

Bangor University

PROFESSIONAL DOCTORATES

An exploration of therapist self-disclosure in psychotherapy

Lea, James

Award date:
2009

Awarding institution:
Bangor University

[Link to publication](#)

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 28. Apr. 2024

Bangor University

PROFESSIONAL DOCTORATES

An exploration of therapist self-disclosure in psychotherapy

Lea, James

Award date:
2009

Awarding institution:
Bangor University

[Link to publication](#)

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 14. Jun. 2022

An Exploration of Therapist Self-Disclosure in Psychotherapy

James Lea

A thesis submitted in partial fulfilment of the regulations for the

Doctorate in Clinical Psychology

at

Bangor University



OVERALL ABSTRACT

Major Issues

Views regarding intentional self-disclosure are closely linked to theoretical orientation; some believe it is beneficial and others suggest that it is potentially harmful. Specific forms of therapist self-disclosure exist, and it has been suggested that self-disclosure of sexuality can be therapeutically beneficial when both therapist and client identify as gay.

Methods

A literature review was conducted focussing on the role of models, assertion and evidence within the area of therapist self-disclosure. A qualitative research study was also conducted with five clinical psychologists. Semi-structured interviews were used to explore participant's views and experiences of disclosing their sexuality to gay male clients. Data was analysed using interpretative phenomenological analysis (IPA).

Findings

The research and theoretical evidence in the literature review suggested that intentional therapist self-disclosure can be helpful, unhelpful or both. Limitations of the reviewed research evidence were noted, and it appears that use and non-use of self-disclosure is based primarily on theoretical constructs and personal perspectives. These issues are discussed in relation to clinical practice. The results from the research study suggest that gay clinical psychologists felt that direct disclosure of their sexuality could have beneficial

and potentially negative effects on psychotherapeutic work with gay clients. The analysis revealed six superordinate themes: being gay in a straight world; disclosure and the therapeutic agenda; the contexts of disclosure; other ways of knowing; disclosure of sexuality: a big deal; and the invisible curriculum. These findings are discussed in relation to previous research, implications for practice and training.

Conclusion

The findings of the literature review and research study indicate that therapist self-disclosure is a complex area, and may be beneficial or unhelpful within therapy. Future empirical research on therapist self-disclosure is necessary, however the current work provides some evidence in relation to the disclosure of sexuality to clients.

CONTENTS

Overall Abstract	2
Table of Contents	4
Acknowledgements	6
Declarations	7
Section 1	8
Ethical proposal	8
Ethical proposal appendices	44
Initial Ethical Approval	49
Section 2	54
Amendments to study	54
Final Ethical Approval	61
NHS Research & Development Approval	66
Section 3	71
Reflective commentary	71

Section 4	75
Literature Review	75
<i>Intentional Therapist Self-disclosure: Assertions, Models and Evidence.</i>	
Journal submission guidelines	106
 Section 5	 108
Research paper	108
<i>Gay Psychologists and Gay Clients: Exploring Therapist Disclosure of Sexuality in the Therapeutic Closet.</i>	
Appendix 1: Interview schedule	142
Journal submission guidelines	144
Information for journal submission	146
 Section 6	 147
Extended discussion: Contributions to theory and practice	147
 Section 7	 156
Word counts	156
 Appendix 2: Example of interpretative phenomenological analysis	 158
Appendix 3: Main table of themes for empirical study	168

Acknowledgements

Firstly, I would like to acknowledge my narcissistic side and thank myself for continuing to write, and trying to remind myself that it just had to be good enough, even when I thought it was too difficult, too important and too imperfect. I would like to thank Rob Jones for giving me the space to breathe and move in a way that felt comfortable to me with the research, and throughout the course as a whole. A huge thank you to Jaci Huws, who read endless drafts and transcripts, and helped me believe that there was a little researcher inside me somewhere. Thank you to Renee Rickard for listening. My dear friend Carmel Harrison, I would like to thank you for always being there at each step of the way, and helping when the steps seemed too steep or I was too tired to keep going. I am eternally grateful for your presence, thank you for the memories: always the hours. To my mum, dad and Kathryn, thank you for being there for me in everything I have done, and will do. Thank you for reminding me who I am, and what I believe in. Most importantly, thank you for your love. Peter Hopkins, I thank you for the music, drinking and talking, as well as reminding me that I'm no better than I ought to be. Thank you for caring and allowing me to escape when I needed to. Thank you to Dawn, Anna, Sheryl, Kath and Lynne, who always believe in me and stand by my side when I need them. Thank you to the nine, I could not have done it without you. Finally, thank you to Effie for being there night and day, and reminding me with a little meow that I was not alone.

Section 1

Ethical Proposal

SCHOOL OF PSYCHOLOGY ETHICAL APPROVAL FORM

Please complete all parts to this form.

Please attach consent and information/debriefing sheets to all applications.

Date: September 2008

Tick one box: **STAFF project** **MASTERS project** **PHD project**

CLINICAL PSYCHOLOGY project ✓ **UNDERGRADUATE project**

Class demonstration

What is the broad research area? **Vision and the Brain** **Clinical & Health** ✓

Language and Development	Other
<p>1. <i>Language Development</i></p> <p>2. <i>Language Development</i></p> <p>3. <i>Language Development</i></p> <p>4. <i>Language Development</i></p> <p>5. <i>Language Development</i></p> <p>6. <i>Language Development</i></p> <p>7. <i>Language Development</i></p> <p>8. <i>Language Development</i></p> <p>9. <i>Language Development</i></p> <p>10. <i>Language Development</i></p> <p>11. <i>Language Development</i></p> <p>12. <i>Language Development</i></p> <p>13. <i>Language Development</i></p> <p>14. <i>Language Development</i></p> <p>15. <i>Language Development</i></p> <p>16. <i>Language Development</i></p> <p>17. <i>Language Development</i></p> <p>18. <i>Language Development</i></p> <p>19. <i>Language Development</i></p> <p>20. <i>Language Development</i></p> <p>21. <i>Language Development</i></p> <p>22. <i>Language Development</i></p> <p>23. <i>Language Development</i></p> <p>24. <i>Language Development</i></p> <p>25. <i>Language Development</i></p> <p>26. <i>Language Development</i></p> <p>27. <i>Language Development</i></p> <p>28. <i>Language Development</i></p> <p>29. <i>Language Development</i></p> <p>30. <i>Language Development</i></p> <p>31. <i>Language Development</i></p> <p>32. <i>Language Development</i></p> <p>33. <i>Language Development</i></p> <p>34. <i>Language Development</i></p> <p>35. <i>Language Development</i></p> <p>36. <i>Language Development</i></p> <p>37. <i>Language Development</i></p> <p>38. <i>Language Development</i></p> <p>39. <i>Language Development</i></p> <p>40. <i>Language Development</i></p> <p>41. <i>Language Development</i></p> <p>42. <i>Language Development</i></p> <p>43. <i>Language Development</i></p> <p>44. <i>Language Development</i></p> <p>45. <i>Language Development</i></p> <p>46. <i>Language Development</i></p> <p>47. <i>Language Development</i></p> <p>48. <i>Language Development</i></p> <p>49. <i>Language Development</i></p> <p>50. <i>Language Development</i></p> <p>51. <i>Language Development</i></p> <p>52. <i>Language Development</i></p> <p>53. <i>Language Development</i></p> <p>54. <i>Language Development</i></p> <p>55. <i>Language Development</i></p> <p>56. <i>Language Development</i></p> <p>57. <i>Language Development</i></p> <p>58. <i>Language Development</i></p> <p>59. <i>Language Development</i></p> <p>60. <i>Language Development</i></p> <p>61. <i>Language Development</i></p> <p>62. <i>Language Development</i></p> <p>63. <i>Language Development</i></p> <p>64. <i>Language Development</i></p> <p>65. <i>Language Development</i></p> <p>66. <i>Language Development</i></p> <p>67. <i>Language Development</i></p> <p>68. <i>Language Development</i></p> <p>69. <i>Language Development</i></p> <p>70. <i>Language Development</i></p> <p>71. <i>Language Development</i></p> <p>72. <i>Language Development</i></p> <p>73. <i>Language Development</i></p> <p>74. <i>Language Development</i></p> <p>75. <i>Language Development</i></p> <p>76. <i>Language Development</i></p> <p>77. <i>Language Development</i></p> <p>78. <i>Language Development</i></p> <p>79. <i>Language Development</i></p> <p>80. <i>Language Development</i></p> <p>81. <i>Language Development</i></p> <p>82. <i>Language Development</i></p> <p>83. <i>Language Development</i></p> <p>84. <i>Language Development</i></p> <p>85. <i>Language Development</i></p> <p>86. <i>Language Development</i></p> <p>87. <i>Language Development</i></p> <p>88. <i>Language Development</i></p> <p>89. <i>Language Development</i></p> <p>90. <i>Language Development</i></p> <p>91. <i>Language Development</i></p> <p>92. <i>Language Development</i></p> <p>93. <i>Language Development</i></p> <p>94. <i>Language Development</i></p> <p>95. <i>Language Development</i></p> <p>96. <i>Language Development</i></p> <p>97. <i>Language Development</i></p> <p>98. <i>Language Development</i></p> <p>99. <i>Language Development</i></p> <p>100. <i>Language Development</i></p>	<p>1. <i>Other</i></p> <p>2. <i>Other</i></p> <p>3. <i>Other</i></p> <p>4. <i>Other</i></p> <p>5. <i>Other</i></p> <p>6. <i>Other</i></p> <p>7. <i>Other</i></p> <p>8. <i>Other</i></p> <p>9. <i>Other</i></p> <p>10. <i>Other</i></p> <p>11. <i>Other</i></p> <p>12. <i>Other</i></p> <p>13. <i>Other</i></p> <p>14. <i>Other</i></p> <p>15. <i>Other</i></p> <p>16. <i>Other</i></p> <p>17. <i>Other</i></p> <p>18. <i>Other</i></p> <p>19. <i>Other</i></p> <p>20. <i>Other</i></p> <p>21. <i>Other</i></p> <p>22. <i>Other</i></p> <p>23. <i>Other</i></p> <p>24. <i>Other</i></p> <p>25. <i>Other</i></p> <p>26. <i>Other</i></p> <p>27. <i>Other</i></p> <p>28. <i>Other</i></p> <p>29. <i>Other</i></p> <p>30. <i>Other</i></p> <p>31. <i>Other</i></p> <p>32. <i>Other</i></p> <p>33. <i>Other</i></p> <p>34. <i>Other</i></p> <p>35. <i>Other</i></p> <p>36. <i>Other</i></p> <p>37. <i>Other</i></p> <p>38. <i>Other</i></p> <p>39. <i>Other</i></p> <p>40. <i>Other</i></p> <p>41. <i>Other</i></p> <p>42. <i>Other</i></p> <p>43. <i>Other</i></p> <p>44. <i>Other</i></p> <p>45. <i>Other</i></p> <p>46. <i>Other</i></p> <p>47. <i>Other</i></p> <p>48. <i>Other</i></p> <p>49. <i>Other</i></p> <p>50. <i>Other</i></p> <p>51. <i>Other</i></p> <p>52. <i>Other</i></p> <p>53. <i>Other</i></p> <p>54. <i>Other</i></p> <p>55. <i>Other</i></p> <p>56. <i>Other</i></p> <p>57. <i>Other</i></p> <p>58. <i>Other</i></p> <p>59. <i>Other</i></p> <p>60. <i>Other</i></p> <p>61. <i>Other</i></p> <p>62. <i>Other</i></p> <p>63. <i>Other</i></p> <p>64. <i>Other</i></p> <p>65. <i>Other</i></p> <p>66. <i>Other</i></p> <p>67. <i>Other</i></p> <p>68. <i>Other</i></p> <p>69. <i>Other</i></p> <p>70. <i>Other</i></p> <p>71. <i>Other</i></p> <p>72. <i>Other</i></p> <p>73. <i>Other</i></p> <p>74. <i>Other</i></p> <p>75. <i>Other</i></p> <p>76. <i>Other</i></p> <p>77. <i>Other</i></p> <p>78. <i>Other</i></p> <p>79. <i>Other</i></p> <p>80. <i>Other</i></p> <p>81. <i>Other</i></p> <p>82. <i>Other</i></p> <p>83. <i>Other</i></p> <p>84. <i>Other</i></p> <p>85. <i>Other</i></p> <p>86. <i>Other</i></p> <p>87. <i>Other</i></p> <p>88. <i>Other</i></p> <p>89. <i>Other</i></p> <p>90. <i>Other</i></p> <p>91. <i>Other</i></p> <p>92. <i>Other</i></p> <p>93. <i>Other</i></p> <p>94. <i>Other</i></p> <p>95. <i>Other</i></p> <p>96. <i>Other</i></p> <p>97. <i>Other</i></p> <p>98. <i>Other</i></p> <p>99. <i>Other</i></p> <p>100. <i>Other</i></p>

Who is the funder of the research?

North Wales Clinical Psychology Programme (NWCPP), University of Wales Bangor.

Title of project:

Gay Clinical Psychologists and Gay Clients: Exploring Therapist Disclosure of Sexuality in the Therapeutic Closet.

Name and email address(es) of all researcher(s):

James Lea

Name and email address of supervisor (for student research):

Dr Rob Jones

Jaci Huws

	YES	NO
Is your project in the area of Health and Social Care requiring sponsorship by University of Wales, Bangor? If yes, please complete your ethics application in NRES format and submit an NHS R&D form alongside it. You should still complete all sections to this form, but do not need to supply the additional information requested in boxes A or B of Part 1.	✓	
Does your project require scrutiny from an outside body that has its own forms? If yes, please complete your ethics application using the forms required by the outside body. You should still complete all sections to this form, but do not need to supply the additional information requested in boxes A or B of Part 1.	✓	
If a student project, is this part of the supervisor's ongoing research that has been previously reviewed and approved? If yes, please give the proposal number of the approved research project, and complete all sections of this form.	Proposal no.	✓

PART ONE: ETHICAL CONSIDERATIONS

		YES	NO	N/A
1	Will you describe the main experimental procedures to participants ¹ in advance, so that they are informed about what to expect?	✓		
2	Will you tell participants that their participation is voluntary?	✓		
3	Will you obtain written consent for participation?	✓		
4	If the research is observational, will you ask participants for their consent to being observed?			N/A
5	Will you tell participants that they may withdraw from the research at any time and for any reason?	✓		
6	With questionnaires, will you give participants the option of omitting questions they do not want to answer?			N/A
7	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	✓		
8	Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?	✓		

If you have ticked No to any of Q1-8, but have ticked box A overleaf, please give an explanation on a separate sheet.

[Note: N/A = not applicable]

		YES	NO	N/A
9	Will your project involve deliberately misleading participants in any way?		✓	
10a	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details on a separate sheet and state what you will tell them to do if they should experience any problems (e.g., who they can contact for help)	✓		
10b	Is there any realistic risk of any participants experiencing discomfort or risk to health, subsequent illness or injury that might require medical or psychological treatment as a result of the procedures?		✓	

If you have ticked Yes to 9 or 10 you should normally tick box B overleaf; if not, please give a full explanation on a separate sheet.

11	Does your project involve work with animals? If yes, please tick box B overleaf.		✓	
12	Does your project involve payment of participants that differs from the standard rates? Is there a significant concern that the levels of payment you offer for this study will unduly influence participants to agree to procedures that they may otherwise find unacceptable? If yes to either, please tick box B and explain in point 5 of the full protocol.		✓	
13	Do participants fall into any of the following special groups? If they do, please refer to BPS guidelines, and tick box B overleaf. Note that you may also need to obtain satisfactory CRB clearance.	Children (under 18 years of age) N.B. You must ensure that you have made adequate provision for child protection issues in your protocol	✓	
		People with learning or communication difficulties N.B. You must ensure that you have provided adequate provision to manage distress	✓	

¹ In questions 1-9, if participants are children, please consider the information that you will supply to the legal guardian in each case.

		Patients N.B. You must ensure that you have provided adequate provision to manage distress.		✓	
		People in custody		✓	
		People engaged in illegal activities (e.g. drug-taking)		✓	
		Participants recruited from one of the Neurology Patient Panels or the Psychiatry Patient Panel and, if so, has the protocol been reviewed by the appropriate expert/safety panel?		✓	
		Physically vulnerable adults N.B. You must ensure that there is a person trained in CPR and seizure management on hand at all times during testing.		✓	
14 Does your project require use of any of the following facilities and, if so, has the protocol been reviewed by the appropriate expert/safety panel? If yes, tick Box B overleaf.		MRI		✓	
		TMS		✓	

There is an obligation on the lead researcher to bring to the attention of the Departmental Ethics Committee any ethical implications not clearly covered by the above checklist.

PLEASE TICK EITHER BOX A OR BOX B OVERLEAF AND PROVIDE THE DETAILS REQUIRED IN SUPPORT OF YOUR APPLICATION.

Please tick

<p>A. I consider that this project has no significant ethical implications to be brought before the Departmental Ethics Committee.</p>	
<p>Give a brief description of participants and procedure, including information on (1) hypotheses, (2) participants & recruitment, (3) research methodology, and (4) Estimated start date and duration of the study. Please attach consent and debrief forms.</p>	
<p style="text-align: center;">PLEASE SEE SEPARATE IRAS FORM</p>	

Please tick

B. I consider that this project may have ethical implications that should be brought before the Departmental Ethics Committee, and/or it will be carried out with children or other vulnerable populations.	√
<p>Please provide all the further information listed below in a separate attachment, in this order.</p> <ol style="list-style-type: none">1. Title of project2. The potential value of addressing this issue3. Brief background to the study4. The hypotheses5. Participants: recruitment methods, age, gender, exclusion/inclusion criteria6. Research design7. Procedures employed8. Measures employed9. Qualifications of the investigators to use the measures (Where working with children or vulnerable adults, please include information on investigators' CRB disclosures here.)10. Venue for investigation11. Estimated start date and duration of the study (N.B. If you know that the research is likely to continue for more than three years, please indicate this here).12. Data analysis13. Potential offence/distress to participants14. Procedures to ensure confidentiality and data protection15. *How consent is to be obtained (see BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The University has its own Welsh translations facilities on extension 2036)16. Information for participants (provide actual consent forms and information sheets)17. Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)18. Payment to: participants, investigators, departments/institutions19. Equipment required and its availability20. If students will be engaged a project involving children, vulnerable adults, one of the neurology patient panels or the psychiatric patient panel, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)21. If students will be engaged in a project involving use of MRI or TMS, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)22. What arrangements are you making to give feedback to participants? The responsibility is yours to provide it, not participants' to request it.23. Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.	

PLEASE COMPLETE PART TWO OVERLEAF.

PLEASE SEE SEPARATE IRAS FORM

PART TWO: RISK ASSESSMENT

If you tick “yes” to any of the questions in the table below, please outline on a separate sheet the probability and significance of the risks involved and the means proposed for the management of those risks. Where relevant, please also describe the procedures to be followed in the event of an adverse event or emergency.

			YES	NO	N/A
1	Is there significant potential risk to participants in any of the following ways?	Potential adverse effects		√	
		Potential distress	√		
		Potential for persisting or subsequent illness or injury that might require medical or psychological treatment		√	
2	Is there significant potential risk to investigator(s) in any of the following ways?	Potential risk of violence or other harm to the investigator(s) (e.g., through work with particular populations or through context of research).	√		
		Potential risk of allegations being made against the investigator(s). (e.g., through work with vulnerable populations or context of research).		√	
3	Is there significant potential risk to the institution in any way? (e.g., controversiality or potential for misuse of research findings.)			√	
4	Is there significant potential risk to other members of staff or students at the institution? (e.g., reception or other staff required to deal with violent or vulnerable populations.)			√	

The following questions address specific situations that can carry risks to the investigators and/or participants. If you tick “yes” to any of the questions below, please refer to the guidance given (see *Ethics Guidance and Procedures*) on procedures for dealing with these risks and, on a separate sheet, outline how these risks will be dealt with in your project.

5	Does the research involve the investigator(s) working under any of the following conditions: alone; away from the School; after-hours; or on weekends?	√		
6	Does the experimental procedure involve touching participants?		√	
7	Does the research involve disabled participants or children visiting the School?		√	

There is an obligation on the lead researcher to bring to the attention of the Departmental Ethics Committee any risk implications of the research not clearly covered by the above checklist.

PLEASE COMPLETE PART THREE OVERLEAF.

PART THREE: RESEARCH INSURANCE

The purpose of this section is to decide whether the University requires additional insurance cover for a research project. In the case of student research, this section should be completed by the supervisor.

		YES	NO	N/A
1	Is the research to be conducted in the UK?	√		
2	Is the research based solely upon the following methodologies? <ul style="list-style-type: none">▪ Psychological activity▪ Questionnaires▪ Measurements of physiological processes▪ Venepuncture▪ Collections of body secretions by non-invasive methods▪ The administration by mouth of foods or nutrients or variation of diet other than the administration of drugs or other food supplements	√		

If you have ticked “Yes” to the questions above, then insurance cover is automatic for your research and there is no need to do anything further.

If the answer to either of the above questions is “No,” we will supply you with a further questionnaire to complete and return to the Insurance Officer; in these cases the research should not commence until it has been established that appropriate insurance cover is in place.

PLEASE SIGN AND DATE THE DECLARATIONS ON THE FINAL PAGE OF THIS FORM OVERLEAF.

School of Psychology Research Ethics Form: Additional Information

Part One: Ethical Consideration

Please refer to IRAS form for all additional information required in this section.

Part Two: Risk Assessment

Question 1: Significant risk of distress to participants

It is possible that information may be disclosed within the interviews which indicates that clients and/or professionals are at risk, or have been harmed. It will be necessary to ensure that any inappropriate and/or unprofessional behaviour disclosed by the participants is followed up, and the relevant people informed. If this occurs, this will be done with the support of my supervisor. In light of this issue, the limits of confidentiality will be clearly stated to participants prior to gaining informed consent and the commencement of interviews.

In addition, there is the potential that participants may not have had an open space in which to discuss in depth the issues surrounding the disclosure of their sexuality to male gay clients. These discussions may prove emotive for the participants when discussing past clients, and it could potentially illuminate the heterosexism and homophobia still prevalent in clinical psychology and therapy, and participants may become upset and/or distressed. As a way to address this risk: (a) the nature of the study and potential negative effects will be fully explained to potential participants in the information sheet; (b) participants are free to withdraw from the interview process at any time if they become too distressed to continue; and (c) all participants involved in the interviews will be fully debriefed after the interview, during which time they will be able to discuss any difficult feelings caused by the interview process. A further way to manage the risk of participants becoming upset and/or distressed, is to recommend that the issues and difficult feelings are taken to clinical supervision, which participants will receive as part of their role as a qualified clinical psychologist. This will hopefully allow the participant to reflect on and process their experience in a supportive and structured supervision context.

Question 2: Significant risk to the investigator

It is not anticipated that there will be any risk of potential violence, however, I will undertake a refresher course in breakaway and de-escalation prior to conducting the interviews.

The interviews will take place on an individual face-to-face basis at the participant's place of work, which may be NHS premises or private practices. The Conwy & Denbighshire NHS Trust Lone Worker Policies will be adhered to (see question 5).

A further issue, although not necessarily a risk, relates to the potential for the interviews to be emotive for myself as the investigator. In order to reflect on,

and manage any difficulties I experience I will regularly access my own supervision.

Question 5: Lone working and Working away from the School of Psychology

Potential risks:

- Unknown risks to the investigator when in locations outside the investigators clinical base to conduct the research.
- Risk of harm to the investigator due to visiting participants in unknown locations.

How the risks will be addressed:

- If the location of the interview is unfamiliar, the investigator will attempt to familiarise himself with the situation, and where appropriate, contact the administration team of the service to gain more information and make relevant links.
- If a suitable location cannot be found, then a suitable room may be hired for the interview to take place.
- Details of what the investigator will be doing, where he will be going (including route details, names, addresses and telephone numbers of interviewees), as well as the expected start and finish times of the visits will be made given to the research supervisor (Dr Rob Jones). A telephone call to Dr Rob Jones will be arranged prior to, and immediately after meeting the participant where necessary.
- If the investigator does not call in, procedures will be instigated.
- The investigator will notify Dr Rob Jones if interview or other plans change.
- The investigator will carry his mobile and Conwy & Denbighshire NHS Trust and University IDs.
- The investigator will be trained in breakaway and de-escalation techniques.

The interviews will take place on an individual face-to-face basis at the participant's place of work, which may be in NHS premises or private practices. The Conwy & Denbighshire NHS Trust Lone Worker Policies will be adhered to.

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Gay Psychologists and Gay Clients: Disclosure of Therapist Sexuality

1. Is your project an audit or service evaluation?
☐ Yes ☒ No

2. Select one category from the list below:

- ☐ Clinical trial of an investigational medicinal product
- ☐ Clinical investigation or other study of a medical device
- ☐ Combined trial of an investigational medicinal product and an investigational medical device
- ☐ Other clinical trial or clinical investigation
- ☐ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- ☒ Study involving qualitative methods only
- ☐ Study limited to working with human tissue samples, other human biological samples and/or data (specific project only)
- ☐ Research tissue bank
- ☐ Research database

If your work does not fit any of these categories, select the option below:

- ☐ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
b) Will you be taking new human tissue samples (or other human biological samples)?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
c) Will you be using existing human tissue samples (or other human biological samples)?	<input type="radio"/> Yes	<input checked="" type="radio"/> No

3. In which countries of the UK will the research sites be located? (Tick all that apply)

- ☒ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland

4. In completing this form, which bodies are you making an application to?

- ☒ NHS/HSC Research and Development offices
- ☒ Research Ethics Committee
- ☐ Patient Information Advisory Group (PIAG)
- ☐ Ministry of Justice (MoJ)

5. Will any research sites in this study be NHS organisations?

- ☒ Yes ☐ No

6. Do you plan to include any participants who are children?

- ☐ Yes ☒ No

7. Do you plan to include any participants who are adults unable to consent for themselves through physical or mental incapacity? *The guidance notes explain how an adult is defined for this purpose.*

- ☐ Yes ☒ No

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service in England or Wales?

- ☐ Yes ☒ No

9. Is the study, or any part of the study, being undertaken as an educational project?

- ☒ Yes ☐ No

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

- ☒ Yes ☐ No

10. Will identifiable patient data be accessed outside the clinical care team without prior consent at any stage of the project (including identification of potential participants)?

- ☐ Yes ☒ No

Integrated Research Application System

Application Form for Research involving qualitative methods only



Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

Short title and version number: (maximum 70 characters – this will be inserted as header on all forms)
Gay Psychologists and Gay Clients: Disclosure of Therapist Sexuality

Please complete these details after you have booked the REC application for review.

REC Name:
Liverpool Adult Research Ethics Committee

REC Reference Number: 08/H1005/111	Submission date: 06/10/2008
--	---------------------------------------

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:
Gay Clinical Psychologists and Gay Clients: Exploring Therapist Disclosure of Sexuality in the Therapeutic Closet

A2. Chief Investigator:

	Title	Forename/Initials	Surname
	Mr	James	Lea
Post	Trainee Clinical Psychologist		
Qualifications	BSc (Hons) Psychology		
Employer	North Wales NHS Trust		
Work Address	NWCPP 43 College Road Bangor, Gwynedd		
Post Code	LL57 2DG		
Work E-mail			
* Personal E-mail			
Work Telephone			

* Personal Telephone/Mobile
Fax

* This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.

