not supported by the findings of the current review. Similarly, this review found that analogue studies utilising student populations continue to be the most common method to examine the topic of TSD. Although they can be valuable in informing field-based research (Watkins, 1990) the generalisability of results to a clinical population is questionable. Therefore it would be useful for future investigations, and subsequent reviews, to focus on clinical populations. Moving the research further into the field could better address issues of external validity.

In addition, the current review focussed solely on quantitative research articles. Several qualitative research pieces regarding the effect of TSD on clients emerged during the search strategy. Our current knowledge is mostly gleaned from questionnaire methods which may fail to capture the intricate and complex nature of the topic. Although the inclusion of qualitative methods was beyond the scope of this review, a review of these investigations could reap rich data regarding the effect of TSD. Future research exploring the effect of TSD from the perspective of the clinician would be extremely valuable in enhancing our understanding.

With the exception of two investigations that focussed solely on the effect of ethnicity on TSD (Cashwell, Shcherbakova & Cashwell, 2003; Kim & Hill et al, 2003), the research reviewed here used a majority of Caucasian, American males and females. As our society continues to become more sensitive to minority issues and needs, enhancing the evidence base and applying findings to the field is ever more important and warrants

further research. In addition to ethnicity, future research should explore the effect of TSD with other minorities, e.g. disability and sexual orientation. Interestingly, TSDs regarding sexual beliefs and practices have been shown to occur rarely, where TSD of significant relationships are more common (Edwards & Murdock, 1994). This is somewhat paradoxical for lesbian, gay or bisexual therapists and warrants further exploration. In addition, differences in the mental health systems of the USA and UK mean that more UK based research is sorely required to enhance our rounded understanding.

Clinical Implications

There are several potentially important clinical implications of the research reviewed here, which broadly indicates a beneficial effect of modest, congruent TSD. Firstly, the research indicates that TSD may be a useful intervention when the WA is perceived to be positive and suggests TSD as an intervention may be less successful when the WA is negative. This finding could allow clinicians to make better informed decisions regarding whether or not to disclose personal information.

Secondly, it appears that certain types of disclosures, for example of religious background, may be useful, and at the least do not appear harmful, when made at the outset of therapy. In line with feminist perspectives of individual therapy (Norcross, 2002) the research suggests that including this level of personal information at the outset of therapy could allow potential clients to make informed decisions about who they wish to enter into a therapeutic relationship with, and potentially enhance engagement. However, more research examining the effects of different types of

disclosures at different stages of therapy would provide more robust evidence regarding this.

Thirdly, it appears that the use of TSD may be a particularly useful intervention when working cross culturally and, more specifically, that clients may differ in their preference for certain types of information dependent on their/ their therapists' ethnicity. An awareness of this and subsequent facilitation of such disclosures could work to enhance engagement with mental health services and improve the WA. This is a particularly useful finding given that previous research indicates that BME populations are less likely to engage with mental health services (Kreyenbuhl, Nossel & Dixon, 2009). However, until more is understood about the effects of a host of other variables on TSD, its use should be monitored by the clinician and reasons for making disclosures evaluated.

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Section B.

Research Report

Clinician Self-Disclosure or Clinician Self-Concealment? Lesbian, Gay and Bisexual
Mental Health Practitioners' Experiences of Therapeutic Relationships.

Introduction

Researchers within the field of psychology have had a longstanding interest in trying to discover ‘what works’ in therapy (Norcross, 2002). Decades of research exploring various possible contributing factors strongly indicate that it is non-specific factors, including empathy, warmth and the therapeutic alliance, across different orientations that appear most important to the effectiveness of therapy (Lambert & Barley, 2001; Wampold, Minami, Baskint & Tierny, 2002; Wampold & Mondin et al, 1997; Spielmans, Pasek & McFall, 2007). The functions of therapist self disclosure (TSD) and its impact on the therapeutic process and outcome is one area of interest to have emerged from this research.

What is TSD?

TSD has been defined in the research literature in many different ways. In common, however, is the idea that a TSD occurs when a therapist verbally (as opposed to non-verbally) reveals something about him/ herself that would not otherwise be known by the client (Norcross, 2002). TSD is an intervention used infrequently (Hill & Knox, 2002) and appears to serve the purpose of modelling appropriate client behaviours, increasing similarity between clinician and client, promoting universality, giving encouragement, and building rapport (Edwards & Murdock, 1994; Simone, McCarthy & Skay, 1998).

Why the continued debate?

The usefulness and appropriateness of TSD evokes a strong continuum of feeling among the differing schools of thought within psychology. The traditional psychoanalytic stance advocates against its use (Norcross, 2002). On the other end of the continuum lies the humanistic approach whereby TSD is both expected and desirable as a means of exhibiting congruence (Rogers, 1951, cited in Norcross, 2002). Similarly, feminist theory posits that TSD can serve several therapeutic goals including addressing the issue of power imbalances and enabling clients to make an informed choice when choosing a therapist (Enns, 1997). Multicultural theory also advocates TSD, particularly when working with clients of different socio-cultural backgrounds and alternative lifestyles to the therapist (Norcross, 2002).

What can we learn from the literature?

The quantitative literature indicates that investigations have utilised various methodologies to explore the usefulness of type, frequency, congruency and intimacy of TSD (Henretty & Levitt, *article in press*; Watkins, 1990). Previous reviews broadly indicate that TSD, as opposed to non-disclosure, can have a positive effect on clients, disclosing therapists are perceived as warmer and are liked more and that TSDs should be considered carefully and used infrequently (Henretty & Levitt, *article in press*; Hill & Knox, 2001; Watkins, 1990). There are several limitations to the current literature including the lack of a unified definition of TSD, failure to consider contextual variables that may influence the impact of TSD, the lack of exploration of different types of TSD and TSD with different types of clients (Watkins, 1990; Kim et al, 2003; Henretty & Levitt, *article in press*). Clearly a complex issue when applied to clinical

practice, the available literature suggests that TSD may be particularly beneficial for members of stigmatised populations to facilitate strengthening of the therapeutic alliance and enhance congruence with the client (Hill & Knox, 2002; Burkard et al, 2006). Despite an ever increasing awareness and understanding of lesbian, gay and bisexual (LGB) individuals, those who identify as a sexual minority remain one such stigmatised population (Corrigan et al, 2009).

Why research TSD with LGB populations?

Working with stigmatised populations and issues of diversity are very current topics within Clinical Psychology and the health professions. Cultural awareness and understanding when working with Black and Minority Ethnic (BME) populations is now well represented within diversity training in the NHS. In comparison, LGB related issues have traditionally been neglected by mainstream psychology (Goldfried, 2001) and are not as well represented in training programmes (Eubanks-Carter, Burkell & Goldfried, 2005). Despite the increasing volume of research utilising a LGB population, there is still a dearth of literature exploring their experiences (Mallinckrodt, 2009).

The relationship between LGB individuals and mental health services has evolved in line with political activism and societal changes (Eubanks-Carter, Burkell & Goldfried, 2005; Silverstein, 2007). Although sexual minority individuals are likely to be over-represented in the mental health system (Cochrane & Mayes, 2000b), most therapists have never received training in working affirmatively with LGB clients (Eubanks-Carter, Burkell & Goldfried, 2005). Whilst adequate gay affirmative therapy can be

provided by well informed therapists regardless of their sexual orientation (Brooks, 1981; Garnets et. al., 1991; Liddle, 1996) there is evidence to suggest that matching on sexual orientation may be beneficial (Liljestrand, Gerling, & Saliba, 1978; Brooks, 1981; Liddle, 1996; Jones, Gorman & Botsko, 2003; Burkell & Goldfried, 2006). Research suggests that clients find such TSDs beneficial as they contribute to the genuineness of the relationship and allow the practitioner to be positioned as a positive role model for the client (Pixton, 2003; Hansen, 2005).

The positive effects on the individual of disclosing LGB orientation to others is widely supported (Davies & Neal, 1996; Ress-Turyn, 2007; Carrigan et al 2009). It is also widely accepted that TSDs should always be for the benefit of the client (Ress-Turyn, 2007). This places LGB mental health professionals in somewhat of a double bind as they must “negotiate an intricate balancing act between self and client welfare in an ethical manner” (Ress-Turyn, 2007, pg. 8). Interestingly, TSDs regarding sexual beliefs and practices have been shown to occur rarely, where TSD of significant relationships are more common (Edwards & Murdock, 1994); a somewhat paradoxical finding for LGB clinicians. So how does the LGB mental health professional go about disclosing sexual orientation to clients? Several resources and personal accounts are available for LGB clinicians to assist decision making and coming out (e.g. Cole & Drescher, 2006; Guthrie, 2006). However, there is a scarcity of empirical research regarding the actual experience of making such disclosures and the area warrants further exploration.

Aims and objectives of the current research

The current research aims to fill some of these gaps in knowledge by exploring the experiences of LGB mental health practitioners' disclosing sexual minority status to clients. The use of qualitative methods of investigation within psychology has become increasingly common over the last ten years as a means of enhancing our understanding of human experience (Smith, Flowers & Larkin, 2009). The current research aims to add to the literature by exploring the experiences of disclosures from the perspective of the clinician utilising a qualitative methodology addressing the following research questions:

- What are the experiences of LGB mental health practitioners in the phenomenon of disclosing their sexual orientation in a therapeutic relationship?
- What are the practitioners' individualised conceptions regarding influencing factors in making such a disclosure or not?
- What are the practitioners' experiences regarding the impact of the disclosure on the client, therapeutic relationship and clinician?

In attempting to better understand the above questions using real clinicians the research aims to fuse the divergence between research and clinical practice. In doing so there are several clinical implications including informing mental health practitioner training on issues of disclosure and adding to our understanding of minority stress issues as they relate to LGB individuals.

Method

This section describes the study design and provides the rationale for selecting Interpretative Phenomenological Analysis (IPA).

Overall design of the study

In light of the research questions a qualitative method was deemed appropriate. Qualitative methods of investigation have grown in popularity within the field of psychology (Smith, Flowers & Larkin, 2009). They are concerned with human experience in “all its richness” (Ashworth, cited in Smith, 2008) and primarily engage with exploring, describing and interpreting the personal social experiences of participants (Smith, 2008). The study aimed to capture LGB participants’ experience, understanding and perceptions regarding disclosing their sexual orientation to clients.

Ethical approval

Ethical approval was sought from the Local Research Ethics Committee (LREC) to carry out the study across Leicestershire Partnership Trust (LPT). A separate application was made to conduct the study across Coventry and Warwickshire Partnership Trust. Ethical approval was granted for the use of both sites in September 2009 (see Appendix B)

Construction of the interview schedule

The use of semi-structured interviews as a flexible data collection tool is recommended for IPA (Smith & Osborn, 2003). The current interview schedule (see Appendix J) consisted of expansive, open ended and non-leading questions which facilitated

discussion around the areas of interest. An initial version of the interview schedule was piloted with the researcher's field supervisor and amended as appropriate to the research aims.

Rationale

Other available qualitative methods were considered and discounted for use in this study. The research is concerned with the meaning-making of the participants, in the context of their personal and social world, who have a shared experience of disclosing sexual orientation to clients. It aims to make sense of and link the findings to current psychological literature as opposed to developing an inductive theory across the group, as would be the aim of a Grounded Theory approach (Glaser & Strauss, 1967). In exploring the experiences of a minority population, the potential difficulties in sampling until 'saturation' occurred also made Grounded Theory a less suitable approach. Other forms of thematic analysis, including template analysis, were considered as potential analytical methods. Although these approaches could have been appropriate, they are less suited for exploring lived experiences and contextualising each of the participants' potentially unique accounts to consider their meaning making of such experiences (Braun & Clarke, 2006). The epistemological position, described in more detail in the following subsection, was also an important consideration when deciding on an analytical approach. Following this deliberation, Interpretative Phenomenological Analysis (IPA) was deemed most appropriate. IPA is a rapidly growing approach to qualitative inquiry in psychology which is committed to exploring in detail the participants lived experience and how participants make sense of that lived experience in the context of their 'life world' (Smith, 2004; Smith, Flowers & Larkin, 2009).

Epistemological Stance

The researcher adopted an epistemological stance of critical realism. This position combines both constructionist and realist positions in that it assumes that the ‘thing’ being explored has a basis in reality for the individual and can be discovered through a process of exploration. However, critical realism recognises that the way the ‘thing’ is perceived depends partly on our experiences, beliefs and expectations (Madill, Jordan & Shirley, 2000) and is constructed by the interactions between the researcher and participant. Therefore the researcher believed that the interview process served to reveal something of the experience in question. She believed that what was said during the interview was applicable and important to the participants outside the realm of the interview whilst acknowledging that the interaction between the researcher and researched inevitably influenced what emerged. This position is compatible with IPA (Smith, Flowers & Larkin, 2009).

Participants

Participants were eight mental health practitioners, all working within LPT who self identified as lesbian, gay or bisexual. All participants had experience of disclosing their sexual orientation to a client whom they were/ are working with and came from a range of professional backgrounds. Most of the participants were not trained therapists and as such their disclosures did not routinely occur in standard therapeutic contexts. Therefore the extent to which the disclosures can be considered instances of *therapist* self disclosure is limited. The research therefore concerns experiences of *clinician* self disclosure (CSD) to clients within a therapeutic relationship. Participant demographic information is displayed in Table 1. Data for one participant is missing as it was not returned to the researcher.

Table 1. Participant demographic information

Job title	1 x clinical psychologist 1 x mental health social worker 1 x healthcare support worker 5 x Community Psychiatric Nurses
Age	1 x 31-40 6 x 41-50 years
Gender	3 x female 5 x male
Ethnicity	7 x white British
Length of time since qualification	Range 10 – 19 years

Recruitment of participants

Participants were recruited using a snowball strategy. Protecting the anonymity and confidentiality of participants was paramount. No attempt was made to directly contact potential participants. The research was advertised through a research flyer (see Appendix E). Recipients of the flyer were requested to forward the information to any colleagues whom they thought may be interested in participating. Contact details for the researcher were included on the advertisement and potential participants were asked to contact her directly via telephone or email.

Procedure

Once potential participants had registered their interest, the researcher sought consent to conduct a short telephone screening interview to ensure they had previously experienced disclosing their sexual orientation to clients. Three people were excluded

from the study at this stage. The suitable candidates were sent a participant information sheet (see Appendix F) and consent form (see Appendix G) and asked to post the consent form back to the researcher. Upon receipt, the researcher contacted them to arrange the interview which was conducted at a time and place of the participants' convenience.

Before commencing the interview participants were asked to read the participant briefing sheet (see Appendix I) and were provided with information regarding LGB support services (see Appendix H). Whilst it was not anticipated that the interview would be distressing, participants were offered the opportunity of meeting with the researcher should they wish to discuss any aspects of the interview further. None of the participants requested this input. All interviews were audio taped and lasted between 30-90 minutes. One interview (number two) was repeated as the audio recording equipment was not functioning adequately for the duration of the interview. The interview began with an introductory section (see Appendix J) then followed the semi-structured interview schedule. The researcher made process notes at the end of each interview to inform later reflection.

Transcription and analysis

The audio data was transcribed verbatim by the researcher as recommended for IPA (Smith & Osborn, 2008). The transcript included every word spoken by the researcher and participant in addition to any laughter, significant pauses and hesitations.

Analysis began when all interviews had been transcribed. Transcripts were read and re-read whilst listening to the audio data to aid with the engagement process. The analysis

was approached as suggested by Smith, Flowers and Larkin (2009) by employing a ‘case by case’ strategy where one transcript is analysed fully before moving onto the next. Following the reading and re-reading the researcher began making note of anything that appeared significant or of interest in the right hand margin. The researcher then returned to the beginning of the transcript and used descriptive, linguistic and conceptual notes to form more specific themes or phrases (see Figure 1 for an example). The themes were then typed up and a cut and paste function used to further reduce the data by clustering the themes and attempting to make sense of connections between them. This process was repeated for each transcript in turn. The clusters were compared across transcripts and assigned super-ordinate labels which illustrated the conceptual nature of the themes within them. Finally, a table was produced that depicted each super-ordinate and sub-ordinate theme, illustrated with extracts from the transcripts (see Appendix K).

Figure 1. Example of how the data was analysed

Theme level coding	Transcript extract	Initial exploratory level coding
<i>impact of non-disclosure on client/ TR</i> <i>client struggle with sexuality</i> <i>CSD as facilitator</i>	P: (8) I mean I think it probably would've made a difference especially to people that were feeling uncomfortable about their sexuality you know, it, it, it would've been an opportunity to, to discuss that further	<i>-idea that disclosing sexuality could be helpful</i> <i>-client struggle with sexuality key to her beliefs re: helpfulness of disclosing</i> <i>-CSD of sexuality as facilitating further work around client struggle with sexuality</i>

Quality measures and validity

Discussion regarding quality and validity in qualitative research has increased in line with the amount of qualitative research published (Smith, Flowers & Larkin, 2009).

