

To disclose or not to disclose? The LGBT therapist's question.

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Portfolio abstract

Background: Research indicates that it is the non-therapeutic factors such as warmth, empathy, understanding and therapeutic alliance that are most effective at creating change. The use of the therapists' own identities has been highlighted as a means of enhancing such non-specific factors. The literature suggests that 90% of therapists disclose something about themselves to clients; however therapist disclosure is a contentious issue. Furthermore, literature suggests that for therapists working with stigmatised or minority groups (e.g. sexual minorities) disclosure can be beneficial. Guidelines suggest that therapist disclosure of sexual orientation (TDSO) should be used judiciously, while others suggest that TDSO could be classed as the therapist displaying sexualised behaviours towards the client.

Aim: This study aimed to understand the purpose of lesbian, gay, bisexual and trans (LGBT) therapists' disclosing sexual orientation to clients, while exploring their perceptions and experiences of disclosure.

Method: This study employed a mixed methods design. Purposeful sampling was used to recruit 53 participants from an international sample of LGBT therapists, through professional body listservs and an LGBT therapist directory, to complete an online survey. From this survey 17 participants were purposively sampled to take part in a semi-structured interview. Quantitative and qualitative analysis methods were utilised.

Results: The findings highlighted that 81.1% of the online survey sample reported that they had disclosed their sexuality to a client, with the majority stating that they mainly disclosed to non-heterosexual clients and 73.6% of participants stating that they were not aware of any guidelines related to using TDSO. Chi-square test of independence found that there was no significant association between therapists' awareness of guidelines and TDSO. A Mann-Whitney U analysis revealed that there was no significant difference between participants post qualification experience (years) and making a disclosure. Three main themes were derived from the qualitative analysis: 1) Function of

disclosure; 2) Function of non-disclosure; 3) How disclosure happens, each of these themes have between two and five subthemes.

Conclusions and recommendations: TDSO was shown to occur mainly with non-heterosexual clients. Disclosure was highlighted to facilitate the enhancement of the therapeutic alliance and create a safe, non-judgemental space for sexual minority clients. However, therapists expressed that concealing their sexuality was common when working with heterosexual clients because of fear of judgement and personal safety. Psychological effects were also noted due to therapists' concealment. Disclosure was found to happen in various contexts, with direct verbal disclosures being one of many ways that sexuality was disclosed.

It is suggested that supervisors and training courses need to acknowledge the psychological impacts of therapists concealing their sexual identity by showing an understanding of how concealment can lead to increased stress for professionals who are trying to maintain focus on the clients. Sexuality is seen as a key characteristic of being human and concealing it is like trying to conceal your gender or ethnicity. Future guidelines need to reflect the experience of non-heterosexuals working within a heteronormative society and understand the importance of therapists' rationales for making disclosures.

Statement of Contribution

Adam Harris was responsible for the design of this project, applying for ethical approval, completing a review of the relevant literature, recruiting the participants, collecting data, transcribing that data, analysis and finally writing up the research.

Dr David Dawson provided supervision and guidance throughout the research process. He was responsible for providing ideas and understanding around the quantitative analysis, reviewing themes, facilitating ideas related to theory and results, while also providing feedback on the writing style.

Dr Roshan das Nair provided supervision and guidance throughout the research process. He was also responsible for independently coding the transcripts, reviewing themes, and reviewing the thematic map, facilitating ideas related to theory and results, while also providing feedback on the writing style.

Dominic Davies, founder and director of Pink Therapy UK, also provided advice and guidance during the early stages of designing the project (including input into devising the online survey and interview questions), while also providing crucial links between the primary researcher and a sample of non-heterosexual therapists.

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Systematic Literature Review

Therapists who disclose their sexual orientation to clients. A systematic review of the qualitative studies.

Abstract

Therapist self-disclosure of (sexual) orientation (TSDO) has been a contentious issue for lesbian, gay, bisexual and trans (LGBT) therapists. Research in this area is limited and often not based on empirical methodologies. In drawing together the available empirical literature, a greater understanding of the use of TSDO can be achieved. This review focuses on understanding the facilitators and barriers of TSDO, the impact on the therapeutic alliance, why therapists chose to disclose and the context in which the disclosure took place. Electronic databases were searched in July 2013 for qualitative papers that have explored therapist experiences of TSDO. Key themes were identified, extracted and grouped. Key themes included: client sexuality, work context, therapist internalised homophobia, oppression, client assumptions and invisibility of LGBT issues. Findings supported the view that judicious case-by-case decisions are required by therapists when exploring TSDO.

Key words: therapist, self-disclosure, TSDO, sexual orientation, LGBT, non-heterosexual, systematic review.

Introduction

Therapist self-disclosure (TSD) is a belligerent topic between professionals (Farber, 2006; Peterson, 2002). Despite this, the literature suggests that TSD is commonplace in therapy. Henretty and Levitt (2010) highlighted that 90% of therapists use some form of self-disclosure. This could include: the therapist's demographic information, relevant struggles that have been overcome successfully, assumed similarities between the therapist and the client, previous therapy mistakes, and the therapist's own thoughts and feeling about the therapeutic alliance. TSD has received much attention from researchers, however very little attention, by comparison, has been paid to examining the phenomenon of therapist self-disclosure of (sexual) orientation (TSDO), particularly amongst lesbian, gay, bisexual and trans (LGBT) therapists to their clients. The findings from the research that is available are fragmented and based on narrow sample sizes. Such studies have offered a much-needed starting point, however there is a need for a far greater and broader understanding of the phenomenon of TSDO. The use of TSDO is a contentious issue and guidance for therapists is limited. A greater in-depth understanding of decision-making processes and the rationale for the use of TSDO is needed in order to appreciate the phenomenon. This review hopes to draw together the available literature and provide a fusion of the findings to increase our existing understanding through a meta-synthesis.

Qualitative methodologies can be utilised to interpret the findings of qualitative studies by honouring the therapists' subjective accounts. Nevertheless, there will be a lack of generalisability in such studies due to limited sample sizes, the uniqueness of the phenomenon being observed and the researchers' subjective interpretation of the data

(Mills, Jadad, Ross, & Wilson, 2005). Through combining the findings of the individual qualitative studies and searching for consistent similar themes, it may be possible to develop an extensive use of the findings, hence the current review.

Conversely, qualitative researchers disagree over the appropriateness of conducting a review in order to integrate standalone qualitative studies (Dixon-Woods & Fitzpatrick, 2001; Dixon-Woods, Fitzpatrick, & Roberts, 2001; Noyes, Popay, Pearson, Hannes, & Booth, 2008). The position of the researcher is likely dependent on their identified epistemological, ontological, and methodological position (Campbell, Pound, Pope, Britten, Pill, Morgan, & Donovan, 2003). It could be argued that it is inappropriate to synthesise such studies because their findings are bound to specific contexts and within a static time point (Campbell, et al., 2003). The current review functions on the assumption that incorporating and integrating qualitative research is both plausible and desirable. Doing so will permit the synthesis of the empirical work, facilitating a broader understanding of TSDO and its implications.

In acknowledgement that the concept of sexual orientation is highly dependent of time and culture, and that transferring the meaning could be detached from its context, this review has been limited to explore the phenomenon of LGBT therapists and has reviewed the literature available since the declassification of homosexuality from diagnostic categories of mental ill health.

Aims

The primary aim of the review is to synthesise the TSDO literature. In doing so the review will consider four questions: -

- (i) What are the facilitators and/or barriers towards TSDO?
- (ii) What is the perceived impact of TSDO on therapeutic alliance?
- (iii) Why did the therapist choose to disclose or not to disclose?
- (iv) In what context was the disclosure made?

The secondary aim of the review is to assess the quality of the literature available on TSDO using a critical appraisal framework.

Method

Systematic Literature Search

Initially, a series of a priori inclusion/exclusion criteria was defined. Studies were included in the review if they:

1. included LGBT therapists. Therapists were defined as professionals who worked within a psychological or a psychotherapeutic framework with clients (e.g. psychologists, counsellors, psychiatrists, clinical social workers, psychotherapists, etc.)
2. explored LGBT therapist experience of disclosing their sexuality to clients during therapy (from the therapist perspective and/or client perspective).
3. involved primary research studies (i.e. not systematic reviews, opinion pieces or editorials).
4. used qualitative methods of data collection and analysis.
5. were published within the last 40 years. The broad timeframe was in recognition of the narrow nature of the topic and potentially the limited number of relevant papers available.

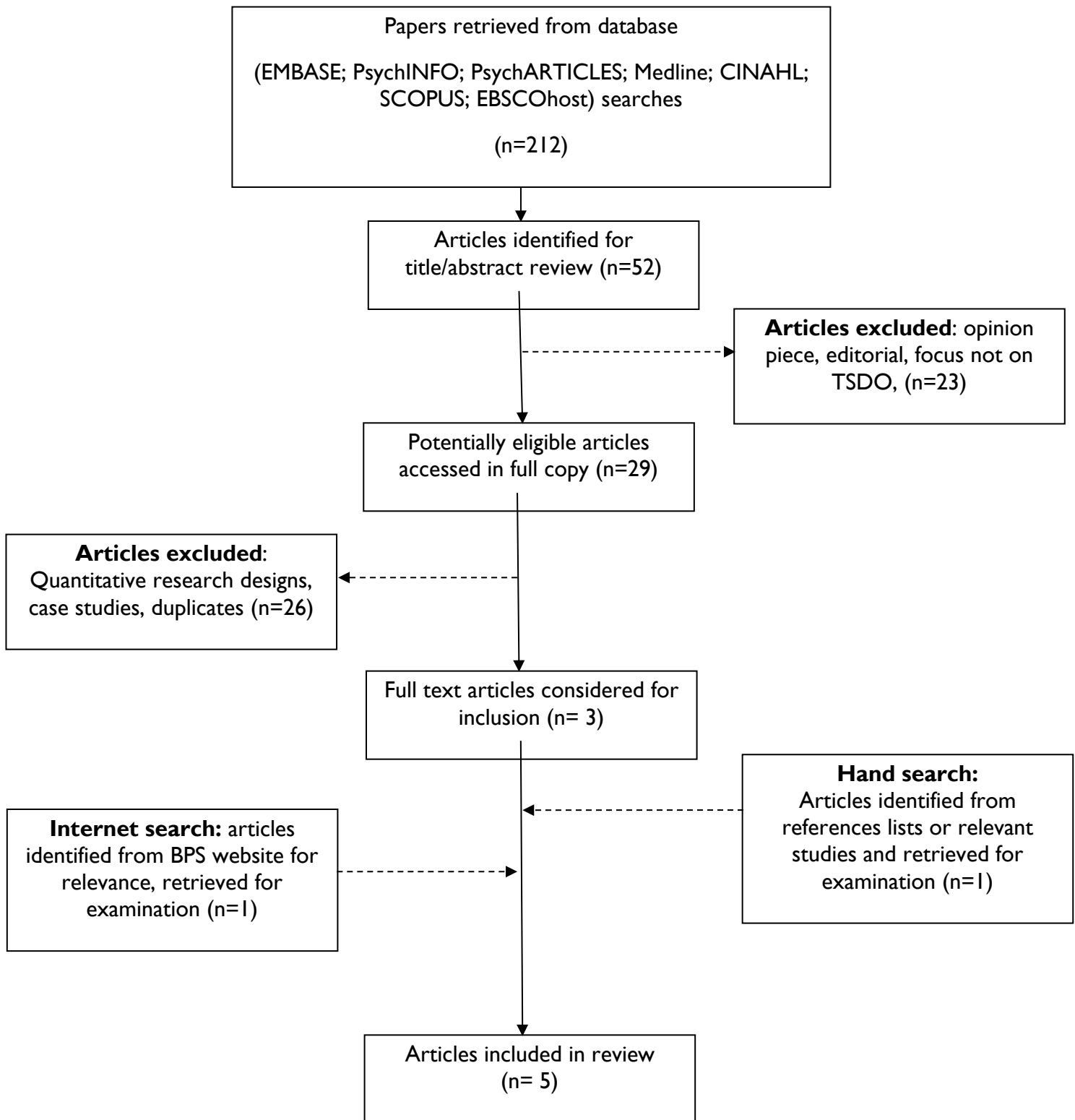
Literature Search and Sources

A systematic search was conducted using the EMBASE, PsychINFO, PsychARTICLES, Medline, CINAHL, Scopus and EBSCOhost electronic databases in July 2013 (Appendix A). Jointly these databases represent the disciplines of social sciences, medicine and allied health professionals. Across the databases, relevant terms were combined relating to three specific factors: a) terms related to therapists, b) terms related to self-disclosure, and c) terms relevant to describe sexual orientation. Reference lists of each article noted as being relevant were searched to identify additional potential studies. Finally, Google Scholar and the British Psychological Society (BPS) website was searched using keywords (therapist) AND (self-disclosure) (sexual orientation OR sexuality) (limiting to the years 1973-2013), the first 100 results were checked.

Study Selection

See figure 1 for an outline of the selection process. The majority of articles were excluded because they did not specifically relate to therapist self-disclosure of (sexual) orientation to client and/or because they were opinion pieces, editorials, and quantitative methodologies, etc. The abstracts of the remaining articles were reviewed and the inclusion/exclusion criteria were applied. If enough information was not available from the abstract the full text was retrieved and reviewed. The reference lists of these selected articles were also reviewed by hand-search by AH and potential relevant full-text papers not identified during the initial search were obtained and deemed to meet the inclusion criteria.

Figure 1: Quorum diagram outlining the selection process¹



¹ N.B. figures should be point 8, but for ease of reading they have been submitted in point 12

Study Characteristics

The following information was extracted from the articles: study aims, sample demographics, study location, data collection methods, data analysis methods, key findings, authors' conclusions and implications as well as the studies limitations (Table 1).

Critical Appraisal

Critical appraisal of the study quality is necessary to avoid over- or under-reliance on particular results that could hypothetically skew the synthesis (Dixon-Woods, Booth, & Sutton, 2007). It is generally accepted that methods of reviewing and evaluating quantitative research cannot be generalised to review and evaluate qualitative research (Jones, 2004; Dixon-Woods, Shaw, Agarwal, & Smith, 2004), although no common method has been established to facilitate the evaluation of qualitative studies (Noyes, et al., 2008).

This review uses a quality assessment framework published by the UK National Centre for Social Research (Spencer, Ritchie, Lewis, & Dillon, 2003) (Appendix B). The framework has been utilised because it encompasses 29 existing frameworks, including interviews with researchers in the field. The tool is also useful for incorporating the diversity and tensions in the area of critical appraisal in qualitative research (Dixon-Woods et al., 2004). The 18 quality criteria were applied to the studies included in this review. To make the application of the quality criteria transparent, an appraisal grade system was developed where A-D was given to each of the criteria: A) No or few flaws, B) Some flaws, C) Significant flaws, D) Untrustworthy. Following this, an overall grade of A to D was given to each study (Table 2). All five studies were included in this review

because it is recommended that qualitative research tools are best used as a process of exploration and interpretation (Noyes, et al., 2008; Spencer, et al., 2003) rather than to inform decisions on inclusion or exclusion of articles. It was also decided that, in spite of flaws in the papers, each study would be able to contribute to the review. Nevertheless, it was decided that the synthesis would be weighted towards studies that achieved grades A-B.

Synthesis of Findings

There are well established methods of synthesising research findings from a quantitative framework, however it is acknowledged that such methods cannot be imposed when reviewing and integrating individual qualitative studies. A diverse array of methods have been utilised to review and integrate qualitative studies, but currently there is no consensus advocating the most appropriate methods (Noyes, 2008; Dixon-Woods, et al., 2004). This review demonstrates a secondary thematic analysis approach. Such an approach was chosen because it can be utilised to conduct an interpretative synthesis, whilst preserving the integrity of the individual studies through closeness to the primary data. Other reviews that have demonstrated this approach have successfully been able to achieve this balance (see McInnes & Chambers, 2008; Carroll, Booth & Cooper, 2011; Thomas & Harden, 2008). All sections labelled as “results”, “analysis” or “findings” would be classed as data and could be included in the overall synthesis (Thomas & Harden, 2008). In order to conduct the analysis, the reviewed articles were initially read independently and key themes extracted and grouped. New themes could be created if necessary, based on the study data. A coding template was then formulated, based on the finalised list of themes (Miles & Huberman, 1994).

Results

The general characteristics of the reviewed studies and critical appraisals are presented in Table 1 and Table 2 respectively. Following this, the questions set by this review are answered using themes that have been extracted from the data.

Table 1. Study Characteristics

Author(s)	Study ref.	Aims	Sample size	Sample composition	Location	Work Context	Data collection method	Data analysis method	Key findings
Moore and Jenkins (2012)	1	To investigate the experiences of gay and lesbian therapists, when considering self-disclosure if their sexual orientation to straight (i.e. heterosexual) clients.	N=8	Profession Counsellors and psychotherapists Ages Range: 33-50; Mean age= 43.75 Gender Male (n=2); Female (n=6) Sexual Orientation Gay (n=2); Lesbian (n=4) Ethnicity White, British/European Theoretical Orientation Person Centred (n=3) Integrative (n=2) Transactional Analysis (n=2) Gestalt (n=1)	UK	Private practice	Face-to-face; one-to-one semi-structured Interviews	Qualitative Thematic Analysis	Use of TSDO with heterosexual clients was contentious there was no consistent approach. All participants reported experiencing past/present feelings of increased anxiety and fear of client judgement (particularly when working with heterosexual clients). Participants identified that these fears were based on their own assumptions and prejudices and the use of TSDO had generally been positive. Internalise homophobia was raised an influential factor in use and consideration of TSDO. Recognition of a substantial gap in our knowledge of the impacts & use of TSDO
Lea, Jones & Huws (2010)	2	To explore the views/experiences of male gay Clinical Psychologists disclosing their sexual identity to gay male clients; the reasons for disclosing or not; influence of training and profession on disclosure.	N=5	Profession Clinical psychologists Ages Range: 28-40 years Gender Male (n=6) Sexual Orientation Gay (n=6) Ethnicity White, British Theoretical Orientation Cognitive Behaviour Therapy (CBT) Cognitive Analytic Therapy (CAT) Psychodynamic Systemic	UK	NHS (n=3) Private Practice (n=2) (incl. LGBT organisations, Sexual health clinic, Inpatient settings)	Face-to-face; one-to-one semi-structured Interviews	Qualitative Interpretive Phenomenological Analysis (IPA)	Use of TSD was generally viewed as beneficial to the client and can positively impact on the therapeutic alliance, however caution needed when the TSDO was for the therapists own needs. Client assumptions, other ways of knowing and discourses of disclosure (seen as "no big deal") were apparent. The context of TSDO was seen as significant (e.g. which organisation the psychologist worked in, NHS, private practice, etc.). Lack of focus and visibility of gay issues, specifically the use TSDO was evident within clinical psychology training. This emphasises an inherent heterosexism and invisibility of gay issues related to training programmes. Little room for trainee to explore and reflect on the use of TSDO, while training.

Evans & Barker (2010)	3	To explore the perceptions and experiences of sexual coming out in counselling of LGB people and parents of LGB children. It incorporated considerations of the coming out of both the client and the counsellor, whether or not they actually disclosed. It also aimed to investigate whether clients felt that self-disclosure (or not) had impacted on the counselling relationship and process.	N=65 (respondents) N=70 (Counselling experiences)	Profession LGB individuals/LBG persons family member Gender Female(n=47), male (n=18) Sexual Orientation Homosexual (n= 56) Bisexual (n=4) Heterosexual (n=3) Undisclosed (n=2)	UK	NHS Private practice Mind Relate	Open-ended questionnaires	Qualitative Thematic analysis	The majority of participants did not view counsellor disclosure as vital. However, most clients did assume the sexuality of the therapist if this was not disclosed. In some cases non-disclosure of counsellor led to distress, particularly for those who had a preference for either an LGB or heterosexual therapist. The context of the disclosure was seen as important and influenced how helpful (or not) it was It was found that clients often researched their counsellor before entering counselling and several chose counsellors who were already known to them in the community, or known to be LGB-affirmative or LGB themselves.
Satterly (2006)	4	The decision-making processes of gay male therapists with respect to self-disclosure of sexual orientation with gay and straight male clients.	N=26	Profession Therapists (clinical Social Workers, Psychiatrists, Psychologists, counsellors and marriage-family therapists) Gender Male (n=26) Sexual Orientation Gay (n=26)	USA	Sexual Health Clinic	Focus-groups, semi-structured schedule	Qualitative Grounded Theory	Findings did not support the use of a static, linear model for decision making for TSDO. A number of factors interact to facilitate disclosures within the workplace Concept of therapeutic neutrality, the false self/real self-dilemma and the sexual identity of the therapist all influence identity synthesis and how a disclosure could be made. Client's best interests, connectivity, and authenticity interface with each other around forces of oppression, which often mediates whether or not therapists disclose their sexual orientation. The balance of social identity and professional identity is a complicated,

Thomas (2008)	5	To explore the ways in which lesbian identified therapists negotiate self-disclosure of their sexual identity to heterosexual clients within the therapeutic relationship.	N=12	Profession Therapists (clinical social workers) (n=12) Ages Range: 30-66 Gender Female (n=12) Sexual Orientation Lesbian (n=12) Ethnicity 11=white/Caucasian 1=American-Indian/Caucasian Theoretical Orientation Eclectic (n=12) (incl. CBT Psychodynamic, Family systems, Gestalt)	USA	Private Practice Public mental health settings	Face-to-face/telephone; one-to-one Semi-structured interview	Qualitative Thematic analysis	<p>Participants stated that intentions TSDO was done on a case-by-case basis, which was influenced by a range of factors.</p> <p>TSDO when working with heterosexuals was noted as being based on the therapists' theoretical orientation; clinical experience; the perceived benefit of disclosure or non-disclosure; personal experience (e.g., participants' own experience in therapy, age, individual comfort level, and sexual identity development/coming out experiences); as well as the prevalence or absence of internalized homophobia, level of clinical experience (being a new & less experience tended to rarely use TSDO)</p> <p>Factors that influenced TSDO were work environment, homophobia and heterosexism, cultural attitudes around homosexuality, and participants' self-acceptance.</p> <p>Participants reported that they felt that the issue of their sexual identity was more present and relevant with queer clients than with straight clients, which impacted their approach to self-disclosure.</p>
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Table 2: Critical Appraisal

Appraisal Question/Study Reference	1	2	3	4	5
How well does the evaluation address its original aims and purpose?	B	A	A	A	A
How has knowledge/ understanding been extended by the research?	B	A	A	A	A
How well does the evaluation address its original aims and purpose?	B	A	A	A	A
Scope for drawing wider inference – how well is this explained?	A	A	A	A	A
How clear is the basis of evaluative appraisal?	C	B	B	B	B
How defensible is the research design?	A	A	C	B	A
How well defended is the sample design/ target selection of cases/documents?	B	A	B	D	B
Sample composition/case inclusion – how well is the eventual coverage described?	C	B	C	D	B
How well was the data collection carried out?	A	A	B	D	B
How well has the approach to, and formulation of, the analysis been conveyed?	B	A	C	B	A
Contexts of data sources – how well are they retained and portrayed?	B	B	C	B	B
How well has diversity of perspective and content been explored?	B	A	B	B	B
How well has detail, depth and complexity (i.e. richness) of the data been conveyed?	B	A	C	A	A
How clear are the links between data, interpretation and conclusions – i.e. how well can the route to any conclusions be seen?	C	A	C	A	A
How clear and coherent is the reporting?	A	A	B	A	A
How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation?	B	A	A	D	B
What evidence is there of attention to ethical issues?	B	A	C	D	B
How adequately has the research process been documented?	B	A	C	D	B
Overall Grade	B	A	B	C	B

Key: A) No or few flaws B) Some flaws C) Significant flaws D) Untrustworthy.

Aims

Despite differences in the studies, the aims of the five reviewed articles were to explore the “experiences” of LGBT therapist in their use of TSDO to homosexual and/or heterosexual clients. All five studies offered a clear statement of their aims and purposes. However, one study [3] in particular did not look explicitly at the therapist’s perspective of “coming out”, but at the client’s experience of TSDO. Nevertheless, this was clearly stated in the aims of the study. All four remaining articles did address their original aims through their findings and conclusions [1, 2, 4, 5]. Two studies explicitly stated that they were looking at use of TSDO to heterosexual clients [1 & 5], one study focused solely on use of TSDO to gay male clients [2], while the remaining studies included experiences of TSDO to homosexual and heterosexual clients [3 -4]. One study [2] also stated that it wanted to study the influence of training programmes in the UK, which it did successfully.

Sample

Cumulatively the articles reported data from a total of 109 therapists who identified predominantly as LGB. Three studies provided an adequate description of the sample composition [1, 2 & 5], however two [3 -4] did not provide sufficient demographic information to explore the impact of age and years of experience since qualification on use of TSDO. Two articles described that they used purposive sampling methods to recruit participants [1-2]; the remaining studies used convenience sampling methods [3-5]. All studies recognised that the sampling method used could generate bias in terms of over-representation. Each study acknowledged that a small number of LGBT therapists were represented and that results were limited in their generalisability.

Location

It was possible to discern country of origin from each study however; specific study location was not stated. It is apparent that there is a bias of therapists' experience of TSDO from the UK and the USA. Currently it is not known whether LGBT therapists' experiences of TSDO will differ from other cultures; nonetheless it is imperative to bear in mind that the generalisability of the synthesis could be limited.

Ethical Considerations

Ethical considerations were apparent in all but one study [4]. However, in one study they simply acknowledged that participants were aware that their personal details would be kept separately from their responses [3]. In other studies [1, 2, 5], it was acknowledged that local ethical approval had been granted, informed consent had been obtained and participants were made aware of local support agencies.

Data collection

All but one article were thought to adequately justify the rationale for using such methods [4]; this made it impossible to discern if the study was adequately designed to address the original aims. One study stated that the researcher made field notes during this phase, but these did not appear to be referred to in the analysis of the interviews [5]. Four out of the five studies gave information pertaining to the content of the topic guides [1, 2, 3, 5] with two providing detailed interview guides in appendices [2, 5]. This made the link between data collection and analysis more transparent. Three studies stated that interviews were audio recorded [1, 2, 5], allowing for response to be transcribed verbatim and analysed; one stated that questionnaire responses were analysed [3], however one study did not provide information about how participants' responses were recorded for analysis [4]. One study reflected that participants may have

censored their responses [2] in order not to be viewed negatively by the research, due to the sensitivity of the topic of research. This is surprising considering that all of the studies asked participants to reveal personal information regarding their attitudes, beliefs and behaviours to the use of TSDO.

Data Analysis

All studies stated their underlying theoretical framework. Three studies reported that coding was conducted by multiple analysts [1-3], while two studies report engaging in credibility checks to assess the accuracy of the coding used [4, 5]. It was not clear how any discrepancies in coding were discussed until a consensus was reached [1-3]. It was felt that some studies [2, 5] detailed how saturation of the data was achieved and demonstrated an adequate justification of the approach used for analysis [1, 2, 5]. While this did not directly impact upon the synthesis, it has made it difficult to explore the impact of the theoretical framework used in the interpretation of the data. All but one study engaged in a reflective stance about how the author's role as a researcher could have impacted upon the data collection and analysis process [1, 2, 3, 5].

Reporting

All of the studies did include original data within their reporting, in the form of direct quotations from participants [1-5]. This was valuable as it facilitated the subjective experiences of the participants to be embodied to a certain extent. It was also helpful to have a distinction between the original data and the author's interpretation, which could have been otherwise due to the descriptive style that was adopted by most authors in their reporting. Due to the use of Grounded Theory in one paper [4] it was reported that each theme would build on the other. Throughout the studies each represented that therapists tended to use case-by-case judgements of their TSDO to LGBT clients, while

when working with heterosexual clients, TSDO tended to be more judicious and the therapist often reflected on their motives for their use of disclosure. It appears that from these studies there is a strong voice that there was uncertainty about the appropriate use of TSDO [1-5].

Value

All five studies alluded to how the study could be used to facilitate an increase in knowledge and understanding in this area and some studies highlighted that their findings were consistent with previous research [1, 2]. In particular, two studies [2, 4] considered the impact that the research could have on the curriculum of training programmes for therapists and three questioned the inherent heterosexism bias within society and training programmes. One study called for a model of TSDO and specific guidelines [4] to be developed to aid therapists who are considering the use of TSDO. Four studies identified areas where further research was required with different populations [1-3, 5] and these studies also recognised that their work had gone some way to “filling a gap” in this understudied area.

(i) What are the facilitators and/or barriers towards TSDO?

Each of the reviewed studies discussed the facilitator and/or barriers in the use of TSDO, whether this was done implicitly or explicitly. Table 3 represents the themes that have been distinguished.

Table 3. The facilitator and barriers in therapist disclosures

Theme	Study 1	Study 2	Study 3	Study 4	Study 5
Work context		+		+	+
Client's sexuality	+		+	+	+
Internalised homophobia	+	+		+	+
Perceived helpfulness for the client	+	+	+	+	
Being gay in a straight world		+	+	+	+
Invisibility of LGBT issues		+	+	+	

Work context was seen as a prevailing theme that could act as a barrier and as a facilitator [2, 4, 5]. Therapists' use of TSDO was guided by the type of organisation that they worked in (public/private healthcare or private practice), the policies, rules and guidelines that the organisations had [4 & 5] and in some cases by their supervisor's attitudes towards the use of TSDO [4 & 5]. Generally, therapists did not like to disclose if the client group was associated with risky behaviours (e.g. forensic inpatient) [2] and if the therapist felt that there was institutional homophobia within the organisation [2, 4, 5]. In contrast therapists who worked with LGBT-affirmative organisation perceived their disclosures to be more acceptable because it was requirement of that organisations membership to be "openly out".

The client's sexual orientation was drawn out as a mediating factor for TSDO. The studies reported that LGBT therapists are more comfortable in making disclosures to LGBT clients than heterosexual clients [1, 3-5]. Many therapists also reported that they often see less reason to come out to heterosexual clients [5]. It was also noted that TSDO tended to be more frequent to LGBT clients because they raised it as an issue more often, asked direct questions or were aware of the therapist's sexual orientation

prior to therapy [2, 4, 5]. Considering the next theme there could be an underlying reason for less frequent disclosures to heterosexual clients. The therapist's own "internalised homophobia" was perceived to be a very distinct theme and barrier in TSDO [1, 2, 4, 5]. Therapists reported that their own assumptions and predicted outcomes based on their internal "sense of shame" was a factor for withholding a disclosure and this generally played out with heterosexual clients. The article suggested that the concept of internalised homophobia is a consequence of living in a hetero-normative society and of therapists' own experiences of homophobic abuse in or out of the therapy room. Therapists highlighted that "being gay in a straight world" was a further barrier to them using TSDO in terms of their fear of the client's reactions and the potential negative, homophobic comments that could be made [2-5]. Not only did some therapists worry about client reactions, but reactions of the wider community as well, should their own disclosed information leak out of the therapeutic relationship [4, 5].

The perceived helpfulness of TSDO for the client was often considered a facilitator within the studies [1, 2, 3, 4]: this theme generally covered working in the client's best interests and using TSDO – if appropriate – for the focus of the work (e.g. to normalise experiences [2]) Studies also highlighted that therapists often use their TSDO judiciously and reflect on their own motivation for bringing up the topic of sexuality [1, 2, 5].

A barrier for therapists was their perception of LGBT issues as invisible [2-4]. Therapists talked about a lack of focus in their training related to non-heterosexual issues, particularly the use of TSDO [2, 4]. It was voiced that without such attention in training programmes, LGBT therapists are unable to explore the use of TSDO until they are faced with an in-the-moment decision. The studies highlighted that this caused

increased anxiety related to the use of TSDO, and therapists were noted for refraining from making a disclosure due to uncertainty or lack of support.

(ii) What is the perceived impact of TSDO on therapeutic alliance?

Surprisingly little attention was given to the impact of TSDO on the therapeutic alliance within the studies reviewed. Table 4 represents the themes that have been extracted from the reviewed studies.

Table 4. Themes related to the perceived impacts of TSDO on the therapeutic alliance

Theme	Study 1	Study 2	Study 3	Study 4	Study 5
Strengthening the relationship	+	+	+	+	+
Damaging the relationship	+				+
Cutting off client's exploration		+			+
Lacking significance		+	+		

All of the studies reviewed demonstrated that the therapeutic alliance could be enhanced through the use of TSDO by normalising, validating and providing a shared experience. One study noted that therapists could attribute losing clients due to the use of TSDO [1], unfortunately, this was not explored further within the article, therefore the exact context of the disclosure and the perceived impact could not be analysed further. While participants in another [5] noted that this could be a risk associated with the use of TSDO. Though it was noted by therapists [2, 5] that TSDO could “cut off client exploration” and therapists felt this was pertinent to the perceived impact on the alliance “... a client...who was very confused about his sexuality, and ... I think that was the only time when I actively withheld...I had a very strong sense that it would be the wrong thing to do there” (male clinical psychologist, age 28-40) [2].

One study reported the relative insignificance of TSDO on the alliance. This was in contrast to views shared in another study [3] which highlighted that there were disadvantages to the client from the therapist use of TSDO: “Well it felt I was at an advantage as she understands but on the other hand I get only her point of view and not a straight person’s point of view” (female client) [3].

The findings of the reviewed studies highlight that there is no clear discernible impact on the therapeutic alliance from therapists who use TSDO. The majority of the findings are taken from the therapists’ perspective [1, 2, 4, 5], with one study focusing on the clients’ perspective [3], meaning that there is an under-representation of the client’s voice in the perceived impact on the therapeutic alliance. One quote summed up the significance of TSDO on the alliance well “...sharing that I’m gay doesn’t mean that their difficulties disappear” (male clinical psychologist, ages 28-40) [2].

(iii) Why did the therapist choose to disclose or not to disclose?

All of the studies noted themes about why therapists choose to disclose or not. Two articles addressed therapist choices in explicit themes [1, 2], while others created a narrative throughout the analysis which drew on therapist choices [3-5].

Table 5. Themes addressing therapists' choices in disclosure.

Theme	Study 1	Study 2	Study 3	Study 4	Study 5
Client's own sexuality	+	+	+	+	+
In the client's best interests	+	+		+	+
The therapeutic alliance	+	+	+	+	+
Fear of client judgement	+	+		+	+
Meeting therapist needs	+	+	+		+
Therapist's Intuition		+			+
Internalised homophobia	+	+		+	+
Other ways of knowing		+		+	+
Assumed sexuality	+	+	+	+	+

One of the most apparent themes that helped answer this question was the “client’s own sexuality”. This theme was highlighted in each of the reviewed studies and was felt to be the single most influential factor in the use of TSDO because it overarched many of the identified themes. Studies reported that often LGBT therapists would disclose more often to LGBT clients than they would heterosexual clients [2, 4, 5].

Furthermore, the reviewed studies identified that disclosures to LGBT clients and straight clients differed greatly “Normally my approach to self-disclosure regarding my own sexual orientation is that I have a double standard. With gay clients, I approach it differently than I do with straight clients” (male clinical social worker) [4]. This could be related to how therapists believe that the client will react. While a double standard was acknowledged between TSDO with straight and LGBT clients, it was also clear that TSDO was not considered to be used to meet the therapist’s own needs [1-3, 5] and that a disclosure was only made if it was felt to be in the client’s best interests [1, 2, 4, 5]. Reasons included deepening of rapport, role modelling and develop and being authentic within the therapeutic alliance [1-5].