A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A5-1. Research reference numbers. Please give any relevant references for your study:

Applicant's/organisation's own reference number, e.g. R & D (if available):

n/a

Sponsor's/protocol number:

n/a

Funder's reference number:

n/a

International Standard Randomised Controlled Trial Number (ISRCTN):

n/a

ClinicalTrials.gov Identifier (NCT number):

n/a

European Clinical Trials Database (EudraCT) number:

n/a

Project website:

n/a

Ref.Number	Description	Reference Number
------------	-------------	------------------

A5-2. Is this application linked to a previous study or another current application?

☐ Yes

☒ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Lay summary. Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. This summary will be published on the website of the National Research Ethics Service following the ethical review.

Little is known about therapists disclosing their sexuality to clients, when both therapist and client identify as gay; and even less is known about why some professionals choose to disclosure their sexuality, and others do not (Satterly, 2005).

The present study aims to better understand and explore male gay clinical psychologists' views and experiences of disclosing and not disclosing their sexuality to male gay clients. It is hoped that eight male clinical psychologists, who identify as gay, and have experience of disclosing and not disclosing their sexuality to gay male clients will be recruited to take part. The proposed study will be qualitative, and individual semi-structured interviews will be carried out with participants to elicit their opinions and experiences. Interview transcripts will be analysed using Interpretative Phenomenological Analysis (IPA). IPA is a qualitative methodology which explores in detail 'personal lived experience and how participants make sense of that experience' (Smith, 2008).

Participants will be asked to describe their experiences of disclosing their sexuality to their gay clients, as well as the factors that influenced their decisions to disclose. They will also be asked to describe their experiences of not disclosing their sexuality to their gay clients, and again, the factors that influenced these decisions will be explored. Further areas of discussion are anticipated to include how the therapists own experiences of 'coming out' influences their disclosing behaviour; how training in clinical psychology has influenced their disclosing behaviour; how any further training they have attended that was specific to therapy with Lesbian, Gay, Bisexual and Transgender (LGBT) clients influences their disclosing behaviour; and finally, how disclosing their sexuality to clients makes them feel. Fundamentally, this study hopes to explore the experiences and factors which may influence gay clinical psychologists' decisions regarding the disclosure of their sexuality to their gay clients.

A6-2. Summary of main issues. *Please summarise the main ethical and design issues arising from the study and say how you have addressed them.*

In order to access clinical psychologists' perspectives and personal lived experiences, individual semi-structured interviews will be carried out. Semi-structured interviews are believed to be the most appropriate method of obtaining rich and meaningful data. Although there are some ethical issues arising from the study, it is important to note that as clinical psychologists, participants will typically have a thorough understanding of confidentiality, and its limits, and may be used to reflecting on their own clinical practice and other sensitive issues within supervision.

Significant Risk of Distress to Participants

There is the potential that participants may not have had an open space in which to discuss in depth the issues surrounding the disclosure of their sexuality to male gay clients. These discussions may prove emotive for the participants when discussing past clients, and it could potentially illuminate the heterosexism and homophobia still prevalent in clinical psychology and therapy, and participants may become upset and/or distressed. These risks will be addressed in the following ways:

- The nature of the study and potential negative effects will be fully explained to potential participants in the information sheet, ensuring that they make an informed choice about whether they wish to participate.
- Participants will be informed that they are free to withdraw from the interview process at any time.
- All participants involved in the interviews will be fully debriefed after the interview, during which time they will be able to discuss any difficult feelings caused by the interview process.
- Where appropriate, participants will be encouraged to take any remaining issues and feelings to clinical supervision, to reflect on and process their experience in a supportive and structured supervision context.

Disclosure within Interviews

It is possible that information may be disclosed within the interviews which indicates that clients and/or professionals are at risk, or have been harmed. This risk will be managed in the following way:

- The limits of confidentiality will be clearly explained to participants prior to consent and the commencement of interviews.
- Following a disclosure that suggests some form of risk, participants will be reminded of the limits of confidentiality and informed that the information must be shared.
- With the support of my supervisor (Dr Robert Jones), the necessary protocol will be followed and the relevant people within the trust informed.

Significant Risk to the Investigator

It is not anticipated that there will be any risk of potential violence, however, I will undertake a refresher course in breakaway and de-escalation prior to conducting the interviews.

Just as this area of discussion has the potential to be emotive for participants, it may have the potential to be just as difficult for myself as researcher. In order to reflect on, and manage any difficulties I experience I will regularly access my own supervision.

Risks as a Lone-worker

The interviews will take place on an individual face-to-face basis at the participant's place of work, which may be NHS premises or private practices. The North Wales NHS Trust Lone Worker Policies will be adhered to (see question 5).

Potential risks:

- Unknown risks to the investigator when in locations outside the investigators clinical base to conduct the research.
- Risk of harm to the investigator due to visiting participants in unknown locations.

How the risks will be addressed:

- If the location of the interview is unfamiliar, the investigator will attempt to familiarise himself with the situation, and where appropriate, contact the administration team of the service to gain more information and make relevant links.
- Details of what the investigator will be doing, where he will be going (including route details, names, addresses and telephone numbers of interviewees), as well as the expected start and finish times of the visits will be given to the research supervisor (Dr Robert Jones). A telephone call to Dr Robert Jones will be arranged prior to, and immediately after

meeting the participant where necessary.

- If the investigator does not call in, procedures will be instigated.
- The investigator will notify Dr Robert Jones if plans change.
- The investigator will carry his mobile and North Wales NHS Trust and University IDs.
- The investigator will be trained in breakaway and de-escalation techniques.

A10. What is the principal research question/objective? Please put this in language comprehensible to a lay person.

What are male gay clinical psychologists' views and experiences of disclosing and not disclosing their sexuality to male gay clients?

A11. What are the secondary research questions/objectives if applicable? Please put this in language comprehensible to a lay person.

What factors influence gay clinical psychologists' decisions regarding the disclosure of their sexuality to their gay clients?
Do clinical psychologists own experiences of 'coming out' influence their decisions regarding the disclosure of their sexuality?
Does training in clinical psychology influence their decisions regarding the disclosure of their sexuality?
Does attending training specific to therapy with LGBT clients influence their decisions regarding the disclosure of their sexuality?
How disclosing their sexuality to clients actually makes participants feel?

A12. What is the scientific justification for the research? Please put this in language comprehensible to a lay person.

Davies (2007) argues that a "heterosexual bias permeates most therapy training programmes and therapy literature. From developmental theories through to the practice of therapy, a heterosexual lens is used" (p.19). This heterosexism within society and psychology is based on the assumption that heterosexuality is equivalent to normality, and whilst usually covert within therapeutic models and practice, continues to exclude, and potentially pathologise Lesbian Gay Bisexual and Transgender (LGBT) clients (Braun, 2000; Butler & Byrne, 2008).

In response to the potential heterosexist nature of psychotherapy, and the very real psychological needs of LGBT clients, an attitude of Gay Affirmative Practice has been proposed as an attempt to create safe, meaningful and non-pathologising therapy for non-heterosexual clients (Coyle et al 2002; Milton & Coyle, 2003; Butler et al, 2008). Gay affirmative psychotherapy is a belief system or attitude, rather than a therapeutic model, which advocates that therapists working with LGBT clients require a substantial knowledge of the issues faced by this diverse group of clients (Milton et al, 2006; Hodges, 2008). Due to this fact some LGBT psychologists and therapists themselves chose to work with non-heterosexual clients in an affirmative manner.

Within gay affirmative practice appropriate therapist self-disclosure is viewed positively, as it reduces the potential power differentials that exist, resulting in a more equal and human therapy (Coyle et al, 2002). This issue of appropriate therapist self-disclosure is particularly salient with regards to the disclosure of sexuality, especially when both therapist and client identify as lesbian, gay or bisexual. Advocates of gay affirmative practice believe that therapist disclosure of their own sexuality has positive effects on the gay client, as it challenges heterosexism and reduces feelings of isolation (Coyle et al, 2002; Milton et al, 2005; Davies, 2007; Moon, 2008). It has also been suggested that this may be a challenge for the client, particularly if they view their sexuality negatively, or are still questioning their sexual identity (Coyle et al, 2002).

Scientific Justification

A preliminary literature review suggested that research into the area of self-disclosure of sexuality from male gay therapists to male gay clients is limited generally, even though this area could be argued to be of significant interest and clinical relevance.

Research that has been completed includes a series of interviews with social work therapists in America (DeCrescenzo, 1997), which reported a variety of professional and personal concerns, practices (i.e. disclosure versus non-disclosure), decision-making strategies, and both positive and negative effects on the therapist. A more recent qualitative study, again within a social work model and carried out in America reported nine relevant themes relating to the issue of gay male therapists disclosing their sexuality to their gay clients (Satterly, 2005). Themes included: professional identity; cultural situation; theoretical orientation; alternative ways of knowing; real relationship; false-self/real dilemma; sexual identity

development; therapist/client boundaries; oppression; and social identity. Whilst this area has not been heavily researched, it would appear that the issue of gay therapists disclosing their sexuality to gay clients is both complex and intriguing, and ultimately impacts upon the effectiveness and meaningfulness of the therapy received by gay clients.

It is hoped that investigating the views and experiences of male gay clinical psychologists in the United Kingdom, and using psychological frameworks to explore their experiences and the influences on their decisions to disclose will be a useful contribution to the minimal body of literature that exists. It is anticipated that the findings may help shape professional guidelines, raise awareness of the salient issues and training needs when offering therapy to gay clients, as well as offering an alternative perspective when considering clinical psychology and therapy practice more generally.

A13. Please give a full summary of your design and methodology. It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.

Prior to embarking on the research, the investigator will record and reflect on their own thoughts and beliefs in relation to the topic of investigation. This is an important aspect of IPA, which attempts to develop an increased self-awareness, and hopefully minimise researcher-bias, in both the interview and analysis stages of the project.

The proposed study will be qualitative in nature, and individual semi-structured interviews will be conducted with participants to elicit opinions and experiences. Once informed consent has been given, participants will be asked to provide basic demographic and professional information. They will then participate in a semi-structured interview, which will take approximately one to two hours (see appendices). The interviews are likely to be face-to-face, and will take place at the most convenient locations for the participants, e.g. place of work or some other agreed location. It is hoped that the interviews will occur in a quiet and private space, where the participant feels comfortable.

Timetable for the research will be as follows:

October 2008/November 2008

As the gay and lesbian psychology community is relatively small, it is anticipated that participants will be recruited by email, and interested individuals will be able to contact me directly via email.

Initially, an email/poster for the study will be used to recruit potential participants (see appendices). The email will be sent to the relevant contact person(s) of Pink Therapy, a LGBT therapy practice in London; The Lesbian and Gay Psychology Section of the BPS; and the HIV and Sexual Health Special Interest Group of the BPS. The contact person will be asked to distribute the email/poster to their members who are clinical psychologists. Interested participants would then be able to contact me directly via email, and I would send them a copy of the participant information sheet. I would then arrange a suitable time to telephone them to discuss the study in more detail. During these discussions, individuals will be free to ask any questions they may have about the research.

A further possible recruitment strategy would be to post a message (consisting of the same email/poster) on the Lesbian and Gay Psychology Listserv (www.jiscmail.ac.uk/lists/lesbian-and-gay-psychology.html) to recruit potential participants free of charge. The Lesbian and Gay Psychology Listserv is a widely used academic and clinical forum for LGBT psychologists, and researchers interested in this area of psychology to communicate, recruit participants and exchange ideas and research. Again, interested individuals would be able to contact me directly via email and I would send them an information sheet. I would then arrange a suitable time to telephone interested individuals to discuss the study in more detail. During these discussions, individuals will be free to ask any questions they may have about the research.

During these initial telephone discussions, participants will be able to give provisional verbal consent if they wish to be involved in the study. Where appropriate, dates, times and places will be arranged for the interviews to take place. Once the interview has been agreed, participants would then be given a contact telephone number for myself, in case they needed to cancel the meeting or rearrange.

Those individuals who would like more time in which to decide whether they would like to be involved will be re-contacted a week after the initial telephone conversation, to establish whether they wish to be involved. For those willing to be involved in the study, dates times and places will be arranged for the interviews to take place. Once the interview has been agreed, participants would then be given a contact telephone number for myself, in case they needed to cancel the meeting or rearrange.

November 2008/January 2009

At data collection (interviews), participants will initially have an opportunity to ask any questions regarding the research. Once any issues have been addressed, participants will be required to provide written consent to take part in the study,

and to the audio recording of the interviews for transcription and analyses. Participants will also be made aware that they are able to withdraw at any stage during the study.

Once written consent has been given, basic professional information will be collected (see interview schedule in appendices for examples).

The semi-structured interview proper will then commence, and will be audio recorded for later transcription and analysis. The interview will take approximately an hour. The interview schedule has been developed following interpretative phenomenological analysis (IPA) training and supervision (see appendices). The schedule consists of broad, open-ended questions and possible prompts for the investigator to consider. In line with traditional IPA investigations, the interview process will be participant led, as the data is a reflection of the participant's individual experiences and beliefs. Following the interview, participants will be fully debriefed and will have the opportunity to discuss any issues or feelings they may have, an/or to ask any questions about the interview. Finally, participants will be thanked for their time, and the address they would like the summary of the research findings to be sent to will be checked.

April 2009/May 2009

Following the completion of the study, all participants will be sent a letter, again thanking them for their participation, and providing them with a summary of the research findings.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, or members of the public?

- ☐ Design of the research
- ☐ Management of the research
- ☐ Undertaking the research
- ☐ Analysis of results
- ☐ Dissemination of findings
- ☒ None of the above

Give details of involvement, or if none please justify the absence of involvement.
Although patients, service users and members of the public are important when considering research projects, they are not under investigation within the current study. The proposed investigation is concerned solely with professional issues, and the participant sample is made up of male gay clinical psychologists only; therefore, it was not deemed necessary to include the opinions of patients, service users or members of the public.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17. Please list the principal inclusion and exclusion criteria.

INCLUSION CRITERIA:

- Participants must be qualified Clinical Psychologists (DClinPsy or equivalent).
- Participants must be male and identify as gay/homosexual.
- Participants must have experience of working therapeutically with male gay clients.
- Participants must have experience of disclosing their sexuality to one or more male gay clients.
- Participants must have experience of not disclosing their sexuality to one or more male gay clients.

EXCLUSION CRITERIA:

- Participants who do not meet the inclusion criteria.
- Participants who are unable to converse fluently in English.

It is hoped that approximately eight male gay clinical psychologists, who have experience of disclosing and not disclosing their sexuality to their male gay clients will take part in the study. The rationale for including participants who have

experience of disclosing and not disclosing their sexuality is an attempt to ensure that the exploration can be discussed fully, and from both types of experience.

The sample consists solely of male clinical psychologists who identify as gay to ensure some homogeneity within the sample, and allow the findings to be specific and meaningful. It was felt that to include lesbian psychologists and/or lesbian clients would be inappropriate for the current study, mainly due to the potential different issues and experiences of lesbian psychologists and lesbian clients during therapy, and indeed life.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.

- Please complete the columns for each intervention/procedure as follows:
- 1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
 - 2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
 - 3. Average time taken per intervention/procedure (minutes, hours or days)
 - 4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Reading of email and information sheet.	1	n/a	10 minutes	Initially, an email/poster will be sent to a contact person of relevant organisations (see question A13 for details) and distributed to their mailing list. Individuals who are/may be interested will email the investigator for an information sheet and a discussion over the telephone will be arranged.
Telephone call to interested individuals.	1	n/a	15 minutes	Trainee clinical psychologist. To telephone potential participants, and discuss the research further. During this time potential participants will be free to ask any questions they may have about the research. If individuals are willing to participate, a suitable date, time and place will be arranged for the interview to take place.
Completion of consent form.	1	n/a	10 minutes	Trainee clinical psychologist. Again participants will have the opportunity to ask any questions about the research before completing the consent form. To take place at the most convenient location for participant. This is likely to be at the participant's place of employment.
Professional information component of interview.	1	n/a	10 minutes	Trainee clinical psychologist. To take place at the most convenient location for participants. This is likely to be at the participant's place of employment.
Semi-structured interview.	1	n/a	30-60 minutes	Trainee clinical psychologist. To take place at the most convenient location for participants. This is likely to be at the participant's place of employment.
Time for questions and debrief following interview.	1	n/a	20 minutes	Trainee clinical psychologist. To take place at the most convenient location for participants. This is likely to be at the participant's place of employment.

A21. How long do you expect each participant to be in the study in total?

Following the telephone conversation, it is anticipated that participants will meet the investigator to complete the professional information questions, semi-structured interview and debrief. It is expected that in its entirety, this process will take no more than 100 minutes (1 hour 40 minutes), and additional meetings should not be necessary.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

There is the potential that participants may not have had an open space in which to discuss in depth the issues surrounding the disclosure of their sexuality to male gay clients. These discussions may prove emotive for the participants when discussing past clients, and it could potentially illuminate the heterosexism and homophobia still prevalent in clinical psychology and therapy, and participants may become upset and/or distressed.

In order to minimise the risk of distress, the following steps will be taken:

- The nature of the study and potential negative effects will be fully explained to potential participants in the information sheet, to ensure that they make an informed choice about whether they wish to participate.
- Participants will be informed that they are free to withdraw from the interview process at any time.
- All participants involved in the interviews will be fully debriefed after the interview, during which time they will be able to discuss any difficult feelings caused by the interview process.
- Where appropriate, participants will be encouraged to take any remaining issues and feelings to clinical supervision, to reflect on and process their experience in a supportive and structured supervision context.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

☒ Yes ☐ No

If Yes, please give details of procedures in place to deal with these issues:

Any form of self-disclosure from therapist to client may be questioned, and deemed 'taboo' within certain models of therapy. Therefore, the topic of discussion can be viewed as intrinsically sensitive, and participants may find it embarrassing or upsetting to talk about.

In addition, as information regarding the participants own practice will be discussed, it is possible that they may disclose information that requires the investigator to take further action. Such information may be that the client and/or professional are at risk or have been harmed, or information that questions the professional's fitness to practice (DCP guidelines), e.g. sexual relationships with clients.

In order to minimise and manage these risks, the following steps will be taken:

- The nature of the study and potential negative effects will be fully explained to potential participants in the information sheet, to ensure that they make an informed choice about whether they wish to participate.
- Participants will be informed that they are free to withdraw from the interview process at any time.
- All participants involved in the interviews will be fully debriefed after the interview, during which time they will be able to discuss any difficult feelings caused by the interview process.
- The limits of confidentiality will be clearly explained to participants prior to consent and the commencement of interviews (though as practicing clinical psychologists it is likely that they will have a thorough understanding of confidentiality).
- Following a disclosure that suggests some form of risk or harm, participants will be reminded of the limits of confidentiality and informed that the information must be shared.
- With the support of my supervisor (Dr Rob Jones), the necessary protocol will be followed and the relevant people within the trust informed.

A24. What is the potential for benefit to research participants?

Participants are able to engage in a study that allows them to discuss and reflect on a salient professional issue that has long been overlooked by research, and even viewed 'taboo' by some models of therapy. In terms of future gain, the study has the potential to shape professional guidelines, raise awareness of the salient issues and training needs when offering therapy to gay clients, as well as offering an alternative perspective when considering clinical psychology and therapy practice more generally.

All participants will receive a summary of the research findings.

There is no material benefit for participation in this study.

A26. What are the potential risks for the researchers themselves? (if any)

Just as this area of discussion has the potential to be emotive for participants, it may have the potential to be just as difficult for myself as researcher.

It is not anticipated that there will be any risk of potential violence, however, as with all one-to-one interview situations, the risk needs to be anticipated and managed.

A further area of potential risk is related to the fact that the investigator will be lone working, and there may be unknown risks due to visiting participants in unknown locations.

The above risks will be addressed in the following ways:

- In order to reflect on, and manage any difficulties I experience I will regularly access my own supervision.
- The investigator will attend a refresher course in breakaway and de-escalation techniques prior to the commencement of the interviews.
- The individual interviews will take place at the most appropriate place for participants, either at their NHS work premises or some other agreed location; therefore, the North Wales NHS Trust Lone Worker Policies will be adhered to.
- If the location of the interview is unfamiliar, the investigator will attempt to familiarise himself with the situation, and where appropriate, contact the administration team of the service to gain more information and make relevant links.
- Details of what the investigator will be doing, where he will be going (including route details, names, addresses and telephone numbers of interviewees), as well as the expected start and finish times of the visits will be made given to the research supervisor (Dr Robert Jones). A telephone call to Dr Robert Jones will be arranged prior to, and immediately after meeting the participant where necessary.
- If the investigator does not call in to Dr Robert Jones, then procedures will be instigated.
- The investigator will notify Dr Robert Jones if plans change.
- The investigator will carry his mobile and North Wales NHS Trust and University IDs.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How and by whom will potential participants, records or samples be identified?

It is envisaged that participants will be recruited by the chief investigator in the following way:

As the gay and lesbian psychology community is relatively small, it is anticipated that participants will be recruited by email, and interested individuals will be able to contact me directly via email.

Initially, an email/poster for the study will be used to recruit potential participants (see appendices). The email will be sent to the relevant contact person(s) of Pink Therapy, a LGBT therapy practice in London; The Lesbian and Gay Psychology Section of the BPS; and the HIV and Sexual Health Special Interest Group of the BPS. The contact person will be asked to distribute the email/poster to their members who are clinical psychologists.

Interested participants would then be able to contact me directly via email, and I would send them a copy of the participant information sheet. I would then arrange a suitable time to telephone them to discuss the study in more detail. During these discussions, individuals will be free to ask any questions they may have about the research, and inclusion and exclusion criteria can be considered prior to consent.

If a sufficient number of participants could not be found in this way, a further possible recruitment strategy would be to post a message (consisting of the same email/poster) on the Lesbian and Gay Psychology Listserv (www.jiscmail.ac.uk/lists/lesbian-and-gay-psychology.html) to recruit potential participants free of charge. The Lesbian and Gay Psychology Listserv is a widely used academic and clinical forum for LGBT psychologists, and researchers interested in this area of psychology to communicate, recruit participants and exchange ideas and research.

Again, interested individuals would be able to contact me directly via email and I would send them an information sheet. I would then arrange a suitable time to telephone interested individuals to discuss the study in more detail. During these discussions, individuals will be free to ask any questions they may have about the research, and inclusion and exclusion criteria can be considered prior to consent.

It should be noted that recruitment may prove difficult due to the specificity of the inclusion criteria, however, due to the relatively small sample size, the investigator is confident that sufficient recruitment will be possible.

A27-2. Will this involve reviewing or screening identifiable personal information of potential participants or any other person?

☐ Yes ☒ No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

☒ Yes ☐ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

If a sufficient number of participants could not be found in this way, a further possible recruitment strategy would be to post a message (consisting of the same email/poster) on the Lesbian and Gay Psychology Listserv (www.jiscmail.ac.uk/lists/lesbian-and-gay-psychology.html) to recruit potential participants free of charge. The Lesbian and Gay Psychology Listserv is a widely used academic and clinical forum for LGBT psychologists, and researchers interested in this area of psychology to communicate, recruit participants and exchange ideas and research.

Again, interested individuals would be able to contact me directly via email and I would send them an information sheet. I would then arrange a suitable time to telephone interested individuals to discuss the study in more detail. During these discussions, individuals will be free to ask any questions they may have about the research, and inclusion and exclusion criteria can be considered prior to consent.

A29. How and by whom will potential participants first be approached?

Potential participants will first be approached by email from the chief investigator. This email may be forwarded from the contact person of their organisation, or viewed directly on the Lesbian and Gay Psychology Listserv; however, on both occasions potential participants will be approached via email, by the investigator.

The first individual who will share information and discuss the study, other than what is included in the information sheet, will be the investigator. All subsequent involvement will only be with the investigator, including the completion of the consent form.

A30-1. Will you obtain informed consent from or on behalf of research participants?

☒ Yes ☐ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Individuals will be provided with an information sheet via email. If interested, the investigator will telephone the potential participant and discuss the information sheet more thoroughly. Individuals will have the opportunity to ask any questions or raise any issues they may have prior to giving consent. Participants will be able to give provisional verbal consent if they wish to be involved in the study on the telephone, and a date, time and place to meet in person will be arranged for the interviews. At this meeting, participants will give written informed consent prior to the interview commencing. Those individuals who would like more time in which to decide whether they would like to be involved will be re-contacted a week after the initial telephone conversation, to establish whether they wish to be involved.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

☒ Yes ☐ No

If No, how will it be recorded?

A31. How long will you allow potential participants to decide whether or not to take part?

Potential participants will have up to one week following the initial telephone conversation with the investigator to decide whether they wish to participate in the study.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters)

Unfortunately, individuals with special communication needs or those who are not able to converse fluently in English will be excluded from the study. This is due to the semi-structured interview component of the investigation, and the investigators inability to use other spoken languages. It is anticipated that as practicing clinical psychologists in the UK that participants will typically have a good understanding of English, and be able to understand and reflect on the topic area.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? Tick one option only.

- ☒ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ☐ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ☐ The participant would continue to be included in the study.
- ☐ Not applicable – informed consent will not be sought from any participants in this research.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? (Tick as appropriate)

- ☐ Access to medical records by those outside the direct healthcare team
- ☒ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☒ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☒ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☒ Use of audio/visual recording devices
- ☐ Storage of personal data on any of the following:
 - ☐ Manual files including X-rays
 - ☐ NHS computers
 - ☐ Home or other personal computers
 - ☒ University computers
 - ☐ Private company computers
 - ☒ Laptop computers

Further details:

Email: To recruit participants, an email/poster for the study will be sent to contact people(s) of relevant organisations and possibly the Lesbian and Gay Psychology Listserv. None of these emails will have any potential participant personal information within them. Those interested individuals will email the investigator directly registering their interest and requesting an information sheet. If participants want to take part in the study, they will be asked to provide a work/home contact telephone number for the investigator to call them and discuss the study further. Email will also be utilised to send information from the chief investigator to those supervising the project (Dr Robert Jones and Jacqueline Huws), although it is not anticipated that these will contain any participant personal information.

Personal Addresses: Participants home and/work addresses will be collected over the telephone to arrange interview visits, and in order to send participants a summary of the findings upon completion of the investigation.

Direct Quotes: All interviews will be transcribed and analysed. Direct quotations from participants will be included in the write up of the investigation to illustrate themes, although pseudonyms will be used when reporting the quotes to maintain anonymity.

Audio Devices: All interviews will be recorded on a digital recording device. During transcription, pseudonyms will be used. Once completed, the recording will be destroyed. and the anonymised transcription will be stored in password protected files.

University/Laptop Computers: A university laptop and computers will be used to write up the investigation, although all participant data will be pseudonymised.

A38. How will you ensure the confidentiality of personal data? Please provide a general statement of the policy for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.

In order to ensure the confidentiality of personal data, no identifiers will be present in the data collected (interview transcripts) or in the computerised write-up of the findings. Participants will be assigned a pseudonym in order to preserve their anonymity.

Contact details are only required in order to arrange the interviews and forward the findings of the study. This information will be stored separately from investigation data (interview transcripts) to preserve anonymity.

All interview audio tapes will be destroyed following transcription.