General guidelines for assessing the quality of qualitative psychological research have been presented by Elliot, Fischer and Rennie (1999), as presented in Table 2. The researcher was mindful of these concepts and attempted to comply with each in order to produce a valid qualitative research piece of quality.

Table 2. Quality qualitative research guidelines

Quality research recommendations	How applied to current research
Owning one's perspective	The researcher made her position explicit in the <i>Epistemology</i> section and <i>Researcher's Position</i> section in the critical appraisal section.
situating the sample	The participant demographic information table situates the sample. The results section also refers to the contextual aspects of the participant's situation.
Grounding in examples	The final results table illustrates the grounding of the themes in examples, and the results section makes use of extracts from the interviews to ground and illustrate the themes.
Providing credibility checks	The researcher made use of a peer review strategy to check the credibility of her analysis. This involved her academic supervisor coding small pieces of transcript for comparison with the researcher's findings.
Coherence	An integrated summary of the findings is presented in the final results table
Accomplishing general vs specific research tasks	The research aimed to explore the participant's individual lived experiences. The researcher used a reasonably homogenous sample and made comparisons across transcripts to understand the phenomena more generally in line with IPA.
Resonating with readers	The researcher hopes that by adhering to the above

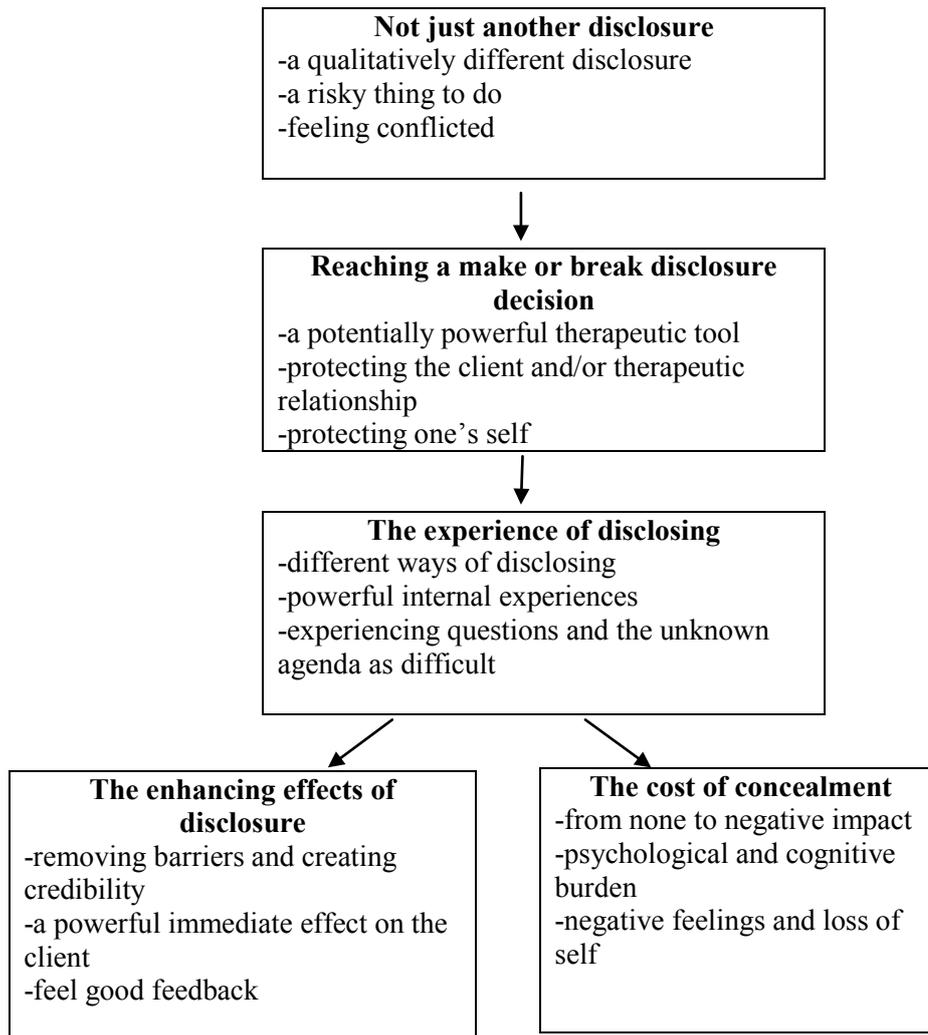
	the research narrative will resonate with the reader.
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In addition to the above the researcher ensured transparency and rigour by keeping a ‘research journal’ to serve as a ‘decision trail’ (Koch, 1994) and by receiving regular supervision from her academic supervisor.

Results

The analysis revealed five super-ordinate themes, each with three sub-ordinate themes as illustrated in Figure 2. The arrows indicate the narrative flow of the results section. The findings suggest that this disclosure was perceived differently to other types of disclosure. Participants entered into a decision making process influenced by their beliefs about the disclosure and weighed up the potential costs and benefits to reach a disclosure decision. Participants reported different disclosure experiences, to which the disclosing situation was central. Participants also revealed their conceptions regarding the enhancing effects of disclosure and the impact of feeling the need to keep their sexual orientation concealed.

Figure 2. Diagrammatic representation of super and sub-ordinate themes



A. Not just another disclosure

When discussing their experiences of disclosing, all of the participants reported feeling that revealing this information was qualitatively different and posed some risk to the therapist, client and/or the therapeutic relationship (TR). To make sense of this the participants discussed how this disclosure differs from other disclosures, reflected on the potential for risk and how they felt conflicted as LGB clinicians.

A qualitatively different disclosure

All of the participants expressed the sense that disclosures regarding their sexuality or relationship status were qualitatively different to their heterosexual peers disclosing similar information. The participants made direct comparisons between heterosexual colleagues' revelation of relationship/ sexuality and their own experiences:

Rob: if somebody were to ask...are you straight, are you married, they would probably answer without a thought and wouldn't see that as a disclosure...whereas I would need to think about it and see whether it's appropriate or helpful to respond (IV1; 841-847)

It is in the context of living in a "heterosexual world" (IV3; 1106) that participants framed this difference. In this way, in the extracts below, Stuart and Vanessa discuss the influence of assumed heterosexuality on their experiences of being a LGB practitioner:

Stuart: a lot of people still haven't got that idea in their head that a wedding ring could mean with equal measure that you're married to someone of the same sex as it could that you're married to someone of the opposite sex and...most people still make the, the assumption I guess (IV3; 1098-1105)

Vanessa: maybe it's that pervasive 'don't talk about it' don't talk about it generally let alone to your clients...I guess it's part of...that whole thing isn't it that sexuality still isn't really talked about, a lot of assumptions are still made that you're heterosexual (IV2; 348-355)

It appears that the underlying assumption of heterosexuality contributed to the notion of a different quality of disclosure. By revealing an alternative orientation the participants

are essentially creating difference between themselves and the majority, and contradicting the expectation of heterosexuality.

A risky thing to do

For most interviewees the qualitative difference in the meaning of disclosing is embedded within an internal sense of perceived threat experienced when contemplating disclosing or when confronted by a disclosing situation. This sense of threat appears to be borne out of their experiences of being a person of sexual minority living and working within a majority context. In this context disclosing their orientation feels like a risky thing to do. In the extract below Stuart discusses the potential for the disclosure to lead to a threatening situation:

Stuart: I need to be a blank canvas in this household, you know. And sometimes, I'll be honest, I've even fibbed because it's felt like the safe option (IV 3; 167-171)

Here then we can see that disclosing can feel like an unsafe thing to do. The threat potential is in response to perceptions regarding how particular clients may respond. For Ryan, the threat of disclosing seems even greater. In the following extract he describes how revealing that he has “a partner”, as opposed to using gender specific language or referring to his sexual orientation, would cause him to consider carefully what the consequences might be:

Ryan: but obviously when you're gay and you say something...like my partner...you have to obviously think a lot more about it and how the person's gonna react...to you saying that (IV4; 211-216)

His use of the word “partner” would not necessarily reveal anything about his sexuality and demonstrates the risk he feels in revealing information about himself that might lead to it being known.

Feeling conflicted

As demonstrated above, the meaning of disclosing sexual orientation to clients is much more complex than simply sharing a piece of factual information. However, many of the participants expressed the belief that it should be no more meaning laden than this. For them, sexuality is “just something about me that I’m sharing with you” (IV6; 826). In the context of being a sexual minority, LGB individuals must work hard to integrate sexuality within their sense of identity in a different way to the heterosexual majority (Davies, 1996). We can understand then that once this integration has been achieved, sexuality becomes just another part of identity no more or less important than any other part. In this context, in the extract below, Rob compares his sexuality with physical characteristics:

Rob: it’s the same as saying I’ve got blue eyes you know, or I’m 6ft 1 or whatever, it’s no more relevant than that to me (IV1; 494-497)

Despite its irrelevance to him, he feels that for others it is much more of an issue. He makes sense of his feelings regarding his own sexuality by directly comparing them to outwardly visible physical attributes. Perhaps then it is the hidden nature of sexuality which adds to feeling conflicted:

Vanessa: I think it’s that hidden issue which we then kind of have to think, ooh, do we don’t we, is it wrong, should it be known (IV2; 331-334)

Ryan: I guess being gay isn't always like a lot of prejudices where it's so obvious all the time... people don't always automatically pick up on the fact. You don't wear a badge, you know and a special hat... shouting it from the roof tops... so I guess it... makes it more of an issue...then when you have to disclose...or think about disclosing (IV4; 244-254)

This seems like logical reasoning; there would be no need for disclosure if sexuality were as obvious as physical attributes. Sharing information about one's sexuality should be as "innocuous" (IV1; 110) as it is perceived to be for their heterosexual colleagues but it was not experienced in this way by the participants. In the extract below Ryan verbalises his internal sense of conflict regarding the meaning of the disclosure:

Ryan: I should be able to be free to be who I am, you know...but...the other side of me thinks well yeah but in the real world in a job where working with random people from all walks of life with all experiences...people aren't always going to react in the way you want them to (IV4; 1509-1517)

For him then the desire to be "free" to be who he is is juxtaposed with the threat of negative responses.

B. Reaching a make or break decision

Several of the participants reflected a dichotomy of potential outcomes, either a positive therapeutic gain or a disastrous "nightmare" (IV6; 434). In this context most of the participants reached a make or break disclosure decision by weighing up the potential costs and benefits. Even when the weighting of benefits was high, the perceived threat was too great for some to facilitate disclosing. Clearly a complex process, for most

participants disclosures were made on a case by case basis by focussing on the potential gains for the client and/or TR and the potential harm the disclosure could cause.

A potentially powerful therapeutic tool

All of the participants spoke of the potential for their disclosure to be a useful and potentially powerful therapeutic tool. There was a sense that by revealing this information they could have a profound and empathic effect on the clients with whom they were working, particularly salient when the participants perceived the client to be vulnerable. For the majority, this vulnerability was related to working with LGB clients who were struggling with issues related to their own sexuality where they drew on their own experiences of being a sexual minority:

Vanessa: I think I felt a kind of empathy for them in that they'd felt marginalised by services before...I guess we all have experienced feeling marginalised within a service and how isolating that is. And also when people have disclosed their sexuality to me erm, that has made me feel 'god you understand where we're coming from' (IV2; 303-312)

The participants' conceptions regarding the client's struggle with sexuality, and the perceived benefit of revealing their own sexuality, were considered by most when deciding how relevant it was to disclose. In this way, in the extract below, Ryan reflects on how for the majority of his clinical work sexual orientation is irrelevant:

Ryan: it's just that it can come out as an irrelevant statement its like, oh by the way I just thought I'd you know I'm gay, and like, why are you telling me that?! cos why is it an issue you know? (IV4; 1229-1233)

The discomfort of creating an “issue” contributed to his decisions not to disclose, protecting him from uncomfortable feelings. The participants’ perceptions of the relevance of the disclosure were embedded within their conceptions of the one way nature of the TR.

For many, one of the main benefits was in removing something negative from the client and instilling something positive in its place, as demonstrated below:

Rob: the rationale around that was someone who...felt that I would be horrified and think it was disgusting [to be a lesbian] ...and it was really important I think to want to kind of dissuade her of those opinions (IV1; 245-250)

In the context of the “heterosexual world” the meaning attached to the disclosure is one of evidencing why they would not encounter homo-negativity by creating similarity between the clinician and the client. Mike made sense of the potential gains for the client more globally:

Mike: I should be able to be open and honest about things that are personal to me if I think it's appropriate in a situation...else...how can I expect the patient to be like that with me if I'm not like it myself? (IV6; 320-325)

Self disclosure was related to the overall functioning of his TRs where the meaning was to model the behaviour expected of the client. In addition to the gain for the client and relationship, some participants expressed a sense of wanting to have a wider impact on the experiences of LGB individuals:

Ben: just trying to pave the way for other people to be the same as me. I think...the more people that are out and feel comfortable, it's gonna be easier

for the next set of people coming along, you know, that's why I was interested in doing this interview with you (IV6; 1267-1274)

Although not directly beneficial for the client at that point in time, disclosing was perceived as having a positive impact on LGB individuals' experiences in society.

Protecting the client and/or the therapeutic relationship

We have seen that disclosing is perceived to have particular benefits for the client and/or the TR. The following extract illustrates how being “open” and “honest” served to protect the integrity of the relationship:

Mike: open, honest relationships is key, I think, to trust and to the kind of relationship I've got to have with somebody so...if I wasn't to be able to be honest about everything that would affect the...the effectiveness of my interaction with somebody (IV6; 1200-1207)

The majority of participants also considered the potential harm the disclosure could cause. The desire to protect the client and/or TR from some negative consequence, and the responsibility felt for doing so, is illustrated in the extract below:

Stuart: So he was somebody I chose deliberately not to tell because...of the level of... expectation he had of...me as a service provider really (IV3; 883-887)

For Stuart a decision against disclosure was based on protecting the clients' expectations and wishes regarding the level of intimacy in the relationship. In the following extract, Ryan illustrates the risk of disclosing for the client and the relationship:

Ryan: you're a bit wary of throwing anything into the works that could potentially stop that [positive working relationship] and be a hindrance to them cos you're constantly thinking of...their needs...more so than your own (IV4; 280-285)

Protecting one's self

We have already discussed the participant's perceptions of threat and risk in disclosing sexual orientation. This perceived risk was important to all but one of the participants and seemed particularly salient when they decided not to disclose. For some the desire to protect themselves from this threat was framed in the context of previous homophobic experiences. In this way, in the extract below, Ruth describes how her previous experiences influenced her:

Ruth: if you have experienced homophobia in any way you're not gonna set yourself up, that's not something I particularly want to do (IV8; 328-331)

In the context of the heterosexual world disclosure brings with it the threat of encountering homo-negativity and non-disclosure served to protect them from such encounters. For Ryan and Sarah, it was the threat of rejection on the basis of their orientation that they wished to protect themselves from:

Ryan: I guess it is just that sort of...reluctance I guess to...open up yourself really because it's putting your vulnerabilities...at the forefront really... I guess it's that...fear of rejection (IV4; 965-971)

Sarah: I think it would be the embarrassment of them saying 'I need another CPN, this one's gay, I'm not having that' or the family making a bit of a hooha about it (IV6; 746-750)

Disclosing is experienced as threatening to both personal safety and to psychological well being. Embedded within the context of homophobia, for Ryan and Sarah the threat seems more personal; to reveal their sexuality is to open up “vulnerabilities” and ignite the threat of rejection and the accompanying “embarrassment” of not being accepted as a professional on the basis of sexuality. For Ben, however, it is being open about his sexuality that served a protective function:

Ben: I never deny what I am but I'm not basically out out, I don't...tell patients but if they ask me I do answer them truthfully (IV5; 5-8). So I just you know made a rule to myself that I'm not gonna deny it any more (IV5; 550)

C. The disclosure experience

The interviewees described not only a range of factors contributing to their disclosure decisions but a range of ways in which the disclosure was experienced.

Different ways of disclosing

How the disclosure was made appears central to most of the participants' experiences. Making a statement regarding sexuality was uncomfortable for several of the participants. In this way, in the following extract, we can see how Ryan disclosed through sharing similar experiences:

Ryan: I didn't actually say 'well, by the way I'm gay! I said 'oh when I had a similar experience with my family when I came out to them they had similar...reactions (IV4; 660-665)

By sharing concrete experiences and coping strategies instead of stating his sexuality Ryan is able to distance himself from the discomfort of statement making.