A further theme that arose when a therapist was making the decision whether to use TSDO was the “fear of client judgement” [1, 2, 4, 5] “I might lose their respect, I might not be taken seriously...it’s like being judged” (Female counsellor, age 45) [1]. In fact all therapists in one study expressed the fear of judgement and rejection following TSDO [1], but it appears that this was based on opinion rather than experience. This theme appeared to be closely related to internalised homophobia [1, 2, 4, 5] and the client’s own sexuality. Importantly, two studies reported that TSDO had been based on the therapists’ intuition [2, 5], which highlights an interesting discussion point about respondents being guided by empirical objective science or their subjective instincts.

In three studies [2, 4, 5], TSDO was not usually performed directly, but indirectly. The theme of “other ways of knowing” captured this well. Therapists reported that it was a rare event that they would actively disclose to clients, but that an indirect disclosure had taken place. In one study the role of the internet and ‘Google factor’ (Zur, 2008) [2] was implicated, but also was sharing a local gay community or scene [2, 4, 5] with potential clients and the referral process [2, 4], specifically if the therapist was registered with an LGBT affirmative agency.

Therapists also reported that some clients projected an “assumed sexuality” onto them, which in some cases made the TSDO easier, because the client had already assumed that the therapist was of an LGBT orientation and it was not an issue [2,3,4]. In some cases the client’s assumption was incorrect, which made therapists uncertain about the use of TSDO and the appropriateness to correct the client if it was not part of the therapeutic agenda [1, 4]. Therapists were uneasy with not being authentic with the client or having to sacrifice part of themselves when not challenging an inaccurate assumption.

(iv) In what context was the disclosure made?

Two of the reviewed papers noted that the context of the disclosure was a standalone theme [2,4]. However in one study [5] the context of the disclosure was mentioned by participants as often informing their judgements about being “out at work”.

Table 6. Key themes related to context of TSDO

Theme	Study 1	Study 2	Study 3	Study 4	Study 5
Organisational culture		+		+	
Work setting		+		+	
Oppression		+		+	+
Risk		+		+	+

Two of the studies noted that the organisation the therapist worked in would be highly influential in determining whether TSDO was acceptable. For one of the studies [4], this related specifically to the organisation’s rules and guidelines, but also the influence of the supervisor. There was also the assumption that the work context could “out” the therapist, especially in the field of sexual health, where therapists are assumed to have an LGBT orientation.

Related to this was also the unlikeliness that an LGBT therapist would disclose their sexuality within an inpatient setting (e.g. forensic secure setting). This was mainly due to the perception that the client group were riskier: “...the issue is nothing to do with their sexuality, they have strongly negative attitudes towards gay people” (male clinical psychologist, ages 28-40 years) [2]. Both studies [2, 4] alluded to institutional homophobia as a factor that would influence the use of TSDO, but neither provided any supporting quotes to demonstrate how this was portrayed by participants. In contrast, it

was seen by participants as acceptable to be “openly out” in private practice, particularly if the therapist was affiliated with a LGBT organisation or through the referral route.

The oppression of sexual orientation faced by LGBT therapists when working with heterosexual clients and how it could affect their use of TSDO was also discussed by therapists [2, 4, 5]. From the findings presented, it is evident that the work context and culture of the organisation is paramount in considering the use of TSDO.

Discussion

The synthesis aimed to provide a fusion of the qualitative literature on the use of TSDO. It did this by considering four questions: (i) What are the facilitators and/or barriers towards TSDO? (ii) What is the perceived impact of TSDO on therapeutic alliance? (iii) Why did the therapist choose to disclose or not to disclose? (iv) In what context was the disclosure made?

The synthesis identified six themes that strongly emerged in being facilitative or presenting a barrier to the use of TSDO. Therapists identified that their work context, client sexuality, their own internalised homophobia, the perceptions of the client's reactions and their own experiences of being an LGBT member of society would prevent them from using TSDO. There was also a sense that the absence of LGBT issues within therapist training could act as a further barrier in using TSDO because of a lack of support available or dominant discourses that any form of disclosure was inappropriate within therapy. It was also identified that TSDO would be facilitated if the client identified as non-heterosexual, or the therapist worked within an LGBT-affirmative organisation. Furthermore, if the therapist perceived that their TSDO would be helpful to the client (e.g. providing a role model, normalising, challenging

misconceptions) they were more likely to disclose their sexual orientation. In work with straight clients, therapists identified that they were assumed to be heterosexual. This demonstrates wider societal views that individuals are generally perceived to be straight, because straight is the “norm”, unless there is evidence to suggest otherwise.

The perceived impacts of TSDO on the therapeutic alliance were captured in four themes. Therapists highlighted that the use of TSDO could strengthen the relationship between the client and therapist, while some cautioned that use of TSDO could lead to irreversible damage and the client disengaging from therapy. It was also evident that therapists believed that, if the disclosure that was untimely or inappropriate, it could cut off the client’s own exploration of their sexuality and give out a simple message that “it’s okay to be gay” (male clinical psychologist, ages 28-40) [2]. Therapists were also aware that their disclosures made relative insignificance to the client and the relationship. The findings here imply that therapists need to make judicious case-by-case disclosures with clients and that a dynamic approach to the use of TSDO should be considered by the therapist.

Ten themes were identified when therapists were choosing whether to disclose or not. Themes that resulted in a therapist not disclosing were fear of client judgement, meeting the therapist’s own needs, the internalised homophobia of the therapist, the client’s sexuality, and assumptions that the client made about the therapist’s sexuality. Therapists were more likely to choose disclosure if they shared an LGBT sexual orientation with clients, if they believed that it would be in the client’s best interests and would enhance the therapeutic alliance, or if they were guided by their intuition. Another interesting theme also arose here, with therapists reporting that their direct use of TSDO was often infrequent and that clients would often come to therapy already knowing the therapist’s sexual orientation. This was captured by the theme of “other

ways of knowing” and highlights that there are multiple ways in which therapists or any sexual orientation can disclose information about themselves unwittingly.

The context of the disclosure was seen as one of the most influential factors in making a disclosure or not. Therapists were guided by the organisational culture, the rules, guidelines and policies that were in place; the setting in which they worked (public/private healthcare, private practice, charities and LGBT-affirmative organisations). Other contextual factors that mediated TSDO were the perceptions of oppression and risk (institutional homophobia, supervisors forbidding the use of TSDO, or the client’s homophobic remarks). It is thought that organisational factors are more likely to be mediated by wider societal views about the acceptability of non-heterosexuals and straight being seen as the “norm”. In contrast to this, therapists reported that being associated with an LGBT affirmative organisation was one work context where being “openly out” was required and illustrated a distinction between the autonomy that therapists have in their use of TSDO, and how this was dependent on the work context.

The factors that have been discussed here illustrated the complexities that LGBT therapists face on a regular basis. The complexities in themselves may deter therapists from making a disclosure because they perceive a lack of support or guidance on this issue. While some therapists may feel that it is important to stand up and be represented as a sexual minority, they also recognise that making disclosures on that basis would be inappropriate. The findings are consistent with the limited previous research that has been conducted in this area; namely that TSDO should be conducted on a case-by-case, judicious basis and that there is often a lack of support for therapists who are considering TSDO. The findings of the studies indicate that LGBT therapists feel more comfortable disclosing their sexual orientation to other members of the LGBT

community and that this may be mediated by their internalised homophobia, fears of rejection and assumptions that they have, based on previous experiences.

It is important to consider the implications of these findings as well as the limitations. This was a relatively small review, based on five articles. It may have been helpful to have developed less stringent inclusion/exclusion criteria to increase the number of studies eligible for the review (e.g. including studies that focused on client experience of TSDO, and quantitative methodologies). While every attempt was made to develop a rigorous search strategy, it may have meant specific search terms led to the omission of articles that may have been valuable to the review.

It could be argued that the methodology of the review is susceptible to inaccuracies; the approach is reliant on the subjective interpretation of the authors. Braun and Clarke (2006) highlight that 'if themes reside anywhere, they reside in our heads' (p.80). This is also true for this analysis inasmuch as the review is dependent upon interpretation and this increases the level of bias within the findings. The use of triangulation with multiple reviewers may have reduced this risk, even though the review has demonstrated that the approach was useful in determining and identifying similar themes across the studies. However, as with any research, it is important to note that therapists may have censored their experiences of using of TSDO.

This review should be useful to therapists who are deciding whether to use TSDO, but also to therapists who currently use TSDO. There are limited guidelines available for therapists to help them in decision-making and this review could potentially help in the development of guidelines and support networks for LGBT therapists who are unsure about applying the use of TSDO appropriately and safely.

The review highlights that LGBT issues are invisible in therapist training programmes and, without the opportunity to explore and reflect on the use and impacts of TSDO for non-heterosexual therapists, this can cause anxieties about acting inappropriately with clients, especially if they have observed the discourse that disclosing anything is wrong. This again could also impact negatively on the therapist's perception of him/herself and the internal struggles that may be apparent, as therapists develop in a society where being heterosexual is seen as "normal". The review also highlights that therapists are aware of the need to use TSDO judiciously and examine their own motives for making their disclosures, which is in line with the BPS (2012) guidance.

Conclusions

This review of five articles indicated that therapists are engaging in the use of TSDO. A number of facilitative factors and barriers, the impact that a disclosure has on the therapeutic alliance, why therapists choose to disclose and the context in which the disclosure happens have all been identified and discussed. The findings identify that therapists often engage in judicious case-by-case decision-making process about their use of TSDO and often reflect in how helpful it is going to be for the client. The review identifies that therapists perceive there to be an invisibility of LGBT issues within training programmes, which were often felt to cause increased anxiety for LGBT therapists because there was a lack of knowledge, understanding and support for the judicious use of TSDO. This review highlights that training policy needs to reflect the needs of LGBT therapists and also service users.

Word Count: 5951

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Appendix A: Search strategy and search terms

Psych INFO (1983-july 2013 week 1)

- 1) exp. counsellors/ or exp. Therapist/ (34907)
- 2) exp. Self-disclosure/ (4210)
- 3) 1 & 2 = 331
- 4) exp. Sexual orientation/ (20734)
- 5) exp. Bisexuality/ exp. homosexuality/ exp. transgendered/ (19086)
- 6) exp. sexuality/ (10491)
- 7) 3 and 4 or 5 or 6 (21)

PsychARTICLES (1983-July 2013 week 1)

- 1) exp. therapist (9232)
- 2) exp. self-disclosure (1727)
- 3) 1 and 2 (44)
- 4) exp. Sexual orientation (1784)
- 5) exp. Sexuality (2258)
- 6) 4 or 5 (3679)
- 7) 3 and 6 (132)

EMBASE (1983-July 2013 week 1)

- 1) exp. Therapist (0)
- 2) exp. Counselling/ exp. Counselling (37728)
- 3) exp. self-disclosure (3453)
- 4) exp. homosexual / exp. sexual orientation (962)
- 5) exp. sexuality (24208)
- 6) 2 and 3 and 4 or 5 (5)

Medline (1983- July 2013 week 1)

- 1) exp. Psychotherapy/ self-disclosure/ (177)
- 2) exp. sexual orientation/ (2558)
- 3) exp. Sexuality/ [psychology] (1343)
- 4) exp. Transgendered person/ exp. Homosexuality/ exp. Bisexuality/ (21420)
- 5) 1 and 2 and 3 or 4 (0)
- 6) 1 and 2 and 4 (3)

Scopus (1983- July 2013 week 1)

- 1) exp. Therapist (46058)
- 2) exp. Counsellor (11899)
- 3) exp. Psychologist (24193)
- 4) 1 or 2 or 3 (73196)
- 5) exp. Self-disclosure(8268)
- 6) exp. Sexual Orientation(7697)
- 7) 1 and 4 (671)
- 8) 6 and 7 (15)
- 9) 2 and 5(381)
- 10) 6 and 7 (9)
- 11) 3 and 5 (246)
- 12) 6 and 9 (2)

CINAHL (1983- July 2013 week 1)

- 1) exp. Therapist (0)
- 2) exp. counsellors (1886)
- 3) exp. self-disclosure (2540)
- 4) exp. Sexuality (17630)
- 5) exp. Homosexuality/ exp. Bisexuality/ exp. Homosexuals/ exp. Homosexuals, Male/ exp. Lesbians (7829)
- 6) 2 and 3 (24)
- 7) 2 and 3 and 4 or 5 (3)

EBSCOhost (1983- July 2013 week 1- academic journals)

- 1) exp. Therapists (1901251)
- 2) exp. Self-disclosure (69606)
- 3) exp. Sexual orientation (722768)
- 4) exp. Sexuality (414791)
- 5) 1 and 2 and 3 or 4 (22)

Appendix B: Critical Appraisal Tool

	A) Appraisal Questions	B) Quality indicators (possible features for consideration)	C) Notes on study being appraised
Findings	How credible are the findings?	Findings/conclusions are supported by data/study evidence (<i>i.e. the reader can see how the researcher arrived at his/her conclusions; the 'building blocks' of analysis and interpretation are evident</i>) Findings/conclusions 'make sense'/have a coherent logic Findings/conclusions are resonant with other knowledge and experience (<i>this might include peer or member review</i>) Use of corroborating evidence to support or refine findings (<i>i.e. other data sources have been used to examine phenomena; other research evidence has been evaluated: see also Q14</i>)	
Findings	How has knowledge/understanding been extended by the research?	Literature review (where appropriate) summarising knowledge to date/key issues raised by previous research Aims and design of study set in the context of existing knowledge/ understanding; identifies new areas for investigation (<i>for example, in relation to policy/practice/substantive theory</i>) Credible/clear discussion of how findings have contributed to knowledge and understanding (<i>e.g. of the policy, programme or theory being reviewed</i>); might be applied to new policy developments, practice or theory Findings presented or conceptualised in a way that offers new insights/alternative ways of thinking Discussion of limitations of evidence and what remains unknown/unclear or what further information/research is needed	
Findings	How well does the evaluation address its original aims and purpose?	Clear statement of study aims and objectives; reasons for any changes in objectives Findings clearly linked to the purposes of the study – and to the initiative or policy being studied Summary or conclusions directed towards aims of study Discussion of limitations of study in meeting aims (<i>e.g. are there limitations because of restricted access to study settings or participants, gaps in the sample coverage, missed or unresolved areas of questioning; incomplete analysis; time constraints?</i>)	

Findings	<p>Scope for drawing wider inference- how well is this explained?</p>	<p>Discussion of what can be generalised to wider population from which sample is drawn/case selection has been made</p> <p>Detailed description of the contexts in which the study was conducted to allow applicability to other settings/contextual generalities to be assessed</p> <p>Discussion of how hypotheses/ propositions/findings may relate to wider theory; consideration of rival explanations</p> <p>Evidence supplied to support claims for wider inference (<i>either from study or from corroborating sources</i>)</p> <p>Discussion of limitations on drawing wider inference (<i>e.g. re-examination of sample and any missing constituencies: analysis of restrictions of study settings for drawing wider inference</i>)</p>	
Findings	<p>How clear is the basis of evaluative appraisal?</p>	<p>Discussion of how assessments of effectiveness/evaluative judgements have been reached (<i>i.e. whose judgements are they and on what basis have they been reached?</i>)</p> <p>Description of any formalised appraisal criteria used, when generated and how and by whom they have been applied</p> <p>Discussion of the nature and source of any divergence in evaluative appraisals</p> <p>Discussion of any unintended consequences of intervention, their impact and why they arose</p>	
Design	<p>How defensible is the research design?</p>	<p>Discussion of how overall research strategy was designed to meet aims of study</p> <p>Discussion of rationale for study design</p> <p>Convincing argument for different features of research design (<i>e.g. reasons given for different components or stages of research; purpose of particular methods or data sources, multiple methods, time frames etc.</i>)</p> <p>Use of different features of design/data sources evident in findings presented</p> <p>Discussion of limitations of research design and their implications for the study evidence</p>	

Sample	How well defended is the sample design/target selection of cases/documents?	<p>Description of study locations/areas and how and why chosen</p> <p>Description of population of interest and how sample selection relates to it (e.g. <i>typical, extreme case, diverse constituencies etc.</i>)</p> <p>Rationale for basis of selection of target sample/settings/documents (e.g. <i>characteristics/features of target sample/settings/documents, basis for inclusions and exclusions, discussion of sample size/number of cases/setting selected etc.</i>)</p> <p>Discussion of how sample/selections allowed required comparisons to be made</p>	
Sample	Sample composition/case inclusion-how well is the eventual coverage described?	<p>Detailed profile of achieved sample/case coverage</p> <p>Maximising inclusion (e.g. <i>language matching or translation; specialised recruitment; organised transport for group attendance</i>)</p> <p>Discussion of any missing coverage in achieved samples/cases and implications for study evidence (e.g. <i>through comparison of target and achieved samples, comparison with population etc.</i>)</p> <p>Documentation of reasons for non-participation among sample approached/non-inclusion of selected cases/documents</p> <p>Discussion of access and methods of approach and how these might have affected participation/coverage</p>	
Data Collection	How well was the data collection carried out?	<p>Discussion of:</p> <ul style="list-style-type: none"> • who conducted data collection • procedures/documents used for collection/recording • checks on origin/status/authorship of documents <p>Audio or video recording of interviews/discussions/conversations (<i>if not recorded, were justifiable reasons given?</i>)</p> <p>Description of conventions for taking field notes (e.g. <i>to identify what form of observations were required/to distinguish description from researcher commentary/analysis</i>)</p> <p>Discussion of how fieldwork methods or settings may have influenced data collected</p> <p>Demonstration, through portrayal and use of data, that depth, detail and richness were achieved in collection</p>	

Analysis	How well has the approach to, and formulation of, the analysis been conveyed?	<p>Description of form of original data (e.g. use of <i>verbatim transcripts, observation or interview notes, documents, etc.</i>)</p> <p>Clear rationale for choice of data management method/tool/package</p> <p>Evidence of how descriptive analytic categories, classes, labels etc. have been generated and used (i.e. <i>either through explicit discussion or portrayal in the commentary</i>)</p> <p>Discussion, with examples, of how any constructed analytic concepts/typologies etc. have been devised and applied</p>	
Analysis	Contexts of data sources- how well are they retained and portrayed?	<p>Description of background or historical developments and social/organisational characteristics of study sites or settings</p> <p>Participants' perspectives/observations placed in personal context (e.g. use of <i>case studies/vignettes/individual profiles, textual extracts annotated with details of contributors</i>)</p> <p>Explanation of origins/history of written documents</p> <p>Use of data management methods that preserve context (i.e. <i>facilitate within case description and analysis</i>)</p>	
Analysis	How well has diversity of perspective and content been explored?	<p>Discussion of contribution of sample design/case selection in generating diversity</p> <p>Description and illumination of diversity/multiple perspectives/alternative positions in the evidence displayed</p> <p>Evidence of attention to negative cases, outliers or exceptions</p> <p>Typologies/models of variation derived and discussed</p> <p>Examination of origins/influences on opposing or differing positions</p> <p>Identification of patterns of association/linkages with divergent positions/groups</p>	
Analysis	How well has detail, depth and complexity (i.e. richness) of the data been conveyed?	<p>Use and exploration of contributors' terms, concepts and meanings</p> <p>Unpacking and portrayal of nuance/subtlety/intricacy within data</p> <p>Discussion of explicit and implicit explanations</p> <p>Detection of underlying factors/influences</p> <p>Identification and discussion of patterns of association/conceptual linkages within data</p> <p>Presentation of illuminating textual extracts/observations</p>	

Reporting	How clear are the links between data, interpretation and conclusions – i.e. how well can the route to any conclusions be seen?	<p>Clear conceptual links between analytic commentary and presentations of original data (<i>i.e. commentary and cited data relate; there is an analytic context to cited data, not simply repeated description</i>)</p> <p>Discussion of how/why particular interpretation/significance is assigned to specific aspects of data – with illustrative extracts of original data</p> <p>Discussion of how explanations/ theories/conclusions were derived – and how they relate to interpretations and content of original data (<i>i.e. how warranted</i>); whether alternative explanations explored</p> <p>Display of negative cases and how they lie outside main proposition/theory/ hypothesis etc.; or how proposition etc. revised to include them</p>	
Reporting	How clear and coherent is the reporting?	<p>Demonstrates link to aims of study/research questions</p> <p>Provides a narrative/story or clearly constructed thematic account</p> <p>Has structure and signposting that usefully guide reader through the commentary</p> <p>Provides accessible information for intended target audience(s)</p> <p>Key messages highlighted or summarised</p>	
Reflexivity & Neutrality	How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation?	<p>Discussion/evidence of the main assumptions/hypotheses/theoretical ideas on which the evaluation was based and how these affected the form, coverage or output of the evaluation (<i>the assumption here is that no research is undertaken without some underlying assumptions or theoretical ideas</i>)</p> <p>Discussion/evidence of the ideological perspectives/values/philosophies of research team and their impact on the methodological or substantive content of the evaluation (<i>again, may not be explicitly stated</i>)</p> <p>Evidence of openness to new/alternative ways of viewing subject/theories/ assumptions (e.g. <i>discussion of learning/concepts/ constructions that have emerged from the data; refinement restatement of hypotheses/theories in light of emergent findings; evidence that alternative claims have been examined</i>)</p> <p>Discussion of how error or bias may have arisen in design/data collection/analysis and how addressed, if at all</p> <p>Reflections on the impact of the researcher on the research process</p>	

Ethics	What evidence is there of attention to ethical issues?	<p>Evidence of thoughtfulness/sensitivity about research contexts and participants</p> <p>Documentation of how research was presented in study settings/to participants (<i>including, where relevant, any possible consequences of taking part</i>)</p> <p>Documentation of consent procedures and information provided to participants</p> <p>Discussion of confidentiality of data and procedures for protecting</p> <p>Discussion of how anonymity of participants/sources was protected</p> <p>Discussion of any measures to offer information/advice/services etc. at end of study (<i>i.e. where participation exposed the need for these</i>)</p> <p>Discussion of potential harm or difficulty through participation, and how avoided</p>	
Auditability	How adequately has the research process been documented?	<p>Discussion of strengths and weaknesses of data sources and methods</p> <p>Documentation of changes made to design and reasons; implications for study coverage</p> <p>Documentation and reasons for changes in sample coverage/data collection/analytic approach; implications</p> <p>Reproduction of main study documents (e.g. <i>letters of approach, topic guides, observation templates, data management frameworks etc.</i>)</p>	

Journal Paper

To disclose or not to disclose? The LGBT therapist's question.

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To disclose or not to disclose? The LGBT therapist's question.

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Abstract

Therapist self-disclosure is contentious; however, little attention has been paid to therapist disclosure of sexuality. **Objective:** This study explored the experiences of non-heterosexual therapists disclosing their sexual orientation to clients, with the aim of establishing the purpose of therapists' disclosure of sexuality. **Method:** 17 LGBT therapists were purposively interviewed. Transcribed responses were analysed using an inductive-deductive hybrid thematic analysis. **Results:** three overarching themes revealed: 'function of disclosure'; 'function of non-disclosure', and 'how disclosure happens'. Participants reported that disclosure to non-heterosexual clients improved the therapeutic alliance; disclosure to heterosexuals was seen as potentially damaging for the alliance. Fear of client judgement also prevented therapist disclosure. Disclosure was reported to happen prior to therapy through online directories, websites and referral pathways. **Conclusions:** This study provides evidence for judicious therapist disclosure of sexuality suggesting that disclosure could help combat minority stress in non-heterosexual groups it also highlights novel findings related to therapists' rationales for withholding disclosures of sexuality; while highlighting that there is a cost to therapists concealing their sexuality.

Key Words: therapist self-disclosure; sexual orientation; non-heterosexual; function; LGBT

Introduction

Therapist self-disclosure (TSD) is a contentious issue, yet literature suggests that TSD is routine in therapy. A recent review highlighted that 90% of therapists use some form of self-disclosure, including: therapist's demographic information, relevant personal struggles overcome, and assumed similarities between therapist and client (Henretty & Levitt, 2010). Thus far, limited attention has been given to therapist self-disclosure of sexual orientation (TDSO), particularly amongst lesbian, gay, bisexual and trans (LGBT) or non-heterosexual² therapists to their clients.

Section 2.8.4 of the *Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients*, published by the British Psychological Society ([BPS], 2012), state that therapist self-disclosure can be beneficial for the client if there is a valid therapeutic rationale. The guidelines also suggest that beneficial self-disclosure can include the therapist's sexuality. However, they also recommend that therapists fulfil the requirements of the *Health Professions Council Standards of Conduct, Performance and Ethics* (Health Professions Council [HPC], 2008) and *Clear Sexual Boundaries between Healthcare Professionals and Patients: Responsibilities of Healthcare Professionals'* guidelines (Council for Healthcare Regulatory Excellence [CHRE], 2008). The CHRE guidelines suggest that practitioners should not display "sexualised behaviours" ("acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires") (CHRE, 2008, p. 2) towards clients. CHRE (2008) guidelines also provide a list of unacceptable sexualised behaviours which include criminal acts such as assaults and rape, but also a wide variety of other behaviours: 'requesting details of sexual orientation, history or preferences that are not necessary or relevant', but also the practitioner 'telling patients about their own sexual, preferences, or fantasies or disclosing other intimate personal details' (CHRE, 2008, p. 13). The BPS guidelines highlight that therapists who do disclose their sexuality to clients, motivated by their own sexual gratification, are violating these boundaries. The BPS guidelines clearly state that practitioners need to 'carefully examine their own motives' before their disclosure and be aware that clients may 'misconstrue their reasons for such disclosure' (BPS, 2012, p. 68).

² Non-heterosexual is an umbrella terms used to categorise peoples whose sexual orientation and/or identity is not heterosexual. This can include: homosexual, bisexual, pansexual and asexual, etc. (Dilley, 2002).

Therapist self-disclosure of sexual orientation (TDSO)

However contentious, TDSO is postulated to be particularly beneficial for members of minority and stigmatised groups within society. In these contexts, TDSO could facilitate the strengthening of the therapeutic alliance, while enhancing congruence with the client (Burkard, Knox, Groen, Perez, & Hess, 2006; Norcross, 2002). In general, the process of disclosing an LGBT orientation, or 'coming out', is associated with positive wellbeing (Corrigan et al., 2009; Davies & Neal, 1996; Meyer, 2003; Rees-Turyn, 2007; Rosario, Schrimshaw, & Hunter, 2011), therefore coming out in therapy may replicate this (Jeffery & Tweed, 2014; Lea, Jones & Huws, 2010; Moore & Jenkins, 2012; Satterly, 2006).

From a gay affirmative perspective, TDSO could potentially generate a more equal and honest alliance between therapist and client (Barker, 2006; Lea, et al., 2010). TDSO may be noticeably salient when the client and therapist share a non-heterosexual orientation, however, therapists should consider disclosing sexuality on a case-by-case basis (Guthrie, 2006; Milton, Coyle & Legg, 2002), disclosing judiciously, in a client focused way (Hanson, 2005; Moore & Jenkins, 2012; Lea, et al., 2010). Research acknowledges that disclosure can provide an opportunity for the therapist to 'be real' with the client, provide normalisation, deepened rapport, challenges to clients' misassumptions, provide a positive role model and allow the client to make reciprocal disclosures thus having a positive impact on therapeutic outcomes (Hanson, 2005; Moore & Jenkins, 2012; Lea, et al., 2010). These factors were generally seen to counter the potential negative effect of perceived exclusion and homophobia expected by the client, because of the perception of therapists having increased empathy (Evans & Barker, 2010; Lea, et al., 2010). Furthermore, Frommer (2003), Cabaj (1996), and Pearlman (1996) all support the view that TDSO can be positive when the therapist and client share the same minority sexuality³. Also, Barrett and Berman (2001) indicate that there are positive outcomes for the client from the appropriate use of TDSO e.g. removing barriers, adding credibility to the clinician while facilitating empowerment of the client (Jeffery & Tweed, 2014).

However, therapists may have concerns over disclosing because of a fear of contravening their professional practice guidelines (e.g. BPS, 2012; CHRE, 2008; HPC,

³ Minority sexuality in this instance refers to lesbian, gay, bisexual and trans orientations.

2008), the negative psychological consequences of withholding a TDSO have been highlighted. Recent evidence suggests that the concealment of the clinician's sexual orientation may also be experienced by the therapist as acting dishonestly because of their own internalised shame and guilt (Jeffery & Tweed, 2014). This can be linked to the *Minority Stress Model*.

Minority Stress Model

This model postulates that prejudice and discrimination can be conceptualised as stress evoking, therefore stigmatised groups within society can experience increased stress compared to non-stigmatised groups (Allport, 1954; Clark, Anderson, Clark, & Williams, 1999; Meyer, 2003). Individuals within stigmatised groups experience: a) *unique* excessive stress (over and above everyday stressors) as a result of their minority position in society, which often leads to increased psychological and physical ill health because stigmatised individuals are required to adapt and cope beyond the level of peers from non-stigmatised groups; b) *chronic* –stable underlying cultural and social structures and c) *Socially based*- stemming from social processes, structures and institutions beyond the individual in contrast to specific events or conditions that comprise general stressors (Allport, 1954; Link & Phelan, 2001; Meyer, 1995; Meyer, 2003;).

The model argues that concealing a stigmatised identity, and increased vigilance due to the concealment, can produce adverse effects. Concealment and vigilance are often used as a way of coping, therefore protecting the individual from discrimination, and facilitating avoidance of the expected negative stigma attached to non-heterosexual orientations (Allport, 1954; D'Augelli & Grossman, 2001; Meyer, 2003). However, concealment can become stressful in itself (Miller & Major, 2000). Hiding a stigma can result in a significant cognitive burden due to preoccupation with hiding (Smart & Wegner, 2000). Concealment of sexuality is seen as a significant source of stress for LGBT individuals, because of the constant monitoring of behaviour (e.g., how one dresses, acts, speaks, walks, etc.) (DiPlacido, 1998; Hetrick & Martin, 1987; Jaspal & Siraj, 2010; Meyer, 2003).

Non-heterosexual therapist disclosure of sexuality is widely accepted to have positive effects on the therapeutic alliance and therapeutic outcomes, as discussed above (Hanson, 2005; Jeffery & Tweed, 2014; Lea, et al., 2010; Moore & Jenkins, 2012;

Satterly, 2006). While more recently, research has started to highlight the psychological impacts of non-disclosure on non-heterosexual clinicians (Jeffery & Tweed, 2014; Moore & Jenkins, 2012). Furthermore, non-heterosexual therapists face being in difficult positions because they must “negotiate an intricate balancing act between self and client welfare in an ethical manner” (Rees-Turyn, 2007, p.8). Within the guidelines TDSO is a contentious issue; however, it is unclear if any of the guidelines are based on empirical research.

Study Aims⁴

This study aimed to garner a fuller understanding into LGBT therapist disclosure of their sexual orientation to clients. We sought to:

- understand non-heterosexual therapists’ perspectives on the purpose of TDSO, and gain insight into the decision-making processes involved.
- examine the perceived consequences that TDSO had on therapeutic alliance.
- examine the context in which a disclosure took place.

Furthermore, we wanted to ascertain if there was a difference between those therapists who considered disclosure, but took no action, and those who had considered disclosure *and* had made a disclosure.

⁴ Additional quantitative aims are presented in the extended background section under *study rationale*

Method

Please see the extended methodology for a greater, in-depth explanation of the study's methodology.

Recruitment

Participants were purposively recruited from an online survey⁵ we created relating to TDSO. The online survey was advertised through the BPS's Psychology of Sexualities Section (PoSS)⁶ listserv via a web-link, Pink Therapy⁷ Newsletter and Facebook page, an advertisement in the College of Sexual and Relationship Therapists (CORST), and International Psychology Network (IPsyNet) LGBTI⁸ listserv (see appendix A). Following the survey, participants were asked if they would be interested in taking part in an interview to discuss their experiences in greater detail. Those interested left their email addresses (which was kept separate from the survey data) so that they could be contacted. Interviews were conducted over the telephone or via Skype.

Participants

53 participants completed the online survey, with 29 agreeing to be interviewed. Out of the 29 participants who showed an interest in being interviewed, 17 participants were interviewed. The online survey results are discussed in the extended paper. All participants met the inclusion criteria of identifying as having a non-heterosexual identity (e.g. LGBT, asexual, queer, non-binary, etc.), had thought about disclosing or had disclosed their sexual orientation to a client they were/are actively working with, were a qualified therapist who uses psychological/psychotherapeutic theories and models to underpin their practice and be registered to an appropriate governing body either in the UK or Internationally (e.g., BPS, BACP, UKCP, Health and Care

⁵ Results of the online survey are discussed in the extended paper.

⁶ PoSS holds an affirmative approach towards sexualities. PoSS aims to provide a forum for clinicians whose work is relevant to LGBT issues. The listserv is an emailing list which is open to all members of the section who share an interest in LGBT issues.

⁷ Pink Therapy is the UK's largest independent therapy organisation working with clients of sexual and gender diversity. It is also host to the UK's first online Directory of Pink Therapists, which lists qualified therapists who adopt a sexuality affirmative stance, not seeing sexual and gender diversity as an illness to be treated.

⁸ IPsyNet consists of a global network of psychological organisations that share knowledge and understanding of sexual orientation and gender diversity, while promoting human rights and wellbeing.

Professions Council (HCPC), and COSRT. Participant demographic information is presented in table 7.

Ethics

Ethical approval was granted by the University of Lincoln's Ethics Committee (appendix B). Informed consent was received during the online survey. Participants were asked to complete a 'tick box' and generate a pseudonym to give their consent prior to survey (appendix C). Participants could only view the survey once these steps had been completed. Participants consented to be contacted for interview by leaving their email address following completion of the survey and verbal consent was given prior to the interview starting.

Table 7:
Participant information collected during the interviews.

Age Range	Gender	No. Post Qual years*	Work Context*	Location	Type of therapist*	Theoretical orientation*
30-40 (n=4)	Male (n=11)	0-5 (n=6)	Private Practice (n=11) (incl. Working from home, a private provider)	UK (n=16)	Psychotherapist/Counsellor (n=10)	Integrative (n=6)
41-50 (n=6)	Female (n=5)	6-10 (n=5)		GER (n=1)	Clinical Psychologist (n=2)	Psychodynamic (n= 3)
51-60 (n=6)	Non-binary (n=1)	11-15 (n=4)	NHS (n=5)		Counselling Psychologist (n=1)	CBT (n=2)
61-70 (n=1)		16-20 (n=1)			Behaviour Therapist (n=1)	Gestalt (n=1)
					Relationship therapist (n=1)	Person-Centred (n=1)
					Psychosexual Therapist (n=1)	Neuro-linguistic (n=1)
						Psychosexual Therapy (n=1)
						Systemic (n=1)

*Indicates one participant did not provide this data.

NHS = National Health Service; UK = United Kingdom; CBT= Cognitive Behaviour Therapy; No. of Post Qual years = Number of post-qualification experience (years)

Age ranges have been used to promote further anonymity

Interviews

Semi-structured interviews were used to facilitate and guide an open dialogue about therapists' experience of disclosing. An interview schedule (appendix D) was used but

the interviews were not restricted to the schedule because interviewees' personal experiences moulded the interview. This captured a wealth of diverse experiences from each participant. Open-ended questions were used to encourage in-depth and detailed responses, while allowing participants to discuss aspects that were pertinent to them. Reflective statements were used for clarification of descriptions that were unclear, while probes were used to facilitate more detailed accounts. Interviews were audio recorded, and on average lasted 60 minutes. During the interviews the first author (AH) made notes to aid reflection and to indicate areas of discussion that might prove useful to follow up.

