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Molly C. Thomas
Shades of Gray: Lesbian
Therapists Explore the
Complexities of Self-
Disclosure to Heterosexual
Clients

ABSTRACT

The purpose of this study was to gain insight into the ways in which lesbian therapists negotiate self-disclosure of their sexual identity—or come out—to heterosexual clients and how such disclosures, or non-disclosures, affect the therapeutic relationship as well as the therapists' personal and professional identities.

Twelve lesbian licensed clinical social workers were interviewed for this study. Participants were questioned about their self-disclosure practices of sexual identity with heterosexual clients, how factors such as their work environment and aspects of their social identity shaped their thinking and practice of self-disclosure of sexual identity, and the extent to which issues of heterosexism and homophobia have emerged in their work with heterosexual clients, how such issues were addressed, and what impact they had on clinicians.

The findings of the research suggest general consensus among the participants with regards to these topics. A major finding was that participants practiced intentional self-disclosure of sexual identity with heterosexual clients on a case-by-case basis, informed by clinical judgment and experience, client variables, theoretical orientation, personal experiences, work environment, and the prevalence or absence of homophobia

and heterosexism. Another major finding was that participants were more apt to come out or consider coming out to queer clients than heterosexual clients. Additionally, therapist self-disclosure of a lesbian identity was found to be revealed or communicated in direct, indirect, behavioral, and unintentional ways. Implications for clinical practice and future research are presented.

SHADES OF GRAY: LESBIAN THERAPISTS EXPLORE THE COMPLEXITIES
OF SELF-DISCLOSURE TO HETEROSEXUAL CLIENTS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2008

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CHAPTER I

INTRODUCTION

According to the National Association of Social Workers 2006 study of licensed social workers in the United States, 81% of the profession is female (Whitaker, Weismiller, & Clark, 2006), although this varies by race and ethnicity. Women therefore make up a disproportionate number of licensed social workers in general compared to the percentage of women in the United States population (Whitaker et al., 2006). Although neither the National Association of Social Workers nor the United States government attempts to collect information on the percentage of people who identify as queer, it has been estimated that approximately 10% of the U.S. population identifies as gay or lesbian (Boslaugh, 2006). While demographic information on queer populations in the U.S. is hard to find and potentially problematic due to inconsistencies in classification, one could surmise based on the available estimation that a significant proportion of female licensed social workers do not identify as heterosexual. This study, therefore, seeks to make visible and give voice to some of the lesbian female social workers in the field in order to diversify and expand the social work literature and research.

The purpose of this study is to gain insight into the ways in which lesbian therapists negotiate self-disclosure of their sexual identity—or come out—to heterosexual clients and how they perceive the effects of such disclosures, or non-disclosures, on the therapeutic relationship as well as the therapists' personal and professional identities. In addition, this study also explores how certain contextual variables, such as work

environment, homophobia and heterosexism, and personal experiences, influence lesbian therapists' self-disclosure practices. Further, attention is paid to how lesbian therapists deal with clients' latent and manifest homophobia and/or negative reactions to self-disclosures of sexual identity.

Therapist self-disclosure has long been an area of interest within the fields of psychotherapy, counseling psychology and clinical social work, particularly as modern schools of thought have moved toward a deeper understanding and acceptance of the importance and use of transference and countertransference in the therapeutic relationship. Numerous studies have explored the controversial nature and complexities of therapists' self-disclosure to clients, yet there is a dearth of information and research that addresses the unique issues that queer therapists and, to a lesser degree, lesbian therapists face with regard to self-disclosure of their sexual identity.

In recent years, therapist self-disclosure issues specifically pertaining to sexual identity, such as the decision of lesbian, gay, bisexual, transgender and queer therapists to come out or not come out to clients and the implications that either decision has for the both the therapeutic relationship and the countertransference experiences of the therapist, have become the focus of a growing, albeit relatively small body of research (Carroll & Gilroy, 2000; Cole, 2006; Coolhart, 2005; Guthrie, 2006; Hanson, 2003; Mathy, 2006; Russell, 2006; Satterly, 2004; 2006). However, much of this limited research has focused on therapist disclosures of a minority sexual identity to lesbian, gay and bisexual ("queer") clients, and on self-disclosure issues for gay male therapists. While there is still the need for further research on the various issues that queer therapists face—particularly those pertaining to therapists of diverse racial, ethnic, and cultural backgrounds—scant

literature seems to exist that addresses queer therapists coming out to straight clients, an absence also noted by Coolhart (2005), Hanson (2003), and Lortie (2005).

This qualitative, exploratory study design utilized interviews with 12 lesbian identified licensed clinical social workers who work with adult heterosexual clients (although not necessarily exclusively.) These interviews provide rich narrative data on the conceptualization and practice of self-disclosure of a generally “hidden” sexual identity. This project is not an attempt to further categorize and/or marginalize persons with targeted social identities, but rather it is an attempt to include a more diverse range of voices in the on-going discussions about self-disclosure practices and to develop a keener understanding of the benefits and risks associated with disclosing a sexual minority identity to heterosexual clients within a culture that is primarily homophobic and heterosexist.

It is hoped that this study will contribute to a developing body of knowledge on the complexities of self-disclosure for queer clinicians and further an understanding of an area that is minimally addressed and explored in research. With little existing data from lesbian therapists on their thoughts and experiences regarding coming out to heterosexual clients, this study will hopefully provide a foundation for future research, build on the limited knowledge of this therapist population, and promote greater discussion and inclusion of the unique issues that queer therapists encounter with clients and colleagues of all sexual and social identities. Further, it is hoped that this research will speak to the question of how therapist self-disclosure of a lesbian identity to heterosexual clients could address heterosexism and homophobia both within the therapeutic relationship as well as the larger population.

CHAPTER II

LITERATURE REVIEW

This chapter provides a review of the literature on therapist self-disclosure, with a particular focus on the unique issues that lesbian clinicians face when negotiating disclosure of their sexual identity, including motivations for and benefits and risks of self-disclosure. Also included, to the extent that literature is available, are certain contextual variables that might influence a lesbian therapist's practice of self-disclosure of sexual identity, such as work environment, homophobia and heterosexism, and personal experiences. Due to the dearth of information in the literature on therapist self-disclosure of a lesbian identity specifically, this chapter draws from the broader literature on self-disclosure and includes research on therapist self-disclosure of a lesbian, gay, bisexual and queer identity or orientation.

Given the heterosexist society in which we live, most people, including therapists, are typically assumed to be heterosexual. A lesbian or queer sexual identity in particular is generally a "hidden" characteristic, as well as a stigmatized one, and can have profound implications on the therapeutic relationship when revealed or disclosed and, paradoxically, when it is concealed or not disclosed. Historically, the psychoanalytic position was that all therapists were heterosexuals and if they were not, they had to pretend that they were (Cole & Drescher, 2006). Therefore, queer therapists often bear the additional pressure of feeling the need to hide or protect their sexual identity or orientation for fear of the effects such disclosure would have on the therapeutic

relationship, their personal lives, and their careers. A number of factors that continue to be considered in the broader research on self-disclosure—such as the usefulness of self-disclosure, its effect on the client, theoretical rationale, timing, intentionality, content, potential benefits and risks, and whether or not it is in fact a therapeutic technique—are also being discussed with specific attention to self-disclosure of a minority sexual orientation or identity.

For lesbian therapists, self-disclosure of one's sexual identity—or coming out—within the therapeutic relationship is a complex and multifaceted issue that is rarely examined in literature on self-disclosure. Some literature has discussed queer therapists working with queer clients and, although this area warrants further research and attention, very little is known about lesbian therapists' experiences of negotiating self-disclosure of their minority sexual identity specifically to heterosexual clients. In more recent years, as lesbian and queer clinicians and researchers have become more visible in the field, they have begun to explore and write about the unique self-disclosure issues that queer therapists face in their work with queer clients, and to a lesser extent with heterosexual clients (Cole & Drescher, 2006; Coolhart, 2005; Gabriel & Monaco, 1995; Guthrie, 2006; Isay, 1991; Mathy, 2006; Pearlman, 1996; Satterly, 2006).

This study aims to contribute to and deepen the discussion on self-disclosure practices within therapeutic relationships, particularly as they relate to lesbian and heterosexual therapy dyads. Further, it aims to explore and develop a deeper understanding of the impact of homophobia as well as one's sexual, professional, and social identities on therapist self-disclosure of a lesbian sexual identity.

Definitions

Throughout much of the literature, the term “sexual orientation” is not clearly defined or is used more frequently to refer to or indicate a non-heterosexual orientation or to describe a person’s sexual behaviors. For the purposes of this study, I will employ the term “sexual identity” to refer to the identity a person chooses for herself, regardless of that person’s behaviors or relative attractions to persons of different sexes. Individuals who engage in same-sex sexual behaviors or who have same-sex sexual attractions may not identify as lesbian, gay, bisexual, queer, etc., so this is an important clarification. However, in the review of the literature, I will employ the terms used by each researcher, although it should be understood by the reader that the term “sexual orientation” may be used to mean “sexual identity” or something akin to “sexual identity.”

Also for the purposes of this study, “therapist” will be defined as a licensed clinical social worker of any theoretical background, and the terms “therapist,” “clinician,” and “psychotherapist” will be used interchangeably and hold the same meaning throughout this study. “Queer” will be used interchangeably with “LGBTQ” (lesbian, gay, bisexual, transgender, queer) when discussing or referring to a group consisting of people of any gender who identify as a sexual minority. “Lesbian” will be used to refer to the study participants in aggregate, although when reporting the participant’s own words, I will use the original term(s) provided by the participants.

Therapist-Self Disclosure

What is Self-Disclosure?

There are numerous definitions of therapist self-disclosure (TSD) that have been described and used in the literature, as well as differing thoughts concerning the content and rationale for TSD (Andersen & Andersen, 1985; Knox, Hess, Petersen, & Hill, 1997; Knox & Hill, 2003; Palombo, 1987; Robitschek & McCarthy, 1991; Weiner, 1983; Wells, 1994; Yalom, 2002). The lack of a consensual definition for what constitutes therapist self-disclosure, according to Farber (2006), has complicated clinical studies and discussions about its benefits and drawbacks, and has hindered the advancement of theory and research in the area. A significant part of the problem, he contends, is that therapist disclosures “tend to fall on the boundary between personal and professional behavior” (Farber, 2006, p. 106).

In the broadest sense, self-disclosure “can refer to any behavior, verbal or nonverbal, that reveals information about a person” (Farber, 2006, p. 133). The majority of research on self-disclosure, however, has focused on intentional verbal self-disclosure. In Simon’s (1988) study on criteria for therapist self-disclosure, for example, she qualified the type of self-disclosure as “intentional” and defined “intentional self-disclosure” as “verbal behavior through which therapists consciously and purposefully communicate private information about themselves to their patients” (p. 405).

The contributions of several authors led to additional definitions of self-disclosure that encompass not only factual information about the therapist that he or she verbally communicates to the client, but also feelings that the therapist has experienced in his or her life and/or feelings he or she experiences toward the client that the therapist reveals to

the client (Mathews, 1988; Weiner, 1983). With the addition of new definitions, subdivisions have emerged that attempt to further refine those definitions and qualify and distinguish self-disclosures from one another. For example, a number of authors have differentiated self-disclosures, or self-revealing statements (statements of factual information about oneself such as personal characteristics), from self-involving responses (statements of emotional reactions to clients that occur within the treatment setting) (Andersen & Anderson, 1985; Farber, 2006; Knox et al., 1997; McCarthy & Betz, 1978; Robitschek & McCarthy, 1991; Watkins & Schneider, 1989). Differentiations have also been made between positive disclosures (sharing favorable information about one's experiences) and negative disclosures (sharing unfavorable information about one's experiences) as well as between past and present personal experiences, and similar and dissimilar statements (Farber, 2006; Knox et al., 1997).

These divergent viewpoints and definitions make it difficult to generalize across studies on therapist self-disclosure. Some studies consider self-involving statements to be a separate entity altogether from self-disclosure, while others do not distinguish between the two, choosing instead to adhere to a more global definition of self-disclosure in order to capture a broad range of data and therapist self-disclosures. Self-involving disclosures, however, have been found to be difficult to isolate for research purposes "because they tend to blend with the constant give-and-take of typical therapeutic interactions" (Farber, 2006, p. 134), which may help to explain the focus within the research and literature on verbal and factual disclosures.

While it is now widely accepted that a therapist cannot truly remain anonymous, there is a lack of attention within the literature to unintentional, indirect and non-verbal

forms of self-disclosures—an area that is garnering increased interest to many but is researched less frequently (Farber, 2006). Most research focuses on direct, intentional and verbal disclosures, which neglects to consider other forms of disclosures and their impact on the client and treatment relationship, and which may be particularly relevant to the discussion on disclosure of a lesbian sexual identity. For instance, a therapist's appearance, gender expression, style of dress, tone of voice, demeanor, office décor, and non-verbal cues, such as body language or facial expressions, are also types of self-disclosures and reveal personal information about a therapist to a client.

One frequent self-disclosure that is often overlooked in the literature and in practice, but that holds great meaning is the display of a wedding ring. The fact that the literature does not acknowledge or identify a wedding ring as a type of self-disclosure or explore its meaning reveals inherent bias or heterosexist assumptions; it assumes that most or all clinicians who wear a wedding ring are heterosexual or will be perceived as such. This oversight also assumes that the disclosure of a heterosexual marriage—and therefore, perhaps, a heterosexual identity—is not a type of self-disclosure or that it is a different type of disclosure than the direct disclosure of sexual identity. While it is certainly true that not all heterosexual clinicians are married and/or wear a wedding ring if they are, the general assumption in society and in the literature on self-disclosure equates wedding rings and marriage with heterosexuality. With the legalization of same-sex marriage in Massachusetts, and most recently in California, marriage is no longer an exclusively heterosexual institution. Thus, the existence of same-sex marriage challenges the predominant assumption that anyone who wears a wedding band is heterosexual. The term 'marriage' is now a more ambiguous term; when a clinician reveals that she is

married it does not inherently indicate the gender of her or his partner. As more and more people integrate the changes taking place in society, the assumptions that the professional community, researchers, and clients make about the sexual identity of married therapists will likely begin to change as well.

Due to the controversial nature of therapist self-disclosure combined with a lack of uniformity regarding the definition of self-disclosure, it is important to be clear about definitions. For the purposes of this study, therefore, therapist self-disclosure will mean disclosures which are either or both self-revealing and self-involving, and will include information (i.e., thoughts, feelings, behaviors, etc.) about a therapist that is communicated to a client through verbal, behavioral, intentional, and unintentional communications, cues or disclosures. This study will specifically focus on therapist self-disclosure of a lesbian sexual identity which, as noted by Hanson (2003), tends to apply most to the self-revealing aspect of this technique. However, while self-involving and behavioral disclosures may prove difficult to identify, it is important to include them in this study particularly because, as noted by a number of authors, the disclosure of a queer or lesbian sexual identity can and often does occur in a myriad of ways.

Variations of Thought on Self-Disclosure

Theory and practice of self-disclosure has dramatically evolved from the early days of psychotherapy to the present. However, therapists' self-disclosure to clients remains a controversial matter. The issue of self-disclosure has its roots in Freud's classical psychoanalytical notion of neutrality, which conceived of therapists as a blank screen and advised that therapists maintain their anonymity and remain non-disclosing within the therapeutic relationship (Coolhart, 2005). It was believed that the more the

analyst revealed of him or herself, the less the patient would reveal. This traditional approach was considered to be essential for “uncovering, interpreting, and ultimately resolving clients’ transference” (Knox & Hill, 2003, p. 530), and it was theorized that any therapist self-disclosure or use of self within the therapeutic relationship might interfere with the client’s transference and adversely affect treatment outcome (Barrett & Berman, 2001).

Traditional psychodynamic theorists have argued that therapist disclosures may expose therapist weaknesses or vulnerabilities and thereby undermine client trust in the therapist (Barrett & Berman, 2001). Further, therapist disclosure may burden patients, shift attention to analysts’ needs and feelings, exclude learning opportunities by preventing fantasies, cause vulnerable patients to overly identify with their analysts, and, at times, seem seductive (Farber, 2006). Disclosure of the analyst’s countertransference feelings or any other form of purposeful self-disclosure was strictly avoided by classical analysts and was not perceived of or used as a useful therapeutic technique or intervention as it is today. Psychoanalytic therapists who adhered to the stance of neutrality, however, did acknowledge that total anonymity was impossible because certain aspects of themselves would inevitably be revealed or disclosed to clients, such as office décor, gender, approximate age, physical appearance, and nonverbal body language (Farber, 2006; Knox & Hill, 2003; Simon, 1988). Nevertheless, these disclosures were thought to be regrettable aspects of the analytic situation (Farber, 2006).

Over the past several decades and among many schools of analytic thought, there has been a dramatic shift in thinking about and understanding of the use of therapist self-disclosure in the therapeutic relationship. In contrast to the classical view on therapist

self-disclosure, Sidney Jourard, among others in the humanist movement of the 1950's and 1960's, suggested that therapist self-disclosure can not only have a positive impact on treatment, but that therapist self-disclosure may in fact elicit greater and authentic disclosures by the client (Barrett & Berman, 2001; Matthews, 1988). From this view, therapist self-disclosure and transparency from the therapist are thought to “encourage an atmosphere of honesty and understanding between client and therapist, fostering a stronger and more effective therapeutic relationship” (Barrett & Berman, 2001, p. 597). Further, therapist transparency and self-disclosures may allow clients to see their therapists as more humane, may normalize clients' struggles and make clients feel more hopeful, and may permit therapists to serve as role models to clients (Knox, et. al, 1997).

The feminist movement in the 1980's added a political dimension to the debate, as advocates openly supported the appropriate use of therapist self-disclosure as a means by which to equalize the power relationship—to the extent possible—within therapy, empower the client, foster a sense of solidarity for the client and between client and therapist, reduce a client's feelings of shame, encourage a client's feelings of liberation, and help convey feminist values (Hanson, 2003; Simi & Mahalik, 1997). Additionally, therapist self-disclosure of theoretical orientation, political and religious ideal, sexual orientation, socioeconomic background and other values, if disclosed early on, was thought to help clients make informed choices about the therapist with whom they work (Knox & Hill, 2003; Simi & Mahalik, 1997).