North Wales NHS Trust Policies on data protection and confidentiality will be followed.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct healthcare team, please justify and say whether consent will be sought.*

The chief investigator (James Lea, Trainee Clinical Psychologist) and research supervisor (Dr Robert Jones) will have access to personal data during the study. The IPA supervisor (Ms Jacqueline Huws) will have access to the interview transcripts for the purposes of supervising the IPA analysis, but will not have access to any other personal data.

No other individuals will have access to any personal data during the study.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

☐ Less than 3 months

☐ 3 – 6 months

☒ 6 – 12 months

☐ 12 months – 3 years

☐ Over 3 years

If longer than 12 months, please justify:

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

☒ Yes ☐ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined. If a suitable venue for the interviews cannot be arranged, participants will be invited to another suitable location, e.g. a rented consultation room. If this occurs, participants will be reimbursed for their travel expenses.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

☐ Yes ☒ No

If Yes, please indicate how much and on what basis this has been decided:

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

☐ Yes ☒ No

If yes, please give details including the amount of any monetary payment or the basis on which this will be calculated:

NOTIFICATION OF OTHER PROFESSIONALS

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

☐ Yes ☒ No

Please give details, or justify if not registering the research.

The study is an investigation of professional issues within therapeutic practice. Whilst it may be useful for the public to access the results of this investigation, the primary audience will be clinical psychologists and other professionals who may be more likely to access the results by consulting journals.

A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:

☒ Peer reviewed scientific journals

☒ Internal report

☒ Conference presentation

☒ Publication on website

☒ Other publication

☒ Submission to regulatory authorities

☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators

☐ No plans to report or disseminate the results

☒ Other (please specify)

Written feedback to be provided to all participants.

A53. Will you inform participants of the results?

☒ Yes ☐ No

Please give details of how you will inform participants or justify if not doing so.

A summary of the research findings will be sent by letter to all participants.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? Tick as appropriate:

☐ Independent external review

☐ Review within a company

☐ Review within a multi-centre research group

☒ Review within the Chief Investigator's institution or host organisation

☐ Review within the research team

☒ Review by educational supervisor

☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

The research proposal was discussed and agreed by the research supervisor (Dr Robert Jones). The proposal was submitted to and authorised by the North Wales Clinical Psychology Programme (Dr Dave Daley), and the School of Psychology Ethics Panel at Bangor University.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:

8

Total international sample size (including UK):

8

Further details:

It is hoped that eight male gay clinical psychologists within England and Wales will be recruited to take part in the study.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The sample size was determined following discussions with the IPA supervisor (Ms Jacqueline Huws), and Senior Research Tutor at the North Wales Clinical Psychology Programme (Dr Dave Daley); in addition to IPA training. Within the qualitative literature, the typical number of participants recruited in IPA studies is around six to eight. It was deemed that eight would be an appropriate number for this investigation.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The present study aims to better understand and explore male gay clinical psychologists' views and experiences of disclosing and not disclosing their sexuality to male gay clients, using Interpretative Phenomenological Analysis (IPA).

IPA is a qualitative methodology which explores in detail 'personal lived experience and how participants make sense of that experience' (Smith, 2008). Each interview will be audio recorded and then transcribed. Analysis will involve careful examination of these transcripts, and themes will be generated from the text. Theme generation will focus on capturing the essence of each individual participant's personal experience, in relation to their disclosure and non-disclosure of sexuality to their male gay clients. When each transcript has been considered individually and themes generated, comparisons will be made between the themes of each of the transcripts.

It is hoped that through exchanging a set number of transcripts with fellow trainee clinical psychologists who are also conducting IPA projects, that themes from the analysis will be further explored and allow inter-rater reliability to be achieved.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers not listed at A3.*

	Title	Forename/Initials	Surname
	Dr	Robert S. P.	Jones
Post	Consultant Clinical Psychologist and Director of CPD		
Qualifications	1980: BA (Hons) in Psychology Trinity College Dublin 1981: MA in Psychology Trinity College Dublin 1982: Diploma in Community Development O.I.C.D.-Dublin. 1984: Diploma in Clinical Psychology British Psychological Society 1986: Doctor of Philosophy Trinity College Dublin 1989: Chartered Clinical Psychologist (C.Psychol.)		
Employer	North Wales Clinical Psychology Programme, Bangor University		

Work Address	43 College Road Bangor Gwynedd, Wales, UK
Post Code	LL57 2DG
Telephone	01248 382205
Fax	01248 383718
Mobile	
Work Email	r.s.jones@bangor.ac.uk

	Title	Forename/Initials	Surname
	Ms	Jacqueline	Huws
Post	Lecturer and Research Fellow		
Qualifications	Completing PhD		
Employer	Bangor University		
Work Address	School of Healthcare Sciences Bangor University Bangor, Gwynedd, Wales, UK		
Post Code	LL57 2EF		
Telephone	01248 383155		
Fax			
Mobile			
Work Email	j.huws@bangor.ac.uk		

A64. Details of research sponsor(s)

A64-1. Lead sponsor *(must be completed in all cases)*

Name of organisation which will act as the lead sponsor for the research:
Bangor University

Status:

☐ NHS or HSC care organisation ☒ Academic ☐ Pharmaceutical industry ☐ Medical device industry ☐ Other

If Other, please specify:

Address School of Psychology
 43 College Road
 Bangor, Gwynedd

Post Code LL57 2AS

Country Wales

Telephone 01248 351151

Fax 01248 382599

Mobile

E-mail o.turnbull@bangor.ac.uk

A64-2. Sponsor's UK contact point for correspondence *(must be completed in all cases)*

	Title	Forename/Initials	Surname
	Professor	Oliver	Turnbull
Post	Head of School		
Work Address	School of Psychology		
	43 College Road		
	Bangor, Gwynedd		
Post Code	LL57 2AS		
Telephone	01248 383670		
Fax	01248 382599		
Mobile			
E-mail	o.turnbull@bangor.ac.uk		

A64-3. Are there any co-sponsors for this research?

☐ Yes ☒ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

☐ Yes ☒ No

If Yes, please give details of each rejected application:

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
	Mrs	Angela	Williams
Organisation	North Central London Mental Health Trusts and PCTs		
Address	NoCLoR		
	Room 3-17, 3rd Floor, West Wing		
	St.Pancras Hospital, St Pancras Way		
Post Code	NW1 0PE		
Work Email	angela.williams@camdenpct.nhs.uk		
Telephone	0207 530 5375		
Fax			
Mobile			

Details can be obtained from the NHS R&D Forum website: www.rdforum.nhs.uk

A69. How long do you expect the study to last?

Planned start date: 01/10/2008
Planned end date: 03/08/2009
Duration:
Years: 0
Months: 10

A71. Where will the research take place? (Tick as appropriate)

- ☒ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland
- ☐ Other states in European Union
- ☐ Other countries in European Economic Area
- ☐ USA
- ☐ Other international (please specify)

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:

- | | |
|--|----|
| <input checked="" type="checkbox"/> NHS organisations in England | 10 |
| <input type="checkbox"/> NHS organisations in Wales | 0 |
| <input type="checkbox"/> NHS organisations in Scotland | 0 |
| <input type="checkbox"/> HSC organisations in Northern Ireland | 0 |
| <input type="checkbox"/> GP practices in England | 0 |
| <input type="checkbox"/> GP practices in Wales | 0 |
| <input type="checkbox"/> GP practices in Scotland | 0 |
| <input type="checkbox"/> GP practices in Northern Ireland | 0 |
| <input type="checkbox"/> Social care organisations | 0 |
| <input type="checkbox"/> Phase 1 trial units | 0 |
| <input type="checkbox"/> Prison establishments | 0 |
| <input type="checkbox"/> Probation areas | 0 |
| <input type="checkbox"/> Independent hospitals | 0 |
| <input type="checkbox"/> Educational establishments | 0 |
| <input type="checkbox"/> Independent research units | 0 |
| <input type="checkbox"/> Other (give details) | 0 |

Total UK sites in study: 10

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (NHS sponsors only)
- ☒ Other insurance or indemnity arrangements will apply (give details below)

Bangor University is a member of UM Association Ltd (UMAL).

Non-negligent Harm has been selected for this study. Cover is provided by UMAI Q QBE Insurance (Europe) Ltd. Employers liability limit of indemnity £10,000,000 and any one event unlimited in the aggregate. Public and Products Liability, limit of indemnity £50,000,000 any one event and in the aggregate of Products Liability and Unlimited in the aggregate in respect of public liability.

Professional Indemnity: Limit of indemnity £10,000,000 any one claim and in the aggregate except for Pollution where cover is limited to £1,000,000 in the aggregate.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
- ☒ Other insurance or indemnity arrangements will apply (give details below)

Bangor University is a member of UM Association Ltd (UMAL).

Non-negligent Harm has been selected for this study. Cover is provided by UMAI Q QBE Insurance (Europe) Ltd. Employers liability limit of indemnity £10,000,000 and any one event unlimited in the aggregate. Public and Products Liability, limit of indemnity £50,000,000 any one event and in the aggregate of Products Liability and Unlimited in the aggregate in respect of public liability.

Professional Indemnity: Limit of indemnity £10,000,000 any one claim and in the aggregate except for Pollution where cover is limited to £1,000,000 in the aggregate.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- ☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- ☒ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Bangor University is a member of UM Association Ltd (UMAL).

Non-negligent Harm has been selected for this study. Cover is provided by UMAI Q QBE Insurance (Europe) Ltd. Employers liability limit of indemnity £10,000,000 and any one event unlimited in the aggregate. Public and Products Liability, limit of indemnity £50,000,000 any one event and in the aggregate of Products Liability and Unlimited in the

aggregate in respect of public liability.

Professional Indemnity: Limit of indemnity £10,000,000 any one cliam and in the aggregate except for Pullution where cover is limited to £1,000,000 in the aggregate.

Please enclose a copy of relevant documents.

North London London Airport Police Units and PCTs	Mr Angela Williams
S Browning Partnership NHS Trust	Tina Stanger
East Chills Care West Foundation Trust	Suzanne Lowe
It is anticipated that there will be further requests as the situation develops and the will be led by equivalent to public health.	

PART C: Overview of research sites

Please enter details of the host organisations (NHS or other) in the UK that will be responsible for the research sites.

Research site	PI/ local collaborator
North Central London Mental Health Trusts and PCTs	Mrs Angela Williams
5 Boroughs Partnership NHS Trust	Tina Stainer
Lancashire Care NHS Foundation Trust	Beverley Lowe
It is anticipated that there will be further research sites, although this will be led by recruitment of participants.	

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
 - ◆ Will be held by the main REC or the GTAC (as applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
 - ◆ May be disclosed to the operational managers of review bodies, or the appointing authority for the main REC, in order to check that the application has been processed correctly or to investigate any complaint.
 - ◆ May be seen by auditors appointed to undertake accreditation of RECs.
 - ◆ Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. I understand that the lay summary of this study will be published on the website of the National Research Ethics Service (NRES) as it appears in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature:

Print Name:	James Lee		
Date:	8/12/2008	(dd/mm/yyyy)	

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

- 1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
- 2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
- 3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
- 4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
- 5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
- 6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
- 7. I understand that the lay summary of this study will be published on the website of the National Research Ethics Service (NRES) as it appears in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

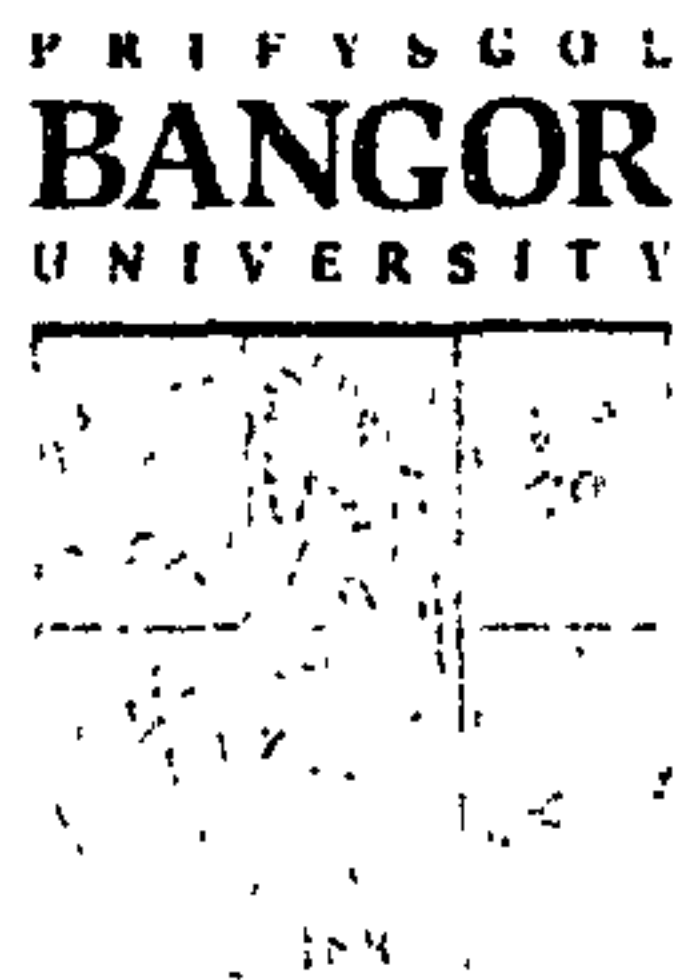
Signature:

Print Name:

Post:

Organisation:

Date: (dd/mm/yyyy)



PARTICIPANT CONSENT FORM

Title of Project: Gay Clinical Psychologists and Gay Clients: Exploring
Therapist Disclosure of Sexuality in the Therapeutic Closet.

Name of Researcher: James Lea.

Please read the following information, delete as appropriate, and sign if you wish to participate in the study.

1.

I have read and understood the information sheet (dated.....) in relation to this study.

YES / NO
2.

I have had the opportunity to think about the information, to ask questions and to consider the answers before making a decision about taking part.

YES / NO
3.

I agree to the audio recording of my interview for the purposes of transcription and analyses (tapes will be kept securely and will be erased following transcription).

YES / NO
4.

I agree to the inclusion of direct quotes from my interview in the final written version of the study. I am aware that this study involves a small sample of participants (approximately eight), and the inclusion of direct quotes may compromise the investigators attempts to maintain participant anonymity.

YES / NO
5.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, at no detriment to myself.

YES / NO
6.

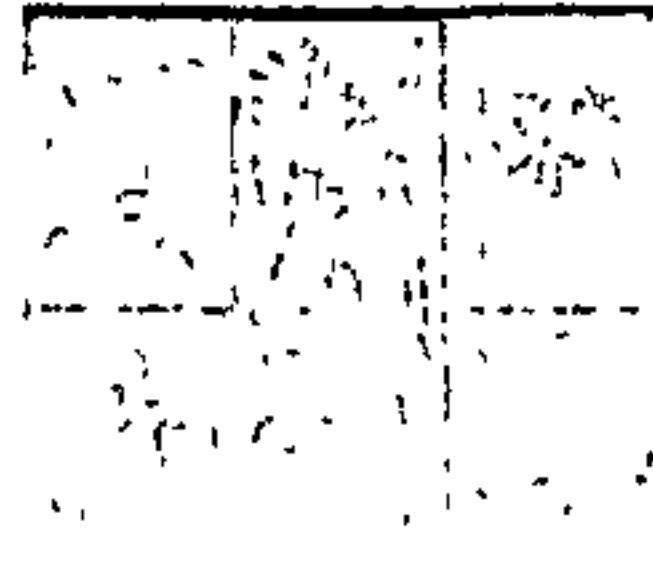
Upon completion of the study, I would like a written summary of the findings.

YES / NO
7.

I consent to participate in the above study.

YES / NO

----- Name of Participant	----- Signature	----- Date
----- Name of Participant	----- Signature	----- Date



PARTICIPANT INFORMATION SHEET

Title of Project: Gay Clinical Psychologists and Gay Clients: Exploring
Therapist Disclosure of Sexuality in the Therapeutic Closet.

Name of Researcher: James Lea.

Why have I been chosen?

You have been sent this information sheet because you registered your interest in the above study and possibly taking part. The study intends to explore the views and experiences of clinical psychologists regarding self-disclosure of their sexuality to their gay clients. You are eligible to take part in the study if you are a male clinical psychologist who identifies as gay, and has experience of both disclosing and not disclosing your sexuality to male gay clients you have worked with therapeutically.

Who is conducting the research?

This research is being conducted by James Lea, trainee clinical psychologist on the North Wales Clinical Psychology Programme. This study is James' large-scale research project, which will be submitted in partial fulfilment of the final award of doctorate in clinical psychology. The study is being supervised by Dr Robert Jones, Consultant Clinical Psychologist and Director of CPD at Bangor University, and Jacqueline Huws, Research Fellow at Bangor University.

Why is the research being done?

Davies (2007) suggests that a heterosexual bias underpins most therapy training programmes and practices, which may covertly exclude and potentially pathologise Lesbian, Gay, Bisexual and Transgender (LGBT) clients. When both therapist and client identify as gay, therapist self-disclosure of their sexuality can be positive, as it challenges this heterosexual bias and may reduce feelings of isolation and difference for the client (Coyle 2002). However, little is known about this practice from the therapists' perspective, and even less is known about why some gay professionals choose to disclose their sexuality, and others do not.

The minimal research literature that exists on this form of self-disclosure focuses on the experiences of social work therapists in America, and reports a variety of professional and personal concerns, practices and decision making strategies (Satterly, 2005). This complex and intriguing professional issue would also be salient for practicing clinical psychologists who identify as gay and work with gay clients in the UK, however, the knowledge and experiences of these professionals has not been forthcoming. This

study hopes to explore this area and give a voice to these professionals. It is anticipated that the findings may help shape professional guidelines by raising awareness of the salient issues when offering therapy to gay clients, as well as providing an alternative perspective for clinical psychologists considering clinical psychology and therapy practice more generally.

What does participation involve?

Participants who would like to take part in the research can contact James directly via email. Participants will then be required to provide a contact telephone number, and James will arrange a suitable time to telephone and discuss the study in more detail. Following this initial conversation, participants will have up to one week to decide if they would like to participate. If they do decide to participate, a convenient date, time and place for the interview to take place will be agreed.

At the meeting, participants will initially have an opportunity to ask any further questions regarding the research. Once any queries have been addressed, participants will be required to provide written consent to take part in the study, and for the interview to be audio recorded for the purposes of transcription and analyses. Each participant will then be required to engage in a single interview, which will take approximately thirty to sixty minutes. The interview will include a small number of questions on demographic information. The majority of the interview will be semi-structured, and will focus on participants' thoughts, opinions and experiences in relation to the disclosure of their sexuality to gay male clients. Some of these thoughts may be documented in the final write up of the study. Following the interview, participants will have time to ask any questions they may have.

Are personal details and interview recordings confidential?

All personal details and interview recordings will be confidential and will be kept securely. Only James Lea, Dr Robert Jones and Jacqueline Huws will have access to this information. All participants who are involved in the research will be assigned a pseudonym, which will be used on all documentation and transcripts throughout the study. Every effort will be made to maintain participant anonymity by using pseudonyms, however, as this study involves a small sample of participants (approximately eight), the inclusion of direct quotes from participants may compromise the investigators attempts to do so. Participants will therefore have the right to choose whether they are happy for their direct quotes to be included in the final document by completing a section on the consent form.

In line with the limits of confidentiality, if information is shared within the interview which indicates that the participant or another person (e.g. client) may be at risk of harm, or that they have been harmed then this information cannot remain confidential. In these circumstances, the research supervisor (Dr Robert Jones) and necessary members of the NHS will be informed.

Upon completion of the study, personal details will be stored for up to twelve months in a locked filing cabinet at Bangor University, and all research data will be stored for a maximum of ten years before being destroyed.

Are there any risks involved in taking part?

It is unlikely that participants will suffer any negative effects as a result of their involvement in this study, however, it is important to note that the topic under discussion could evoke strong feelings in some participants and potentially lead to distress. In order to minimise these risks, participants will be free to withdraw from the study at any time, and will also have to chance to discuss any issues which may have arisen as a result of the interview process once the interview has ended.

Are there any benefits to participants or others as a result of taking part?

There are no material benefits for participants involved in this research, however, this study allows professionals to engage in a study which enables them to discuss a professional issue that has long been overlooked by research, as well as to reflect on their own clinical practice. In terms of future gain, this study has the potential to give a voice to the gay clinical psychologists facing the issue of whether to disclose their sexuality and the factors that impact on this. It is also hoped that this investigation will help shape professional guidelines by raising awareness of the salient issues when offering therapy to gay clients.

Upon completion of the investigation, all participants will receive a summary of the findings.

Has this study been ethically approved?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study was reviewed and authorised by the educational supervisor Dr Robert Jones and the North Wales Clinical Psychology Programme. Ethical approval was gained from the School of Psychology Ethics Panel at Bangor University, and the Liverpool Adult NHS Research Ethics Committee.

Complaints

If you decide to take part in the study, please keep this information sheet so that you can refer to it in the future. If you should have any concerns or complaints about the conduct of this study, these should be addressed to:

- Mary Burrows, Chief Executive, North Wales NHS Trust, Trust Headquarters, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD.
- Professor O. Turnbull, Head of School of Psychology, Bangor University, Bangor, Gwynedd, LL57 2DG.

How can I get more information about the study?

If you would like to hear more about the study, or if you feel that you are eligible and would like to consider taking part, then please contact:

James Lea (Trainee Clinical Psychologist), North Wales Clinical Psychology Programme (NWCPP). Email: jpsych757@hotmail.com

Email to potential participants

James Lea
Trainee Clinical Psychologist
North Wales Clinical Psychology Programme
University of Wales
Bangor
43 College Road
Bangor
Gwynedd
LL57 2DG

Email: psp462@bangor.ac.uk

Dear All,

Re: Gay Clinical Psychologists and Gay Clients: Exploring Therapist Disclosure of Sexuality in the Therapeutic Closet.

I am currently seeking to recruit participants for the above study. You are eligible to take part in this exciting study if you are:

- Male.
- A qualified Clinical Psychologist.
- Identify as gay/homosexual.
- Have experience of working therapeutically with gay men.
- Have disclosed your sexuality to one or more male gay clients.
- Have refrained from disclosing your sexuality to one or more male gay clients.

If anyone would like any further information, or feels that they would like to participate in the research then they can contact me directly via email for an information sheet.

Thank you for your support in this endeavour.

Yours sincerely,

James Lea
Trainee Clinical Psychologist

Supervised by:
Dr Robert Jones
Consultant Clinical Psychologist

Initial Ethical Approval

School of Psychology Ethics proposal 1208

Dear Colleagues

*Gay Clinical Psychologists and Gay Clients: Exploring
Therapist disclosure of Sexuality in the Therapeutic
Closet Proposal 1208*

Your research proposal referred to above has been reviewed
by the School of Psychology Research Ethics Committee and
they are satisfied:

(i) That the research proposed accords with the relevant
ethical guidelines. (ii) That the research proposed is
appropriate for sponsorship by the University of Wales,
Bangor.

Approval is granted subject to you submitting Welsh
translations of your information/consent and debrief forms
to me.

If you wish to make any non-trivial modifications to the
research project please inform the committee in writing
before proceeding. Please also inform the committee as
soon as possible if research participants experience any
unanticipated harm as a result of participating in your
research.

You should now forward the application to COREC and to the
appropriate Local Research Ethics Committee (LREC). If you
need a signature on the form regarding research
sponsorship by the University, and/or a letter confirming
this sponsorship, please send the final version of your
COREC form to me and I will make arrangements for this.

The NHS Research Ethics Committee expect one of the
investigators to make an oral presentation in support of
the proposal at their meeting. You will be contacted by
their committee with details as to the date and place of
the meeting at which your proposal will be considered.

You may not proceed with the research project until you
are notified of the approval of the Local Research Ethics
Committee and have R&D approval from the relevant NHS
Trusts. The approval for this project is given on the
understanding that you will complete a review form on the
project when requested; to this end I would be grateful if
you could complete the form below and return it to me.

Yours sincerely

Everil McQuarrie (Finance and Research Administrator)

National Research Ethics Service

Liverpool (Adult) Research Ethics Committee

Bishop Goss Complex
Victoria Building
Rose Place
Liverpool
L3 3AN

Telephone: 0151 330 2077
Facsimile: 0151 330 2075

12 November 2008

Mr James Lea
Trainee Clinical Psychologist
North Wales NHS Trust
NWCPP
43 College Road
Bangor, Gwynedd
LL57 2DG

Dear Mr Lea

Full title of study: Gay Clinical Psychologists and Gay Clients: Exploring
Therapist Disclosure of Sexuality in the Therapeutic
Closet
REC reference number: 08/H1005/111

The Research Ethics Committee reviewed the above application at the meeting held on 05 November 2008. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Participant Consent Form	1	06 October 2008
Participant Information Sheet	1	06 October 2008
Letter of invitation to participant	1	06 October 2008
Interview Schedules/Topic Guides	1	06 October 2008
Compensation Arrangements	QBE	01 August 2008
Letter from Sponsor		06 October 2008
Protocol	1	22 February 2008
Investigator CV	J Lea	06 October 2008
Application		07 October 2008
Investigator CV	RSP Jones	

Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

Further information or clarification and amendments required : -**Patient Information Sheet (PIS) Issues : -**

- E-mail address and telephone number to be obtained (solely used for this study) and to be put on the PIS.

Consent form :

- Yes/No boxes to be replaced with boxes for initials of participants

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 12 March 2009.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. However, all researchers and local research collaborators who intend to participate in this study at NHS sites should seek approval from the R&D office for the relevant care organisation.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

08/H1005/111**Please quote this number on all correspondence**

Yours sincerely



Dr Tej Purewal
Chair

Email: Ronald.Wall@liverpoolpct.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to: Professor Oliver Turnbull, School of Psychology, Bangor

Section 2

Amendments to Study

SCHOOL OF PSYCHOLOGY ETHICS AMENDMENT REQUEST FORM
[To be used to request Ethics Committee approval for non-trivial modifications to a previously approved research project.]

Date: 27th November 2008

Title of project: Gay Clinical Psychologists and Gay Clients: Exploring Therapist disclosure of Sexuality in the Therapeutic Closet Proposal

School Ethics Approval number: 1208

Name(s) and email address(es) of researchers: James Lea
Dr Rob Jones
Jaci Huws

N.B. If you wish to amend your currently approved procedure to do one or more of the following:

- a) Pay participants;
- b) Work with children or other vulnerable populations (i.e. patients, people in custody, physically vulnerable adults, people engaged in illegal activities, people with learning or communication difficulties);
- c) Deliberately mislead participants;
- d) Utilise procedures that carry a realistic risk of participants experiencing physical or psychological distress or discomfort
- e) Work with animals;

AND your previous approval was based on there being no significant ethical implications of the research (i.e. you ticked box A on the original ethical approval form), then you will need to complete a new ethical approval form and give all the information required in Box B. PLEASE DO NOT USE THIS FORM.