Transcription and Analysis

All interviews were transcribed verbatim (including laughter, significant pauses, and hesitations) and AH made accuracy checks against the original recordings. This assisted familiarisation with the data ready for analysis. Participants were given a pseudonym and any identifying information (e.g. place names) was anonymised. We identified thematic analysis (TA) as a suitable analysis method for this research because of its ability to identify and analyse patterns (themes) of meaning in a data set (Braun & Clarke, 2006). TA is a flexible approach that can provide rich, detailed and complex accounts of data.

The current study was conducted from a contextual critical realist position, (Patomaki & Wight, 2000). It was recognised that each participant could develop meanings shaped by their own situation, environment, personality, experience and expectation. The impingement of wider social context on participant's meaning was also acknowledged (Borrell, 2008). Analysis used a hybrid of inductive deductive stances (Fereday & Muir-Cochrane, 2006), allowing the analysis to be data driven (Boyatzis, 1998), while being able to make use of *a priori* coding templates (appendix N) constructed from previous research (Crabtree & Miller, 1999). Using a hybrid approach has ensured that analysis could be grounded in the data (Braun & Clarke, 2013), allowing participants' experiences to be stated accurately and comprehensively. This would provide some flexibility for unknown themes to emerge. We acknowledge that as researchers, we cannot be fully free from the knowledge and theory already acquired within this area, which would undoubtedly impact on analysis (Braun & Clarke, 2006). We were

therefore mindful of our own preconceptions about this topic, and our own agendas, when analysing the data.

The analysis followed the six phase guide provided by Braun and Clarke (2006). In line with guidance, the approach was used flexibly to allow movement between each phase. Stages were revisited with transcripts and codes being checked to ensure accuracy throughout the analysis process. Transcripts were read and re-read to enable AH to become familiar with and immersed in the data. A systematic line-by-line analysis of each transcript took place. Initial codes were assigned, representing features of the data that were important in answering the research question. Initial codes were gathered into potential themes with codes being separated onto pieces of paper and ordered into theme piles, enabling links to be made between codes and themes. This facilitated the identification of the overarching themes, main themes and sub-themes which were ratified by the two other authors (DD and RdN). Initial themes were checked for accurate representations of the coded extracts by reviewing the transcripts with some themes being further collapsed. A thematic 'map' of the analysis was generated to demonstrate the conceptualisation of the data and their relationship. Finally, themes were refined and named, ensuring that the essence of the themes and encapsulated data was captured.

Results

The analysis revealed that disclosing one's sexual orientation was a contentious issue for the participants, with distinct rationales for and against disclosing sexual orientation appearing in each interview. The results (summarised in Table 8) are discussed in terms of the function of disclosure, the function of non-disclosure, and how disclosure happens (appendix E).

Table 8.

Thematic table presenting participants' conceptualisation of disclosure

Overarching themes	Main themes	Sub-themes
Function of Disclosure	Making a connection	Deepening rapport Being real versus being a fraud
	Communicating*	Safety Non-judgement Non-pathology
	Disclosure as an intervention*	Role model Shortcut Challenge or correct assumptions Toolkit Challenging homophobia
Function of Non-disclosure	Damaging the alliance	Similarity versus differences Being seen as a fraud*
	Risk	Judgement Personal safety Concealment*
	The client's focus*	Shifting focus Relevance
How Disclosure Happens	Pre-therapy disclosure	Physical world Online world
	During therapy*	Direct Indirect Accidental

*indicates the themes discussed in the extended paper.

Function of disclosure

For all participants, the function of disclosure was discussed under three smaller sub-themes: (i) making a connection, (ii) communicating, and (iii) disclosure as an intervention.

Making a connection

Participants rationalised their decision to disclose because it allowed the therapeutic process to be either kick-started or become enhanced. Some participants used disclosure as a 'short-cut' while others deemed that a disclosure should only be made once an alliance had been created and was strong enough to withstand the therapist bringing themselves into the room.

Participants' disclosure was related to deepening rapport between the client and the therapist. This was important when participants perceived that clients held back because of the assumed lack of understanding and empathy from the therapist. Participants' assumed their disclosure had a meaningful impact on rapport, which was based on how their clients' described their previous experience of therapy (e.g. a lack of understanding), while many assumed a deepening of rapport based on client changes they witnessed. Deepening rapport was seen to create space for the client to discuss their problems:

...to help make it ok for the client to talk about their stuff, whatever it is that they are going through, to strengthen and allow the deepening of that therapeutic relationship to the best of your abilities... And it just seems to go onto the next step in the therapeutic process, which is where you can build on and solidify that relationship... (Evelyn).

Disclosure allowed participants to harness a sense of similarity between them and the client, which facilitated an increased level of empathy expressed by the therapist. Therefore, there was a greater understanding of the client's experience, which made the connection stronger. Participants' experience of living within a heteronormative culture offered insight into the potential prejudice, stigma and homophobia faced by clients who identify as non-heterosexual. This knowledge and experience of a non-heterosexual lifestyle was situated between the participants' personal and professional role, therefore there was an insider insight in their work with non-heterosexual clients:

So it would be for them (laugh) to be able to feel more open, to feel a sense of similarity. So that they could think about themselves and their life without fearing a homophobic response or that they can't even talk about potentially their own internalised homophobia and what that may mean for them, yes. (Paul).

All participants agreed that disclosing was done in the 'best interests of the client' and that the aim was to enhance the therapeutic alliance: 'it has a positive function it could be affirmative, helpful in the way of giving the patient a role model, helping the patient feel more understood or making your solidarity more authentic' (Wendy). Participants felt that it was important for the client to feel understood and accepted by the therapist.

Nonetheless, a small proportion did say that they made a distinction between a disclosure during the assessment phase (where they would make a disclosure) and the intervention phase (where they would explore the client's rationale for asking and potentially not disclose anything).

Participants who identified as 'person-centred' based their decision to disclose on their congruence with the client. Some participants discussed how it was important for them to 'be real with clients' (Evelyn). Their need to be real was identified to provide the client with authenticity within the relationship; and to allow the therapist to stop pretending that they are something that they are not: 'In some ways it's a relief [to disclose] because it means that I can stop pretending, um, I hope that I wouldn't pretend anything to clients so why would I feel like I need to pretend my sexuality. So in some ways it's a relief' (Janet).

The need to reveal just enough of themselves within the relationship was to allow the client to reciprocate that. Encouraging the client to be real was seen as generating better outcomes because there was no need to withhold anything within the relationship. This was tempered with therapists' need to maintain their professional boundaries. Further instances of the participants wanting to be real with clients were related to the potential that the therapist could be 'outed' (e.g., being seen in a gay bar, at a pride event, or through LGBT activism). There was a definite fear of being seen as a 'fraud' by the client if a disclosure had not been made and the client 'found out' through other means. Participants felt that this would cause trust and the alliance to be damaged.

Function of Non-disclosure

Participants talked freely about their experience of non-disclosure, offering insight into the reasons for withholding their sexual orientation. Participants highlighted that they would not disclose their sexual orientation to heterosexual clients, for reasons (discussed below), which conflicted with their reasons for making a disclosure. Three

clear subthemes were identified for not making a disclosure: (i) damaging the alliance, (ii) risk, (iii) the client's focus, the first two will be discussed here.

Damaging the Alliance

Participants offered an insight into the potential damage a disclosure of sexual orientation could have on the therapeutic alliance, often stating that they would withhold a disclosure of sexuality to clients who they assumed were heterosexual. Participants did not see that it was important for their heterosexual clients to know: 'What it doesn't mean actually is that I would automatically disclose with other clients, with non-gay clients, because I don't think it has the same relevance there' (Simon).

Many expressed that they thought sexuality was not an issue that was pertinent to heterosexual clients, with some suggesting it was not on the radar of heterosexuals. This view is based in the assumption that sexuality is only an issue for those who are different to the heterosexual majority. Disclosure to heterosexual clients was felt to be potentially damaging because it highlighted differences between the client and therapist. Again, participants assumed that they were acting in the client's 'best interests' and that to make a disclosure when a client's issue was not related to sexuality was inappropriate, and made therapy about the therapist.

For some participants this view is contradicted by their view of it being important to disclose therapist sexual orientation to non-heterosexuals, regardless of the client's problems. However, this was tempered by the majority of therapists acknowledging that a disclosure to a non-heterosexual client did happen when the client asked the therapist about this directly. However, they would feel compelled to make a disclosure following exploration when challenged by a non-heterosexual client, but if a heterosexual asked such a direct question, the participants explored the client's motives for asking - often withholding a disclosure. Some participants were conflicted about their own stance on disclosure and were able to recognise that for non-heterosexual clients there was one rule and for heterosexual clients there was another: 'Um, and I suppose, to be perfectly honest one could argue that there are double standards going on here, in the sense that, I don't disclose anything about myself in order that things can happen in the transference and I have a policy with that...' (Simon).

The experience of withholding a disclosure was also discussed by other participants, who thought that disclosing their sexuality to heterosexual clients would be counterproductive when trying to build and maintain rapport, because such a disclosure would only highlight differences. This contradicted therapists' explanation of disclosure when working with non-heterosexual clients. In these cases disclosure of sexuality was viewed as enhancing the alliance between the non-heterosexual client and the therapist:

I've realised that I've only been talking about disclosure of my sexual orientation to gay people, because it has occasionally happened to people who don't identify as LGBT, so one of the complications is that they feel that you don't understand them as well because they might identify as heterosexual and as a non-heterosexual there is no way that I could comprehend that so there is the danger that it could distance them (Brad).

Risk

Participants expressed different ways in which they felt at risk during the therapeutic process and this was discussed in how participants' perception of risk prevented them from making a disclosure. Some participants recognised that the differences in their way of approaching TDSO was linked to how they felt client perceptions would change if a disclosure was made: 'But I guess I do hide behind the non-disclosure of sexuality with heterosexual clients on the basis that there might be a danger that I might be viewed differently, um if they knew I was gay' (Simon).

Some therapists stated that they would withhold a disclosure when working with a heterosexual because of a fear that the client would judge them based on sexual orientation: 'It might be that patients don't accept me as a therapist anymore' (Wendy).

Expectation of being judged was identified by some as being linked to their own internalised shame and guilt, because they were experiencing shame related to their sexual identity because of previous stigma and prejudice that they had experienced within society. Participants who identified these internal processes were keen for them not to interfere with the therapeutic process and therefore making the decision not to disclose their sexual orientation was used as a way of keeping their internalised shame out of the therapeutic space. Although, some identified that they felt they should not

feel ashamed of being who they are, they continued to hide their sexuality in the therapeutic space:

There is the additional thing about internalised homophobia and the fact that I was silenced for many years of my life, overtly and covertly, so there's that additional thing going on. But what I am feeling more and more is because we have always having an internal debate about disclosure; we should still feel more comfortable about disclosing. (Martin).

For some participants the function of non-disclosure was related to personal safety because the therapist felt threatened by the homophobia exhibited by the client: 'I've had it whereby it just hasn't felt quite safe. There was one person in particular who did express very, very homophobic attitudes and racist attitudes and I just felt no...' (Evelyn).

Withholding a disclosure was also thought of in terms of not wanting to give the client cause to discriminate against the therapist because of their sexual orientation. Concealment occurred due to the participants' discomfort, and due to the fear of discrimination. Participants also feared that this would directly impact on therapy outcomes.

How Disclosure Happens

There were numerous ways participants make disclosures to clients. This section highlights that the participants identified different ways of sharing personal information, such as sexuality, without there being a verbal disclosure (from themselves). The results also highlighted that a disclosure can be made without the therapist being present.

Pre-therapy Disclosure

There were various ways that participants disclosed their sexual orientation prior to meeting the client. The way that this was done depended on the referral route of the client. Participants identified that clients would either be referred by other professionals (e.g. GP, colleague, and agency) or through self-referral after the client had seen an online directory or a professional website that the participant was advertising on: 'I'm hesitating because with X directory, my sexuality is on the website. So if they see the

directory it's there already so I assume that they already know and that it's not a secret' (Janet).

Some participants discussed how it was common for the referrer to make a disclosure about the participant's sexuality to the client. Participants' understanding of this was that the client was believed to have a need that would be best met by seeing a non-heterosexual therapist. This was generally regarded as positive; however, one participant described how he felt his control over his disclosure was removed by the referrer in these situations. This participant also felt unable to confront those who made the pre-therapy disclosure because his reputation and sexuality had spread by word of mouth and therefore it was uncontrollable. For this participant the client knowing the therapist's sexual orientation was not always helpful; there was the potential that the dynamic between the client and therapist had been generated artificially with information that the therapist has not willingly given.

Work context was another factor that mitigated the participants' disclosure. In a few examples of pre-therapy disclosures, participants acknowledged that the 'choice' was taken away from them because of the organisational policy within the workplace. In some work places it is a requirement of the organisation that a therapist's sexual orientation is articulated (e.g., on websites) for potential clients to see. This was the case when one participant worked for an LGBT mental health charity. In this setting the participant discussed how he felt annoyed and unsure when the disclosure was made for him, but also how he felt compelled to comply with the organisation's requirements because his sexuality was the main reason that he was offered the position:

Initially I was very wary about it and it was nobody's business and why would they do that? But had to accept that I had gone there, had a placement and part of the reason I was accepted was that I was a gay male and they wanted gay men and so therefore it was part of the package and either I wanted it or I didn't it, it was non-negotiable (John).

The type of community that the participants lived and worked within were discussed as a potential way of sexual orientation being disclosed. Participants described how non-heterosexual communities are often very small, even in large towns and cities, and if the therapist works and lives in a community that is also small, there is the potential that clients will know something of the therapist prior to therapy.

Participants agreed that by being on ‘the scene’ it was possible to disclose their sexual orientation, though it was unusual for the participant to associate themselves with such settings, there was still the potential to disclose:

...I’m in a town where there’s a limited amount of gay bars, which I don’t tend to go to them so much now... Erm, but I tend to think that, it’s also, I’m also not going to conceal myself (laugh). So I’m not going to not go to certain places in case I meet clients (Percy).

However, Percy states that he is making an active choice not to conceal his sexual identity through avoiding going to places where his sexuality could be given away. This is in contrast to Percy’s general view about disclosure, where he felt that the therapist’s sexual orientation should rarely be disclosed to the client, even if the therapy or therapeutic alliance could benefit. Here we see that outside of the therapeutic setting Percy is unwilling to hide his sexuality, but that in therapy he believes that concealing his sexuality is highly important because of the transference emerging between the client and therapist. This highlights a paradox that many participants discussed; they wanted to be seen as a ‘blank slate’ during the therapeutic process because they wanted to keep therapy client-focused, nevertheless, these participants advertised their service on the directories and/or information about their sexuality could be discerned (rightly or wrongly) through simple internet searches which revealed previous research disclosing the participants orientation or previous jobs linked to well-known LGBT mental health organisations. These experiences highlight that participants were aware of multiple ways in which their sexual identity could be potentially disclosed to prospective clients. For many participants this was the most frequent form of disclosure that was made outside of the therapy room: ‘...as I say because I’m online, really people can find me, with the website saying that I’m gay’ (Henry). Many of the participants identified that LGBT online directories and professional websites formed part of their referral source, however they recognised there were various referral sources which were not specifically linked to LGBT affirmative practices.

Discussion

The current study highlights three overarching themes: (i) the function of disclosure, (ii) the function of non-disclosure, and (iii) how disclosure happens. Generally participants discussed disclosure as beneficial when working with non-heterosexual clients due to the positive consequences that disclosure has on the therapeutic alliance. However, participants were more cautious about disclosure when working with heterosexual clients. Participants agreed there was less relevance for this group to be privy to this information, and withholding such disclosure was seen to prevent a rupture in the working alliance. The findings within the first two over-arching themes indicate that the participants are conflicted in their use of TDSO. Disclosure was seen to occur in numerous ways and often without the participant verbalising the disclosure, with pre-therapy disclosure being very common amongst this sample.

The function of disclosure

In the current study participants described how they perceived their disclosure of sexuality to have the same enhancing properties of more general disclosure. Participants noted that they were more likely to disclose their sexuality to clients they knew or believed to be non-heterosexual. The participants' experience and insight into the negative impacts of exclusion and homophobia facilitated a context of disclosure that was unique. Participants described increased empathy and understanding to the client's potential discomfort of working with a heterosexual therapist situated within a heteronormative context (Bartlett, Smith & King, 2009; Lea, et al., 2010; Rochlin, 1982). Thus, disclosure enhanced the therapeutic alliance through allowing the client to engage meaningfully in therapy, being an insider rather than an outsider (Frommer, 1995; Lea, et al., 2010). Participants reflected on the enhancing impacts of their disclosure to non-heterosexual clients, highlighting that clients also experience therapist disclosure as helpful because it allows genuineness within the relationship, while the client could use their therapist as a positive role model (Audet & Everall, 2003; Hanson, 2005). From the participants' perspective, disclosure was used to facilitate the normalisation of the client experience; it enabled reciprocal disclosures from the client (e.g., allowed the client opportunity to express their own sexuality); created a therapeutic space that was safe, non-pathologising, non-judgemental; and provided a role model for the client. These have also been cited by other authors as potential

functions of disclosure (Faber, 2006; Lea, et al., 2010; Jeffery & Tweed, 2014), particularly so for non-heterosexual therapists working affirmatively with gay clients (Davies, 2007; Milton, Coyle & Legg, 2002; Moon, 2008). Studies researching the crucial ingredients to therapy have highlighted that it is non-specific techniques (e.g., warmth, empathy, understanding, similarity, authenticity) and the therapeutic alliance that are the most effective at bringing about therapeutic change (Norcross, 2002; Wampold, Minami, Baskin & Tierney, 2002; Wampold, et al., 1997), which this study's participants cite as the function of their disclosure: to harness and strengthen the alliance with non-heterosexual clients.

Participants were mindful of disclosures only being made to benefit the client in some way. Disclosure that did not benefit the client was seen to change the focus of therapy away from the client unnecessarily, nullifying the purpose and uniqueness of the alliance (Farber, 2006). Their rationale for this was that it was unethical to disclose anything that would serve the therapist in some way, because the therapeutic space was for the issues that the client was presenting with, not for the therapist to resolve their own problems. It was interesting to note that all of the participants highlighted that if a disclosure was made that it was only done in the client's 'best interests'. However, during the interviews this became part of a mantra as if the participants were reciting verbatim their professional body's own guidance, with many referring to the guidance provided by such organisations. It is interesting to note that, in the majority of interviews, there was an absence of how the disclosure could have benefitted the *participant* in some way. It is plausible that participants censored their experiences of disclosure because of the discourses surrounding inappropriate disclosures and how the participants may be perceived by other professionals. Furthermore, participants were aware of restrictions of ethical approval of this study. If participants revealed anything that the researchers deemed to be 'risky or unethical' then the interview would be terminated. This may have caused participants to withhold information that could be perceived as such.

The function of non-disclosure

Participants appeared conflicted about making a disclosure. There was a consensus that they would withhold a disclosure to a heterosexual client. There is limited evidence suggesting that divulging a sexual identity within healthcare settings can damage the

relationship between the client and the professional (Lee, Melhado, Chacko, White, Huebschmann & Crane, 2008). Disclosures were withheld because of a fear of damaging the alliance; therefore non-disclosure would prevent a rupture. This was because the therapist wanted to maintain the sense of similarity, empathy and understanding between the LGBT therapist and the heterosexual client. Participants feared that by making a disclosure they would highlight differences, which could potentially cause the client to wonder if the therapist understood their experience. Participants made sense of this in terms of non-specific techniques that facilitate the greatest therapeutic change (Norcross, 2002; Wampold, et al., 2002; Wampold, et al., 1997). Therefore, generating difference and distance was seen as counterintuitive.

Participants described concern that a heterosexual client would 'judge' them and they 'feared' being stigmatised by clients because of sexuality. The participants' responses were mainly linked to their assumptions of how they would expect heterosexual clients to react. Minority stress model highlights that members of minority groups come to expect prejudice and discrimination because of their minority status (Meyer, 2003; 1995) due to wider societal attitudes and discourses. Participants explained that their own internalised shame and homophobia was a mediator in disclosure and participants linked their previous experiences of suffering homophobia and how they wanting to avoid re-enacting this within therapy. For some participants this produced damaging psychological effects including guilt, shame and feelings of not being honest. Such experiences internalised by some of the participants were evident even when the participant recognised that concealing their sexual orientation was for the client's 'best interest'. Central to this is the 'coming out' process which is seen as an essential way of non-heterosexual individuals achieving a healthy self-perception (Davies & Neal, 1996; Rosario, Schrimshaw & Hunter., 2011).

The majority of participants' indicated that they were aware of at least one set of professional guidelines related to TDSO. As highlighted earlier, therapists are warned off TDSO because of the potential that clients could misconstrue the therapists' actions of disclosing their '*preference*' as a come on (CHRE, 2008, p. 13). Therefore, it could be argued that participants do not disclose to heterosexual clients for fear of being seen as a sexual predator or by trying to satisfy their own sexual needs.

How disclosure happens

It appears that there are numerous ways in which therapists can disclose their sexuality to clients. The majority of participants stipulated that they worked privately and were members of multiple online directories with some stating that they had worked for LGBT organisations. This provided a unique context for TDSO because therapists' sexuality was known to clients prior to therapy, with TDSO being required in advertising or by the organisation (Lea, et al., 2010).

Unintentional and non-verbal disclosure was highlighted as an alternative way in which therapists disclosed (Farber, 2006; Lea, et al., 2010; Knox & Hill, 2003). This finding highlighted the importance of client assumptions in the process of TDSO and in some cases a direct disclosure was not necessary. This was essentially the case when clients and therapists shared the same LGBT community. Sharing 'the scene' or unexpectedly meeting clients at pride events added to the participants' dilemma of disclosure. In these contexts TDSO was unintentional, but the risk of being 'outed' in such events appeared to push participants to make a verbal disclosure to avoid anxiety or a rupture in the alliance. Participants also discussed how likely it is the clients, particularly private clients, would research their therapist prior to the first session (Lea, et al., 2010). Known as the 'Google Factor' (Zur, 2008) this added a further complexity to participants' disclosure because the client would be privy to information about the therapist that the participant may not want to disclose, in this case sexuality.

The paradox of the "blank slate" appeared during the study. Some participants were keen to withhold information about themselves, while using their home as a clinic. Some participants stated that clients became aware of their sexuality because of cues picked up from the home (e.g. meeting partners at the front door, many books on show about LGBT matters or clients commenting on wedding rings). For example, gay clients are seen to be sensitive to cues of sexuality (e.g. manner, tone, jewellery) with sexuality being 'invisibly visible' to the gay client (Lea, et al., 2010, p. 69; Satterly, 2004). This finding highlights that therapists may be unaware of how they can leak disclosures about themselves unintentionally. The concept of leaking disclosure is also present for heterosexual therapists, but is seen as less of an issue in the context of a heteronormative society. For example, although 'gay marriage' has been legalised in the UK, for many a wedding ring is synonymous with a heterosexual lifestyle.

Limitations and future research

Previous self-disclosure literature has attempted to highlight the function disclosure may serve from the client's perspective and the therapeutic outcome (see Henretty & Levitt, 2010 for review). However, such literature has not directly focused on the disclosure of sexual orientation, which is often seen as a taboo topic. Previous reviews also utilised quantitative methodologies that have failed to consider the contextual factors that influences the decision-making process and the perceived outcomes of disclosure (Jeffery & Tweed, 2014). It is acknowledged that participants may have censored their accounts especially when discussing the instances that have not gone so well in therapy, which could be the focus of future research in this area.

The current research adds to the nascent literature in this area, supporting the findings of more recent studies (Jeffery & Tweed, 2014; Lea, et al., 2010; Moore & Jenkins, 2012; Satterly, 2006), with a larger sample and a wider range of therapists than has gone before. The study provides insight into the function of non-disclosure and illustrates the multiple ways that a disclosure can be made, both of which are novel findings in this area and allow us to understand better the complexities of disclosing sexual orientation. Future research would benefit from gaining a wider international sample, something that was not possible in this study. Doing so would provide a perspective on therapist disclosure of sexuality that is not based on a majority UK sample. This would also help researchers examine differences in disclosure trends across cultures. The recruitment source of the sample may have biased the results. Many of the participants identified that they had seen the study advert through a specific organisation. It became a theme in the analysis that many of the participants used some directories as a way of generating referrals. Therefore *how disclosure happens* may be influenced by the stipulation of disclosing sexuality on gay-affirmative directories. Thus, this sample could over represent the number of therapists who make pre-therapy disclosures in this way.

The minority stress model suggests that stigmatised individuals develop their minority status through negative appraisal of themselves, which is in line with the cognitive model of psychological distress (Beck, Rush, Shaw & Emery, 1979). However, the model proposed has little or no explanation of how these beliefs may develop in the first instance, which is a significant limitation in its explanatory power. Furthermore, the model states that minority members learn to expect negative reactions from members of

the dominant groups within society, but fails to explain how this learning takes place (i.e. does learning occur through a process of classical and operant conditioning (Mowrer, 1960; Pavlov, 1927; Skinner, 1937), or by the process of the modelling of such behaviour in social learning theory (Bandura, 1977).

Clinical implications

Reviews suggest that therapist self-disclosure can have a positive impact on clients and it has been reported that therapists need to consider the use of self-disclosure as a vehicle for therapeutic change (Barrett & Berman, 2001; Hanson, 2005; Henretty & Levitt, 2010; Rochlin, 1982). Findings from the present study may provide useful insight into to psychological benefits of therapists disclosing sexuality to clients by combatting the impacts of minority stress and 'outsider syndrome' experienced by non-heterosexual groups because of the normalisation of non-heterosexual identities. Minority members respond to discrimination through coping and resilience (Allport, 1954; Clarke, et al., 1999). While a minority status can be viewed as stressful, it can also be as protective factor generating solidarity and cohesiveness for group members, therefore reducing the adverse psychological impacts of minority stress (Branscombe, Schmitt, & Harvey, 1999; Clark et al., 1999). By coming out non-heterosexuals learn to cope and overcome adverse stress (Morris, Waldo, & Rothblum, 2001), through establishing alternative values and structures that enhance their group (Crocker & Major, 1989; D'Emilio, 1983). Therapist disclosure could therefore provide similar positive psychological impacts for clients through the perception of group affiliation; stigmatised individuals have the opportunity to experiences social environments where they are not stigmatised (e.g. clients having their experiences normalised by a non-heterosexual therapist, not feeling judged or pathologised by professionals) (Jones, et al., 1984).

Finally, it is important to consider that coping can also have adverse stressful impacts (Miller & Major, 2000). For example, concealing one's stigma is a common way of coping with stigma, generally to avoid negative regard, however as highlighted there is a heavy cognitive burden on the person using this coping strategy (Smart & Wegner, 2000). Based on this it could be essential that non-heterosexual therapists are encouraged to discuss, explore and reflect on the potential psychological impact that having to conceal their sexual identity is having upon them and their clinical practice.

This also raises the question of how focused the therapist is on the client's problems if they are heavily invested in concealing part of themselves, which could be the focus of future research.

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Extended Paper

EXTENDED PAPER

EXTENDED INTRODUCTION

This section expands on the journal paper, providing an overview of the relevant literature, and forming the rationale for the current study and the research aim.

Background research

What works in therapy?

Clinicians and researchers alike have made attempts to understand the crucial ingredients in therapy, trying to answer the elusive 'what works' question (Norcorss, 2002). The majority of the research conducted to date strongly suggests that non-specific factors such as warmth, empathy, understanding and therapeutic alliance that are the most effective at bringing about therapeutic change, regardless of therapeutic orientation (Lambert & Barley, 2001; Spielmans, Pasek, & McFall, 2007; Wampold, et al., 2002; Wampold, et al., 1997). Within this area of research the use of the therapist's own identities, through therapist self-disclosure (TSD) and the impact this may have on the therapeutic process has become an area of interest.

Therapist self-disclosure

TSD can be considered as the therapist revealing information about them that the client would not otherwise be privy to (Norcross, 2002). Some class TSD as an intervention that appears to build rapport, promote universality, provide a sense of similarity between the therapist and client, encourage the client and model appropriate behaviours, while providing a normalising experience and encouraging alternative views (Farber, 2006; Jeffery & Tweed, 2014;; Knox & Hill, 2003). Literature also sights potential reasons for withholding a disclosure, which include: altering boundaries within therapy, burdening the client with the therapist's information and altering the focus from the client to the therapist (Hill & Knox, 2001).

Reviews suggest that TSD can have a positive impact on clients and it has been reported that therapists need to consider the use of self-disclosure as a vehicle for therapeutic change (Barrett & Berman, 2001; Hanson, 2005;

Henretty & Levitt, 2010;; & Rochlin, 1982). However, non-judicious therapist disclosure is also not helpful (Audet & Everall, 2003; Gelso & Mohr, 2001). Some clients may report that therapist disclosure has enhanced the alliance and overall outcome for therapy (Hill & Knox, 2001); however therapists should always have a clear rationale for making a disclosure and have thought about the use of the disclosure in facilitating therapeutic gains (BPS, 2012). TSD is a belligerent topic between professionals (Farber, 2006; Moore & Jenkins, 2012; Peterson, 2002). Despite this, literature suggests that TSD is routine in therapy (Henretty & Levitt, 2010). Over the past decades there has been increased interest in theoretical and research regarding TSD suggesting that there is a shift in focus from intrapersonal aetiology for distress to interpersonal understandings (Farber, 2006). TSD has received much attention from researchers, however by comparison very little attention, has been given to the phenomenon of therapist self-disclosure of sexual orientation (TDSO), particularly amongst lesbian, gay, bisexual and trans (LGBT) or non-heterosexual therapists to their clients.

Therapist self-disclosure of sexual orientation (TDSO)

Early studies have highlighted that shared sexual orientation between therapist and client enhanced the therapeutic relationship because of increased empathic understanding, genuineness, positive regard, openness, confidence and mutual disclosure all of which were reported to have increased the probability of successful therapeutic outcomes (Liljestrand, Gerling, & Saliba, 1978; Rochlin, 1982). It has further been argued that having similar sexual orientations between the therapist and the client impacts upon the client perception of therapist helpfulness, with therapists whose orientations are not disclosed being seen as less helpful (Liddle, 1996).

Non-heterosexual people often experience stigma, even though, within society, there is increasing awareness of LGBT individuals' experience of stigmatisation (Corrigan, et al., 2009). It is generally accepted that gay affirmative therapy can be delivered by well-informed therapists regardless of their own orientation (Liddle, 1996; McGeorge & Carlson, 2011), but evidence also suggests that

matching sexual orientation between client and therapist can be beneficial (Burckell & Goldfried, 2006; Jones, Botsko, & Gorman, 2003; Liddle, 1996).

From a gay affirmative perspective TDSO could have the potential to reduce power disparities and create a more equal and honest therapy (Barker, 2006; Lea, et al., 2010). It is argued that TDSO may be noticeably salient when the client and therapist share a non-heterosexual orientation, with some authors suggesting that therapists consider disclosing sexuality on a case-by-case basis (Guthrie, 2006; Milton, Coyle & Legg, 2002).

Research acknowledges that disclosure can provide an opportunity for the therapist to 'be real' with the client, provide normalisation, deepened rapport, challenging clients' assumptions, provide a positive role model and allow the client to make reciprocal disclosures thus having a positive impact on therapeutic outcomes (Hanson, 2005; Lea, et al., 2010; Moore & Jenkins, 2012). Counsellor disclosure of sexuality has been cited by clients as being an important part of the therapeutic process with 92% of the sample (n=25) stating disclosure was essential for developing the alliance (Galgut, 2005). Participants' discussed previous experiences of unhelpful situations where presumed heterosexual therapists had not disclosed their sexuality and the participants felt that there was a lack of understanding of being a lesbian within society. It was further highlighted that heterosexual therapists would not allow an open discussion regarding sexual issues. Others have reported that participants stated wanting to know their therapist's sexuality in order to feel safe (Galgut, 2005; Knox, Hess, Peterson & Hill, 1997). Furthermore, Barrett and Berman (2001) indicate that there are positive outcomes for the client from the appropriate use of TDSO: removing barriers, adding credibility to the clinician while facilitating client empowerment (Jeffery & Tweed, 2014). These factors were generally seen to counter the potential negative effect of perceived exclusion and homophobia expected by the client, because of the perception of the therapists having increased empathy (Evans & Barker, 2010; Lea, et al., 2010;), removing or decreasing stigma associated with sexuality (Satterly, 2006; Thomas, 2008); and harnessing a shared understanding through being a more credible source of help (Atkinson, Brady & Caas, 1981; Henretty and Levitt, 2010). Research has further highlighted that disclosure should be made

judiciously, keeping in mind the best interests of the client (Lea, et al., 2010; Moore & Jenkins, 2012). Some researchers have postulated that perceived similarity between the client and therapist is a factor which may influence the therapist's decision to disclose (Guthrie, 2006). However, use of TDSO remained limited and participants were uncertain of its use. Such uncertainty appears to be attributed to potential client reactions and the therapists' fear of rejection, discrimination and internalised homophobia (Lea, et al., 2010; Moore & Jenkins, 2012; Thomas 2008).

In contrast non-disclosure can be experienced as negative and could lead to potential ruptures in the alliance (Ehrenberg, 1995; Hanson, 2005). Research suggests that therapist non-disclosure can inhibit clients from disclosing information about themselves and can be destructive to the therapeutic alliance (Hanson, 2005). Hence, these findings suggest that TDSO can be an important part of therapy.

Nevertheless, some authors argue that TDSO can have a negative impact on the clients' experience of therapy, suggesting that some clients do not find it useful to know the therapist's sexuality (Mair, 2003). Other negative impacts for therapy include, removing the focus from the client's problem; the potential for disengagement of some clients (attributed to TDSO) (Moore & Jenkins, 2012); meeting the needs of the therapist over the needs of the client (Lea, et al., 2010); and inhibiting a fully shared understanding and prevent exploration (Guthrie, 2005; Thomas, 2008), with Barker (2010) cautioning that assumed similarity can be risky, highlighting that shared understanding is not indicative of a shared meaning. In addition, Audet and Everall (2003) suggest that TDSO may hinder the client exploring their own issues as they feel the need to protect the therapist from discomfort, including the client's own internalised homophobia⁹ (Evans & Barker, 2010).

⁹Internalised homophobia is the internalisation of societal antigay attitudes in gay men and lesbians. Conceptualised as "the gay person's direction of negative social attitudes towards the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard" (Meyer & Dean, 1998, p. 161). Coming out is a process where the individual generates a healthy identity of themselves and their sexuality (Cass, 1979). Internalised homophobia signifies that the coming out process has not been successful in overcoming the negative self-perceptions (Morris, et al., 2001)

Gelso and Mohr (2001) further identified that disclosure could have a negative impact on therapy outcomes because of the development of a “superficial pseudo-alliance”, slowing the therapeutic progress, therefore reducing the effectiveness of the therapeutic alliance and increasing the time in which therapeutic gains can be made. Furthermore it is reported that therapists seldom admit to disclosing sexual orientation because of uncertainty attributed to potential client reactions (e.g. rejection and discrimination), the therapists’ sense of internalised homophobia and concerns over being seen as ‘predatory’ and using disclosure in a self-serving way (Moore & Jenkins, 2012, p. 312). These findings offer a fragmented and conflicted evidence base, which is grounded on narrow sample sizes. Such studies have offered a much-needed starting point, however, there is a need for a far greater empirical evidence and broader understanding of TDSO.