Therapists who align with cognitive-behavioral orientations also view therapist self-disclosures as potentially beneficial to the therapeutic process, as such disclosures may improve the therapeutic bond and foster client change (Knox & Hill, 2003). In the

field of family therapy, self-disclosure has been supported by many therapists, for the most part, in order to facilitate joining, add affect, and increase collaboration (Coolhart, 2005). Similarly, therapists of a multicultural orientation support therapist self-disclosure as a way to develop a client's trust, particularly when therapists work with clients who are culturally different from themselves (Sue & Sue, 1999).

The conceptualization and practice of therapist self-disclosure has clearly changed over time and varies across a wide range of theoretical orientations. According to Farber (2006), as psychotherapy shifted from a focus on intrapsychic issues to a primary focus upon interpersonal issues, the relationship and nature of communication between therapist and client has become a more prominent part of the therapeutic process. The therapist is not perceived as the only expert in the room but rather she is part of system in which two people interact, impact one another, and reveal parts of oneself to the other, both intentionally and unintentionally (Farber, 2006). Therapist self-disclosure is now considered by many to be a therapeutic technique rather than something forbidden or to be avoided. Nevertheless, there continues to be ongoing discussions and debates within the field regarding appropriate guidelines and techniques for therapist self-disclosure, the impact and effectiveness of therapist self-disclosure, therapists' motivations for self-disclosure, and considerations for therapist self-disclosure by and to specific populations of people, particularly sexual minorities. Although there is a growing, albeit very small, body of literature that addresses the self-disclosure practices of queer therapists, little is known about the specific self-disclosure practices and experiences of lesbian therapists who work with heterosexual clients. The focus of this study is intended to begin to fill this gap.

Frequency and Patterns of Therapist Self-Disclosure

The literature and research concerning the prevalence, content, types, and usefulness of therapist self-disclosure being practiced is fairly extensive. It is beyond the scope of this project to examine the full range of research on the topic; however, the most pertinent information has been distilled and included herein for the readers.

Researchers have not been able to come up with a figure for the frequency of self-disclosure due to inconsistencies with the definition of therapist self-disclosure and numerous forms of measurement (Farber, 2006). A number of studies have found that most therapists practice self-disclosure at some point in their therapeutic work, although there was a large amount of variability (Anderson & Mandell, 1989; Berg-Cross, 1984; Edwards & Murdock, 1994; Simi & Mahalik, 1997). However, Hill and colleagues have produced evidence based on studies and a comprehensive review of the literature that indicates that intentional therapist self-disclosure is, in fact, a rather uncommon occurrence, yet it is used by many clinicians.

Hill and Knox (2002) found that across several studies, 1-13% of all therapist interventions were self-disclosures. In one study of actual therapy, self-disclosures accounted for only 1% of therapists' total responses to clients (Hill et al., 1988). This behavior, however, received the highest client helpfulness ratings and led to the highest level of emotional experiencing. Hill et al. hypothesized that therapists' infrequent use of disclosures contributes to the potentially profound impact and value of these interventions. The effect of the intervention may be reduced if therapists disclose either too frequently or too infrequently, whereas therapists who never disclose may be experienced by clients as less "human", aloof, and impenetrable, which may compromise

the therapeutic relationship (Hill et al., 1988; Watkins, 1990). Therapists who disclose too frequently or inappropriately, on the other hand, may be experienced as having loose or questionable therapy boundaries as the focus becomes the therapist and not the client (Hill et al., 1988; Watkins, 1990). Many researchers and authors suggest that while therapist self-disclosure may be a helpful intervention, its frequency and intentionality should be carefully considered and monitored.

Existing research on the content or topic of therapist self-disclosure indicates that the most frequently disclosed topics relate to therapists' professional background (e.g. degree, therapy style, and training), beliefs about the efficacy of therapy, and apologies for clinical mistakes (Edward & Murdock, 1994; Knox & Hill, 2003; Lane et al., 2001 as cited by Farber, 2006; Robitschek & McCarthy, 1991). A frequently cited study by Anderson & Mandell (1989), found that therapists also often disclosed about their personality, personal history, and current relationships (Simi & Mahalik, 1997). Some of the least frequently disclosed topics include sexual practices and beliefs, therapists' dreams, physical attraction to patients, and personal problems (Edward & Murdock, 1994; Knox & Hill, 2003; Lane et al., 2001 as cited by Farber, 2006; Robitschek & McCarthy, 1991).

Within these studies, however, there seems to be some inconsistency and heterosexist bias in terms of how disclosures such as personal history, current relationships, and sexual practices are defined and/or presented. Whether or not therapists have children and their marital status, for example, is information that is often included under the terms 'personal history' or 'personal information' (Knox & Hill, 2003), and sexual orientation often falls under the category of 'sexual practices and beliefs.' The

failure to acknowledge that the disclosure of marital status frequently also reveals sexual orientation exhibits bias and makes it difficult to determine how frequently disclosures of sexual orientation—particularly a heterosexual orientation—are actually made. Based on the information available, it seems likely that disclosures of a heterosexual identity may in fact be a more common type of disclosure than the existing research would indicate.

Some studies have found that a therapist's theoretical orientation affects the use and frequency of self-disclosure. For example, therapists who espouse a humanistic/experimental orientation and view self-disclosure as an expression of realness, openness, honesty, and communication (Edwards & Murdock, 1994; Simon, 1988) tend to disclose more than psychoanalytic therapists. Simi and Mahalik's (1997) study indicates that therapists of a feminist orientation are more likely than therapists of a psychoanalytic/dynamic or other orientation to disclose salient aspects of their personal background—including political beliefs, class and religious background, and sexual orientation—endorse the use and “feminist principles” of self-disclosure, and disclose as a means of promoting an egalitarian relationship between therapist and client.

The self-reporting inventory used in their study, however, did not ask therapists to indicate how they self-disclosed, which could have implications for the results, particularly with regard to the frequency of self-disclosure of sexual orientation. As discussed earlier, information about one's sexual identity can be disclosed indirectly and non-verbally by wearing wedding/commitment rings, behavioral cues, or through other means. However, the literature seems to indicate that many researchers and clinicians do not consider these to be disclosures of sexual identity or do not examine the unintentional and behavioral ways in which clinicians, particularly heterosexual clinicians, disclose

their sexual identity. It is therefore possible, that the clinicians in Simi and Mahalik's study disclosed with similar frequency as clinicians of other theoretical orientations, but that they did so more intentionally, thoughtfully and directly.

Another variable that has been found to impact the use of therapist self-disclosure is the therapist's own experience in therapy. One study found that therapists who themselves had a disclosing therapist are especially likely to self-disclose with their own clients (Simon, 1990). Additionally, a later study found that clinicians who report having had a positive experience of self-disclosure in their personal therapy are more likely to self-disclose in their own practice (Simone, McCarthy, & Skay, 1998).

There is also clinical evidence to suggest that therapist experience level may affect the type and process of therapist self-disclosure (Farber, 2006). Inexperienced therapists, for example, may rely more heavily upon and follow the perceived "rules" of therapy more strictly and, therefore, avoid making any kind of personal disclosures. Others may disclose certain things to attempt to establish an informal therapeutic relationship or to achieve greater personal comfort (Farber, 2006).

Additionally, the therapist's practice setting may influence self-disclosure practices. Therapists in private practice typically have greater control over the rules of therapy as well as the actual physical office space than do those in institutional or agency settings. Many therapists are beholden to the rules and restrictions of the agency for which they work, which could include rules about self-disclosure.

The use of therapist self-disclosure has not been found to be greatly affected by biological sex (Edwards & Murdock, 1994; Robitschek & McCarthy, 1991; Simone, et al., 1998) or racial or ethnic origins (Edwards & Murdock, 1994). However, Edwards &

Murdock (1994) support a suggestion made by Watkins (1990) that the biological sex of practitioners may be less influential than their sex role orientation. In the Edwards & Murdock study, 88% of the 184 participants were Caucasian and only 12% identified as Hispanic, African-American, Asian, or “other;” the sample size of participants of color is not great enough to generalize these findings. More research is needed to discern whether or not a therapist’s race and/or ethnicity impacts self-disclosure practice, as the number of participants of color included in most studies is minimal. The aforementioned studies are also at least 10 years old and likely are not representative of the current demographics of mental health professionals or students. Additionally, previous research has not been conducted to determine whether or not the use or frequency of self-disclosure varies based on the therapist’s sexual identity, which represents a significant gap in the literature.

Reasons and Motivations for Therapists Self-Disclosures

Studies of therapists, as well as theoretical articles, have revealed a variety of reasons and motivations for self-disclosing within the therapeutic relationship. Some rationales or guidelines may correspond most with certain modalities, and some may be more generally used. While most of the findings on and guidelines for therapist self-disclosure do not explicitly mention disclosures of sexual orientation or identity, they have served as a foundation for the research that does exist in this area and are still relevant. Lane, Farber, and Geller (2001) found that the three most common reasons given by therapists for utilizing self-disclosure with patients were “strengthening the therapeutic alliance, normalizing the patient’s experience, and providing the patient with

alternative ways of thinking” (Farber, 2006, p. 139), findings that are in line with other literature in the area (Knox & Hill, 2003; Knox et al., 1997; Simon, 1988).

Other reasons cited for therapist disclosure were to provide information, enhance the perceived similarity between therapist and client, model behavior, offer clients different ways to think and act, satisfy clients’ desires that therapists disclose (Hill & Knox, 2002), and validate reality (Mathews, 1988). Evidence from both clients and therapists suggests that another function of therapist disclosure is that it encourages patients’ own disclosures (Knox & Hill, 2003); the more a therapist is willing to disclose personal information or feelings toward the client and be seen as more human, the more likely the client is to open up, provided that the therapist discloses judiciously and appropriately so as not to overburden the client.

Similarly, research on cross-racial and cross-cultural therapy dyads indicates that therapist self-disclosure can be a tool for developing and maintaining therapeutic alliances between clients of color and their therapists (Constantine & Kwan, 2003; Sue & Sue, 1990). For example, some clients of color may be more willing to engage with and trust culturally dissimilar therapists who self-disclose, particularly related to issues such as theoretical orientation and credentials, and sensitivity and skills in dealing with ethnic and racial matters (Constantine & Kwan, 2003).

Finally, as noted by Hanson (2003), some authors believe that a client’s right to make informed decisions is, to a certain degree, dependent upon therapist self-disclosure. As consumers, some believe that clients “have a right to know therapists’ values, positions, views or experience about some potentially controversial issues such as sexual orientation, abortion or religion in order to be able to evaluate the quality of the therapy

they receive” (Hanson, 2003, p. 4). While some clients may seek out such information from therapists in order to eliminate them for consideration so as to not be subtly influenced by their beliefs, other clients may seek out therapists whose beliefs, attitudes or personal characteristics are most similar to their own. If therapists disclose certain requested information upfront, clients can potentially have more control over what they chose to be influenced by (Hanson, 2003).

Throughout the literature the two most frequently endorsed reasons for not utilizing therapist self-disclosures with patients, on the other hand, are the therapist’s sense that a disclosure might interfere with the flow of the client’s material and could shift the focus of attention from patient to therapist (Farber, 2006). After therapists self-disclose, it has been recommended that they return the focus back to clients so that the clients receive the message that the proper focus of the therapeutic work is on them, not the therapists (Knox & Hill, 2003), and they do not feel overwhelmed or over-burdened with worries about the therapists. In the Anderson and Mandell (1989) survey of 365 practicing social workers, nearly half of the respondents cited the most common reasons for not disclosing to clients were shifting focus from the client, decreasing time available for client disclosure, interfering with the transference, creating role confusion, and deviating from the client’s expectations of professional behavior.

Another of the least endorsed reasons for therapist self-disclosure, as noted by therapists in various studies, was disclosing to meet the therapist’s own narcissistic needs to feel, for example, useful, smart, or friendly (Farber, 2006; Hill & Knox, 2002). In the Lane et al. (2001) study, as noted by Farber (2006), some therapists felt they should not act on their own self-gratifying needs or at least felt they could not acknowledge having

done so (Farber, 2006). However, Farber (2006) raised an important question related to the limits of permissible self-gratification for therapists: “to what extent are the personal benefits of self-disclosure (e.g., experiencing a sense of genuineness or mutuality) acceptable either because the patient is also benefiting or because occasional ego gratification is deemed reasonable or even necessary in the context of a positive therapeutic relationship?” (p.153). More therapists, particularly in the humanistic and relational fields, are also considering how their own needs to experience intimacy, gratification, or authenticity play a role in their interactions with clients and in the development of a professional identity as a therapist.

There are a number of dilemmas underlying the decision to disclose in general, particularly in cases in which the potential benefits and risks seem equally balanced. After all, the potential impact of a disclosure, or non-disclosure for that matter, may not be known until after it is made and sometimes, may never be fully known to the therapist. Nevertheless, with regard to motivations for self-disclosure there is general consensus among researchers and therapists that therapists should closely examine their motivations for self-disclosure and that self-disclosures should only be used when in the best interest of the client—when disclosure will aid in the client’s therapy and/or is appropriate for a particular client. The majority of literature on self-disclosure, however, does not examine the reasons and/or decision-making process associated with therapist self-disclosure of a non-heterosexual sexual orientation or identity. Further research is needed to provide a more thorough understanding and a diverse representation of the self-disclosure practices of all clinicians, especially those whose voices have consistently been under-represented or ignored.

Biases Revealed

A review of the research and literature on self-disclosure reveals inherent biases that are largely reflective of heterosexist assumptions held within the dominant culture which may impact the design and implementation of some studies and limit the usefulness of the results. Heterosexism has been defined as “a world-view, a value-system that prizes heterosexuality, assumes it as the only appropriate manifestation of love and sexuality, and devalues homosexuality and all that is not heterosexual” (Herek, 1986, p. 925 as quoted by Ritter & Terndrup, 2002, p. 12). In particular, the research designs, research questions and sample populations used in numerous studies highlight the lack of attention paid to diversity, including sexual orientation/identity, race and ethnicity, and heterosexist assumptions.

Throughout the literature, disclosures of sexual orientation or sexual identity have primarily been discussed or considered when the orientation or identity is a lesbian, gay, or bisexual one. This, in and of itself, exhibits bias on the part of researchers and theorists who often fail to recognize that a heterosexual orientation is, in fact, a sexual orientation. However, since heterosexuality is considered to be normative and is institutionally and socially promoted to be the preferred and acceptable sexual orientation, the term “sexual orientation” tends to be used to describe those who identify as gay, lesbian, or bisexual; such identification contributes to separating “the powerful and the powerless into mutually exclusive categories” (Ritter & Terndrup, 2002, p. 12) and further reinforcing heterosexist assumptions and ideals.

Examples of bias can be also seen in studies that fail to define sexual orientation—and again, seem to imply a homosexual orientation when mentioned—or

place it on a subscale of sexual behaviors and attitudes as opposed to one of identity (Edwards & Murdock, 1994; Hendrick, 1988). The primary association of a gay or lesbian orientation with sexual acts or thoughts is a reductionistic and diminishing one; further, it is reminiscent of pervasive and harmful societal attitudes that equate homosexuality with sexual perversion and promiscuity. Heterosexist bias is also evident in studies that fail to identify sexual orientation or sexual identity as a client or therapist variable but instead collect information on the participants' sex and/or marital status, (Anderson & Mandell, 1988; Edwards & Murdock, 1994; Farber, Berano and Capobianco, 2004). These studies seem to assume that participants are heterosexual and that they could only be married, unmarried or divorced—all relationship status indicators that privilege heterosexuality and marriage. Similar problematic study designs associate “marital status” with “personal information” whereas “sexual orientation” seems to fall into a separate category or indicate a different degree of personal disclosure—presumptively, a more taboo form of disclosure.

Hendrick (1988) developed the Counselor Disclosure Scale to explore the types of disclosure desired by clients. A questionnaire administered to 235 undergraduate students asked the students to rate their interest in hearing about 38 different kinds of counselor disclosures. The specific disclosures were grouped into broader categories including, interpersonal relationships, personal feelings, sexual issues, professional issues, success/failure, and attitudes. Interestingly, information about “the counselor’s relationship with his/her spouse” was grouped with disclosures of “interpersonal relationships,” whereas information pertaining to “the counselor’s sexual orientation” and “the counselor’s sexual practices” fell under the category of “sexual issues.” Further,

results of the study indicated that students had a greater overall and relatively positive interest in hearing about a clinician's relationship with his or her spouse than they did in hearing a disclosure about a clinician's sexual orientation.

One of the limitations of Hendrick's study design is that she failed to define "sexual orientation." The fact that sexual orientation is equated with "sexual issues" implies, by default, that Hendrick intended for sexual orientation to indicate a clinician's attractions (e.g., same-sex, different sex, or more than one sex) rather than a clinician's sexual identity (e.g., straight, lesbian, gay, bisexual, etc.). However, Hendrick either did not believe or assumed that a disclosure about a counselor's spouse would reveal anything about his or her sexual identity or orientation. Additionally, the term "sexual issues," which in her study included "whether the counselor has ever been physically or sexually abused," has a rather negative connotation and implies that "sexual orientation" may be considered deviant, negative or inappropriate.

The assumption that "marital status" or disclosures about a spouse does not reveal anything about a therapist's sexual identity or orientation, as evidenced in the Hendrick (1988) study, is likely one of the most common assumptions and biases throughout the literature. Even more current research demonstrates that therapist self-disclosures of marital status are considered to be rather innocuous and common, whereas disclosures of "sexual orientation" or "sexual behaviors" are considered to be risky and less desirable (Edwards & Murdock, 1994; Knox & Hill, 2003). That is, of course, when "sexual orientation" is intended to mean a lesbian, gay or bisexual orientation.