Please describe the nature of your amendment(s) in the box below (and on a separate sheet if necessary):

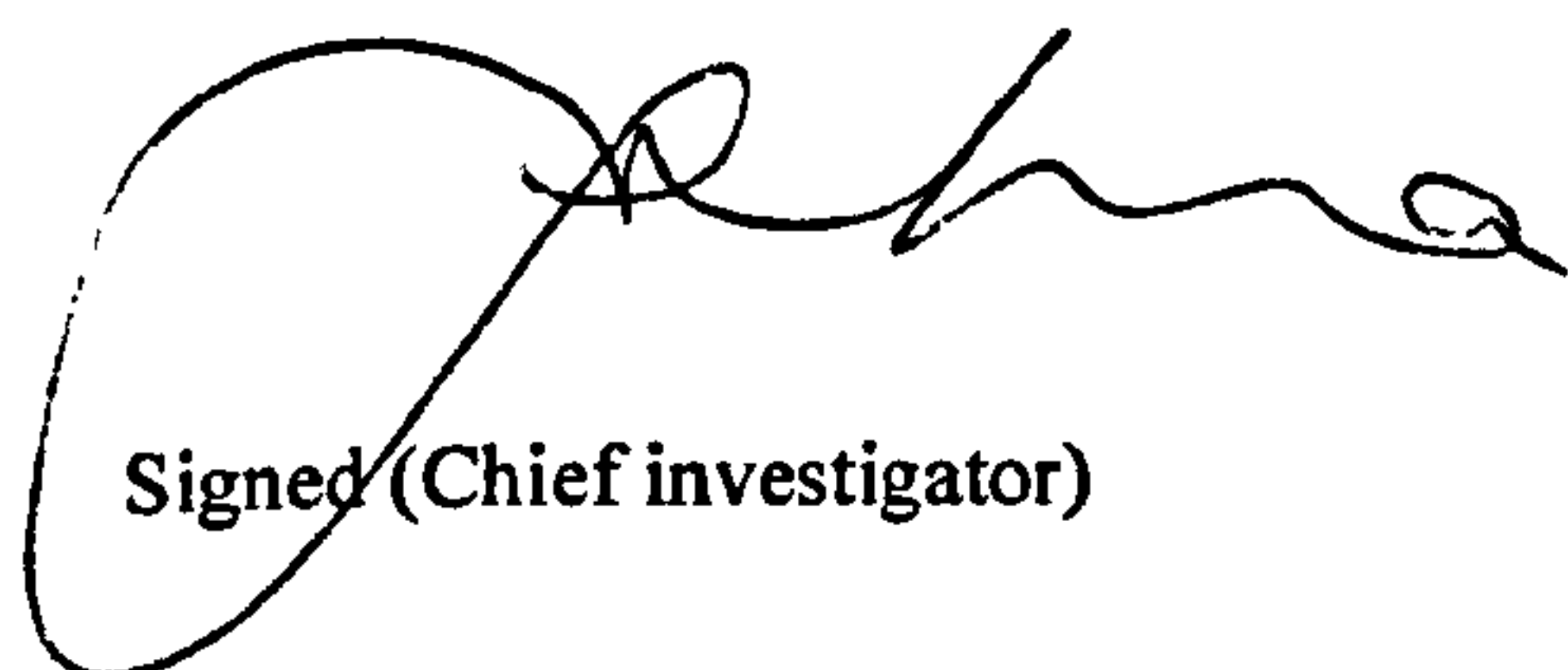
- On the participants consent form I have changed the YES/NO option to boxes that need to be initialled by participants when consenting to take part.
- On the participant information sheet I have changed my email address, and will now appears as my Bangor university email address. I have also included a contact telephone number, which will be used specifically for this research project.

Please consider carefully whether the amendment(s) to your research will affect the following:

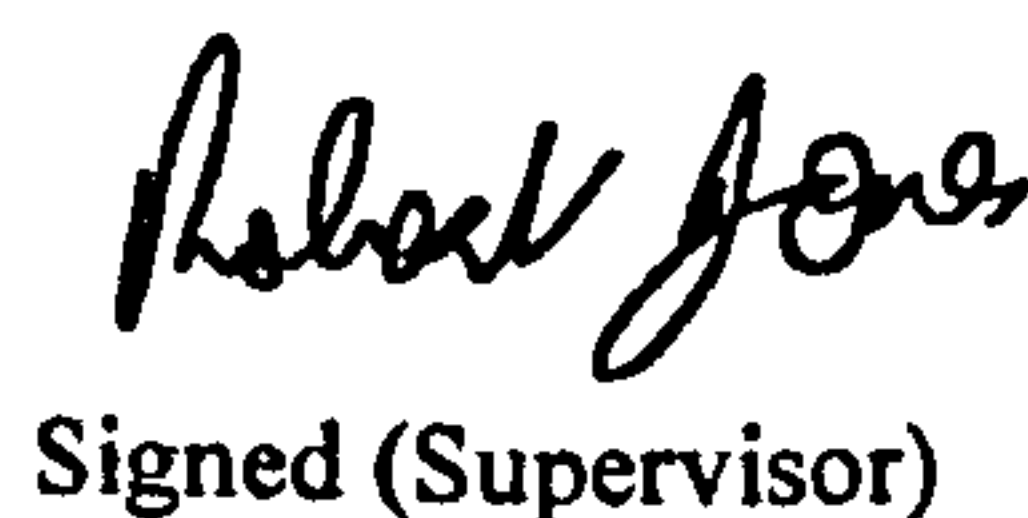
		YES	NO	N/A
1	Participants' ability to give informed, voluntary consent		✓	
2	Participants' ability to voluntarily withdraw from the research		✓	
3	In questionnaire-based studies, participants' option to omit questions			✓
4	Maintenance of confidentiality of participant data		✓	
5	The ability to give a full participant debriefing		✓	
7	Risks to participants, investigators, or the institution		✓	

If you have answered "yes" to any of the questions above, please provide a full explanation on a separate sheet. There is an obligation on the lead researcher to bring to the attention of the Ethics Committee any further ethical implications not clearly covered by the above checklist.

- If you intend to use additional questionnaires, please attach copies.
- If the nature of your request entails changes to consent/debriefing information, please attach the amended documents.



Signed (Chief investigator)



Signed (Supervisor)



PARTICIPANT CONSENT FORM

Title of Project: Gay Clinical Psychologists and Gay Clients: Exploring Therapist Disclosure of Sexuality in the Therapeutic Closet.

Name of Researcher: James Lea.

Please read the following information, initial the boxes, and sign if you wish to participate in the study.

I have read and understood the information sheet (dated.....) in relation to this study.	
I have had the opportunity to think about the information, to ask questions and to consider the answers before making a decision about taking part.	
.I agree to the audio recording of my interview for the purposes of transcription and analyses (tapes will be kept securely and will be erased following transcription).	
.I agree to the inclusion of direct quotes from my interview in the final written version of the study. I am aware that this study involves a small sample of participants (approximately eight), and the inclusion of direct quotes may compromise the investigators attempts to maintain participant anonymity.	
.I understand that my participation is voluntary and that I am free to withdraw from the study at any time, at no detriment to myself.	
Upon completion of the study, I would like a written summary of the findings.	
.I consent to participate in the above study.	

Name of Participant

Signature

Date

Name of Person Taking Consent

Signature

Date



PARTICIPANT INFORMATION SHEET

Title of Project: Gay Clinical Psychologists and Gay Clients: Exploring Therapist Disclosure of Sexuality in the Therapeutic Closet.

Name of Researcher: James Lea.

Why have I been chosen?

You have been sent this information sheet because you registered your interest in the above study and possibly taking part. The study intends to explore the views and experiences of clinical psychologists regarding self-disclosure of their sexuality to their gay clients.

You are eligible to take part in the study if you are a male clinical psychologist who identifies as gay, and has experience of both disclosing and not disclosing your sexuality to male gay clients you have worked with therapeutically.

Who is conducting the research?

This research is being conducted by James Lea, trainee clinical psychologist on the North Wales Clinical Psychology Programme. This study is James' large-scale research project, which will be submitted in partial fulfilment of the final award of doctorate in clinical psychology. The study is being supervised by Dr Robert Jones, Consultant Clinical Psychologist and Director of CPD at Bangor University, and Jacqueline Huws, Research Fellow at Bangor University.

Why is the research being done?

Davies (2007) suggests that a heterosexual bias underpins most therapy training programmes and practices, which may covertly exclude and potentially pathologise Lesbian, Gay, Bisexual and Transgender (LGBT) clients. When both therapist and client identify as gay, therapist self-disclosure of their sexuality can be positive, as it challenges this heterosexual bias and may reduce feelings of isolation and difference for the client (Coyle 2002). However, little is known about this practice from the therapists' perspective, and even less is known about why some gay professionals choose to disclose their sexuality, and others do not.

The minimal research literature that exists on this form of self-disclosure focuses on the experiences of social work therapists in America, and reports a variety of

professional and personal concerns, practices and decision making strategies (Satterly, 2005). This complex and intriguing professional issue would also be salient for practicing clinical psychologists who identify as gay and work with gay clients in the UK, however, the knowledge and experiences of these professionals has not been forthcoming. This study hopes to explore this area and give a voice to these professionals. It is anticipated that the findings may help shape professional guidelines by raising awareness of the salient issues when offering therapy to gay clients, as well as providing an alternative perspective for clinical psychologists considering clinical psychology and therapy practice more generally.

What does participation involve?

Participants who would like to take part in the research can contact James directly via email. Participants will then be required to provide a contact telephone number, and James will arrange a suitable time to telephone and discuss the study in more detail. Following this initial conversation, participants will have up to one week to decide if they would like to participate. If they do decide to participate, a convenient date, time and place for the interview to take place will be agreed.

At the meeting, participants will initially have an opportunity to ask any further questions regarding the research. Once any queries have been addressed, participants will be required to provide written consent to take part in the study, and for the interview to be audio recorded for the purposes of transcription and analyses. Each participant will then be required to engage in a single interview, which will take approximately thirty to sixty minutes. The interview will include a small number of questions on demographic information. The majority of the interview will be semi-structured, and will focus on participants' thoughts, opinions and experiences in relation to the disclosure of their sexuality to gay male clients. Some of these thoughts may be documented in the final write up of the study. Following the interview, participants will have time to ask any questions they may have.

Are personal details and interview recordings confidential?

All personal details and interview recordings will be confidential and will be kept securely. Only James Lea, Dr Robert Jones and Jacqueline Huws will have access to this information. All participants who are involved in the research will be assigned a pseudonym, which will be used on all documentation and transcripts throughout the study. Every effort will be made to maintain participant anonymity by using pseudonyms, however, as this study involves a small sample of participants (approximately eight), the inclusion of direct quotes from participants may compromise the investigators attempts to do so. Participants will therefore have the right to choose whether they are happy for their direct quotes to be included in the final document by completing a section on the consent form.

In line with the limits of confidentiality, if information is shared within the interview which indicates that the participant or another person (e.g. client) may be at risk of harm, or that they have been harmed then this information cannot remain confidential. In these circumstances, the research supervisor (Dr Robert Jones) and necessary members of the NHS will be informed.

Upon completion of the study, personal details will be stored for up to twelve months in a locked filing cabinet at Bangor University, and all research data will be stored for a maximum of ten years before being destroyed.

Are there any risks involved in taking part?

It is unlikely that participants will suffer any negative effects as a result of their involvement in this study, however, it is important to note that the topic under discussion could evoke strong feelings in some participants and potentially lead to distress. In order to minimise these risks, participants will be free to withdraw from the study at any time, and will also have the chance to discuss any issues which may have arisen as a result of the interview process once the interview has ended.

Are there any benefits to participants or others as a result of taking part?

There are no material benefits for participants involved in this research, however, this study allows professionals to engage in a study which enables them to discuss a professional issue that has long been overlooked by research, as well as to reflect on their own clinical practice. In terms of future gain, this study has the potential to give a voice to the gay clinical psychologists facing the issue of whether to disclose their sexuality and the factors that impact on this. It is also hoped that this investigation will help shape professional guidelines by raising awareness of the salient issues when offering therapy to gay clients.

Upon completion of the investigation, all participants will receive a summary of the findings.

Has this study been ethically approved?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study was reviewed and authorised by the educational supervisor Dr Robert Jones and the North Wales Clinical Psychology Programme. Ethical approval was gained from the School of Psychology Ethics Panel at Bangor University, and the Liverpool Adult NHS Research Ethics Committee.

Complaints

If you decide to take part in the study, please keep this information sheet so that you can refer to it in the future. If you should have any concerns or complaints about the conduct of this study, these should be addressed to:

- Mary Burrows, Chief Executive, North Wales NHS Trust, Trust Headquarters, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD.
- Professor O. Turnbull, Head of School of Psychology, Bangor University, Bangor, Gwynedd, LL57 2DG.

How can I get more information about the study?

If you would like to hear more about the study, or if you feel that you are eligible and would like to consider taking part, then please contact:

James Lea (Trainee Clinical Psychologist),
North Wales Clinical Psychology Programme (NWCPP)
Email: psp462@bangor.ac.uk
Telephone: .

Thank you for taking the time to read this information.

Final Ethical Approval

School of Psychology Ethics proposal 1208 Amendment

Dear Colleagues

Gay Clinical Psychologists and Gay Clients: Exploring
Therapist disclosure of Sexuality in the Therapeutic
Closet Amendment to Proposal 1208*

Your Amendment to research proposal referred to above has been considered by the School of Psychology Ethics Review Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines.

If you wish to make any modifications to the research project, you must speak to your supervisor about it. If your supervisor thinks that the modifications are at all important, you must inform the committee in writing before proceeding. Please also inform the committee as soon as possible if participants experience any unanticipated harm as a result of taking part in your research.

Good luck with your research.

Regards

Everil McQuarrie
Finance and Research Administrator

National Research Ethics Service

Liverpool (Adult) Research Ethics Committee

Bishop Goss Complex
Victoria Building
Rose Place
Liverpool
L3 3AN

Telephone: 0151 330 2077

Facsimile: 0151 330 2075

24 November 2008

Mr James Lea
Trainee Clinical Psychologist
North Wales NHS Trust
NWCPP
43 College Road
Bangor, Gwynedd
LL57 2DG

Dear Mr Lea

Full title of study: **Gay Clinical Psychologists and Gay Clients: Exploring
Therapist Disclosure of Sexuality in the Therapeutic
Closet**

REC reference number: **08/H1005/111**

Thank you for your letter of 18 November 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Participant Consent Form	2	18 November 2008
Participant Information Sheet	2	18 November 2008
Letter of invitation to participant	1	06 October 2008
Interview Schedules/Topic Guides	1	06 October 2008
Compensation Arrangements	QBE	01 August 2008
Letter from Sponsor		06 October 2008
Protocol	1	22 February 2008
Investigator CV	J Lea	06 October 2008
Application		07 October 2008
Investigator CV	RSP Jones	
Response to Request for Further Information		18 November 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H1005/111

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

A large, stylized handwritten signature in black ink, appearing to be 'T Purewal', written over a horizontal line.

Dr T Purewal
Chair

Email: Ronald.Wall@liverpoolpct.nhs.uk

Enclosures: **"After ethical review – guidance for researchers"**

Copy to: **Professor Oliver Tumbull, Bangor University**
 A Williams , Camden pct, R &D

NHS Research & Development Approval

Greater Manchester West Mental Health NHS Foundation Trust

Manchester Mental Health & Social Care Trust

Calderstones NHS Trust

**Submission Point for Electronic
Approval of Research**

12 January 2009

Mr James Lea
Trainee Clinical Psychologist
North Wales NHS Trust
NWCPP
43 College Road
Bangor
Gwynedd LL57 2DG

Research & Development Office
Room 109, Harrop House
Bury New Road
Prestwich
Manchester M25 3BL

Tel: 0161 772 3591/3954
Email: kathryn.harney@gmw.nhs.uk
jennifer.higham@gmw.nhs.uk

Information for ID Badge if required:

Research Project Ref No: 573
Expiry Date: 1 September 2009

You must take this letter with you.

Dear Mr Lea

Re: Research Governance Decision Letter

Project Reference: 573
Unique SPEAR Identifier: 0812
**Project Title : Gay Clinical Psychologists and Gay Clients: Exploring Therapist
Disclosure of Sexuality in the Therapeutic Closet.**

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study.

Trust R&D approval covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&D Office should you require any further information. You may need this letter as proof of your approval.

May I wish you every success with your research.

Yours sincerely



Dr Stephen Colgan
Medical Director and R&D Lead

cc : Research Governance Sponsor, Bangor University (o.turnbull@bangor.ac.uk)

Enc: Approval Conditions Leaflet
Induction & ID Badge Information, TrustTECH Leaflet

**Submission Point for Electronic
Approval of Research**

James Lea
Trainee Clinical Psychologist
North Wales NHS Trust
NWCPP
43 College Road
Bangor, Gwynedd
LL57 2DG

R&D Office
Room FC027, 3rd Floor
Rawnsley Building
Hathersage road
Manchester
M13 9WL

15/1/09

Information for ID Badge if required:
Research Project Ref No: 0812
You must take this letter with you.

Dear James

Re: Research Governance Decision Letter

Project Reference: 0812

Unique SPEAR Identifier: 0812

**Project Title: *Gay Clinical Psychologists and Gay Clients: Exploring Therapist
Disclosure of Sexuality in the Therapeutic Closet***

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study.

Trust R&D approval covers all locations within the Trust; however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&D Office should you require any further information. You may need this letter as proof of your approval.

May I wish you every success with your research.

Yours sincerely



R&D Lead

Enc: Approval Conditions Leaflet, Induction & ID Badge Information, TrustTECH Leaflet

Trust Headquarters
Mitton Road
Whalley
Clitheroe
Lancs
BB7 9PE

Tel: 01254 822121
Fax: 01254 823023

**Research and Development Department
Calderstones NHS Trust
Mitton Road
Whalley
Lancashire
BB7 9PE**

Direct Tel: 01254 821289
Email: Rachael.Clarkson@Calderstones.nhs.uk
Date: 13th January 2009

**Mr James Lea
Trainee Clinical Psychologist**

Dear James,

**Project: Gay Psychologists and Gay Clients : Exploring Therapist Disclosure of Sexuality in the
Therapeutic Closet.
REC Reference: 08/H1005/111
Calderstones Reference: 2008- 06**

Following the approval by the Liverpool (adult) Research Ethics Committee and Calderstones Research and Development Academic Liaison Group, I am pleased to confirm that your proposed research study within Calderstones NHS Trust can proceed.

I would bring your attention to the responsibilities of researchers and principal investigator required by this Trust in accordance with the Department of Health's Research Governance Framework. All research conducted within this Trust must comply with the full requirements of the Research Governance Framework for health and social care (www.doh.gov.uk) and fully adhere to the submitted project protocol approved by Calderstones NHS Trust and the relevant Research Ethics Committee. Please remember that any protocol amendments/changes will also require further review by the Research Ethics Committee.

This letter provides proof that the Trust Research and Development Academic Liaison Group have formally reviewed and approved your project. Members of staff from Calderstones NHS Trust are fully entitled to ask to see your formal letter of approval before they agree to allow



Chairman: Mr. F. G. Parr. JP
Chief Executive: Mr. T. R. Pearce

you to access a ward or have any contact with other members of staff or service users or carers from the Trust.

A representative from the Research Department will continue to contact you in the near future to monitor the progress of your research. Please inform the department immediately of any proposed changes, amendments to or deviations from the ethics committee and research governance approved protocol. On completion of the research, the Research Department should be informed of the outcome of the research, in particular any presentation of the results at scientific and professional meetings or papers published. The Trust may also request you to present your research study and findings to the wider Trust.

Best wishes for your research and I look forward to finding out more about the progress and outcomes. Please contact Rachael Clarkson in the Research and Development Department on 01254 821289 if you require any further information and guidance at any stage of the research study.

Yours Sincerely,

A handwritten signature in black ink, appearing to read 'RClarkson', followed by a period.

Rachael Clarkson
Research Governance Coordinator

Section 3

Reflective Commentary

To be honest, the unrefined seed for this research was planted a few years ago during my time as an assistant psychologist, when I was struggling to understand *if* my sexuality was relevant or not to my work. Once on the course, I was struck by the lack of formal teaching that spoke to me, my relationships and my beliefs; indeed my life as a gay man. I made a deal with myself that I would challenge this, so I filled in feedback forms, brought it up at various committees and basically told anyone that would listen. Eventually, I accepted that things don't change over night. Part of this acceptance was to study something significant for me as a gay trainee clinical psychologist, therefore, I focussed on researching the experiences of gay male clinical psychologists disclosing their sexuality to gay male clients.

Finding a supervisor was easy, I had a good relationship with Dr Rob Jones and knew that he would give me the freedom to research something that interested me in a way that felt meaningful. I was sure that I wanted to do something qualitative, as I wanted to capture, interpret and report the stories I heard. Interpretative Phenomenological Analysis (IPA) seemed the most appropriate methodology to capture, interpret and report the stories I heard. The fact that I had never used IPA before did not concern me, because I was interested in learning and was booked on a course, plus, there was someone called Jaci Huws who could help. So, I had an idea, a rationale and a methodology, next came the presentation to the course staff. I had gotten

myself into somewhat of a panic about the presentation, believing that I would be told my study was not clinically relevant, that I had chosen the wrong methodology, and that I was flying the gay flag just a little bit too high. I listened for the criticism, but could only hear constructive comments; the proposal was approved! At the time it felt like a small victory for gay trainees everywhere.

And then the humour stopped! I had never before had to wrestle with the world of ethical approval, and just managed to struggle my way through the school of psychology ethics, and National Health Service (NHS) ethics was even more difficult. Rather late in the day it became clear that I was unable to gain ethical approval within Wales, so, panic stricken, off to England I went to have a 'chat' with a room full of people about my research. Thankfully, the meeting wasn't too bad, and I only had minor corrections to make to the proposal. Subsequent NHS Research and Development (R&D) approval was a little more taxing, and meant filling in more forms and liaising with a variety of people; and I'm still not sure what site specific approval means, just that I didn't need it! Reflecting on the ethical process now still reminds me of the anxiety and uncertainty, but I also have a new found understanding of the process; that fundamentally its there to make sure you don't harm anyone during your research, which thankfully I didn't.

Recruiting participants was rather difficult, as was to be expected. I had developed very specific inclusion criteria to explore the areas necessary, but had not envisaged getting participants would be as difficult as it was. I had lots

of interest, but in the end only five people fit the criteria and were willing to take part. Conducting the interviews was a challenge to begin with, and I had to continually remind myself that my role was as researcher, not therapist, and the people I was talking to were participants, not clients. Using IPA allowed me to have a subjective perspective during interviews, and in this sense the roles of researcher and therapist were not completely dissimilar. During data collection I moved house, from Wales back to England, which was quite a stressful time, especially as I was travelling north to south in my car and on trains to conduct the interviews. On reflection, it may have been simpler to conduct the interviews over the telephone, although I believe that this would have meant missing out on non-verbal information and a getting a sense of the participants, which I think is important.

Transcribing the interviews proved rather laborious and time consuming, taking a full day to transcribe one interview. The course were unable to provide us with any funds to pay for transcription, which seemed a little unfair given the fact that trainees doing quantitative studies were spending lots of money buying psychometric measures. However, looking back on this experiences I have come to the conclusion that: (a) it was not fun, at all; but (b) it allowed me to become familiar with the material prior to formal analysis, which in turn made analysis a little more fluid. Speaking of analysis, I attended the IPA workshop, which left me thoroughly confused, but also excited. When it came to the process of analysis, I realised that I had a rather naive view of qualitative research; and that person called Jaci Huws was an IPA genius. I certainly hadn't realised how long analysis would take, how much cross referencing and

going back over transcripts would be required, and how difficult it can be to develop superordinate themes that encompass the initial themes; in sum, not an easy methodology at all! Reviewing the analysis now, I feel, well I guess I feel proud of it, I feel proud that it tells a story based on peoples experiences, and my interpretations of that. Actually, I feel more proud and humbled by this piece of research than any other I have been involved with.

Writing up this thesis has been exhilarating, time consuming and very draining. In some ways it feels like my life has had to go on hold for the past few months, but unfortunately that was not always possible. There have been times when the thesis came second to more urgent family matters, including a bereavement and sickness. I do not include this information for special consideration, but use it more to illustrate that my world did not stop turning during this thesis, even though I felt over-stretched and sleep deprived, even when I shouted 'Stop!' At times I have struggled emotionally and intellectually to make sense of what I was doing, and in some moments, usually late at night, have actually questioned how important it is to me to be a clinical psychologist, and whether I'm cut out for it anyway. Sitting here two days before the deadline, with an abscess in the bottom of my back, I'm still not sure of the answers to my questions, but what I do know is that I'm more than willing to find out.

Section 4

A Review of Intentional Therapist Self-disclosure: Assertions, Models and Evidence.

Abstract

Background: Intentional Therapist self-disclosure (TSD) is a contentious issue, and the debate for and against its use is very much alive. Views regarding TSD are closely linked to theoretical orientation, whereby some therapists believe it to be beneficial, while others disagree, suggesting that it is risky and potentially harmful.

Method: A literature review was conducted, which critically explored the definitional, theoretical and research evidence.

Results: Distinctions between different forms of intentional self-disclosure are overlooked within the literature, which causes confusion between therapists, and makes it difficult to draw meaningful conclusions from the data. Many of the assertions made regarding the effects of TSD remain empirically unsupported, seemingly based on theoretical constructs alone. Limited empirical evidence that does exist, at best, suggests that TSD can be helpful, unhelpful or both.

Conclusion: The discourse around TSD is controversial and littered with passionately held theoretical views about its helpfulness versus unhelpfulness. Empirical evidence for the use of TSD is equivocal, and it would seem that the only thing that is clear is that the argument for and against continues.

Keywords: Therapist Self-disclosure; Professional issues; Psychotherapy.

Some form of human relationship exists in all psychotherapy, and some have argued that “the relationship *is* the therapy” (Kahn, 2001, p. 1). Indeed, there has been increased recognition and evidence for the positive effects of the therapeutic relationship on process and outcome (Constantino, Castonguay & Schutt, 2002; Crits-Christoph, Gibbons & Hearon, 2006; Horvarth & Symonds, 1991; Horvath, 1994; Martin, Garske & Davis, 2000). Acknowledging the significance of the therapeutic relationship also requires the therapist, and the decisions they make in that relationship to be explored, as “the person of the psychologist (*therapist*) is critical” (Wampold & Bhati, 2004, p. 566). One such relationship variable that relates to the person of the therapist is Therapist Self-Disclosure (TSD).

“...therapists’ must consider what they will disclose to their patients, a topic that has attracted enormous debate...Controversy has raged over such questions as: What constitutes therapist disclosure? Is therapist disclosure helpful or ultimately and essentially narcissistic? And, if helpful, which kinds of disclosing are most useful and under what conditions?”

(Farber, 2006, p.2).

The above extract epitomises the complexity and uncertainty faced by therapists considering TSD as relevant to the therapeutic process. A variety of theoretical and research perspectives exist in relation to TSD, with some believing appropriate TSD is beneficial to the therapeutic endeavour, and others cautioning against its use due to the potential risks and taboo nature of this area (Hill & Know, 2001). The current piece endeavours to critically review the literature on intentional TSD, exploring the evidence on which these

assertions are based. The aim of this review will be achieved by exploring definitions, theoretical notions and empirical research. Unintentional TSD will also be mentioned as an area for future research.

Methodology:

A review of the literature for this piece was conducted using the search terms: therapist self-disclosure; helpful therapist self-disclosure; unhelpful therapist self-disclosure; and therapeutic models and therapist self-disclosure. Searches revealed 41 relevant papers, 1 literature review and 3 books. Various chapters from a range of other books were also used to inform the review. Combined, these sources provided the main theoretical, research and contextual literature for the production of this review article.