The perceived obviousness of sexuality appears important to how some of the participants went about disclosing as illustrated below:

Mike: I didn't specifically tell her...I think the assumption just grew and grew until a point where it just...I just talked about going to gay festivals (IV6; 817-821)

No actual verbalisation regarding his sexuality was made in Mike's scenario. The revelation formed part of a complex interaction based on assumptions and sharing different aspects of himself with the client. Whilst Mike reflected on stereotype indicators picked up on by his clients, Ryan, who perceived his sexuality as less obvious, experienced greater discomfort when disclosing:

Ryan: I wouldn't say I'm not obvious but there are...gay people that are more obvious...and sometimes I think well that that's maybe a defence because then they don't have to broach that question...it's obvious straight away to other people that they're gay so people either feel comfortable or they don't, you know, so it's never an issue. Whereas if you're not so obvious...and then people have to ask you it automatically you're put on that pressure, that sort of like 'oh right I've got to disclose again now' (IV4; 1261-1275)

This additional discomfort and “pressure” can be understood in the context of the hidden nature of his own sexuality and of assumed heterosexuality so that for him, disclosing meant providing information which is contrary to what the client presumes to be true.

Powerful internal experiences

Disclosing situations evoked powerful internal experiences for most of the participants. How the disclosure was made was central to the accompanying internal experience. For example, in the above extracts making statements regarding sexuality was uncomfortable. The meaning attached and the discomfort experienced in these statement making scenarios appears to be embedded within a sense of moving backwards through time. In this way, in the extracts below, Rob and Ryan discuss the regressed feeling experienced when making statements regarding sexuality:

Rob: it's very rare that I'd make a statement that I'm gay... so to actually say 'oh I'm gay' feels actually...quite a regressed stage to be at...it's a bit like...coming out the first time (IV1; 487-492)

In the present day Rob no longer makes statements of this kind. His identity and the awareness of those he surrounds himself with makes such behaviour redundant. This sense of moving backwards is also illustrated by Ryan:

Ryan: It is strange. It's almost like stepping back years to actually having to come out every time...you sort of approach the subject...back to when I was younger with my parents and friends and things like that...there is anxiety there every time (IV4; 507-514)

We can see that far from a detached sharing of information, the current experience is a powerful reminder of past, more anxiety provoking disclosures. In this context we can begin to understand why stating one's sexuality feels uncomfortable; it is a stage previously passed through in identity formation. We can understand this discomfort further in the context of assumed heterosexuality; the process of disclosing, and correcting wrongful assumptions, means to create difference and separate one's self from the cultural majority and norm. For Ruth the experience of disclosing stirred within her a sense of uneasiness:

Ruth: I was slightly worried by it...apprehensive probably, probably put it off for a bit...I was probably relieved when I said it (IV8; 292-294)

For Ruth, the negative internal experience is emphasised by the feeling of relief when the feared consequences were not encountered.

Experiencing questions and the unknown agenda as difficult

Central to most of the accounts was the context in which the disclosure situation arose. Knowing the client, and thus being able to evaluate their potential response, was a protective mediator in the experience. Participants' perceived choice regarding disclosing or not acted as a powerful mediator of the internal experiences evoked. Questions were perceived as particularly difficult to negotiate. The participants experienced feeling stripped of the ability to make a considered voluntary decision and were instead in a position where a fight or flight response must be made. In the extract below Rob discusses how his sense of lack of control raises discomfort:

Rob: With this it's much more personal...I'm in control of my answer but I'm not in control of the situation in which it's arisen whereas perhaps in a one to one situation erm, where I'm thinking about shall I volunteer that information I'm pretty much in control (IV1; 926-933)

In addition to lacking perceived choice and control, Mike expressed the discomfort of the unknown agenda behind questions:

Mike: what makes me anxious about people asking me about it is when they ask me about it for no particular reason because it hasn't got a relevance. It has to have a relevance to why they're asking. Then I...see that the relevance is detrimental relevance (IV6; 1267-1273)

Here then the unknown raised the threat of encountering abuse. When in a position of choosing when and how to share personal information this dilemma is eased. For Stuart, the experience of being questioned results in two scenarios:

Stuart: people spot...my wedding ring...and course the inevitable question's 'oh, what does your wife do?' ...and sometimes...I reveal that my partner is not a woman...and other times it's kind of ok, make up scenario time...let's say as little as possible (IV5; 174-182)

Framed in the context of assumed heterosexuality, questions resulted in the dilemma of either giving up the relative safety of this assumption or concealing his true identity. For Sarah, the threat of revealing her sexuality was great and she has formed strategies to deal with such situations:

Sarah: I can't remember if she's ever directly asked me but...she's tried to get details out of me about...what do I do and stuff like that and 'if you were gay Sarah, cos it's ok if you are' and you know you just sort of build up this face where you just don't flinch at all (IV7; 514-521)

This suggests a switch in the power dynamic of the relationship whereby the client has taken on the role of clinician. Sarah has built up an ability to manage these situations without revealing anything of her inner experiences; the need to not “flinch at all” suggests she experiences some inner discomfort.

D. The enhancing effects of disclosure

Although differing in the importance attached to the disclosure, all of the participants experienced it as enhancing in some way. For some, the disclosure represented a pivotal point in the relationship, for others it had a less dramatic impact.

Removing barriers and creating credibility

For the majority of the participants disclosing was conceived to have removed a barrier within the relationship. In the extract below Sarah reflects on how disclosing removed a personal barrier and allowed her contribute more fully to the relationship:

Sarah: the relief was great I could just say... 'my partner we did this and that' and...give little bits of myself to them and it felt ok to do that (IV7; 469-473)

We can make sense of this perceived impact in the context of Sarah's concerns regarding the potential negative consequences of disclosure. In order to protect from

these consequences Sarah usually shared “nothing” (IV7; 843) about her personal life with clients. The disclosure facilitated a different experience as demonstrated by her feeling “ok” about sharing bits of herself.

For Vanessa the disclosure meant removing a barrier formed as a result of the clients’ previous homophobic encounters:

Vanessa: My gut feeling would be that we would’ve got stuck because it wouldn’t have been explicit but they would’ve attributed, I wouldn’t have said things that I did say...or asked the questions that I’d said cos I think they would’ve interpreted it as being intrusive or ignorant or possibly homophobic so I think having disclosed my sexuality enabled me to ask questions and move it along faster or further than it would otherwise (IV2; 564-575)

Vanessa perceived that by making her position as a lesbian clinician explicit from the outset the barrier of negative expectation was eliminated. It appears that revealing shared minority status enabled her to talk about areas which otherwise may have been uncomfortable for both her and the client. For Vanessa the meaning of the disclosure was two fold as she also described the “credibility or authenticity” (IV2; 207) she felt it provided. In the extract below Mike describes a different type of credibility afforded:

Mike: Because sometimes...I have to talk to people about things that they don’t want to talk about...or accept...and that allows me to say that more...because they know I’ll be honest. Because I’m honest about everything (IV6; 858-873)

The enhancing effect of disclosure was not the result of sharing specific information but about what the giving of that information represented; a validated, open and honest

relationship which enabled him to be upfront with the client. In Stuart's account, revealing his sexuality was perceived to have removed the barrier of threat which the client felt at the prospect of working with a male clinician and represented a pivotal moment in the development of a positive TR:

Stuart: we've been able to talk about so much since then including details of...what these abusive guys did...I really don't think that would've been possible otherwise (IV3; 711-716)

A powerful effect on the client

Most participants reported that the disclosure had a powerful effect on the client. In the extracts below Vanessa and Stuart illustrate the sense of relief in response to the disclosure made to a gay couple (extract one) and a heterosexual female anxious about working with a male clinician (extract two):

Vanessa: their response was that they really appreciated kind of felt better knowing that, there was a kind of visible and verbal acknowledgement later on, but visual kind of [acts out relieved sigh] (IV2; 395-399)

Stuart: it did cause this kind of physical relief. You could kind of see it happening about her face and her shoulders and stuff like 'thank god' you know (IV3; 616-619)

In the extracts below Ben and Rob describe the effect of revealing a shared minority status:

Ben: I think that...the feelings he had he wasn't ashamed about any more, that he realised...there's other people with the same kind of feelings that are out there (IV5; 801-805)

Rob: I think as far as she was aware she would probably be under the impression that she'd never met a gay person, obviously that would not be true, she would have met them but not knowingly...so I think it was positive in that respect seeing somebody who was supposedly...fairly responsible and successful what have you (IV1; 557-566)

In the context of both people being of sexual minority, sharing that identity removed an element of shame from the client. The impact of the disclosure is framed in the context of the hidden nature of sexuality and making the invisible visible. In doing so the sense of isolation conceived to be the experience of the client was reduced.

Feeling good and feedback

All of the participants reported a positive effect of disclosure on themselves. For some this was an immediate effect, for others a cumulative one. In the extracts below Sarah and Ruth describe the impact of the disclosure:

Sarah: I suppose it felt like a weight had been lifted, I could just be myself...just felt freer I think. Quite empowering actually (IV7; 458-476)

Ruth: in some ways it was quite empowering (IV8; 246)

For them the experience of being open about their orientation was particularly powerful, possibly because the experience was infrequent and the feared consequences were not encountered. In this context being accepted despite their sexuality was particularly empowering. Similarly, for Ben the personal impact of the disclosure was positive:

Ben: I get some man hugs off most of them when they leave...it breaks the barriers down (IV5; 222-224)

The physical contact between him and clients represented a sense of acceptance and being liked or respected by clients who initially may have “kick(ed) off” (IV5; 982).

Ben’s self imposed rule of non-denial has also had a cumulative effect on him:

Ben: my life felt easier then and I think my nursing turned a lot better. I do feel like... it’s quite uplifting (IV5; 552-555)

Also reflecting on the cumulative effect of disclosure experiences, Rob discussed how his sense of self has been impacted upon:

Rob: I think disclosures of any nature, whether it’s to service users or colleagues what have you...I think in terms of...one’s own self esteem...I think it affirms it (IV1; 1166-1171)

The experience of being open about his sexuality in the professional setting not only affirmed self esteem but also consolidated his personal and professional self. In line with previous statements around feeling regressed when not able to be open, his experiences of disclosing can be understood as representing more realistically a current stage of identity formation and integration of sexuality into this.

E. The cost of concealment

We have seen so far that for many of the participants, on the occasions when they made a considered voluntary decision to disclose their sexual orientation they experienced a generally positive impact on the client, TR and on them. When discussing occasions when they had decided not to share the same information many of the participants

recognised a negative impact. They experienced feeling the need to conceal their sexuality as having a cost to the relationship and a psychological impact.

From none to negative impact

For most of the participants the non-disclosure or concealment of sexuality was experienced as having either no impact or a negative impact on the TR. For many, feeling the need to conceal represented a lack of intimacy or genuineness within the relationship. In this way, in the extracts below, Stuart and Mike make sense of the impact of concealment:

Stuart: If you don't tell people...you're not giving them your whole self in a sense are you. Well, you're certainly not operating as the person that you ought to be I guess...some people don't work as well with you as...others do...And I guess because... it's about that sense of not getting the wholeness... and so... the whole relationship feels then, I guess, feels sort of perfunctory (IV3; 1209-1235)

Mike: that would be a professional patient type relationship where it's not, it wouldn't be a true relationship as far as I was concerned because I couldn't be absolutely honest (IV5; 527-532)

For Stuart then, not being able to share his “whole self” was conceived of as a barrier.

We can see that for Stuart sexual orientation now forms a core part of his self identity.

When concealed he cannot feel like a whole person or work in the way he “ought”.

Mike greatly values honesty which he feels adds something fundamental to the relationship. An inability to be honest led to a sense that the relationship is not “true” and their interaction not being “to its fullest benefit” (IV6; 1077). Here the impact of concealment is made sense of in a more generalised manner, drawing on experiences of

different TRs over time. For Vanessa the impact is understood in a more localised way when working with a LGB client:

Vanessa: some of the questions that I asked her which were informed because of my own experiences she experienced as being intrusive and possibly homophobic (IV2; 682-686)

Without positioning the information the client was receiving, the intervention was experienced as intrusive. In the context of heterosexuality as the societal norm Vanessa perceives the revealing of a shared sexual minority status, when appropriate, as facilitating a more positive experience of TRs for the LGB client.

Psychological and cognitive burden

The majority of the participants reflected on the increased effort involved in keeping their sexuality concealed. Giving up the relatively safe position of assumed heterosexuality felt too threatening and they engaged in costly methods to maintain the concealment. In this way, in the extract below Rob illustrates how he does this:

Rob: I certainly have found myself...either not speaking at all or using non-gender specific language...I suppose it does add a, another level of thought processes in terms of how you respond to somebody that perhaps otherwise might not have (IV1; 140-160)

In order to maintain the position he must focus his attention inwards and engage in “another level of thought processes”. For Ryan the need to conceal permeates much of his thoughts:

Ryan: I don't know really when it's been a, a particular burning issue but it's sort of there in the background a lot of the time (IV4; 741-745)

In the context of having disclosed his sexuality only once it appears that the majority of the time Ryan is burdened with engaging in effortful tasks to avoid discovery. For Sarah, the cognitive and psychological burden is even more entrenched:

Sarah: I can sort of feel myself tensing up and trying to get out of it...wondering what I'm going to say, what did I say before, my stories have to tally up...especially when you've...known people a long time you don't, you can't remember what you might have said to them years ago but you're sort of always trying to make sure that your story's there, it's in place, you know, what you're going to say (IV7; 784-794)

We can see the psychological impact that concealment has on her. Anxiety is evoked and results in a flight response as evidenced by her “tensing up and trying to get out of it”. On a cognitive level she describes the effortful task of maintaining her “story”, made more taxing when the relationship is long standing. The threat of clients knowing her sexuality is great and she creates a “bunch of lies” (IV7; 242) to prevent discovery, but she experiences the consequences to herself as damaging. Concealment and the efforts to maintain it result in incongruence between her actions and her self perception as an “upfront and honest” person (IV7; 245).

Negative feelings and loss of self

For most of the participants concealing their sexuality had a powerful negative impact. For some the concealment resulted in a loss of their sense of self as real within the

relationship. In the context of LGB identity formation, juxtaposed with the need for disclosures to be in the best of interests of the client, concealment even when understood as being in their or their clients' best interests evoked strong negative feelings or was conceptualised as a loss. In this way, in the extract below Stuart describes the impact of concealment on how he feels about himself:

Stuart: I hate doing it. I feel like I've been really treacherous whenever I do that (IV3; 1076-1078)

Although infrequent, such occasions evoked powerful feelings emphasised by his "hate" for doing it. Stuart has also previously participated in political activism for gay rights. In this context we can understand the sense of treachery he experiences; in concealing he is actively going against "the cause" (IV3; 1168) and contradicting his identity as an openly gay male. The concealment of this now integrated part was also conceptualised as a loss. In this way Stuart reflects on what it means to conceal his sexuality:

Stuart: it's a huge part of who you are all the time...it's about personality stuff as well isn't it. It's kind of like chopping a bit off, chopping a section of your personality off and...allowing some people to have it and others not (IV3; 1216-1221)

Concealing a core part of his identity was consistent with "chopping off" a part of him. His use of "chopping" evokes a somewhat brutal image, which can be understood in the context of him hating to do it. For Ryan concealment led to negative feelings towards himself:

Ryan: I guess it's a feeling of you feeling you're letting them [the client] down by something, some way by not being fully honest with them...or holding

something back (IV4; 1242-1256) not shame or guilt...but sometimes I suppose it touches on that thinking well...I should be able to be who I want, who I am and, and, without regret or without having to hide away (IV4; 1502-1507)

“Holding back” evokes feelings of dishonesty, which Ryan experienced as letting the client down so that the impact was two fold. He experienced a level of shame and guilt, a deeply negative psychological cost. It appears that in order to manage these emotions Ryan reasoned that this is something he has to do because of the “real world” (IV4; 1509) in which he works. Ryan also expressed a sense of a false professional identity:

Ryan: I guess it's almost a feeling of having to go back inside and shut and be somebody else...but I guess there's part of that in everyone... in that type of job. Erm, wearing a uniform and a mask type thing (IV4; 1495-1501)

Maintaining the position of assumed heterosexuality is experienced as him “being somebody else”. The concealment of sexuality takes him “back inside” linking him with past times when he has felt the need to conceal. Heterosexuality is worn as a “mask” and a “uniform”, usually worn to provide protection to the wearer and/or others and give uniformity amongst colleagues. In this sense concealment of sexuality can be understood as both protective for Ryan and for his clients whilst simultaneously causing psychological harm. Sarah’s “secretive world” (IV7; 252) also evoked a sense of a false professional identity:

Sarah: it's almost like not having an identity...I hear my other colleagues talk about their children, partners quite freely with people and course I don't so they don't know, I'm just a face, they don't know anything about me (IV7; 796-802)

For Sarah, the effort of concealing led to feeling detached from her clients, experienced as being “just a face” where nothing of her inner lifeworld is revealed. Giving false information compounds the internal sense of lacking an identity as maintaining the false projected self ensures that her true identity remains locked away.