Coming out and therapy

Coming out is one of the main ways that non-heterosexual individuals learn to overcome adverse stress (Morris, Waldo & Rothblum, 2001) because alternative values and structures are established that fit better with their identity (Crocker & Major, 1989; D’Emilio, 1983). It is suggested that gay men are prone to develop outsider syndrome because the gay child perceives themselves to be an alien within the family, often adopting the identity of an outsider before the nature of the difference can be labelled (Frommer, 1995) which is carried through to adolescence and adulthood. It is argued by Rochlin (1982) that openly gay psychotherapists are able to embody a positive role model, share enhanced empathy and have knowledge of gay culture, reducing the need of the therapist to be educated by the client. Each of these may act to counter the client’s sense of outsider syndrome (Lea, et al., 2010). Literature suggests that TDSO can be useful for LGBT clients because it provides a challenge to heterosexism, can act to reduce the client’s feeling of isolation, provide a greater therapeutic alliance, allow the LGBT client access to positive role models and provide a space that is safe away from judgement, facilitated by the therapeutic alliance (Lea et al., 2010; Moon, 2008; Davies, 2007). Therefore,

therapist disclosure could provide similar positive psychological effects for clients through the perception of affiliation with their therapist; thus stigmatised individuals have the opportunity to experience social environments where they are not stigmatised (e.g. clients having their experiences normalised by a non-heterosexual therapist, not feeling judged or pathologised by professionals) (Jones, et al., 1984).

Minority Stress Model (MSM)

What is stress?

Stress is defined as an external condition or event that places demands on an individual. These demands often exceed the individual's perceived ability to cope or endure. Therefore prolonged stress has the potential to cause psychological and somatic ill-health (Meyer, 2003; Dohrenwent, 2000). Within psychological literature, stressors are defined as incidents that induce change and require adaptation from the individual in order to cope (e.g. losing a job, moving house, etc.). Stress theory has been extended to the concept of social stress by signifying that social environments (as well as personal events) are often stressful and have the potential to develop the physical and psychological impacts of stress. Stress is increasingly described as a transaction (Lazarus, 1999; Lazarus & Folkman, 1984) where an individual's appraisal is seen to significantly mediate the stress response (Lazarus, 1999). By extension social stress could therefore have an effect on stigmatised groups within society, including race, gender, sexuality and socioeconomic status. From this, prejudice and discrimination could then be conceptualised as stressful (Meyer, 2003; Clark, Anderson, Clark & Williams, 1999). This idea is both conceptually difficult and naturally appealing; stress is still conceived as a personal event rather than in social elements (Hobfoll, 1998; Lazarus & Folkman, 1984), however, it draws on psychological theory of environmental and social experiences being stressful, while acknowledging that individuals must be viewed within their own context (Meyer, 2003; Allport, 1954).

Minority Stress

An elaboration of social stress theory is *minority stress*. This concept stems from the idea that individuals from stigmatised social groups are exposed to

excessive stress as a result of their minority position within society. Minority stress is inferred from numerous social psychological theories discussing the adverse impacts of social conditions (e.g. prejudice and stigma) on individuals within that group (Allport, 1954; Crocker, Major, & Steele, 1998; Goffman, 1963; Jones et al., 1984; Link & Phelan, 2001)

Social psychological theories help us understand intergroup relations and the impact of minority positions have on health. Self-categorisation and social identity theories allow us to understand intergroup relations and the impact they have on the individual. Such theories suggest that categorisation (e.g., distinction among social groups) generates important intergroup processes (e.g., discrimination and competition), providing a base for group and self-definition (Tajfel & Turner, 1986; Turner, 1999). The social environment provides individuals with meaning in their world and allows them to organise their experiences (Stryker & Statham, 1985), therefore interactions are crucial for the development of a sense of self and well-being. Symbolic interaction theories suggest that negative regard from others leads to negative self-regard. Likewise, social evaluation theory suggests that humans learn about themselves by making comparisons to others (Pettigrew, 1967). By extension, both theories suggest that stereotypes, prejudice and discrimination directed at minority groups could trigger adverse psychological effects, something highlighted by Allport (1954). There is a conflict between the individuals and their experience of society that is the essence of all social stress (Lazarus & Folkman, 1984) with ambient stressors being associated with position within society (Pearlin, 1999b). Therefore, if the individual is an affiliate of a stigmatised minority group, the conflict between the dominant culture and the individual can become arduous, resulting in significant stress (Allison, 1998; Clark et al., 1999).

Meyer (2003) suggests that there are three processes of minority stress that are relevant to LGBT individuals. These include: external objective stressful events and conditions (chronic and acute), expectation and vigilance of such events, internalisation of negative societal attitudes. Meyer (2003) further postulates that one more stress process is important to consider: the concealment of one's

sexual orientation. This is seen as a proximal stressor because its impact is on internal psychological process (Cole, Kemeny, Taylor & Visscher, 1996a, 1996b; DiPlacido, 1998; Jourard, 1971; Pennebaker, 1995).

Coping with minority stress

Vigilance is described as defensive coping strategy to combat prejudice (Allport, 1954), enabling the explanation of the stressful effect of stigma. Similarly to other minority groups, LGBT individuals learn to expect negative favour from society, developing vigilance is a means of warding off discrimination. If there is a high level of perceived stigma there is the greater need to be increasingly vigilant during interactions with members of the non-minority group. The level of vigilance required is chronic and repeatedly enacted (Meyer, 2003). Maintaining this level of alertness is likely to require substantial energy and activity.

Minority stress model takes into account the impact of concealing one's stigmatised identity may have on minority groups. For many LGBT individuals concealment is often utilised as a coping strategy, facilitating the avoidance of the negative impact of the stigma attached to their orientation therefore serving to protect themselves from physical attacks or shame (D'Augelli & Grossman, 2001). However, this strategy can become stressful in itself (Miller & Major, 2000). Smart and Wegner (2000) postulated that hiding one's stigma can result in a significant cognitive burden due to the preoccupation with hiding. Concealment of sexuality is seen as a significant source of stress for LGBT individuals, because of the constant monitoring of behaviour e.g. how one dresses, acts, speaks, and walks, etc. (DiPlacido, 1998; Hetrick & Martin, 1987). Therefore minority stress suggests that stigmatised individuals attempt to cope with social stress (e.g. prejudice and discrimination) through vigilance and concealment, both of which can cause a significant cognitive burden on the individual because of constant self-monitoring (Meyer, 2003).

Study Rationale

Non-heterosexual therapist disclosure of sexuality is widely accepted to have positive effects on the therapeutic alliance and therapeutic outcomes, as discussed above (Hanson, 2005; Jeffery & Tweed, 2014; Lea, et al., 2010; Moore & Jenkins, 2012; Satterly, 2006). Such studies have offered a much-

needed starting point, however there is a need for a far greater and broader understanding, but findings can be are fragmented and based on narrow sample sizes. More recently, research has started to highlight the psychological impacts of non-disclosure on non-heterosexual clinicians (Jeffery & Tweed, 2014; Moore & Jenkins, 2012), which appear to be somewhat novel. Non-heterosexual therapists face difficult positions because they must “negotiate an intricate balancing act between self and client welfare in an ethical manner” (Rees-Turyn, 2007, p.8). Within the guidelines TDSO is a contentious issue; however, it is unclear if any of the guidelines are based on empirical research or if they are conceptualised within heteronormative culture. In light of this it is important to study and understand the rationales that therapists’ have for disclosing their sexuality to clients.

From the available literature it is also noted that there are a greater number of female, lesbian participants compared to male, gay participants, which can lead to biases in the data reported. We also acknowledged that many of the studies reviewed here do not include individuals who class themselves as bisexual or trans, which again leads to an underrepresented population within the research area. The current research sought to sample a diverse range of participants representing a wider demographic of individuals. A further limitation of the literature reviewed here is that the samples have been selected from small geographical areas. This may have an impact of the kind of experiences that participants have had regarding TDSO. The current study sought to recruit therapists from a national and international level, which we hoped would provide a range of experiences and increase the richness of the data collected. This research looked to expand the definition of a “therapist” to psychologists (clinical or counselling), cognitive-behavioural therapists, etc. This again was to increase the diversity of the sample and increase the depth of the data.

Study Aims

This study aimed to garner a fuller understanding into LGBT therapist disclosure of their sexual orientation to clients. We sought to:

- examine the extent of non-heterosexual therapists’ disclosure of sexuality to clients*

- examine therapists' awareness of guidelines related to disclosing sexuality*.
- assess if awareness of guidelines impacts on disclosure of sexuality*.
- assess if post-qualification experience impacted on TDSO*
- examine the context in which a disclosure took place**
- understand non-heterosexual therapists' perspectives on the purpose TDSO, and gain insight into the decision-making processes involved**
- examine the perceived consequences that TDSO had on therapeutic alliance**

*discussed in extended paper.

**partly discussed in the journal paper with further discussion in the extended paper.

EXTENDED METHODOLOGY

This section expands on the journal article, opening by considering the epistemological underpinnings for the study. The section provides a rational and critical examination. A detailed account of the research procedure is described, with a critical reflection of the qualitative analysis used (Thematic Analysis [TA]) and quantitative analysis conducted (Chi-square test for independence and Mann-Whitney U test). Finally this section offers researcher's statement of perspective of the present study.

Research Design

Ontology and epistemology

Research that involves qualitative analysis relies on the ontological and epistemological position of the researcher (Braun & Clarke, 2013). Ontology is the study of the nature of reality (Braun & Clarke, 2013) and epistemology is the theory of knowledge, how we know things or believe them to be true (Barker, Pistrang, & Elliott, 2002). Researchers need to consider their position prior to starting research because it is argued that their position can determine and direct the knowledge generated, methodological and theoretical frameworks used (Braun & Clarke, 2013).

Ontology ranges across a continuum from relativism, where reality is dependent entirely upon human interpretation, to realism where reality is entirely independent of human ways of knowing. Realism is based on the assumption that a knowable world can be achieved through research, with the 'truth being out there' (Braun & Clarke, 2013). Realism is also referred to as 'a correspondence theory of truth' (Madill, Jordan, & Shirley, 2000), assuming that what we know mirrors truthfully what there is. Conversely, relativism states that there are multiple constructed realities and the 'truth' and what is 'real' differs across times and contexts (Braun & Clarke, 2013). Between these stances lies a critical realist position, postulating that a real and knowledgeable world exists behind the subjective and socially located knowledge of the researcher (Madill et al., 2000). A critical realist stance is said to underpin a variety of qualitative approaches including TA (Braun & Clarke, 2013).

Epistemology addresses the question of what is possible to know. There are basic distinctions between epistemological positions, which are based on whether reality is created or discovered through a research process. Epistemological positions are distinguished by their place on the realist-relativist continuum. A realist perspective assumes the 'truth' is obtainable, where in contrast, a relativist position assumes that there is no absolute truth because knowledge is based on our assumptions (Braun & Clarke, 2013). There are a number of variants within the continuum (Harper, 2012). The paper will now briefly outline positivism, constructionism and contextualism, which are stated to be prominent within psychology (Braun & Clarke, 2013).

Positivism assumes that the truth is discoverable through applying appropriate scientific measures, therefore assuming a straightforward relationship between the world and our perception of it. Postpositivism, argued to be less pure than a positivist position seeks to find a truth, while acknowledging that researchers are influenced by context, which in turn influence the research, and therefore findings are facts of truth but subject to theoretical influence (Guba & Lincoln, 2005). Within this position the researcher aims to seek the truth through controlling or removing the subjective influences on knowledge as far as possible (Braun & Clarke, 2013). Conversely, constructionism argues that what we know is an accurate reflection of the world, with our knowledge (of self and world) being constructed through discourses and various systems. Constructionism assumes our knowledge is a product of how we come to understand it (Braun & Clarke, 2013). Finally, a contextualism stance is seen to be akin to a critical realism perspective, assuming that knowledge emerges from contexts, reflecting researcher position with findings being provisional and situated in that context (Madill et al., 2000). Contextualism acknowledges that a truth may not be found through a solitary method, but truth can be found in a specific context (Braun & Clarke, 2013).

Researcher's epistemological position

TA is often criticised because it is not affiliated with an epistemological position. However, Braun and Clarke (2006) argue that if the researcher clearly states

their epistemological stance at the start of the research then TA can be used flexibly to answer a range of research questions. The current study was conducted from a contextual critical realist position. This position is dedicated to an ontological realist position, where a structured, differentiated and independent reality exists; and an epistemological stance of relativism where beliefs are socially produced, potentially fallible, while arguing that in principle it is probable to provide justifiable grounds to have a preferred theory to another (Patomaki & Wight, 2000). This perspective assumes that there is a real world, however, no a priori assumptions can be made regarding the end of scientific endeavour and that the real world could fully be reflected (Harper, 2012; Howitt, 2010; Patomaki & Wight, 2000). It was recognised that each participant could develop meanings shaped by their own situation, environment, personality, experience and expectation. The impingement of wider social context on participant's meaning was also acknowledged (Borrell, 2008).

Rationale for a mixed methodology

Many researchers suggest that research methods are arranged along a continuum spanning quantitative to qualitative approaches (Leech, Dellinger, Brannagan & Tanaka, 2010). Traditionally quantitative research designs have been rooted in a positivist epistemology (Ayre, 1959) where the research aim is to create objective knowledge that is unbiased, and impartial to the researcher's vested interests or personal involvement (Moran, Matthews, & Kirby, 2011; Willig, 2008). On the other hand, qualitative designs are influenced by 'naturalistic inquiry' (Lincoln & Guba 1985, p. 227) where problems are resolved through amassing adequate knowledge that leads to an explanation. Hence, qualitative research seeks to understand how individuals make sense of their world, gaining an insight of how they experience events, rather than attempted to find a cause-effect relationship (Willig, 2008).

Historically, both approaches have been seen as incompatible (Guba, 1990), however, in recent years researchers have recognised the boundaries of both approaches are more permeable than discrete (Moran, et al., 2011). It has been highlighted that qualitative researchers may not adhere to constructionist principles of interpreting interview data, while quantitative designs do utilise

non-random and small samples (Bergman, 2011). Therefore some researchers argue that quantitative and qualitative designs can be used in conjunction to complement research design, hence mixed methods research designs have been placed in the middle of the continuum (Johnson & Onwuegbuzie, 2004; Leech, et al., 2010). Mixed methods research allows the investigator to collect and analyse data, integrating the results and drawing inferences using both quantitative and qualitative approaches in a single study to explore the same underlying phenomenon (Leech & Onwuegbuzie, 2009; Tashakkori & Creswell 2007).

There are a number of advantages to utilising mixed methods on research including: a) triangulation - mixed methods can be used to corroborate the underlying meaning within the data; b) complementarity - otherwise known as enhancement, allowing clarification of the findings of one method by using another; c) development – using the findings from one phase of the research to inform the methods in the subsequent stage(s); d) initiation – allowing access to new insights into a particular phenomenon (Greene, Caracelli, & Graham, 1989). In this study triangulation, complementarity and initiation have been used.

Limitations of mixed methods

Barriers to mixed methods research can be viewed at both the conceptual and methodological level (Moran, et al., 2011). Concerns have been raised about the actual complementarity of mixed methods. Some argue that in mixed method designs the qualitative aspect of the research can easily be downgraded to a subordinate status because quantitative research typically adopts a predetermined meaning prior to data collection- something highlighted as an anathema in qualitative research (Shank, 2006). While, methodological challenges include the optimal integration of qualitative and quantitative findings in an efficacious and valid way. This has been suggested as a reason for the scarcity of exemplars of mixed methods designs in social science research (Bryman, 2007; Moran, et al., 2011). In conclusion combining mixed methods design is suggested to develop a more comprehensive understanding of the phenomena of TDSO, than would be achievable through singular qualitative or

quantitative designs. When combining these methods the authors considered the ontological and epistemological issues when triangulating and proceeded with the contextual critical realist position.

Methodology considerations

Given that mixed methods design was deemed appropriate for the present study, consideration of the most appropriate means to collect data was required. The researcher's epistemological stance was important to consider to ensure that the data collection methods were compatible and numerous methods were identified (Frith & Gleeson, 2004). Critical evaluation of internet-mediated research and interview methods was conducted to select the most appropriate method for the present study, this is outlined below.

Rationale for online survey

An online survey (esurv.org) was utilised during the first stage of data collection, with this type of research method now being widely used in research that is based on internet mediated research (Hewson, 2014). Online surveys also provide an effective way to collect quantitative data from a large sample. Evidence to date on the quality of online surveys is promising (see Hewson et al., in press, for detailed overview). The evidence suggests that online surveys can produce valid, reliable data (Hewson, 2014) with research comparing online and offline samples highlighting that online samples tend to be more diverse (Gosling, Vazire, Srivastava & John, 2004). Online surveys enable a shift from the over reliance on student samples and can enable a sample from a wider geographical area, which is further reaching than offline methods would allow. Therefore the probability of reaching a representative sample is greater due to utilising online surveys (Hewson, 2014). A large benefit of utilising online surveys is that these methods facilitate access to hard to reach groups (Barratt, 2012) and it is highlighted that such methods have enabled high-quality data to be obtained (O'Conner & Madge, 2003). This method was particularly appealing for gathering data from an international sample, while providing anonymity to participants to enable them to feel able partake safely. To ensure anonymity the function on esurv.org of collecting the computers' internet protocol (IP) address was disabled.

Limitations of online survey

Online surveys were once criticised for the limited sample that they were likely to recruit from (e.g. mainly white, middle-class, males who were technologically minded). However, today many of these concerns are attenuated due to the shifting patterns in internet use (Hewson & Laurent, 2008), while it is suggested that some biases remain (e.g. users are younger, more educated and wealthier) (Dutton & Blank, 2011).

Rationale for individual interviews

Interviews are not bound to a specific epistemological stance, therefore it is important to understand the social structure of an interview (Frith & Gleeson, 2004). Interviews allow there to be face-to-face contact between researcher and the participant and are typically viewed as 'gold standard' or ideal way to collect qualitative data in terms of validity and rigor (McCoyd & Kerson, 2006; Novick, 2008). Interviews conducted by different means (e.g. telephone, email and online communication software) are being increasingly used as an extension of traditional face-to-face methods (Sturges & Hanrahan, 2004).

It is proposed that interviews are an appropriate method that fit experience-type research questions because they allow detailed and rich data about individual experiences and perspective to be given (Braun & Clarke, 2013). The rich data gathered from interviews often means that smaller sample sizes are required to obtain adequate data (Braun & Clarke, 2013). Using open-ended questions encourage the participant the opportunity to divulge information that might not have been considered and following a semi-structured interview approach provides the researcher flexibility in asking follow-up questions, based on the participant's responses. Individual interviews are seen to allow the researcher more control over the data produced, in comparison to focus groups. In an individual interview the researcher has the ability to guide the interview, increasing the likelihood of useful data being gathered (Braun & Clarke, 2013).

Telephone interviews are seldom suggested to be a practical alternative to face-to-face interviews (Hanna, 2012; Struges & Hanrahan, 2004). While Holt (2010) argues that telephone interviews offer a viable alternative to face-to-face

interviews because of the practical benefits that the method offers. Telephone interviews are postulated to provide versatility as a data collection method (Carr & Worth, 2001), which provide rich and detailed high quality data (Hanna, 2012; Struges & Hanrahan, 2004). It is acknowledged that telephone interviews can lose some of the subtleties associated with physical face-to-face interactions, but that loss allows the data gathering to be more contextually free, allowing the researcher to stay at the text level (Holt, 2010). McCoyd and Kerson (2006) stated that telephone interviews could be conducted for up to two hours with little participation fatigue, despite suggestions that telephone interviews need to be shortened in comparison to face-to-face interviews (Chapple, 1999; Sturges & Hanrahan, 2004; Sweet, 2002).

Despite the dearth of literature supporting the use of telephone and online interviews in qualitative research, many reported advantages include: offering decreased cost and travel, sampling from a large geographical area and enhanced interviewer safety (Hanna, 2012; Holt, 2010; Novick, 2008). An online method (Skype) for interviews was considered. Over recent years there has been an increased focus on the utility of online communication software for conducting qualitative research (Hanna, 2012). Skype software is freely available for download and provides a variety of communication choices, including the use of audio and video calling to other Skype users and the ability to telephone call landlines and mobile phone numbers (Deakin & Wakefield, 2014). Skype is also nationally and internationally recognised, compared to other online software available. While standard telephone interviewing has the capacity for researchers to communicate over long distances (See Holt, 2010), Skype creates a medium that seems the most feasible alternative to face-to-face interviews. Skype provides synchronous interaction with the participant and researcher, but goes some way to avoid the criticisms, associated with standard telephone interviewing, of losing visual and interpersonal aspects of the interaction (Evans, Elford & Wiggins, 2008; Hanna, 2012), allowing a greater connection between the participant and researcher with the option of video calling (Deakin & Wakefield, 2014). Therefore to enable recruitment from a wide geographic location, without impacting on the research budget face-to-

face, telephone and Skype interviews were considered feasible methods to collect data.

Limitations of individual interviews

This method is not without its limitations. Conducting individual interviews is time consuming, compared to focus groups and collecting data from individual participants has direct impacts on the data collection period. Due to individual interviews requiring smaller sample sizes, it could be disputed that the data is only representative of a restricted sample, which therefore may not capture a breadth of information, when compared to survey studies (Braun & Clarke, 2013).

Moreover, interviews have the potential to create power imbalances. It is suggested that by the researcher being in control of the interview the participant may view the researcher as an expert and therefore the relationship between the researcher and participant becomes hierarchical, having the potential to disrupt the shared experience (Braun & Clarke, 2013). Conversely, Russell (1999) disputes that power dynamics are inherently present within an interview, but rather they develop during the course of the interview.

Conducting telephone interviews has additional limitations. Attention has focused on the absence of visual cues in telephone interviewing (Garbett & McCormack, 2001). Research suggests that participants are less likely to disclose sensitive information and emotional reactions when visual cues are unavailable (Groves, 1990; Moum, 1998). It is postulated that the absence of visual cues impacts the informal communication and contextual information, while also effecting the development of rapport and lead to misinterpretations of responses (Chapple, 1999; Sturges & Hanrahan, 2004; Sweet, 2002;). However, Novick (2008) argues that there is little evidence to support these claims.

Conducting interviews via Skype can also have its own drawbacks. Due to Skype being an online method of collecting data and being a relatively new technology, there is the increased potential of unfortunate technical glitches.

Hanna (2012) cites examples of faulty video connectivity, disabling the visual content, and having to reschedule interviews at different times. Other limitations of Skype interviews are that technological problems can cause poor sound quality and therefore recordings will be poor. Collecting data through Skype only can put potential participants off for various reasons: unfamiliarity with the software, lack of computer literacy and use of Skype is dependent upon the participant being able to access the internet (see Deakin & Wakefield, 2014).

Methodology used in the study

In order to address the proposed research question the study was conducted in two phases, using two data collection methods: (i) an online survey, followed by (ii) a semi-structured interview. The online survey (quantitative) provided opportunity to collect data from a wide sample, while the interview (qualitative) allowed participants' experiences to be explored in greater detail and facilitated insight into these experiences. The results from the survey provided purposive sampling for the interview. Participants interested in taking part in the interview opted in by leaving contact emails. Participant inclusion criteria are given below.

Although the present study offered an integrated approach to data collection for the interviews, face-to-face interviews were not utilised, with Skype being the preferred option (n=13) over telephone contact (n=4). Conducting interview remotely was necessary due to the geographical location of the participants. Those who opted to use telephone interviews stated that they did not have access to online communication software.

Procedure

This section elaborates on the rationale for the procedure outlined in the journal article and includes procedure for the online survey. (See appendix F for procedure flow chart).

Rationale for number of participant for interviews

Consensus theory specifies that small sample can deliver accurate and complete information, based on the assumption the sample constitutes a

degree of expertise in the area under research (Romney, Batchelder & Weller, 1986). Saturation of TA could be achieved following the analysis of 12 interviews, assuming that the interviews were conducted with a degree of structure and participant homogeneity (similar experiences with the research domain) (Guest, Bunce & Johnson, 2006). The idea of saturation invokes an experiential and positivist model of qualitative research, which signifies that data can produce a truthful and complete picture of the research area (Braun & Clarke, 2013), with this not being wholly in line with the critical realist position of the author. Notwithstanding this Braun and Clarke (2013) provide evidence of appropriate sample size, arguing that small to moderate samples are appropriate for experiential studies using interviews alongside TA. Braun and Clarke (2013) suggest that small sample sizes would include six to ten participants, with moderate samples ranging from 10-20 participants. The current study sample size for interviews (15-30) met the moderate study sample size. This sample size reached both Braun and Clarke's (2006) criteria and that of Guest, et al., (2006).

Sampling and recruitment

The focus for recruitment was defined by the inclusion criteria. Participants were required to: identify with a non-heterosexual identity (e.g. lesbian, gay, bisexual, trans, asexual, queer, non-binary, etc.), have thought about disclosing or have disclosed their sexual orientation to a client they were/are actively working with, be a qualified therapist who uses psychological/psychotherapeutic theories and models to underpin their practice and be registered to an appropriate governing body either in the UK or Internationally (i.e. BPS, BACP, UKCP, HCPC, and COSRT).

It was acknowledged in the study design process that there would be a lack of control over the completion of the online survey, thus very robust exclusion criteria could not be achieved. However, it was deemed unlikely that non-therapists will attempt to partake in this study because of the limited places it would be advertised. Participants were asked which governing body they registered with and which profession they see themselves aligned to. Participation was voluntary and the only contribution that participants had was

the completion of the online survey and interview. This was managed and coordinated by primary author.

Online survey -Participants were recruited via the BPS Psychology of Sexualities Section (PoSS) listserv (n=198) via a web-link. PoSS as a section holds an affirmative approach towards sexualities. The section aims to provide a forum for clinicians whose work is relevant to LGBT issues. The listserv is an emailing list which is open to all members of the section who share an interest in LGBT issues. The listserv frequently advertises such studies.

The study was also advertised through Pink Therapy Newsletter and Facebook page. Pink Therapy is the UK's largest independent therapy organisation working with clients of sexual and gender diversity. It is also host to the UK's first online Directory of Pink Therapists, which lists qualified therapists who adopt a sexuality affirmative stance, not seeing sexual and gender diversity as an illness to be treated.

The study was advertised through CORST in their newsletter. CORST is the UK's leading membership organisation for therapists specialising in sexual and relationship issues. UKCP, BACP and American Psychological Association (APA) were also approached to advertise the study, but the study was not advertised by these agencies, because of financial implications or because of ethical approval needing to be acquired in America.

The International Psychology Network (IPsyNet) LGBTI listserv was also used to advertise the study. IPsyNet consists of a global network of psychological organisations that share knowledge and understanding of sexual orientation and gender diversity, while promoting human rights and wellbeing.

Interviews - It was recognised that the recruitment process may not reach those therapists who were not member of the selected listservs or newsletters. Whilst the author recognised the advantages of recruiting from such samples, it was acknowledged that this could potentially skew the results because views may be over-represented. In order to account for this an ongoing reflexive analysis of the researcher's role and interpretations was vital (Braun & Clarke, 2013).

All participants were recruited through the means discussed, the exact numbers from each source is not known because this data was not collected. 54 participants completed the online survey; however one person withdrew their data stating that they did not feel that their input would be valid, hence 53 sets were analysed for the online survey. 17 interviews were completed out of a 29. Two of the 29 were excluded because they did not meet the inclusion criteria (they were not qualified therapists), three people who were contacted about arranging an interview could no longer participate, citing personal reasons, and the seven people did not respond. Participant demographics for the online survey are provided in table 9.

Table 9:
Participant Information: Online Survey.

Age	Gender	Sexual Orientation	No. Post Qualification years	Location	Type of therapist
25-30 (n=5)	Male (n=24)	Gay (n=22)	0-5 (n=30)	UK (n=38)	Psychotherapist/ Counsellor (n=34)
31-40 (n=13)	Female (n=20)	Lesbian (n=14)	6-10 (n=7)	GER (n=5)	Clinical Psychologist (n=8)
41-50 (n=21)	Non-binary (n=4)	Heterosexual (n=2)*	11-15 (n=12)	NZ, AUS, UK (n=1)	Counselling Psychologist (n=5)
51-60 (n=11)	Transfemale (n=1)	Queer (n=2)	16-20 (n=3)	RSA (n=1)	Social Worker (n=1)
61-70 (n=3)	Transwoman (n=2)	Gay BDSM (n= 1)	21-25 (n=1)	AUT (n=1)	Educational Psychologist (n=1)
	Transperson (n=1)	Pansexual (n=3)		SNG (n=1)	Psychosexual Therapist (n=1)
	Gender Queer (n=1)	Bisexual (n=4)		IRE (n=2)	Art Therapist (n=2)
		Attracted to Males (n=1)		NTH (n=1)	Medical Psychologist (n=1)
		Gay BDSM Kink (n=1)		ISR (n=2)	
		Bisexual Kink (n=1)		COL (n=1)	
		Asexual (n=1)			

* Participants identified as Trans

BDSM= Bondage discipline dominance submission sadism masochism; UK=United Kingdom; GER= Germany; NZ = New Zealand; AUS = Australia; RSA= Republic of South Africa; AUT = Austria; SNG= Singapore; IRE= Ireland; NTH=Netherlands; ISR=Israel; COL=Columbia.

Online survey

The survey was open between March 2014 and August 2014. The survey compiled a mix of open-ended and closed questions. Closed questions gained important demographic information of the sample (e.g., sexual orientation, therapist governing body, etc.). Open-ended questions asked for information regarding therapist views and experiences of disclosure and if they have ever considered TDSO. (see appendix G for the survey questions). Those interested in taking part were shown a participant information screen, giving the rationale of the research and were required to give their informed consent to proceed. Participants were informed that they had the right to withdraw their data for up to one week after participation. Participants were reminded that their information would remain confidential. Participants generated a unique pseudonym that could be used to identify their data should they wish to withdraw it.

Interview and transcription

Interviews were conducted between April 2014 and September 2014, by the primary researcher. Brief notes were jotted during the interview as a prompt for the researcher to ask for clarification or further elaboration on points made by the participant. A reflective diary was kept and maintained after each interview, during transcription and during data analysis. Researchers play a role in co-constructing meaning of the participant's experience, while this is meant to be minimal; the role of the researcher needs to be reflected upon, being critical of the practices and values that may have shaped the data. Participants were sign-posted to appropriate services if any issues arose during the interviews. They were also provided with debriefing information to help them make sense of their experience of the interview and to re-clarify the aims of the research (see appendix I). All interviews were audio-recorded. 13 of the interviews were transcribed by the primary researcher, however due to time limitations four interviews were transcribed by a transcription service (appendix J).

Ethical considerations and approval

This study was granted ethical approval from the University of Lincoln's School of Psychology Ethical Committee on 5th March 2014 (see appendix B). The study followed BPS Ethical Guidelines (Francis, 2009); BPS guidance on

gaining consent for online surveys and the Department of Health Research Governance Framework for Health and Social Care (DOH, 2005).

Ethical considerations were given to:

1. Participant information and Informed Consent

- a. Participants were provided with information to allow informed choices regarding their participation. Participant information sheet were available at the start of the online survey and sent either via email to all interested recruits.
- b. All participants had an opportunity to ask clarify any concerns they had prior to the interview starting.
- c. Participants of the online survey were asked to provide a unique participant identifier and tick a tick box to indicate that they consented to completing the online study. Participants interested in taking part in the interview were asked to leave their contact email address. This was taken as consent to partaking in the interview stage. Participants who were interviewed were also contacted via email and asked again if they consented to taking part.

2. Participant withdrawal

- a. Participants were informed about their right to withdraw and notified that they were able to withdraw data, without providing a reason, up to a week following completion of the online survey and/or interview.

3. Adverse events

- a. It was not expected that participants would experience adverse events from their participation; however in the event that this occurred, the researcher was able to provide contact details for the appropriate support services. In addition the researcher was able to access supervision if an adverse event occurred.

4. Risk for researcher

- a. The risk to the researcher was deemed to be low due to interviews being conducted remotely. If issues arose to do with the content on the interview, then supervision was sought.

- b. If face-to-face interviews were conducted then the researcher would have adhered to the lone worker protocol for conducting interviews within the individual's home. A contact person would have been appointed, they would have been informed of all appointments, names, participant contact details, start time for appointment and estimated end time. A procedure was agreed and adhered to regarding the appointments. Confidential information held by the named contact person would have been destroyed after the researcher had returned from the visit.
- c. If any incidents occurred they would have been reported through the University reporting system.

5. Confidentiality

- a. Participant's confidentiality was maintained by the use of participant identification numbers, pseudonyms and omitting all identifiable information from transcripts.
- b. The employed transcription service signed a confidentiality agreement prior to receiving audio recordings.

6. Data protection

- a. In accordance with the Data Protection Act, all data was kept secure in a locked filing cabinet at the University of Lincoln.
- b. Electronic data was stored on an encrypted password protected memory stick

7. Participants were offered a summary of the results in accordance with the British Psychological Society (BPS) recommendations (Francis, 2009).

Participants were advised to contact the Chair of the University of Lincoln, School of Psychology Ethics board (Patrick Bourke – pbourke@lincoln.ac.uk) for further advice and approval if there are any concerns regarding the ethics of this study. The primary and secondary researcher's details were also available for participants to seek further clarification.

Data Analysis

This section provides an overview of the quantitative approaches used to analyse the data gathered from the online survey and expands on the qualitative analysis covered in the journal paper providing an overview of qualitative approaches considered and a rationale for the use of TA.

Quantitative approaches

Preliminary analysis- the dataset used for the preliminary analysis was originally compiled in a spreadsheet, which was later converted into an SPSS data set.

Missing data- the data set was checked and it was apparent that some participants had not completed each field, however, they had not withdrawn their consent- therefore all data collected was analysed. Two options for missing data analysis were considered (1) - *exclude cases pairwise*- exclude the missing variable for that case for that specific analysis or (2) *exclude cases listwise*- exclude the missing value for any variable for that participant that was selected. The *exclude cases pairwise* option was chosen.

Normality- with research based in social sciences scores on the dependent variable are not always normally distributed. Normality can be assessed by obtaining the skewness and kurtosis values (Pallant, 2010). However, most tests can withstand this violation, especially for larger sample sizes (e.g. 30+) and any violation should not cause any major problem. Within the current study normality was assessed in three ways: 1) test of normality- which produced statistically significant results for all variables, with the exception of age. 2) histograms- were used to visually assess for a bell shaped curve (for examples, see appendix K) and 3) skew and kurtosis absolute value scores were assessed. Scores of greater than +/- 3.0 indicates a result that is removed from normality, as highlighted in table 8 (appendix K). One variable fell outside the parameters of normality on this test: 'Gender', while 'Sexual Orientation', 'Profession', 'Governing Body', 'Post-qualification Experience' and 'Gender' violated the test of normality and histograms.

Non-parametric tests- Due to the sample not being normally distributed and the majority of data being categorical (nominal) in nature it was decided that using non-parametric tests would be more appropriate for the analysis because the assumptions of parametric tests have been violated. Unlike, parametric tests, non-parametric tests do not have stringent constraints and do not assume that the population will be normally distributed (Pallant, 2010). However, non-parametric tests can be less sensitive than parametric tests and may fail to detect differences between groups that do exist. Nonetheless, non-parametric tests are ideal if the data is categorical; when there are small sample sizes or when then the data do not meet the strict assumptions of parametric techniques (Pallant, 2010).

Chi-square test for independence- this test allows the researcher to explore the relationship between two categorical variables. The test compares the observed frequencies of cases that happen in each category, with values that would be expected if there was no association between the two variables that are measured (Pallant, 2010). However, Chi-square does have an additional assumption stating that the lowest expected frequency in any cell should be five or greater, although some suggest that at least 80 per cent of cells should meet this assumption (Pallant, 2010). If this assumption is not met then the test has been violated.