Therapist Disclosure: Society and Culture

From the outset, it is important to situate this review within the current social and cultural context, as this invariably impacts upon the clinical interest and constructions of TSD within psychotherapy. Psychotherapy could be viewed as a cultural technology that is constructed by humanity, for humanity, to alleviate suffering (Berger & Luckman, 1966); therefore any form of useful therapy should be flexible enough to accommodate the needs of the people it serves. Individuals within contemporary western society are far more eager to explore their relationships and disclose intimate details from their lives (Farber, 2003), which is in stark contrast to society 30 years ago when Jourard (1971)

first began researching self-disclosure in the wider society. Examples of this “tell-all mentality” (Farber, 2003, p.526) include: talk shows (e.g. Tricia and Jeremy Kyle); celebrity magazines; confessional autobiographies; self-help books; and on line chat rooms and diaries (e.g. Facebook, Myspace). Clients and therapists are immersed within this cultural and social shift towards openness and connectedness, and it could be argued that there is an expectation from clients, and possibly therapists themselves that they should be more visible and maybe more human when necessary within the consulting room.

“...social changes contribute to shifts in clinical practice, it is likely that increased public interest over the past few decades in understanding and promoting healthy personal relationships has seeped into the general psychotherapeutic culture, and at least indirectly contributed to a therapeutic climate in which some personal disclosure on the part of the therapist is an expected aspect of the relationship. Far fewer clients than ever would either expect or tolerate their therapist's adoption of an unvarying, seemingly distant, professional stance.”

(Farber, 2006, p.109)

Whilst accepting that wider society and culture influences clients and therapists desire for openness, it undoubtedly poses questions regarding the nature of TSD, what is deemed an appropriate level of openness and humanness of the therapist, and what effect this has on clients?

Intentional Therapist Self-disclosure:

A considerable number of attempts to define intentional TSD are evident within the literature. In one of its earliest incarnations, TSD referred to verbally disclosing more than just professional expertise, such as feelings, attitudes, experiences or history (Weiner, 1983). The generic nature of this definition seemed to be its downfall, and Matthews (1988) further developed a distinction made between *self-disclosing* and *self-involving* disclosures (McCarthy & Betz, 1978), whereby TSD was an umbrella term for (a) the verbal disclosure of factual information about the therapist (self-disclosing), and (b) the verbal disclosure of therapist feelings of and with the client in the session (self-involving). Watkins (1990) stated that “although therapist self-involving statements are often contrasted with self-disclosing statements, self-involving statements are still regarded as a form of self-disclosure” (p.478-479). This distinction between self-disclosing and self-involving disclosures was maintained in subsequent attempts at conceptualising intentional TSD (Hill, Mahalik & Thompson, 1989; Hill and O'Brien, 1999; Knox, Hess, Peterson & Hill, 1997; Robitschek & McCarthy, 1991), and has been honoured in more recent definitions (Farber, 2006; Knox & Hill, 2003; Zur, 2008a). However, it would seem that this useful and necessary distinction is subtle and possibly overshadowed by the umbrella term of TSD when outside the world of academia. Many therapists may associate TSD as referring only to the disclosure of personal information about oneself, and be unaware that more relational dialogue about the therapeutic process and reactions to the clients are classified as TSD. This lack of communication between academic

research and clinical practice may account for some of the controversy associated with TSD in psychotherapy.

Whilst the theoretical distinction between intentional self-disclosing and self-involving disclosure has survived (at least in academic circles), the linguistic labels have not. Zur (2008a) refers to self-disclosing disclosures (i.e. factual information) as self-revealing. While this may create confusion, the label is actually more descriptive and arguably useful, as it refers specifically to information revealed about the therapist, by the therapist. A relational psychodynamic discourse exists in which self-involving disclosures are viewed as synonymous with transference and countertransference interpretations (Bridges, 2001; Manning, 2005). Furthermore, Bridges (2005) questioned the generic label of intentional TSD, instead preferring to label it as therapist self-revelation. It is clear that many attempts have been made to label, quantify and qualify intentional TSD, although it seems to have caused more confusion than clarity.

The majority of the literature presents TSD as a unitary phenomenon, but a more critical analysis suggests that such homogeneity may present an overly simplistic presentation of the evidence, and that there are inherent difficulties in both definition and translating the findings of research into clinical practice. For the purposes of the current review, it is accepted that TSD can be intentional and unintentional, although focus will be given to intentional TSD. Intentional TSD as a general term will include *self-revealing* and *self-involving* self-disclosure. Self-revealing TSD refers to the information and facts that are

shared with the client about the therapist (i.e. professional qualifications, relationship status, sexuality). Self-involving TSD refers to sharing the therapist's feelings and experiences in response to the client's feelings and experiences in session, which could also be viewed as transference and countertransference.

Use of Intentional Therapist Disclosure in Psychotherapy:

A survey of therapists' use of self-disclosure suggested that TSD was used relatively infrequently during sessions, ranging from 1.49 to 2.98 using a 5-point likert scale (1 = rarely or never, 3 = disclosed half the time, and 5 = always shared) (Berg-Cross, 1984). Further studies have also reported moderate levels of TSD (Anderson & Mandell, 1989; Barkham & Shapiro, 1986; Edwards & Murdock, 1994; Hill, Mahalik & Thompson, 1989). Problems with definition make it difficult to make meaningful comparisons between these studies, or explore the relative differences between self-revealing and self-involving TSD. A recent review of several studies, including their own, by Hill and Knox (2001) suggested that in general the frequency of TSD as coded by judges was relatively low, only accounting for 1-13% of all therapist interventions. In their subsequent research based suggestions for practitioners, Knox et al (2003) state that "therapist self-disclosure is one of the rarest, but potentially most potent, techniques" (p.533), however, it is unclear how they conclude this unequivocally from the specific studies, mainly due to the inherent differences in definition used and the potential subjectivity of judges rating TSD.

Edwards et al (1994) explored the views of 184 qualified psychologists regarding the content of their self-disclosures. Findings suggested that the most frequent topic of disclosure was professional training and practice. Other topics from most to least frequent included: disclosure of success and failure; disclosure of interpersonal relationships; attitudes and personal feelings; and sexual issues. Much of the existing research echoes the findings of Edwards et al (1994), citing the least disclosed topic as sexual attraction to clients and the most frequent topic of disclosure as where the therapist earned their degree, years of experience and values regarding therapy (Fisher, 2004; Geller & Farber, 1997; Robitscheck et al, 1991; Wells, 1994). This finding is interesting as the self-revealing disclosure of professional background may simply be an artefact of statutory regulation and informed consent, whereby ethically a client should know the qualifications of their therapist and type of therapy they are entering into (Peterson, 2002). However, including this as a form of self-revealing TSD would certainly lend support to the idea that TSD is beneficial to clients.

From a contemporary relational psychodynamic perspective, the most cited content of TSD is of a self-involving disclosure. As mentioned earlier, this is regarded as relating to the concepts of transference and countertransference (Aron, 1991; Bridges, 2001; Cooper, 1998; Manning, 2005), although such assertions have not been subjected to empirical analysis. Examples of self-disclosures included: acknowledgement of mistakes and technical errors; reactions to client emotions and experiences; and naming possible dynamics within the therapeutic relationship (Geller et al, 1997; Myers & Hayes, 2006).

In line with more eclectic therapists, Geller et al (1997) also noted that psychodynamic therapists did use some self-revealing disclosures (e.g. whether they had children and marital status), although these were less frequent. In contrast, within a feminist perspective the content of TSD was more broad and intimate. Research suggests that both self-revealing and self-involving forms of disclosure are evident, content of the disclosures included: therapeutic orientation; political beliefs; religious beliefs; sexual identity; and socioeconomic status (Brown & Walker, 1990; Rochlin, 1982; Simi & Mahalik, 1997; Webster, 1986).

Yalom (1985) states that, "More than any other single characteristic, the nature and degree of therapist self-disclosure differentiates the various schools of...therapy" (p.212). As would be expected, an exploration of these theoretical models provides a lens from which to explore whether the use of TSD is viewed as beneficial or unhelpful to therapy.

Classical psychoanalytic schools believe that the "*(therapist)*...should be opaque to his patients, and like a mirror, should show them nothing but what is shown to him" (Freud, 1912, p.117). This neutrality, abstinence and anonymity are seen as the foundations for transference analysis, which represents the primary focus and theory of change for many of these therapies (Clarkson, 1994). Therefore, any TSD may be viewed as risky due to the negative impact it would have on the transference between analyst and client. Indeed, studies have supported this idea, suggesting that TSD is generally low within these approaches (Edwards et al, 1994; Simi et al, 1997; Simon, 1990).

Although the research supports this theoretical notion, it is interesting to note that this discourse of non-disclosure is perpetuated by many studies into TSD, ironically by non-psychoanalytic psychotherapists. Whilst this point may be criticised, it could be argued that the outdated analytic concept of a 'blank screen' provides a useful place for researchers to 'project' their uncertainty and anxiety regarding TSD, thus leaving analytic approaches as the 'poor relation' who never disclose anything to clients.

In contrast to classical analytic approaches, Stricker (2003) argued that, "theory and culture have changed since Freud's initial comments about self-disclosure...we must note the shift from a private, Victorian culture to a more open, contemporary scene" (p.624-625). Awareness of this shift is visible within contemporary relational psychodynamic approaches (Aron, 1991; Bridges, 2001; Cooper, 1998; Manning, 2005). Maroda (1999) suggests that the analyst's emotional responses to the client are the focus of TSD (i.e. self-involving disclosures), as it allows: something to be made conscious in the transference; a deeper level of exploration; and an exploration of relationship styles (Aron, 1991; Bridges, 2001; Cooper, 1998; Manning; Myers et al, 2006). Relational models of psychodynamic practice seem to embrace self-involving TSD (i.e. transference and countertransference disclosures), as it is believed to be an integral part of the therapy, and thus supports the use of this form of TSD. Ironically, when viewed from a relational and self-involving disclosure position, it could be argued that contemporary psychodynamic therapists use a form of TSD routinely in their work, which contrasts to the widely held view of

non-disclosure. “Self-disclosure is not only inevitable, but also an essential, aspect of the psychotherapeutic process” (Bridges, 2001, p.22).

Cognitive behavioural therapists have emphasised the importance of modelling, reinforcement and normalising as significantly contributing to change in clients behaviour, and have recently begun to suggest explicitly that TSD can be an effective way of supporting these techniques (Freeman, Fleming and Pretzer, 1990; Goldfried, Burckell & Eubanks-Carter, 2003). Within Dialectical behaviour Therapy (DBT), Linehan (1993) distinguishes between disclosure of personal information (self-revealing) and disclosure of personal reactions to the client (self-involving). Therapist's disclosure of reactions to the client is consistent with reinforcement principles, and can be used therapeutically to increase helpful behaviour (e.g. regulating emotions) and decrease unhelpful behaviour (e.g. self-harm). The disclosure of facts or information about the therapist (self-revealing) has been conceptualised as an example of modelling and normalisation within Cognitive Behavioural Therapy (CBT), whereby the therapist is able to model effective ways of coping to clients by disclosing their own experiences of coping in difficult situations, which also serves to normalise the client's struggles (Goldfried et al, 2003; Linehan, 1993). Although cognitive behavioural therapists use of TSD seems to be based on theoretically sound and beneficial reasons, it nevertheless begs the question of why TSD needs to be used to supplement a whole range of techniques and homework exercises specifically designed to reinforce, normalise and model clients experiences. It may be that the technique driven

world of CBT still needs some form of human connection and relationship to achieve its therapeutic goals, which is provided by TSD.

Therapists from humanistic and/or existential perspectives have always supported the use of TSD within their theoretical constructs, and view the role of therapist as fellow traveller (Yalom, 2001). The notion of universal human suffering is a fundamental position of these approaches (Spinelli, 1994), and the use of TSD, also known as therapist transparency, allows clients to recognise and accept that all people have failings, difficulties and strong emotions, because they are part of being human (van Deurzen, 1998). Research findings support the idea that therapists subscribing to these models disclose more frequently than other types of therapists (Simon, 1990; Edwards et al, 1994; Simi et al, 1997), although sampling and methodological problems make it difficult to state this with certainty, even though these conclusions are perpetuated within the literature. A further difficulty related to TSD within this approach is that theoretical constructs, especially existential, are rather ambiguous (Spinelli, 1994), and it is usually taken as a given that TSD is widely accepted in these approaches, rather than being subject to rigorous empirical research.

Advocates of feminist theories represent the most openly supportive model for the use of TSD (Mahalik, VanOrmer & Simi, 2000). Feminist therapists widely acknowledge the power imbalances within society and also within therapy, therefore a therapeutic focus is given to monitoring power issues and creating an egalitarian therapeutic relationship (Simi et al, 1997). A variety of self-

disclosures are used to allow the relationship to be as equal as possible, and allow the therapist to act as a role model for the client. Simi et al (1997) explored the use of TSD of feminist therapists and developed the Feminist Self-Disclosure Inventory (FSDI). Findings suggested that reasons for disclosure echoed the values of the approach, which included: serving as a role model, promoting the liberation of clients, validating client feelings and promoting solidarity in the relationship. Feminist theory and therapy lends one of the most persuasive arguments for the beneficial effects of TSD in therapy. However, it should be noted that much of the research into the effects of TSD use the value base of feminist therapy as a foundation of research, even though there is little empirical evidence to support the theoretical value base of feminist theory. Therefore, the positive effects of TSD in feminist therapy may be a product of bias, in a sense, using findings to support what is already believed to be true, and then labelling that as evidence.

Bringing together the theory and research on the use of intentional TSD within psychotherapy seems to lead to more questions than answers, especially given the obvious biases and potentially questionable research findings. However, it would seem that what is clear is that there are valid and provocative reasons for and against its use within different models of therapy.

Reasons to Intentionally Disclose and the Effect on clients:

The crux of the matter for many therapists regarding self-disclosure seems to relate to asking oneself: whose needs does the disclosure serve? When a

therapist's story is of benefit to the client, then it is perceived as therapeutic and ethical, although when it solely serves the needs of the therapist then it is believed to be unethical and counter therapeutic (Peterson, 2002).

Within the practice based guidelines for TSD, Knox et al (2003) report that reasons for therapists to disclose usually belong to one of four broad categories: strengthening the therapeutic relationship; modelling and normalising clients experiences; providing alternative views of the world; and allowing reciprocal disclosure (i.e. disclosure from therapist allows clients to feel more able to disclose). It is often asserted that therapists view self-disclosure as especially valuable, as it allows them to be viewed as more real and human, which in turn helps clients' feel less interpersonally vulnerable and more able to engage in the process (Hill et al, 2001). Mahalik et al (2000) cites similar beneficial reasons that therapists might engage in self-disclosure, including feelings of universality, increasing client disclosure and acknowledging the relationship between therapist and client. It has also been suggested that a further reason therapists may self-disclose is to address power issues and racism when working with clients from different racial and cultural groups (Constantine & Karl Kwan, 2003). Whilst it is useful to consider the above points, it should also be noted that they are mainly based on review, assertion and personal views.

Focussing on the limited empirical research regarding therapists' reasons to disclose, Edwards et al (1994) found that therapists reported using self-disclosure to model behaviours and increase a sense of similarity and

relatedness. Matthews (1988) reported that therapists disclosed to help clients see themselves as similar to others and allow clients to feel relaxed and comfortable in therapy. These studies lend some support to the assertions made above, although it would seem that therapist views regarding reasons to disclose have taken a life of their own, and may not always be supported by extensive empirical research

Knox et al (2003) outline a number of reasons why they feel that therapists should not disclose: disclosure would meet the needs of the therapist; shift focus from the client to therapist; burden or confuse clients; and blur therapeutic boundaries. Research seems to support these views, especially regarding disclosures that meet the needs of the therapist. Edwards et al (1994) found that therapists did not disclose for the purposes of increasing the client's perception of their expertness, attractiveness and trustworthiness, presumably as this related to their own narcissistic needs. In a survey of social workers, Anderson et al (1989) found that the most common reasons for not using self-revealing or self-involving disclosures was shifting focus from the client, decreasing time available for the client and creating role confusion. Whilst it could be speculated that the role of social workers is different to that of psychotherapists, this study offers some support to the assertions made regarding reasons not to disclose within professional relationships. An interesting study by Kelly and Rodriguez (2007) attempted to explore the relationship between TSD and client symptomatology, hypothesising that therapists' would view high levels of client distress as a reason to self-disclose, presumably to make clients feel more comfortable. Findings were

counterintuitive, and it was found that therapists disclosed more to clients with less levels of distress, as it was felt boundaries needed to be more rigid in therapeutic work with distressed clients. This finding would suggest that sometimes clients need containment in the form of boundaries, rather than to 'know' their therapist, which seems to make intuitive clinical sense.

One of the most persuasive arguments for the taboo and possibly risky nature of TSD relates to therapist disclosure of attraction to clients, which could be argued to always serve the therapists needs (Goldstein, 1994; Gutheil & Gabbard, 1998). Although a therapist's non-disclosure of physical attraction does not remove the emotions, therapists should be aware of the potentially harmful effect that this type of disclosure may have on clients. Fisher (2004) reviewed the small literature on this issue, and concluded that TSD of attraction to a client was potentially harmful, unethical and never encouraged. As well as potentially causing harm to clients, it is intuitively sound to assert that disclosure of attraction also blurs boundaries, shifts focus to the therapist and may burden clients, which all serve to invalidate the uniqueness of psychotherapy, which is ultimately to allow an exploration of the client and their world.

It could be speculated that therapist's beliefs about what is appropriate and helpful TSD, versus what is inappropriate and unhelpful TSD are related to specific therapeutic models and more generic socially constructed ideas about a therapeutic relationship; with some of these reasons being empirically

supported and others not. However, this still begs the question, is TSD useful or harmful to therapy, and what effect does it have on clients?

Most of the existing research on the effects of TSD within psychotherapy has been analogue in design. Analogue studies involve simulations of therapy, where participants, usually undergraduate psychology students, are presented with a TSD that is embedded within a transcript, audiotape, videotape or an actual simulation of a therapy session; participants are then asked to rate their perceptions of the disclosure. In one of the earliest studies of this kind, Simonson (1976) explored the effect of TSD on 'client' self-disclosure by simulating a therapy session in which undergraduate students spent 1 hour with a psychotherapist. Results suggested that participants disclosed more to a 'warm' therapist that offered moderate self-revealing disclosures (i.e. demographic information), than they did to a 'warm' therapists that was non-disclosing or personally self-revealing (e.g. I tried this technique to help me sleep). Obviously, there are inevitable flaws with this research endeavour, namely that it did not use a 'real life' therapy encounter. However, the value of illustrating the obvious flaws of this empirical research is that it brings into question the views of contemporary therapists regarding reciprocal disclosure, if this is the evidence upon which this assertion is based. In a recent, and rather confusing analogue study of TSD, Myers et al (2006) asked 224 undergraduates to watch videos of simulated therapy and rate how useful they felt the TSD had been. Results suggested that participants rated sessions as 'deeper' and the therapist as more expert when they made general self-disclosures compared to no disclosures, but only when the alliance was

perceived as positive to begin with. If therapists believe that this represents evidence for the 'deepening' effects of TSD during psychotherapy then they are more than slightly off the mark!

The reliance of research into TSD employing analogue designs has not gone unnoticed, and in their review of studies Hill et al (2001) cited the 'results' of over 18 papers, of which 14 reported positive perceptions of TSD, 3 found negative perceptions of TSD and 1 reported mixed findings. Hill et al (2001) state that analogue studies are only able to provide heuristically useful information regarding the effects of TSD, and it could be argued that the only conclusion that can be drawn is that non-clients typically perceive TSD positively (Watkins, 1990). Situating the mass of analogue research within the current review further suggests that the 'evidence' on which many notions about the usefulness of TSD are based on severely questionable research findings. However, the significant issue is that this limitation is not always reported in the literature.

Orlinsky & Howard (1986) noted that 'real-life' studies of the effects of TSD on therapy outcome have yielded less consistent results than analogue studies. Using actual clients, Hill et al (1988) concluded that reassuring disclosures, which were comparable to self-revealing normalising disclosures, were rated as most helpful by clients and therapists, and led to more emotional experiencing (i.e. insight and involvement with their emotions). A survey of former clients who had received at least six sessions of therapy reported that clients rated TSD of personal information as being beneficial to therapy

(Ramsdell & Ramsdell, 1993). In a qualitative study of client's perceptions, TSD was rated as beneficial to the therapeutic endeavour as it gave clients insight, improved the therapeutic relationship, normalised their experiences and provided them with a positive role model (Knox et al, 1997). Long-term client perceptions of TSD suggested that clients who received reciprocal TSD (i.e. disclosure in response to a similar client disclosures) liked their therapists more and reported less symptom distress once therapy had ended, which the authors reported as representing the positive effect of TSD on the quality of relationship and outcome of treatment (Barrett & Berman, 2001). Findings such as the ones outlined would indeed lend some support to the positive effects of TSD on therapy and clients, however, it is unclear what the label of 'beneficial' specifically refers to, and as usual definitions of TSD are not homogenous across studies making true comparisons and universal statements about the positive effects of TSD impossible.

The potentially negative effects of TSD on therapy outcome were explored by Braswell et al, (1985), who reported a negative correlation between frequency of TSD and therapists ratings of client improvement. Furthermore, using a correlational design, Kelly et al (2007) found that TSD was not significantly related to client or therapist ratings of the working alliance. Although correlations do not represent cause and effect, it would seem that there is some minimal evidence that TSD may not be helpful in therapy and may have possibly negative effects on the relationship. It is noteworthy that research endeavours actually interested in exploring negative effects of TSD are relatively rare within the literature, and it may be that empirical research has

not illustrated the negative effects because they have not focussed on researching them.

Research has also reported mixed results of the effect of TSD, which may represent a compromise between TSD as completely helpful and TSD as completely unhelpful. In a qualitative study of eight clients in psychotherapy, Wells (1994) found that some participants felt that TSD made the relationship feel more equal and their experiences validated, but created a decrease in trust and confidence that the therapist could help them with their difficulties. The small sample size and qualitative nature of this study reduces the generalisability of its findings. However, similar findings have been suggested, which state that the effect of TSD is to equalise the relationship, but can also lead to clients questioning how able the therapist is to help them (Audet & Overall, 2003). It is interesting that the asserted, and in some ways empirically supported, effect of TSD positively affecting the relationship may also invalidate the helping nature of the therapeutic relationship. It may be that therapists viewed as too human and fallible are perceived as unable to help clients with their psychological difficulties.

Empirical and qualitative research findings of the actual effects of TSD on clients and therapy seem to correspond to the reasons therapists may or may not self-disclose in therapy. This phenomenon is significant, and may suggest a reciprocal interaction between why therapists disclose and why clients view it as helpful, however, it nevertheless does not unequivocally suggest that TSD is always helpful or always unhelpful. Possibly all that can be concluded is that

there are differing views about the use of TSD and that corresponding evidence exists on either side of that debate, which lends support to that particular view.

A Note on Unintentional Therapist Disclosure:

Whilst the focus of this literature review has been on the relative benefits and risks associated with intentional TSD, it is worth noting the existence of unintentional TSD. Indeed, the focus of the current review is a product of the literature seeming to focus solely on intentional self-disclosure. Equally important is the less researched area of unintentional TSD, which adds a further layer of complexity to this subject. Unintentional TSD may relate to a therapist's gender, age, race, accent, religion (e.g. wearing a cross) manner of dress and marital status (e.g. wedding ring) (Barnett, 1998; Tillman, 1998; Zur, 2008a). Unintentional TSD is even more relevant when therapists practice in small or rural communities, as many aspects of their lives are displayed in clear view of their clients by virtue of the setting (Zur, 2008a). Unintentional TSD is frequent within minority groups, where therapist and client belong to the same community and may meet accidentally outside the therapy room, e.g. Lesbian, Gay, Bisexual and Transgender (LGBT) culture (Kessler & Waehler, 2005) and Deaf culture (an upper case D is a convention in the literature to describe culturally Deaf people that use British Sign Language (BSL) (Glickman & Gulati, 2003). A further form of unintentional TSD discussed recently in the literature is the 'Google Factor' (Zur, 2008b), whereby clients are able to gain a variety of information about their therapists by doing a simple Internet search.

Unintentional TSD illustrates that a huge amount of information is 'disclosed' by therapists to clients without uttering a single word, although this phenomenon is not widely discussed within the empirical literature, and seems to be conceptualised as a novel issue for specific types of therapists. It is plausible that unintentional TSD would have an equally significant effect on clients and therapy as intentional TSD is presumed to have. The literature on unintentional TSD is not forthcoming, and the author urges the research community to begin the exploration of this intriguing and complex issue.

Conclusion:

The current review illuminates much of the complexity and passion inherent within TSD. Interest in this area has been rekindled as result of social and cultural shifts towards openness. Definitions developed in the world of academia seem divorced from clinical practice, and the helpful distinctions and potential effects of self-revealing and self-involving disclosures are lost within the research papers, which only serves to create confusion about its effects. What is clear is that there are strongly held views regarding TSD based on theoretical model, although research evidence supporting these assertions is equivocal. What is not clear is what effect TSD has on clients in therapy, especially since the assertion that it is ultimately beneficial seems to supersede the limited and dated evidence that suggests, at best, that it may be helpful, unhelpful or both. Stating the obvious, it is recommended that more research should be carried out on actual therapist self-disclosures within on going therapy, using comparable definitions and measurable aspects of client

change. This would hopefully provide more robust evidence on both sides of the TSD debate, as all that we truly have at the moment are views for and against.

References

- Anderson, S. C. & Mandell, D. L (1989). The use of therapist self-disclosure by professional social workers. *Social Casework: The Journal for Contemporary Social Work*, 70-267.
- Aron, L. (1991). The patients experience of the analyst's subjectivity. *Psychoanalytic Dialogues*, 1, 29-51.
- Audet, C. & Everall, R. D. (2003). Counsellor self-disclosure: Client-informed implications for practice. *Counselling and Psychotherapy Research*, 3, 223-231.
- Barkham, M. & Shapiro, D. A. (1986). Counsellor verbal response models and experienced empathy. *Journal of Counselling Psychology*, 33, 3-10.
- Barnett, J. E. (1998). Should psychotherapists self-disclose? Clinical and ethical considerations. In L. VandeCreek, S. Knapp, & T. Jackson (Eds). *Innovations in clinical practice: A Source book*. (Volume 16, p. 419-428).
- Barrett, M. S. & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, 69, 597-603.
- Berg-Cross, L. (1984). Therapist self-disclosure to clients in psychotherapy. *Psychotherapy in Private Practice*, 2, 57-64.
- Berger, P. L. & Luckman, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. Penguin Press: London.