Vanessa, however, does not express this sense of cognitive or psychological burden. We can understand this difference in the context of her professional identity. As a psychodynamically orientated clinical psychologist, disclosures of any kind are always carefully considered and emerge as a function of the “relationships that are here” (*IV2*; 52). In contrast, CPNs Mike, Ryan, Stuart and Sarah report a more eclectic approach to their clinical practice. Also contrasting is the setting within which the professionals work. Psychological therapy sessions are usually limited to a boundaried setting and time allocation and focus on the clients’ presenting difficulty. In comparison, the CPNs work within the clients’ “territory” (*IV4*; 407) and “social setting” (*IV4*; 1073) where the perceived expectation for sharing information is experienced much more intensely.

We have seen then that for the LGB professionals interviewed, disclosing sexuality is a complex, risky and meaning laden experience that requires careful consideration of the potential costs and benefits to the client, clinician and relationship. When a considered disclosure is made the participants usually experience the client, relationship and themselves as enhanced in some way. The perceived need to conceal was experienced as having a negative impact on the clinician and/or relationship. Clearly a complex process, disclosures of this nature are usually infrequent and done with the best interests of the clients and relationship in mind.

Discussion

This study points to some of the additional difficulties that LGB mental health practitioners may face when considering sharing personal information about themselves with clients. Self disclosure research has previously indicated some of the functions that disclosures may serve from the perspective of the client and to psychotherapeutic outcome (see Henretty & Levitt, *in press*; Watkins, 1990 for reviews). Previous research has mostly utilised quantitative methodologies which fail to take into account complex contextual factors influencing the decision making process and perceived outcomes of disclosure. This study adds to the psychological literature by exploring in detail the experiences of LGB mental health practitioners disclosing sexual orientation. In doing so the technique has allowed a rich and contextualised understanding of the experiential dimension of disclosure and to better understand how this experience is conceived to impact upon the client, clinician and TR. The five super-ordinate themes revealed in the analysis will be discussed in turn before focussing on the strengths and weaknesses of the study and the clinical implications.

A. Not just another disclosure

Previous literature reviews have indicated the different dimensions of disclosure relating to the amount of information disclosed, the type and intimacy of the information shared and the amount of time spent disclosing with varying results (Henretty & Levitt, *in press*; Watkins, 1990). Research into different types of disclosure has focussed on multi-cultural therapy (e.g. Kim, Hill, Gelso, Goates, Assay et al, 2003), disclosures of religious affiliation (Gregory et al, 2008) and attraction to clients (see Fischer, 2004 for a review). What is lacking is an understanding of how the

clinician feels about and experiences different types of disclosure. The current study addresses this and reveals that for these participants it was experienced as being qualitatively different from their heterosexual peers revealing similar information about their orientation and relationship status. The potential vulnerability for the therapist in disclosing has been found previously (Knox & Hill, 2003). By contextualising the participants' accounts within their experiences of being of sexual minority we can see that for these participants there is an intensely experienced sense of threat in disclosing their sexuality with both LGB and heterosexual clients. This can be understood by looking historically at the experiences of LGB individuals in wider society. Massive changes in the awareness and acceptance of alternative sexual orientations have afforded LGB individuals increased protection and rights through political activism and governmental level policy (Silverstein, 2007).

As outlined above, the participants perceived their experiences of disclosing as qualitatively different from other disclosures, understood as relating to being a sexual minority in a majority context. However, it could be argued that comparisons can be drawn between this and the disclosure of other types of potentially stigmatising and concealable information. Clinicians' experiences of illness such as HIV/AIDS, bereavement or religious beliefs are examples of personal information which mental health practitioners may choose to conceal (Goldstein, 1997; Peterson, 2002; Cole, 2006; Tsai et al, 2010). As Cole (2006) writes "for a gay male therapist to disclose his HIV seropositivity...instantly exposes the conflicts among the professional, social, and private realms of his multiply layered experience." (Cole, 2006, pg. 5), experiences reflected by some of the current participants. Also in common among these different types of disclosure is the potential for harm to the client and TR through sharing

burdensome information which could inhibit the client's ability/willingness to bring their own difficult material to the relationship (Goldstein, 1997; Hanson, 2005). In addition, by revealing information such as clinician sexual orientation or religious affiliation it could be argued that clinicians are imposing their own belief systems on that of the client in an unethical and unhelpful manner (Peterson, 2002; Hanson, 2005). Also in common is the clinicians' struggle in deciding how, to whom, when and how much to disclose to their clients (Goldstein, 1997; Tsai et al, 2010). It appears then that the commonalities of sharing meaning laden 'facts' means that the disclosure of sexual orientation may not be as unique as was perceived by the participants, in the context of the wider disclosure debate.

B. Reaching a make or break disclosure decision

It is widely recognised in the literature that self disclosures should always be in the best interest of the client (Rees-Turyn, 2007). This is echoed in the current research as most participants entered into a complicated decision making process evaluating the perceived costs and benefits of sharing this information. For the most part, the clinicians perceived that disclosing was particularly pertinent when working with a LGB client. It was conceptualised to serve as a powerful therapeutic aid when clients were vulnerable in their struggle with sexuality. However, for other interviewees the meaning attached to their disclosure was one of staying true to their sense of self in their lifeworld outside of work. This is perhaps dissimilar to other types of disclosure decisions as it was conceived as integral to their self concept. However, this reasoning therefore raises the question of for whose benefit the disclosure served and takes us back to the "intricate balancing act between self and client welfare" (Rees-Turyn, 2007, pg. 8). The choice of a therapist to withhold or disclose information has ethical implications, including

whether or not the clinician could be considered exploitative in their actions (Peterson, 2002). Whether or not the sharing or withholding of personal information is considered exploitative depends in part on the theoretical orientation through which the decision is being observed (Peterson, 2002). However, basing one's disclosure decisions around staying true to one's self could be argued as not necessarily being in the best interests of the client.

Previous research has cited the weighing up process in disclosure decisions (Burkard, Knox, Groen, Perez & Hess, 2006; Bridges, 2001; Satterly, 2006) as has been found here, but has not explored the contextualising factors behind this beyond theoretical alignment (Simi & Mahalik, 2003; Knox & Hill, 2003). The participants here felt conflicted about this disclosure in that "it shouldn't be a matter of do you disclose or not...because actually it's not really that big an issue. But unfortunately it is" (IV1; 732). By exploring the participant's lifeworld we can achieve a different understanding of this conflict. Relating to LGB identity development (e.g. Cass, 1979; Coleman, 1981; Woodman & Lenna, 1980 in Davies, 1996) the participants, having fully integrated sexuality into their identity, perceived it to be no more or less important than any other aspect of them. Conflicting feelings occurred when they perceived others to feel that it was more of an issue.

The participants' reflections regarding a dichotomy of potential outcome of disclosing is extremely pertinent. Embedded within the perceptions of it being a risky thing to do, the participants experienced the decision as make or break with regards to their TRs. This strength of feeling about the potential consequences does not appear to have been reported in the literature. In addition to the weighing up of costs and benefits for the

clients, the participants revealed the role of self protection in reaching a disclosure decision. Again, the potential for clinician vulnerability in disclosing is not new (Knox & Hill, 2003) but the intensity of the participants' concerns for their physical and psychological well being in the disclosure decisions reported here is. Indeed, even when the potential benefits for the LGB client were weighted as high, the threat potential of disclosing led to non-disclosure for some participants. In gaining a sound understanding of therapist disclosure decisions then it is important to look beyond the immediate and distal gains for the client and necessary to understand the lifeworld in which the clinician is making such decisions.

C. The disclosure experience

Previous research has explored the ways in which clients experience CSD and generally reports a positive effect when therapeutically relevant and done sparingly (Audet & Everall, 2003; Hanson, 2005; Knox, Hess, Peterson & Hill, 1997). However, the way in which clinicians experience the process of disclosing is an area sorely missed in the current literature. This study highlights the different ways of disclosing sexual orientation, the powerful internal experiences evoked and the importance of the disclosing situation to how it was experienced. For these participants, making statements regarding their sexuality was uncomfortable. This can be understood in relation to the previous literature pertaining to LGB identity formation. Many psychological models have been posed exploring how LGB people come to terms with and integrate their sexuality within their self identity (e.g. Cass, 1979; Coleman, 1981; Woodman & Lenna, 1980, in Davies, 1996). Although not describing a linear, progressive continuum, many of the models describe phases of development through

which LGB individuals pass. Statement making was experienced as a regression, understood in terms of moving backwards through the stages of identity development.

In addition to the discomfort and regressed feelings evoked by statement making, participants experienced the unknown agenda behind questions regarding their relationship status or sexuality as uncomfortable and anxiety provoking. This can be framed as a switch in the power dynamic between client and clinician, so that the protectiveness of choice and control in disclosing is removed. It is well recognised by feminist perspectives that power imbalances in favour of the professional are present (Simi & Mahalik, 2003) and form the basis of their argument for disclosure. However, the current literature does not explore the impact of such disclosing situations on the clinician and given the powerful internal states reported here, further exploration is warranted.

D. The enhancing effects of disclosure

Studies regarding the effects of self disclosure in general indicate that it can enhance the TR and is found helpful by clients (Barrett & Berman, 2001; Knox et al, 1997; Myers & Hayes, 2006). When the participants disclosed their sexual orientation, all reflected on the enhancing effects for them, the client and TR. Previous literature has indicated that from the client perspective disclosures are useful in contributing to the genuineness of the relationship and serve to position the clinician as a positive role model (Audet & Everall, 2003; Hanson, 2005). The interviewees reflected on both of these consequences of disclosure indicating some similarity between theirs and the client's experiences. However, it is also possible that through not specifying the type of disclosure to be discussed (i.e. beneficial, neutral or harmful) the participants here chose only to reveal

those instances in which they felt the disclosure had been beneficial for the client in some way. It may have felt too personally and/or professionally threatening to have revealed instances whereby the disclosure was perceived as harmful, although several participants did discuss instances of disclosures which they perceived as having a neutral consequence. It is therefore possible that the experiences in discussion may not be representative of the clinicians' overall experiences which should be borne in mind when viewing these results.

Very little research has previously been undertaken into the effects of disclosing sexual orientation to clients (Henretty & Levitt, *in press*). These studies suggest that disclosure of orientation has a positive effect when the clinician and client are both of sexual minority orientation (Brooks, 1981; Burkell & Goldfried, 2006; Jones, Gorman & Botsko, 2003; Liddle, 1996; Liljestrand, Gerling, & Saliba, 1978). This has been illustrated here in that disclosing to LGB clients served to reduce feelings of shame, position the information being offered and contributed to a more genuine TR. The disclosures were experienced as enhancing the clinicians' credibility by creating similarity. This in turn facilitated further therapeutic work which was not necessarily related to sexuality. These reasons for disclosing have been found by investigations exploring self disclosure more generally (Edwards & Murdock, 1994; Simone, McCarthy & Skay, 1998).

The qualitative methodology employed has facilitated findings that are contrary to the current literature. For some of the participants, disclosure was not only enhancing when in relation to the clients' sexuality but represented a pivotal moment in the relationship when working with other vulnerabilities e.g. a gay male clinician working with a female

client who'd previously suffered abusive male partners. Other participants reflected the integral nature of honesty within their TRs so that the disclosure served to protect the integrity of the relationship and afforded them credibility in their interactions with heterosexual clients. However, the expressed sense of therapeutic benefit for the client was juxtaposed with the clinicians' desire to feel "whole", "authentic" or "credible". This has been understood in relation to the affirming effects for the LGB individual of 'coming out' to positive identity formation but again raises questions regarding for whose benefit the disclosure served.

E. The cost of concealment

The extent of the damaging effects of concealment on the clinician and the TR was an unexpected finding. Whilst it is recognised that disclosures should be in the best interest of the client, some of the participants experienced a damaging psychological effect of keeping their sexuality concealed including shame, guilt and feeling dishonest and treacherous. These negative feelings towards the self were experienced even when participants acknowledged that the concealment was in their or their clients' best interests. This can be understood in relation to psychological models of LGB identity formation (e.g. Cass, 1979; Coleman, 1981; Woodman & Lenna, 1980). Central to these is the role and function of 'coming out' (i.e. to share one's sexual orientation with others), recognised as an important aspect of achieving a healthy self perception as a LGB person (Davies, 1996). The negative psychological impact of concealment, and the accompanying feeling of being in a regressed position, can be understood in this context. The participant's loss of self, or of the self as unreal in the relationship, can also be understood by looking to this literature. The now fully integrated sexuality forms a core part of the individual, lost as a result of feeling the need to conceal. The

loss leaves a less than whole person with which to work, leaving the relationship not “to its fullest benefit” (*IV6; 1077*).

The psychological well being of clients is paramount, but the well being of the clinician should not be overlooked and the powerful impact revealed here warrants further exploration. In line with the well being of the clinician, it is interesting that none of the participants discussed the role of supervision in either the decision making process or in managing the emotive situations described. Supervision has been described by the NHS Management Executive as “a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations” (cited by the Nursing and Midwifery Council). It forms a core part of continual professional development within the field of clinical psychology (British Psychological Society, 2005). However, as the majority of those interviewed were CPNs it is necessary to look to how it is viewed and utilised within the nursing profession. According to the Nursing and Midwifery Council clinical supervision should be provided to all mental health nurses. However, some research has highlighted that team and individual supervision are the least used methods of coping with work related stress (Coyle, Edwards, Hannigan, Burnard & Fothergill, 2000) and that there are difficulties in separating out clinical and managerial supervision (Edwards et al, 2005). It appears that despite drives to implement clinical supervision through policy initiatives, nurses are not always receiving the benefit of effective clinical supervision (Coyle et al, 2000; Nursing and Midwifery Advisory Group, 2004). For the current participants, having access to and utilising clinical supervision to discuss their feelings and decisions regarding disclosure could have been beneficial in managing the negative

consequences of concealment revealed. It is therefore possible that those interviewed either did not receive supervision or did not utilise supervision time to discuss their reactions to and feelings about self disclosure.

The participants' perceptions regarding the negative consequences of concealment on the TR despite an awareness and acceptance of the reasoning for their decisions to conceal, is particularly interesting. It appears that participants' perceived lack of choice and control regarding whether they could be open about their sexuality or not, in the context of feared physical and psychological consequences, contributed to this impact. Previous literature suggests that disclosing therapists are generally viewed more favourably than non-disclosing (Knox, Hess, Peterson & Hill, 1997; Myers & Hayes, 2006) but the clinicians' conceptions regarding the impact of non-disclosure have received little attention and are an important addition to our knowledge base.

Strengths and limitations of the study

The qualitative methodology utilised has yielded rich, in depth and contextualised findings previously lacking in the literature. Whilst not directly generalisable to all LGB clinicians, it represents a starting point in attempting to understand the experiences of sexual minority clinicians and has added to our understanding of the issues unique to them. One of the strengths of qualitative methods is the flexibility it allows in data collection and therefore in understanding what matters for the participants. The damaging effect of non-disclosure is an example of this.

In utilising genuine clinicians working within NHS mental health services the research also begins to move TSD research "into the field" (Watkins, 1990, pp.494). However,

any conclusions drawn must be tentative because of questions regarding how representative the accounts are.

The age of the interviewees ranged from 30-50 years, with the majority being between 41-50 years, providing a fairly homogenous data set. However, changing societal attitudes towards alternative sexual orientations means that the contexts within which the participants' accounts are embedded may differ from those of different ages. One reason for the limited age range may be that younger, and therefore less experienced clinicians, may have had fewer opportunities to experience this type of disclosure, or that the changing societal attitudes and their level of identity integration warrant their exploration of this as redundant. Older clinicians, who will possibly have lived through homosexuality being classified as a mental illness and/or illegal may not have felt comfortable discussing the topic.

In addition, the accuracy of the retrospective nature of the accounts could be argued as questionable. However, the critical-realist epistemological stance adopted by the researcher recognises these limitations and asserts that the recollections of the participants are both significant to them and important to their meaning making outside of the interview.

It should also be acknowledged that all of the participants identified as white British. It is possible that LGB clinicians of other ethnic backgrounds may hold differing perspectives of TSD due the impact of additional minority experiences (Garnets & Kimmel, 2003). There is a need for further research which explores this type of disclosure from people of different ethnicities (Watkins, 1990).

Clinical Implications

The analyses indicate that disclosure of sexual orientation can, from the perspective of the clinician, be beneficial to the client and the TR. The implications of this, and of other similar findings regarding the use of CSD, is that professionals working within mental health services should be open to the possibility of utilising CSD as a therapeutic aid. The motivations around disclosing such information or not should be carefully considered in the context of the particular client and TR at that particular point in time. However, such a disclosure can leave the clinician feeling vulnerable and is not without risk to both the clinician and the TR. Therefore appropriate support should be provided in the decision making process and to discuss the post disclosure impact.