All of these factors are illustrative of the various and pervasive ways in which heterosexist assumptions and bias exist in society, clinical practice and scientific

research, and have an impact on the way clinicians conceptualize and practice self-disclosure. Future researchers, theorists and clinicians should strive to become more conscious of and transparent about their own heterosexist bias and assumptions that inevitably affect the design, implementation, usefulness, and generalizability of research on self-disclosure; a failure to do so would be irresponsible and counterproductive to understanding the needs of clinicians and clients alike, and to providing all clients with the best care.

Therapist Self-Disclosure of a Lesbian Identity

Self-disclosure of a lesbian, gay, bisexual or queer identity—or coming out—is often thought of or discussed as an intentional, direct, and verbal disclosure (i.e., “I am a lesbian”), yet coming out with a queer identity is a complex and continuous process that is negotiated and communicated in a number of ways. For instance, it is important to consider and include the variety of ways in which the disclosure of a queer identity can occur, such as through indirect verbal disclosures (e.g., referring to a partner’s gender), third party disclosures (e.g., therapists or clients identifying a therapist’s sexual identity to other clients), disclosures from information available on the Internet, or behavioral disclosures (e.g., attending public and/or social functions with a same-sex partner, identifying with a gay community, etc.). According to Russell (2006), therapist self-disclosure can also include unintentional or dialogic communications between a client and therapist—dialogic disclosures being those “that occur wordlessly as an outgrowth of an ongoing interaction between two (or more) people that creates a ‘knowing-from-within’” (p. 80).

Although still understudied, there seems to be increasing interest in exploring unintentional, indirect and non-verbal forms of self-disclosure, particularly related to the self-disclosure of a queer identity. In their review of the literature, Carroll and Gilroy (2000) found that coming out as gay, lesbian or bisexual—or disclosing one’s minority sexual orientation or identity to others—has generally been described as “a continual, non-linear, multidimensional, process which includes self-labeling, self-acceptance, and self-disclosure of sexual orientation” (pp. 69-70). Carroll and Gilroy conducted a study to explore the frequently overlooked behavioral language used in the self-disclosure of sexual orientation. Their study of 177 participants used an objective measure to explore and assess the continuum of behavioral and indirect ways—as opposed to verbal ways—in which gay men, lesbians, and bisexual persons disclose their sexual orientation in both the coming out and “being out” processes. One of their instruments included categories of questions that would assess a participant’s degree of being out via behavioral self-disclosures among family and friends, in the general public and at work, through suggestive conversation/arts/books, in the gay community, through gay symbols, and financially.

The results of the study indicated that the verbal and behavioral language used by gay men, lesbians, and bisexual persons in the being out process are highly correlated. In other words, the behavioral ways in which gay men, lesbians and bisexual persons come out and continue to convey their sexual orientation to others are similar in effect and meaning to verbal disclosures. Additionally, the degree of acceptance gay persons anticipated receiving following an action or behavior was found to be more strongly associated with the frequency of use of behavioral self-disclosures than the suggestibility

of the behavior (i.e., behavior that suggests homosexuality). Interestingly, Carroll and Gilroy (2000) also found that lesbians perceived greater acceptance following verbal disclosures than did gay men. While this study did not focus on behavioral self-disclosures of lesbian and gay therapists, the results seem relevant to the discussion of therapist-self disclosure of a lesbian identity. Lesbian therapists—like lesbian non-therapists—may intentionally or unintentionally suggest or disclose a lesbian identity or orientation to clients through behavioral language and by “being out” in various contexts. As with verbal self-disclosures, these may also impact the therapeutic relationship and treatment with clients.

In this day and age, clients can gather a great deal of personal information about a therapist, including sexual identity, through the Internet, friends and colleagues, advertisements or even as a result of living in the same town or being in the same social networks. The extent to which a therapist’s sexual identity is known before clients come to therapy and how clients knowing such information may lead to direct therapist self-disclosure or impact the treatment, are issues that are under-explored in the literature on self-disclosure. This study is interested in exploring both the verbal and non-verbal ways in which a lesbian therapist’s sexual identity is revealed or communicated to heterosexual clients.

Reasons and Motivations for Therapists Self-Disclosure of a Lesbian Sexual Identity

Lesbian and queer therapists hold diverse views and rationales with regard to the self-disclosure of sexual identity or orientation, despite the fact that they are extremely under-represented in the literature on therapist self-disclosure. Many therapists are out about their sexual identity to colleagues and clients in a public or agency setting as well

as in private practice. In fact, some may advertise themselves as lesbian, gay, or queer clinicians or treat their sexual identity as a known demographic fact in the beginning of their work with some or all clients. Other lesbian therapists, on the other hand, may never disclose their sexual identity to clients and may even remain closeted in their work setting. Such variance in practice, combined with a lack of research on the issue, makes it difficult to assess and generalize the decision making process of therapist self-disclosure of a lesbian identity.

While guidelines exist for therapist self-disclosure in general (see, for example, Knox & Hill, 2003), they typically neglect to consider the multi-faceted issue of disclosure of a queer identity or the implications associated with taking a heterosexual identity for granted. In recent years, however, queer therapists have developed and written about guidelines or considerations regarding therapist self-disclosure of sexual identity that are largely based on personal and clinical experiences, but that also draw from existing findings on therapist self-disclosures (Coolhart, 2005; Guthrie, 2006; Mathy, 2006; Pearlman, 1996). For example, Mathy (2006), who has a complex social identity as “an ethnically diverse, lesbian female clinician who is a former male-to-female transsexual,” predicates her decisions about self-disclosure on an understanding of herself and the needs of her clients (p. 109). She strives to follow several evidence-based guidelines regarding self-disclosure which generally relate to the breadth, depth, and duration of self-disclosures. Her decisions are influenced by the clients, the settings in which their work is occurring, the mode of treatment they are using, and clinical judgment. However, she lacks the benefit of utilizing existing research to help her negotiate self-disclosures of her gender identity—another neglected area of research.

Instead, she must rely on her own instincts as well as clinical and personal experiences when she makes decisions about the self-disclosure of her sexual identity and/or gender identity.

For lesbian psychotherapist S. F. Pearlman (1996), coming out to her lesbian clients is always an issue and becomes a “necessary conversation” at some point during therapy (p.73). Pearlman is publicly out as a lesbian and prefers that her clients learn of her sexual orientation from her rather than through word-of-mouth or another source, partially because she does not want them to feel a sense of betrayal which could adversely affect the therapy. Pearlman also has a feeling of fraudulence if she does not come out to a client who is talking about her life as a lesbian and does not know that Pearlman’s responses are based on her own personal experience as a lesbian. Thus, she often chooses to come out in order to model pride and empowerment as a lesbian instead of modeling secrecy and concealment by not coming out. Whereas some therapists make the decision not to disclose their sexual identity, Pearlman as well as Gabriel and Monaco (1995) believe that when working with lesbian and gay patients, the question becomes not whether to disclose their sexual identity, but rather “how and when such disclosure inspires progression and integration in treatment” (p. 171).

The question of therapist self-disclosure of sexual identity or orientation has primarily and most frequently been discussed in relation to queer therapists working with queer clients however, not straight clients. Research and clinical and personal experiences have indicated that sexual minority clients have unique and complex concerns, particularly related to coming out, and that considerations for therapist self-disclosure of sexual identity may be different when working with queer as opposed to

straight identified clients. Some research suggests that therapist self-disclosure of sexual identity or orientation may be more acceptable, warranted, important, or effective with certain populations and in specific instances. For example, several theorists and therapists agree that it is of therapeutic value for queer therapists to disclose their sexual orientation to sexual minority clients for a variety of reasons, including: joining with clients; helping clients to feel safe and understood; promoting genuineness and transparency so as to not be misleading or concealing about sexual identity; validating clients' experiences; serving as a role model of a healthy and positive queer identity, especially during the coming out process; and addressing internalized homophobia (Cabaj, 1996; Coolhart, 2005; Falco, 1991; Isay, 1996; Hanson, 2003; Mahalik, van Ormer, & Simi, 2000; Pearlman, 1996). Although these rationales and motivations pertain to queer therapists working with queer clients, many of them may also be pertinent to lesbian therapists working with straight clients.

Lesbian therapists who use self-disclosure judiciously or who are willing to self-disclose often consider numerous factors in deciding how to address questions from heterosexual clients about their personal lives, such as about one's spouse (Falco, 1991; Goldstein & Horowitz, 2003). Making a decision about the appropriateness of coming out to a particular heterosexual client can be a challenging dilemma that has different implications for different therapist-client dyads (Goldstein & Horowitz, 2003). One of the risks of a lesbian therapist coming out to a nongay client, as noted by Falco (1991), is that it can result in the loss of the client, especially for out lesbian therapists who want to attract and maintain a caseload of both queer and straight individuals. Additionally, if the straight client finds out that the therapist is lesbian from external sources or social

networks, it could be damaging to the therapeutic relationship and/or the client could feel betrayed (Falco, 1991).

Alternatively, nondisclosure of the lesbian therapist's sexual identity or orientation has implications for the therapeutic relationship as well. Therapist nondisclosure of sexual identity may result in the client assuming that the nondisclosure was caused by the therapist's shame regarding her sexual orientation (Farber, 2006). This could make it more difficult for the issue of sexual orientation to be discussed in therapy and greatly affect the client's ability to be forthcoming and honest about other sensitive topics. Farber (2006) notes that a "therapist's willingness to discuss his or her sexual identity creates opportunities for patients to more fully address a host of related issues, including sexuality, secret keeping, identity formation, and relationships with family members and friends" (p. 174).

In light of the challenges of negotiating self-disclosure issues, Falco (1991) makes the personal decision to always disclose her sexual orientation to clients who ask her directly—which her nongay clients rarely do—and to refrain from disclosing to clients who do not ask her directly. She argues that such disclosure can be therapeutic for a client who asks a direct question and it can also facilitate modeling. Goldstein and Horowitz (2003) caution that therapists who manage the discomfort of having to reveal their lesbian identity to heterosexual clients by refraining from disclosing any personal information, may in fact "hamper development of a deeper and more vital therapeutic intimacy" (p. 182). Further, they argue that the therapist's avoidance of coming out to clients does not necessarily prevent clients from sensing or knowing about the therapist's sexual identity.

Although disclosing a sexual minority identity to straight clients may be difficult in light of the potential risks of negative or homophobic client reactions, as well as the potential for loss of clients, some therapists argue that coming out may be a therapeutic decision for several reasons. For instance, Richard Isay (1991), an out gay psychoanalyst, concluded that disclosure of gay and lesbian therapists' orientation, to both heterosexual and lesbian and gay clients, was essential in order to normalize the client's experience.

Isay stated:

I do believe, however, that the gay analyst or therapist who hides or disguises his sexual orientation by refusing to acknowledge it implies that he's heterosexual and may further damage the self-esteem of his patients by conveying his shame, self-deprecation, or fear of disclosure. Equally important, he fails to provide a corrective for his patient's injured self-esteem that derives from internalized social attitudes and parental and peer rejection. Self-revelation through confrontation or confirmation at some appropriate points, I feel, are necessary and important to an effective therapeutic effort for men in treatment with a gay therapist (p. 203).

Similarly, Coolhart (2005) advocates for transparency when working with heterosexual clients. Coolhart, like some other therapists, feels uncomfortable evading clients' questions by providing vague answers or by not mentioning a partner's gender because she feels that they mislead her clients and misrepresent her. To reconcile this dilemma, Coolhart often makes the decision to correct clients' heterosexist assumptions and come out to clients in order to promote transparency.

Another motivation for coming out to heterosexual clients may be to take an active stance against societal injustice (Coolhart, 2005). Because of the positive and negative values assigned to many aspects of identity in society—such as sexual identity, race, ethnicity, gender, class, ability, and religion—some individuals and groups of people experience unearned privileges and benefits, while targeted groups are viewed as

“less than” and are systematically denied access to society’s benefits (Perez, 2005; Ritter & Turndrup, 2002). As a therapist, a commitment to social justice involves recognizing the ways in which oppression and prejudice shape reality and using oneself to change attitudes, behaviors, and conditions that create or reinforce injustices (Hardy & Laszloffy, 1998). Therefore, after careful consideration, Coolhart (2005) comes out to heterosexual clients who typically assume that she is heterosexual and make homophobic comments in an effort to challenge stereotypes and prejudice and confront oppression.

Coming out to straight clients can also serve the purpose of modeling a healthy and positive sense of self and sexual identity (Coolhart, 2005; Mathy, 2006). Coming out as lesbian, gay, bisexual, or queer is a process and one that can begin at any age or stage in life and therefore, some clients who identify as heterosexual may in fact be closeted or questioning their sexual identity. Queer therapists who come out to heterosexual identified clients in the therapeutic relationship can serve as role models of queer, healthy, and functioning people—representations which are few and far between in society (Coolhart, 2005). However, the timing and manner of self-disclosure may be critical when working with certain clients who, depending on the degree of their shame, denial, boundaries, and internalized or externalized homophobia, may not be ready or able to tolerate learning such information about their therapist; for some, a therapist’s self-disclosure of sexual identity could negatively affect the therapeutic alliance.

Finally, therapist self-disclosure of a queer identity can “provide a channel for discussing clients’ experiences of oppression” and allow therapists to join with their heterosexual clients around these experiences (Coolhart, 2005, p. 7). While all forms of oppression (e.g. racism, heterosexism, sexism, classism, etc.) are unique, they have

similar dynamics and effects on individuals, groups, and society. A therapist could use her experience as a lesbian, as Coolhart (2005) does, to relate to a client who experiences other forms of discrimination, such as racism, thereby strengthening the alliance and making it easier for the client to trust that the therapist could understand her position.

Although therapists may approach self-disclosure differently, there is general agreement among queer therapists that self-disclosure of sexual identity should be carefully considered. The sparse literature on the topic reveals that queer therapists tend to follow certain guidelines for self-disclosure that are usually based on a combination of models and studies which involve using informed, intentional clinical judgment, and self-disclosing on a case-by-case basis (Mathy, 2006; Pearlman, 1996; Satterly, 2006). Therapists also largely come to personal decisions regarding self-disclosure of sexual identity (Falco, 1991). Very few qualitative or quantitative studies, however, have specifically explored queer therapists' decision-making processes regarding self-disclosure of their sexual identity with queer or heterosexual clients (Satterly, 2006). This is an area that deserves further attention, particularly as it relates to lesbian clinicians and their work with heterosexual clients.

Contextual Variables

The question of self-disclosure of a lesbian identity may be informed and guided by a number of factors, including theoretical orientation and the perceived benefit that such disclosure or non-disclosure would have on the therapeutic process, as mentioned previously. However, this question must also take into full consideration factors such as historical, psychological and social oppression, internalized/externalized homophobia, and the pervasive heterosexual assumption that informs a client's perception and

understanding of who a therapist is (Gabriel & Monaco, 1995). There are numerous variables which may significantly influence a lesbian's coming out process, including but not limited to: gender; race or ethnic group; geographic location in the U.S.; the values and attitudes of the society at a given time in history; and individual variation (Hanley-Hackenbruck, 1989; Spaulding, 1993).

Deborah Coolhart (2005), an out lesbian therapist, acknowledged how her practices of disclosing her sexual identity to clients must take into account her contextual location. She identified that her ability to be publicly out to all the important people in her life, as well as being able to make a public commentary on the proposed amendment to the Constitution to exclude same-sex couples from being allowed to marry, is "related to [her] privilege as a white, middle-class, professionally respected, not religiously affiliated woman" (p. 4). Despite the challenges of being out, Coolhart acknowledged having an easier experience than many other queer people, such as people of color, who face more layers of oppression and for whom coming out may be a more complex issue. Also, for lesbian therapists living or working in the context of certain cultural and/or religious communities that reject homosexuality, coming out to clients may be a more complicated and complex issue (Coolhart, 2005).

Each therapist's social identity varies and contributes to her understanding and experience of herself in the world as well as in relation to each client in the therapeutic relationship. Gender, racial, and sexual identities of a therapist and client contributes to the dynamics of the relationship, the form of communication, and the degree of understanding of the self and other, which may impact the therapist's thinking and practice around self-disclosure in general, and that of sexual identity.

The geographic location of a therapist may also contribute to her decision-making process regarding self-disclosure of a lesbian sexual identity to clients. For example, a lesbian therapist who lives or works in a socially and politically liberal town or city in which there is a prominent queer community may feel more comfortable and safe disclosing her sexual identity to clients than one who lives or works in a more conservative or socially isolated location.

Additionally, the professional environment within which a lesbian therapist works could greatly affect her decision-making process around self-disclosure of her sexual identity to both clients and colleagues. The threat of losing one's job, being discriminated against, or experiencing homophobia and heterosexism in the workplace are still a reality for many lesbians (Goldstein & Horowitz, 2003; Perez, 2005). Employers that have written or unwritten self-disclosure policies favoring heterosexual therapists further stigmatize lesbian therapists and force them to remain closeted, which could negatively impact therapists as well as clients who might benefit from having information about the therapist's sexual identity.

The impact of homophobia and heterosexism on lesbian therapists' self-disclosure practices has not been previously studied; however, some lesbian clinicians have written about their experiences of homophobia and heterosexism within the therapy setting and work environment. Goldstein and Horowitz (2003) discussed different forms of bias that lesbian trainees or therapists continue to experience in training institutes and mental health clients. They described an out lesbian therapist at a predominantly heterosexual psychoanalytic institute who had only been assigned gay or lesbian patients; the therapist felt that such practice pigeonholed her as "the" lesbian analyst. The assignment of

patients who share a similar sexual identity with the therapist is often rationalized as being beneficial for patients; yet it also reflects the bias that a lesbian therapist will not be able to be as helpful to a nongay patient (Goldstein & Horowitz, 2003). Upon confronting her colleagues about the situation, they revealed that they felt conflicted about the “treatment implications of a lesbian analyst treating heterosexual patients,” although many of them treated homosexual patients (Goldstein & Horowitz, 2003, p. 174). According to the Goldstein and Horowitz, the therapist found the entire experience to be extremely distressing. A double standard clearly existed regarding the perceived impact of a therapist’s sexual identity on her or his clients; such a double standard likely continues to exist for lesbian social workers who work in diverse settings and impacts not only their work, but their sense of self.