Mann-Whitney U test- this is a non-parametric alternative to an independent t-test. It is used to test for differences between two independent groups on a continuous measure. However, instead of comparing means, the Mann-Whitney U Test compares medians. The test converts continuous scores to ranks and evaluates if the ranks for the two groups differ significantly. Due to using ranks the distribution of the score is not important (Pallant, 2010).

Qualitative approaches

There are a number of qualitative approaches, all of which have different methods that are suited to answering different kinds of research questions (Harper, 2012). Epistemological stances of the researcher are important in the

decision-making process of the data analysis method; however, epistemological stance does not indicate the specific analysis method that should be used. Harper (2012) argues that some methods can be used from different epistemological stances. In line with a critical realist position some versions of TA, Interpretative Phenomenological Analysis (IPA) and Grounded Theory (GT) could be used to analyse data. A summary of these approaches is provided:

TA identifies and analyses patterns (themes) of meaning in a data set (Braun & Clarke, 2006) and is viewed by some as a foundational procedure in other qualitative approaches (Boyatzis, 1998). Nevertheless it is stipulated to be a valid method in its own right, but an approach that has only recently been recognised as a distinctive method and clearly defined procedure (Braun & Clarke, 2006). TA is thought to be a flexible approach that can provide rich, detailed and complex accounts of data and it is argued that the method can be applied to almost any type of research question and data. An inductive (bottom-up) approach can be used to identify themes, where themes strongly link to the data, or from a theoretical (top-down) approach, where the analysis is theoretically driven (Braun & Clarke, 2013). A hybrid inductive-deductive approach can also be used for data analysis (Fereday & Muir-Cochrane, 2006), which incorporates a data-drive approach (Boyatzis, 1998) with a deductive *a priori* template of codes (Crabtree & Miller, 1999). The saliency of a theme is not determined by its frequency within the data set. Themes can contain semantic (manifest) or latent content (Braun & Clarke, 2006). Semantic content refers to data that is apparent at surface level, while latent content is the essential ideas, assumptions or conceptualisations within the data (Joffe, 2011). TA offers a rich description of the data set or it can provide an in depth account of one aspect of the data. Although using this approach in an under-researched area, it is suggested that an account of the entire data set is more useful (Braun & Clarke, 2006).

IPA, like TA describes patterns within the data, although it is bound theoretically (Braun & Clarke, 2006). IPA has a psychological interest in how people make sense of their experiences (Larkin & Thompson, 2012), with its roots firmly in an interpretive phenomenological epistemology. IPA is concerned with

understanding a person's relatedness to the world through the meaning that is made, with the focus being centred on the individual's meaning of the experience and the significance it has for individuals (Larkin & Thompson, 2012). During an IPA study the researcher is tasked with making sense of the individuals reported experiences, interpreting the participant interpretation (Howitt, 2010).

GT is an inductive approach that is systematic yet flexible in nature. GT has been conceptualised in numerous ways (Charmaz, 2002), nevertheless the approach focuses on systematically enabling the development of theory through reaching data saturation (Willig, 2008). Data is analysed in an ongoing fashion, guiding the collection of further data. Theory building consists of constant checking between multiple aspects of the analysis (Howitt, 2010). GT is argued to be best suited to answering research questions about social pressures and influencing factors that underpin a particular phenomenon (Braun & Clarke, 2013). Through a focus on social processes GT is able to examine social structures, situations and relationships, interactions, patterns of behaviour and interpretations (Charmaz, 2002).

The current study aimed to explore in detail LGBT therapists' experience of disclosing their sexual orientation to clients, and identifying patterns reported by the participants. The current study did not aim to generate a theory of participant's experiences and thus GT was not considered an appropriate analysis method for this research. However, TA and IPA are deemed appropriate for studies exploring experiences (Braun & Clarke, 2013). The following sections critiques both approaches with regard to the current research and provides a rationale for the use of TA.

Rationale for TA

TA identifies the most salient patterns and themes of meaning across a dataset in relation to the research question (Braun & Clarke, 2006). Although IPA also studies patterns in the data, its focus is on how people make sense of the lived experience and is theoretically bound (Braun & Clarke, 2006). IPA considers how perception and language regarding objects and events (phenomenology)

and understanding how people make sense of their experience through the researchers offering interpretations.

IPA identifies the significance of events for the participant, an ideographical level of analysis (focus on the specific rather than the general) (Smith, Flowers, & Larkin 2009). IPA is described as a contextualist approach based on the assumption that the person is part of the context (Larkin, Watts, & Clifton, 2006), causing the role of social-cultural context to be blurred (Braun & Clarke, 2013). IPA also assumes that individuals are self-interpretative and self-reflective, allowing reflection on their experience. However, it is recognised that the researcher cannot directly access the participant's world and therefore a dual interpretative process (double hermeneutic) is used. Braun and Clarke (2013) argue that due to the dual focus on the individual and themes across cases, IPA exhibits a lack of depth and substance when compared to TA. Both TA and IPA acknowledge that the researcher has influential role, yet in TA there is less of a central role, particularly at a semantic level of analysis which aims to remain close to the data. However, Frith & Gleeson (2004) suggest that Inductive TA [ITA] (based within the data) and IPA are very similar in the analysis stages. Both approaches remain close to the data as long as possible; however, ITA takes what is said at face value, searching for themes across the data. This contrasts with IPA where the researcher aims to interpret what the participant means.

IPA and TA are argued to be accessible approaches (Braun & Clarke, 2013). IPA is seen as a wholesale approach to research, providing a methodology rather than an analytic method. On the other hand, TA offers flexibility, without prescribing data collection, theoretical positions, ontological or epistemological frameworks, but provides an analytic method for analysis. Braun & Clarke (2013) suggest that flexibility is one of TAs main strengths, while they acknowledge that flexibility has been described as indicating a method lacking in substance, unlike theoretically driven approaches like IPA (Braun & Clarke, 2013).

TA was the chosen approach for the current study due to the aims and the epistemological stance of the researcher. TA was considered more appropriate over IPA because of the paucity of research in this area of therapist disclosure. TA was thought to enable the researcher to remain close to the data, while having less influence over the interpretation than an approach like IPA.

***A priori* decisions**

Numerous *a priori* decisions were needed prior to using TA. It was important to consider how the analysis should be approached either inductive or deductive. It has been argued that a deductive approach risks ignoring the naturalistically occurring themes (Joffe, 2011). Researchers need to consider what constitutes a theme. Braun and Clarke (2006) argue that the saliency of a theme is not solely dependent upon its frequency and prevalence. The researcher also needs to consider the level of analysis that is to be undertaken. 'Semantic' level (manifest) refers to what is obvious at surface level, or what is explicit in the data (Boyatzis, 1998). However, a 'latent' level discovers underlying ideas, conceptualisations, assumptions and theories that might influence the data (Braun & Clarke, 2006). Therefore a hybrid approach was taken because this would allow previous knowledge to be present, while also allowing themes to emerge from the data through inductive coding. It was recognised that researchers play an active part in identifying and selecting themes of interest to disseminate, thus the analysis can never be free from the researcher's theoretical and epistemological stances (Braun & Clarke, 2006). It is also argued that the saliency of a theme is not dependent upon quantifiable measure, therefore in the current study a theme constituted ideas important in relation to the research questions. To ensure that the analysis was grounded in the data a semantic level of analysis was selected in the current research.

TA procedure

During the analysis (Braun & Clark, 2006) stages were revisited with transcripts and codes being checked to ensure accuracy throughout the analysis process. The six phases are outlined below:

1. Familiarising oneself with the data:

The data was transcribed, read and re-read and initial ideas were noted down. The researcher transcribed 13 interviews with the remaining four being transcribed by a transcription service. The transcription process facilitated the researcher familiarity and immersion in the data. Initial ideas and patterns and meanings were created. With the four interviews, the researcher spent time checking the transcription, spending time to become familiar with the data and start the procedure of immersion.

2. Generating initial codes:

A systematic line-by-line analysis of each transcript took place. Initial codes were assigned, representing features of the data that were important in answering the research question. The researcher consulted supervisors (DD and RdN) during this stage and supervisors independently reviewed coding and coded a selection of interviews (See section on establishing quality).

3. Searching for themes:

Initial codes were gathered into potential themes. An *a priori* decision stated data that was important in relation to the research question constituted a theme (Braun & Clarke, 2006). Codes were separated onto pieces of paper and ordered into theme piles, enabling links to be made between codes and themes. This helped identify main themes and sub themes.

4. Reviewing themes:

Initial themes were checked for accurate representations of the coded extracts by reviewing the transcripts. Themes were checked in relation to the entire data set. A thematic 'map' of the analysis was generated to demonstrate the conceptualisation of the data and their relationship. Some themes were further broken down and, or collapsed. Revisions of the thematic map were produced to illustrate this.

5. Defining and naming themes:

Themes were refined and named, ensuring that the essence of the theme was caught.

6. Producing the report:

Themes with clear, compelling examples were extracted to address the research aims. Clear examples were used to demonstrate the analysis process in the write up.

Establishing quality

In contrast to quantitative research no absolute criteria for establishing quality is available, with quantitative methods not being deemed appropriate (Braun & Clarke, 2013). Although a consensus has been reached stating that qualitative studies need to demonstrate credibility (Creswell & Miller, 2000). Specific methods for qualitative have been developed (Braun & Clarke, 2013), nevertheless there does remain a debate around such methods constraining the freedom and methodological development (Elliot, Fischer & Rennie, 1999; Reicher, 2000). Audit trails, member checking, and triangulation are utilised in qualitative research. Madill, et al., (2000) argues that measures of quality vary greatly across epistemological positions. Therefore, it is recommended that researchers state their epistemological position at the outset of the work so that their research is conducted and presented in a way that is consistent with their stance.

Establishing quality in TA is the ambition to balance being faithful to the data with being systematic in one's approach (Joffe, 2011). A good quality TA provides a balance in observation of the data and meaning, while not attaching too much emphasis on the incidence of codes removed from their context (Joffe, 2011). The reader is allowed to make their own decision about the applicability of the findings to other contexts by being provided with thick and rich descriptions of the participants, setting and themes (Creswell & Miller, 2000). It has been stated that thick and rich descriptions enhance the reader's sense of connection with the participants. The current study intended to offer thick descriptions of the data and participants, while maintaining confidentiality. It was also acknowledged that it is not practically possible to always achieve thick descriptions because of the limitations of space (Joffe, 2011).

Triangulation was used to enhance the quality of the research, based upon the idea of convergence of multiple perspectives. Essentially, data is examined

against one another, enabling cross-checking of data and interpretation (Krefting, 1991). Four methods of triangulation are proposed: data source triangulation, data methods triangulation, investigator triangulation and theoretical triangulation. The current research utilised investigator triangulation and theoretical triangulation. Data was coded independently by the researcher and supervisors. Cross-checking of themes and codes happened to give credibility, ensuring that the researcher's perspective was understood by others (Boyatzis, 1998; Yardley, 2009). Analysis meetings were held between the researcher and supervisors to discuss the data, and competing interpretations and explanations of the data. Themes were revisited and amended as required. Triangulation with results from the quantitative analysis was also used to ensure quality in the qualitative analysis.

Member checking is a commonly used approach in research; participants check the data for accuracy (Krefting, 1991). This method was not utilised in the current research. It can be argued that member checking indicates that there is a fixed truth that can be confirmed by the participants. This opposes the epistemological stance of the researcher. Furthermore, from a pragmatic point of view the researcher had to consider the practical implications (e.g. time) of utilising member checking.

Krefting (1991) reminds researchers that they are part of the research bringing their own background, perceptions and interests and while the researchers aim is to be close to the data, they should be reflective about the effect of pre-existing assumptions. The write up aimed to provide extensive direct quotes, allowing the readers to assess the validity of the themes. Researchers need to continuously reflect upon their own characteristics and understand how they might impact on the data gathering and analysis. A clear audit trail indicating the process of data collection through to write up was produced. The six-stage TA procedure (Braun & Clarke, 2006) was followed and supplemented by a research diary following the process from development to completion. The diary contained information relevant to the development of the study through to its completion. Reflections made in the diary enabled the researcher to become aware of their biases and facilitated the alteration of data collection and analysis

if required. This is a further process of enhancing credibility (Krefting, 1991). A 15 point checklist is proposed by Braun and Clarke (2006) for conducting good TA. The current study adhered to these markers to safeguard a quality analysis.

Researcher's statement of perspective

A statement of perspective can orientate the reader to interpret and understand the research analysis, positioning them to the research and the researcher conducting it (Elliott, Fischer, & Rennie, 1999). I am a gay, male, Trainee Clinical Psychologist who has developed an interest in the process of therapists disclosing their sexual orientation following my experience, as an Assistant Psychologist, of disclosing my sexual orientation to a client. Through my experience of considering disclosure I have reflected upon what I think the purpose is and what enables and restricts me to consider making a disclosure. This research has been entered into as a fulfilment of the course requirements. I started the research with the assumption that therapist disclosure their sexual orientation in multiple settings, but perhaps not regularly.

EXTENDED FINDINGS

This section reports the findings of the online study, which were not presented in the journal paper and also elaborates upon the themes and sub themes described in the journal article (themes not already presented in the journal paper are summarised in table 13). A thematic map illustrates the interaction between the main themes and sub-themes in relation to the research aim (appendix E). To ensure the quality of the research, extracts from the interviews are provided to demonstrate and support the findings. As themes are not wholly independent quotes are at times used to illustrate these.

Quantitative findings

Online survey characteristics

53 participants completed the online survey. 81.1% of participants (n = 43) stated that they had disclosed their sexuality to clients. From that 81.1% table 4 indicates that for some therapist disclosure of sexuality is something that occurs infrequently, while 24.5% of participants stated that they had disclosed their sexuality over 20 times.

Table 10:

Estimated number of clients participants have disclosed to

How Many	Frequency	Percent
<i>0</i>	10	18.9
<i>Less than 5</i>	16	30.2
<i>6-10</i>	7	13.2
<i>11-15</i>	5	9.4
<i>16-20</i>	2	3.8
<i>More than 20</i>	13	24.5

47.3% of participants reported that they had disclosed their sexuality to LGBT clients (n = 25) compared to 5.7% of participants who reported that they had disclosed to heterosexual clients (n= 3), with 22.6% of therapists stating that they have disclosed to non-heterosexual and heterosexual clients (n= 12).

Table 11 demonstrates that disclosure of sexuality is more likely to happen in private practice. However, 28.3% of participants stated that the clinical context of their disclosure was 'other', which included voluntary and research settings.

Table 11:

Clinical context that disclosure occurred

Clinical Context	Frequency*	Percent
<i>Private Practice</i>	20	37.8
<i>Community</i>	5	9.4
<i>Public Hospital</i>	9	17
<i>Other</i>	15	28.3

*Four participants did not complete this question

The majority of participants responded that they were unaware of any guidelines that would help them in the decision-making process in relation to disclosing their sexuality as presented in table 6. Interestingly a large majority of UK based therapists reported that they were unaware of any guidelines related to TDSO, which is surprising considering that many of them will have been registered with a professional body (e.g. HCPC, BACP) that would be regulated by CHRE.

Table 12:

Participants' awareness of disclosure guidelines

Awareness	Frequency*	Percent
<i>Yes</i>	13	24.5
<i>No</i>	39	73.6

*1 participant did not complete this question

Inferential statistics

Given the backdrop of this study, it was hypothesised that therapists' awareness of guideline related to disclosure would be linked to their use of disclosure with clients. A chi-square test for independence (with Yates Continuity Correction) indicated no statistically significant association between

therapist disclosure and therapists' awareness of guidelines, $\chi^2 (1, n = 52) = 0.28, p = 0.104, \phi = 0.28$, suggesting that participants awareness of guidelines was not an influencing factor over their decision to disclose their sexuality to clients.

Analysis using a Mann Whitney U test also demonstrated that therapist disclosure of sexual orientation was not influenced by the length of their post-qualification experience with no significant difference in number of post-qualification years of therapists who disclosed ($Md = 5, n = 43$) and those who did not disclose ($Md = 2, n = 10$), $U = 165.5, z = -1.130, p = 0.26$, therefore highlighting that therapists increased post qualification experience has no bearing on their decision to disclose their sexual orientation.

Qualitative results

Function of disclosure

For all participants the function of a disclosure was discussed under three smaller sub-themes: (i) making a connection, (ii) Communicating, and (iii) disclosure as an intervention. Below (table 7.) the themes that are discussed in the extended results are presented. Themes are presented as a thematic map in appendix E, which highlights how the themes are interconnected.

Table 13.

Thematic table presenting participants' conceptualisation of disclosure

Overarching themes	Main themes	Sub-themes
Function of Disclosure	Making a connection	Deepening rapport Being real versus being a fraud
	Communicating*	Safety Non-judgement Non-pathology
	Disclosure as an intervention*	Role model Shortcut Challenge or correct assumptions Toolkit Challenging homophobia
Function of Non-disclosure	Damaging the alliance	Similarity versus differences Being seen as a fraud*
	Risk	Judgement Personal safety Concealment*
	The client's focus*	Shifting focus Relevance
How Disclosure Happens	Pre-therapy disclosure	Physical world Online world
	During therapy*	Direct Indirect Accidental

*indicates themes discussed in extended results

Communicating

Disclosure was seen as a way of communicating to the client that this therapy was a safe space to discuss things, where there would be no judgement and that sexuality would not be pathologised: 'Erm, to provide safety for the, the main focus is provide a safe therapeutic environment for clients to be able to talk as broadly and as openly as they feel they can' (David). Some participant's alluded to their client's experiencing therapists who had pathologised their sexuality or sexual interests. There was an overarching assumption that non-heterosexual clients were at greater risk of having their difficulties pathologised or stigmatised: 'most bisexual clients I have worked with have been pathologised to some extent by previous therapists e.g. assuming that they are confused, or that they should choose one gender' (Kate). Disclosing sexuality

was done in attempt to help the client feel safe within the therapeutic space and that they did not have to hide anything or be ashamed: 'I think it allows the client –as I said earlier – to actually not feel that they've got to explain everything to me but that I'll understand...' (Thelma).

Participants' assumptions of the client seeking safety were based in their own experience of sexuality being invisible to heterosexual therapists because of a lack of training, naivety or ignorance. Some participants talked about having to hide part of themselves in certain contexts and some participants recognised that they were not only giving the client permission to be themselves but also providing permission for themselves (therapists) to be real in that space and was seen as a by-product of living as a non-heterosexual in a heteronormative world. This acted as a mediator for disclosure with participants noting that disclosures were used to create a space that was trusting, accepting and safe because the client needed this to fully engage in the process.

The participants' rationale for disclosure during the assessment phase was to communicate to the client that the therapist was not going to judge them for their non-heterosexual identity. However, some participants were conflicted between the importance for the client or the importance for the therapist in not portraying another person judging the non-heterosexual lifestyle. There was a consensus amongst the participants that the client could benefit from knowing the therapist's sexual orientation in order to combat the client's own internalised shame, guilt or homophobia and there was a definite sense that disclosing sexuality was a way that the therapist could combat these internalisations while not having to hide.

Disclosure as an intervention

Disclosure of sexuality was seen as an intervention by some participants because it could be used to facilitate the therapeutic process and produce positive therapeutic outcomes. Some participant's discussed how they would offer themselves as a role model. Participants would disclose sexual orientation as a way of offering the client the opportunity to explore and challenge the perceptions and assumptions that they held about a non-heterosexual lifestyle: 'If it's a model for a client...I don't want to be gay cos their all sad people that

live on their own, then I'll say, well the 28 years that I've had with my husband suggests different. So I offer myself as a more positive role model'. (Stuart)

Participants used information about themselves in this way that provided an alternative perception of what a non-heterosexual can be. These participants described that society still hold negative stereotypes and assumptions about non-heterosexual individuals, particularly gay men. The participants hoped that their disclosure would offer the client an alternative narrative about what being non-heterosexual can mean. This was also talked about when participants felt that the client had limited accessible role models or lived within a culture where non-heterosexual identities were not accepted. Participants also recognised that they would offer themselves as a role model particularly if the client was isolated within a heteronormative society:

I'd have certain clients who would seem like...they're locked in this prison, isolated on their own, can't communicate, or at least tries to reach out and communicate but is surrounded by people who don't get it, they don't understand it. (Danny)

Many of the participants talked about their experiences of disclosure being limited and happening rarely in a direct verbal articulation. However, when disclosure did happen participants expressed that it had the potential to be very 'powerful' and cause a shift in the client thinking or assumptions: 'I think that it's going to be very useful I have the sense the self-disclosure can be a very powerful intervention, when it's appropriate'. (Jamie)

For some they made reference to other clients who had been through similar struggles. Participants rationalised this in terms of not feeling that it was important to reveal anything of themselves to the client, but that it was important for the client to have their experience validated and normalised within the therapeutic space.

Disclosures served the function of providing a short cut to strengthen an alliance: '...I see it as a short cut. So I must see it as a form of intervention but maybe I just suddenly conceptualise it as being similar to asking someone to recall their thoughts, well not that I ever asked anyone to do that' (Paul). Paul

likens his use of disclosure to other therapeutic techniques that would be used during therapy, highlighting that some of the participants think of disclosure as being a useful intervention. There were stark differences in how participants thought of disclosure as a short cut. Some participants thought that it was acceptable to use this as a way of removing barriers for a client, while accepting that they could use other therapeutic means (e.g. working with the transference) they explained that it could be beneficial to remove that barrier for and allow the client to explore their problems: 'yeah you can work with this transferentially and see what emerges or you can tell this person that you're gay and then other stuff can emerge and they can have one less thing to struggle with in this relationship...' (Henry).

Some participants described 'using' their disclosure a tool within their therapy toolkit, likening it to other types of therapeutic technique that can be used to impact upon the client in a beneficial way: 'it's part of a repertoire of therapeutic interventions...' (Olga). While some participants expressed concerns of seeing disclosure as a technique because of the unknown potential consequences of offering that information to a client. In contrast, other therapists took the stance that using any form of intervention can be 'risky' (e.g. thought challenge or behavioural experiment), it is impossible to understand and anticipate every reaction a client might have: '...it's because I can't know everything about my clients, so I can't fully know the impact on my client, from what I disclose to them and I can't actually know the impact of disclosure until I disclose...' (Janet).

A small number of participants discussed how making a disclosure, to act as a short cut in the therapeutic process, would not be appropriate: 'So I don't tend to disclose when there's a direct question. I don't think that's helpful, I think it's more useful to explore why they're asking it... It means that I am providing a therapy that I feel is relevant to that client...' (Brad). Disclosure was seen as detracting from the therapy. Participants thought it more important to understand why the client might be asking about sexuality than to disclose it. This was echoed by many of participants; however, their approach was more dynamic than having static stance and was dependent on what the participant thought the client needed in the moment.

The need to challenge the client's homophobic views and expression of those views were also discussed. Few participants stated that they felt comfortable making a disclosure to challenge homophobia within therapy and this was linked to their perception of personal safety (see function of non-disclosure for more details). In contrast some participants agreed that when a client expressed homophobia there was no alternative but to use their disclosure to challenge that view:

So where there has been, there was one case of quite overt homophobia... It was very easy to challenge in the sense that I knew that I had to do it ...I said that I will not continue to work with you if you continue to be, use those words to talk about a group of people, it's just not acceptable... (Martin).

Participants described how clients held, what were assumed to be, misinformed stereotypes about the lifestyles of non-heterosexual clients or because the client was making incorrect assumptions about the therapist which were unhelpful within the therapeutic context. These positions were seen as barriers because the client was 'stuck' and this needed to be addressed to help the client move on within the therapeutic process:

That there was a very strong tendency on the part of the client to see their therapist as heterosexual, regardless of evidence to the contrary and that it was important for them to know that the therapist, who had been somewhat idealised was in fact another gay person (Jamie).

Where participants had offered disclosure to their client some of them were able to talk about the outcomes of challenging the client's assumptions about the client's projections of heterosexuality onto the therapist.

Function of non-disclosure

This section continues with the main theme damaging the alliance from the journal paper, discussing those themes that were not included.

Damaging the alliance continued

Some therapists expressed that there was fear of being seen as a fraud or incompetent when working therapeutically with heterosexual clients, especially if they were a couple in therapy. Participants' held assumptions that their experience of relationships, life and to some extent therapeutic skills would count for nothing when working with heterosexual clients:

I wonder how they would see me as a relationship therapist. I've been in a relationship for 17 years and along with my qualification that makes me experienced, but I wonder if some clients knew that I have been married to a man for 17 years would they give me the same credence? And it's interesting isn't it because that's all my shit. No one has ever given me the impression that is what they would think. This is what I am bringing to the table all the time. (Martin).

Participants' reflected that they had rarely experienced a negative reaction from making a disclosure of their sexuality to clients, but still they felt this lingering shame about sexuality and how it would be viewed by others in society. The assumption that participants would be seen as frauds was apparent. In their experience no one had ever said that they were a fraud, but it was still a perception that clouded their understanding of what a heterosexual client might feel towards the therapist.

Risk continued

Withholding a disclosure was also thought of in terms of not wanting to give the client cause to discriminate against the therapist because of their sexual orientation:

I think it's the case because, erm, I think there's probably some (pause) some fear of homophobia potentially, when disclosing to heterosexual people. But I also feel that it's not always necessarily been that relevant with heterosexual people. I think that the times when it has been relevant, has been when there's been a significant negative reaction to how they perceive me and my sexuality. (Paul).

Some identified that they felt they should not feel ashamed of being who they are, but continued to hide their sexuality in the therapeutic space. Here the function of non-disclosure is about concealing an aspect on oneself because the therapist is not comfortable with the client knowing, due to the fear of discrimination: '...And the prejudice: I think the negative would be because being discriminated against or ignored or, you wouldn't know would you?' (Thelma).

Some participants explained that there were specific cases when they would avoid making a disclosure about their sexual orientation, which are linked to the outcome of therapy and also how the therapist would be viewed:

Erm, yes, so if I think it's going to negatively affect therapy, then I might not disclose. So, for example, erm, if it's clear that someone holds very strong religious views, then I would be less likely to disclose under the circumstances. Because I think they would then make certain judgements about me. (David)

This suggests that therapists are aware of the needs of their clients but are also aware of the potential for the client to make judgements about them based on their sexual orientation. This was another important mitigating factor in the participant's decision to withhold a disclosure.

The client's focus

There were differences between the participant's views on when a disclosure would be appropriate. Some felt that it was important not to overload the client with the 'therapist material' during therapy and therefore refrained from making a disclosure and relied on their therapeutic skills, while others felt that non-heterosexual clients 'have a right' to know the sexuality of the therapist, but disclosure was rare. A few therapists conceded that they would make a disclosure during the early stages of therapy because they thought it was 'important' for the client to know the therapist's sexual orientation. This was either because a client might be seeking a non-heterosexual therapist or because the participants thought the client would benefit from knowing

Many of the participants talked of the importance of keeping the focus on the client during therapy. The danger in making a disclosure of sexuality was that it could shift the focus of therapy onto the therapist: 'It could be that I get too much in the focus and therapy starts turning on me and my life and it might be hard to get out of that again' (Wendy). Participants did not want to use the clients' space to talk about their own distress and furthermore they accepted that doing so would be unethical. To avoid taking the focus away from the client participants stated that they would not make a disclosure when they thought it may have that effect: 'My role as a counsellor is to be there for the client and be able to meet their needs. That has to be front and foremost of everything that we do. So whether or not I do disclose will always depend on what is the best thing for them...' (Martin).

The relevance of the disclosure was also considered by participants. Making a disclosure to a heterosexual client was discussed as being far less relevant compared to if the participant was working with a client who identified as a non-heterosexual. It appears that their disclosure was not always related to the client's presenting problems – there are conflicting accounts of when a therapist might disclose or not; this appears to be mediated by the clients' sexuality, rather than the client's presenting problems. Participants discussed that if LGBT client would bring up sexuality – it would be important to disclose, but if a heterosexual client brought it up, it would be more important to withhold.

How Disclosure Happens

This theme now expands on disclosure that happens once therapy has started: *During therapy disclosure*, which was not covered in the journal paper.

During therapy

Participants identified that during the therapeutic process there could be direct and indirect ways of disclosing their sexual orientation, which are dependent upon the context that the disclosure happens in. Direct disclosures tended to be in the early sessions, normally during the assessment phase. Many of the participants clearly stated that although direct disclosures are made, they generally do not happen very often and only when the participant thought that there would be some added benefit to offering this information to a client.

Disclosures during therapy were more likely to be direct, with the participant making a verbal statement: 'Point blank in about the second or third session I just said something like, "you might benefit from knowing that I'm gay" or something like that, I mean it was years ago' (Henry). Participants identified that these early disclosures were to let the client know that there was another non-heterosexual person in the room. For some their direct disclosure was not done through a blatant statement, but through the subtle use of a pronoun:

...you can kind of drop hints sometime without having to say "oh hey, by the way I'm a lesbian" so you can drop hints by saying things like "...oh my partner, she..." or perhaps I'll happen to drop into the conversation that I've recently done a course with other LGBTQ therapists... (Evelyn).

Here Evelyn suggests another way of making the client aware of her level of understanding of non-heterosexual identities; through discussing the type of courses she has attended. Although this is not a direct articulation of sexuality it can be seen as a subtle, indirect way of disclosing information that has the potential to communicate sexuality. Some participants described how they would use the pronoun to correct an assumption that the client had made about the participants sexuality. For example the client might assume that a male therapist had a wife or vice versa: '...And so when they, I said, you know, "my partner's a doctor", they start saying things like she. And I start to feel a bit uncomfortable because I don't think I'm being authentic. So I correct them by saying, my partner's a male' (Paul). A direct disclosure is made to the client to alleviate any uncomfortableness that there might be in the future if the client realises that his partner is a doctor or that he is gay, however, in this case it appears as though the disclosure is made because it will remove the uncomfortableness for the therapist, not the client.

Other participants described how they may pre-empt an indirect disclosure that could potentially happen outside the therapeutic space with a direct disclosure during therapy. Participants describe how they would explore the clients' reaction if they saw their therapist out of context:

Y'know if we're out and about and we're going to be at pride next weekend, what happens is that, more when, than if we run into clients.

That's something that I tend to, with my clients, that's something that I tend to explore, very early on: what will happen if we meet outside of the therapy room? (Jamie).

Related to the context of therapy was the potential that participants could be disclosing their sexuality to clients without necessarily realising that they were. Participants who used rooms in their house or an office space where personal artefacts were visible stated that clients could make an educated guess about the therapists' sexuality. In these settings participants reflected on the type of books that were visible on bookshelves, for example. Some participants noted that clients would have to walk through their house to get to the therapy room and while those who talked about using these spaces said that hallways were neutral, there was still the potential for the client to make assumptions about the therapist, which may not be solely related to sexuality.

Making a disclosure to challenge homophobia was another way in which participants could make a direct disclosure. This was seen as a subtle way of disclosing sexuality, while for others the disclosure was even more discreet and the client may not have totally understood what was being communicated by the participant. This type of disclosure usually entailed the participant challenging the clients views of non-heterosexuals through thought challenging techniques, rather than by stating the therapists' own sexuality in that discussion. While not a blatant disclosure participants did think that this type of challenge was enough to cause the client to make assumptions about the therapist's sexuality: 'It wasn't an outright disclosure of, you know, "I'm gay". I think it might have got in the way, but like I said at the beginning I think it might have been a defensive disclosure to close his horrid comment' (Henry).

The ways in which indirect disclosures took place could be seen as out of the participants control because of the way that information is communicated and interpreted with other. Indirect disclosure during therapy were usually non-verbal and included: characteristics, such as pronunciation of words, certain gestures and appearance that would disclose the participant's orientation. These factors were discussed in terms of how we communicate various things about ourselves such as class, background, how we look, and our character.

Participants did not see how indirect disclosure of sexuality was any different to an accent disclosing which part of the country the therapist was from. Some participants recognised that clients would be able to discern their sexuality from their appearance or that way that they acted. :

... I do not look stereotypically masculine or heterosexual. I look the way that I look and that's alternative and that could be perceived in lots of different ways. That could be perceived as being gay... But my sexuality is kind of ... I think my sexuality is obvious and I choose that I think. So I probably come out to everyone, just not always verbally.' (Paul).

While it is acknowledged that there does not have to be a verbal disclosure Paul also highlights that there is an element of choice in how he looks and potentially it is his intention to disclose his sexuality this way. On the other hand, not all participants identified or engaged with the stereotype that may be held about non-heterosexual groups within society: 'But then when I walk in, I tend to dress very plain because I have no fashion sense anyway, so I dress very plain (laugh). So they can't immediately make those assumptions about me I don't think' (Danny). The majority of participants thought that their sexuality was not readily discernible from their physical appearance or the way that they dressed, however, over time certain gestures or ways of saying certain things may cause the client to assume sexuality of the participant, accepting that there could be certain aspects of the characteristics that would give more information than others:

I don't see myself as a, I'm not particularly flamboyant, I'm not particularly camp, so I don't think that many people would, especially kind of, I don't know if it would be on their radar initially. It would be over time, when I, you know, maybe have certain gestures or ways that I say things might, you know, kind of, might make them think, oh actually, maybe. (David).

Some of the participants talked about how 'accidental' disclosures had been made to clients over their careers. Such disclosures included the client turning up to the participant's house at the wrong appointment time and being greeted by the participant's partner:

And then in fact, two or three times by his own mistake (well I call them mistakes, but how often are they ever mistakes) he turned up at the wrong time, but not only that at times when I wasn't here at all and my partner opened the door, with no idea that there would be a client waiting. (Jamie)

This highlights the intricacies of working from home and the difficulties of not letting disclosure leak through the boundaries of therapy. There were added complexities of the participants using their own home to work from, when their partners worked from home also. This would generally give the client opportunity to observe someone else at the house, whether it be the partner or because of the participants job younger people who were sometimes thought to be the participant's children. One participant spoke about how a client had known the participant's partner prior to engaging in therapy and how this disclosed a lot of personal information through association: 'And the first thing he did was say "oh, I hadn't realised that you were such-and-such's husband until I saw your address". Of course he's come here for teaching'. (Simon). Other participants described how something like a wedding ring had caused him to out himself to a client through a slip up:

...well on one occasion, one person asked me, erm, what did my wife think about it? I can't remember what, oh I know what it was, it was, erm, it was the end of a session and they, erm, I had been on holiday and the client asked if my wife enjoyed the holiday. I said, oh I don't have a wife. And they said, oh but you're wearing a wedding ring. I said, oh that's awkward, isn't it? (laugh). But I have a partner who's male, and that's how that happened (David).

The therapist described how this led to an uncomfortable moment between the client and therapist, where the therapist felt that there was no choice, but to make a disclosure. The participant reflected on their choice to make a disclosure in this context, not saying anything in this case was seen to communicate a lot of information and could potentially lead to the client speculating and making assumptions, which dependent upon the therapist theoretical orientation may have or may not have been useful. In this case the participant decided that it would be best to disclose his sexuality to close the

issue. This also highlights that clients assume the therapist's sexual orientation and that assumption is heteronormative.

EXTENDED DISCUSSION

This section elaborates on the discussion provided in the journal article. A summary of the results are provided and considered in context to the relevant literature, the strengths and limitations of study are discussed, and a proposed model of therapist minority stress. This section will conclude by discussing the clinical implications of the study, suggestions for future research and provides a critical reflection of the research process.