The majority of participants expressed that to reveal personal information about themselves, especially relating to sexuality, was contradictory to what they had learned throughout training, and yet the enhancing effects were clearly felt. This contrast can lead to concern regarding the appropriateness of their disclosure (Knox & Hill, 2003) and suggests areas for development within the training provided to clinicians around the role of disclosure. Training providers should consider the evidence base around disclosure. Clinical psychologists could have a role in disseminating the most recent information regarding the possibilities and pitfalls of disclosure to team members of all professions and could be proactive in supporting training courses to adapt to the most recent evidence base. In doing so clinicians should be better equipped to manage disclosing situations with confidence whilst still doing so in the best interests of the client.

Secondly, most NHS Trusts operate within 'Equality and Diversity' policies. However, many of the participants reflected that the diversity training they had received was lacking in its attention to the specific needs, concerns and issues faced by LGB individuals. They reflected on how disclosing can feel risky and lead to feelings of vulnerability and many highlighted the role of heterocentric assumptions in their experiences. If clinicians can feel such a disclosure may be taboo and recognise heterocentric assumptions present in the Trust within which they work then it is possible that clients may experience the same. Previous research exploring the relationship between LGB consumers and healthcare providers indicates that many people do not disclose their orientation, despite feeling it would be helpful for their healthcare providers to know such information (Stein & Bonuck, 2001). Research also indicates that the majority of LGB healthcare consumers have experienced heterocentric assumptions on the behalf of healthcare providers, which subsequently impacts negatively upon LGB use of healthcare services (Beehler, 2001; Eliason & Schope, 2001; Eubanks-Carter, Burckell & Goldfried, 2005; Neville & Henrickson, 2006). It appears that when asked about sexual orientation in a non-assumptive manner many individuals do disclose, which is associated with regular healthcare use and a positive relationship with healthcare providers (Beehler, 2001; Stein & Bonuck, 2001; Steele, Tinmouth & Lu, 2006). Without adequate training it is difficult to see how these clients' needs can be understood and met. It is also possible that by not addressing LGB issues a powerful message is being sent; that talking about issues of sexuality is not acceptable. To address this, training providers should evaluate the weighting afforded to LGB issues and ensure appropriate information and room for discussion is facilitated. To improve clients' experiences of, and engagement with mental health services it is important that all staff are trained to communicate in an open, forthcoming and non-

assumptive manner with patients. It is also important to consider issues related to sexual orientation and homophobia, including identifying and confronting personal and institutional bias.

Lastly, the damaging psychological effects of feeling the need to conceal is concerning and LGB clinicians may lack the opportunity to discuss such feelings in the work setting unless access to appropriate, regular supervision is provided for. As none of those interviewed discussed the role of supervision in managing such situations, it is possible that this is not the case at present. NHS Trusts should evaluate the role of supervision for nurses at a local level and ensure adequate clinical supervision is maintained (Nursing and Midwifery Advisory Group, 2004). Where appropriate, clinical psychologists could play a valuable role in establishing and/or facilitating peer and/or individual supervision within their teams.

Conclusion

In summary, this study provides a valuable insight into the experiences of LGB clinicians engaging in TRs within NHS mental health services. The findings indicate some additional difficulties that CSD may pose for these individuals and points to the unique and contextually dependent factors involved in reaching a disclosure decision, the disclosure experience and its effects. Far from a simple exchange of innocuous information, the powerful feelings evoked and potential for therapeutic gain or detriment as a result of the disclosure appear to have been over looked in the current literature. Participants experienced an enhancing effect of the disclosure on them, the client and the TR. A corresponding cost to themselves and to the relationship was

revealed when feeling the need to keep their sexual orientation concealed, a finding which is new to the literature and warrants further exploration.

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Section C.

Critical Appraisal

Critical appraisal

Reflexivity has been positioned as a methodological tool within qualitative research that researchers can and should use to “legitimize, validate, and question research practices and representations” (Pillow, 2003, pp. 175) and as a means of acknowledging the researcher’s preconceptions in order to enhance transparency and the rhetorical power of the account (Brocki & Wearden, 2006). This section aims to look reflexively at the research process from its inception to date and to critique the methods employed before offering suggestions for further research.

Researcher’s position and research conception

It is suggested that one aspect of ‘good practice’ in qualitative research is for the researcher to ‘own one’s own perspective’ (Elliot, Fischer & Rennie, 1999, pp. 221). One of the criticisms of published IPA studies is that the researcher does not always explicitly recognise the preconceptions they bring to the data or their role in the interpretation (Brocki & Wearden, 2006). I will attempt to combat this in these sections.

I am a 27 year old female trainee clinical psychologist who identifies as being lesbian and became interested in the idea of disclosing sexual orientation to clients through my clinical work. Although I had not experienced such a disclosure directly, I had often wondered what the impact of sharing such knowledge could be on the client and the therapeutic relationship. I discussed the topic with colleagues whilst employed as an assistant psychologist prior to clinical psychology training with particular reference to working with clients who appeared prejudiced. I had also conversed with heterosexual and non-heterosexual, psychology and non-psychology colleagues about this type of

disclosure and found a mixed response as to why and when it would be appropriate to share this information. When first commencing the training course I found myself to be the only sexual minority member of the cohort. This initially caused some discomfort as I had to decide when, how and to whom I should disclose my sexual orientation; this added to my curiosity regarding disclosures of this nature. I looked to the literature to further my knowledge of others' experiences and at this stage recognised that although the area of therapist disclosure has been researched in different ways over time, there was a distinct lack of research relating to the clinician's experiences of sharing personal information such as sexual orientation. I believed that sexual minority mental health professionals could face additional challenges in sharing this information as a result of hidden minority status and sought to explore the area through my third year research project.

Choosing a methodology

The research questions emerged as a result of the literature review. However, as noted above the topic was of interest to me prior to this and influenced my decision to undertake TSD as a topic for review. It revealed only a small body of qualitative research exploring TSD and it was felt that these methods could add something new to the well researched area.

Qualitative methods of investigation have grown in popularity within the field of psychology over the last decade (Smith, Flowers & Larkin, 2009). They are concerned with "human experience in its richness" (Ashworth, pp.4 cited in Smith, 2003) and primarily engage with exploring, describing and interpreting the personal social

experiences of participants (Smith, 2008). IPA is a rapidly growing approach to qualitative inquiry in psychology which is committed to exploring in detail the participant's lived experience and how participants make sense of that lived experience in the context of their 'life world' (Smith, 2004; Smith, Flowers & Larkin, 2009). IPA is ideographic, inductive and interrogative and therefore aims to enhance our understanding of aspects of human experience by exploring in detail those individual experiences, making comparisons across the group whilst retaining the ideographic qualities of each account and contributing to psychology by challenging and/or illuminating existing research (Smith, 2004).

IPA is partly rooted within the hermeneutic tradition which recognises the integral nature of the context within which we operate in the world on how we experience it. According to phenomenological philosophers such as Husserl and Heidegger, the human individual is an inclusive and active part of their reality, as opposed to there being a divide between subject and object as would be endorsed by a Cartesian stance (Larkin, Watts & Clifton, 2006). This is important as it asserts that the outcome of qualitative analysis inevitably represents an interaction between the participant and the researcher, as opposed to a positivist claim of truth or reality, as both will enter into the process as people in context; the researcher is trying to make sense of the participant making sense of the experience in question, in the context of their personal and social worlds (Smith, 2004). This philosophical underpinning fits well within a critical-realist epistemological stance and the aims of the current study matched well with the philosophy of IPA. I was a novice at conducting qualitative research prior to this research piece and after exploring options such as Grounded Theory and discursive methods was also attracted to the approach for its flexible and approachable framework.

Before commencing the research I believed that it would be paramount for me to engage fully with the participants' accounts which I felt would be time consuming in a different way to quantitative pieces. I also anticipated that deciding what was to be represented in the final write up, and deciding when I had done enough, would be anxiety provoking as there could be many ways to represent the data appropriately.

Constructing the interview schedule

The aim of interview schedules for use with IPA is to facilitate comfortable interaction with the participant and enable them to provide a detailed account of the experience under investigation (Smith, Flowers & Larkin, 2009). To achieve this aim, I considered at length, and with consultation from my academic and field supervisors, the areas of interest I would like the participants to cover based on the literature review and reading around the area. Before meeting with the participants, I piloted the initial interview schedule with my field supervisor, also a lesbian female therapist. It became clear that the formal wording and style of the schedule was not conducive to the conversational atmosphere I was attempting to create. The style of questioning was adapted to consist of expansive, open ended and non-leading questions which facilitated discussion around the areas of interest. I ensured a thorough knowledge of the schedule to facilitate as much as possible an unstilted dynamic between myself and the participant (Smith, 2008).

The consultation process with my field supervisor led me to question whether or not I would make my sexual orientation explicit to interviewees at the outset and how this may impact upon the interviews. The critical-realist stance adopted recognises the impact of the interview process and dynamic between researcher and researched on that

which is revealed during the interview (Madill, Jordan & Shirley, 2000; Smith, Flowers & Larkin, 2009). In addition, it has been reflected that what is revealed during the interview, and therefore forming the data set upon which an appropriate argument is formed, is not only reflective of the questions asked of the participants but is incumbent of “the whole history of the research encounter” including how they were recruited and what they were told the interview was about (Holloway, 2005, pp. 312). It was decided that in revealing this information I could set a relaxed and open tone to the interview which would facilitate the participants’ sharing of information. Therefore all participants were provided with the information that I was interested in the experiences of *other* non-heterosexual clinicians in the interview introduction (see Appendix J).

Advocates of alternative qualitative methods such as conversation analysis have shown scepticism about the use of interviews for data collection (Potter & Hepburn, 2005). This has been mainly due to using them within a positivist framework, whereby that which is revealed is viewed as ‘factual’, or from an emotionalist stance whereby the interview is viewed as a pathway to the experience itself (Potter & Hepburn, 2005). The hermeneutic approach adopted by IPA goes some way in countering this argument by approaching the interview as a vehicle through which some of what was experienced by the participant is revealed, as opposed to it being an open window onto the ‘truth’, and by recognising the influence of the researcher and researched as people in context on the data revealed and its analysis (Larkin, Watts & Clifton, 2006).

Carrying out the interviews

I made use of a field diary in which I detailed my experience of the interviews, in line with qualitative research recommendations (Elliot, Fischer & Rennie, 1999; Yardley,

2000). The interviews were carried out over a three month period and I noted a growing confidence with each interview as illustrated in the field diary extracts below:

[Interview one] Felt quite anxious initially but less so once we'd started. I was looking forward to hearing about the participants' experiences but during the interview found it difficult to be 100% focussed on the narrative. My mind was sometimes wandering; what will this look like in the analysis? Will this data be sufficient?

[Interview two] Felt engaged with the participant in a more real sense and was less concerned about the questions I was asking (memorised them better?) and felt more engaged with the conversation.

[Interview three] I felt much more at ease during this interview and more confident in veering away from the set questions to follow up what the participant was saying.

It is possible that growing familiarity with the schedule, in addition to overcoming the initial anxiety experienced in conducting the interviews, played a part in this. However, as noted below, later interviews were not necessarily easier or more comfortable:

[Interview six] was difficult at points and I didn't feel it flowed as easily as some of the others, felt like I was pressing for specifics that he couldn't provide.

I felt that some of the interviews flowed more naturally than others. After completing the interview discussed above I reflected that the room set up may have influenced my

sense of it feeling stilted as unlike other interviews, this was carried out at my university base where the rooms are smaller with space for only two chairs, one of which was higher than the other which gave an odd dynamic. Humour was used by myself and the participant in most interviews which I felt was useful in maintaining a relaxed atmosphere in which participants could feel relaxed enough to discuss what may have been a difficult topic. The natural flow of some over others could have impacted on what was revealed during the interview and the subsequent analysis. During the transcription stage I noted my internal experiences which I framed as evoked by how I felt about the interview:

Felt less interested when transcribing [interviews five and six]. Because I found the interviews more difficult (hence more of my own voice on the recording)? Or because what they said didn't fit with previous accounts...and felt more muddled during the interviews?

In order to address my own conceptions regarding the expected outcome of the questions I attempted to bracket them off before each interview by making a note of them, and then noting feelings evoked from the interview process.

The second half of one of the interviews (interview two) was repeated two months after the initial interview took place due to the recording equipment failing. On this occasion the participant was asked to read through the transcript of the first interview to aid recall and position the following questions. It is likely that this impacted upon the interaction as the participant would have been further along in her thinking around the subject matter. However, allowing a greater amount of time between interviews allowed for a more natural and relaxed flow so that the questions didn't feel contrived or rehearsed

even though the participant discussed the same experience examples as the first interview.

I found it difficult at times to refrain from a therapeutic stance during interviews. This was especially difficult when the participants were reflecting on something distressing, such as the interview making them “feel bad” (IV7; 644). However, although all of the participants were offered the opportunity of meeting again to discuss the topic further, which could have facilitated approaching the interaction from a more therapeutic stance, none of the participants requested this further input. For interviewee seven, declining further support was conducive with her presentation as a “secretive” (IV7; 98) individual who did not readily discuss this part of her personal life. This may also have been due most participants being significantly older and more clinically experienced than me and they may have felt it would not be helpful to discuss the topic, or because they felt it unnecessary to do so.

Transcribing the interviews

Debate around how audio data should be transcribed has received some attention in the literature (Potter & Hepburn, 2005). I followed the framework suggested by Smith, Flowers & Larkin (2009) which suggests transcribing every word spoken by the researcher and participant verbatim, in addition to significant pauses and hesitations and other emotional expression such as laughter. It has been suggested that “the best interview studies” (pp. 291) concur with features of transcribing in a Jeffersonian style whereby intricate details attempting to represent the interaction between the interviewer and interviewee are present (Potter & Hepburn, 2005). However, it has also been argued that there is no one naturalistic method of transcription as to graphically

represent an interaction involves a choice as to what one represents, which will in turn influence the analysis (Smith, 2005). The task for me was to describe and interpret the experiential claims of the participant, as opposed to looking to the use of language in revealing something of the experience, making the method of transcription utilised appropriate (Holloway, 2005).

Analysing the transcript data

The analysis stage commenced once all interviews had been completed and transcribed. At the beginning of this stage I felt overwhelmed by the task at hand, exacerbated by being a novice at qualitative research. The case by case approach suggested for use with IPA (Smith, Flowers & Larkin, 2009) made the analysis more manageable as I was able to break up the enormous task of making sense of the data by approaching one level of analysis, one transcript at a time. I used the field diary to note any emerging ideas and to pose questions that arose as a result of the analysis so that they could be returned to when making sense of the data at a later stage. The diary was also used to note the internal experiences evoked from the analysis. By recognising and recording these feelings I was able to both use and distance myself from them to check whether my interpretations were truly grounded in the transcript material or more based on my own conceptions. This process also facilitated trying to understand the participants' experiences by looking to my own experiences as a lesbian clinician in an attempt to fully engage with their meaning making, as illustrated below:

[Interview 4; 507] Recognised/ resonated with what he was saying about having to come out and the strangeness of it because of moving to different placements so regularly and the assumption of heterosexuality, almost like having to correct people rather than being able to discuss personal life on own terms, does then

feel like an issue/ statement...felt quite outraged at times during analysis, particularly around his experiences of prejudice at work at the hands of staff members. Even more than this though I felt annoyed that he didn't seem to feel outraged by it!!!

I found it interesting that I felt annoyed at both the homophobic staff member and the interviewee. I reflected that in distancing himself from the homophobic encounter by saying it was not directly aimed at him, I felt frustrated that he had not challenged them and wondered if the response would have been the same if encountering other forms of prejudice. I also felt defensive of other LGB staff that would perhaps experience the same discrimination as a result of this person not being challenged, and the training that could have happened to educate her about LGB issues etc. as a result.

My own experiences of being a lesbian clinician contributed to my understanding of the LGB participants' experiences. I feel I was able to use similar experiences to achieve a level of understanding, and also to explore where experiences diverged. I was aware of the possibility that I was making assumptions about my data at different points based on my own experiences and so re-read the data to explore what other explanations or meanings that could be present so as not to be assumptive. This was an enlightening process and by recording thoughts and feelings such as those above I was able to step back somewhat from my own experiences to fully appreciate those of the participants.

I was mindful throughout the analysis and write up processes that one of the criticisms of IPA is that it is "simply descriptive", especially so when working with groups whose voices are not heard such as LGB mental health professionals (Goldfried, 2001; Larkin,

Watts & Clifton, 2006, pp. 102). I was keen to do justice to both the methodology employed and to the participants who had volunteered their time and strove to strike a balance between giving voice to the participants and making sense of their experiences through interpretation. This has been recognised as difficult for the novice qualitative researcher (Larkin, Watts & Clifton, 2006; Smith, Flowers & Larkin, 2009). I made use of regular research supervision from my more experienced academic supervisor in order to address the balance of description verses interpretation.