Although great strides have been made to increase the visibility, acceptance, and legal rights of lesbian, gay, and bisexual individuals, heterosexism and homophobia remain a real and pervasive aspect of the lives of many queer individuals (Perez, 2005; Smith & Ingram, 2004). Unfortunately, homophobia continues to be a fairly accepted form of oppression in the United States and “the preferential treatment of heterosexuals is not only mandated by law, it is upheld by many governmental, cultural and religious institutions” (Perez, 2005, p. 25). The dynamics of homophobia and heterosexism play out on the personal, interpersonal, institutional, and cultural levels and lesbian therapists are not free from experiencing any of these.

Homophobia and heterosexism can impact lesbian therapists’ work with heterosexual clients in the context of therapy and it can also have an effect on the therapists personally. Lesbian therapists, unlike heterosexual therapists, bear the

additional burden of having to worry about a client's negative judgments of her sexual orientation or the financial and professional consequences of becoming known as a lesbian (Goldstein & Horowitz, 2003). Frank and Leary (1991) found that in the coming out process, the factor of social acceptance was the best predictor of openness. They concluded that "one's willingness to 'come out' to others is largely a matter of the degree to which one is concerned about what others' reactions are perceived to be" (p. 268). In a previous study, Wells and Kline (1987) found that lesbians tend to come out more readily when they expect a more positive reaction from others. Satterly (2006) did a qualitative study with 26 individuals in four focus groups examining the decision-making processes of gay male therapists regarding self-disclosure of their sexual orientation with straight and gay male clients. He found that through participants' experiences of oppression primarily with straight clients, including heterosexism (client assumes therapist is straight), negative comments (a client makes a disparaging remark about gay people), and therapist projection of homophobia onto the client, participants came to expect negative client reactivity to therapist self-disclosure of sexual orientation. Consequently, he found that internalized homophobia and projection of homophobia onto clients occur more often in participants' work with straight clients (Satterly, 2006). Although Satterly's study was done with gay male therapists, it is likely applicable to lesbian therapists' experiences as well. Thus, due to the heterosexist and homophobic cultural context, the lesbian therapist's perception of how a straight client would respond or react to her coming out is likely to factor into her decision-making process of self-disclosure.

Additionally, coming out as a lesbian—which is a stigmatized and devalued identity in this society—can ignite feelings of shame and internalized homophobia within

the therapist (Gair, 2003). The lifelong process of coming out can gradually reduce feelings of shame; yet the awareness that others might react negatively to a lesbian woman's coming out is present "regardless of the woman's level of self-esteem and the degree to which her self worth is independent of other's reactions" (Gair, 2003, p. 117). Lesbians can feel shame related to disclosing their sexual identity as well as perpetuating the heterosexual assumption by not disclosing. Falco (1991) described the way in which internalized homophobia sometimes gets rekindled for her in her work. She said:

Although I feel I make my choices to refrain from disclosure based on clinical therapeutic reasons, I also recognize a dose of homophobia within myself, in that I do fear (and have experienced) unpleasant losses of clients who may be unwilling or unable to stay long enough to work through their feelings about my orientation (p. 54).

Shame and internalized homophobia may consciously or unconsciously impact a therapist's decision-making process regarding coming out to heterosexual clients. Shame and internalized homophobia might also manifest themselves as anxiety about other's reactions or the fear of losing the esteem of others. Such fear can obfuscate the process of determining a critical aspect of self-disclosure: whether it opens up or forecloses the analytic work (Silverman, 2001). Thus, the very fear of becoming known as a lesbian and the anxiety about withholding this information can have a substantial impact on the therapist's work, regardless of whether or not she ever intends to disclose her sexual identity to clients (Silverman, 2001).

While psychological theories, research, and clinical experiences have contributed to the understanding of therapist self-disclosure, certain social, contextual, and individual variables cannot be ignored. These, as much as any other factors, may inform a lesbian therapist's clinical thinking and practice of self-disclosure of her sexual identity to

heterosexual clients. Further empirical research is needed to explore the intricate relationship between such contextual variables and therapist self-disclosure of sexual identity.

Summary

The research to date illustrates somewhat contradictory information on clinician self-disclosure. There is diversity of views in terms of what constitutes self-disclosure, how self-disclosure should be practiced, the effectiveness of therapist self-disclosure, clinicians' reasons for self-disclosure, and self-disclosure issues specifically related to sexual identity. Research on the self-disclosure of sexual identity, in particular, is sparse and often laden with heterosexist biases. The lack of information or consideration given to the complex issues lesbian clinicians face in the literature and research seems to be representative of a set of assumptions which include: that most, if not all, clinicians are or are assumed to be heterosexual and therefore self-disclosure of a sexual minority identity is a separate type of disclosure; that lesbian clinicians are able to practice self-disclosure as easily and freely as straight clinicians; and that minority sexual identities are unrelated and unimportant to this area of practice and research.

By drawing from the existing body of literature on self-disclosure and sexual identity, as well as their own personal and clinical experiences, queer researchers and clinicians have begun to address more nuanced issues of self-disclosure, such as non-verbal, indirect, and unintentional disclosures, in addition to self-disclosure of a queer sexual identity or orientation. Some clinical evidence suggests that a lesbian therapist's decision-making process regarding self-disclosure of sexual identity is influenced by a various factors other than theoretical orientation, including the sexual identity of clients,

the therapist's work environment, cultural attitudes, personal experiences, and internal and external homophobia and heterosexism.

At this time, however, it appears that there is very little research that specifically explores the way that lesbian clinicians negotiate self-disclosure of their sexual identity with heterosexual clients. Lesbian therapists who work with heterosexual clients face the complicated task of having to manage a largely hidden identity, which may have implications for both therapists and clients. The experiences of some lesbian therapists reveal a need for a greater understanding of the benefits and risks associated with disclosing a sexual minority identity to heterosexual clients within a culture that is primarily homophobic and heterosexist. While the experiences of a handful of lesbian clinicians are helpful in beginning to understand and address their thought process and practice of self-disclosure of sexual identity, more empirical research is needed to fill this gap. This literature review reveals opportunities to improve our understanding of issues around self-disclosure in general, and with regard to sexual identity in specific.

CHAPTER III

METHODOLOGY

The purpose of this qualitative study was to explore the ways in which lesbian identified therapists negotiate self-disclosure of their sexual identity to heterosexual clients within the therapeutic relationship. Due to limited existing research on these questions and with the lesbian therapist population, this exploratory study used a flexible and qualitative research design, which emphasizes the discovery of new phenomena (Anastas, 1999). In-depth, semi-structured interviews were conducted with 12 lesbian therapists, resulting in thematically analyzed narratives from each of the participants. This chapter presents the methods of research used in this study and will describe the sample recruitment and selection, data collection, and data analysis procedures.

Participants

The sample for this study was comprised of 12 participants. All participants identified as lesbian and biologically female. One participant identified her racial/ethnic identity as biracial (American Indian and Caucasian) (8.3%), two identified as Caucasian and Jewish (16.6%), and nine identified as Caucasian or white (75%). The participants ranged in age from 31 to 66. Five participants were married (41.6%), four were partnered (33.3%), two were single (16.6%), and one was engaged (8.3%). Of the 12 participants, six did not have children (50%), four had children (33.3%), and two reported having step-children (16.6%).

All 12 participants were licensed clinical social workers and two held Doctorate degrees (one in social work and one in sociology) (16.6%). Two participants were in the process of obtaining their Doctorate degrees in social work (16.6%). Participants practiced in urban, suburban and/or rural areas of four different northeastern states—Massachusetts, New York, New Hampshire, and Maine. Eight participants lived in Massachusetts (66.6%), three lived in the New York City Metropolitan area (25%), and one lived in Maine (8.3%). Six participants (50%) were in part-time private practice and five participants (41.6%) were in full-time private practice. Ten clinicians practiced in private or public settings, such as colleges, schools, or mental health clinics in addition to private practice (83.3%). Seven participants had over 10 years of post-master’s experience in social work (58.3%) and five had less than 10 years of post-master’s experience in social work (41.6%) (with a range of 7 to 35 years).

The majority of participants reported having various and multiple theoretical orientations, as outlined in the chart below.

<u>Theoretical Orientation</u>	<u>Number of Participants</u>	<u>Percentage</u>
Eclectic	6	50
Psychodynamic	2	16.6
Relational	4	33.3
Feminist Theory	2	16.6
Gestalt	1	8.3
Family Systems	1	8.3
CBT	1	8.3
Psychodynamic background	6	50%

Additionally, all participants stated that they draw from different theoretical orientations and techniques. Of the 12 participants, six reported having received psychodynamic training (50%), although this question was not included in the questionnaire, so it is possible that more therapists also came from a psychodynamic background as well.

Participants were asked to approximate the percentages of both heterosexual and LGBTQ clients in their current caseloads for all work settings. Out of 12 participants, five reported having an evenly balanced (50/50) caseload of straight and LGBTQ clients. The percentages of straight clients for six participants ranged from 60% to 95% and one participant reported having 33% straight clients. The percentages of LGBTQ clients for six participants ranged from 5% to 40% and one participant reported having 66% LGBTQ clients. It should be noted that a number of participant specified that their queer clients were largely comprised of lesbian and bisexual women. Three participants reported serving a growing number of transgender clients who either have a queer identity or identify as heterosexual.

Participants were also asked to report the degree to which they are out as lesbians in their personal and professional lives (excluding clients). Eight participants expressed that they were “totally” out in their personal lives and professional lives. Two participants stated that they were “very out” or “entirely out” in their personal lives but that the extent to which they are out varies with colleagues; one of these participants said that she is “more careful” in her position as a professor because of it being a less accepting work environment. Two participants described being “pretty out” or “entirely” out in their personal lives and “very out” in their professional lives. Across the board, no participant reported being completely closeted in any area of her life.

Recruitment and Data Collection Procedures

Measures to protect the rights and privacy of the participants were taken as outlined in a proposal of this study that was presented to the Human Subjects Review Board at Smith College School for Social Work before data collection began. Approval of the proposal (see Appendix A) indicated that the study was in accordance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects.

Participants were recruited using non-probability sampling techniques, including convenience sampling and snow-ball sampling from the following sources: the researcher's social and professional contacts; participant and/or potential participant referrals; the Smith College School for Social Work student body; and the Smith College School for Social Work alumni network. All recruitment materials included the researcher's confidential voicemail phone number, internship address, and Smith School for Social Work email address (see Appendix B for recruitment letter). Participants were forwarded the study's inclusion criteria and an informed consent form to review (see Appendix C). All identifying information from individuals who expressed interest in the study and did not participate was kept confidential and destroyed once data collection was completed.

Individual in-depth, semi-structured interviews were conducted to give voice to the participants' unique and subjective experiences of self-disclosure of their sexual identity to heterosexual clients. A total of 12 interviews were conducted over a two-month period, 11 of which were conducted in-person and one of which was conducted via telephone. In-person interviews were held at a mutually agreed upon time and all 11

participants agreed to hold the interviews at their work place or private practice. The interview conducted over the phone was held at a mutually agreed upon time and a phone adapted recording device was used to ensure the participant's confidentiality. Interviews ranged in length from 60 to 90 minutes, depending upon the participant's presentation. All 12 interviews were digitally recorded while the researcher took minimal notes during the interview.

Demographic data was collected from participants at the start of each interview and a pre-defined list of questions was used to guide the interviews (see Appendix D for instruments). The interview guide utilized in this study was designed to elicit rich, narrative data regarding lesbian clinicians' thoughts and experiences of self-disclosure of their sexual identity with adult heterosexual clients, including: clinicians' motivations for disclosing or not disclosing sexual identity; the risks and benefits associated with disclosure or non-disclosure; the way in which information about sexual identity is revealed or communicated to clients; and the impact of disclosure or non-disclosure on participants, clients, and the therapeutic relationship. Participants were also asked how factors such as their work environment and aspects of their social identity shaped their thinking and practice of self-disclosure of sexual identity. Finally, clinicians were asked to discuss the extent to which issues of homophobia and heterosexism have emerged in their work with heterosexual clients, how such issues were addressed, and what impact they had on clinicians. However, probes and modifications of questions were used when themes, patterns, and concepts emerged during the interviews and thus, each interview varied depending on the information that came out of the discussion. Also, at the beginning of the interviews, each participant was given the written definition of the term

'self-disclosure' that was operationalized in this study; the definition was comprised based on a review of the literature and the researcher's study design. The interview guide was formulated based on previous research and information currently used in the area of social work in regards to self-disclosure practices and sexual identity, as well as the researcher's thinking.

The researcher transcribed all interviews and confidentiality was maintained, per the Human Subjects Review Board at Smith College School for Social Work. To further ensure confidentiality, all identifying information (i.e., names, agencies, location, etc.) was removed in reporting the data. Participants were each assigned a pseudonym during data collection and only this name was associated with each person's data (i.e., data files, notes, transcriptions, etc.).

Data Analysis

Thematic and content analysis were used to examine the data collected from interviews. During and following the interviews, limited notes were taken in order to capture important data that cannot be recorded otherwise, such as non-verbal cues, gestures, and physical presentation, and to begin identifying common themes and unique responses across interviews. The interviews were then explored for commonalities and themes in order to begin the process of categorizing data into sections of major findings. The content of the interviews were coded by question responses and then by compartmentalizing emerging commonalities and differences in the words, phrases, ideas, and themes across the responses of the study participants. Data were also compared to determine similarities and differences with respect to the literature review.

CHAPTER IV

FINDINGS

This study attempts to explore the ways in which lesbian therapists conceptualize and practice self-disclosure of their sexual identity with adult heterosexual clients within the therapeutic relationship. This chapter will present the emerging themes and qualitative data from interviews conducted with 12 lesbian licensed clinical social workers who practice in Massachusetts, the New York City metropolitan area, New Hampshire, and Maine.

The findings reported in this chapter will follow roughly the same order as the questions contained in the interview guide. Participant quotes will be included in order to provide in-depth information about major themes that emerged from the data. Additionally, this chapter presents other themes relevant to the research questions that were brought up or explored during the interviews. Participants were each randomly assigned a pseudonym in order to identify their responses across questions. The greater meanings and implications of these findings will be addressed in the following chapter.

Conceptualization of Therapist Self-Disclosure

Across the board, participants expressed a great deal of similarity in their beliefs about the use of self and their thoughts about self-disclosure in general. One common theme that emerged across interviews is that participants felt there was no clear-cut, uniform way to approach self-disclosure, and that there are no “right answers.” Gail, a Gestalt therapist, said:

Well, it's always been a judgment call from the beginning as to whether one believes that self-disclosure on any level will be helpful, and if it certainly feels that it's going to be helpful, then within a certain context I'll use it.

For the most part, participants had difficulty stating any hard and fast rules about self-disclosure or making generalizations about when and how they use self-disclosure. Many participants revealed that they might use self-disclosure differently with certain clients (e.g., adults vs. children or personality disordered clients) or depending upon the treatment modality (e.g., individual therapy vs. couple therapy), for example. Most participants also stated that they might self-disclose in response to a direct question from clients. These factors will be explored in greater depth in the following sections on self-disclosure of sexual identity in specific.

For many participants, conceptualizations and practices of self-disclosure represent an on-going, “life-long” process that is informed by a number of factors. These factors include experiences and relationships with clients, experiences in the field, theoretical orientation, personal beliefs, and individual experiences. While a number of the therapists were psychodynamically trained, the majority expressed that they do not perceive themselves to be a “blank slate;” rather, they believe that the use of self within the therapeutic relationship is very important and they bring themselves into the therapy just as clients do. Angela, who has a psychoanalytic background and a current relational approach, described her stance toward self-disclosure in the following manner:

We are human beings with a whole set of not just feelings and experiences, but the way that we interact is so much even out of our awareness but has so much of an impact on what goes on in the room. So I think that the self of the therapist—intentionally and unintentionally—is very powerful...so I try to acknowledge that and work with that. I'm far away from the blank screen model...I make decisions when I first start working with someone about how much they will be comfortable knowing or not knowing.... I start from a position of I'm the professional and

we're gonna talk, but then things will evolve and as I feel comfortable and have a sense of who the person is, I may disclose more.

Angela pointed out a perspective that was shared by all of the participants and is also supported by the literature, namely, that therapists are always disclosing something about themselves in their relationships with clients, much of which is unintentional or unavoidable. Two participants acknowledged that a lot of information may be communicated to clients unconsciously or subconsciously, although they are not always aware of what is being communicated. Even Megan, the only participant who expressed that she strives to be a “blank slate overall” and a “neutral person” onto whom clients can project anything, stated she believed that information may be communicated unintentionally. She acknowledged that as much as she may try to be open and neutral, she is also a person with her own experiences and background which she inevitably brings with her to the therapy setting.

In discussing their belief in the use of self and therapist self-disclosure, three participants spoke directly about the importance of being authentic in their therapeutic relationships with clients, while others alluded to a similar theme. For them, authenticity was related to being real, bringing themselves into the room with clients, using a “sense of humor,” and not being a blank screen. One explained that as a result of being authentic with clients, a therapist might unintentionally disclose many things about oneself; yet for all three participants, being authentic does not preclude them from maintaining “good boundaries” or being “thoughtful” and “intentional” about the use of self-disclosure. While all three of the participants acknowledged that self-disclosure happens unintentionally or in the moment, they also all seem to subscribe to the idea that ideally,

self-disclosures should be thoughtful and intentional, particularly around “personal details.”

One participant, Beth, voiced a common theme when she explained that cautious self-disclosure should be done once rapport has been established with clients. All of the participants felt that getting to know clients helps them to determine the appropriateness and relevance of self-disclosures since each client comes to therapy with a unique set of needs, beliefs, and therapeutic goals. Additionally, Beth also stated that self-disclosure should be made “in a cautious, judicious, thoughtful way with some goal in mind and always keeping in mind that it needs to be in the service of the client.” In fact, all 12 participants felt that self-disclosure should only be used if it is “helpful” to clients, clinically sound, “appropriate” for the client or treatment goal(s), or for the purpose of “furthering the treatment.” Kristen described that she watches “to see how much of me someone needs...in order to accomplish what they’re coming here for,” which helps her determine what and how much of herself she discloses to clients. Three participants mentioned going to supervisors or peers to talk about the appropriateness of self-disclosure and/or to prepare themselves for making an intentional, clinically relevant disclosure to clients. Another simply stated, “unfortunately, it’s a gut thing.”