- Braswell, L., Kendall, P. C., Braith, J., Carey, M. P. & Vye, C. S. (1985). Involvement in cognitive behavioural therapy with children: Process and its relationship to outcome. *Cognitive Therapy and Research*, 9, 611-630.
- Bridges, N. A. (2001). Therapist self-disclosure: Expanding the comfort zone. *Psychotherapy*, 38, 21-30.
- Bridges, N. A. (2005). *Moving Beyond the Comfort Zone in Psychotherapy*. Lanham: MD Jason Aronson.
- Brown, L. S. & Walker, L. E. A. (1990). Feminist therapy perspectives on self-disclosure. In G. Stricker & M. Fisher (Eds). *Self-disclosure in the therapeutic relationship*. (pp. 135-154). New York: Plenum.
- Constantine, M. G. & Karl Kwan, K. L. (2003). Cross-cultural considerations of therapist self-disclosure. *Journal of Clinical Psychology/In Session*, 59, 581-588.
- Constantino, M. J., Castonguay, L. G. & Schutt, A. J. (2002). The Working Alliance: A Flagship for the Scientist-Practitioner Model in Psychotherapy. In G. Tryon (Ed). *Counseling Based on Process Research* (pp. 81-131). New York: Allyn & Bacon.
- Cooper, S. (1998). Countertransference disclosure and the conceptualization of analytic technique. *Psychoanalytic Quarterly*, 67, 128-154.
- Crits-Christoph, P., Gibbons, M. B. C. & Hearon, B. (2006). Does the Alliance Cause Good Outcome? Recommendations for the Future Research on the Alliance. *Psychotherapy: Theory, Research, Practice, Training*, 43, 280-285.

- Edwards, C. E. & Murdock, N. L. (1994). Characteristics of therapist self-disclosure in the counselling process. *Journal of Counselling and Development*, 72, 384-389.
- Farber, B. A. (2003). Self-disclosure in psychotherapy practice and supervision: An Introduction. *Journal of Clinical Psychology/In Session*, 59, 525-528.
- Farber, B. A. (2006). *Self-disclosure in psychotherapy*. New York: Guilford Press.
- Fisher, C. D. (2004). Ethical issues in therapy: Therapist self-disclosure of sexual feelings. *Ethics & Behaviour*, 14, 105-121.
- Freeman, A., Fleming, B. & Pretzer, J. (1990). *Clinical implications in cognitive therapy*. New York: Plenum Press.
- Freud, S. (1912). Recommendations to physicians practising psychoanalysis. In J. Strachey (Ed. & Trans.). *The standard edition of the complete psychological works of Sigmund Freud* (1966) (Vol. 12, p. 109-120). London: Hogarth Press.
- Glickman, N. S. & Gulati, S. (2003). *Mental Health Care of Deaf People: A Culturally Affirmative Approach*. New Jersey: Lawrence Erlbaum Publishers.
- Goldfried, M. R., Burckell, L. A. & Eubanks-Carter, C. (2003). Therapist self-disclosure in cognitive-behaviour therapy. *Journal of Clinical Psychology/In Session*, 59, 555-568.
- Goldstein, E. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal*, 22, 417-433.

- Gutheil, T. G. & Gabbard, G. O. (1998). Misuses and Misunderstandings of Boundary Theory in Clinical and Regulatory Settings. *American Journal of Psychiatry*, 155, 409-414.
- Hill, C. E., Mahalik, J. R. & Thompson, B. J. (1989). *Therapist self-disclosure. Psychotherapy, Theory, Research and Practice*, 26, 290-295.
- Hill, C. E. & O'Brien, K. M. (1999). *Helping skills: Facilitating exploration, insight, and action*. Washington DC: American Psychological Association.
- Hill, C. E. & Knox, S. (2001). Self-disclosure. *Psychotherapy*, 38, 413-417.
- Hill, C. E. & Knox, S. (2002). *Therapist self-disclosure*. In J.C. Norcross (Ed). *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients* (p. 255-265). Oxford University Press.
- Horvath, A. O. & Symonds, B. D. (1991). Relation Between Working Alliance and Outcome in Psychotherapy: A Meta-analysis. *Journal of Counseling Psychology*, 38, 139-149.
- Horvath, A. O. (1994). Research on the Alliance. In A. O. Horvath & L. S. Grennberg (Eds). *The Working Alliance: Theory, Research and Practice*, (pp. 259-286). New York: Wiley.
- Kahn, M. (2001). *Between Therapist and Client: The new Relationship (Revised Edition)*. New York: Owl Books, Henry Holt and Company.
- Kelly, A. E. & Rodriguez, R. R. (2007). Do therapists self-disclose more to clients with greater symptomatology? *Psychotherapy: Theory, Research, Practice, Training*, 44, 470-475.

- Kessler, L. E. & Waehler, C. A. (2005). Ethical Issues in Professional Practice: Addressing Multiple Relationships between Clients and Therapists in Lesbian, Gay, Bisexual and Transgender Communities. *Professional Psychology: Research and Practice*, 36, 66-72.
- Knox, S., Hess, S. A., Peterson, D. A. & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counselling Psychology*, 44, 274-283.
- Knox, S. & Hill, C. E. (2003). Therapist self-disclosure: Research based suggestions for practitioners. *Journal of Clinical Psychology/In Session*, 59, 529-540.
- Linehan, M. M. (1993a). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.
- Mahalik, J. R., VanOrmer, E. A. & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck (Ed). *Practicing feminist ethics in psychology* (pp. 189-201). Washington DC. American Psychological Associations.
- Manning, E. A. (2005). Wrestling with vulnerability and countertransference disclosures and the training therapist. *Psychotherapy Bulletin*, 40, 5-11.
- Maroda, K. (1999). Creating an intersubjective context for self-disclosure. *Smith College Studies for Social Work*. 69, 475-489.
- Martin, D. J., Garske, J. P. & Davis, K. M. (2000). Relation of the Therapeutic Alliance with Outcome and other Variables: A Meta-analytic Review. *Journal of Consulting and Clinical Psychology*, 68, 438-450.

- Myers, D. & Hayes, J. A. (2006). Effects of therapist general self-disclosure and countertransference disclosure on ratings of the therapist and session. *Psychotherapy: Theory, Research, Practice, Training*, 43, 173-185.
- Orlinsky, D. E. & Howard, K. I. (1986). Process and outcome in psychotherapy. In Garfield & A. E. Bergin (Eds). *Handbook of psychotherapy and behaviour change* (Third Edition) (pp. 311-381). New York: Wiley.
- Peterson, C. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy: Theory, Research, Practice, Training*, 19, 21-31.
- Ramsdell, P. S. & Ramsdell, E. R. (1993). Dual relationships: Client perceptions of the effect of client-counselor relationship on the therapeutic process. *Clinical Journal of Social Work Journal*, 21, 195-212.
- Robitschek, C. G. & McCarthy, P. R. (1991). Prevalence of counselor self-reference in the therapeutic dyad. *Journal of Counseling and Development*, 69, 218-221.
- Rochlin, M. (1982). Sexual orientation of the therapist and therapeutic effectiveness with gay clients. In J. C. Gonsorick (Ed). *A Guide to Psychotherapy with Gay and Lesbian Clients* (pp. 21-29). New York: Hawarth Press.
- Simi, N. L. & Mahalik, J. R. (1997). Comparison of feminist versus psychoanalytic/dynamic and other therapists on self-disclosure. *Psychology of Women Quarterly*, 21, 465-483.
- Simon, J. C. (1990). Criteria for therapist self-disclosure. In G Stricker & M. Fisher (Eds). *Self-disclosure in the therapeutic relationship*. (pp. 207-225). New York: Plenum.

- Simonson, N. R. (1976). The impact of therapist disclosure on patient disclosure. *Journal of Counselling Psychology*, 23, 3-6.
- Spinelli, E. (1994). *Demystifying therapy*. London: Constable.
- Stricker, G. & Fisher, M. (1990). *Self-disclosure in the therapeutic relationship*. New York: Pendulum.
- Stricker, G. (2003). The many faces of self-disclosure. *Journal of Clinical Psychology/In Session*, 59, 623-630.
- Tillman, J. G. (1998). Psychodynamic psychotherapy, religious beliefs and self-disclosure. *Journal of Psychotherapy*, 52, 273-286.
- van Deurzen, E. (1998). *Paradox and passion in psychotherapy: An existential approach to therapy and counselling*. John Wiley & Sons.
- Wampold, B. E. & Bhati, K. S. (2004). Attending to the Omissions: A Historical Examination of Evidence-Based Practice Movements. *Professional Psychology: Research and Practice*, 35, 563-570.
- Watkins, C. E. Jr. (1990). The effects of counsellor self-disclosure: A research review. *The Counselling Psychologist*, 18, 477-500.
- Webster, D. (1986). Models of therapy used by feminist nurse psychotherapists. *Women and Therapy*, 5, 277-287.
- Weiner, M. F. (1983). *Therapist disclosure: The use of self in psychotherapy (Second Edition)*. Baltimore: University Park Press.
- Wells, T. L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. *Smith College Studies in Social Work*, 65, 23-41.

Yalom, I. D. (1985). *The theory and practice of group psychotherapy*. New York: Basic Books.

Yalom, I. D. (2001). *The gift of therapy: Reflections on being a therapist*. Harper Collins Publisher.

Zur, O. (2008a). *Self-disclosure & transparency in psychotherapy and counselling: To disclose or not disclose, this is the question*. Accessed 25/05/2009 from <http://www.zurinstitute.com/selfdisclosure1.html>.

Zur, O (2008b). The Google Factor: Therapists unwitting self-disclosure on the net. *New Therapist*, 57, 16-22.

Journal Submission Guidelines

Psychotherapy: Theory, Research, Practice, Training

Notes for contributors

Psychotherapy Theory, Research, Practice, Training publishes a wide variety of articles relevant to the field of psychotherapy. The journal strives to foster interactions among training, practice, theory, and research, as all are essential to psychotherapy.

Authors may submit theoretical contributions, research studies, novel ideas, and the controversial, as well as examples of practice-relevant issues that would stimulate other theorists, researchers, and/or practitioners.

Articles based on individual cases are occasionally published. Brief reports are also published and should be no longer than 10 pages, including text and tables, but not abstract or references. The journal includes the widest scope of orientations to inform its readers.

This journal is an invaluable resource for practicing clinical and counselling psychologists, social workers, and mental health professionals.

The following instructions pertain to all journals published by APA and the Educational Publishing Foundation (EPF).

Manuscript Preparation

Prepare manuscripts according to the Publication Manual of the American Psychological Association (5th edition). Manuscripts may be copyedited for bias-free language (see Chapter 2 of the Publication Manual).

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts appear in the Manual.

If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.

Review APA's Checklist for Manuscript Submission before submitting your article.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 180 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal Article:

Fullagar, C. (1986). A factor analytic study on the validity of a union commitment scale. *Journal of Applied Psychology*, 71, 129–136.

Authored Book:

Mitchell, T. R., & Larson, J. R., Jr. (1987). *People in organizations: An introduction to organizational behavior* (3rd ed.). New York: McGraw-Hill.

Chapter in an Edited Book:

Bjork, R. A. (1989). Retrieval inhibition as an adaptive mechanism in human memory. In H. L. Roediger III & F. I. M. Craik (Eds.), *Varieties of memory & consciousness* (pp. 309–330). Hillsdale, NJ: Erlbaum.

Section 5

Gay Psychologists and Gay Clients: Exploring Therapist Disclosure of Sexuality in the Therapeutic Closet.

Abstract

Therapist self-disclosure of sexuality can be therapeutically beneficial when both therapist and client identify as gay (Coyle & Kitzinger 2002). This study attempted to explore the views and experiences of gay male clinical psychologists disclosing their sexuality to gay male clients. Five gay male clinical psychologists were interviewed, subsequent transcriptions were analysed using Interpretative Phenomenological Analysis (IPA). Six main themes emerged from the data: being gay in a straight world; disclosure and the therapeutic agenda; contexts of disclosure; other ways of knowing; disclosure of sexuality: a big deal; and the invisible curriculum. Overall, disclosure of sexuality was a complex area, which could have both positive and negative effects on the therapeutic endeavour. Implications for practice and future research are discussed.

Keywords: Clinical Psychologist; Therapist Self-disclosure; Sexuality; IPA.

Background

Mental health difficulties within the Lesbian, Gay, Bisexual and Transgender (LGBT) community are reported to be high (King et al, 2003), and it has been suggested that LGBT people may encounter institutional heterosexism and homophobia when seeking psychotherapy (McFarlane, 1998; Bartlett, Smith & King, 2009). Davies (2007) argues that a “heterosexual bias permeates most therapy training programmes and therapy literature” (p.19), and it has been argued that LGBT lifestyles and culture are overlooked in clinical psychology training (Butler, 2004; Milton, Coyle & Legg, 2002). This heterosexism is based on the assumption that heterosexuality is equivalent to normality (Braun, 2000; Butler & Byrne, 2008). An attitude of gay affirmative practice has been proposed as an alternative to this heterosexist bias, and attempts to create safe, meaningful and non-pathologising therapy for non-heterosexual clients (Butler et al, 2008; Coyle & Kitzinger 2002; Davies & Neal, 1996; Langdridge, 2007; Lebolt, 1999). Gay affirmative practice is a belief system or attitude, rather than a therapeutic model, and advocates that therapists (heterosexual or non-heterosexual) have a substantial knowledge of the issues faced by this diverse group, ensuring culturally competent practice (Crisp & McCave, 2007; Hodges, 2008; Milton & Coyle, 2003). Limited empirical support exists for gay affirmative practice, although recent qualitative studies suggested that an affirmative approach was valued by LGBT clients (Lebolt, 1999; Pixton, 2003).

Therapist self-disclosure (TSD) remains a controversial area (Knox & Hill, 2003), and in its broadest sense “can refer to any behaviour, verbal or non-verbal, that reveals information about a person (*therapist*) (Farber, 2006, p.133). Appropriate TSD should be used for the benefit of the client, and not serve the needs of the therapist (Hill & Knox, 2002). A review of TSD suggested that benefits to the client include: strengthening the therapeutic relationship; normalising client’s experiences; providing alternative points of view; and encouraging clients to disclose (i.e. reciprocal disclosure) (Farber, 2006; Knox et al, 2003). Possible reasons to not disclosure include: shifting the focus from client to therapist; burdening or confusing clients; and altering boundaries and the therapeutic relationship (Hill et al, 2002). Within gay affirmative practice, appropriate TSD is believed to reduce potential power differentials and result in a more equal and honest therapy (Barker, 2006; Coyle et al, 2002), which is in line with more feminist approaches to TSD (Simi & Mahalik, 1997). TSD of sexuality may be particularly salient when both therapist and client identify as *non-heterosexual*, and it has been suggested that therapists be willing to consider disclosure of sexuality on an individual client basis (Guthrie, 2006; Milton et al, 2002).

A preliminary literature review suggested that research into TSD of sexuality is limited, although theoretical and experiential accounts exist. Frommer (1995) suggested that gay men can develop an ‘outsider syndrome,’ whereby “(*the gay*) child is most often an alien within his family...(and) often adopts the identity of an outsider even before he can label the nature of his difference” (p.78). Rochlin (1982) believed that openly gay psychotherapists are able to

share an enhanced empathy, represent a positive role model and have knowledge of gay culture, without needing to be educated by the client, which may counter the 'outsider syndrome' within therapy. Recent literature shares the above sentiment, and suggests that TSD of sexuality can indeed be helpful for gay clients, as it challenges heterosexism; socialises clients into positive gay roles; reduces feelings of isolation; and aids connection with the therapist as they are perceived as being safe to engage with within a therapeutic relationship (Davies, 2007; Milton et al, 2002; Moon, 2008). However, it should be noted that there are levels of therapist outness with clients (Barker, 2006), and TSD of sexuality must be appropriate to the clients needs so as not to cause confusion about boundaries, or stunt the therapeutic exploration of clients who are questioning or ambivalent about their sexuality (Coyle et al, 2002).

Literature exploring contextual issues illustrates the inherent complexity of this area (Coolhart, 2005; DeCrescenzo, 1997; Kane, 2006), especially given the fact that therapists' sexuality may be assumed (Russell, 2006); or disclosed unintentionally by meeting clients in a relatively small gay scene (Kessler & Waehler, 2005; Taylor, Solts, Roberts & Maddicks, 1998). The influence of clinical setting on TSD of sexuality has also been implicated, whereby the disclosure of sexuality by therapists is more visible and acceptable within sexual health (Hanson, 2003), whilst in contrast is less visible and possibly more risky within inpatient settings (Fish, 1997). Bartlett, King and Phillips (2001) also commented on the fact that gay and lesbian clients may actively

seek out therapists that share their sexual identity, which demonstrates a further complexity, as sexuality is disclosed at the point of referral.

Using focus groups and a grounded theory approach, Satterly (2004) researched a diverse group of gay male therapists' experiences of disclosing their sexuality to gay and heterosexual clients. Themes implicated in the decision to disclose or not disclose included: professional identity; clinical setting (e.g. sexual health); alternative ways of knowing; benefit of the client; reciprocal disclosure; authenticity of the relationship; role modelling; and sharing a culture and community. These research findings seem to echo the more theoretical ideas presented above, and suggest that gay therapists working with gay clients offers a unique context for understanding and researching TSD of sexuality.

The aim of the proposed study was to supplement the relatively limited research investigating gay male therapists' disclosure of sexuality to gay male clients. Using Interpretative Phenomenological Analysis (IPA: Smith, Jarman & Osborn, 1999), the research focused solely on exploring the views and experiences of male gay clinical psychologists' disclosing their sexuality to male gay clients in Great Britain, as they are under-represented within this area. Particular attention was given to exploring the reasons for disclosure and non-disclosure from a gay perspective, and also the influence of training in clinical psychology and the clinical psychology profession on the disclosure of sexuality.

Method

Qualitative Perspective

This research used Interpretative phenomenological analysis (IPA: Smith, 1996; Smith, Jarman & Osborn, 1999) to explore and understand participants' experiences of disclosure and non-disclosure of their sexuality to their gay clients. IPA adopts an interpretative approach to data collection and analysis, whereby a double hermeneutic exists (Smith & Osborn, 2004), as the researcher uses their own beliefs and expectations of the world to interpret the personal worlds of participants. IPA research recognises that a researchers interpretations are not free from bias, and these biases are embraced within the methodology and deemed necessary to make sense of a participants lived experience (Smith et al, 2004). Fundamental assumptions underlying the use of IPA are as follows: peoples narratives are a product of cognition and how they construct the world; language does not represent reality; more than one reality exists; and participants narratives can be understood through subjective interpretation of the researcher (Willig, 2001).

Participants

Five participants took part in the study. Participants were qualified male clinical psychologists who self-identified as gay or homosexual. As the purpose of the study was to explore the disclosure of sexuality to clients, further criteria for inclusion were: (a) experience of working therapeutically with

male gay clients; (b) experience of disclosing their sexuality to male gay clients; and (c) experience of not disclosing their sexuality to male gay clients. The aim of these inclusion criteria was to attempt to obtain some homogeneity within the sample, which is an important detail of IPA methodology, given that the focus is on understanding the frames of reference for a small group of people (Smith et al, 2004).

Once ethical approval had been granted from the relevant National Health Service (NHS) Research Ethics Committee, participants were recruited by emailing an outline of the study and inclusion criteria to a private Lesbian, Gay Bisexual and Transgender (LGBT) therapy practice; two relevant sections of the British Psychological Society (BPS); and the Lesbian and Gay Psychology Listerv, which is an academic and clinical Internet forum for LGBT psychologists. Interested potential participants contacted the first author (JL) by email and were sent a copy of the participant information sheet describing the study. A subsequent telephone conversation was arranged to discuss the study and inclusion criteria more thoroughly. Fifteen potential participants expressed interest in taking part in the study, although only five were suitable once the inclusion criteria were applied. The ages of participants ranged from 28 to 40 years old, and the number of years since qualification was between 2 and 17 years. Participants worked with a variety of client groups, including adults with mental health difficulties, adults with a learning disability and adults with HIV and/or AIDS. In terms of theoretical orientation, all participants described themselves as eclectic and integrative: specific models included Cognitive Behaviour Therapy (CBT); Cognitive Analytic Therapy (CAT);

Psychodynamic; and Systemic approaches. All participants trained within Great Britain: three worked within the NHS and two worked in private practice.

Data Collection

Individual interviews were conducted at a convenient time and location for the participants. Prior to commencing the interview, participants were given a further written outline of the study, information about consent, anonymity and their right to withdraw. Participants were informed that pseudonyms would be used instead of their real names in any subsequent reports, but they were given the option of refusing to allow their direct quotes being included in the write up, if they felt it would compromise their anonymity. All participants consented to the inclusion of direct quotes, and gave written informed consent to participate.

In accordance with the guidelines for the conduct of IPA studies (Smith et al, 2004) the interviews followed a semi-structured style. This maintained some form of structure for collecting data and later analysis, but also allowed participants the opportunity to share personal experiences beyond the researchers preconceived ideas (Smith et al, 1999). The interview began by asking participants to talk about their professional background. Participants were then asked more exploratory open ended questions related to: views of own sexuality; experience of disclose and non-disclosure; own experience of coming out; and training (*see Appendix 1 for interview schedule*). The interview schedule was based on a review of related information and literature,

and informed by the first author's (JL) own experience of being gay and a trainee clinical psychologist. The average length of the interviews was 50 minutes. Interviews were audiotaped and later transcribed verbatim. After completing the interview, participants were given the opportunity to ask questions of the researcher and reflect on their experience of taking part.

Analytic Process

The first author (JL) read the first transcript thoroughly several times, annotating significant points, making preliminary interpretations and noting any connections or contradictions within each participants account. The transcript was then read again. Using the preliminary notes a higher level of abstraction took place, whereby themes, connections, concepts and links with the literature were made. Connected themes were then clustered and main themes were generated. Each main theme was re-checked against participants' accounts to make sure they were consistent and credible. During this process, certain themes were discarded if the evidence in the transcript was not rich enough or did not fit into the overall structure (*see Appendix 2 for an example of analysis*). Initially, the same procedure was carried out on each transcript. However, as themes were developed they were tested against earlier transcripts for convergence and divergence, meaning that modifications were made to previous coding. Eventually a list of six master themes and corresponding sub-themes was created for the five participants, and this was used to produce a coherent narrative of participants' experiences. The other members of the research team (RSPJ and JH) also made credibility checks to ensure that the

analytical interpretations were grounded in the data. Finally, it is noteworthy that the analysis and subsequent writing up of the results informed each other as a flexible process, and this is comparable to the experience of other IPA researchers (Smith et al, 1999).

Reflexivity

The first author (JL) conducted the interviews and identified himself as gay. Politically he adopted the label as representing his membership to a minority cultural group. He was also within his final year of clinical psychology training, and described his therapeutic style as relational and psychodynamic. He had experience of disclosing his sexuality to a gay client during therapy, which he had reflected on both personally and professionally. Fundamentally, he believed that disclosure of sexuality could be beneficial for gay clients in reducing feelings of isolation and creating a safe therapeutic space for the exploration of issues related to gay life and culture. During the research, he chose to reveal his sexuality and profession to participants, which appeared to aid in the development of rapport and a shared language with participants, but may have also suggested that the researcher would take a gay affirmative position. Being of the same sexuality and profession as all participants afforded an insider perspective from the outset, and allowed the iterative search for themes from a fundamentally psychological and gay position. Any findings should be taken as attempts to understand this area, speaking to and for the people involved, the information shared, and the researchers knowledge of the topic.

Results

From the process of analysis, six major themes emerged: being gay in a straight world; disclosure and the therapeutic agenda; the contexts of disclosure; other ways of knowing; disclosure of sexuality: a big deal?; and the invisible curriculum. Each theme will be discussed and illustrated with grammatically corrected extracts to enhance readability.

Being Gay in a Straight World

Participants offered a rich insight into the potential exclusion, stigma and homophobia faced by gay men within a heterosexual majority. It seemed that this knowledge of the 'gay experience' inhabited the space between personal and professional, thus providing an insider perspective in their clinical work with gay men:

I think a lot of gay men feel they would be judged by straight people when talking about particular types of sex, or relationships, or bits of their identity. (Neil)

Understanding the potential difficulties gay clients experience relating to the straight world seemed to influence participants' choices about disclosure of their own sexuality. Neil, Nick and Rhys noted that a function of disclosing their sexuality was to allow clients to feel at ease and comfortable in the room. This disclosure of sameness created a space of comfort and free disclosure of the client's difficulties.

...it sometimes kind of feels like something you just have to give away in order to make the conversation easier. (Neil)

...he justified it by saying that he wasn't that comfortable disclosing some of the sexual practices that he might do with a man who may be heterosexual...I decided that the right thing to do was to tell him that I was gay. He accepted that very well and was able to disclose some of the issues he had, which I thought was therapeutically very helpful. (Rhys)

Disclosure was also seen as part of being real with a client by reciprocally sharing information, and allowed a human connection to develop:

I think clients really appreciate it you know, you can be flexible, and if you're real with them, and that (disclosing) can be part of being real actually. (Nick)

This process of being real has links with the notion of normalisation. For example, Neil suggests that disclosure of one's sexuality could be facilitative when "the client has had difficulties relating to therapists or to other people who might have been helpful, because of perceived differences in sexuality." Nick's disclosure of his position of knowing "as a gay man myself" provides an opportunity for the processes relevant and specific to a gay identity to be explored and normalised. Rhys elaborates on this theme when discussing the process of coming out:

...sometimes its important to be able to tell them that it isn't easy for many people to come out, and if they're aware of your sexual orientation then you could easily say, or

I could easily say...that its not always easy to come out and I know that from personal experience...there are very few that just get on through without the slightest hitch.
(Rhys)

The reasons to disclose sexuality could also be based on how therapists might present themselves as role models, and how this might offer clients the opportunity to explore themselves in relation to a similar, yet distinct other. Kevin suggests that:

...it would be important to provide them with hopefully reasonably positive role models of people who you know were comfortable and accepting and confident about their own sexuality...we saw it as a strong therapeutic tool to be openly gay. (Kevin)

Finally, all participants were emphatic in their discourse that disclosing sexuality should be therapeutic and meaningful, and ultimately be done for the benefit of the client.

I kind of have a sense that it should be useful to the client in some way, it's not something I like to do just as a routine thing. (Neil)

Disclosure and the Therapeutic Agenda

Participants dealt with the complexities of disclosing their sexuality (or not) to clients based on the therapeutic agenda, and their roles as psychologist and psychotherapist. If asked directly, there appeared to be a desire to explore and understand the meaning behind the question. Whilst this may be

interpreted as a caricatured therapist response to any question, it seemed more about honouring and understanding the individuality of the client, and whether it was necessary for them to know:

I think its important to be curious about why and how that question came into their mind, is it because they feel that you, that they're not understood by you, you know there are so many different hypotheses to explore before you give a response. (Nick)

Disclosure for whom was an issue most participants grappled with, and there was a reflective thoughtfulness about their own motivations to disclose:

...absolutely, I don't ever feel I have reasons myself to disclose my sexual orientation, I've never felt that they have needed to know that because of my agenda...I never feel as though it's my agenda and that the person sat across from me needs to know my sexual orientation. (Rhys)

There was also a concern that the disclosure could be perceived and experienced as meeting the needs of the therapist, rather than the client, thus breaking a fundamental rule of psychotherapy:

...some of the clients were really cute, it just makes the issue of disclosing my sexuality more complicated because I find a client attractive, then am I telling them that I'm gay for my own reasons, which feels very uncomfortable and I wouldn't do it, its not about the therapy, its about me. (Kevin)

A further theme related to therapeutic boundaries was evident, whereby participants cautioned against making their own sexuality too much of a focus if it had the potential to nullify the uniqueness of a therapeutic relationship:

...at the end of the day, the relationship needs to be a therapeutic one and an effective one really...if it sort of descends into sort of chit chat, you know its not going to happen because its not going to be helpful. (Nick)

Revealing one's sexuality therefore served as a means of developing an effective psychotherapeutic relationship and agenda. However, Jon and Rhys noted that such disclosures might be boundaried, such that the disclosure does not necessitate disclosing personal aspects of life as a gay man. The focus is on disclosure of sexuality alone, with its purpose being to ensure the development of a meaningful therapeutic relationship.