At times I questioned the usefulness of the research and how it could profit the psychology literature and LGB clinicians. However, all of the participants reflected a belief that the topic of investigation has been under researched and warranted further exploration, bolstering my beliefs about the importance of the subject.

Parallel processes

Throughout the process of carrying out this research I became aware of some of the parallels occurring between my experiences in conducting the research and those of the participants in disclosing. When first formulating my ideas for the research I began to feel quite exposed at the idea of ‘wearing my sexuality on my sleeve’ and wondered how the idea would be received by others. This was reflected on by some of the people I interviewed when talking about how they felt about sharing their orientation with others. In addition, some of those interviewed discussed the protectiveness of being out to work colleagues. This made me reflect on how I might have felt about doing the research if I had not already come out to my course colleagues and various placement supervisors and I think without doing this I probably wouldn’t have felt able to do the research.

At the stage of constructing the interview schedule, the consultation process with my field supervisor (also a lesbian clinician) led me to question whether or not I would make my sexual orientation explicit to interviewees at the outset and how this may impact upon the interviews. Initially I was cautious about this as I did not want to impose too much of myself on the interview. Reflecting on this at that stage I wondered whether this concern would in some ways parallel the process which the LGB clinicians face when considering disclosing with clients. Through the stages of analysis the participants' concerns regarding the relevance and appropriateness of disclosing resonated with this earlier consideration.

The supervisory process with my academic supervisor was extremely valuable to the research process. It was reflected that throughout our many meetings neither of us had actually disclosed our sexual orientations to one another- I had assumed that she was heterosexual from discussions about her home life and perspectives on the research and she had assumed that I was lesbian. This provided an interesting dynamic and perspective on the participants' experiences. It was also reflected that this may parallel with the accounts of some of the participants who discussed the role of client assumptions and the hidden nature of sexual orientation in their disclosure decisions. Both my supervisor and I were working on the assumption that we knew something about the other's sexual orientation but, as reflected in the participants' accounts, the hidden nature of sexuality means that without disclosing neither of us could have known for sure. I felt at the time that to positively state my sexuality would have felt uncomfortable because I was not sure how relevant or appropriate it would be to do so. This is paralleled by the participants accounts of the decision making process when

considering disclosure with clients. At times, perhaps because of my underling assumptions, I felt quite protective about the participants' accounts but on reflection having someone of an alternative sexual orientation was invaluable in understanding and making sense of their experiences in a more holistic manner.

My perspective

I feel that the process of creating, carrying out and writing up this research piece has had an impact on me both personally and professionally. I will attempt to share my reflections on how and why this is below.

Personal perspective

I have already discussed the feeling of exposure that came with formulating this idea as a research topic. Although I had a positive response from colleagues and course staff both in disclosing my orientation and putting my research ideas forward, the initial discomfort and exposed feeling caused me to question how comfortable I really was with my own sexuality. I had previously taken this somewhat for granted as I have been out to friends, family and colleagues for many years. Feeling this way caused me to think about ideas of internalised homophobia (i.e. that LGB people internalise the negative societal attitudes about homosexuality) (Ross & Rosser, 1996) and to recognise that, without being consciously aware of it I had concerns that others might perceive me differently and potentially less favourably for covering this topic as it could reveal to everyone who was inclined to ask about the research what my sexual orientation was. Parallels can again be drawn between my feelings of vulnerability and the participants' experiences of disclosure being a risky thing to do. I feel that this has been an enlightening and positive journey for me personally and that by recognising and

reflecting on this I have come some way in overcoming these concerns and feel more comfortable with my own sexuality.

Clinical perspective

When I embarked on this research journey I was unsure even whether clinicians did disclose their orientation to clients and, like one of my participants (Vanessa), had an underlying sense that it could in some way be viewed as going against professional codes of conduct. I have learned that disclosing this information is not a simple process of 'to tell or not to tell' (Goldstein, 1997) but rather one of what, to whom, why, when and how to tell. The enhancing effects of disclosing, and the cost implications of not, found here has caused me to reflect on what impact my disclosure decisions have had on me and my therapeutic relationships and how I might go about my thinking about disclosure with clients in the future. I can recall many occasions when I have shared something of myself with clients, like overcoming difficult times, what I enjoy outside of work etc as part of the relationship building process but have never deemed it relevant to share this part of myself. Perhaps, like my participants, disclosing has felt too risky to do. I have however had accidental contact with a service user when in a gay venue and found it to have been initially uncomfortable but beneficial in that he knew I had an understanding of that aspect of his life which he then felt more comfortable discussing with me compared with his heterosexual case worker. Similarly to the participants I would still consider carefully the potential impact on the client and relationship. Being a person in my own context, my previous disclosing experiences will influence my decisions too. I do however feel that if it were relevant to the client and/or relationship I would now feel more comfortable in sharing this aspect of myself by understanding something of how others have experienced it. It is my hope that this

research will enable others to feel similarly reassured about the potential for this type of disclosure to benefit clinicians and clients alike.

Ideas for further research

The findings of this investigation point to some of the difficulties that TSD poses for the LGB mental health professionals interviewed. The findings point to potentially fruitful areas for future research, as outlined below:

- The study indicated the risk and vulnerability felt by the participants in disclosing their sexual orientation. This was understood in the context of the hidden nature of sexual orientation. Further research could explore the experiences of therapists disclosing other hidden statuses, for example, the experience of mental health problems. Some research has begun to look at the lessons that coming out as LGB could have for people stigmatised by mental health difficulties (Corrigan et al, 2009) and it would be interesting to compare the findings of this study to the experiences of mental health professionals revealing mental ill health.
- All of the participants in the current study identified as white British. There is a recognised dearth in the literature regarding our understanding of the experiences of BME populations (Watkins, 1990) although clinical psychology as a discipline has come a long way in improving understanding and cultural competence when working with BME populations. Less is understood about the impact of a double minority status (i.e. BME and LGB) in general, and even less with regards to mental health professionals. This could enhance our understanding of the unique issues faced by people with more than one minority

status in addition to enhancing our understanding of minority stress in today's society.

- Most of those interviewed were aged between 41-50 years and the participants recognised an “absolute sea change” in their experiences of living and working in Britain over time. The ever changing zeitgeist regarding the acceptance of alternative sexualities means that further research utilising different age groups and time since qualifying in their particular field may enhance our understanding through their different experiences of the cultural and social context through which they have lived.
- Most of the participants reflected a lack of adequate training regarding LGB specific issues and needs when attending equality and diversity training. It has been previously recognised that increasing interaction with stigmatising subject matters, such as mental health problems, improves the attitudes of people towards these issues (Corrigan et al, 2009). It would be valuable to assess the impact of improvements of such training changes on the attitudes of those undertaking the training.
- All of the participants here were out with the colleagues with whom they work and for most this served as a protective factor in their disclosure experiences. Given the negative impact of concealment with clients revealed here, it would be valuable to explore the experiences of individuals who have not disclosed their orientation to colleagues in order to understand their conceptions regarding the impact on them, the clients with whom they work and the TR, although recruitment may prove difficult.
- Although exploration of LGB client preferences in therapy is increasing, there is very little empirical evidence to indicate the type of therapist characteristics

important to LGB clients (Burkell & Goldfried, 2006). This problem is compounded by most therapists never having received training in working affirmatively with LGB clients (Eubanks-Carter, Burkell & Goldfried, 2005). The participants interviewed here reflected that disclosing their status was more likely when working with LGB clients to position information and create similarity. Future research could explore how this is received by clients.

- The way in which disclosures were made was central to the participants' experiences of disclosing. Researchers have looked at impact of the congruency of general disclosures on therapy outcome (e.g. Nyman and Daugherty, 2001) but little is understood about how the way in which a disclosure is made is received by clients and impacts on the relationship and the area warrants further exploration.
- Some research has looked at client symptomatology and the frequency of TSD and indicates that therapists generally disclose more to those with lower initial symptomatology (Kelly & Rodriguez, 2007). The participants in the current study framed their disclosure decisions in the context of client struggle with issues pertaining to their sexuality and other vulnerabilities. It would be useful to understand if therapists disclose more when they perceive clients to be vulnerable.

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APPENDIX A:

CHRONOLOGY OF RESEARCH PROCESS

Chronology of Research Process

2009

July

-Research proposal submitted to Local Research Ethics Committee (LREC)

August

-LREC approval for study received

-R&D approval for conducting study across Leicestershire Partnership Trust received

September

-R&D approval for conducting study across Coventry and Warwickshire Partnership Trust received

-Research flyer sent out to LPT and CWPT employees

-Literature review completed

October – January

-Research interviews carried out

-Transcription of interviews completed

2010

January – March

-Analysis of interview transcripts completed

March – April

-Research report and critical appraisal written up

-Critical appraisal written up

-Thesis submitted

APPENDIX B:

LETTERS OF ETHICAL APPROVAL

APPENDIX C:

LITERATURE REVIEW: DATA EXTRACTION TOOL AND JOURNAL
GUIDEANCE FOR PUBLICATION

Data extraction tool

Study ID:	Author (1st only):		
Publication date:	Place of publication:		
Journal:			
Volume:	Number:	Pages:	
Keywords/definitions:			
Aims:			
Study type/ design:			
Inclusion criteria:		Exclusion criteria:	
Total number of participants:		Number of conditions:	
Number per condition: 1- 2- 3-		Contol group:	Y / N
		Randomozed:	Y / N
		Blind:	Y / N
Analyses/ statistics:			
Findings:			
Conclusions:			
Rating: quality of research		Rating: relevance to review:	
A	High quality	1	extremely relevant
B	Medium quality	2	quite relevant
C	Low quality	3	marginally relevant

Data extraction form-created based on data accessed from
[http://eppi.ioe.ac.uk/cms/Portals/0/PDF%20reviews%20and%20summaries/EPPI%20R
EPOSE%20Guidelines%20A4%202.1.pdf](http://eppi.ioe.ac.uk/cms/Portals/0/PDF%20reviews%20and%20summaries/EPPI%20R%20EPOSE%20Guidelines%20A4%202.1.pdf). Accessed on 15/01/2008.

APPENDIX D:

LITERATURE REVIEW: TABLE OF ARTICLES REVIEWED

Table 1. Summary of articles reviewed

Study ID, 1 st author and year	Aims	Study Type/Design/Intervention	Participants	Measures/ Analysis/ Statistics Dependent Variables	Results/ Conclusions	Comments/ Limitations
1. Myers & Hayes (2006)	Examine how perception of therapists and sessions are affected by general TSD and counter transference disclosures in comparison to no disclosures. Role of working alliance (WA) previous experience of therapy on perception.	3x2 factorial design. Manipulated simulated therapy sessions to vary along type of disclosure (general v's countertransference v's no disclosure) and working alliance (positive WA v's poor WA)	224 undergraduate students -74 male -150 female -90% European American -4% African American -2% Hispanic -2% Asian -1% other -2% unreported	Counsellor Rating Form (CRF) Session Evaluation Questionnaire (SEQ) Working Alliance Inventory (WAI)	Perception of therapist and session affected by working alliance. When WA was strong general self disclosure condition rated more expert and in depth than counter transference and no disclosure conditions. Participants with previous experience of therapy rated counter transference condition as more expert and in depth. When WA poor no disclosure condition rated as more expert. Self disclosure may be problematic when WA poor but beneficial when WA strong, genuine and humane.	Laboratory analogue study limits generalisability. Data from single observation of single segment of therapy limits generalisability to clinical practice. Therapists' view of alliance not explored. Therapists in video White, limits generalisability.
2. Barrett & Berman (2001)	Assess whether TSD made in response to client disclosures can influence outcome of therapy.	Manipulated number of self disclosures made by therapist (increased with one client and decreased with another) over 4 sessions.	36 clients at a university counselling centre. -15 male -21 female -ethnicity not reported 18 therapists each treating two clients -7 male -11 female -ethnicity not reported	Client measures – expectation of disclosure and improvement, liking of therapist on 4 point likert type scales, Hopkins Symptom Checklist and Observer measures – frequency, duration, intimacy (on 9 point likert type scale) and congruency of	Participants in the increased disclosure condition reported lower symptom distress and greater liking for therapist following session. Nearly all TSD judged to be in response to similar client disclosure. No effect of TSD on frequency or intimacy of client disclosure.	Findings limited to reciprocal TSD. Cannot address possible differences in types of disclosures (i.e. factual information v's personal thoughts/ feelings). Therapists generally around same age as clients, limits generalisability. Possible selection bias (self selection by observed counsellors).

				disclosure.		
3. Nyman & Daugherty (2001)	Examine relationship between the congruence of counsellor religious self disclosure and observer perceptions of counsellor.	Manipulated counselling vignettes (congruent counsellor prayer disclosure v's incongruent counsellor prayer disclosure)	67 university students. -24 male -43 female -55 Caucasian -12 non-Caucasian	Counsellor Rating Form (CRF) Ways of Religious Coping Scale Single response items (evaluate effectiveness of manipulation)	Participants in congruent disclosure condition had more favourable perception of counsellor. Participants across conditions didn't differ significantly on ratings of trustworthiness or expertness but did on ratings of attractiveness. Significantly more likely to choose to see counsellor in congruent condition for own therapy.	Non-clinical, ethnically homogenous sample limits generalisability. Didn't examine different counsellor techniques as factor.
4. Kelly & Rodriguez (2007)	Assess whether therapists self disclose more to clients with greater initial levels of distress and whether male or female clients receive more disclosures.	Correlational design.	22 therapists -4 male -18 female -21 White -1 Black 83 clients -66 female -17 male -76 White -5 Black -1 Latino	Client measures: Several likert type scales assessing problematic behaviours and symptoms. WAI Therapist measures: WAI Self Disclosure Index (SDI)	More therapist self disclosure not linked to better therapy outcome. Therapists disclosed significantly more to clients with lower initial symptomatology and to female clients irrespective of sex of therapist. TSD not significantly related to WA scores. Self disclosure scores not significantly correlated with symptom change.	Didn't explore effects of different types or congruency of TSD. Therapist self selection of clients. Therapist self reports not validated. Didn't specify type of correlational analysis.

<p>5. Kim, Hill, Gelso, Goates, Asay, & Harbin (2003)</p>	<p>Examine how Asian American participants react to counsellor disclosures during session. Examine immediacy effects of type and intimacy of disclosure on Asian American participants' perception of each disclosure.</p>	<p>Manipulated disclosures of personal information during one session.</p>	<p>62 university students -33 male -29 female -27 Korean -19 Chinese -9Taiwanese -3 Japanese -3 Chinese- Taiwanese-American -1 Chinese Korean American 17 European-American Counsellors -11 female -6 male</p>	<p>Asian Values Scale Several likert type scales to measure client perceived strength of therapeutic relationship, counsellor effectiveness and empathy, helpfulness of disclosure and intimacy of disclosure.</p>	<p>Disclosure condition and client adherence to Asian values did not predict session outcome. Disclosures of reassurance/ approval and strategies used more frequently than other types of disclosure. Clients rated strategies as more helpful than approval/reassurance. Intimacy of disclosures related to helpfulness.</p>	<p>Based on only one session, Asian clients and European American counsellors limits generalisability. Soundness of one scale used questionable. Paid for participation.</p>
<p>6. Cashwell, Shcherbakova, & Caswell (2003)</p>	<p>Consider the influence of client and counsellor ethnicity on client preferences for CSD.</p>	<p>2x2 factorial design Manipulated ethnicity of hypothetical counsellor on CDS (ethnicity of respondent x ethnicity of counsellor)</p>	<p>441 university students -118African American -294 Caucasian -32 other ethnicity or non response to item</p>	<p>Counsellor Disclosure Scale – likert type scales of CSD in 6 domains; Personal Feelings, Interpersonal Relationships, Sexual Issues, Attitudes, Professional Issues and Success/Failure</p>	<p>Respondent ethnicity affected preferences for certain types of information about the counsellor (personal feelings, sexual issues, professional issues and success/failure). Both African American and Caucasian participants indicated stronger preference for disclosures re: interpersonal relationships and success/failure when counsellor of different ethnicity to participant.</p>	<p>Non-clinical sample and younger students limits generalisability. Did not examine timing, frequency, intimacy or congruency of self disclosures as factor.</p>

7. Goodyear & Shumate (1996)	Investigate practicing therapists' perceptions of a therapists' disclosure of sexual attraction to a client. Focussed on perceived consequences of the disclosure on the client and on therapists' power.	2x2x2 factorial design. Manipulated simulated therapy sessions (disclosure of attraction to client v's non-disclosure; male client-female therapist v's female client – male therapist) in response to client disclosure of attraction.	120 licensed mental health professionals -60 female -60 male -92.5% White and non-Hispanic -3.3% Black -1.7% Hispanic -1.7% Asian -0.8% other ethnicity	Counsellor Rating Form (short version) – 7 point likert type scales to assess counsellor Expertness, Attractiveness and Trustworthiness. 2 single item likert scales to assess plausibility.	The self disclosing condition was rated as less therapeutic for the client and the mental health practitioner was rated as less expert. No significant effect of condition on rating of mental health practitioners trustworthiness; practitioner rated as more attractive in disclosure condition.	Analogue study. Doesn't specify how participants assigned to condition. Background information provided to participants may have effected ratings.
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<p>8. Gregory II, Pomerantz, Pettibone, & Segrist (2008)</p>	<p>Examine the effects of psychologists sharing their personal religious background as part of the informed consent process.</p>	<p>5x2 factorial design. Manipulated vignettes in which hypothetical psychologists reported different variables. Manipulated religiosity of psychologist (atheist, Christian, Jewish, Islamic and no mention of religion) x participant religiosity (high v's low).</p>	<p>165 undergraduate students. -69.7% female -30.3% male -78.1% European American -11.5% African American -4.2% Hispanic -2.4% Asian American -3.6% other or non response to item -84.8% Christian -9.7% agnostic -1.8% atheist -0.6% Buddhist -3% other</p>	<p>Participants self reported likelihood to see the therapist described in the vignette.</p>	<p>Across both levels of religiosity, participants more likely to see to see psychologists who described themselves as having an affiliation to a major religion than atheist. Particular religion of psychologist significant for high religiosity and non-significant for low religiosity.</p>	<p>Analogue study vignettes may not accurately reflect how therapist in real clinical situation would make such a disclosure. Majority female, European American participants limits generalisability.</p>
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APPENDIX E:

RESEARCH ADVERTISEMENT FLYER



Wanted: LBG Clinicians to take part in research interviews!