In describing their beliefs about the use of self-disclosure, participants also cited reasons why they would not self-disclose to clients. Most participants stated that do not believe in making disclosures out of their own “self-interest” or for the therapist’s benefit. Another common theme is that participants described that they would refrain from self-disclosing if it would not be helpful or was harmful to clients or the therapeutic process. Additionally, seven participants specifically identified that they believe in and

want to work with transference within the therapeutic relationship, and a number of others alluded to the same. If therapists self-disclose, they argued, it could impact or interfere with a client's transference to her or his therapist. Megan commented on this relationship between self-disclosure and transference as follows:

The biggest thing is just about me really interfering with their inability to transfer things onto me. I think for me, that's the biggest, biggest, biggest issue...because anytime I'm giving personal information—anytime—I am decreasing the amount that they can put onto me. So by any self-disclosure I'm doing that.

Although participants seem to vary in terms of the extent to which they work with transference, all shared the belief that transference operates within the therapeutic relationship and that, to one degree or another, it is important.

As discussed in the literature review, self-disclosure can be defined in various ways and often a distinction is made between self-revealing disclosures (i.e., personal or factual information about a therapist) and self-involving or counter-transference disclosures (i.e., emotional reactions to clients that occur within the treatment setting).

While not a major theme, a few participants commented briefly on their use of or feelings about these different types of disclosures. Gail and Michelle, both therapists in their 60's, stated that they may disclose what they're feeling in "the here and now" to try to "figure out what's going on," or so that clients "feel there's a human being at the other end of what they're talking about." On the other hand, Angela described herself as being flexible about self-disclosure but also said that flexibility does not necessarily mean that she discloses how she feels about clients in the moment. She further explained her position as follows:

I think some people use self-disclosure of counter-transference in ways that I don't agree with because there I feel very protective of the patient's

vulnerabilities and I think sometimes disclosure can be a really great powerful tool...of your actual experience of the patient when it's used right, and I think it can be very hurtful or it can even be an attack when it's used incorrectly.... I think sometimes people use self-disclosure in a way that I think is blaming the patient—like you're making me feel a certain way...because I think people do that. They get themselves off the hook and say, oh, well this is why I did it.... I feel like I don't want to use disclosure to dilute strong feelings.

Since this study focuses on the self-disclosure of sexual identity, which is typically a self-revealing type of disclosure, participants were not asked to elaborate on their views of different types of disclosures. Nonetheless, this seemed a noteworthy distinction to include as it reveals some variation in participants' thinking and practice of self-disclosure.

In sum, the majority of participants indicated that they feel comfortable using self-disclosure but that they do not intentionally self-disclose frequently. Their decision-making process around self-disclosure is impacted by a number of different factors, such as the therapist's own comfort level, the clients' needs and presentation, theoretical orientation, and personal experiences. These factors will be further explored later in this chapter as they relate to therapist self-disclosure of sexual identity in specific.

Therapist Self-Disclosure of Sexual Identity

Similarly to the first theme, across the board, it was difficult for participants to generalize about their practice of self-disclosure of sexual identity with clients. In discussing their thoughts on self-disclosure of sexual identity, all 12 participants stated directly or indirectly that disclosure of their sexual identity would be done on a “case-by-case” basis or would “depend” on various factors. For most participants, unless the issue of sexual identity or orientation “comes up” within the context of therapy, is “relevant”,

or is brought up in the form of a question, therapists generally said that they would not address it. As one participant said:

I think issues around sexual identity, unless they're showing up in the therapy, then it's not something I talk about. I mean, if I'm directly asked, then I'm gonna talk about it. But if it's not something they bring into therapy then I don't disclose.... It's interesting how often it doesn't come up (Jackie).

Kristen voiced a similar belief when she said, "I don't self-disclose around sexuality or around anything—it's the same thing—around anything unless it's asked for, unless it's invited and wanted, or feels like it is inside the relationship." Amanda described self-disclosure of sexual identity as "an issue or a non-issue" and said that she does not "even really think about it unless it raises itself in some way that has to be addressed therapeutically." Many of the participants' ideas about self-disclosing sexual identity are similar to their thoughts about self-disclosure in general. Participants felt that ideally, self-disclosure of personal information to clients, including sexual identity, should be "in the service of [their] clients;" it should not, as Sheila stated, be about "wanting to share who I am with them, or gratifying some need I have, or not tolerating some anxiety that they have or some anxiety that I have in the moment."

Although most participants reported that they try to be intentional and thoughtful about self-disclosures, many also acknowledged that sometimes self-disclosures occur in different ways. For Ruth, self-disclosure of sexual identity is not something she is always thoughtful or planful about—"it just kind of happens." She went on to say:

I think that I—and it might be for good or bad...I am myself and I'm in the treatment and I'm doing whatever needs to be done...if the self-disclosure happens in the context of whatever's happening then I'll explore it right then and there and might, two or three sessions down the road, say 'anymore thoughts about that?'

Ruth also stated that over time, she has stopped changing pronouns if and when she makes a reference to her partner. Part of Ruth's stance echoes the sentiments of other participants in that she values being authentic and "real and not phony;" coming out was talked about as being something that might occur in the course of being authentic with clients. On the other hand, Ruth also noted that when she is thoughtful about disclosing her sexual identity, she is "cautious" and assesses who would benefit from the disclosure (i.e., her client or herself), as well as if it is relevant with certain clients and within the context of therapy. This view was shared by the majority of participants.

A few participants similarly described that they do not necessarily go out of their way to "hide" their sexual identity and that disclosing it might in fact be part of a disclosure about something else. Beth stated:

Fundamentally I feel like I am who I am and if anybody's thinking about it or looking for it, they could probably look at me and having short hair and dressing kind of casually and make a guess that I am [gay]. So I don't try to hide it.... And as I get to know people, I self-disclose about things that have worked or that have not worked in my life. And sometimes being gay might be part of that. But I do think about it carefully.

For Liz, self-disclosure of sexual identity with straight clients is usually part of a decision that is about something else, like relating to somebody as a mother, for example. She further explained:

And the pull to [relate to a client] gets strong enough that I understand that in the midst of that—if I'm not gonna lie—it may come out that I have a partner. I'm opening up a conversation that may lead to them understanding that I have a female partner. But rarely is that the purpose of the conversation. It's something I know is gonna happen and I agree to in order to allow some other conversation that it will open up.

This same participant, however, also reported that with certain clients she may go out of her way to ensure that she does not disclose her sexual identity because having such

information may not be relevant, it may divert the therapy in an unproductive way, or it may interfere with the transference.

Influence of Client Sexual Identity

One common theme that emerged across all interviews is that participants generally experienced the issue of their sexual identity to be more present and relevant with lesbian and gay clients than with straight clients. This view also impacted participants' approach to self-disclosure. Patty, who works in a college setting as well as private practice, explained her thoughts about the relevance of coming out to straight versus lesbian or gay clients as follows:

I'm not even sure that I would do this consciously, but I would see it as more relevant with a gay or lesbian or queer client than I would see with a straight client. Or be aware that it's something that they may want to know... I think because for my gay or lesbian clients or the clients who are uncertain or struggling, it's [sexual orientation] in the room. For my heterosexual clients, although their sexual orientation is certainly in the room, a struggle about it isn't in the room. So it doesn't seem to come up in the same way or they don't seem to be worried about what I think or my approval or disapproval. I think students struggling with sexual orientation and thinking they might be gay, can have a lot of worries about thinking will I approve, will I not approve, how will I react, what will I think?

Similarly, Liz expressed why she is not as likely to self-disclose her sexual identity to heterosexual clients:

I think I'm less likely to [come out to straight clients], not because I assume they disapprove... but because as I move more toward needing a particular reason to disclose, I'm less likely to come upon that reason with them.

Other participants also felt that generally, the context in which they would directly come out to heterosexual clients was not as clear as it was with lesbian and gay clients, particularly because lesbian and gay clients would more frequently raise the issue, ask participants direct questions about their sexual identity, or come into therapy already

knowing that the participants were lesbian. Overall, participants were less likely to intentionally or directly come out to straight clients than they were to lesbian or gay clients. Although the interview guide did not include a question about participants' practice of self-disclosure of sexual identity with queer clients, it was a frequently discussed topic in all of the interviews.

Motivations and Reasons for Self-Disclosure of Sexual Identity

Participants were asked to talk about their decision-making process of disclosing or not disclosing their sexual identity to heterosexual clients, including their motivation and/or rationale, which yielded a variety of responses. Some participants expressed that they had not “ever thought of a rationale” for coming out to clients or that they did not have “any particular rules” about self-disclosure. Overall, participants seem to follow a similar decision-making process around direct disclosure of their sexual identity, whether or not they adhered to specific rules or guidelines. All participants expressed that their decision-making process involves considering factors such as: the relevance of the disclosure to clients; clinical goals and the therapeutic relationship; whether or not a disclosure would help or hinder a client's process; and to some extent, the therapists' comfort level with disclosing such information to clients. In general, decisions about self-disclosure of sexual identity were made on a very individual, case-by-case basis.

One common theme that emerged across all the interviews is that the issue of the therapist's sexual identity rarely comes up in the therapeutic relationship with heterosexual clients. If the therapist's sexual identity does come up, it generally tends to come indirectly from clients as a result of clients wanting to feel like their therapist understands them and can relate to them. However, participants reported that

heterosexual clients rarely directly ask about their sexual identity and participants rarely directly disclose their sexual identity to heterosexual clients.

Rather, some participants reported that clients have or may have learned about the participants' sexual identity through unintentional and/or indirect means. Three participants reported that they had either run into or been seen by some of their heterosexual clients outside of the office. One of those participants acknowledged that any kind of self-disclosure with most of her straight clients happened unintentionally in the course of the clients seeing her out in public and then exploring or expanding upon the interaction in therapy sessions. Other indirect and sometimes unintentional ways in which straight clients might learn about the participants' sexual identity are through therapist advertisements or websites that identify therapists as being LGBT supportive, or through publications, lectures, or conferences. Participants also mentioned that some heterosexual clients might pick up certain symbols, cues, or nuances in language that do not necessarily or exclusively disclose a lesbian sexual identity (e.g., having purple business cards, "safe space" stickers, or LGBT related books; the use of the word 'partner'; overall appearance, etc.).

As mentioned above, participants reported that heterosexual clients rarely, if ever, directly asked them about their sexual identity. Nevertheless, 10 of the 12 participants reported that they would most likely disclose their sexual identity to any client who asked a direct question. Most of those also reported that they might explore the question with clients prior to or after answering it and that sometimes the process of simply exploring the question satisfied clients' desires to know the answer. Ultimately, however, if clients really wanted or needed to know the answer and the participants felt that coming out

would not hurt or completely disrupt the therapeutic process, participants expressed that they would likely disclose their sexual identity. One of these participants stated she might not always disclose her sexual identity in the moment clients ask her, but that she has “never not disclosed if someone’s asked me.” Two of the 12 participants did not report that they would necessarily answer direct questions about their sexual identity; rather, they stated that they would explore the questions and wonder about them with clients. Sheila, one of those participants, directed toward exploring questions about sexual identity rather than answering them because of her belief in transference and what can be learned through exploring transference and the unconscious. She further explained:

And if we rush to answers before kind of looking for the meaning or the affect and miss out on some valuable information and opportunities, and as kind of awkward or stilted or anxiety-producing it can be to hold off on getting to the answer, I think the process is far more important. And I think I owe my clients the chance to have that process without just rushing to the conclusion.

Participants cited a number of other reasons why they would intentionally disclose their sexual identity to heterosexual clients. Some participants described that they might come out if it was clear that a client “needed to know” the therapist’s sexual identity, as opposed to a mere wondering or curiosity. Amanda described working with some heterosexual clients who, in “a good natured” but somewhat “aggressive” way, were not going to stop asking about her sexual orientation until they had an answer. She explained that if the client still wants or “needs” to know her sexual orientation even after exploring the issue, she would self-disclose. Alternatively, Michelle said that she does not think self-disclosure is “just a matter of the third person’s right to know,” but if a client comes to her for a consultation and requests a lesbian therapist, she believes that “you have an obligation to reveal.” However, according to most participants, gay and

lesbian clients more frequently present with a “need to know” the therapist’s sexual identity than do heterosexual clients.

Other reasons cited by participants for coming out to straight clients include role modeling, normalizing and/or conveying understanding of a client’s issue, and promoting authenticity. Five participants expressed that they might disclose their sexual identity to clients who were questioning their sexual orientation/identity in order to serve as a positive role model of an “out successful lesbian,” or to have someone to identify with. However, some participants stated that coming out to questioning clients may not always be helpful depending on where the clients are in their coming out process or how it would affect their view of the therapist. For Kristen, serving as a role model may also help heterosexual clients to work through issues of homophobia that are “impacting their lives negatively.” She explained this motivation in the following way:

If I’ve already established a good connection with them, I’ll use myself to move them for their own good on the issue.... If somebody had a child that they were really like ‘oh my God’—really struggling with that their kid that might be gay—well having a therapist that you already trust who says they’re gay, well that could be okay for them. That could help them kind of in their own relationships.

Similarly, a few participants believed that coming out as lesbian and partnered or married could help to model healthy, lesbian relationships for all clients—queer and heterosexual.

Some participants acknowledged that they might disclose their sexual identity to heterosexual clients as a way of normalizing or conveying understanding of a particular feeling or struggle. Beth described the purpose for which she might directly or indirectly disclose something about her sexual identity to heterosexual women who have had lesbian relationships. She said:

So then I might disclose something about the community or resources or myself to establish: I understand that about you and that's okay. So I guess 'I understand that about you and that's okay' is a reason to self-disclose. Although I know it's not a requirement.

Another participant, Megan, explained that she came out to a heterosexual female client who appeared "so vulnerable" after she disclosed to the participant that her son was gay and had HIV. Megan felt that it was important for the client to know that she had an "ally" in her therapist and that she would not be "judgmental."

Being authentic was cited again by participants as a reason why they would come out to heterosexual clients. According to some participants, one's authenticity may be tested most when clients wonder or directly ask about their therapist's sexual identity.

Amanda voiced this in the following way:

I think that there's a lot of tests of your authenticity in therapy all the time, you know whether or not you're gonna be judgmental or whether or not you're gonna be understanding or patient or whether or not you're gonna have a bad day that day. I mean I think that there are constantly tests of your authenticity and so I see potentially coming out to a heterosexual client as part of that. Because my feeling is that if they ask or if they insinuate, then they suspect and they want to know, and they're wondering how truthful I'll be.

Although this participant expressed a belief in being authentic, she also stated that she generally does not "direct toward self-disclosure of any kind" with any client.

Additional Factors Impacting Decision to Self-Disclose Sexual Identity

Theoretical Orientation

A number of participants reported that their theoretical orientation(s) impacted their self-disclosure practices to some extent. Four participants stated that feminist and political theories have influenced their thinking about and practice of self-disclosure of sexual identity. Three of those participants believed that, especially years ago, it was

important for lesbian and gay clients to have the right and option to be treated by lesbian and gay therapists; this belief influenced participants to be out for and self-disclose to lesbian and gay clients. The fourth participant reported that she works in an environment that espouses a model of practice based on a feminist approach, which does not discourage therapists from coming out in any way; the sense that she can do what she wants, including come out to clients if she sees fit, helps her to feel more comfortable about self-disclosure.

Three participants stated that their relational approach encourages them to use themselves more in their relationships with clients, which may or may not involve self-disclosure of sexual identity. Two participants reported that their psychodynamic orientation generally encourages them to be less disclosing so that clients can project more onto them. Lastly, Gail, who is a Gestalt therapist believes in the co-creation of a therapeutic environment and she does not subscribe to “the guidelines that, for instance, psychoanalysts or psychoanalytic practitioners would have about [self-disclosure] interfering with the therapeutic milieu.” Therefore, self-disclosure is not inherently viewed as an unfavorable intervention and may be regarded as more useful.

Personal Experiences

Participants cited various personal experiences that shaped their self-disclosure practices. Three therapists mentioned that their own experiences in therapy helped them to develop their own style around self-disclosure over time. Amanda described “wasting a lot of time” trying to figure out if her therapist was gay or gay friendly before she was “willing” to open up about her self. She felt that contributing to such a high level of “hypervigilance is unfair to gay or lesbian clients” who may need to know such

information. Amanda's experience in therapy has made her more conscious of her own use of language and cues, particularly with gay and lesbian clients. The other two participants who spoke about their time in therapy experienced their therapists' use of self-disclosure positively. Ruth said that her therapist, who was a lesbian, would disclose information about herself which the participant found to be helpful. Ruth has modeled herself somewhat based on that experience and said, "And I've never had a therapist who was that withholding either and that's something that has worked for me." Lastly, Beth felt very strongly that her long-time therapist's use of self-disclosure helped her to see the therapist as a "real person;" had the therapist been very guarded, the participant said she might have ended treatment with her. None of the participants mentioned benefiting from non-disclosing therapists.

Eight participants expressed that their comfort level with disclosing their sexual identity to clients has changed over time. They reported an increased comfort level with their self-disclosure practices as a result of becoming older, gaining more experience in the field, feeling more accepting of themselves and due, in part, to changes in cultural attitudes around homosexuality. Gail and Angela, who are in their 60's, stated that now that they are older they are "out of the sexual realm" of most of their clients and no longer perceived as "sexual beings," which has decreased the presence of sexuality within the therapeutic relationships. Angela felt that being older gives her "some kind of authority" she did not feel like she had before. Gail described the impact of her age on her self-disclosure practices as follows:

But in the days when the threat of crossing certain boundaries was greater—because talking about gay or lesbian is also talking about, in our culture, being sexual—so one always had to be conscious of that. These days I don't have to be

conscious of it because it doesn't generally come up, which is another kind of prejudice.