Previous self-disclosure literature has attempted to highlight the function disclosure may serve from the client's perspective and the therapeutic outcome (see Henretty & Levitt, 2010 for review). However, such literature has not directly focused on the disclosure of sexual orientation, which is often seen as a taboo topic. Previous reviews also utilised quantitative methodologies which have failed to consider the contextual factors that influences the decision-making process and the perceived outcomes of disclosure (Jeffery & Tweed, 2014). The online survey has provided some novel findings. It is believed that this is the first study to capture how many clients therapists have disclosed to, the clinical context of these disclosures and therapists awareness of guidelines related to disclosing sexuality. Participants illustrated variance in the number of clients that they have disclosed to with the majority of therapist stating that they had disclosed to less than five clients, closely followed by some therapists stating that they had over 20 clients.

An important finding from the survey respondents is that the majority of participants were not aware of guidelines related to TDSO. More interesting was that the analysis found participants' awareness of guidelines had no bearing on the use of disclosure. During the interviews a similar trend was apparent, the majority of participants were not aware of any guidelines. While some participants stated that they were unaware of the guidance, most of the participants stated that they were aware of the CHRE (2008) document, but did not distinctly call these guidelines. Some participants also stated that they were aware of the BPS (2012) working party document.

The function of disclosure

In line with previous research the current study found that therapists disclose their sexual orientation to clients, more than they withhold, this is in line with previous findings related to TSD (Henretty & Levitt, 2010) and offers new insight specifically into therapist disclosure of sexuality. Participants who completed the online survey highlighted that their disclosure was likely to happen more often to non-heterosexual clients, which is supported by participant responses within the interviews. This suggests that therapists may be aware of the previous literature which supports the use of disclosing sexuality if they therapists and client share a non-heterosexual orientation (Burckell & Goldfried, 2006; Guthrie, 2006; Jones, Botsko, & Gorman, 2003; Liddle, 1996; Milton, Coyle & Legg, 2002).

Research regarding the impacts of general self-disclosure indicates that the disclosure can have enhancing effects on the therapeutic alliance and is generally perceived to be helpful by the clinician and client (Knox, Hess, Petersen & Hill, 1997; Myers & Hayes, 2006). Participants suggest that disclosure is to communicate their understanding of the client's experience, but also the sense of safety, non-judgement and non-pathology within the therapeutic space. It appeared that some clients would actively seek out non-heterosexual therapists because of previous experience with therapists who had a lack of training, were ignorant or naïve to the non-heterosexuals within a heteronormative society. By creating this safe space, participants recognised that they were giving themselves permission 'to be real' with the client.

On the other hand, the *function of disclosure* can be explained by minority stress theory through the therapist's attempts to create a therapeutic space that is safe, non-judgemental and affirmative. Therefore therapist disclosure can be seen as an attempt to remove the clients' perceived stigma about their own minority status. The model suggests that disclosing a shared or similar sexual identity could alleviate minority stress because the non-heterosexual identity becomes normalised (Branscombe, Schmitt, & Harvey, 1999; Clark et al., 1999). It could be argued that sharing a minority status can act as a protective factor because the client can establish alternative values and structures (Crocker & Major, 1989; D'Emilio, 1983). Hence, through the process of

disclosure, the therapist is facilitating an opportunity for the client to experience social environments where there is no discrimination.

This process can be considered using social evaluation theory (Pettigrew, 1967) which suggests the concept of minority coping. Individuals within a minority group, who have a strong sense of community cohesiveness, can evaluate themselves compared to other who are similar, rather than to others in the dominant culture. Therefore, therapist disclosure to non-heterosexual client (i.e. the in-group) may provide a reappraisal of the stressful condition, therefore reducing the adverse psychological impacts of minority stress. Through reappraisal, the in-group validates deviant experiences and feelings of minority persons (Thoits, 1985). Indeed, reappraisal is at the core of gay-affirmative, Black, and feminist psychotherapies that aim to empower the minority person (Garnets & Kimmel, 1991; Hooks, 1993; Shade, 1990; Smith & Siegel, 1985) and the function of disclosure could also be situated under this theory, as the disclosure allows a perceived affiliation with the client. This could be viewed as helpful to both client and therapist and may suggest a rationale of why therapist disclosure is more common with non-heterosexual clients. It could be argued that because of the LGBT therapists' own experience of discrimination within society they are attempting to remove the expectation that (they perceive) the client has about being with a heterosexual. By naming their sexuality therapists are aligning with the clients own sexual identity as a way of communicating that the client does not need to feel judged for identifying as a non-heterosexual, as they might have done if they were seeing a heterosexual therapist.

Disclosure was highlighted as being used as an intervention by participants. In some cases disclosure was used to facilitate a challenge to the clients' assumptions, to challenge homophobia and provide a role model for clients (Hanson, 2005; Lea, et al., 2010; Moore & Jenkins, 2012). It could be argued that this type of disclosure was used to meet the needs of the therapist rather than the participants. Some may argue whose issue is the homophobia in this context. Those who discussed making a disclosure to nullify the homophobia did so in a way that was again acting in the client "best interest", rather than how their disclosure may help them alleviate the distress that they felt during the exchange with the client because of feeling judged. Therefore there is the

potential that the majority of participants did not feel confident discussing their experiences of disclosure having a negative impact on the client or the alliance because it may have been too risky to discuss times when a disclosure may have been made to meet therapist needs.

Disclosure was used to facilitate the normalisation of the client experience; enabling reciprocal disclosures (e.g., allowing the client opportunity to express their own sexuality); creating a therapeutic space that was safe, non-pathologising, non-judgemental; and role modelling (Faber, 2006; Jeffery & Tweed, 2014; Lea, et al., 2010). These are particularly pertinent for non-heterosexual therapists working affirmatively with gay clients (Davies, 2007; Milton, Coyle & Legg, 2002; Moon, 2008). Studies researching the crucial ingredients to therapy have highlighted that it is the non-specific therapy techniques (e.g., warmth, empathy, understanding, similarity, authenticity) have been highlighted to be crucial in effecting therapeutic change (Norcross, 2002; Wampold, et al., 2002; Wampold, et al., 1997), with participants stating the function of their disclosure is to harness and strengthen the alliance with non-heterosexual clients. This finding was supported by the online survey responses, highlighting that LGBT therapists are most likely to disclose their sexual orientation to clients who identify as LGBT. The survey results also found that therapists were more likely to have disclosed their sexuality to many or few clients. This finding could suggest that therapists who disclose often do so because they have had a positive experience of disclosing their sexuality to clients, seeing first-hand the benefits of TDSO. However, the survey did highlight that the post-qualification experience was not a significantly influential factor in therapists' disclosure, which suggests that therapists may develop a stance on disclosure early on in their career which does not change significantly across increasing professional experience. Conversely, the findings suggest decisions to disclose are not significantly influenced by the therapists' profession (Carew, 2009), which does suggest that non-heterosexual therapists may not be rigidly tied to their theoretical orientation when it comes to disclosing to non-heterosexual groups. This was apparent in the interviews; participants who identified as being more relationally orientated discussed working with the

transference when seeing a heterosexual client, but making a disclosure to remove a barrier when with a non-heterosexual client.

The function of non-disclosure

Participants identified that they would withhold a disclosure if they thought that it was going to impact the client's perception of them. Participants wanted to be viewed as competent and some suggested that disclosing their sexual identity could potentially undo the perception that clients' may have held. Some went as far as to suggest that the client could see them as a 'fraud' because of the shattered illusion. Participants discussed how they battled with the need to protect their integrity and credibility within the alliance, but that to do so with heterosexual clients meant that they needed to conceal part of themselves (Jeffery & Tweed, 2014). There is a delicate balancing act that participants have to contend with. Many of the therapists could see the value of making a disclosure because they believed that it would lead to positive effects on the therapeutic alliance and therapy outcomes (Lea, et al., 2010; Moore & Jenkins, 2012), but at the same time participants accepted that making a disclosure for their needs would be inappropriate and not relevant when working with a heterosexual. This was further supported by results from the online survey which illustrated that disclosure to heterosexual clients was less common compared to disclosure to non-heterosexual clients. Participant's responses about disclosure to non-heterosexual clients were grounded with phrases like 'in the client's best interests' or 'it has to be useful for the client to know' and 'if I think that it is appropriate then I will disclose', however, it was contrasted by their aspiration to credible and honest, which is what therapists were able to achieve with non-heterosexual clients by disclosing.

Other reasons for withholding a disclosure included participants not wanting to alter the boundaries of therapy by making the therapist the focus (Hill & Knox, 2001), or be seen as a biased witness, when working with clients who were ambivalent about their sexuality. Participant's largely agreed that in this case sending out the message "it's ok to be gay" could be potentially damaging for the client because it lessens the client's own exploration (Satterly, 2004) and for the professional's reputation (Lea, et al., 2010).

Participants also described how they feared that a heterosexual client would “judge” them and participants “feared” being stigmatised by heterosexual clients because of sexuality. Participant’s responses were mainly linked to their assumptions of how they would expect heterosexual clients to react (Moore & Jenkins, 2010). There appeared to be little evidence to substantiate the participants’ assumptions of client perceptions changing based on the therapists’ sexual orientation. However, participants’ linked this to their personal sense of internalised shame, and or homophobia. While participants raised concerns about how the clients’ perceptions may change because of a disclosure, very little was discussed in terms of how the participants’ perception of the client would change if the client demonstrated prejudicial views. The absence of a theme related to this suggests that participants did not feel able to discuss how their perception of the client may have changed because of the clients views of non-heterosexual groups. Participants may filter their experience of negative reactions to clients because of being uncomfortable with them, especially if utilising a model where positive warm regard and congruence are essential in developing and maintain an effective alliance. It is plausible that participants did not want to be judged by the primary researcher if they expressed these negative reactions about their clients. Furthermore, it could be possible that participants feared that their interviews would be terminated if they expressed such negative feelings about their clients such feeling could be seen as unacceptable and therefore ‘unethical or risky’.

Participants appeared to exhibit a lack of choice regarding their concealment when working with heterosexual clients. Issues discussed were around the relevance for heterosexual clients to know the therapists sexuality. Many discussed that if they did disclose their sexuality to a heterosexual then the participants would view it as inappropriate, doing it for themselves, rather than for the client. The potential that a therapist may act inappropriately by disclosing sexuality was shameful and can be situated in the context of the available guidelines on therapist disclosure (e.g., CHRE, 2008) The disclosure of sexual preferences is also considered in the same vein as criminal acts, such as rape, which could suggest that therapists disclosing sexual preferences is as serious

as a therapist committing a criminal act. Such guidelines make it clear that disclosure of sexual preferences can be classed as an unacceptable sexualised behaviour and hence the guidelines are probably heightening the LGBT therapists' awareness that disclosure could be viewed as wrong or inappropriate.

What the guidelines communicate, coupled with the expectation that heterosexual clients will present with some form of prejudice against non-heterosexuals adds to the adverse consequences related to concealment of sexuality (Jeffery & Tweed, 2014; Moore & Jenkins, 2010). Concealment of sexuality is linked to amplified stress within LGBT groups, therefore increasing the likelihood of adverse psychological and physical consequences (Meyer, 2003; 1995). While it is widely agreed that that psychological wellbeing of clients is overriding, it is clear from this research that the clinicians' wellbeing should not be disregarded. Furthermore, previous research suggests that therapists who disclose are generally regarded more favourably compared to non-disclosing therapists (Knox, et al., 1997; Myers & Hayes, 2006).

It is interesting to note that the reasons therapists give for withholding a disclosure to a heterosexual client (e.g., fear of prejudice, judgment, discrimination). These are contrasted with the reasons therapists give for explaining why they see it is as beneficial to disclose their sexuality to non-heterosexual clients (e.g. removing judgement, pathology and enhancing the alliance). This suggests that LGBT therapists disclosure of sexuality can be viewed within the context of minority stress, particularly the three processes that Meyer (2003) suggests are pertinent to LGBT individuals (i.e. external objective stressful events and conditions (chronic and acute), the expectation and vigilance of such events, and the internalisation of negative societal attitudes) and social evaluation theory (Pettigrew, 1967). Participants highlighted that disclosing their sexuality to their heterosexual clients would be more "risky" because of the perceived damage it could cause to the therapeutic alliance or the expectation that the therapist may be faced with personal risk.

The model would suggest that participants *expect* that heterosexual clients will act in a discriminatory or prejudicial way based on their previous experience of

suffering discriminatory behaviour from some heterosexuals. The model would further suggest that the therapist's previous knowledge of experiencing discrimination from heterosexuals has increased their vigilance for negative societal attitudes and behaviour towards non-heterosexuals. This could be either in their private and/or professional lives e.g. many participants spoke about growing up before homosexuality was decriminalised or being an adolescent or young adult during the aids/HIV crisis. Living through these times will have increased the frequency of the external objective events and through the discrimination and prejudice seen or experienced will have increased the individual's expectation of being discriminated in some way. Hence non-heterosexuals become more vigilant of discriminatory behaviour. Due to feeling unable to come out and form a more positive self-identity the negative attitudes held about LGBT individuals within society will have become internalised as the LGBT individual will have attempted to conceal their sexual identity. Due to the expectation of discrimination, based on their prior experience, and internalised negative attitudes of non-heterosexual individual within society, LGBT therapists are more likely to conceal their sexual identity to a heterosexual client, compared to non-heterosexual client.

How disclosure happens

Literature examining the contextual issues demonstrate the inherent complexities of this area, increasingly so as therapists' sexuality may be assumed (Coolhart, 2005; Russell, 2006) or disclosed unintentionally out of context (e.g. at pride event or being seen with a partner) because the client and therapist share the same gay community (Farber, 2006; Knox, et al., 2002; Lea, et al., 2010). The clinical context has also been suggested to influence the therapists' TDSO and research has suggested that disclosure in some contexts is more widely accepted and visible (Hanson, 2003). Furthermore, with the increase in TDSO pre-therapy there is an increasing likelihood that clients actively seek LGBT therapists because of sharing a sexual identity (Bartlett, King & Phillips, 2001). The online survey results suggest that many of the sample were working within private practice, which the findings of the interviews found was more likely to be linked to pre-therapy disclosure (see journal article for discussion) because of the type of referral sources that non-heterosexual

therapists use to generate clients (e.g. online directories, professional websites, etc.). These findings further highlight that clinical context can be an important factor in TDSO. The survey also revealed that disclosure was also common in voluntary settings or within research settings.

Some participants stated that clients became aware of their sexuality because of cues picked up from the home (e.g. meeting partners at the front door, many books on show about LGBT matters or clients commenting on wedding rings). Gay clients are seen to be sensitive to cues of sexuality (e.g. manner, tone, jewellery) with sexuality being “invisibly visible” (Lea, et al., 2010, p. 69; Satterly, 2004). The role of cues such as a wedding ring was also discussed in terms of accidental disclosures, with clients making assumptions about the therapist’s sexuality, which led to a disclosure. Other participants discussed how their characteristics or the way they looked could act a disclosure. This highlighted that there was a paradox to the “blank screen” that participants professes they used during therapy. This was highlighted because participants were keen to withhold information about themselves while using their home as a clinic; choosing to dress in a certain way; project an image of themselves that could be considered as ‘gay’. This finding highlights that therapists may be unaware of how they can leak disclosures about themselves (Carew, 2009). The concept of leaking disclosure is also present for heterosexual therapists, but is seen as less of an issue in the context of a heteronormative society. For example, although ‘gay marriage’ has been legalised in the UK, for many a wedding ring is synonymous with a heterosexual lifestyle. Finally, this overarching theme highlighting that disclosure is more than just a verbal articulation of “I’m gay” or “I’m bisexual”, but rather, there are multiple ways that therapists may ‘come out’ to clients. It is also worth noting that disclosure of sexuality does not only happen for LGBT therapists. While it is taken for granted that heterosexual individuals do not have to ‘come out’ as heterosexual their subtle disclosures should not be overlooked. As already stated a wedding ring is synonymous with a heterosexual lifestyle, but disclosure could also happen through mentioning that they have children or by having family photographs on display. Carew (2009) discovered that heterosexual therapists had limited appreciation of the how much information can be communicated without the

therapist making a verbal disclosure. The findings of this study highlight the intricacies of disclosure and the complex decisions that non-heterosexual and heterosexual therapists must make.

A model of therapist minority stress

Meyer (2003) suggests that there are three processes of minority stress that are relevant to LGBT individuals. These include: external objective stressful events and conditions (chronic and acute), the expectation and vigilance of such events, and the internalisation of negative societal attitudes. In the context of this research it could be argued that historically non-heterosexual individuals will have suffered some form of prejudice or discrimination because of their sexuality or their perceived sexuality. These events will have been viewed as stressful because they will be beyond the individuals' perceived ability to cope (Dohrenwent, 2000). These stressful events may occur during adolescence, prior to the individual 'coming out', therefore there may be an enhanced risk of being found out by family or friends, which heighten the individuals need to conceal their sexuality until they have 'come out'. As discussed previously, coming out is one of the main ways that non-heterosexual individuals learn to overcome adverse stress (Morris, Waldo, & Rothblum, 2001) because alternative values and structures are established that fit better with their identify (Crocker & Major, 1989; D'Emilio, 1983). Coming out is an ongoing process and at times it may be appropriate for the individual to conceal their sexuality as a way of mitigating potential prejudice from others. Within training courses messages of maintaining the 'blank screen' are abundant, while disclosure, of more general information or more personal information (e.g. sexuality) is absent. Non-heterosexual therapists qualify from training programmes having learnt that disclosure is not condoned (Lea, et al., 2010), and there is little space for reflection on practice. From the findings it appears that therapists have come to assimilate gay-affirmative practices in relation to the benefit of disclosing sexuality to non-heterosexual clients, with a definitive rejection of making disclosures to heterosexual clients. Heteronormativity effects, including the guidance available and the expectation of heterosexual prejudice and discrimination will cause LGBT therapists, like other non-heterosexuals, to expect a negative response within a heteronormative society and therefore

conceal or hide their identity in the therapeutic context. The prejudice therefore becomes internalised “disclosure would be making it about me” or “it’s not their issue, it’s mine”, because the sexual identity is hidden, which leads to the adverse psychological effects of concealment discussed in this research (Jeffery & Tweed, 2014; Meyer, 2003).

Clinical implications

Findings from the present study may provide useful insight into to psychological benefits of therapists disclosing sexuality to clients by combatting the impacts of minority stress and ‘outsider syndrome’ experienced by non-heterosexual groups because of the normalisation and reappraisal of non-heterosexual identities (Pettigrew, 1967). While often evoking stress reactions, minority status can promote solidarity and cohesiveness, which serve to combat adverse psychological impacts (Branscombe, Schmitt, & Harvey, 1999; Clark et al., 1999). Therapist disclosure could therefore provide similar positive psychological impacts for clients through the perception of group affiliation; and stigmatised individuals having the opportunity to experience social environments where they are not stigmatised (e.g. clients having their experiences normalised by a non-heterosexual therapist, not feeling judged or pathologised by professionals) (Jones, et al., 1984).

The study has provided further insight into the negative effect of therapists withholding or concealing their sexualities and considered the current guidelines and the minority stress model to explain the psychological processes involved. A rationale was provided about why therapists feel the need to withhold sexuality when working with heterosexual clients. The current research also highlights the rationale that therapists have for disclosing to non-heterosexual clients. The impact of concealment is an important consideration on the therapeutic process. If non-heterosexual therapists are constantly self-monitoring themselves in therapeutic interactions with heterosexual clients, how present can they be in the room with the client? It could be argued that the LGBT therapist may be preoccupied with hiding certain aspects of themselves (e.g. monitoring the way that speak, what they say, certain gestures). This

suggests that LGBT therapists have an added pressure to retain the sense of a “blank slate” compared to their heterosexual counterparts. Participants expressed that revealing any personal information about themselves, particularly sexual orientation, challenged what they had been told on training courses or what was expected from their theoretical orientation. However, the current research supports previous findings which highlight the benefits and usefulness of TDSO. It is clear that training courses and therapeutic guidelines suggest that therapists use disclosure judiciously with CHRE (2008) suggesting that revealing a sexual preference could be classed as a “sexualised behaviour”, adding to the mixed messages that therapists are confronted with about TDSO and TSD more generally. Therefore therapists are left questioning the appropriateness of their disclosure and sometimes have limited support networks to discuss such issues. In light of this, it is suggested that the topic of disclosure is covered widely and in-depth across professional training courses, providing a space that is reflective for professionals to discuss and gain support for issue related to disclosure.

While CHRE guidelines are in place to protect service users, they have created a discourse which enhances the taboo nature of sexual identities. It is unclear if such guidelines are based on empirical evidence related to disclosure and therefore it is suggested that professional bodies take into account the impacts of TDSO on the therapist, especially non-heterosexual therapists' who are concealing their sexual identity. Increasingly, like race or ethnicity, sexuality is becoming visible within society and while therapists should be judiciously disclosing, professional bodies and society should not be advocating that non-heterosexual therapist go back into the closet, to protect the heterosexual majority from knowing their therapist is non-heterosexual. If this is the case it should be situated in the context of discrimination on the basis of minority status and the results from this study, which can be summed up as disclosing to an LGBT client was acceptable because of the therapeutic benefits it would bring about, however there was a fear that disclosing to a heterosexual would lead to prejudice and be seen as inappropriate or wrong.

This research highlights the need for there to be increased awareness of the intricacies of disclosure of sexuality, but also for therapists of all sexual identities to reflect upon and understand the numerous ways in which disclosures (of any kind) can leak into the therapeutic space. This highlights the need for therapists to have supervisors who are aware of the potential issues faced by non-heterosexual therapist in order to provide appropriate support for issues of concealment within clinical practice.

Strengths and limitations

One of the key strengths of the study was the mixed methodology used to gather and analyse the data, with this being the first study to use this method. This methodology combines those therapists' subjective experiences of TDSO across cultures and disciplines. The online survey is the first attempt to gather data about therapist behaviour and provides insight into the commonality of TDSO across the UK and across some other countries. There is however a number of limitations that needs to be considered. While the mixed methodology is considered strength it is also clear that the quantitative analysis is limited to descriptive information with minimal inferential analysis. This is impart due to the level of categorical data collected by the survey, along with the lack of normal distribution within the sample.

The qualitative analysis explores LGBT therapists' subjective perceptions and experiences of TDSO and is the first study to explicitly explore the purpose of TDSO, while also highlighting reasons why non-heterosexual therapists would chose to withhold a disclosure. This study has come some way to bolstering the findings of smaller qualitative studies conducted in this area. For the interviews the sample may have been homogenous, with a small number of participants, it did represent a geographically diverse population, within the UK. One participant practiced in Germany and therefore it could be argued that the results are not representative of an international sample of therapists, unlike the online survey.

Purposive sampling was utilised to select therapists who would fulfil the inclusion criteria. Although, it is acknowledged that this may have generated a

bias in the sample with only those professionals who had an interest in the research area volunteering. Furthermore, the study may have not attracted therapists who would not be comfortable discussing their experience of TDSO because a fear of being judged by the researcher. However, it is acknowledged that this is a population that would be persistently difficult to access, but that using an online survey and individual interviews may have gone some way to provide a confidential space to express their opinions and experiences.

It is recognised that participants of the interview may have censored their accounts somewhat because of a fear of being judged or reported to their governing body. Participants would have been aware, that if they discussed anything that I deemed to be 'unethical or risky' their interview would have been terminated. This may have created an essence of social desirability (Hollander, 2004), which may have skewed the data. The context of the research also needs to be considered, many of the participants were recruited from gay-affirmative sections or organisations, therefore the findings may only reflect the dominant ideas of such organisations. It is hoped that triangulating the interviews online survey results may have enabled deeper insight into understanding the research question (Lambert & Loiselle, 2008).

A final limitation that has to be acknowledged is how the online survey was constructed. It was intended that some questions participants would be able to give multiple responses; however, when the survey was published an oversight meant that some questions were restricted to single answers. As soon as possible attempts were made to correct the mistake, but the question type could not be changed because responses already given to that question would be lost. Therefore, a free text box was added to the affected questions. This may have meant that some participants limited their responses and therefore the data from the survey may be restricted and not fully representative of sample.

Recommendations for future research

Future research should aim to further explore the experiences of therapists TDSO within an international sample, especially within qualitative methodologies, because it would be useful to understand if there are cultural

differences in how therapists approach TDSO. Furthermore, it would also be interesting to study heterosexual TDSO. While it is generally assumed that heterosexuals do not need to disclose, because of heteronormativity, it would be beneficial to understand the perceptions and experiences of this group of therapists and compare this to non-heterosexual therapists' experiences. It would also be interesting to assess how confident therapists were in making disclosures to clients to examine if there was any relationship between confidence and disclosure. Likewise, assessing competence and disclosure would also be interesting to establish. Finally, it would be useful to ascertain clients' experiences of TDSO. Doing so would help triangulate the findings of studies based on therapist samples and help researchers and clinician fully understand the impacts of TDSO on the client, therapeutic alliance and therapeutic outcomes.

Critical reflection

This section critically discusses some of the wider issues raised by this research study. The discussion is organised as a temporal account around themes derived from the researcher's reflective research diary (extracts are presented in *italics*). Throughout this section, the main difficulties faced during the development and data collection phases of the study are outlined.

Conceptualising the research

The rationale for undertaking this study came from my own previous experience of experiencing homophobia during a therapeutic session. Following a discussion with my supervisor we decided that the best way to deal the situation was for me to disclose or 'come out'. I began to think about the other potential reasons for therapists disclosing their sexuality. The project was initially designed to be an interview study, but later in the development stage we decided to incorporate the online survey to increase the likelihood of sampling from a diverse range of experiences. Diversity was also why the study was aiming to reach an international sample, however obtaining ethical approval for an international sample was challenging due to the sensitivity of the topic (i.e. talking about sexuality with individuals where non-heterosexual identities may

be criminalised). Therefore, the ethics committee were only willing to approve recruitment within the UK. It took a further five months for the ethics panel to approve recruitment for an international sample, with increased safeguards in place to protect the anonymity of participants.

The next stage was to speak with professionals about the feasibility of conducting research in this area. *From those clinicians who have been contacted the idea has been met with positivity and enthusiasm, with professionals agreeing that TDSO is an under-studied area and that further exploration would be a useful addition to the literature. One professional thought that the aims of the study are too broad and that given the data collection method, it might be difficult to generate the purpose of TDSO. It has also been highlighted that this is a sensitive area and therapists might not feel comfortable to discuss their experiences of disclosing because of how it might be viewed by others. I expect that therapists are going to be extremely busy and it may be hard to recruit because I presume many will be self-employed that they may not be able to take time away from paid work to take part. I hope that by having both online survey and interviews therapists will think that if they can't commit to an interview, then they could complete the survey.*

A number of decisions

The following weeks and months were categorised by many decisions. *Individual interviews would certainly be appropriate; however, if I am to recruit from an international sample, I need to use methods that do not rely on face-to-face interviews. It will be important to recruit a varied sample of therapists who work in various settings; this should allow the study to capture diverse data about therapists' experience of TDSO.* Participants were not recruited through the NHS and therefore the sample is heavily reliant on those working in private practice. However, some participants who do have experience (previous or current) of working in the NHS formed part of the sample. It was hoped that this would increase the heterogeneity of the sample. Heterosexual therapists were excluded from the study because the literature suggests that clients generally assume the therapist to be heterosexual and it is assumed that disclosure of a heterosexual identity would be less frequent, if at all, because of living in a

heteronormative society. Reflecting on my epistemological stance and the mixed methodology that I am utilising I decided that TA would be the best qualitative analysis methods. TA is not bound to any particular epistemological stance and although it has faced criticism for this (Braun & Clark, 2006), it provides a flexible approach that I can use to examine TDSO.

Ethics

The ethical application process has been one of the most challenging parts of the research process so far. I became frustrated as I learned that part of the reason that my ethical approval had taken from September 2013- March 2014 was because there had been a major lack of communication within the committee. In October 2013 the project was granted approval by one of the reviewers, however this was not communicated to the committee, therefore when I re-submitted to ethics for approval for an international sample, the committee were raising some of the original concerns that had been addressed in October 2013. This was really frustrating because it caused unnecessary delays in recruitment and additional stress.

Planning the online survey

After a discussion about the pros and cons of multiple online survey sites, I have decided to use one (esurv.org). It might not be as aesthetically pleasing as some of the others, but it does have slightly better functionality and is free for multiple responses. Let's hope that there aren't any hiccoughs with it!

Using the online survey

Well the online survey is up and running. There were a few glitches with some of the types of question, some of them would not allow multiple responses so have had to be altered, but after some small changes this should not be a problem any longer.

Initially I thought that setting up the online survey would be relatively simple. While not overly complicated to do, I did find the process somewhat confusing and tedious. *I guess that is the downside to using a free online platform.* Following the initial difficulties that I noticed with some of the question types, I

made changes to ensure that the questions would allow multiple answers. However, when the survey was launched some participants informed me that they were not able to give multiple responses. Unfortunately, because the survey had started collecting data I could not make any changes to the question type without the data being deleted, therefore I had to include a free text box and make participants aware that they should use the text box for multiple responses.

Planning the interviews

I have just booked in my first interview! I have been reading up on some of the papers that have researched TDSO and familiarising myself with the interview schedule. It has been quite difficult to organise this initial interview, I'm having to be extremely flexible with participants to fit around their schedule, after all they are participating for free. I'm slightly disappointed by the low number of people who have signed up for the interview so far. I think recruitment may take some time.

I need to think of how I am going to approach these interviews. I don't want the participants to think that I am judging them in some way because of the questions that I'm asking. It's going to be a balancing act between asking the probing questions and facilitating a space where the participants feel that they can speak freely about their experiences.

I encountered a number of complications in the logistics of setting up interviews. Participants had limited availability to squeeze in the interview, which meant me having to be very flexible with my time. Due to participants being extremely busy interviews were cancelled at short notice or participants were late. However using skype and the telephone to contact participants did mean that my time was not wasted in travelling to meet participants if they were going to cancel at short notice.

After the interviews

I have just finished my last interview. It's been quite a few weeks since anyone signed up for the interview regardless of how frequently it's been advertised. I

have noticed that over time, I have become more comfortable with engaging the participants and not feeling tentative in asking difficult and probing questions. I've also noticed that I more able to be flexible with my interview schedule and ask other questions that seem relevant. Overall, I think that the interviews have gone better than I anticipated: Participants were able to challenge their own ideas.

Transcription

When reviewing the audio recordings and during transcription it became clear that some participants would pause for very long periods, while they were thinking about their answers this led me to reflect on the importance of incorporating significant pauses into the transcripts. Initially I had not considered using an external transcription service, because I realised that the transcriber would lack such contextual knowledge, however, due to time restrictions I had to reconsider this choice. The transcriber was informed of the as much contextual information as possible and asked to leave in significant pauses. Following each finished transcription I reviewed the transcript for accuracy checks and could suggest changes that needed to be made.

I did have the expectation that transcription was going to be a chore, but I have found it helpful during the analysis: Braun and Clarke (2006) have stated that immersion within the data is an important first stage. I think that this helped me remain grounded in the data rather than my own interpretation.

Analysis stage

I have chosen to undertake a hybrid deductive-inductive analysis to ensure that my analysis stays grounded in the data, but acknowledging that I cannot be free of my prior knowledge and own assumptions of the area. I also need to bear in mind that this is a mixed methods study and to be coming to the qualitative analysis with an inductive stance seemed odd, especially as quantitative research is usually associated with positivist assumptions. Therefore, in line with my contextual critical realist position, I am aware that no research is conducted in a vacuum. I have come to the analysis with knowledge of the

existing literature, and this will undoubtedly lead me to focus on certain aspects of the data at the expense of others, especially if I have conducted preliminary analysis on the online survey data.

In an attempt to minimise bias, the transcripts were coded independently by one of my research supervisors. The discussions which followed were incredibly helpful, enabling me to consider other possible competing interpretations and explanations of the data. This involved both of us playing “devil’s advocate” at times (Barbour, 2001). While drawing the themes together, both research tutors and myself discussed and agreed on what fitted where. Even so, I do not think that research can be completely free of bias and I did not strive to achieve this.

Writing up

Writing the results and discussion were another part of the analysis process. Numerous decisions had to be made regarding which data to include and which data to leave out, because there was such a large volume of it. I wanted to do justice to all the participants’ contributions but given space constraints this proved difficult. Although attempts were made to justify decisions of what to include through an audit trail, I have inevitably had an important influence over which data to present and which not to.

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APPENDICES

Appendix A: Study Advert

My name is Adam Harris and I'm a Trainee Clinical Psychologist. As part of my thesis I am interested in conducting research with an aim to increasing our understanding of LGBT therapists'¹⁰ perspectives on disclosing their sexual orientation to clients.

Primarily I am interested in LGBT therapists' views of therapist self-disclosure of (sexual) orientation (TDSO). From this research the objective is to gain a better understanding of the decision-making processes involved when considering making a disclosure. It is also anticipated that the function of the disclosure for the therapist can be established. Furthermore, I am interested in the context of the disclosure and the perceived consequences on the therapeutic alliance.

In order to conduct this study I am inviting you to take part in an online survey with some brief questions related to your profession and experiences of making a disclosure. The survey will take about 5-10 minutes of your time. For those who are interested in discussing their experiences in more depth there is the option to opt in to be interviewed at a later date.

To take part:

- You must be registered with a governing/professional body
- Identify as non-heterosexual
- Have thought about making a disclosure
- Have a qualification that enables you to be a therapist

If you wish to take part please click on the link below where you will be shown more information about the study and then asked for your consent to take part.

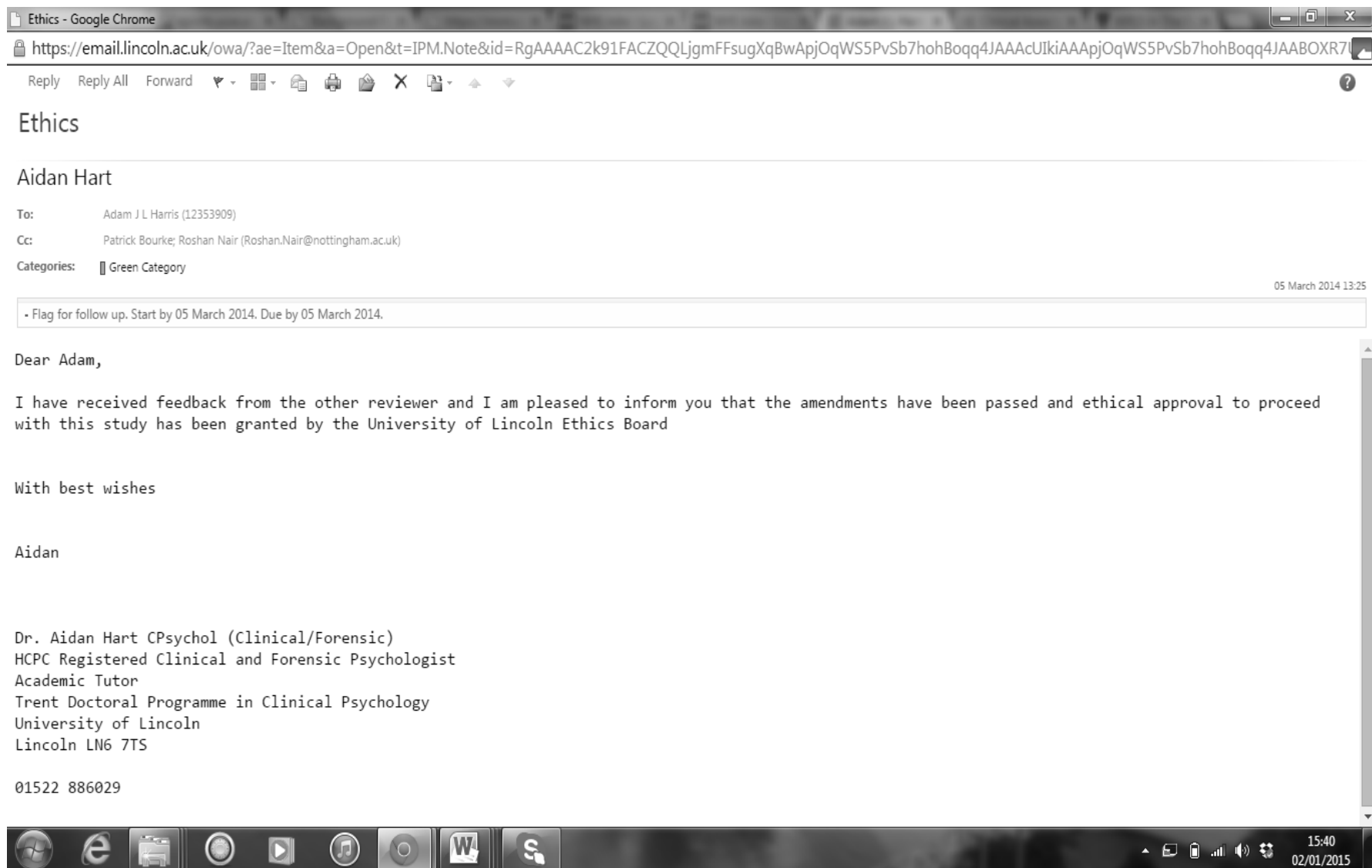
http://eSurv.org?u=LGBT_therapist_disclosure

If you have any questions about this research please contact the lead researcher on the details provided below:

Adam Harris – Trainee Clinical Psychologist
Trent Doctorate in Clinical Psychology
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¹⁰ The term therapist refers to any professional who engages with clients using psychological/psychotherapeutic perspective including Clinical or Counselling Psychologists, Counsellors, CBT therapists, Psychotherapists, family therapists, etc.