Are you a lesbian, gay or bisexual Clinician working therapeutically with clients/ patients?

Have you experienced disclosing your sexual orientation to a client you have been working with?

If so, I would like to hear about your experiences of deciding whether or not to disclose your sexual orientation to a client that you have been working with.

Which professions could be eligible to participate?

If you are a Clinical Psychologist, Nurse Therapist, Psychiatric Nurse, Psychiatrist or a Systemic/Family Therapist then I would very much like to speak with you. This is not an exhaustive list so if you work therapeutically with clients/ patients in an alternative profession then I would also like to speak with you!

What about confidentiality?

Your participation in this study will be treated with the upmost confidence and you will be able to decide when and where interviews take place.

Want to find out more?

So if you would like to find out more about this valuable research, discuss what it will involve or if you think you might be interested in participating then please contact Melissa either by phone or email on:



ail: mkj9@le.ac.uk
one: 07513 064 330

Version 2 20/05/09



APPENDIX F:

PARTICIPANT INFORMATION SHEET

Participant Information Sheet

Title of Study: Lesbian, Gay and Bisexual (LGB) Mental Health Practitioners' Self-Disclosure of Sexual Orientation: Impact on Clinician and Therapeutic Relationships

I would like to invite you to take part in a research study aimed at exploring LGB Clinician's experiences of deciding whether or not to disclose their sexual identity to patients or clients who they are working with.

1. What is the purpose of the study?

This study is an in depth exploration of how LGB mental health practitioners' experience deciding whether or not to disclose their sexual orientation to a client who they are working with. It will aim to understand the experience of making such a disclosure or not and the effect this may have on your relationship with the patient/ client. I am also very interested in exploring ideas about what some of the influencing factors in making such a disclosure or not are, and how the experience of making such a disclosure or not may influence personal and professional identity.

2. Why have I been invited?

I am seeking LGB Clinicians with an interest in discussing the subject matter to participate in this study. You have been provided with this information sheet because someone who has indicated interest feels the research may be of interest to you.

3. Do I have to take part?

It is up to you whether or not you decide to take part in this study. After you have read through this information sheet, you will be given a consent form which you must sign if you wish to take part. If you change your mind about participating you may withdraw your data by contacting the researcher. You will have up until the write up stage of the research (February 2010) to choose to withdraw your participation.

Your details *will not* be passed on to the researcher by the person who provided you with this pack. If after reading through this information sheet you decide that you would like to participate, or would like to discuss your participation, please contact the researcher directly on the telephone/ email details provided.

4. What will I have to do?

If you choose to participate in this study you will be asked to contact the researcher and participate in a short (roughly 10-15 minute) screening interview to ensure that you meet the criteria for participation and have the opportunity to ask any questions.

This will be done via telephone at a time arranged between yourself and the researcher. You will be asked to take part in one interview which will last for between 60-90 minutes and will be audio taped. The interview can be conducted at the most convenient time and place for you. The audio tapes will be transcribed by the lead researcher and all identifiable information will be removed. You will be offered the opportunity to receive the transcript and amend any data that you feel is potentially identifiable before it is used for the study.

5. Expenses and payments

The researcher will endeavour to arrange for interviews to be conducted at a time and location most convenient for you. Should you be required to travel anywhere, your travel expenses will be fully reimbursed by the researcher.

6. What are the possible risks and disadvantages of taking part?

The main cost of taking part in this research will be the time taken to complete the interview, which will be between 60-90mins. Whilst it will not be possible to reduce the time required, every effort will be made to ensure the interview is conducted at a location and time most convenient for you.

It is possible that some participants may find some of the questions raised during the interview distressing. All participants will be provided with an information sheet detailing sources of support and advice help lines and support websites. All participants will also be offered one support session with the researcher post interview should you require any further support.

7. What are the possible benefits of taking part?

By taking part in this research, you will be helping to enhance our knowledge base of an under researched area within psychology. The findings of the research will potentially reveal enlightening information for the clinical practice of therapists and others working therapeutically and increase our understanding of an area that is relevant to all participants as LGB individuals and as Clinician's more generally. In addition, the interview process will provide an opportunity for participants to share and process their experiences in a safe setting.

8. What happens when the research study stops?

Once the data has been analysed, the findings will be submitted to the University of Leicester in partial fulfillment of a Doctorate in Clinical Psychology. It is also expected that findings will be presented at conferences and in peer-reviewed journals. Any data presented will not be identifiable to specific participants. Under University regulations, all participant data will be stored for five years at the Clinical Psychology base at the University of Leicester. Data will be stored securely and there will be a named member of administration staff who will be able to access this data. All data will be destroyed after five years.

9. What happens if there is a problem?

If you have a concern about any aspect of this study, you may first speak to the researcher who will do her best to answer your questions: Melissa Jeffery at (new mobile number) or mkj9@le.ac.uk. If you remain unhappy and wish to complain formally you can do this through the University of Leicester by contacting David Hall on 0116 252 2411 or by contacting the Patient Advice and Liaison Service on 08081 788 337.

10. Will my participation in the study be kept confidential?

Your participation in the study will be kept confidential. In the exceptional circumstance that information gleaned during the interview process gives rise to concerns regarding either the safety of the participant, the safety of other persons who may be endangered by the participants behaviour, or the health, welfare or safety of children or vulnerable adults, the researcher is legally and professionally bound to breach confidentiality and will contact relevant services, for example, child protection services.

If you decide that you would like to be interviewed at home, the researcher's supervisor will need to be informed of the address at which the interview will be taking place, in accordance with Lone Working policy and procedure.

Each participant will be given a unique participant number to identify the audio tapes. The audio data will be transcribed by the researcher and each transcript will be identified by an alternative name, which participants may choose if they wish. The record which links participant names to the allocated participant numbers and allocated alternative names will be stored securely, as will participant consent forms, and accessed only by the researcher, her supervisor and a named administrative member of staff based at the University. All identifiable data will be removed from the transcript and you will have the opportunity to check through your transcript for identifiable information before it is used. Quotations may be used in the write up of the study, and will be identified by the alternative names allocated to each transcript. Data will be stored securely and will be retained for five years, in accordance with University regulations, before being destroyed.

11. What happens if I don't want to carry on with the study?

At any time you may choose to withdraw from the study by communicating this wish in writing (including email) to the researcher.

12. What will happen to the results of the research study?

I aim to publish the results of this research in peer-reviewed academic journals and to disseminate the findings at professional conferences. You will not be identified in any articles or dissemination materials. It is hoped that the results of the study will inform clinical training related to LGB issues.

13. Who is organising and funding the research?

The research is being organised by the Lead Researcher, Melissa Jeffery, at the School of Psychology – Clinical Psychology Section at the University of Leicester. The research is being funded by the University of Leicester.

14. Who has reviewed the study?

The study has been approved through the ethics procedure at the University of Leicester and has received ethical approval from North Nottinghamshire Research Ethics Committee.

Thank you for reading this information sheet. For further information, or to speak with the lead researcher about participating in the study, please do not hesitate to contact:

Melissa Jeffery
Trainee Clinical Psychologist
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Telephone: 07513 064 330

Email: mkj9@le.ac.uk

APPENDIX G:

PARTICIPANT CONSENT FORM

Participant Consent Form

Title of Study: Lesbian, Gay and Bisexual (LGB) Mental Health Practitioners' Self-Disclosure of Sexual Orientation: Impact on Clinician and Therapeutic Relationships.

Name of Lead Researcher: Melissa Jeffery

Please initial the boxes to the right of each statement to indicate that you have understood and agree to the statement:

1. I confirm that I have read and understood the Participant Information Sheet for the above study in its entirety. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that by signing this form, I am giving permission for the written and audio data collected in the course of the research to be used for the above study.

3. I understand that I can withdraw my permission to use my written or audio data at any time without reason, up to the write up stage of the research, and any results already obtained from the material will be removed from the study.

4. I understand that relevant sections of my research notes and data collected during the study, may be looked at by individuals from the University of Leicester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research.

I hereby give permission for my data to be used for the above study:

SIGNATURE OF PARTICIPANT:

NAME (in block capitals):

DATE:

SIGNATURE OF LEAD RESEARCHER:

DATE:

Please return this completed form to Melissa Jeffery, Trainee Clinical Psychologist, University of Leicester, School of Psychology (Clinical Section), 104 Regent Road, Leicester, LE1 7LT.

APPENDIX H:

LGB SUPPORT INFORMATION

Some LGB Resources

www.midlandlgbt.com

Resource for all things Lesbian, Gay, Bisexual and Trans in the workplace – advice on company policies on LGBT issues, understanding of the law, or just someone to talk to about being LGBT at work.

www.queery.org.uk

Resource of LGBT events and organizations in the UK.

www.stonewall.org.uk

An LGB charity with information regarding LGB issues and sources of support.

[08000 502 2020](tel:080005022020)

Stonewall telephone support number.

www.pacehealth.org.uk

Workshops and counselling for primarily gay men with limited services for women.

www.outeverywhere.com

Resource for LGB community groups and activities.

www.regard.org.uk

Resource for LGBT individuals with disabilities.

www.deafgayuk.com

Resource for deaf LGB community.

APPENDIX I:

PARTICIPANT BRIEFING SHEET

Participant Briefing Sheet

Thank you taking part in this research interview!

- The interview should take around 60-90 minutes.
- The interview will be audio recorded.
- Sources of support for LGB individuals have been provided should you wish to access them following the interview.
- A 50 minute support session with Melissa is available should you find anything talked about during the interview distressing and would like to talk it through some more.
- In the interview you will be asked to discuss in detail occasions when you have worked therapeutically with clients. In the interest of client confidentiality please do not to reveal any identifiable information about the clients. Instead, please use an alternative name or initials for the client.

APPENDIX J:

INTERVIEW SCHEDULE

Interview schedule

Thanks for taking time out to come and meet with me today. Before we start I've got a short briefing sheet I'd like you to look through and then we can have a chat about it.

Give sheet and LGB resources

Any questions?

Just before we start I'd like you to know that I'm doing this research because I have a particular interest in the clinical experiences of other non-heterosexual clinicians. There aren't any right or wrong answers to the questions I'll be asking and what I'm really interested in is trying to understand your experiences of sharing personal information with clients/patients. Any questions?

1. **How would you describe yourself as a clinician at the moment?**
Possible prompts: clientele, orientation, roles?
2. **I'd be interested to hear what you think about clinicians sharing personal information about themselves in general?**
Possible prompts: what factors play a role?
3. **Can you talk me through a time when you've told a client about your sexual orientation? If it's helpful take a couple of minutes to bring an occasion to mind....**
Possible prompts: What was your relationship with the client like before telling them?
Tell me about the decision making process?
How did you make the decision to share that information with them?
What did you think the potential risks/benefits could be?
What was it like for you when you told them?
What were you thinking at the time? How were you feeling at the time?
4. **What effect do you think the sharing of that information had on the client?**
Possible prompts: How did they respond? How do you think they felt? What do you think they were thinking? How did that make you feel?
5. **Do you think the therapeutic relationship was changed at all?**
Possible prompts: How do you think it was changed? Why do you think it was changed in that way?
6. **Has there been a time when you've considered telling a client/patient about your orientation and decided not to?**

Possible prompts: Why did you decide not to tell them? Can you talk me through the decision making process you went through? What was your relationship like with this client?

What effect do you think not telling them had on the client?
What effect do you think not telling them had on the therapeutic relationship?

(going back to the time that you did disclose)

7. **What do you think your colleagues thought about you sharing this information with your client?**

Possible prompts: What were their views? How useful was that for you? What role did their views have in your decision to disclose or not?

8. **Do you think the experience of making this disclosure has affected how you see yourself?**

Possible prompts: as a clinician? Personally? As a lesbian/gay/bi-sexual man?

Thanks again for today. I'll now go away turn the audio data into a transcript. Would you like me to forward it on to you for you to check that all identifiable information has been removed? I'm also going to allocate the transcript with an alternative name...is there one that you'd like me to use?

APPENDIX K:

MASTER TABLE OF THEMES ACROSS TRANSCRIPTS

Master table of themes

A. Not just another disclosure	Line Number
<i>A qualitatively different disclosure</i>	
<u>Rob:</u> if somebody were to ask, you know, are you straight, are you married, they would probably answer without a thought and wouldn't see that as a disclosure erm, whereas I would need to think about it and see whether it's appropriate or helpful to respond.	841
<u>Vanessa:</u> no	
<u>Stuart:</u> a lot of people still haven't got that idea in their head that a wedding ring could mean with equal measure that you're married to someone of the same sex as it could that you're married to someone of the opposite sex and, and most people still make the, the assumption I guess.	1098
<u>Ryan:</u> I guess if you're straight it, it just turns, the conversation just goes that way and you know, about your children or your wife or your husband erm so I don't know. I think its something you're just more ware, aware of having to think about all the time erm.	498
<u>Ben:</u> no	
<u>Mike:</u> no	
<u>Sarah:</u> I hear my other colleagues talk about their children, partners quite freely with people and course I don't so they don't know.	797
<u>Ruth:</u> I think we are compromised because we do have to think about what we say whereas listening to a lot of	634

my nursing colleagues, erm, they wont think twice about saying my husband, you know, how often are you asked if you're married?	
<i>A risky thing to do</i>	
<u>Rob</u> : it might be that I decide actually, if I were to respond positively to this that actually I might find myself in a threatening situation.	183
<u>Vanessa</u> : maybe its that pervasive 'don't talk about it' don't talk about it generally let alone to your clients, maybe, erm, I, I guess its part of the, that that whole thing isn't it that sexuality still isn't really talked about, a lot of assumptions are still made that you're heterosexual.	348
<u>Stuart</u> : just that, that certain hostilities and languages that people use and stuff and you just think 'un un, nah, this is not a good place to be disclosing anything'.	1070
<u>Ryan</u> : but obviously when you're gay and you say something, oh, like my partner or, you know, you have to obviously think a lot more about it and how the persons gonna react, erm, to you saying that.	211
<u>Ben</u> : I have been targeted, you know, verbally targeted a lot because I'm gay.	276
<u>Mike</u> : I've done some work say in young offenders prisons for example erm, and young, young men are less er accepting about those kind of things so () its, it, its, its as if its not, its not even discussed or contemplated.	517
<u>Sarah</u> : the wrong people might get to know and it might change my working relationship with people.	574
<u>Ruth</u> : I suppose at, at the back of my mind I'm always bothered about the implications of coming out.	159

<i>Feeling conflicted</i>	
<u>Rob:</u> it shouldn't be a matter of do you disclose or not, you know, because actually it's not really that big an issue. But unfortunately it is [laughs].	732
<u>Vanessa:</u> I think it's that hidden issue which we then kind of have to think, ooh, do we don't we, is it wrong, should it be known, er, and I feel there's this sense maybe that we do feel its wrong to disclose it.	331
<u>Stuart:</u> Cos I just wish that, I just wish that I was able to say really 'oh actually yeah I have got a wedding ring but no I'm not married to a woman' so. But you just know that some people would be like 'well get out my house' and 'you're not touching my husband again' or whatever.	1183
<u>Ryan:</u> I should be able to be free to be who I am, you know. Erm, but, you know, the other side of me thinks well yeah but in the real world in a job where working with random people from all walks of life with all experiences and erm, and you know, people aren't always going to react in the way you want them to.	1509
<u>Mike & Ben:</u> no	
<u>Sarah:</u> And now I sort of question why do I do that? Why can't it just be like everybody else? Why can't you just be the person that you are?	245
<u>Ruth:</u> no	