A number of participants reported that as new therapists they either never or very rarely came out to clients. For most, that changed once felt like they had “followed the rules” of self-disclosure long enough or became more comfortable in their work environments and with themselves as therapists and lesbians.

Some participants believed that changes in the culture have impacted their self-disclosure practices of sexual identity. Gail attributed some of her increased comfort with coming out to clients to the fact that “the whole notion of sexuality being so dangerous” in society has changed. At the same time, she also felt that a lot of queer therapists—especially newer therapists—still have the “fear that their sexuality can negatively impact a client or steer therapy in a particularly harmful way,” but that “as you get more experienced, you just start to realize that it's all part of the human fabric.” Angela reported feeling like people in society are changing and “catching up and understanding” more about homosexuality; thus, the changes in her comfort level of disclosing are “interactive” with changes in others' perceptions and reactions. Lastly, Liz, who has been a prominent lesbian therapist for many years, felt that changes in the culture—such as decreased levels of homophobia and greater numbers of lesbian and gay therapists—give her “more permission to keep more private.” She explained that if it were a “social possibility” to be more private as a therapist, she would likely take advantage of that because it would give her more control over what goes on between the client and her.

Other personal experiences that therapists felt had an influence on their self-disclosure practices were the prevalence of internalized homophobia and participants'

own sexual identity development and/or coming out processes. A number of participants revealed that their coming out process coincided with the beginning of their careers in social work, and thus acknowledged that their lesbian identity and professional identity were very much intertwined. Seven of the 12 participants reported that they were aware of having and dealing with more internalized homophobia earlier in their careers, which impacted their self-disclosure practices. Amanda discussed the relationship between her internalized homophobia and self-disclosure practices, and the evolving process that informs her work today. She stated:

You know I think I was smart enough to know early on in my career when I still was dealing with my own level of internalized homophobia, I certainly wasn't gonna be comfortable bringing that up to clients. And so the whole topic in that sense was avoided. And whatever therapeutic gain there might have been didn't happen...with anybody because of I think just my own process of dealing with my own internalized homophobia. And at some point, when I really in the largest part don't feel like that's really an issue that I struggle with in my life, then it doesn't have the emotional charge to it so I can decide in a sort of rational way whether or not to do that with anybody. So I think my thoughts or my ideas about whether or not to self-disclose, either intentionally or unintentionally or really in any way, just relate to my own level of comfort with myself or my own lack of internalized homophobia at this point.

Amanda's experience, and her practice of avoiding disclosing information that she was not yet at peace with herself, were similar to those expressed by other participants. A few therapists reported that they would not want to disclose information to clients that they had a lot of feelings about because they would not want their "anxiety to be in the room in some way" that might impact the client. Michelle, who after coming out and living as a lesbian for years, moved to a different and less open-minded area. She began questioning her lesbian identity and wondered if it was related to internalized homophobia. However, Michelle felt that if she had been self-disclosing about her sexual

identity with clients, “if would have been really confusing for my clients because my life was in so much upheaval at the point.” Similarly, although not related to internalized homophobia, another participant did not want to inform her clients that she was pregnant and “stir things up” until she felt like the pregnancy was going to be okay.

Another participant felt that part of her earlier efforts to “project heterosexuality” to clients was related to her internalized homophobia. Ruth described that over time and as she worked toward overcoming her internalized homophobia, she became more comfortable dressing the way she wanted to and revealing different aspects of herself that she had kept hidden. Authenticity plays a big role in Ruth’s self-disclosure practices, as echoed in the statement: “So part of the coming out process was to be who I am.” Lastly, Liz described certain feelings brought up in her work with a female Catholic client that have contributed to her being less disclosing about personal information in their relationship. Liz described her reactions to the client as follows:

It’s reactions emanating from me that are determining the limits I’ve placed on this relationship. So it is in the realm of countertransference. I don’t know if it’s homophobia exactly as it is a projection that I could lose her esteem and not wanting to lose her esteem—partly for her sake but also partly for mine. So I’m not sure that that’s exactly the same as not feeling good about my self. You know, it’s more feeling vulnerable about how she’s gonna feel about me and being worried about that. But that does come up for me... I can say that I used to be way more aware of that 20 years ago, when I was in a very different state in my own process.

The feelings described by Liz are similar to those expressed by others, in that there is often some worry, anxiety, or fear related to disclosing one’s sexual identity to heterosexual clients; whether or not those feelings would be classified as being remnants of internalized homophobia is not always clear.

Some participants discussed the ways in which where they live and/or work have shaped their self-disclosure practices. A number of participants felt that being in private practice allows them to have more control over who they choose to see as clients, the office environment, and what and how much they choose to disclose to clients. For Sheila, the comfort she feels in her own space gives her “far more permission to be who I am.” She also described the hospital environment where she works as “warm and inviting” where “you could be out if you wanted to be,” and stated that it is important for her to know that if she were to come out to clients in her work, it would be acceptable. Sheila has not, however, come out to any of her heterosexual clients. In contrast, Patty described how early in her career, she worked at a residential treatment program for adolescents that had a policy in place that if staff wanted to come out to clients, they had to have their supervisor’s approval as well as that supervisor’s supervisor. The policy changed over time, but Patty felt that “given my personality that, if anything, would have pushed me to want to be out more because I just thought that was ridiculous.” She had difficulty identifying how the policy directly affected her work with clients, but she did express feeling uncomfortable that such a policy was in place.

One participant reported that part of the reason she feels free to disclose her sexual identity to clients (if and when such disclosure is warranted), is because of where she lives. Amanda believed that if she were to work in different, less open-minded area—like the one she grew up in—she would be “cautious, probably because I would know that even if my co-workers were open, that the larger community wasn’t necessarily.” Interestingly, Kristen, who lives in a “pretty narrow-minded community,” said she feels a “social responsibility to live out,” where she would not necessarily if she lived in a town

where there are a lot of out gays and lesbians. She believes that living in community that is somewhat homophobic provides her with opportunities to “change things.” However, Kristen described having different roles in her two work settings. As a supervisor at a foster care agency, she is totally out because she believes that it is important for people to be out in “organizational structures” and for diversity among teams to exist and be visible. As a therapist in her small private practice, on the other hand, Kristen does not go out of her way to conceal her sexual identity, but she also does not believe in coming out to clients unless it is clinically warranted or asked for within the relationship.

Although participants were asked to discuss the impact of various aspects of their social identity on their self-disclosure practices, there was very little mention of the impact of factors such as race, class, gender, or religion. A few participants noted that issues of classism frequently come up in sessions with clients, and Amanda acknowledged that she sometimes struggles with her “internal classism” as a result of growing up as a “working-class Irish Catholic.” Amanda believed that if she were to work with working-class Irish people in her old neighborhood, it might raise the level of her concern regarding self-disclosure of her sexual identity. Two participants questioned whether or not self-disclosure of their sexual identity would vary based on the gender of their clients. They acknowledged having the potential to feel more apprehensive about coming out to male clients than to female clients, because of male clients possibly eroticizing the therapists or becoming violent. The only participant who talked about the impact of her racial identity on self-disclosure practices identifies as bi-racial (American Indian and Caucasian). Beth described the importance for her of disclosing her bi-racial identity to all of her clients who are not Caucasian because it is “not obvious by looking”

at her and she wants them to know that she is “aware of diversity and racial issues.” She also stated that when deciding what pictures to hang in her office, it was much more important for her to think about racial diversity than sexual orientation. She stated, “I don’t know if that’s internalized homophobia...but I figured that people can look at me and see that I’m gay friendly just by looking at me, and again maybe that’s an erroneous assumption.”

Risks and Benefits of Self-Disclosure of Sexual Identity

Risks to Therapist

When asked about the potential risks to participants associated with coming out to heterosexual clients, a rather small range of responses were given. One common theme was that coming out to clients could result in a decrease of perceived and actual safety for therapists. Three participants worried that if clients were homophobic, they might cause damage the therapists’ personal property, “stalk” the therapists, or make up slanderous allegations that would affect therapists’ reputations. Another participant mentioned that in certain places of employment or parts of the country, therapists could potentially be fired for coming out or being outed. Kristen commented that she might feel particularly vulnerable coming out to male clients in a “fairly secluded private practice” because of the “violence thing and eroticized lesbian thing.” Similarly, Jackie thought that she might feel “somewhat exposed” upon initially coming out to clients.

Three participants mentioned the risk that clients might share information about the therapist’s sexual identity with other individuals and community members. For Megan, who serves a number of people within a small deaf community, the risks associated with members of that community finding out her sexual identity or learning

about “real hateful wrong slander” could include a loss of business and damage to her reputation. Sheila, who is intentionally not out to any of her heterosexual clients, spoke about this risk in more general terms by stating the following:

I think the other tricky thing is what clients tell us, we keep confidential and yet what we share with them, they don't. And yet while I might be open to being out—I mean I am out in every other area of my life—I think I'm aware of that power differential that happens with any knowledge they have about us. And not that I can really think of any sort of bad thing that's happened yet or that I imagine somebody would do...but there is that sense of I'm not in charge of what they do with it or where the information goes from there...There is that imbalance around any sort of self-disclosure.

Some participants also discussed the impact of non-disclosure of sexual identity to clients. Angela spoke about a feeling of personal loss associated with certain therapists not disclosing their lesbian identity to clients. She talked about a prominent lesbian analyst who is a “brilliant” published writer who does not write on “gay issues” because she does not want her patients to have that information, even though she is not “in the closet.” Angela elaborated below on her feelings about the dilemma:

That's her business and I respect her obviously to do what she wants to do, but I do feel like that the negative of that is that she has to hide. I mean what she tells or doesn't tell her patients is completely her business, but the fact that it limits on what she's willing to write...and if she didn't write, it wouldn't be an issue, because that's lots of people. But here's somebody who writes and who's very brilliant and very well thought of in her writing and it would be nice...there was a time when that would have been more of a loss because there was so little out there; now we've got lots of really smart people writing from a queer perspective, but still, I felt like that's a shame.

A few other participants reported that when faced with a decision of whether or not to come out to a client, there is “always that moment of anxiety around coming out that you have your whole life.” These participants acknowledged having some worry about what a

client's reaction would be and how a client would feel about learning the therapist's sexual identity.

Finally, a few participants felt like it was difficult to be on the receiving end of clients' assumptions, despite their belief that disclosing their sexual identity may not necessarily be clinically relevant or appropriate. Sheila described how she felt about clients' reactions to her wedding ring after being married and returning from her honeymoon. She stated:

It was a very strange feeling and knowing that what's going through all of their minds is that I've got a husband and that I married a Mr. [last name] and....that they have this whole fantasy about that...I mean I lot of the women in the group were widowed or divorced or had failed relationships in one way or another or were angry at men for affairs and you know lots of things and were able to speak to that. There wasn't even an inkling that someone had the idea that it could've been anything other than that. And I had to tolerate their fantasies and their assumptions and not correct it because I guess my idea was that it wasn't really about me.

The sentiments expressed above also reflect similar feelings expressed by other participants regarding the impact of not disclosing their sexual identity to clients and being perceived as heterosexual.

Risks to Clients & Therapeutic Relationship

When asked about the associated risks of disclosing their sexual identity to heterosexual clients, a variety of themes emerged from participants' responses. Five participants identified a risk of self-disclosure as being the potential for a rupture in the therapeutic alliance that results in clients dropping out of therapy. Participants reported various reasons why self-disclosure might lead to a permanent rupture, including: if a disclosure occurs before an alliance is formed; if clients are not ready for such information and feelings of "otherness," pain, anger, betrayal and "a sense of not

understanding” are too strong; or if certain clients “who for religious or political or cultural beliefs feel strongly about anti-gay beliefs.” One of these participants felt that clients dropping out of therapy could occur as a result of therapist self-disclosure of any kind of personal information, but she acknowledged that “there’s a loadedness” to disclosures of a gay or lesbian identity in this society because of heterosexist assumptions that “people are straight.”

Another risk cited by two participants was that self-disclosure of sexual identity could affect the client’s transference to the therapist. One of these participants stated that it could “reduce how much they can project onto me” which could limit the roles she might be able to have with a particular client. Three participants expressed that self-disclosure of sexual identity could “cut off exploration of other things,” which one participant said was always a risk when therapists disclose something. Other risks of self-disclosure cited by participants include: “it could be an added agenda” or bring up issues the client was not wanting or ready to deal with; it could be gratifying the therapist’s need rather than the client’s; it could inject into the treatment the therapist’s anxiety if she is struggling or experiencing anxiety around her own sexual identity; it could make a client feel like she or he has to take care of the therapist; it could put “too much focus” on the therapist and deflect attention from the client; or it could “stir up [the client’s] internalized homophobia that they might not even be cognizant of.”

Participants also reflected on the ways in which not coming out to clients might impact clients and the therapeutic relationship. Five participants stated that a risk of not coming out to clients is that clients might feel “betrayed,” “hurt,” or that the therapist had not been “honest” if clients were to find out the therapist’s sexual identity. This risk was

thought to be especially great if a therapist had worked with a client long-term and built a strong alliance with him or her. The following quote from Megan captures the sentiments of the participants who worried that clients might perceive them to be dishonest for not coming out to clients:

I think that the vast majority, if often they found out and I hadn't told them, I think they'd feel dismayed that somehow I didn't feel safe to tell them or trust them or think they could handle it. I think they would take it as an insult on our relationship. And specifically that topic [sexual identity], versus where I live or whatever. I think that topic just specifically because in society it's such a hot topic, I think that they would feel kind of like 'you don't feel like you could share that with me?' I think that's how they would take it.

Patty voiced a struggle around this issue with clients despite the fact that clients typically had not directly asked her about her sexual identity. She wondered if there was a way in which she felt "not completely honest even though I'm not quite sure I would do it differently."

Similarly, another impact of non-disclosure of sexual identity voiced by participants is that therapists might be perceived as straight and thus as hiding their true sexual identity from clients. Angela wondered about the message that might be sent to clients when therapists do not directly reveal their sexual identity, especially for heterosexual clients who might struggle around issues of secrecy or hidden identities. She described this dilemma that arose with one of her heterosexual male clients who "put it together that I am gay," as follows:

I think he Googled me—you know Google now, everything's out there—so that was really important because here's this guy with secrets. He's been living with secrets and so now he called me on my secret and so I think that the whole issue of secrets around sexuality is very important... I always feel like, what's the message when we hide our sexual identity? Because it's still assumed that you're straight unless it's proven otherwise; so if you're neutral, it's like you're hiding. It's like you're passing for straight and I'm always aware of that—that when I

don't come out, I'm pretending that I'm straight. And often people are aware that I have a child which reinforces that, too....I think that it's hard not to say that when you are not disclosing your sexual orientation, you're basically passing for straight—I think that's true. Because it's just a given in this culture, in this world, but that doesn't mean that you have to reveal it, but I think it's a piece of it.

Other participants acknowledged that in both coming out or not coming out to clients they might be delivering some kind of message or possibly perpetuating a stereotype or assumption about what it means to be perceived as lesbian or heterosexual.

Benefits to Therapist

Participants reported considerably fewer benefits than risks to themselves associated with disclosing their sexual identity to heterosexual clients. A few participants stated that coming out to clients could allow therapists to feel more authentic or comfortable in their work. Sheila, however, categorized feeling “fully present and authentic” as a “selfish” desire in that she would “get to bring in key pieces of myself that might otherwise be assumed or misrepresented in some way.” Another reported that she felt a sense of relief after coming out to one of her heterosexual clients who raised the issue in therapy. For her, the relief stemmed from having the information “on the table” and no longer feeling any worry about what the client would think or how she would feel if she knew the therapist was a lesbian. Liz also stated that generally she feels more comfortable when she is out:

I'm more comfortable when I'm out; I prefer it. It's kind of a subliminal strain with people where I'm deliberately not or I'm trying to keep that from happening, because I'm always a little bit on watch for where this is headed and sort of wanting to see three steps ahead in case I need to veer it someplace. But it's an additional thing I have to pay attention to. So it's kind of a relief to me when it's not a factor. Either somebody isn't remotely interested in who I am in that way or they come in knowing and that's perfectly clear to me.

The sense of relief Liz described is similar to the views expressed by other participants about being able to feel authentic and “real” in therapy with clients. Another participant who is out in her private life and with colleagues similarly reported that being out to clients might make her happier in some ways because it might “feel more congruent with my identity.” However, the participants who reported a feeling of authenticity or relief as a benefit of coming out to clients, also reported that they do not self-disclose their sexual identity solely to achieve those benefits.

Lastly, Michelle stated that she could not think of any personal benefits associated with disclosing in the therapy setting. Not all of the participants reported any perceived benefits to themselves.

Benefits to Clients & Therapeutic Relationship

In terms of the potential benefits to clients and the therapeutic relationship associated with coming out to heterosexual clients, participants’ responses were similar to the themes that emerged from therapists’ motivations and rationales for self-disclosure of sexual identity.

Seven participants felt that in certain instances, self-disclosure of sexual identity could increase the therapeutic alliance, create a closer bond or connection, increase a feeling of safety for a client, establish a commonality between client and therapist around similar struggles, and help a client to feel understood. Another benefit reported by three participants was providing positive role modeling for clients. Patty felt that “being out” for straight clients, especially “straight kids,” is equally as important as being out for gay clients and kids. Three participants stated that increasing awareness, breaking stereotypes or stigma, and expanding one’s perception of lesbians could be benefits to self-disclosing

sexual identity. Sheila, who is completely out in her agency work as a supervisor but deliberately not out to all clients in her private practice, described this benefit in greater detail:

I think the more professionals or more people who are out, the better. I mean, it's with visibility, it's with personally knowing somebody, it's with hearing, liking, feeling helped by, connecting with, finding commonalities with people who you think are different than you are that break down stigma and increase visibility and eventually create more acceptance.

Additional benefits reported by participants include: establishing therapist “credibility” around issues related to sexual orientation or being seen as someone with whom questioning clients could talk about their own sexual identity; opening up conversations with clients and promoting client self-disclosure; promoting or modeling honesty, openness, and non-defensiveness; being perceived as someone who might possibly understand various forms of oppression; and creating an opportunity to discuss differences between client and therapist.