Appendix B: Ethical Approval Email



Appendix C: Consent Page (Online Survey)

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← → ↻ https://esurv.org/surveyEditor.php?survey_ID=OCDENF_c3fd3dec

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Drag & Drop

✕ Edit Copy Move Split Page Delete

+ Add Question

*** CONSENT**
I have read the participant information above and understand that by clicking the button below:

- I am giving my consent to take part in this survey.
- I am 18 years or older, and I understand that participation is voluntary and that I am free to stop completing the survey at any time.
- I am stating that I am a qualified therapist registered with a professional/governing body

Please provide a pseudonym by combining the first three letters of your mother's maiden name with your month of birth in numerical form (i.e. If your mother's maiden name is Henderson and you were born in September you should write 'HEN09'.)

Please take note of this name as you will need to quote it if you wish to withdraw your data. You are able to do this up to 1 week after submitting your survey.

☐ I consent to taking part in this online study and understand that I can withdraw my data up to one week after taking part

Unique pseudonym (First 3 letters of your Mother's maiden name and the month of your birth in numerical form)

https://esurv.org/surveyEditor.php?survey_ID=OCDENF_c3fd3dec

+ Add Question

15:44
02/01/2015

Appendix D: Interview Schedule

N.B. The interview will follow a semi-structured format. The research conversations that I have with participants will be centred on the following themes and prompts, but may not include the specific questions noted here or follow this specific narrative structure.

During today's interview I am going to be asking you about your experiences of TDSO. It may be the case that you want to talk about a specific case or multiple cases; this is for you to decide.

What are your views of TDSO?

Have you thought about disclosing your sexual orientation to a client?

Have you disclosed your sexual orientation to more than one client?

What made you think about making a disclosure?

Do you remember the first time you disclosed your sexual orientation to a client?

In what context was this disclosure made? Please explain.

What was the work setting?

How did you make your disclosure?

Have there been other experiences or other clients that you've disclosed to?

Can you explain more about that?

What reasons do you have for making a disclosure?

What impact did this disclosure have on you as a therapist?

What impact did this disclosure have on the therapeutic alliance with the client(s) you disclosed to?

How has your experience of disclosing your sexual orientation to clients influenced your views on therapist disclosure of sexuality?

What advice would you have for therapists who are considering disclosing their sexual orientation?

If no...

What was the context?

What work setting were you in?

What has stopped you from using TDSO?

What reasons do you have for not making a disclosure?

What impact did non-disclosure have on you as a therapist?

What impact did this non-disclosure have on the therapeutic alliance with the client(s) you disclosed to?

How has your experience of disclosing your sexual orientation to clients influenced your views on therapist disclosure of sexuality?

What do you think are the difficulties in making a disclosure? Why do you think such difficulties exist?

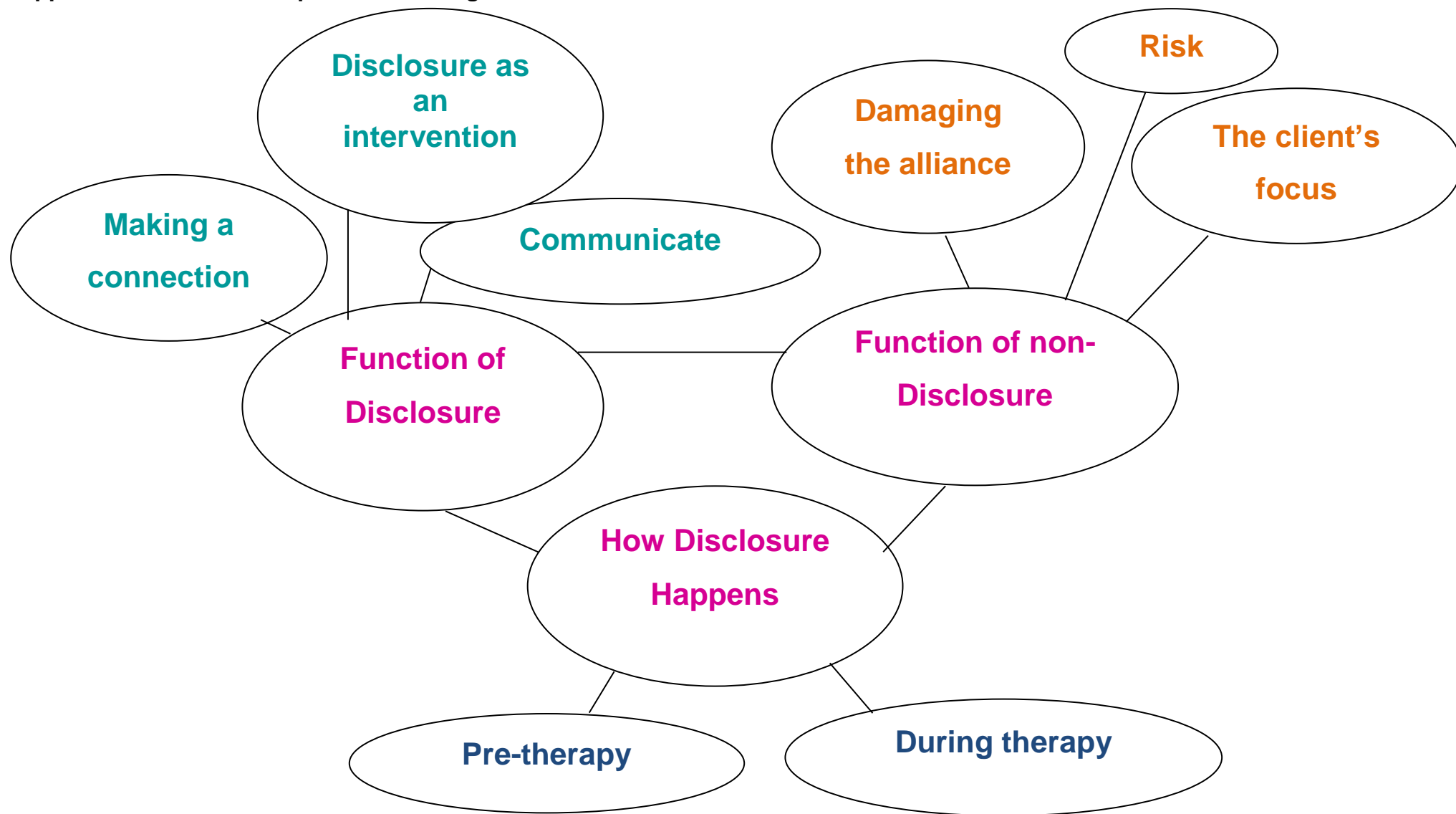
What factors helped you in making a disclosure? Why do you think such factor assist your disclosure?

Have you used supervision or specific guidelines to help you consider the use of TDSO?

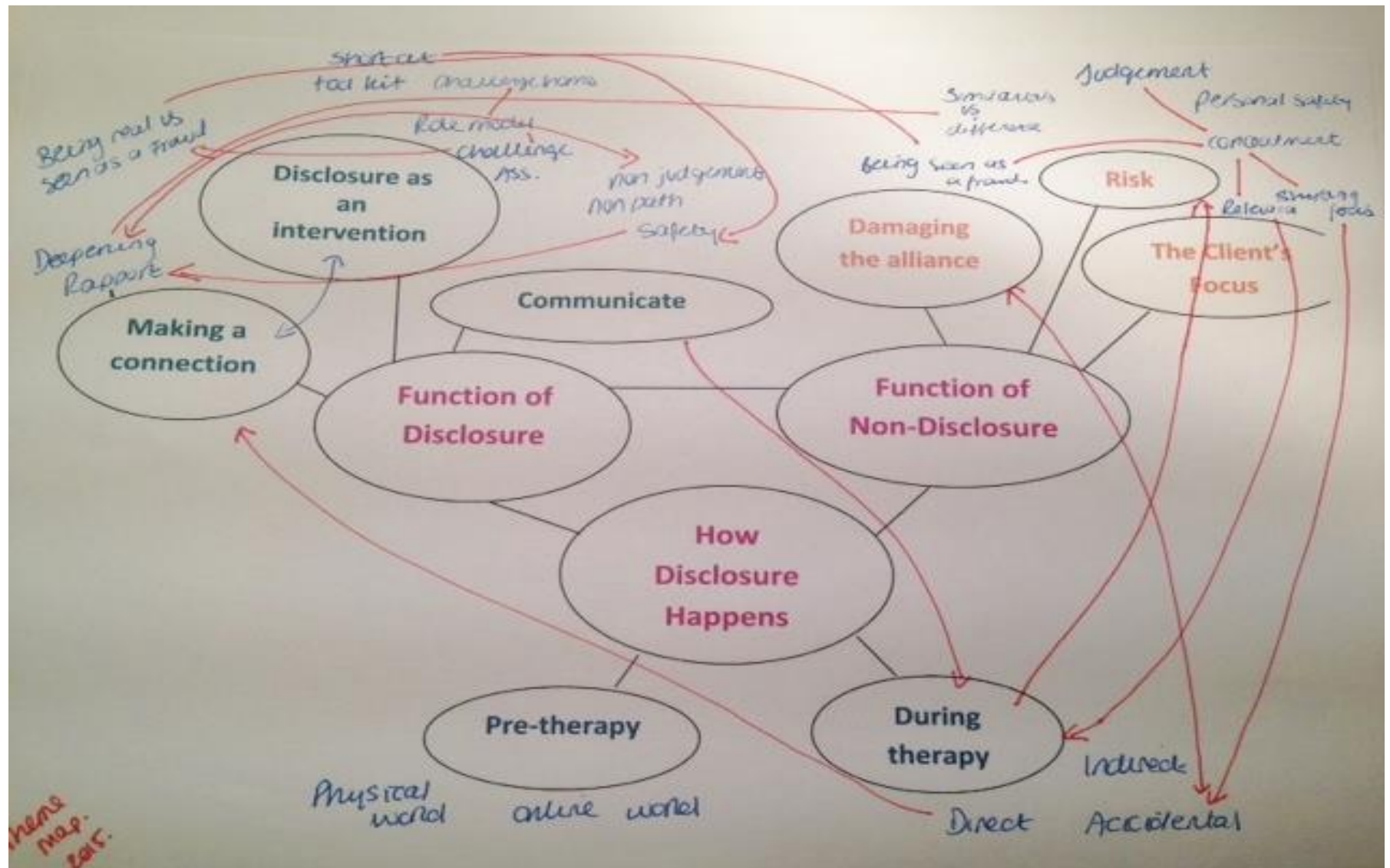
What did you feel was the function of the disclosure? (Prompt- Do you think it was related to your clients' presenting problem?)

If not, what prompted the disclosure?

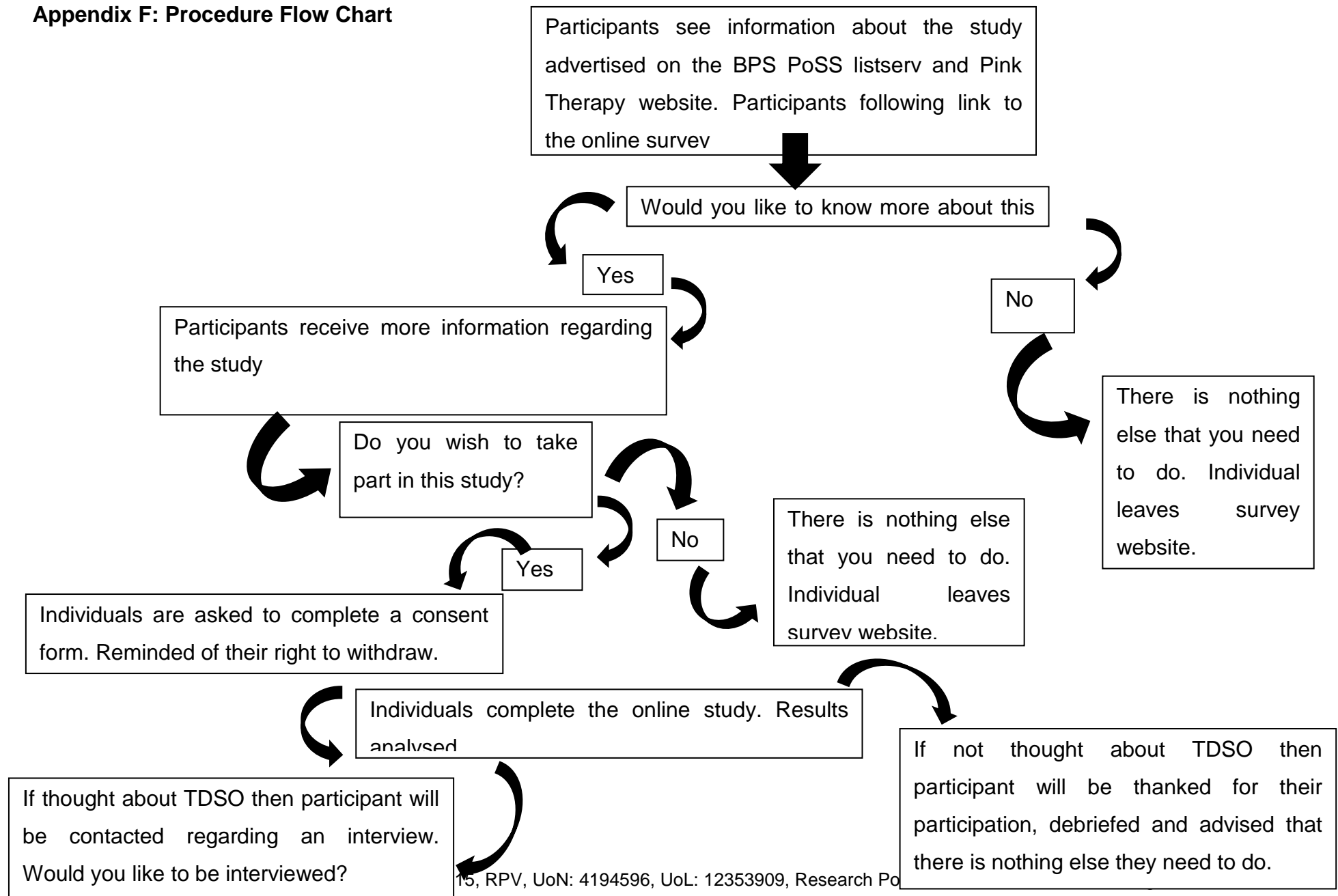
Appendix E: Thematic Maps: Overarching themes and main themes



Thematic Map: Overarching themes – sub-themes



Appendix F: Procedure Flow Chart



Appendix G: Online Survey Questions

Initially the survey will collect some demographic information from you followed by specific information related to TDSO

What is your age?

How do you define your gender?

Male
Female
Transwoman
Transman
Non-binary
Other (Please state)

How do you define your sexual orientation?

Heterosexual
Gay
Lesbian
Bisexual
Asexual
BDSM/Kink
Other (Please state)

Please state your profession:

Counselling Psychologist
Clinical Psychologist
Counsellor
Psychotherapist
Sex Therapist
Other (Please state)

Please state your professional/governing body:

BACP

UKCP
BPS
HCPC
CORSTBABCP
NCP
NCS
Other (Please state)

How many years post-qualification experience do you have?

Please state which county/countries you most regularly practice:

Have you ever disclosed your sexual orientation to a client?

Approximately, how many clients have you disclosed your sexual orientation to?

None
Less than 5
Between 6-10
Between 11-15
Between 16-20
More than 20

In what clinical context did the disclosure take place?

Before the client came to therapy
Public hospital/clinic
Private hospital/clinic
Voluntary sector
Priavet work/practice
Secure setting (e.g. prison, etc)
Community setting (e.g. drop in clinic)#
Not applicable
Other state

Who have you disclosed to? (Please state all that apply in the text box)

Heterosexual

Gay

Lesbian

Bisexual

Trans

Not Applicable

Other (please state)

Have you disclosed your sexual orientation to? (Please state all that apply in the text box)

Male clients

Female clients

Trans clients

Have you disclosed your sexual orientation to (Please tick all that apply)

Clients who have the same sexuality as you

Client who have a different sexuality to you

Are you aware of any professional/statutory guideline related to disclosure of therapist sexual orientation to clients?

Yes (please state which)

No

Appendix H: Participant Information Sheet – Online survey

Survey Editor - (PAGE 1) x

https://esurv.org/surveyEditor.php?survey_ID=OCDEF_c3fd3dec

Purpose of the research
The research aims to understand LGBT therapist's perspectives of disclosing their sexual orientation to clients. It hopes to understand the rationale and decision making processes that occur before making such a disclosure. It will also seek to understand the context for the therapist's disclosure and the function that the disclosure has. You should also be aware that the research will be included in a Clinical Psychology Doctorate thesis as part of the Trent Doctoral training programme.

Why me?
You have responded to an email forwarded by the British Psychological Societies (BPS) Psychology of Sexualities Section (PoSS) Listserv or an advertised web-link. We are looking for therapists who identify as lesbian, gay, bisexual and/or trans, who have at least thought about therapist self disclosure of (sexual) orientation (TSDO). Therapists must also be registered with a governing body (e.g. BPS, HCPC, BACAP, CORST, UKCP, etc). **N.B. You do not need to be a member of the BPS or be based in the UK to take part in the study.**

Do I have to take part?
It is your decision. If you do decide to take part you will be asked for your consent, but you will still be free to withdraw from the research after you have completed the survey.

What do I have to do?
Initially you will be asked to complete an online survey. The survey should take about 5 minutes to complete. Depending on the results of this survey you may be asked, at a later date, to take part in an interview in which you will be asked more detailed questions. If you would like to be considered for an interview please provide some contact details when prompted to do so. Further information about this interview will be forwarded to those participants identified to take part.

What are the disadvantages of taking part?
Taking part in this research will mean that you have to give up some of your time in order to complete the online survey. At the end of the survey you will have the option to put yourself forward to take part in an interview with the researcher. If you take part in an interview this will mean giving up an hour or so of your time. The researcher is flexible and can provide face-to-face interviews, telephone interviews or conduct interviews over Skype. Participants should also be made aware that interviews will be audio recorded so that the data can be transcribed and analysed.

Please note that this research is interested in the therapist's experience of disclosing their own sexual orientation to clients. You may wish to discuss a particular case or scenario, but please bear in mind the confidentiality limits that you have agreed with your clients.

What are the potential benefits?
By taking part in the research you will be adding to increasing literature focusing on LGBT therapists and disclosure. The data that you provide will facilitate an increased understanding into the LGBT therapist's disclosure of sexuality, the rationale for making a disclosure, the consequences of this disclosure but most importantly the function of that disclosure.

Will my data be kept confidential?
Yes, all the data collected will remain confidential. You will be asked to generate a unique pseudonym, so that your data can be identified should you want to withdraw it. Any identifiable information given (e.g. contact details to be invited for an interview) will remain confidential. All survey response and subsequent audio recordings will be given pseudonyms so that no one can be identified by their information. **Please do not provide personal information that you are not comfortable for the researcher to keep securely on record.**

Can I withdraw from the study?
As a participant you have the right to withdraw. There will be no penalty for doing so. However, you will only be able to withdraw up to one week after you have taken part in each component of the research. This is because the data will have been transcribed and it will no longer be identifiable from the entire dataset.

What will happen to the results of the research?
The results of the study will be disseminated in a peer reviewed journal. If you would be interested in the study's findings, then please let the researcher know so that you can be contacted at a later date.

Drag & Drop

09:55
03/01/2015

Participant Information sheet: Interview

Version 2: 06/04/13

You are being invited to take part in a piece of research. Before you can decide whether or not to take part you must understand the rationale behind it. Please take some time to read the following information. Please contact the researcher (details below) if you want clarification over anything or just want more information.

Purpose of the research

The research aims to understand LGBT therapist's perspectives of disclosure their sexual orientation to clients. It hopes to understand the rationale and decision making processes that occur before making such a disclosure. It will also seek to understand the context for the therapist's disclosure and the function that the disclosure has. You should also be aware that the research will be included in a Clinical Psychology Doctorate thesis as part of the Trent Doctoral training programme.

Why me?

You recently completed an online survey regarding the current research topic. You have specified that you would like to be contacted to give a more in depth account of your experiences of disclosure.

Do I have to take part?

It is your decision. If you do decide to take part you will be asked for your consent, but you will still be free to withdraw from the research after you have completed the survey.

What do I have to do?

The interview should take about 60 minutes to complete. You will be asked similar questions to those included in the online survey, but you will be asked to give more details. It will be a semi-structured interview so the researcher will be asking some questions however, you will be able to expand on your answers. You may also be prompted to do so.

What are the disadvantages of taking part?

Taking part in this research will mean that you have to give up some of your time. The researcher is flexible and can provide face-to-face interviews, telephone interviews or conduct interviews over Skype. Participants should also be made aware that interviews will be audio recorded so that the data can be transcribed and analysed.

Please note that this research is interested in the therapist's experience of disclosing their own sexual orientation to clients. You may wish to discuss a particular case or scenario, but please bear in mind the confidentiality limits that you have agreed with your clients.

What are the potential benefits?

By taking part in the research you will be adding to an increasing literature focusing on LGBT therapists and disclosure literature. The data that you provide

will facilitate an increased understanding into the LGBT therapist's disclosure of sexuality, the rationale for making a disclosure, the consequences of this disclosure but most importantly the function of that disclosure. It is also hoped that the results from this research will inform future guidelines for LGBT therapists.

Will my data be kept confidential?

Yes, all the data collected will remain confidential. Your contact details will be kept confidential and you will remain anonymous during the interview. Any identifiable information that you provide will not be used in the study write up. All survey response and subsequent audio recordings will be given pseudonyms so that no one can be identified by their information. You should be aware that if any safeguarding issues arise (e.g. if unethical or risky behaviours are identified) I will be obliged to end the interview immediately.

Can I withdraw from the study?

As a participant you have the right to withdraw. There will be no penalty for doing so. However, you will only be able to withdraw up to one week after you have taken part in each or either component of the research. This is because the data will have been transcribed and it will no longer be identifiable from the entire dataset.

What will happen to the results of the research?

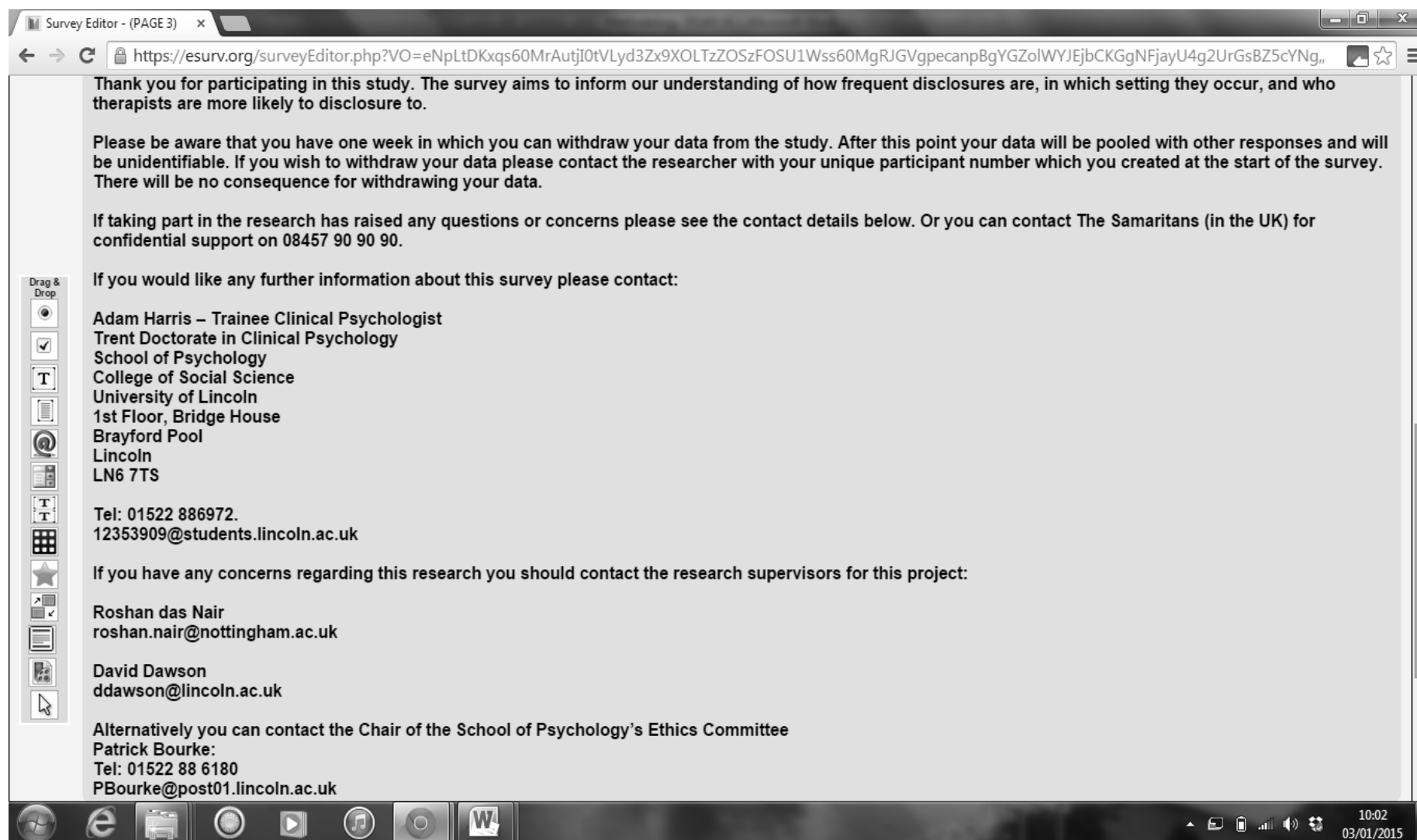
The results of the study will be disseminated in a peer reviewed journal. If you would be interested in the study's findings, then please let the researcher know so that you can be contacted at a later date.

*Adam Harris – Trainee Clinical Psychologist
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12353909@students.lincoln.ac.uk

Appendix I: Debriefing Information Sheet: Online Survey



The screenshot shows a web browser window with the address bar displaying a URL from esurv.org. The page content is a debriefing information sheet for an online survey. The text is as follows:

Thank you for participating in this study. The survey aims to inform our understanding of how frequent disclosures are, in which setting they occur, and who therapists are more likely to disclosure to.

Please be aware that you have one week in which you can withdraw your data from the study. After this point your data will be pooled with other responses and will be unidentifiable. If you wish to withdraw your data please contact the researcher with your unique participant number which you created at the start of the survey. There will be no consequence for withdrawing your data.

If taking part in the research has raised any questions or concerns please see the contact details below. Or you can contact The Samaritans (in the UK) for confidential support on 08457 90 90 90.

If you would like any further information about this survey please contact:

Adam Harris – Trainee Clinical Psychologist
Trent Doctorate in Clinical Psychology
School of Psychology
College of Social Science
University of Lincoln
1st Floor, Bridge House
Brayford Pool
Lincoln
LN6 7TS

Tel: 01522 886972.
12353909@students.lincoln.ac.uk

If you have any concerns regarding this research you should contact the research supervisors for this project:

Roshan das Nair
roshan.nair@nottingham.ac.uk

David Dawson
ddawson@lincoln.ac.uk

Alternatively you can contact the Chair of the School of Psychology's Ethics Committee
Patrick Bourke:
Tel: 01522 88 6180
PBourke@post01.lincoln.ac.uk

The browser window includes a toolbar on the left with icons for 'Drag & Drop', a checkmark, a text box, a list, a magnifying glass, a grid, a star, a document, and a mouse cursor. The Windows taskbar at the bottom shows the Start button, Internet Explorer, a folder icon, a media player, a music player, a CD/DVD icon, and a Word document icon. The system clock in the bottom right corner shows 10:02 on 03/01/2015.

Debriefing information: Interview

V2 22/04/2013

Thank you for participating in this study. The research has focused on understanding LGBT therapist's perspectives of disclosing their sexual orientation to clients. It has aimed to gather information that will help the researcher develop an understanding of the rationale and decision-making processes involved in such a disclosure. A further aim of the study is to examine the context and perceived consequences that making such a disclosure had on therapeutic alliance. These aims hope to establish the function that the TDSO has for the therapist.

Please be aware that you now have a week in which you can withdraw your data from the study. After this point your data will be pooled with other responses and will be unidentifiable. If you wish to do so please contact the researcher immediately. There will be no consequence for withdrawing your data.

If taking part in the research has raised any questions or concerns please see the contact details below. Or you can contact The Samaritans for confidential support on 08457 90 90 90

Adam Harris – Trainee Clinical Psychologist

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Alternatively you can contact the research tutors

Roshan das Nair:

Roshan.nair@nottingham.ac.uk

Or David Dawson:

ddawson@post01.lincoln.ac.uk

or the Chair of the School of Psychology's Ethics Committee

Patrick Bourke:

PBourke@post01.lincoln.ac.uk

Appendix J: Transcription Confidentiality Agreement

Transcription Services - Section 7

UNIVERSITY OF
LINCOLN

Data Protection Act 1998 Confidentiality Agreement for Transcribers

This Agreement is made as of 7/10/14 (Date), by and between the University of Lincoln, with principal offices at Brayford Pool Lincoln LN6 7TS (the University) and HELEN SMITH with principal offices at 21 SOUTHFIELD AVENUE, SYSTON, LEICS (the Transcriber). LE7 2LL

The Transcriber has been appointed by the University of Lincoln to transcribe audiotapes/audio files and documentation resulting from research undertaken by ADAM HARRIS which will involve the disclosure to the Transcriber of personal data held by the University. Accordingly the Transcriber is required to deal with any such information in accordance with the terms of this Agreement and the Data Protection Act 1998.

The Transcriber undertakes to respect and preserve the confidentiality of personal data. Accordingly, for an indefinite period after the date of this Agreement the Contractor shall:

- maintain the personal data in strict confidence and shall not disclose any of the personal data to any third party;
- restrict access to employees, agents or sub-contractors who need such access for the purposes of the contract (and then only if the employee, agent or subcontractor is bound by conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request);
- ensure that its employees, agents or sub-contractors are aware of and comply with the Data Protection Act 1998; and
- not authorise any sub-contractor to have access to the personal data without obtaining the University's prior written consent to the appointment of such sub-contractor and entering into a written agreement with the subcontractor including conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request.

The Transcriber agrees to indemnify and keep indemnified and defend at its own expense the University against all costs, claims, damages or expenses incurred by the University or for which the University may become liable due to any failure by the Transcriber, its employees, agents or sub-contractors to comply with any of its obligations under this Agreement.

For the avoidance of doubt, the confidentiality imposed on the Transcriber by this Agreement shall continue in full force and effect after the expiry or termination of any contract to supply services.

The restrictions contained in this Agreement shall cease to apply to any information which may come into the public domain otherwise than through unauthorised disclosure by the Transcriber.

This Agreement shall be governed by and construed in accordance with the laws of England and the parties hereby submit to the exclusive jurisdiction of the English courts.