...in my opinion (that) was crossing a different type of boundary, and I didn't necessarily want to disclose any more about my life, but my sexuality was fine, and I disclosed because it was anonymous enough. (Jon)

Although disclosure of sexuality might provide a role model for clients, the metaphor of a 'biased witness' was nonetheless referred to. There was a sense that their disclosure would in some way minimise the significance of their exploratory role in the therapy, and give the simplistic message that it is okay to be gay:

...that the person would be able to dismiss your views that it was ok because you were gay as well...they would just see it as bias and therefore it wouldn't mean anything, therefore my attempts to help people to become more confident about their sexuality would be undermined by the process...I could just be seen as a biased witness. (Kevin)

The notion of a biased witness also seemed linked to Neil and Rhys' refusal of disclosing their sexuality to clients who were still questioning their sexual identity. It could be speculated that their disclosure would not only give the potentially glib message it is okay to be gay, but more importantly, that it would colour the clients exploration of themselves within therapy.

...a client...who was very very confused about his sexuality, and...I think that was the only time when I have actively withheld...I had a very strong sense that it would be the wrong thing to do there. (Neil)

Some participants also felt that disclosing their sexuality might take precedence over their professional identity, leading to reduced disclosure, especially in inpatient settings.

...one of the reasons for me not disclosing...(is) that that might take over my identity too much, so I wouldn't be a clinical psychologist, I would be the gay clinical psychologist, which would be frustrating because I'm not a gay clinical psychologist. (Jon)

Finally, most of the participants alluded to the fact that their decisions and reasons to disclose were in some ways intuitive. However, Neil expressed this idea eloquently, and in particular hinted at the mismatch between the objective scientific approach to therapy, and how this contrasted to the subjective art of therapy:

...how you make sense of it I suspect ends up more an intuition than anything else with individual clients, and that's never been a satisfactory explanation has it in the research literature...but I suspect that is what a lot of therapists do, unless there's some more formal way of doing it. (Neil)

The Contexts of Disclosure

It was apparent that participants' disclosure of their sexuality was influenced significantly by the setting within which they offered therapy to gay clients. Due to experience within the sexual health field, Rhys, Nick, Neil and Jon noted how their sexuality was usually assumed by clients, rather than directly disclosed.

I think there is a big assumption working in sexual health that a man working in sexual health is likely to be gay and there is a lot of truth in that as well...but they're not all, and so I think clients might probably err on the side of likelihood. (Neil)

In contrast, disclosure of any kind for participants working within inpatient settings (i.e. forensic secure services) was perceived as less appropriate, due to the risk issues related to this client group. There was a sense that

institutional homophobia might create therapeutic difficulties between participants and the heterosexual clients they worked with.

...the reason for not disclosing in this environment is because...most of the clients know each other and I'm aware some of my individual clients that I work with, where the issue is nothing to do with their sexuality have strongly negative attitudes towards gay people. (Kevin)

For Kevin and Jon, their relationship with colleagues was also an issue that further complicated disclosure. There was a concern that they would be 'outed' by colleagues, and felt that this would affect their role as a clinical psychologist.

I wonder whether there will be leakage from staff. (Kevin)

...its not something they would mention in front of that patient because there's an implicit agreement that I choose to disclose what I wish with the patient, others don't do it on my behalf. (Jon)

In contrast, private work within a LGBT therapy organisation presented a different and unique context for disclosure, as participants' sexuality was known to clients from the outset, as this information was included in the organisations website. In some ways it was more acceptable for participants to be openly 'out' in private practice:

...it's different though in my private work with (LGBT organisation), because you have to be open about it, you're required to be open about it to be on the register...its just something that people will know about me really. (Nick)

This context illuminated the idea of client choice and that gay clients may actively seek a gay therapist. Neil noted that expressing this choice was akin to asking for a certain gender, race or model of therapist. However, there was a sense that this was only available to clients within private practice.

...the idea that we're seeing in private practice of gay affirmative therapists, that one might actually chose a therapist who is known to be gay or not straight and you know (LGBT organisation) of course are based upon these lines...perhaps in the same way that they might choose the gender of the therapist, or the ethnicity of the therapist, that they actually want to try and get as similar match as possible. (Neil)

Other ways of Knowing

Participants noted that direct verbal disclosure of their sexuality was relatively infrequent, and it seemed that this was due to other ways of knowing. As within sexual health, client assumptions about the sexuality of the participants played a significant role across settings, suggesting that sexuality is possibly invisibly visible between two gay men:

...a lot of them like I said earlier assume it rather than necessarily know, and I never try and correct them. (Rhys)

Neil expressed the notion of unconscious communication, whereby the client may be given hints as to the sexuality of the participant because of their style of interacting, and that this acted as a type of non-verbal disclosure of sexuality:

...I don't think I do it consciously but I might drop hints along the way that I have some knowledge or understanding or experience of some things they are speaking of, and that in itself is a kind of more implicit coming out or disclosure (Neil).

Sharing the gay scene with clients also emerged as another way of clients knowing the sexuality of the participants without direct verbal disclosure. Participants felt that gay clients were sensitive to cues of sexuality through experience of the gay scene and life as a gay man, and that this accounted for some of the assumptions made by clients.

I guess that there might be something there that makes me look gay, and if you're a gay man and you're out on the scene then you will probably be more cued into who looks gay and who doesn't...I wish I knew the answers, but there are obviously subtle cues that aren't necessarily verbal. (Rhys)

Finally, Neil and Kevin implicated the role of the Internet and the 'Google factor' (Zur, 2008) as a non-verbal disclosure of their sexuality. Whilst it was not considered that clients would search their therapist's research in psychological journals, it was conceptualised as an aspect of the participants' identity that was open in other professional arenas, and theoretically was accessible to their gay clients.

...actually it would be easy enough for people to find out about my sexuality if they really wanted to in terms of the research I do, and some of the things I contribute to could easily be Googled...of course there are places on the internet and in the real world where I can be found, where my sexuality is probably obvious. (Neil)

Disclosure of Sexuality: A Big Deal?

Disclosure was not always an easy option, and revealing one's sexuality to gay clients could be anxiety provoking. Waiting for a reaction to one's disclosure was associated with the metaphor of an unexploded bomb, whereby the anticipated aftershock of a negative reaction was generally absent.

...there's a kind of microsecond when its actually in the space between you, and you've said it and they haven't responded and you wonder how its going to land...my experience tells me that its generally going to be okay...I've never had an experience where the client has reacted in a way that has not felt okay. (Neil)

Whilst it is clear that disclosing sexuality is a complex and potentially emotive issue for gay clinical psychologists in this sample, it was also interesting to note that the act of disclosing to a client was usually described as more mundane and less extraordinary than initially thought.

...by and large its something that happens and happens without much event, and that would be an interesting thing to report, that actually it's no big deal, because its set up even in the asking of the question. (Neil)

Participants also questioned how useful their disclosures had actually been, and there was a sense that it may not have been as significant within the overall therapeutic encounter.

...sharing that I'm gay doesn't mean that their difficulties disappear. (Rhys)

...you know (it) didn't seem to have a big influence or be a big factor in whether you get somewhere with someone really (Nick)

The Invisible Curriculum

Participants expressed an irritation at the heterosexist views that permeate clinical psychology training, and the fact that the profession in general is unable to speak to, and speak of, those members who identify as gay. Gay issues were viewed as being the invisible and overlooked component of curriculum and practice.

...I know it isn't being discussed and can feel the absence of it, but I think if I was heterosexual then I would understand less the homosexual issues, and perhaps I wouldn't even notice it isn't even there in clinical psychology, but I notice that its not there...I'm part of that minority group. (Jon)

It was also apparent that participants felt that gay issues were situated under the umbrella of diversity and difference, and in one case as pathology.

I remember having some teaching in my training around dealing with difference, which did include other issues such as race and religion and not just sexual orientation. (Rhys)

...it was about clients that identified as gay and were messed up, and might have problems with that and maybe discrimination and abuse and some sort of sexual problems. (Jon)

Disclosure of sexuality was absent within training. Generally, therapist self-disclosure was presented within the classical psychoanalytic concept of a blank screen, advocating the avoidance of any intentional personal disclosure.

...such a powerful discourse in psychology and therapy generally that you shouldn't, that you should keep your personal details about yourself out of everything. (Nick)

The lack of relevant LGBT teaching coupled with a biased model specific view of self-disclosure seemed to create an uncertainty within the participants about their disclosing behaviour. Nick noted the anxiety and potential difficulties that can arise from this position of uncertainty:

...when you're having powerful discourses about not doing something, and you find yourself in a different situation or get a different point of view you can feel quite anxious, like am I doing something wrong here, and could lead to a situation when you feel you cant talk about it in supervision. (Nick)

Overview and Discussion

The present study supports much of the literature within this area, including Satterly's (2004) research, but also adds to the literature in novel ways by providing a clinical psychological view using an IPA analysis. Generally, TSD of sexuality was viewed as beneficial to gay clients, as it positively impacted on the therapeutic relationship. However, caution was expressed when disclosure served the needs of the therapist or affected the uniqueness of that therapeutic encounter. Further complexities, such as client assumptions of sexuality and other ways of knowing, as well as the discourse of disclosure being no big deal were apparent. Finally, a lack of focus and visibility of gay issues, and specifically disclosure of sexuality, was evident within clinical psychology training and the profession.

Insight into the negative effects of exclusion and homophobia created a unique context for disclosing sexuality. Participants seemed to have an increased empathy and sensitivity to the potential discomfort clients experienced relating to a presumed heterosexual psychologist, and a heterosexist healthcare setting (Bartlett et al, 2009; McFarlane, 1998; Rochlin, 1982), therefore, disclosure allowed clients to engage meaningfully, and be an insider rather than outsider (Frommer, 1995). Disclosure of sexuality as normalisation (i.e. coming out process); allowing reciprocal disclosure (i.e. therapist disclosure to allow client disclosure); and providing a role model for clients were evident. These functions of disclosure have been noted generally within the literature (Farber, 2006; Knox et al, 2003), and specifically with regards to gay therapists

working affirmatively with gay clients (Davies, 2007; Lebolt, 1999; Milton et al, 2002; Moon, 2008; Pixton, 2003; Satterly, 2004). However, it was also noted that there were hierarchies of outness (Barker, 2006) and that disclosure of sexuality needed to be boundaried, whereby disclosure of sexuality was not synonymous with disclosure of the intricacies of life as a gay man.

The therapeutic agenda and role of psychologist/psychotherapist seemed paramount regarding the disclosure of sexuality, and disclosure seemed to be reflected on within a generic therapeutic framework. Disclosure was considered inappropriate when it was beneficial only to the psychologist and moved focus from the client's story, as this only served to nullify the purpose and uniqueness of therapeutic boundaries and the relationship (Coyle et al, 2002; Farber, 2006; Knox et al, 2002; Knox et al, 2003; Satterly, 2004). However, it was expressed that the actual decision to disclose may be more intuitive, rather than guided by formal concrete frameworks (Farber, 2006). The potential for disclosure of sexuality to take over professional identity, and being seen as the 'gay psychologist' echoes findings in the literature, especially within inpatient settings (Fish, 1997; Satterly, 2004). Disclosure of sexuality when clients were ambivalent about their own sexuality was not endorsed, as it may skew clients' exploration of themselves (Coyle et al, 2002; Satterly, 2004). Interestingly, this was further illustrated in the notion of a biased witness, whereby therapists may be perceived as giving clients the message 'it's ok to be gay.' This point relates to Barker's (2006) reflection regarding the disclosure of sexuality, that ultimately "we may be damned if we do and damned if we don't" (p. 294).

The context in which disclosure of sexuality took place was also significant. Linking to previous findings, sexuality within sexual health settings seemed more visible and acceptable due to the significant number of gay male clients receiving services (Hanson, 2003; Satterly, 2004). Therefore, sexuality was usually assumed by clients rather than directly disclosed by participants (Russell, 2006; Satterly, 2004). This possibly highlights gay cultural assumptions about the sexuality of men working in sexual health, thus therapists are presumed as 'gay in gay places.' Conversely, inpatient settings were viewed as less conducive to the disclosure of sexuality due to the small closed environment, and there was also a concern that disclosure may be done on ones behalf by colleagues. This reticence to disclose may be due to the institutionalised homophobia that exists, as well as the potential risk of physical harm from clients in forensic settings (Fish, 1997; Satterly, 2004). Private practice and work with an LGBT organisation (e.g. Pink Therapy and Lesbian and Gay Foundation) was a unique setting for TSD of sexuality, as sexuality was known to clients from the outset, in fact openness of the therapist regarding their sexuality was required. This relates to the ideas of client choice (Bartlett et al, 2001), although this choice, or matching of sexuality may only be actively endorsed in private and voluntary sectors (Satterly, 2004).

Other ways of knowing was an interesting theme, which related to unintentional and non-verbal disclosures referred to in the literature (Farber, 2006; Knox et al, 2002). Again, the role of assumption was significant as it meant direct disclosure was not necessary. Gay clients seem to be sensitive to cues of sexuality in their therapists (Satterly, 2004), e.g. manner, jewellery, tone of

voice, such that sexuality could be argued as invisibly visible to gay men generally. Sharing the gay scene with clients and unexpectedly meeting clients on the scene created a further complexity to disclosure, as the 'disclosure' was ultimately unintentional, which seemed to cause anxiety and concerns regarding therapeutic boundaries for therapists (Kessler & Waehler, 2005; Satterly, 2004; Taylor, Solts, Roberts & Maddicks, 1998). The 'Google factor' (Zur, 2008) represented a further non-verbal form of disclosure, as the sexuality of therapists could be researched using the Internet, which has not been reported within the literature.

The present study illuminates how disclosure of sexuality may not be perceived as a big deal by therapists. Similar to views expressed in the literature, there is an inherent anxiety and concern about the effects of TSD on clients (Farber, 2006; Knox et al, 2003), but interestingly, the idea that disclosure of sexuality specifically may be mundane and happen without much event seems novel. Furthermore, the disclosure of sexuality is believed to exert positive therapeutic effects in gay affirmative and feminist practices, indeed the current research also supports this; but there was also the finding that it may not be as significant as initially thought. The actual effects that disclosure of sexuality have on therapy were questioned, and it could be argued that its positive effects are related to the relationship and process issues within therapy, rather than on the psychological difficulties per se.

Reflection and Future Research Direction

Participants were difficult to recruit due to the restricted inclusion criteria and the limited number of male gay clinical psychologists within the profession. Whilst the inherent insider perspective of the first author (JL) was viewed as a strength of the study, it may also have meant that participants censored their accounts as they may have felt exposed discussing their sensitive experiences with a trainee clinical psychologist. Within the current study, participants own coming out experiences did not emerge as a rich theme related to participants disclosure of sexuality, however, future IPA research could focus on this issue, and explore whether therapists own experiences of coming out relate to their disclosure of sexuality to clients.

In terms of future research, the current findings represent one side of the story, and it would be invaluable to explore the views and experiences of gay male clients whose gay male clinical psychologist and/or therapist had disclosed their sexuality to them. As with the current study, semi-structured interviews could be conducted and analysed using IPA. A study of this nature would be an attempt to gain a more complete understanding of the helpful and unhelpful effects of TSD of sexuality on the therapeutic process from the client's perspective, which would aid therapists in their decision-making. It would also be helpful to explore the views and experiences of lesbian and bisexual clinical psychologists disclosing their sexuality to clients, as this would hopefully highlight similarities and differences within this intriguing and complex area. Fundamentally, more qualitative and quantitative research focussing on the

effects of TSD of sexuality is needed from both therapist and client perspectives, which will hopefully ensure that sexuality becomes visible in the therapy room, and in psychotherapy training.

First and foremost, findings from this study suggested that therapist disclosure of their sexuality is a complex issue, and that the reasons to disclose were influenced by the participants' insight into gay men's experiences, the therapeutic agenda, clinical context and the individual client. The study highlighted the participants' thoughtfulness regarding their decisions and reasons to disclose, suggesting that disclosing their sexuality could be beneficial, but also potentially unhelpful to their gay clients. It is hoped that these findings will generate discussion and reflection within the world of clinical psychology training, and in a small way help to make gay issues more visible. The piece also provides a narrative for gay trainees and qualified clinical psychologists that is based on the experiences of other gay clinical psychologists, which will allow exploration and reflection upon their own dilemmas regarding the disclosure of their sexuality to gay clients.

References

- Barker, M. (2006). Critical Sexology: Sexual self-disclosure and outness in academia and the clinic. *Lesbian and Gay Psychology Review*, 7, 292-296.
- Bartlett, A., King, M. & Phillips, P. (2001). Straight talking: An investigation of the attitudes and practice of psychoanalysts and psychotherapists in relation to gays and lesbians. *British Journal of Psychiatry*, 179, 545-549.
- Bartlett, A., Smith, G. & King, M. (2009). The response of mental health professionals to clients seeking help to change or redirect same-sex sexual attraction. *Psychiatry*, 9:11. Draft article accessed 01/05/2009 from <http://www.biomedcentral.com/1471-244X/9/11>
- Brauun, V. (2000). Heterosexism in focus group research: Collusion and challenge. *Feminism and Psychology*, 10, 133-140.
- Butler, C. (2004). Lesbian and gay trainees: The challenge of personal and professional integration. *Lesbian and Gay Psychology Review*, 55, 22-29.
- Butler, C. & Byrne, A. (2008). *Queer in Practice: Therapy and Queer Theory*. In L. Moon (Ed). *Feeling Queer or Queer Feelings? Radical Approaches to Counselling Sex, Sexualities and Genders* (pp. 89-105). Routledge: London.
- Coolhart, D. (2005). Out of the closet and into the therapy room: Therapist self-disclosure of sexual identity. *Guidance and Counselling*, 21, 3-13.
- Coyle, A. & Kitzinger, C. (2002). *Lesbian & Gay Psychology: A New Perspective*. BPS Blackwell Publishers Ltd.

- Crisp, C. & McCave, E. L. (2007). Gay affirmative practice: A model for social work practice with gay, lesbian and bisexual youth. *Child Adolescent Social Work*, 24, 403-421.
- Davies, D. & Neal, C. (1996). *Pink therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients*. Buckingham: Open University Press.
- Davies, D. (2007). Not in front of the students. *Therapy Today*, 18-21.
- DeCrescenzo, T. (1997). *Gay and Lesbian Professionals in the Closet: Who's In, Who's Out, and Why?* Binghamton, NY: HarringtonPark.
- Farber, B. A. (2006). *Self-disclosure in psychotherapy*. Guilford Press: New York.
- Fish, R. C. (1997). Coming out issues of gay and lesbian mental health professionals in voluntary and involuntary setting. *Journal of Gay and Lesbian Social Services*, 6, 11-24.
- Frommer, M. (1995). Countertransference obscurity in the psychoanalytic treatment of homosexual patients. In T. Domencici & R. C. Lesser (Eds). *Disorienting Sexuality* (pp. 65-82). New York: Routledge.
- Guthrie, C. (2006). Disclosing the therapist's sexual orientation: The meaning of disclosure in working with gay, lesbian and bisexual patients. *Journal of Gay and Lesbian Psychotherapy*, 10, 63-77.
- Hanson, J. (2003). Coming out: Self-disclosure as a therapeutic technique with specific application to sexual minority populations. *American Journal of Psychotherapy*, 62, 521-531.

- Hill, C. E. & Knox, S. (2002). *Therapist self-disclosure*. In J.C. Norcross (Ed). *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients* (pp. 255-265). Oxford University Press.
- Hodges, I. (2008). *Queer Dilemmas. The Problem of Power in Psychotherapeutic and Counselling Practice*. In L. Moon (Ed). *Feeling Queer or Queer Feelings? Radical Approaches to Counselling Sex, Sexualities and Genders* (pp. 7-22). Routledge: London.
- Kane, G. (2006). A case of an unplanned self-disclosure and the ethics guiding psychological practice with non-heterosexual clients. *Gay and Lesbian Issues and Psychology Review*, 2, 134-140.
- Kessler, L. E. & Waehler, C. A. (2005). Ethical Issues in Professional Practice: Addressing Multiple Relationships between Clients and Therapists in Lesbian, Gay, Bisexual and Transgender Communities. *Professional Psychology: Research and Practice*, 36, 66-72.
- King, M., McKeown, E., Warner, J., Ransay, A., Johnson, K., Cort, C., Wright, L., Blizards, R. & Davidson, O. (2003). *Mental health and social well-being of Gay men, Lesbians and Bisexuals in England and Wales: A summary of findings*. London, Mind.
- Knox, S. & Hill, C. E. (2003). Therapist Self-Disclosure: Research Based Suggestions for Practitioners. *Journal of Clinical Psychology*, 59, 529-539.
- Langdridge, D. (2007). Gay affirmative therapy: A theoretical framework and defence. *Journal of Gay and Lesbian Psychotherapy*, 11, 27-43.
- Lebolt, J. (1999). Gay affirmative psychotherapy: a phenomenological study. *Clinical Social Work Journal*, 27, 355-370.

- McFarlane L. (1998). *Diagnosis: Homophobic. The experiences of lesbians, gay men and bisexuals in mental health services*. PACE.
- Milton, M., & Coyle, A. & Legg, C. (2002). *Lesbian and gay affirmative psychotherapy: Defining the domain*. In A. Coyle & C. Kitzinger. (Eds). *Lesbian & Gay Psychology: A New Perspective*. BPS Blackwell Publishers Ltd.
- Milton, M. & Coyle, A. (2003). *Sexual Identity: Affirmative Practice with Lesbian and Gay Clients*. In R. Woolfe, W. Dryden & S. Strawbridge (Eds). *Handbook of Counselling Psychology (Second Edition)* (pp. 481-499). London: Sage.
- Moon, L. (2008). *Feeling Queer or Queer Feelings? Radical Approaches to Counselling Sex, Sexualities and Genders*. Routledge: London.
- Pixton, S. (2003). *Experiencing gay affirmative therapy: An exploration of clients' views of what is helpful*. *Counselling and Psychotherapy Research*, 3, 211-215.
- Rochlin, M. (1982). *Sexual orientation of the therapist and therapeutic effectiveness with gay clients*. In J. C. Gonsoriek (Ed). *A Guide to Psychotherapy with Gay and Lesbian Clients* (pp. 21-29). New York: Hawarth Press.
- Russell, G. M. (2006). *Different ways of knowing the complexities of therapist self-disclosure*. *Journal of Gay and Lesbian Psychotherapy*, 10, 79-94.
- Satterly, B. (2004). *Self-disclosure in gay male therapists: A qualitative assessment of decision-making*. Unpublished Dissertation. Obtained from UMI Dissertation Service: 3125893.

- Simi, N. L. & Mahalik, J. R. (1997). Comparison of feminist versus psychoanalytic/dynamic and other therapists on self-disclosure. *Psychology of Women Quarterly*, 21, 465-483.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, 261-271.
- Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds). *Qualitative Health Psychology: Theories and Methods* (p.219-240). London: Sage.
- Smith, J. A. & Osborn, M. (2004). Interpretative phenomenological analysis. In J. A. Smith (Ed). *Qualitative psychology: A practical guide to research methods* (pp.51-80). London:Sage.
- Taylor, G., Solts, B., Roberts, B. & Maddicks, R. (1998). A queer business: Gay clinicians working with gay clients. *Clinical Psychology Forum*, 119, 9-13.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.
- Zur, O (2008b). The Google Factor: Therapists unwitting self-disclosure on the net. *New Therapist*, 57, 16-22.

Appendix 1

Interview Schedule

Professional Background Information

- Number of years post-qualification experience (DClinPsy or equivalent).
- Region of residence and employment.
- Current place of work and client group.
- Therapeutic orientation.
- Approximate number of gay male clients worked with.
- Clinical settings where work with male gay clients took place.
- Types of therapy and/or intervention offered to gay clients.

Views of Own Sexuality

In your own words, how would you describe your sexual identity or sexuality?

How does your sexuality influence your role as a clinical psychologist generally?

Experiences of Disclosing and Not Disclosing Sexuality to Gay Clients

Can you tell me about your experiences of disclosing your sexuality to gay male clients? What are the factors that influence your decisions to disclose your sexuality?

Can you tell me about your experiences of not disclosing your sexuality gay male clients? What are the factors that influence your decisions to not disclose your sexuality?

Experience of 'Coming Out'

How has your own experience of 'coming out' in your life influenced your decisions regarding the disclosure of your sexuality to gay male clients?

Experience of Clinical Psychology Training

How has your own experience of clinical psychology training influenced your decisions regarding the disclosure of your sexuality to gay male clients?

Experience of Training on LGBT Issues

Have you any experience of receiving training relating to therapy with gay clients? If YES, how has this experience influenced your decisions regarding the disclosure of your sexuality to gay male clients?

Conclusion

Finally, in light of what we have discussed today, can you tell me how disclosing your sexuality to your clients actually makes you feel?

Journal Submission Guidelines

Notes for contributors to Psychology of Sexualities Review:

Articles

1. All articles will be peer reviewed. Article manuscripts (maximum 6000 words excluding references) should be typewritten in 12 point Arial font, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count (both for the entire article and for the abstract). ***N.b. Following a discussion with the editor, it was agreed that the empirical paper could be submitted with a word count of 8000 (including references).***

2. On a separate sheet, include the author's name, professional address, telephone number, email address and current professional activity. As all academic articles are subjected to blind peer-review, the rest of the manuscript should be free of information identifying the author(s).

3. Empirical, theoretical and review articles should include an abstract (maximum 120 words) and up to six key words that describe the paper (for indexing purposes). Words in the abstract may be conserved by: using digits for numbers (except at the beginning of sentences); using well-known abbreviations; using the active voice. Graphs, diagrams, etc. should be supplied in camera ready form. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., from other sources.

4. Full bibliographic references should be contained in the list of references at the end of each article. They should be listed alphabetically by author, be complete, accurate and in APA format (see <http://www.apastyle.org>). For example:

Journal Articles:

Peel, E. (2001). Mundane heterosexism: Understanding incidents of the everyday. *Women's Studies International Forum*, 24(5), 541-554.

Books:

Kitzinger, C. (1987). *The Social Construction of Lesbianism*. London: Sage.

Edited Books:

Rothblum, E.D. & Bond, L.A. (Eds.) (1996). *Preventing Heterosexism and Homophobia*. Thousand Oaks, CA: Sage.

Book Chapters:

Ellis, S.J. (2002). Student support for lesbian and gay human rights: Findings from a large-scale questionnaire study. In A. Coyle & C. Kitzinger (Eds.), *Lesbian and Gay Psychology: Newperspectives* (pp.239-254). Oxford: BPS Blackwell.

References within the text should be listed in alphabetical order separated by a semi-colon. Footnotes should be kept to a minimum.

5. In preparing your manuscript please avoid the following common errors:

- Omitting the page numbers of book chapters, or the issue number of journal articles.
- Using capital letters in titles or headings (except the initial character or character following a colon).
- Not using an ampersand where necessary.

If in doubt about any formatting issue, authors should consult the Editors or should adhere to the format used in past articles published in *Psychology of Sexualities Review*.