Finally, some respondents noted that non-disclosure of sexual identity might permit certain clients to identify and work through their own issues and maintain the therapeutic alliance, as opposed to potentially creating a disruption or diversion in the work by coming out. Michelle described a case in which, three years into treatment, a heterosexual female client told her “I think you're a lesbian.” Michelle explored this idea with the client and it was revealed that the client felt like she would not be able to work with the therapist if she were a lesbian. Eventually, the client told Michelle that she gets scared about her own feelings toward other women. Although the client never asked her directly, Michelle stated that “if she had asked me directly and I had said yes, she

would have been out the door.” In certain cases and around certain issues, therefore, it may not always be beneficial for lesbian therapists to disclose their sexual identity.

The Role of Assumptions

The original interview guide used for this study did not include a question specifically addressing the role of client assumptions in the therapeutic relationship. However, during the first interview the participant discussed the role of assumptions and it became clear that it was a relevant and important topic to pursue. In the remainder of the interviews, the topic of assumptions about the therapist’s sexual identity was either raised in form of a question or participants spoke about it spontaneously. All of the participants reported, to varying degrees, being aware of clients’ assumptions about them, especially with regard to their sexual identity. They were also able to give examples of how or why clients might make certain assumptions.

These findings reveal several common themes. First, in general, the participants felt that clients’ assumptions about the participants’ sexual identity differed based on the sexual identity of the clients. The findings also reveal that a therapist’s perception of a client’s assumption regarding the therapist’s sexual identity is often related to various indirect and/or behavior self-disclosures a therapist may make about her sexual identity. In other words, participants expressed having awareness that some of their behaviors may impact what assumptions clients make about their sexual identity. Finally, the therapists’ perception of a client’s assumptions about her sexual identity may impact the way she approaches self-disclosure of sexual identity.

The majority of participants thought that their straight clients and lesbian clients generally made different assumptions about their sexual identity. Nine participants

thought that lesbian clients were more likely than straight clients to know or assume that the participants were lesbian. Three participants became well-known in their communities as lesbian therapists during the feminist movement of the 1970's, which contributed to these participants having a great number of lesbian clients. These participants therefore presume that many of the lesbian clients who come to see them either know or assume that they are lesbian because of their longstanding reputations as being lesbian therapists. Some participants attributed lesbian clients' assumptions about them to one or more of the following: the way in which clients were referred to them (e.g., through somebody who is lesbian, through online therapy referral sources in which participants identify themselves as being LGBT supportive, word-of-mouth, etc.); information that is available about participants online (e.g., publications, organizational affiliations, etc.); or through appearance, behavioral cues and language choice (e.g., hairstyle, style of dress, body language, use of the word 'partner' and other non-gendered language).

Ruth thought that some people can "sense" that she is lesbian based her overall appearance and demeanor. She said:

I guess 'cause I don't try to hide it so...my hair's always been short, always been sort of butchy in the cut...I've been told, 'well you look like one'. I walk like one. When I smoked, I smoked like a guy. I mean, I sit like this [legs relaxed, open], I don't cross my legs like this. You know? I think there are probably some behavioral self-disclosures.

Despite calling herself a "lipstick lesbian," Michelle said that "appearance-wise, I think lesbians know I'm a lesbian; they've got gaydar." Patty discussed the ways in which lesbian clients might pick up on certain clues that inform their assumptions about the participant's sexual identity in ways that straight clients do not. She stated:

I think there are enough clues in my office and in the things I might say, but a straight client might not see those clues. So I feel like I would know whether or not my therapist were a lesbian based on what I've said or done over the years, but a straight client may not. If they're attuned to it— kind of like when someone uses the word 'partner'—I think gay and lesbian people notice that and straight people might not even notice it to that extent...not sort of attuned to nuance and language.

Patty's assertion that straight clients might not be attuned to or interpret certain cues, symbols, or nuances in language about a lesbian identity in the same way that gay and lesbian clients do was expressed by a number of other participants as well. Megan said that because a lot of her lesbian clients make the assumption that she is gay, she does not "even have to self-disclose." She reported that certain clients make an assumption and then it is up to her to either validate the assumption and say, "yes, I am [gay/lesbian]" or not. Overall, the majority of participants felt that lesbian clients in particular would be much more likely than straight clients to look for clues about the participant's sexual identity and to make correct assumptions about it. Some therapists therefore assume that their lesbian clients know their sexual identity before they come to therapy or that they learn it over the course of treatment through indirect disclosures, behavioral cues, or even direct disclosures.

Participants were fairly evenly divided (and overlapped) in terms of their perceptions of heterosexual clients' assumptions about their sexual identity. Six participants reported that they typically thought that some or most of their straight clients assumed they were lesbian. Two of those participants felt that if clients did not actually know their sexual identity prior to beginning therapy—by hearing about it on campus or through the grapevine, etc.—then they either made correct assumptions about it or assumed the therapist was straight. Six participants thought that some or most of their

heterosexual clients made the assumption that the participants were also heterosexual. Two participants reported that they were not sure what most of their clients assumed about them, although they would be interested to know. One said that “nobody has ever asked” [about her sexual identity], so she does not know what they think or if they are even curious.

Again, therapists thought that straight clients might wonder about their sexual identity based on the therapists using more inclusive language when doing assessments, because of information available on the Internet, or because of the participants’ careful use of pronouns (e.g., saying ‘I’ instead of ‘we’). Liz noted that clients might assume she is lesbian because of everything she does *not* reveal or say to them. She explained that her relationship with one client involves “tons of use of self with very, very little self-disclosure,” mostly because the client has never asked personal questions, some of which Liz actually felt comfortable answering and had answered for other clients. Liz did not directly come out to this client but explained why she may in fact assume the participant is lesbian anyway. She stated:

For all I know, she assumes I’m a lesbian because of all I haven’t said. That sometimes trying to hide who you are and being so good at using non-descript pronouns gives it away for people. I’ve had people say that to me—not in therapy I don’t think, but in my life earlier on when I wasn’t out to people yet. I would subsequently come out to them and they’d say the way they knew that was from all I didn’t say and from how adept I was at something you wouldn’t be good at unless you had a need to develop that skill. So saying nothing does not always mean we’re not telling people.

The notion that therapists might be revealing something about their sexual identity by not saying anything echoes a similar sentiment expressed by other participants who said that

therapists are always disclosing something about themselves to clients, even in the absence of direct disclosures.

Some participants suspected that clients assumed they were lesbian because of statements or questions brought up by clients. A few participants reported that heterosexual clients—especially heterosexual women—would say things like, “I don’t know if you know what I’m talking about” when discussing relationship problems, which Amanda thought implied “I think you’re gay and you probably don’t know what I mean.” Amanda reported that she does not necessarily correct or confront such statements or directly self-disclose, although she might explore the underlying concern being expressed about a perceived lack of understanding. Gail described the way in which she might deal with a client’s assumption that she could not understand something because she is lesbian. She said:

I will explore with them how we’re always in a heterosexual environment and how we all come from that heterosexual environment. So there have been some rare occasions when I’ve done that and it, again, brings it down to the commonality that we’re all raised with certain kinds of paradigms and that one may...start to develop a lesbian identity at a certain point, but we’re all coming from the same place. So again, it’s an attempt to create an alliance of commonality. It’s always worked when I’ve done that—when differences start to fade and the alliance builds.

Overall, the majority of participants were less apt to disclose their sexual identity to heterosexual clients or to confirm or negate clients’ assumptions about them unless it was clear that the therapist’s sexual identity was a real and underlying issue. Participants were more likely to explore heterosexual clients’ assumptions without making a direct disclosure about their sexual identity.

Five participants reported that clients' assumptions about their sexual identity come up indirectly with questions about marriage. A number of participants reported that clients' questions, if any, more frequently tended to be 'are you married?' rather than 'are you a lesbian?' or 'are you straight?', which are different types of questions; the first question is asking about a participant's relationship status whereas the others are asking about sexual identity, although marriage is still typically equated with heterosexuality.

While marriage between same-sex couples has been legal in Massachusetts since 2004 and same-sex couples engage in commitment ceremonies around the country, participants reported that generally when clients ask them if they are married, the assumption is still that the participants are heterosexual. As Sheila put it, "It's hard because the assumptions are implicit. The question isn't, are you married to man?, it's are you married?" Even participants who wear wedding or commitment rings reported that clients rarely ask if they are married but most of those participants still assume that clients think they are married and heterosexual. Only one participant, Amanda, reported that when clients commented on her wedding band and congratulated her for getting married, they avoided using gendered pronouns when asking about the participant's "person." Amanda thought that if clients really believed she was straight they would have made reference to her 'husband' rather than seeming like they were wondering and at a loss of words. Amanda responded to these types of questions by saying something like, "my partner and I", which she assumed implied that her partner is a woman. In this instance, Amanda did not directly disclose her sexual identity by saying "I am lesbian," but instead made an indirect disclosure by referring to her partner. Three other

participants also felt that the use of the word 'partner' is a self-disclosure about a lesbian sexual identity or orientation.

Other participants who discussed being asked about marriage varied somewhat in the way that they such handle questions. Seven participants reported that they do or would answer the question 'are you married?' by either saying 'yes' or 'no.' Some indicated that they might explore the question first and then answer it. Two of these participants felt like the marriage question is more straight-forward and perhaps less "controversial" or loaded than questions about sexual identity which is why they would answer them more readily. Sheila explained that although she answers questions about marriage but not about her sexual identity:

There's always a little part of me that either feels like a fraud or feels like I'm fueling some false fantasy that they have about who I am when I say, 'I am married but no, I don't have children'. Because I'm sure that they're not thinking expansively about marriage.

Although Sheila reported that she does not always feel comfortable with clients assuming that she is heterosexual, she also believed that "offering extra information is really not always helpful to clients," such as informing clients that she is married to a woman.

Three participants reported that if clients asked about them having a husband or wife, for example, they might disclose the gender of their spouse or say 'partner.' Kristen, who is currently engaged to be married, indicated that if clients ask her if she is married and if it is clear that they are assuming she is straight and married to a man, she will not "leave that alone and let it be a lie in the relationship." She reported that she would correct a client's assumptions about the gender of her spouse because she would not want the

client to feel betrayed by her in any way, especially if she ran into the client in the community with her partner.

Lastly, Liz, who is married, discussed the complex relationship between self-disclosure and questions about marriage now that same-sex marriage is legal in Massachusetts. She stated:

The married one [question] is the hardest one now that it's legal because right before that, if I said 'I'm not married, but I am partnered,' everybody understands what partnered means. So I could have spelled it out or not but everybody sort of would know; that that was kind of cultural—I'm probably with a woman. Now that we can get married, it's a much more ambiguous term; it doesn't indicate who I might be partnering with.

Liz did not elaborate on how she would address questions about marriage but reported that clients rarely ask her anymore. It is noteworthy to acknowledge that the legalization of same-sex marriage may change the assumptions clients make about a therapist's sexual identity; it may also change the way therapists self-disclose around questions of marriage.

Prevalence and Impact of Oppression

The reporting of the prevalence and perception of homophobia within the therapeutic relationship varied somewhat among participants. Only one participant out of 12 reported that she had one “very hostile” experience in which homophobic remarks were directed at her. The incident occurred when Amanda worked at a previous job in a different state. Amanda retold the experience in which, unbeknownst to her, the potential adoptive heterosexual family of her adolescent client saw her out in the community with a rainbow sticker on her car. During the following therapy session, the family confronted Amanda and told her, “Yeah, I think it was really hard for this girl and for our family in general, to be out with our friends and have to explain to our friends why our therapist is

a faggot.” Amanda described how she handled the situation and the impact it had on the relationship with her adolescent client:

I absolutely was speechless and so I didn't know what to say. And this kid is crying and this mom's enraged, and she goes “So is it true? Is it true that you're gay?” And I tried to get her in all of my ways to talk about what that meant—talk about what she really needed to know, and to talk about blah, blah, blah and how would that change our relationship if I were or I weren't—you know all those great psychodynamic things. But... it kept coming back to: Are you queer? Are you a faggot, are you a dyke? 'Cause we need to know, 'cause you can't work with this family if you are, basically. And then kind of a tirade about religious Christian stuff and so then I said, you know what, I've always been honest with you about trying to work with your family, and I'm a lesbian and if you can't work with me that's fine... And she said, “No, you're not. You're not gonna work with this girl anymore because we don't want that kind of influence. We don't want that kind of perversion in our lives”... And I did continue to see that kid and it's not surprising that that kid blew out of that home. She's an adolescent. And then I had to talk about it with her to some extent. I mean this huge ordeal has just happened and what we ended up talking about...the way she framed it was that she had been in group homes and foster homes and...in and out of some orphanages. And she had basically made the assumption that the nicest staff people and the people who had been kindest to her—social workers, staff, me—were gay or lesbian and there wasn't anything wrong with that and she thought it was stupid that they acted that way and she was sorry. You know, and to that end, I felt like that kind of summed it up. We never really approached it again.

Although Amanda ultimately decided to continue her work with the client, she described going through a long and hard process of deciding whether or not it was in her and her client's best interest to work together. She was concerned with her own safety in terms of a potential lawsuit ensuing should the family spread misinformation about her “perversion.” However, she did not want to send the message to the client that “I don't want to deal with you.” Amanda expressed that she was “absolutely torn up” about the incident and found it to be “very, very personally upsetting.” She described having had other experiences in the community of being harassed and being nervous for her own

safety, “but never in my own office...and never at my agency. And somehow that really sort of disturbed the bubble that I had around me and my work with people.”

The majority of participants reported that issues of homophobia had surfaced in their work with clients, although nothing directed at them personally. Beth stated that she could not recall externalized homophobia having been “an issue” with clients; rather, racism and classism presented as issues in her work much more so than homophobia. She partly attributed the absence of homophobia to the fact that she is not seeing “fundamentalist Christians” who, in her mind, “are the last group that’s still pretty homophobic,” and partly to the fact that as a private practitioner, she has control over who she accepts as clients. Ruth suspected that a few cases of “premature terminations” could have been related to homophobia based on the fact that in each case, “the common denominator was they were often Caribbean and Christian and went to some type of Pentecostal or Evangelical church, and used that in a lot of how they talked about issues.” Ruth also felt that part of the reason she has not experienced a client “making a tough homophobic remark” was due to a “self-protective” aspect within the structure at her agency. She explained that supervisors and intake workers were sensitive about case assignments and would not “give an outrageous homophobe” to a gay or lesbian therapist.

Four participants specifically stated that homophobia was much more prevalent in their work with adolescents than with heterosexual adults. Of those four participants, three said that they would address remarks such as, “oh, that’s so gay,” and “explore” or “challenge” them, or offer an “alternative” perspective. Patty reported that she might pursue such comments if it seemed clear to her that they were “about the client’s own

internal struggle.” Megan felt strongly that it was important to challenge clients about homophobic or racist remarks, even though she felt like she was taking on a different role in doing so. She explained her view as follows:

You know, I’ll kind of challenge them on that. And I feel like I do step out of the therapy role when I’m doing that... I feel like I’m socially correct in that way, but...I feel like it’s an important thing to do. Quite frankly, if someone was saying, “oh that nigger” or whatever, I would question that word choice. I would question whether it’s therapeutic or not. I would question their word choice ‘cause that’s also part of my job I think as educating and advocating somewhat.

For another participant, the process of deciding how to handle derogatory, homophobic, or racist comments was a challenging and thought-provoking one. The dilemma Sheila described in the following passage was similar to that expressed by some of the other participants:

You know, teenagers I’ll see in family therapy and the in-thing right now is to say, ‘oh that’s so gay’ which, you know, do I just say that’s just how teenagers talk? Or is that yet another micro-aggression, if you will, about gay people and am I colluding with them if I don’t say anything, or am I veering us off in another direction if I take that up with them?...I think these are really tough, gray areas...I think a lot of it has to do with context of the work, the length of the relationship, a lot of it’s a judgment call... So far I’ve realized if they really thought I was gay, I don’t think they would say that and so I wouldn’t want to address it in a way that shames or blames my client. But I might poke at it... And sometimes I’ll—I mean I guess I’ve done this with more racist comments than anything else—is to make it clear that I don’t see it that way but that I can appreciate that they do, just because I don’t believe in colluding with my clients. Or I believe in offering an alternative to how it could be seen. So I guess I should pay attention more to do it in the same way with things related to sexual identity than I do it with other forms of oppression.

While some participants acknowledged that they might challenge or explore homophobic, racist, or negative remarks that come up in passing with clients, there was not consensus among participants about how they perceive or handle such situations. For example, some of the participants who said that they would confront adolescents who

made homophobic and/or racist comments also reported that they might not address the issue in the same way with adult clients. Amanda reported that she generally lets things go or does not “deal with it” unless she thinks addressing it could lead to “a larger therapeutic goal that is helpful,” or unless a client makes “overtly homophobic” remarks. Angela, who said that she might explore remarks with clients if it sounded like there was “really an issue,” also made it a point to clarify how she perceives such comments. She stated, “I mean when someone makes a negative remark about a gay person, it’s not necessarily homophobic; it may just be a negative remark about someone and then because they’re gay, it may be couched in a way that is homophobic.” Patty also acknowledged that certain comments could be “interpreted as homophobic or racist,” but that they have not always “hit me in that particular way.” Although all of the participants acknowledged that homophobia is still prevalent among clients, their perceptions of certain comments and the way in which they address them differ somewhat.

A number of participants acknowledged that they believe there is a difference between being a therapist and being an “activist” or “superimposing a political stance” within the therapeutic milieu. However, they also stated that they might challenge or explore a client’s blatant homophobic or racist remarks. Michelle had a notably different stance as to how she viewed and would handle oppression that emerged in the therapeutic relationship. She seemed less willing than other participants to challenge or address certain comments made by clients, as shown below:

It’s one of those things where I don’t think that we are the social police—we’re therapists... people can have all kinds of beliefs and all kinds of ways of living in the world... I’ll say when I’m working with someone who has no basic ADL skills, ‘you smell, you need to really work on that’. But I won’t say, I have a problem with your saying queer or saying horrible things about Black people or

horrible things; I won't say 'that's offensive to me'. I will help them if it's offensive in the world, if it's interfering with their lives.