Signed for and on behalf of

Signed: H. Smith Name: HM SMITH
Title: MISS Date: 7.10.2014

Signed for and on behalf of the University of Lincoln

Signed: J. Tompkins Name: JUDITH TOMPKINS
Title: ADMIN OFFICER Date: 09.10.14

Appendix K: Quantitative Analysis

Table of skew and Kurtosis statistics to test for normality

Table 8:

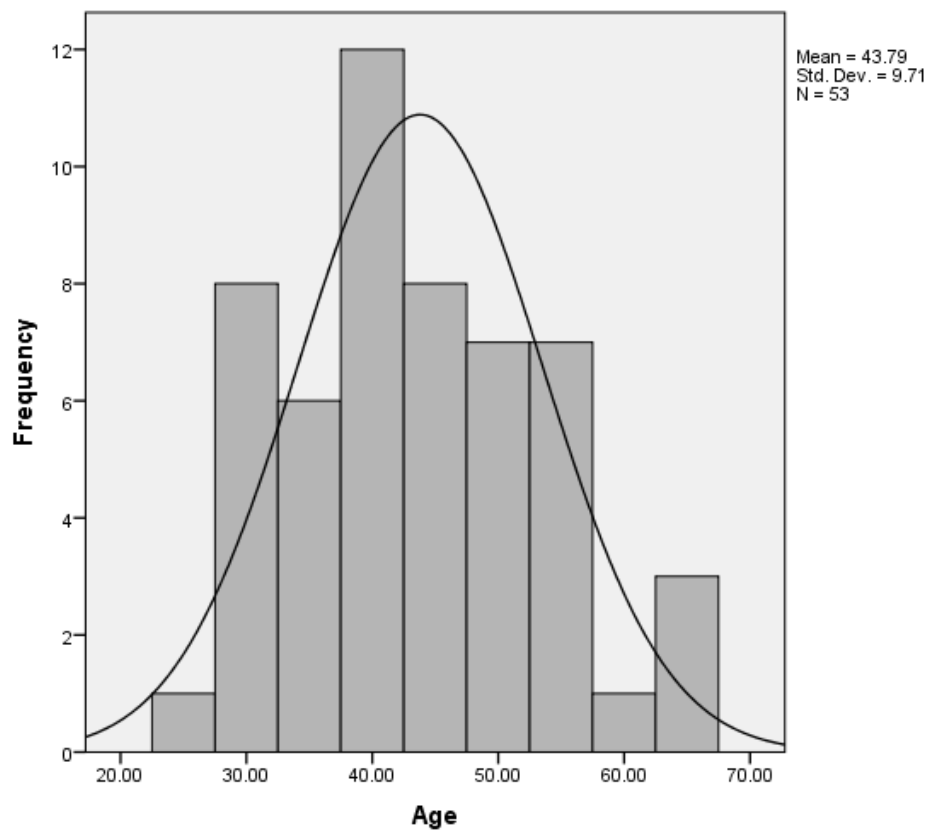
Statistics with Standard Error (SE)

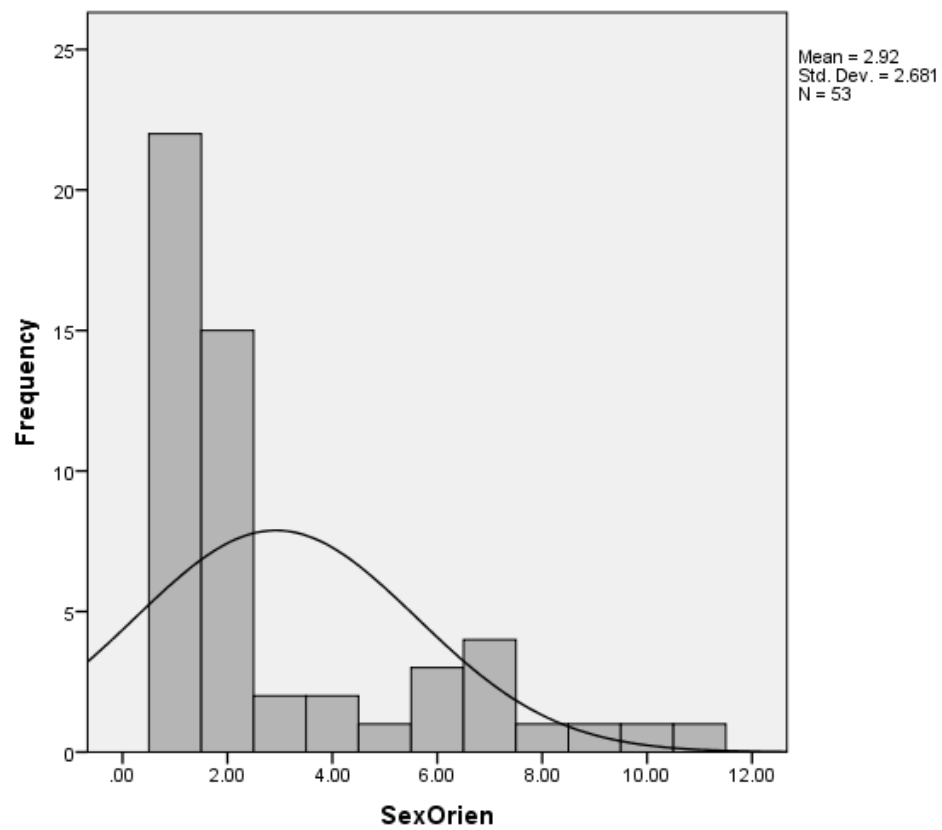
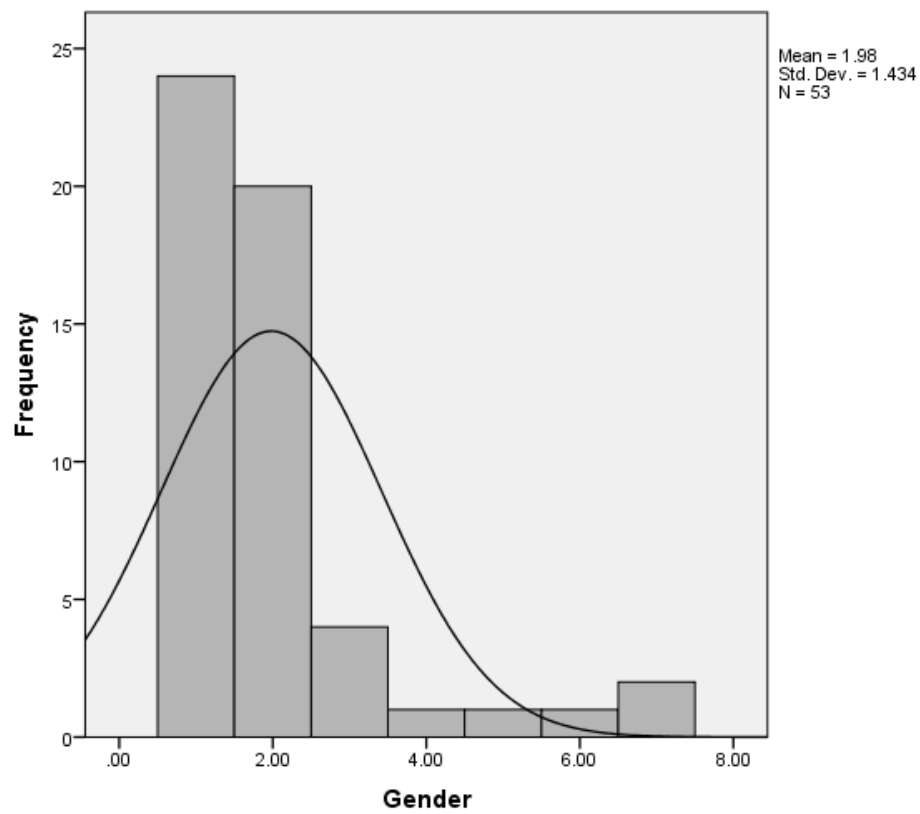
	Skewness	SESkewness	Kurtosis	SEKurtosis	Shapiro-Wilks Statistic	p-value
Age	0.245	0.327	-0.358	0.644	0.981	0.541
Gender	2.269	0.327	5.264	0.644	0.665	0.000
Sexual Orientation	1.490	0.327	1.203	0.644	0.734	0.000
Profession	0.999	0.327	-0.321	0.644	0.814	0.000
Governing body	0.397	0.337	-1.535	0.662	0.826	0.000
Post-qualification experience	0.768	0.327	-0.368	0.644	0.901	0.000

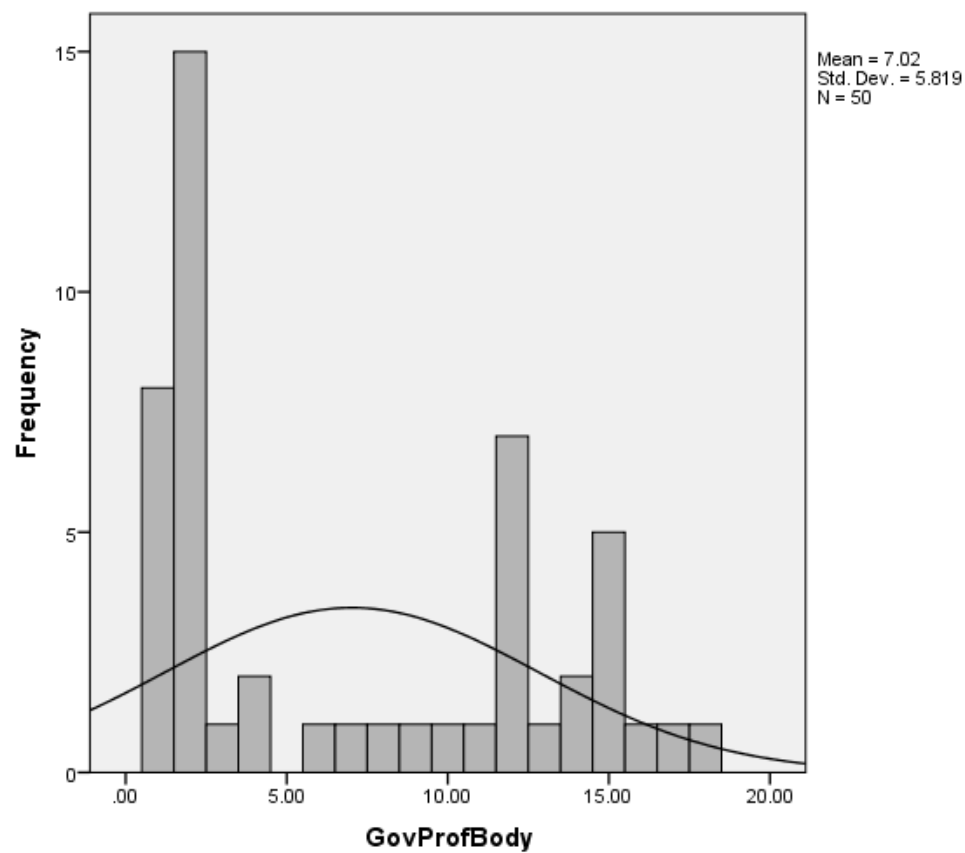
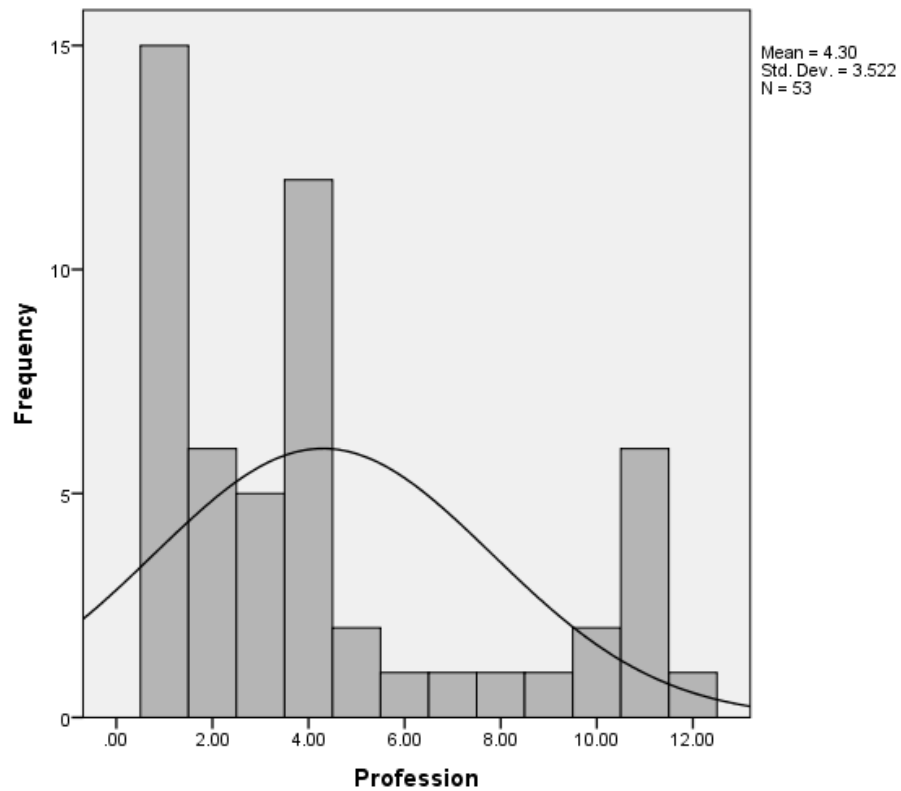
Notes: Text highlighted in bold suggests a deviation from normal distribution with absolute values scores being assessed as those greater than ± 3.0 .

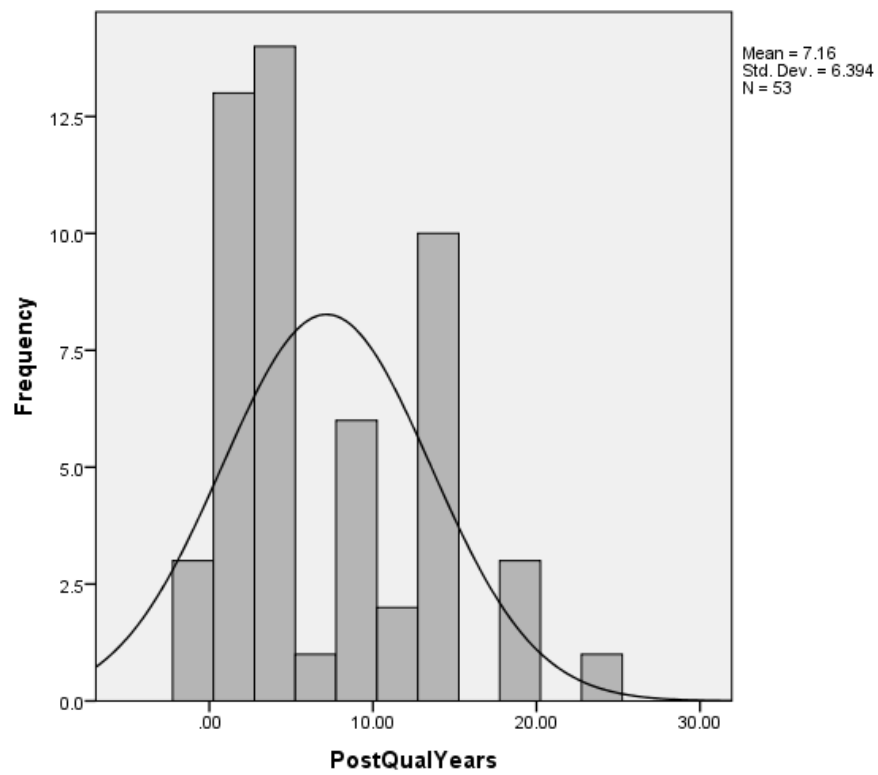
Histograms of bell curve to illustrate distribution

As can be seen all histograms do not follow a normal distribution.









Appendix L:

Example Theme 1: Checking Codes under their Theme Headings

Function of disclosure		
Making a connection	Communicating	Disclosure as an intervention
<p>I think that on the therapeutic alliance it has a good effect</p> <p>all the research says that the modality, the school of therapy doesn't matter: what matters is the relationship</p> <p>to actually not feel that they've got to explain everything to me but that I'll understand. Because I think sometimes there is that thought that if you're not gay you won't understand</p> <p>to establish some sort of safe space, or freedom</p> <p>so that's the bit that I was talking about before, where I felt that [pause] my hope and actually what happened was that it felt like the therapeutic alliance got strengthened, because it felt like there was an ally in the room, was my sense of it</p> <p>he felt a bit more understood, accepted and I think that he takes my solidarity more seriously, because he's very self-conscious of being gay</p> <p>In some ways it's a relief because it means that I can stop pretending</p> <p>where somebody has obviously assumed that my sexuality not to be the same as theirs and that I don't understand or that I have no empathy or that I just can't comprehend where they are coming from at all</p>	<p>So I think it's important in terms of making them feel safe and making them feel – as far as possible – the equal to the therapist in the room and not somebody who will be viewed negatively by the therapist.</p> <p>So again giving that different perspective. And also being able to say that yeah, at times I've struggled as well</p> <p>So it was in the context of being able to talk about shared experiences</p> <p>I would aspire for my clients to feel free and at ease with who they are, so in a way I guess I'm being that thing or demonstrating it</p> <p>it felt very important to build the rapport and develop the safe relationship for him so that he could be heard and understood</p> <p>I think it's easier for him to accept from me when I try to support him and reinforce to him to be a bit more proud about who he is</p> <p>to communicate or identify with.. to hopefully aid my client to understand that I might know what they are talking about</p> <p>if it's going to be helpful for the client, then yes. If I feel that they are concerned that they are going to be judged or it feels like, you're picking up that vibe from somebody that they don't feel comfortable to be completely honest, then yes, that's another signifier for me</p>	<p>"How does your wife feel about you seeing women on your own during the day?" and I said, "Well actually-" (coz I had to think for a few seconds) "well actually, I have a husband." And she said, "oh – OH! Oh, OK!" And that dealt with that one</p> <p>If I think it's going to help them because perhaps they have skewed views of gay/lesbian/transgender, then I will disclose</p> <p>Well fine, it's part of a repertoire of therapeutic interventions I think, so we think of it – well I think of it – that way</p> <p>you can work with this transferentially and see what emerges or you can tell this person that you're gay and then other stuff can emerge and they can have one less thing to struggle with in this relationship</p> <p>it allowed clients to walk into the therapy room and talk about it and they may not have felt able to do that or comfortable to do that otherwise</p> <p>I have never used to rescue the alliance, it's always been to enhance it and where I've done it my experience is that there has been a relaxation of the client to enable them to talk more openly about what is going on for them</p>

Example Theme 2: Checking Codes under their Theme Headings

Function of non-disclosure		
Damaging the alliance	Risk	The client's focus
<p>There wasn't really anything that I could do to make it better or to improve it because he didn't really want to be, share a space with me anymore</p> <p>but it's not without its nerves, there's always that little hint of nerves about, well should I or shouldn't I? And what if it breaks it? But actually, in practice, I don't think it ever has.</p> <p>and they'd begun to imagine other similarities between you and wanted to align themselves with you, there could be reasons for withholding that difference</p> <p>And, erm, and I would be concerned that, at a later time, they may find out that I was gay and then they might question my authenticity</p> <p>I have a feeling that some may use it to rescue an alliance and that is not a way to rescue the alliance</p> <p>And it could possible rupture the relationship if somebody holds views that you weren't aware of before</p> <p>When I thought that it might cause my client a problem, a loss of trust in me.</p> <p>So I would imagine that there are times during therapy that it could be that we find that we have the same experience as somebody there, that could be dangerous</p> <p>But I guess I do hide behind the non-disclosure of sexuality with heterosexual clients on the basis that there might be a danger that I might be viewed differently, um if they knew I was gay</p>	<p>Erm, I think it's the case because, erm, I think there's probably some (pause) some fear of homophobia potentially, when disclosing to heterosexual people</p> <p>So that's why I think it's a big decision because you can't, any disclosure, you can't rewind, take it back</p> <p>if you disclosed to the wrong person and then they used that to make like an allegation, that would be difficult.</p> <p>My fear about disclosure is not being taken seriously because how can a gay possibly know anything about relationships because all we do, obviously, is have casual sex and sniff poppers and things</p> <p>I think that is a major risk, being judged by potential or current clients so I can't fully know the impact on my client, from what I disclose to them and I can't actually know the impact of disclosure</p> <p>I could've started challenging some of his homophobic remarks in particular and that might have helped the therapeutic relationship, but that was out-weighed by the potential risks</p> <p>It might be that patients don't accept me as a therapist anymore</p> <p>And I thought, oh my god I've just broken all the rules I've been taught and my god I'm going to be struck off right now and my supervisor is never going to let me come back</p>	<p>So I think I felt lots of guilt and I also thought that, I suppose it made me question a little</p> <p>Will the change be for the better or will it be for the worse, or will it throw in complications that they shouldn't have to face?</p> <p>a client could feel, erm, that the disclosure was premature and now the work has suddenly changed focus</p> <p>For the simple reason, I'm keeping therapy about the client, not necessarily, not me.</p> <p>My role as a counsellor is to be there for the client and be able to meet their needs.</p> <p>if someone was uncertain about their sexual orientation and were discovering it or trying to find out who they were I think that disclosure in the therapy room would be fraught with them trying to figure out themselves within the therapy work</p> <p>I would be afraid that they client would think that I was anxious and they would try to take care of me. It's their time, not my time</p> <p>It could be that I get too much in the focus and therapy starts turning on me and my life and it might be hard to get out of that again</p> <p>I think in general there is a sense of it is the clients space, it isn't my space</p> <p>Have we got into a conversation where the focused has changed for my client</p>

Example Theme 3: Checking Codes under their Theme Headings

How disclosure happens	
Pre-therapy	During therapy
<p>And then about a third of clients are LGBT, who have found me through X directory or through googling me or finding me through my own website</p> <p>Um, err, people who find me by my website, if they know how to read my website they will realise that I am from a GSD background myself, but it's not overtly stated in the website</p> <p>Bearing in mind that a lot of my clients come from [agency] so they would've been told by the person referring them, coz they often say because they will say, as a gay man, or from what perspective</p> <p>I suppose I'm on the X directory, and I'm probably on some other lesbian and gay directories on the web</p> <p>So some people I've seen already knew I was a lesbian before they saw me, so I've not done the disclosure in those cases</p> <p>It'd only happen if...I mean, the person...the one I'm thinking of, the young woman was already being seen by a therapist, who felt that it might be quite important for her to see that therapists can be LGBT too</p> <p>Well I'm a member of a few directories, including one which interestingly requires you to disclose your sexuality to be part of it, don't know if you know that, but it's already a given</p> <p>So when I was working in an agency supporting gay men, they knew about my sexuality before they came to me and they didn't have a choice</p> <p>There was no question, before we started, that I was a gay man. It was pre-disclosed. Which also is the case for anyone who comes through a directory because I tend to identify there</p> <p>well, I did a course on affirmative therapy, it thin two years ago and since then I offer it on my home page and I am on a list of the lesbian and gay counselling institution here in X</p> <p>If they've come through X directory, I usually ask how they got my contact details and I automatically assume that they've read it</p> <p>Whether that's because they've been on my website and seen that or they've looked through my professional body's website</p>	<p>But again, I guess, you know, probably most people who see the ring</p> <p>My partner is a singing teacher and my partner has clients coming to the house and there are occasions when my clients see people going to the house or see him answering the door</p> <p>Yeah I often wonder, when I pause when they say things like 'your husband' or 'are you married', because I say 'yes I'm married' because I'm in a civil partnership, but then I refer to my partner.</p> <p>if they've seen us out in the town centre or in a restaurant or whatever, they think 'God she's with that woman they must really good friends! [laughs]' – because I do sometimes bump into people I places like that</p> <p>Sometimes I get referred young people because they've come out to the person who's working with them, and the person working with them has thought it would be helpful for them to speak to a therapist who was Lesbian/Gay themselves</p> <p>it'll be something that happens as part of describing examples of things – so to do with pronouns, things like that</p> <p>Normally not because my partner works from home as well so we usually stagger our appointment times by half an hour. But is just so happens that in 4.5 years, this incident happened where, yeah, the eye was taken off the ball</p> <p>if I am [pause] likely to be in a place where I might meet a client. So it may not be a direct disclosure, it maybe indirect</p> <p>If a gay client asked my orientation in the assessment phase, I would simply tell them without any further comment.</p> <p>Y'know if we're out and about and we're going to be at pride next weekend, what happens is that, more when, than if we run into clients. That's something that I tend to keep in my with clients and something that I tend to explore, very early on</p> <p>have specifically disclosed about being bisexual with clients who have asked</p>

Appendix M: Example Transcript with Codes

Line	Speaker	Verbatim	Code(s)
431 432	INT	OK, that's interesting. Erm, what impact do you think the disclosure has on the therapeutic alliance?	
433 434	P	Erm, I suppose in reality, it gives that little bit of strength to it, you know, there's been, I know someone will understand my world that little bit better.	Potential for the alliance to be enhanced
435 436	P	Erm, but it's not without its nerves, there's always that little hint of nerves about, well should I or shouldn't I?	Nervous about the potential outcomes
436 437 438 439 440	P	And what if it breaks it? But actually, in practice, I don't think it ever has. Erm, you know, even the guy who said, well I don't know either way or I don't know, the comment about the wife. Even, you know, he was quite happy to just accept that he didn't know and wouldn't find out. And then things carried on as they did anyway	Risk of damaging the alliance Experience suggests it doesn't break
441 442 443 444	P	So even when I thought, this could be a disaster if he finds, if he kind of asks me directly and then finds out, and then realises that he's got these issues with this. But then he was quite happy to just, to carry on and not ask the question.	Bigger deal for therapist Internalised shame Client not needing to know
445	INT	Do you think that not making a disclosure has any impact on the alliance	
446 447 448	P	I suppose the difference between not making the disclosure and withholding, erm, a disclosure (pause) in my experience it hasn't, I don't think it's been any problem really.	No perceived problem from not making TDSO
449	INT	OK	
450 451	P	I've never walked away from a client and thought, you know, what they've just said about sexuality has, you know, left me with all this baggage.	No sense of personal baggage
452 453 454	P	I mean I've never had to go to supervision, erm, I mean we always do that, you know, was the impact the client has had on you, you know, kind of transference stuff	Use of supervision Transference
455 456 457	P	But I've never, I've never had to go in supervision and examine whether I've been wounded, err, because of a sexuality issue or anything, that's never come up.	No damage Use of supervision
458	INT	That's probably a good thing, being abused by your client would not be fun.	

Appendix N: Coding template

Work context	The therapeutic alliance
Client's sexuality	Fear of client judgement
Internalised homophobia	Meeting therapist needs
Perceived helpfulness for the client	Therapist's Intuition
Being gay in a straight world	Internalised homophobia
Invisibility of LGBT issues	Other ways of knowing
Strengthening the relationship	Assumed sexuality
Damaging the relationship	Organisational culture
Cutting off client's exploration	Work setting
Lacking significance	Oppression
Client's own sexuality	Risk
In the client's best interests	

To disclose or not to disclose? The LGBT therapists' question.

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Trent Doctorate in Clinical Psychology

Introduction

Therapist disclosure of sexual orientation (TDSO) is a contentious issue, yet it happens in therapy, particularly amongst lesbian, gay, bisexual and trans (LGBT) therapists (Hanson, 2005). Argued to be beneficial for members of minority and stigmatised groups TDSO could facilitate a stronger therapeutic alliance (Jeffery & Tweed, 2014). However, guidelines state therapists should not be: *'telling patients about their own sexual, preferences, or fantasies or disclosing other intimate personal details'* (CHRE, 2008, p.13).

Aims

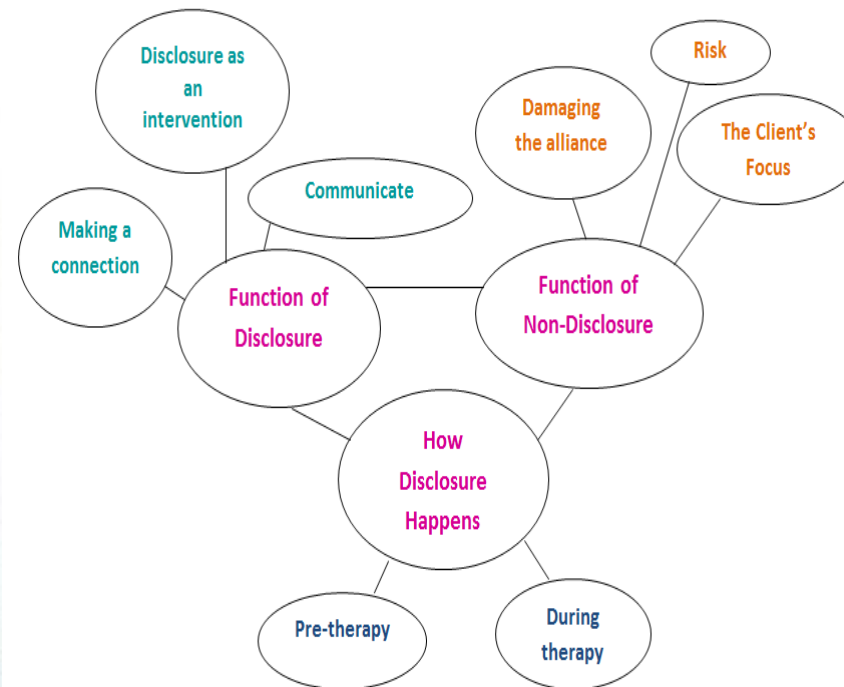
To understand LGBT therapists' rationale and decision making process involved in TDSO, while *establishing the purpose* of TDSO.

To ascertain if there is a difference between those therapists who thought about disclosure, but took no actions and those who had thought about TDSO and subsequently made a disclosure.

Method

17 LGBT therapists were purposively selected. Semi structured interviews focusing in therapist views and experiences of TDSO were audio recorded and transcribed verbatim. A hybrid inductive deductive thematic analysis was used conducted, from a contextual critical realist stance.

Thematic Map



Findings

Function of disclosure: TDSO was used to deepen the rapport, show understanding, harness similarity, which allow increased empathy: *...to strengthen and allow the deepening of that therapeutic relationship* (Evelyn)

Function of non-disclosure: TDSO to straight clients was thought to be highlighted differences between the client and therapist therefore could be damaging to the alliance.

References:

- CHRE (2008). *Clear sexual boundaries between health care professionals and patients: Responsibilities of health care professionals*. London: Council for Healthcare Regulatory Excellence; Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counselling and Psychotherapy Research*, 5(2), 96-104
- Jeffery, M.K., & Tweed A.E. (2014). Clinician self-disclosure or clinician self-concealment? Lesbian, gay and bisexual mental health practitioners' experiences of disclosure in therapeutic relationships. *Counselling and Psychotherapy Research: Linking research with practice*, DOI: 10.1080/14733145.2013.871307;
- Meyer, I.H. (2003). Prejudice, social stress and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129 (5), 674-697

Findings cont.

Some withheld disclosures when with a straight client because of a fear that they would be judged because of sexuality: *'It might be that patients don't accept me as a therapist anymore'* (Wendy). Therefore, participants would conceal their sexual identities from straight clients. This was linked to the need to maintain similarity within the therapeutic alliance.

How disclosure happens: TDSO happened pre-therapy via the internet and by word of mouth of referrers or through mutual acquaintances.

Discussion

This study is line with previous research. Participants stated that TDSO was a useful way of enhancing therapy with LGBT clients linking to the non-specific therapeutic skills (Jeffery & Tweed, 2014). Participants were conflicted in their approach to TDSO when working with LGBT & straight clients and it was noted that TDSO happens in many ways. Concealment was an important finding, suggesting that LGBT therapists expect prejudice and discrimination from straight clients related to minority stress model (Meyer, 2003).

Summary of Service-Related Research and associated Impact (SSRI)

Trainee(s)	Supervisor(s)	Placement	Cohort	Date Completed
Adam Harris	Dr Liz Boyd	Learning Disabilities Psychology	2012	December 2014

Research background and context

Learning Disability (LD) inpatient services across the UK need to evidence their effectiveness at helping service users transition from secure settings back to the community or to supported living. Inpatient units support Service Users who have reached crisis point in their community setting and require a hospital stay. With LD services this is usually because there has been an increase in challenging behaviour that cannot be managed safely in the community. LD Inpatient setting also provides assessment and treatment facilities for service user with LD when they have become unwell.

There is also growing need to evidence that vulnerable adults are kept safe from abuse and neglect in inpatient settings following recent high-profile cases e.g. Winterbourne. Furthermore given the current economic climate there is increased pressure for inpatient services to be evidencing that they offer value for money or provide the “added value” for the premium paid by placing authorities. Therefore it was suggested that a review of the service user perspective of being an inpatient within the current service, would help evidence the service’s “added value”.

The importance of Service Users being more empowered and active both within research and their care is widely recorded with service users are now being

seen as “experts by experience” providing leadership for their own care (Lloyd, Hemming & Tracy, 2013). NHS professionals are required to adhere to the National Institute for Health and Clinical Excellence (NICE) guidelines for best practice although for patient choice and need, clinical judgment and flexibility in treatment is acceptable (NICE, 2004; 2006). Part of key role for Clinical Psychologists is to ensure developing and monitoring outcomes for individuals and services (DCP, 2011).

The role of inpatient assessment and treatment units for people with LD is currently being scrutinised nationally, following the Winterbourne enquiry (DoH, 2012). Inpatient services are currently under review across England, under NHS England, due to Winterbourne case. This report summarises a service evaluation of the Trust’s Rehabilitation Service for Adults with Learning Disabilities (AwLD) in August 2014.

Research aims

Clinicians within the service were keen to formally ascertain the experiences of current service users regarding current care and support being received within the inpatient service. Of specific interest were the service user’s perspectives of how they have experienced rehabilitation, taking into account what has helped and what has hindered their progress since admission. There was local interest in the effectiveness of the inpatient service for clients with LD due to the inpatient service being small and therefore expensive in comparison to larger providers who may be “preferred” by placing authorities. There were further drivers for evaluation due to recent shortcomings highlighted in care inpatient settings e.g. Winterbourne. In response to these drivers, the trainee and supervisor conducted semi-structured interviews and analysed the audio-recorded data that was transcribed. Thematic analysis (Braun & Clarke, 2006) was used to gain an understanding of the service user’s experience of the inpatient service.

What the research discovered

From participants that were eligible to be interviewed (n=5) (dependent on (a) cognitive ability, (b) level of distress/anxiety caused by process (c)

communication abilities) the analysis revealed 15 themes related to the service users perceptions of their care. Themes included: *current placement versus other placement; home versus hospital; freedom versus restriction; our involvement; power; feeling secure; recovery; external/social support; access; activity; active support model; staff meeting needs; orientation; physical environment; placement is alright*. For ease of reading the themes will be separated into the benefits of the inpatient service and the drawbacks of the inpatient service.

The Benefits

The analysis indicated that service users thought that there were benefits of being an inpatient in the LD Service. Participants were able to compare their experiences of being in the current service to previous placements (e.g. medium secure, supported living, independent living). One of the main benefits highlighted by participants was the current inpatient setting were a lot smaller than their previous placements. Important advantages of this included: it being less noisy, staff having more time to meet service user needs. Other benefits included staff being available to provide 1:1 support when it was requested or for staff to help participants resolve issues and worries quickly. There was a sense that participants felt safe and cared for during their time at the inpatient unit.

Participant's felt involved in timetabling how they would spend their time and they appreciated having responsibilities within the service, this included taking on responsibility for house chores (e.g. cooking, cleaning, and gardening). This enabled the participants to become skilled and more independent and helped them distinguish the progress that they were making. There was also the opportunity for participants to give feedback and recommendations about how the service could be made better. There was another clear advantage of being an inpatient in this service; this was the onsite activity centre.

The Drawbacks

Participants were able to identify some of the limitations of being in their current placement. As discussed earlier, staff were seen to be very supportive and

central to services users recovery, however, issues with staffing numbers were raised by all participants. It was evident that if staff numbers were low on a specific day then some activities that had been planned could not happen or would be rescheduled. This included service users going out for personal shopping or day trips. However, participants commended staff for being flexible and trying to make sure activities went ahead as planned, nevertheless participants reported that they were often worried if activities would go ahead because of problems with staffing. Other drawbacks included participants receiving inconsistent messages from different staff. Inconsistent messages often confused participants because they did not know what was expected of them by staff, with different staff expecting different things at different times.

The evaluation indicated that participants overall experience of the inpatient service was positive. They felt engaged in their recovery and that staff were able to meet their needs. The participants were able to recognise that their current placement benefitted from being smaller than their previous placements and their responses indicated that living in a smaller service was better for their recovery.

How the findings will be disseminated

The findings of the current evaluation are to be disseminated during the LD Psychology team meeting, which happen monthly. A report will be disseminated to the service manager(s) and MDT of the inpatient unit and the result will be discussed at subsequent LD steering group meetings. This will be done during January-March 2015.

Service impact achieved by the research and future plans

The evaluation will help highlight to service managers that staffing levels in the inpatient service needs to be addressed as a priority. While it is acknowledged that service managers will be aware of the concerns around staffing, this evaluation provided service users an explicit opportunity for their concerns to be heard, especially related to staffing issues causing disruptions in the service users day-to-day recovery.

This evaluation has helped the inpatient service evidence that they are committed to engaging with service user for the provision of their care. The evaluation has given the service users a on official voice that can be reached at management level. This evaluation can form part of a wider evaluation being undertaken by the Care Quality Commission and NHS England and can feed into evidence to illustrate service involvement in evaluating and guiding service development.

Future evaluation would be suited to focus on the providing outcome measures for service users level of recovery following a placement with the service, this could include service user wellbeing and satisfaction with service.

Please sign **electronically** below and send to the module convenor (David Dawson - ddawson@lincoln.ac.uk) in the first instance. The form will then be forwarded by the module convenor to the DClinPsy administrators for storage if appropriately detailed, or will be returned to the trainee if more information is required. The trainee should also retain a copy as it will need to be placed within Volume 2 of the final bound thesis.

By electronically signing below, the trainee and supervisor are confirming that the above report is accurate and has been **viewed and agreed by the placement supervisor(s)**.

Trainee's Signature: _____

Date: _____

Supervisor's Signature: _____

Date: _____

Module Convenor's Signature: _____

Date: _____