6. Authors should avoid the use of *sexist*, *racist* and *heterosexist language*. Authors should follow the BPS guidelines for the use of non-sexist language contained in this booklet: Code of Conduct, Ethical Principles and Guidelines (2004)

Steps 1 - 6 should be followed carefully before submission.

The article should be submitted as a Word attachment to the Editor: roshan.nair@nottingham.ac.uk with **Manuscript Submission LGPR** indicated in the email header. A copy should be retained by the author(s). Alternatively, three hard copies of the manuscript should be submitted. A copy should be retained by the author(s). Contributors are asked to supply a PC-compatible 3.5"disk.

Information for Journal Submission

Authors: James Lea, Dr Robert S. P. Jones and Dr Jaci C. Huws.

Address: North Wales Clinical Psychology Programme, 43 College Road,
School of Psychology, Bangor University, North Wales,
LL57 2DG.

Telephone: 01248 388365

E-mail:

James Lea is a trainee clinical psychologist at Bangor University. The research was completed as part of a Doctorate in Clinical Psychology. His research interests include sexuality development, gay culture, deaf culture and relational issues within psychotherapy.

Dr Robert Jones is a Consultant Clinical Psychologist and Head of Learning Disability Services within North Wales. He is also the deputy course director of the North Wales Clinical Psychology Programme at Bangor University.

Dr Jaci Huws is a lecturer at the School of Healthcare Sciences at Bangor University. Her research interests include qualitative methodology, social representation and social constructivism within autism and learning disability.

Section 6

Extended Discussion: Contributions to Theory and Practice

The research and theoretical evidence in the literature review suggested that intentional therapist self-disclosure (TSD) can be helpful, unhelpful or both on the therapeutic endeavour. Limitations of the reviewed research evidence were noted, and it appears that use and non-use of TSD is based primarily on theoretical constructs and personal perspectives. The results from the research study suggest that gay clinical psychologists felt that direct disclosure of their sexuality could have beneficial and potentially negative effects on psychotherapeutic work with gay clients. Results also suggested that the disclosure of sexuality is made more complex due to the roles of assumption, context and lack of relevant training on gay issues and TSD.

Implications for Future Research and Theory Development:

Based on the findings from the literature review, the main implication for future research is that more quantitative and qualitative investigations into the actual effects of TSD on therapy are needed. This would provide evidence for its use or non-use, rather than the current position, where assertion is believed synonymous with evidence. Much of the research findings used in the review were hindered by definitional and methodological limitations (Hill & Knox, 2001), such as the use of analogue studies with undergraduate students, which were then generalised to the consulting room as evidencing the positive effects of TSD. More recent research of actual client perceptions of TSD and

effects on therapy outcome suggest a rather mixed picture, and further research would provide a clearer and more useful reference for therapists. As a result of the review, the general lack of research and discourse regarding unintentional TSD was illustrated, and it would seem that this arguably equally relevant and complex clinical issue has not received the attention it warrants.

Directions for future research may include the use of comparable definitions of TSD, which would allow findings of studies to be compared and contrasted in a meaningful way. It would also be useful to make explicit the distinction between self-revealing and self-involving disclosures, and their corresponding effects on clients; presently, these details are swamped by the rather cumbersome umbrella term of TSD. Embracing and researching these distinctions may also have a positive effect on clinical practice, and may reduce the negative connotations associated with the generic label of TSD. This may be of particular relevance to those using relational psychodynamic models that involve self-involving disclosures more frequently than self-revealing disclosures (Bridges, 2001). Research could be aimed at exploring TSD within specific therapeutic orientations, and focus on the positive and negative effects of the disclosures believed significant in that approach, rather than focussing on whether the disclosure is appropriate or not, based on the models theoretical framework (e.g. client perceptions of the normalising effects of TSD within cognitive behaviour therapy). Moreover, as there appears to be no research into unintentional TSD, it would be useful to generally investigate this phenomenon, and explore what effect this had on clients and the therapeutic process. Interestingly, the use of interpretative phenomenological

analysis (IPA: Smith, Jarman & Osborn, 1999) to explore the area of TSD was not evident in the literature. The current research study suggests that this may be a useful methodology to explore views and possible effects of TSD, and this could be applied to explore client experiences.

Findings from the empirical study suggested that there was a complex relationship between sexual identity and the role of a clinical psychologist, with regards to disclosure of sexuality. Future research may focus more specifically on the interplay between the sexuality of clinical psychologists and how that relates to their role as psychologist when working with clients of the same sexuality. Equally significant identities to explore would include psychologists from other minority groups, such as racial, cultural and Deaf. Research also needs to explore the effects of TSD of sexuality from the perspectives of the client, as this might provide insights into its perceived benefits or limitations. As forms of unintentional TSD emerged as significant within the research, e.g. meeting clients on the gay scene, it would be useful to explore the effects of such inadvertent 'disclosures' on clients, and would provide a foundation for this under-researched area.

With regards to developing theory, the current review illustrated that there was some similarity between the reasons therapists disclose and the reasons that clients find it beneficial or unhelpful. The views of therapist and clients should inform the theory of TSD, although, at present, it would seem that the views and beliefs of therapists supersede those of the client. A more integrated approach to TSD is necessary, allowing the voices of both therapist and client

to be heard, as this might allow a more clinically relevant and clinically meaningful conceptualisation. Findings from the research study gave a voice to gay clinical psychologists, who were absent within the literature on disclosure of sexuality. This perspective is useful to generic and specific theories about TSD as it represents participant's own words, own phenomenological views of the world, and own frames of reference, which will hopefully provide a richness and realness to theory on TSD of sexuality. The thesis also supplements the theory of gay affirmative practice, and supports the idea of embracing and naming gay identities of both therapist and client as equal to the heterosexual majority. However, it should also be noted that some findings implicated potential negative effects of disclosing sexuality to gay clients, e.g. being viewed as a 'biased witness.' This suggests that gay affirmative theory, which is fundamentally political, is in many ways biased, and may not be balanced in its conception regarding psychotherapy: thus, therapist disclosure of sexuality may always be politically beneficial, but may not always be therapeutically beneficial.

Implications for Clinical Practice:

A clinically relevant application of the information within the literature review is to provide therapists with a relatively thorough account of the issues pertinent to TSD, especially the limitations of the evidence base. It is also hoped that it will allow therapist to reflect on their own beliefs regarding the beneficial versus unhelpful effects of TSD, and remind them that assertion is not equivalent to empirical evidence.

It is important to note that the findings of the research study do not attempt to reflect the heterogeneity of the wider population of gay clinical psychologists. The aim of an IPA study is not to produce generalisable results, rather, the aim is to explore and interpret the detailed experiences of a particular group, and to suggest the applicability of findings to clinical practice. As such, findings from the present study could be used to inform gay affirmative practice, as such practice highlights the unique issues faced by gay men within society, e.g. exclusion, homophobia and heterosexism, and the unique role of a gay therapist disclosing their sexuality within therapy, and the effects of this. The findings of the present study will hopefully be a useful reference for gay clinical psychologists considering disclosing their sexuality, and provide a practical guide to a complex decision. These clinical applications are especially topical given the findings of a recent report by Bartlett, Smith and King (2009) who surveyed 131 psychologists within the United Kingdom (UK), and found that 19 (5%) of practicing psychologists would attempt to change a client's sexuality if the client wanted such a therapy. Whilst it is important to note that 52% of the sample of psychologists reported that they would help the client accept their sexuality, it nevertheless illustrates the current rise of reparative therapies (i.e. therapies focused on changing one's sexuality from homosexual to heterosexual) (Zucker, 2003) within America and the UK. Gay affirmative practice in general, and the perspective of the current research represents an antithesis to the reparative therapies movement, which arguably represents explicit homophobia within psychotherapy, and illustrates that therapy can be abused and used as a form of social control.

The findings of the research suggested that Lesbian, Gay, Bisexual and Transgender (LGBT) issues, and specifically the disclosure of sexuality were not covered in any significant depth, if at all, on clinical psychology courses. Gay issues were not dealt with in mainstream clinical psychology training, and when there were taught components they were conceptualised as diversity and difference, which perpetuate heterosexual norms. This would suggest that there is inherent heterosexism and an invisibility of gay issues within clinical psychology training and the profession, which has previously been noted in the literature (Butler, 2004; Milton et al, 2002). These issues relate to Davies' (2007) argument that a "heterosexual bias permeates most therapy training programmes and therapy literature. From developmental theories through to the practice of therapy, a heterosexual lens is used" (p.19). In fact, Dominic Davies is the Director of Pink Therapy, which is an organisation providing LGBT affirmative therapy to clients, and offers the only course specifically focussing on sexual minority therapy. By highlighting the inherent heterosexism and invisibility of LGBT issues within clinical psychology training, it is hoped that this research provides useful information for course directors regarding the inclusion of LGBT psychology and therapy within wider clinical psychology training.

Furthermore, results also suggested that TSD was an area that did not receive much attention during training, and when presented was usually in conjunction with classical psychoanalytic ideas of the 'blank screen.' This discourse of non-disclosure leaves little room for trainees to consider and reflect on the possibility of disclosing their sexuality to a client. This rigid view of self-

disclosure may create anxiety about the disclosure of sexuality, and it could be speculated that training does a disservice to gay trainees, and simply compounds the anxiety when thinking about disclosing sexuality. As with LGBT issues, it is hoped that these findings will motivate clinical training courses to review and diversify their content and teaching around TSD.

It seems relevant to consider how the findings of the research paper may relate to professionals working within North Wales. As a gay trainee clinical psychologist within North Wales, I am unaware of any specific therapeutic services for LGBT people, and believe that therapists do not engage in gay affirmative practice. One of the only Lesbian, Gay and Bisexual (LGB) organisations within Wales is Stonewall Cymru, who have become more active in recent years, and have explored the experiences of LGB people accessing health and mental health services in Wales. In a recent report titled "Double Stigma" (2009), it was suggested that the LGB community within North and Mid Wales is rather dispersed due to the large geographical area, meaning that many LGB people have no real sense of community when compared to their counterparts in larger cities. Findings from the study also suggested that LGB people within North Wales access mental health services regularly, but have experienced discrimination while doing so. Stonewall Cymru propose that mental health services should: recognise LGB identities; raise awareness of LGB issues in administration and therapeutic staff; increase access to specific sexual health services and seek advice from the LGB community regarding service provision. Many of these proposals are comparable to the ideas presented within gay affirmative theory, and it is felt that this thesis could begin

the process of awareness raising within North Wales regarding therapeutic work with LGB clients. It would be of value for both heterosexual and non-heterosexual therapists and clinical psychologists to access aspects of this thesis to reflect on, and consider the work they do with LGB people within North Wales.

In conclusion, the current thesis has explored the models, assertions and evidence relevant to the use and non-use of TSD. It has also explored the experiences of a sample of gay clinical psychologists disclosing their sexuality to gay clients. The phenomenological approach within the empirical study enabled some professional thoughts and experiences of disclosing sexuality to be captured, and the interpretative nature of the analysis explored meaning and created themes relevant to the sample. Aspects of this thesis have a number of potential clinical implications, and will hopefully inform future research on the issue. It is hoped that this thesis will provide a reference for professionals with regards to TSD, and will supplement the extremely limited research on the disclosure of sexuality within therapy. Fundamentally, it is hoped that this thesis is meaningful and useful to gay clinical psychologists and therapists alike: for once you are the focus, and more importantly, you are included.

References:

- Bartlett, A., Smith, G. & King, M. (2009). The response of mental health professionals to clients seeking help to change or redirect same-sex sexual attraction. *Psychiatry*, 9:11. Draft article accessed 01/05/2009 from <http://www.biomedcentral.com/1471-244X/9/11>
- Bridges, N. A. (2001). Therapist self-disclosure: Expanding the comfort zone. *Psychotherapy*, 38, 21-30.
- Davies, D. (2007). Not in front of the students. *Therapy Today*, 18-21.
- Hill, C. E. & Knox, S. (2001). Self-disclosure. *Psychotherapy*, 38, 413-417.
- Pink Therapy (2009). <http://www.pintherapy.com>
- Maegusuku-Hewett, T., Raithby, M., Winter, B., Huxley, P. & Evans, S. Stonewall Cymru (2009). Double Stigma: The needs and experiences of lesbian, gay and bisexual people with mental health issues living in Wales. Accessed 03/06/2009 from:
http://www.stonewallcymru.org.uk/cymru/english/what_we_do/research_and_policy/lbg_mental_health_research_project
- Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds). *Qualitative Health Psychology: Theories and Methods* (p.219-240). London: Sage.
- Zucker, K. J. (2003). The politics and science of 'reparative therapy.' *Archives of Sexual Behaviour*, 32, 399-402.

Section 7

Word Counts

Title page	27
Overall Abstract	300
Table of Contents	136
Acknowledgements	300
Declarations	99
Total	862
 Section 1	
Ethical proposal	6515
Ethical proposal appendices	1898
Total	8413
 Section 2	
Amendments to study	65
Amendments appendices	1573
Total	1638
 Section 3	
Reflective commentary	1133
 Section 4	
Abstract	176
Literature Review	5330
References	1454
Journal submission guidelines	380
Total	7340

Section 5	
Abstract	119
Research paper	6623
Appendix 1: Interview schedule	273
Journal submission guidelines	526
Information for journal submission	142
Total	7683

Section 6	
Extended discussion: Contributions to theory and practice	2063

Section 7	
Word counts	142

Appendix 2: Example of interpretative phenomenological analysis	2137
Appendix 3: Main table of themes for empirical study	314
Total	2451

Total word count	31725
-------------------------	--------------

Appendix 2

Example of Analysis

Includes:

Initial table of themes (1).

Clustering of themes (2).

Table of themes (3).

Note: An actual transcript was not included due to the potential that this would compromise the participant's anonymity.

Initial Theme List (1)

Labels self as a gay man.

Link between sexuality and role as a clinical psychologist.

Presence of own sexuality more significant working in sexual health.

Insight and understanding into issues relating to clients sexuality.

Experienced coming out links to formulating clients difficulties.

Not assuming sameness because of sexuality.

Coming out is a lifelong process for anyone.

Knowledge of difference confirms that sharing same sexuality impacts of work.

Clients making assumptions, rather than direct self-disclosure.

Happy for assumptions about sexuality to be made.

Complexity of coming out in personal life, i.e. to family and friends.

Comfort with own sexuality links to comfort working with a gay client group.

Own experiences of coming out allows to understand clients difficulties with it.

Knowing and sharing coming out experience, but not necessarily fully understanding clients story and/or difficulties with the process.

Understand complexities for clients of how, when and whom to disclose to.

Tolerance and acceptance of sexuality.

Questioning whether clients are more comfortable because of shared sexuality.

Own sexuality means no right to judge clients sexuality.

Because gay doesn't mean you're same as every other gay man.

Interested what the meaning is when clients ask sexuality directly.

What is the meaning of my sexuality for the client.

Client needs to justify why they want to know.

If deemed a useful justification then will disclose.

Disclosure based on clients needs.

Clients expressing discomfort at disclosing gay sexual practices to a straight male therapist.

Disclose sexuality to allow client to feel more comfortable and disclose more.

Disclosure of sexuality leads to increased client disclosure: therapeutic benefit.

Previous reflection and discussion of how to manage client's questions of sexuality.

Disclosing sexuality not an issue if client can justify and is therapeutically helpful.

More clients assume sexuality, rather than directly question it.

Other ways of knowing therapist's sexuality.

Won't disclose if client is being nosey.

Won't disclose if it won't be therapeutically beneficial to the client.

Disclosing sexuality doesn't mean disclosing my experiences or life.

Clients trying to connect on sexuality may suggest some discomfort.

Trying to connect on sameness of sexuality may suggest unhelpful motives.

Meeting clients on the scene.

Increased chances of meeting clients outside therapy room because gay community is small.

Policy of not talking to clients outside the therapy room.

Work/life balance.

Disclosures are made on an individual basis.

Disclose if therapeutically beneficial – increased comfort and disclosure from client.

Clinical judgement of what is the therapeutic benefit.

If not knowing sexuality is problematic and client cannot engage then happy to disclose.

Won't disclose if client is moving focus from them to me.

If just client's curiosity, not therapeutically beneficial, then tell them it's not important for them to know.

Therapeutic boundaries: if meet outside will remove self from situation.

Boundaries and confidentiality: what if meet clients outside?

Vigilance of meeting outside therapy room: small size of gay community.

Other cues to knowing sexuality of psychologist: wearing rings, male psychologist working in sexual health.

Setting of work (sexual health), assume psychologist gay, but not medics.

Gaydar: cues into knowing sexuality of psychologist.

Out and proud: happy for clients to assume.

Different process of knowing – assuming Vs direct verbal disclosure

Sexuality: invisibly visible?

Clients don't always use sexuality in sessions: not an issue.

Clients pushing boundaries: wanting to know more.
No sex with clients.
Professional regulations state no sex with client.
Don't disclose because of own agenda or needs.
Clients don't need to know my sexuality for me.
Disclosing my sexuality is fine if it is helpful for client to know because of something in their story or history.
Shame around sexuality wouldn't lead to disclosure.
Tricky territory to disclose and give message, I'm gay so why is it such an issue for you?
Disclosing may make it about you and not the client.
Disclosing sexuality and sharing sameness doesn't remove differences.
It is beneficial for them to know given most assume anyway?
Shame and guilt need to work on therapeutically: is an issue for all gay men.
Sharing and understanding sexuality may allow you to help clients understand and gain insight into the impact of their sexuality on their depression.
Disclosing because of shame in client may be negative – talking about self and lose meaning of why they're in the room.
Disclosing because of shame may lose benefit of therapeutic relationship.
Timing of disclosure is important.
Shame and guilt need to be worked with sensitively.
Don't remember non-disclosure so well as disclosure of sexuality.
Feeling pressured by client to disclosure is warning signal.
Discomfort is clients want disclosure to act as a role model for what they should do.
Discomfort at being a role model.
Not beneficial to disclose if client will use your story rather than their own.
Acting as role model may be damaging long term for client.
More difficult to remember when no disclosure, as there's no story to follow on.
Confusion of sexuality in client may mean not helpful to disclose.
Disclosing may colour client's own views about their sexuality and be unhelpful.
Disclosing the complexity of coming out generically helpful as it normalises.

Disclosing that know that coming out is complex from personal experience can be helpful.

Disclosing I'm gay is no big deal, as long as there's justification, but don't need to know life and story behind that.

Clients don't need to know about personal story behind gay, but sometimes need to know that I am gay.

Slippery slope: fear of clients wanting to know more.

Disclosure of sexuality may set up precedence for them wanting more disclosure.

Never truly know what a client will do with a disclosure.

Disclosure done on an individual basis, assess on the spot.

Disclosure based on person of client and clinical judgement.

Wouldn't disclose if client doesn't respect the separateness of therapeutic boundary.

Gay psychologist: not very visible in the field.

As a trainee represented gay within clinical psychology.

Gay trainee linked to political views, also professional self and client group.

No formal training about disclosing sexuality to clients.

No real formal training on gay issues and therapy with this client group.

Potential for homophobia in clinical psychology.

Training gave understanding of generic therapeutic frame/boundaries.

Double message: reasons not disclosing and reasons for disclosing.

Being closed book always and not disclosing is unhelpful.

Discloses for client and therapeutic benefit, not own personal set of rules.

Small literature in this area is helpful to reflect and think about.

Belonging to same community that your clients do.

Outside of psychology, training on awareness of sexuality.

Provide training for others.

Disclosure feels, happy, no comfortable.

Disclosure not such a big deal if its just disclosing sexuality and not story behind it.

Settings, if not sexual health then what do you do with your sexuality then?

Clustering of Themes (2)

Insight into gay men's issues.

Understanding the coming out process.

The complexity of coming out.

The need to feel comfortable about sexuality with others.

Sameness and Difference.

Sexuality, shame and guilt.

Acceptance of client's sexuality

Client needing a justification to know.

Individuality of the client.

The impact of the client's history.

Disclosure for benefit of client.

Disclosure for the benefit of the psychologist.

Feelings of psychologist regarding disclosure of sexuality..'

Disclosure to allow client to feel comfortable.

Disclosure to allow client to disclose.

Disclosure as normalising.

Blank screen.

Times of non-disclosure more difficult to recall.

Meaning of clients trying to connect using sexuality.

Clients pushing the boundaries.

Moving focus to the psychologist.

Disclosing sexuality doesn't eradicate client difficulties.

Sexuality, shame and guilt.

Lack of discourse around professional guidance for disclosure, only no sexual contact.

Client assumptions.

Cues to psychologist's sexuality.

Belonging to the same community and culture that your clients do.

Influence of clinical setting.

Disclosing and giving the message I'm ok so should you be.

Client's confusion about their sexuality.

Clients need to find their own way to come out.

Being role model can be unhelpful.

Disclosing sexuality as no big deal.

Disclosing sexuality doesn't mean disclosing story behind it.

Does disclosure of sexuality have a positive effect on clients?

Invisibility of gay psychologists generally.

Impact of small, but relevant literature.

LGBT issues dealt with under difference in training.

Potential for homophobia in clinical psychology.

Table of themes (3)

Insight into the Gay World

- Insight into gay men's issues 1.11 'gay man working with gay men's issues.'
- The coming out process 1.17 'having gone through the process.'
- The complexity of coming out 4.8 'my story wasn't horrific or awful.'
- The need to feel comfortable about sexuality with others 3.26 'helping me to relax.'
- Sameness and Difference 5.11 'because you're gay doesn't mean you're the same.'
- Sexuality, shame and guilt 11.35 'every gay man has had some degree of shame.'
- Acceptance of client's sexuality 5.9 'I'm gay myself and have no right to judge.'

Reasons to Disclose Sexuality

- Client needing a justification to know 6.13 'depend on the reasons they want to know.'
- Individuality of the client 15.30 'you just have to assess on the spot.'
- The impact of the clients history 10.34 'its always if there's something within their story.'
- Benefit of client 18.28 ' I use it to help someone gain some benefit.'
- Comfort of client 5.28 'he wasn't comfortable disclosing some of the sexual practices.'
- Allow client to disclose 5.33 'was able to disclose some of the issues he had.'
- Normalising 14.4 'its not easy to come out, I know from personal experience.'
- Blank screen 18.22 'to be that closed book isn't always going to be the most helpful.'

- Disclosing sexuality doesn't mean disclosing story behind it 14.9 'not telling them the ins and outs of why, but to help them appreciate as a process its difficult.'
- Feelings associated with disclosure 21.2 'could be clichéd and say happy, but more comfortable and able to do it where it's appropriate.'

When Sexuality is Left Unsaid

- Times of non-disclosure more difficult to recall 13.13 'they're more difficult to remember because you decide to withhold, but there's no story to follow on with.'
- Meaning of disclosure for client 6.24 'when they try and connect with you on the gay.'
- Client's confusion about their sexuality 13.15 'other reasons that I might not disclose when they're having difficulty coming to terms with their sexuality or coming out.'
- Being role model 12.31 'I think was looking for someone to tell him how to do it.'
- Clients need to find their own way to come out 13.1 'it shouldn't be my story.'
- Pushing the boundaries 6.20 'they may push the therapist, they're curious.'
- Moving focus to the psychologist 7.29 'they're fed up of talking about themselves.'
- Giving the message I'm ok so should you be 11.12 'quite tricky territory to say well I'm gay so why is it such a big issue.'
- Disclosure doesn't eradicate client difficulties 11.16 'sharing that I'm gay doesn't mean that their difficulties disappear.'
- Sexuality, shame and guilt 12.15 'its something to handle very sensitively, they may not benefit from you disclosing at that point, if its around shame and guilt.'
- Needs of the psychologist 10.30 'never felt they needed to know because of my agenda.'

Non-Verbal/Intuitive Knowing

- Client assumptions 6.8 'a lot of them assume it rather than necessarily know.'
- Cues to psychologist's sexuality 9.18 'a gay man out on the scene may be more cued into who looks gay.'
- Belonging to the same community and culture that your clients do 6.28 'when I do go out on the gay scene they may see me.'
- Influence of clinical setting 9.9 'if you're working in HIV and you're a man, then you may possibly be a gay man.'

Influence of Training and Profession

- Invisibility of gay psychologists 16.31 'I sort of took it upon myself to be the representation of gay clinical psychology.'
- Impact of small, but relevant literature 19.2 'I think there are a couple of research papers, hugely influential.'
- LGBT issues dealt with under difference 19.35 'teaching in my training around dealing with difference.'
- Potential for homophobia in clinical psychology 17.23 'I felt that was homophobia at some level and addressed that directly with the course and the matter was dealt with.'
- No sexual contact with clients 10.22 'even if you're drop dead gorgeous.'

Disclosing Sexuality - Less Significant than Initially Thought

- Disclosing sexuality as no big deal 14.28 'bigger scheme of things telling them I'm gay is not big deal as far as I'm concerned.'
- Does knowing psychologists sexuality have a positive effect on clients 11.17 'would it benefit them to know I was gay, well given that a lot of them assume that I'm gay, maybe it isn't benefiting them a huge deal.'

Appendix 3

Main Table of Themes for Empirical Study

Master themes for the group					
1. Being Gay in a Straight World	Rhys	Nick	Jon	Neil	Kevin
Insider perspective	4.8	2.10	2.21	14.15	8.15
Relating to the straight world	11.35	-	4.31	4.27	4.34
Disclosure to allow comfort	5.28	-	3.19	5.19	-
Reciprocal disclosure	5.33	-	7.16	5.24	-
Normalising	14.4	5.7	-	8.3	8.3
Being real	18.22	5.26	13.7	-	7.32
Disclosure as beneficial	18.28	5.10	13.29	4.25	7.8
2. Disclosure and the Therapeutic Agenda	Rhys	Nick	Jon	Neil	Kevin
Disclosure for whom	10.30	5.29	-	11.19	17.24
Exploring motivation	6.13	6.9	-	5.13	-
An intuitive decision	-	-	-	10.18	-
Shifting boundaries	14.9	7.32	7.27	-	-
Biased witness	11.12	5.24	-	-	10.2
Confusion about sexuality	13.15	-	-	12.7	-
The gay psychologist	-	-	9.5	-	12.9
3. The Contexts of Disclosure	Rhys	Nick	Jon	Neil	Kevin
Assumptions in sexual health	9.9	3.8	3.9	6.5	-
Inpatient setting	-	-	13.24	-	10.18
Relationships with colleagues	-	-	8.15	-	12.22
Client choice	-	3.11	-	9.9	-

4. Other Ways of Knowing	Rhys	Nick	Jon	Neil	Kevin
Invisibly visible	6.8	3.6	6.33	-	6.19
Sharing the scene	6.28	11.19	4.14	-	-
Non-verbal cues	9.18	-	6.5	-	6.25
Google factor	-	-	-	5.1	13.6
Unconscious communication	-	-	-	7.21	-

5. Disclosure of Sexuality - A Big Deal?

The unexploded bomb	-	-	-	19.10	18.9
Sharing sexuality - Useful?	11.17	8.4	-	-	15.5
Disclosing sexuality - No big deal	14.28	-	-	20.2	-

6. The Invisible Curriculum	Rhys	Nick	Jon	Neil	Kevin
Gay - Invisible and overlooked	16.31	-	17.5	18.25	17.12
Gay - Umbrella of diversity	19.35	-	15.29	-	4.13
Guidance - No sex	10.22	-	19.2	17.4	-
Disclosure - The blank screen	-	3.31	14.31	10.15	14.23
Disclosure - Anxiety	-	10.8	-	-	-