B. Reaching a make or break disclosure decision	
<i>A potentially powerful therapeutic tool</i>	
<u>Rob:</u> I do think it would be potentially quite withholding to not share that something that might make somebody feel more supported really, or heard.	446
<u>Vanessa:</u> I just thought do you know, actually it would be really useful here to be transparent about my sexuality	178
<u>Stuart:</u> it would help to make her feel a hell of a lot safer.	590
<u>Ryan:</u> I guess from the point of trying to reassure him or offer reassurance that it just felt right to say.	657
<u>Ben:</u> to give them more confidence I guess, you know, if, if they are worried about their sexual orientation its just to give them that its not all bad, its not all bad.	731
<u>Mike:</u> I think because it sets you out from everybody else so it helps that, helps the patient think 'well yeah I have got mental illness but you know, there are other people that have got different things about them that not everybody else has got that they have to put up with the same as me'.	1019
<u>Sarah:</u> to sort of show that its ok to be gay, you can go out there and do what you wanna do and its fine.	290
<u>Ruth:</u> I felt that I had information that could make her feel less isolated and move her onto services that I knew were available. That I probably could have done as a, as a straight woman but I think that she would kind of; it would help our relationship move on if I did that.	202
<i>Protecting the client and/or the therapeutic relationship</i>	

<u>Rob:</u> I think my rationale with him was much more erm, you know, talking to him as an equal really, erm and just wanting to be honest.	268
<u>Vanessa:</u> I think I () would've used it [disclosure] to, to make an engage, to engage her erm () but I think what would've happened then was that she would've become focussed on my sexuality and my experience. / I think she had an issue anyway with boundaries so I, the reason why I didn't I guess was primarily because I felt that that might complicate a, an already fairly complicated issue.	640/654
<u>Stuart:</u> So he was somebody I chose deliberately not to tell because erm () because of the level of you know, sort of expectation he had of, of, of me as a service provider really. / some patients it's just kind of () your role as a CPN is very perfunctory really. It's kind of, you know, 'are you ok?' I, it's almost like the relationship that they want you to have with them is is about asking whether they're balmy or not and them getting their bum cheek out to do their depot and that's it. You know, that's all they want to know.	883/787
<u>Ryan:</u> you're a bit wary of throwing anything into the works that could potentially stop that and be a hindrance to them cos you're constantly thinking of, you know, their needs, erm, more so than your own I think.	280
<u>Ben&Mike:</u> no	
<u>Sarah:</u> I think they're not there to listen to us, it it's the other way around / therapeutically it is one way, I'm there for them to talk to.	82/814
<u>Ruth:</u> I didn't want her to feel compromised in any way, giving something personal. Cos I think as well service users are very much used to not being told personal things. / that actually might have posed more stress cos it's kind of like leaving, it's almost like, not dumping on somebody but its, you know, can make people feel	114/373

quite uncomfortable.	
<i>Protecting one's self</i>	
<u>Rob</u> : not wanting to put myself in either, you know, a, a threatening situation, or an embarrassing one, you know, I don't want someone taking the piss out of me. / I think most gay people have suffered some form of homophobic abuse at some point in, in their life, and certainly as a younger person I experienced a lot erm, so I suppose one is not wanting to replicate that.	807/964
<u>Vanessa</u> : no	
<u>Stuart</u> : it would be safer for me to either say nothing or if pressed fib. Just, just in order to keep myself safe really. / I'm kind of doing this for my own protection at the minute because I've sensed its not a good idea to, to talk about that kind of thing here.	1063/1284
<u>Ryan</u> : you're aware that, you know, that if people, if it got into the wrong hands that people could make your life difficult. / I guess there's a lot of self projection there on people assuming that everyone's gonna react in a bad way. / I guess it is just that sort of erm (...) reluctance I guess to, to, div, to open up yourself really because its putting your vulnerabilities and erm (...) at the forefront really, open to, I guess its that rejection isn't it.	712/844/965
<u>Ben</u> : I never deny what I am but I'm not basically out out, I don't, you know, tell patients but if they ask me I do answer them truthfully / So I just you know made a rule to myself that I'm not gonna deny it any more.	5/550
<u>Mike</u> : in a situation where I think it, it may be used in a erm, in a, in (xxx) a derogatory respect erm I've sort of	509

<p>reverted back to erm a position where I don't like to be, to be honest where I cant be honest about the thing.</p> <p><u>Sarah:</u> I think it would be the embarrassment of them saying 'I need another CPN, this ones gay, I'm not having that' or the family making a bit of a hooaha about it.</p> <p><u>Ruth:</u> making sure that I know about the gay and lesbian community so I can help other people access that service rather than access me and me personal self.</p>	<p>756</p> <p>324</p>
<p>C. The experience of disclosing</p> <p><i>Different ways of disclosing</i></p> <p><u>Rob:</u> I think because I've been out you know, since I was 16, erm, it, it's actually very rare that I will actually state, I don't know if this will make sense, its very rare that I come out to somebody and say 'oh, by the way I'm gay'. I will usually tell people in a different way. / I do remember one person that I responded in a 'well, I'm not sure you really need to know' and they basically said, 'oh, I'll take that as a yes'.</p> <p><u>Vanessa:</u> no</p> <p><u>Stuart:</u> no</p> <p><u>Ryan:</u> I didn't actually say 'well, by the way I'm gay! (laughs) I said 'oh when I had a similar experience with my family when I came out to them they had similar, you know, reactions.</p> <p><u>Ben:</u> if somebody says in an aggressive manner 'are you gay?' I'm like, 'no I just help them out when they're</p>	<p>459/990</p> <p>660</p> <p>1154</p>

busy', try and make a joke of it.	
<u>Mike</u> : I didn't specifically tell her erm. I think the assumption just grew and grew until a point where it just, you know, I talked about, I just, I just talked about going to gay festivals.	817
<u>Sarah</u> : no	
<u>Ruth</u> : I think I just came out, you know, in a general kind of conversation.	217
<i>Powerful internal experiences</i>	
<u>Rob</u> : its very rare that I'd make a statement that I'm gay... so to actually say 'oh I'm gay' feels actually erm, quite, quite a regressed stage to be at (smiles), you know, it's a bit like you know, coming out the first time.	487
<u>Vanessa</u> : I didn't doubt that I should have told them. Actually there was a small bit where I thought, 'oh god is this, have I broken some unspoken BPS code of conduct by disclosing my sexuality?'	465
<u>Stuart</u> : I've thought 'oh sod it I'm gonna be honest' you know and then you kind of think 'oh I really wish I hadn't been' because you can feel the change in the atmosphere and kind of a bit of recoiling going on.	663
<u>Ryan</u> : It, it is strange. Its almost like stepping back years to actually having to come out every time you, you know, you sort of approach the subject, you know, back to when I was younger with my parents and friends and things like that so its almost (...) well, there is anxiety there every time.	507
<u>Ben</u> : very hard, it was scary, like, its like coming out again everywhere you go.	548
<u>Mike</u> : no	
<u>Sarah</u> : I think it was quite a relief when it actually came out.	197

<p><u>Ruth</u>: I was slightly worried by it erm, apprehensive probably, probably put it off for a bit erm ()...I was probably relieved when I said it.</p>	292
<p><i>Experiencing questions and the unknown agenda as difficult</i></p>	
<p><u>Rob</u>: I think it's the intent behind the question that makes it uncomfortable because it could be a negative one. It, it could be erm, be because actually somebody has a real problem with gay people and is gonna become abusive in some way. / I think its its not knowing the intent behind the question that makes it uncomfortable. Are they asking for a positive reason, a potentially negative one, or is it just, you know, it might just be a statement of fact.</p>	958/978
<p><u>Vanessa</u>: no</p>	
<p><u>Stuart</u>: people spot my ring, my wedding ring and its, and course the inevitable question's 'oh, what does your wife do?' you know and sometimes I've, I've kind of I, I reveal that my partner is not a woman, you know, and other times its kind of, ok, make up scenario time you know, lets, lets say as little as possible.</p>	174
<p><u>Ryan</u>: I think the hardest is when, is when people ask specific questions, you know, about your personal life or, or, you don't want to be evasive you know, but, but at the same time you don't want to divulge all your personal information.</p>	706
<p><u>Ben</u>: I have people basically, some patients have basically asked me and I said yes I am and they kick off.</p>	980
<p><u>Mike</u>: what makes me anxious about people asking me about it is when they ask me about it for no particular reason because it hasn't got a relevance. It has to have a relevance to why their asking. Then I, I get, I see</p>	1267

that the relevance is detrimental relevance.	
<u>Sarah</u> : I cant remember if she's ever directly asked me but erm she's tried to get details out of me about, you know what do I do and stuff like that and 'if you were gay Sarah, cos its ok if you are' and you know you just sort of build up this face where you just don't flinch at all.	514
<u>Ruth</u> : no	
D. The enhancing effects of disclosure	
<i>Removing barriers and creating credibility</i>	
<u>Rob</u> : we had an honesty and they understood that I understood that aspect of their lives.	718
<u>Vanessa</u> : I feel it gives me some credibility as well with them I think, or authenticity.	207
<u>Stuart</u> : no	
<u>Ryan</u> : I think he actually gained a lot probably from it, the fact that oh actually someone else knows what I've been through and I'm going through and, and, erm, and can advi, and there is hope on the other side you know.	620
<u>Ben</u> : the more you're honest with them the more they see you've got nothing to hide they seem to warm to you more.	226
<u>Mike</u> : Because sometimes erm, I have to talk to people about things that they don't want to talk about or to, or	858

accept...and that allows me to say that more because, because er, because they know I'll be honest. Because I'm honest about everything.	
<u>Sarah</u> : the relief was great I could just say, you know, 'my partner we did this and that' and you know, give little bits of myself to them and it felt ok to do that.	469
<u>Ruth</u> : just so that we could move on and look at an area of her life that she would feel comfortable with me and she would feel comfortable about me talking to other people about it, that I wasn't just some straight woman coming along telling her she needed to be part of the gay wor, gay community.	142
<i>A powerful immediate effect on the client</i>	
<u>Rob</u> : I do think it was positive. / I think it would be seen as, you know, in quite a positive way, so I think, I think that would've been helpful erm, and I think in both cases it, it, it was actually.	555/569
<u>Vanessa</u> : there response was that they really appreciated kind of felt better knowing that, there was a kind of visible and verbal acknowledgement later on, but visual kind of (acts out relieved sigh).	395
<u>Stuart</u> : it did cause this kind of physical relief. You could kind of see it happening about her face and her shoulders and stuff like 'thank god' you know.	616
<u>Ryan</u> : I think he actually gained a lot probably from it.	620
<u>Ben</u> : I think that, that the feelings he had, he wasn't ashamed about anymore, that he realised, you know, there's other people with the same kind of feelings that are out there, you know, so, kind of broke the barriers down for him.	821

<u>Mike:</u> no	
<u>Sarah:</u> no	
<u>Ruth:</u> I think she felt less isolated by it.	262
<i>Feel good feedback</i>	
<u>Rob:</u> I suppose it probably consolidates or confirms things in a, in a way.	1153
<u>Vanessa:</u> it felt really positive and it really, I, I didn't doubt that I should have told them.	465
<u>Stuart:</u> that's the best kind of feedback isn't it cos you feel like you, you know, you're doing your job absolutely on the ball then don't you. You know, really making a difference which is why we all do it isn't it.	1262
<u>Ryan:</u> afterwards it felt quite good actually cos I thought, well, actually some positive came from that really erm, and probably more so than if I hadn't so that was er, you know in hind sight that was, felt quite, quite good erm.	813
<u>Ben:</u> I get some man hugs off most of them when they leave, you know, it breaks the barriers down.	222
<u>Mike:</u> I mean, you know, its all part of me, its, its about my own self isn't it? Er and my, my self worth and my self belief and my professional self and its all those isn't it?	1161
<u>Sarah:</u> I suppose it felt like a weight had been lifted, I could just be myself 458 just felt freer I think. Quite empowering actually.	475
<u>Ruth:</u> in some ways it was quite empowering.	246

E. The cost of concealment	
<i>From none to negative impact</i>	
<u>Rob:</u> no	
<u>Vanessa:</u> some of the questions that I asked her which were informed because of my own experiences she experienced as being intrusive and possibly homophobic.	682
<u>Stuart:</u> If you don't tell people its, kind of, you're not giving them your whole self in a sense are you. Well, you're certainly not operating as the person that you () ought to be I guess...some people don't work as well with you as, as others do and the kind of. And I guess because its, its about that sense of not getting the wholeness isn't it and () so, you know, the whole relationship feels then, I guess, feels sort of perfunctory.	1229
<u>Ryan:</u> the times when I've not I don't think it has really because erm its not necessarily been relevant, essential to them. You know what I mean? I don't think, I think the times when it, you know, like with the guy who I did tell it, it, if I hadn't it probably would've hindered the relationship because it would've helped him.	1306
<u>Ben:</u> Sometimes I don't think your therapeutic relationships are quite there if you're holding back on something.	1045
<u>Mike:</u> that would be a professional patient type relationship where its not, it wouldn't be a true relationship as far as I was concerned because I couldn't be absolutely honest. / So I would see probably that it wouldn't, it wouldn't affect the relationship to a detrimental degree but it wouldn't necessarily be to its fullest benefit.	527/1073
<u>Sarah:</u> I don't think it would be any different because I'd just be the same to them.	767
<u>Ruth:</u> I mean I think it probably would've made a difference especially to people that were feeling	347

uncomfortable about their sexuality you know, it, it, it would've been an opportunity to, to discuss that further.	
<i>Psychological and cognitive burden</i>	
<u>Rob:</u> I certainly have found myself erm either not speaking at all or using non-gender specific language...I suppose it does add a, another level of thought processes in terms of how you respond to somebody that perhaps otherwise might not have.	140
<u>Vanessa:</u> no	
<u>Stuart:</u> And what I do on that occasion is just change my partner's name slightly to feminise it and, and kind of say little more really.	182
<u>Ryan:</u> I don't know really when its been a, a particular burning issue but its sort of there in the background a lot of the time. / I guess at the time it's, there's that quick thinking 'right ok, how do I get out of this one' sort of scenario.	741/1385
<u>Ben:</u> you're more uncomfortable when you know you're working with somebody and you're wondering, oh how are they gonna react when they find out I'm gay, or if they've said something to me and I've kind of talked in a conversation with them and you know like in a weeks time they're gonna know you're gay in a weeks time.	1134
<u>Mike:</u> I've sort of reverted back to erm a position where I don't like to be, to be honest where I cant be honest about the thing, about things.	511
<u>Sarah:</u> I can sort of feel myself tensing up and trying to get out of it erm, wondering what I'm going to say, what	784

<p>did I say before, my stories have to tally up. Erm, especially when you've, you know, known people a long time you don't, you cant remember what you might have said to them years ago but you're sort of always trying to make sure that your stories there, its in place, you know, what you're going to say.</p> <p><u>Ruth</u>: no</p> <p><i>Negative feelings and loss of self</i></p> <p><u>Rob</u>: I think if I felt I had to conceal it and, and it was never going to be appropriate to disclose it I think you know, my, my self esteem probably would be damaged by that, erm, and would probably be a retrograde step.</p> <p><u>Vanessa</u>: no</p> <p><u>Stuart</u>: I hate doing it. I feel like I've been really treacherous whenever I do that. / it doesn't feel good. I don't like, I always understand the reasons why I've done it, I don't particularly like doing it.</p> <p><u>Ryan</u>: I guess it's a feeling of you feeling you're letting them down by something, some way by not being fully honest with them or, or holding something back. / not shame or guilt or, but sometimes I suppose it touches on that thinking well, you know, I should be able to be who I want, who I am and, and, without regret or without having to hide away.</p> <p><u>Ben</u>: just erm, like how I, how I feel, like I'm not being honest and you, your holding something back.</p> <p><u>Mike</u>: no</p> <p><u>Sarah</u>: Why can't you just be the person that you are? So it's really annoying and you sort of put yourself down a bit and, you know, make up lies and secrets and it turns into a very sort of secretive world which I don't like.</p>	<p>1186</p> <p>1076/1180</p> <p>1242/1502</p> <p>1042</p> <p>248</p>
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<u>Ruth</u> : I still feel that I can't share my sexuality with people and I'm not sure where that's really come from.	528
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