Unlike the participant who said she felt like being an educator and advocate was part of her job in certain situations, Michelle specifically stated that it is "not my job to educate" clients who frequently make comments like 'he's so gay.' She went on to say that she perceives of some of her clients' comments as "ignorant comments" rather than "hateful comments," and acknowledged that "maybe that's the way that I deal with it."

The majority of participants reported that issues of homophobia had emerged to some extent with clients and a number of them also commented on the personal impact of such issues. A few participants acknowledged that they would be much less likely to come out to clients who they perceived or knew to be homophobic. Gail said that she had to be careful not to allow her "own feelings to influence the session" and instead "maintain a detached therapeutic stance while at the same time exploring somebody's blatant homophobia." Kristen said that when her straight clients make homophobic comments they "hit [her] in a different way" and she has to be careful not to respond in a way that is not "making [her]self better." A few other participants' comments echoed this struggle.

Two participants said that clients' homophobic statements and heterosexual assumptions affected them more when they were younger and less experienced therapists. Megan explained that she has done a lot of work to think about and understand where "straight people are coming from;" as a result, she felt like in her current work such statements "don't impact me either way." Angela attributed her increased feelings of

comfort and safety with coming out to straight clients to both changes in the larger culture and her own level of self-acceptance. She described these changes as follows:

I think I used to be more afraid to disclose to straight patients. I don't feel as afraid now. I think that everybody's changed and I think that people really are more comfortable. I feel that straight people are more comfortable—that their stereotypes about lesbians have changed...I think especially in [place of residence] people know more gay people...it's much more an integrated part of their lives. So I think my own anxiety of how they're going to react to me, it's made it easier. I think earlier on, I was more scared about, you know, would they want to work with me...So I think that that's evolved along with the culture and I guess with my own self-acceptance, but it's a different kind of self-acceptance because it feels like it's also paralleled in the culture.

However, another participant raised an important point about how progressive changes in the culture have also impacted the way in which heterosexual clients might react to disclosures of homosexuality. Liz said:

But you know also we're living in a time where there's so much political pressure to be fine with it that I think people who are coming out are really short-circuiting the process because in a very strange way, an unintended by-product of all this progress is that I think there's an assumption that it's supposed to be easier now...and people feel some pressure to tell you they're fine with it before they are. And I think straight people—at least in liberal areas like this—also feel some pressure to be fine with it. And I also think people who are involved in really important relationships with you so want to be fine with it.

While most participants reported that they have experienced homophobia from clients or employers at some point in their careers, the prevalence and impact of blatant homophobia seems to have lessened over time and in conjunction with environmental factors, such as geographic location and cultural attitudes.

CHAPTER V

DISCUSSION

This qualitative study explored how lesbian therapists think about and practice self-disclosure of their sexual identity with heterosexual clients. The goal of this study was to gather in-depth information about lesbian therapists' decision-making process regarding self-disclosure of their sexual identity to heterosexual clients, and how such disclosures or non-disclosures affect the therapeutic relationship and therapists' personal and professional identities. Literature and research frequently overlook the complexities and challenges that lesbian clinicians face regarding self-disclosure, particularly when working with clients of a different sexual identity; thus, this study aims to further an understanding of these unexplored areas. This chapter will discuss some of the major findings as they relate to previous research in the field. Implications for social work education, practices, and future research will also be addressed, as well as limitations of this study.

Participant Demographics

One noteworthy point regarding the participants interviewed for this study relates to their collective level of experience as clinicians. A total of 12 clinicians participated in this study. No therapist had less than seven years of clinical experience and four had been practicing for at least 29 years each. It is difficult to determine what impact the group's extensive professional experience had on findings of this study; however, it seems possible that participants with less clinical experience might have responded differently

to questions about their thinking and practice of self-disclosure of their sexual identity. Less experienced therapists might be more guarded and rigid with their boundaries, and less self-disclosing in general. In fact, a number of participants reported that they became more comfortable using self-disclosure—both in general and of sexual identity—as they grew older and gained more clinical experience. On the other hand, it is also possible that the age at which therapists came out as lesbian and achieved a more integrated lesbian identity impacted their comfort level surrounding self-disclosure. Since more and more individuals are coming out as gay and lesbian at younger ages, a similar study with younger lesbian therapists might produce different findings as well. As noted above, without additional information, it is not possible to know exactly how the study results were impacted by the experience level of the clinicians interviewed, but this demographic should be kept in mind when interpreting the data.

Major Findings

In general, participants presented with a range of thinking and practice of self-disclosure of sexual identity consistent with the limited current research on the topic. All of the participants reported that they practice self-disclosure at some point in their therapeutic work, which is in line with a number of studies on this topic (Anderson & Mandell, 1989; Berg-Cross, 1984; Edwards & Murdock, 1994; Simi & Mahalik, 1997). Participants acknowledged that while they generally believe in being thoughtful and intentional about self-disclosure, at times it can and does occur unintentionally, indirectly, and behaviorally as well. There was consensus in participants' thinking that, in spite of various influences on self-disclosure practices, there was no clear-cut, uniform way to approach self-disclosure and no "right answers." The vast majority of participants

expressed that they do not perceive themselves or aim to be a “blank slate;” instead, they believe that intentional, judicious self-disclosures can be an effective therapeutic intervention. The participants’ stance is far from that of traditional analysts or psychodynamic theorists; rather, it represents the changes in thinking that have occurred across a wide range of theoretical orientations in the fields of psychology and social work toward a greater use of self within the therapeutic relationship (Farber, 2006).

With regard to therapist self-disclosure of sexual identity, all 12 participants conveyed that intentional disclosure would be done on a “case-by-case” basis or would “depend” on various factors. The paucity of literature regarding queer therapists’ approach to and practice of self-disclosure of sexual identity reveals, similarly, that queer therapists tend to make decisions based on informed, clinical judgment, and self-disclose on a case-by-case basis (Mathy, 2006; Pearlman, 1996; Satterly, 2006). Falco (1991) believes that therapists also largely come to personal decisions regarding self-disclosure of sexual identity, which was the case for the majority of the participants in this study.

Participants’ self-disclosure practices with heterosexual clients were influenced by a number of factors emanating from both the participants themselves and their clients. Some influences participants mentioned include: the therapists’ theoretical orientation; clinical experience; the perceived benefit of disclosure or non-disclosure; personal experience (e.g., participants’ own experience in therapy, age, individual comfort level, and sexual identity development/coming out experiences); as well as the prevalence or absence of internalized homophobia. Some studies have produced evidence confirming that a therapist’s theoretical orientation (Edwards & Murdock, 1994; Simi & Mahalik,

1997; Simon, 1988) and personal experience in therapy (Simon, 1990; Simone, et al., 1998) affects the use and frequency of self-disclosure.

It is difficult to clearly discern how or the extent to which participants' theoretical orientations impacted their self-disclosure practices of sexual identity, but a number of participants reported that the principles of their theoretical orientation offered some guidance around general self-disclosure. Some participants also reported that their own experiences in therapy helped them to develop their individual style around self-disclosure over time, which was supported in the literature as well. Clinical evidence also suggests that the degree of therapist experience may affect self-disclosure practices (Farber, 2006), which was true for a number of participants. Many of the participants reported that as new and less experienced therapists they either never or very rarely disclosed their sexual identity to clients—queer or heterosexual. Since all of the participants had been practicing for at least seven years, it is likely that the findings would be slightly different had less experienced therapists taken part in this study.

However, the process of becoming more comfortable and confident with self-disclosure of sexual identity was not only related to increased clinical experience, but to the work environment, homophobia and heterosexism, cultural attitudes around homosexuality, and participants' self-acceptance as lesbians. A number of participants stated that their coming out process coincided with the beginning of their careers in social work and thus intimately informed one another. As their internalized homophobia decreased over time, participants generally felt more comfortable and open to the possibility of disclosing their sexual identity to clients; the decrease in fear, anxiety, and strong feelings about the issue allowed for participants to consider the potential

therapeutic value of coming out to clients and to explore this option. The findings seem to imply that greater levels of self-acceptance and decreased internalized homophobia contributes to lesbian therapists' overall comfort and willingness to come out to heterosexual (and queer) clients, and to perhaps more objectively determine the usefulness or relevance of disclosures of sexual identity.

In spite of feeling accepting and secure of their lesbian identities, some participants acknowledged having a certain amount of worry, anxiety, or fear related to disclosing their sexual identity to heterosexual clients. A few participants wondered if coming out to heterosexual clients might result in them losing esteem for the therapists and/or changing the way they feel about the therapists. Gair (2003) contends that an awareness that others might react negatively to a lesbian woman's coming out is ever-present regardless of her self-esteem level. Another study found that lesbians tend to come out more readily when they expect a positive reaction from others (Wells & Kline, 1987). The concern, shame, and internalized homophobia lesbians can feel as a result of having a minority sexual identity, however, may consciously or unconsciously impact therapists' decision-making process of coming out to heterosexual clients. Regardless of whether or not a lesbian therapist ever intends to disclose her sexual identity to clients, the very fear of becoming known as a lesbian and the anxiety about withholding this information can have a substantial impact on the therapist's work (Silverman, 2001).

While it was not the purpose of this study to do so, it seems difficult to isolate the extent to which such contextual variables affect lesbian therapists' self-disclosure practices as they frequently overlap and are interrelated. For instance, some participants' professional identities as social workers and their self-disclosure practices have been

informed by their sexual identities, personal experiences in therapy, work environment, relationship with the queer community, political activism, and the overall culture, in addition to other contextual variables. It may be that for sexual minority clinicians, such contextual variables potentially have just as much impact, if not more, on their self-disclosure practices than their theoretical orientation does, yet these factors have not previously been studied. While some of these contextual variables are also likely to affect heterosexual clinicians, the findings of this study reveal that lesbian therapists' self-disclosure practices are impacted by a great number of variables that not all clinicians must contend with, such as the multi-layered implications of being a sexual minority, internalized and externalized homophobia and heterosexism, or discriminatory practices and attitudes. A handful of lesbian clinicians have written about their personal clinical experiences, but this is definitely a neglected yet important area for further research, as it may have implications for clinical practice and clinician-supervisor relationships.

Study participants were asked to discuss their thinking and practice of self-disclosure sexual identity specifically with heterosexual clients; however, the findings revealed a common theme in that participants were more apt to come out or consider coming out to queer clients than to heterosexual clients. Participants felt that the issue of their sexual identity was more present and relevant with queer clients than with straight clients, which impacted their approach to self-disclosure. While a number of participants expressed that they would feel more authentic and at ease either being out to all clients or having their sexual identity be a non-issue, they had difficulty identifying the context in which they might come out to straight clients.

One reason for the “double standard” of self-disclosure practices expressed by some participants is that straight clients rarely directly asked participants about their sexual identity or raised the issue in a way that was seemed clinically relevant to the participants; thus, participants were not frequently presented with a distinct moment in which it might be relevant or useful to come out. Some research and literature does in fact suggest that therapist self-disclosure of a minority sexual identity/orientation may be more acceptable, warranted, important, or effective with clients who share a similar sexual identity/orientation (Cabaj, 1996; Coolhart, 2005; Falco, 1991; Isay, 1996; Hanson, 2003; Mahalik et al., 2000; Pearlman, 1996). For some even, the question is no longer whether to disclose to queer clients, but how and when such disclosure can further and become integrated into treatment with queer clients (Gabriel & Monaco, 1995; Pearlman, 1996). However, it is possible that the assumption or perception that it is not as useful to disclose a sexual minority identity to heterosexual clients may be influenced by homophobic and heterosexist beliefs that still tend to perceive of homosexuality as overly influential, perverse, and taboo.

As this study was limited in scope, further research should explore self-disclosure practices of lesbian and queer clinicians when disclosure reveals a difference instead of a similarity. It seemed that many of the participants worried that coming out to heterosexual clients and revealing such a difference could negatively impact treatment or introduce a topic that the client would have to integrate. Nonetheless, very few negative experiences associated with coming out to heterosexual clients were reported. It would be important to explore the benefits and risks associated with coming out to straight clients in greater depth, since it is possible that positive therapeutic moments might be missed

when lesbian therapists do not come out and, in some cases, indirectly perpetuate heterosexist assumptions.

The findings also reveal that when self-disclosure of a lesbian identity to heterosexual clients does occur, it happens in various ways. While all participants reported that self-disclosure of sexual identity should ideally be thoughtful and intentional, which is supported by the literature (see Knox & Hill, 2003), a number of participants described often not feeling “in charge” of the decision to disclose their sexual identity to clients. One participant thought that clients come into therapy already knowing that she is lesbian, either because they have “done their homework” or because she has published writings. However, many participants thought that the potential for heterosexual clients to know their sexual identity prior to beginning therapy was not as great as it was for queer clients because generally, heterosexual clients do not seek out that information. Nonetheless, the findings reveal that the question of therapist self-disclosure may no longer only be able to focus on intentional self-disclosures, especially since personal and private information is often readily available for discovery in today’s technology-driven culture.

Even if participants did not directly come out to clients, they thought that most queer clients would learn the information from external resources or intuit it from participants’ behavior, cues, demeanor, or language. Russell (2006) acknowledged that therapist self-disclosure can also include unintentional and dialogic communications between a client and a therapist. Self-disclosures of sexual identity to heterosexual clients were primarily talked about being made in response to a direct question, indirectly as part of a disclosure about something else (e.g., a story in which the participant refers to a

partner or the gender of partner), via unintentional meetings outside of the therapeutic setting, or via public information available about the therapist that is communicated through websites, publications, word-of-mouth, etc. The majority of participants stated that they would most likely disclose their sexual identity to any client who poses a direct question about it, although they might first explore the matter with clients. Research has typically focused on the prevalence and impact of direct, verbal disclosures, yet these findings suggest that self-disclosure of a lesbian identity occurs on various levels and in myriad ways. As more and more information about individuals becomes public and available through the Internet, it is possible that therapists will not be able to ensure or have as much control over what clients could learn about them. An important and interesting area of future research might focus on indirect forms of therapist self-disclosure of sexual identity, how they enter the therapeutic relationship, and their impact on clients, therapists, and the therapeutic alliance.

Participants reported a number of reasons why they would intentionally disclose their sexual identity to heterosexual clients, which were in line with those included in the broader literature on self-disclosure. All participants expressed that their decision-making process around self-disclosure of sexual identity involves considering factors such as: the relevance of the disclosure to clients, clinical goals, and the therapeutic relationship; whether or not a disclosure would help or hinder a client's process; and to some extent, the therapists' comfort level with disclosing such information to clients. Some of the reasons for coming out to clients cited by participants include: a client's "need to know;" role modeling; normalizing and/or conveying understanding of a client's issue; and promoting authenticity. These motivations for coming out to heterosexual clients are

some of the same as those cited in both the broader literature on self-disclosure and specifically with regard to queer therapists working with queer clients (Cabaj, 1996; Coolhart, 2005; Falco, 1991; Isay, 1996; Hanson, 2003; Mahalik et al., 2000; Pearlman, 1996). Participants generally felt that more reasons exist for them to come out to queer clients than to straight clients, but it is also possible that a more in-depth or different study design might elicit more thorough or a greater range of responses from participants.

One consideration to keep in mind is that so much of what happens within the therapy setting is spontaneous and unique—it is a result of the dynamics and relationship between a therapist and a client in the moment. Thus, it can be challenging and perhaps even unreliable for therapists to consider and report their decision-making processes and motivations for disclosing or not disclosing their sexual identity to clients after the fact. Therapists often have to make a split-second decision as to what they choose to say or do, and having the privilege of hindsight and distance may impact how therapists rationalize a particular intervention or what they chose to report. For example, in the Lane et al. (2001) study, as noted by Farber (2006), some therapists felt they should not act on their own self-gratifying needs or at least felt they could not acknowledge having done so. Although some participants acknowledged making disclosures that were not always therapeutic or that were largely for their own benefit, it is possible that some participants had a desire to present themselves in a strictly professional and unflawed manner, which would influence their responses. Future research that includes clients' perceptions and responses to therapist self-disclosure would be illuminating and a great contribution to the literature on self-disclosure, as well as helpful to clinicians.

Limitations of Current Study

Various limitations and potential bias within this study must not go unacknowledged. The qualitative, exploratory research design selected for this study fulfilled the goal of contributing to the dearth of literature on the self-disclosure practices of lesbian clinicians. However, the small sample of licensed clinical social workers (N=12) limits the generalizability of this study. The lesbian therapists selected for this study may not be representative of social workers in general or of lesbian social workers in specific. The racial homogeneity and relatively narrow geographic locations of participants (three Northeastern states) are also limitations to this research. Only one participant out of 12 identified as biracial (American Indian and Caucasian), making it difficult to discern any differences or similarities in practice based on racial identity. Further, the majority of participants either could not indicate or did not discuss the influence of their racial identity on their approach to self-disclosure of sexual identity. Since people of color are “more likely to be aware of racism and themselves as racial actors” (Miller & Garran, 2008, p. 89), it is likely that lesbian therapists of color might be more attuned than white therapists to the ways in which their racial identity influences their self-disclosure practices. Also, the vast majority of participants lived and practiced in largely socially progressive areas; including participants from more diverse locations may have allowed for a greater range of responses, although it might also further reduce the ability to generalize from the findings.

Other limitations and potential sources of bias are found in the recruitment of participants. Participants were recruited via convenience and snowball sampling techniques from various sources, including my professional and social contacts and

potential participant referrals. Multiple participants may have learned of the study from the same source and might be representative of a relatively small network of social workers. Thus, some participants might share similar practice styles, educational or theoretical backgrounds, etc., with each other and/or with me, which is a potential bias and might not be an accurate representation of lesbian clinicians in general. A more thorough participant selection process might have produced greater diversity within the sample; however due to the largely invisible queer population within society, it could be difficult to acquire a totally random sample of lesbian therapists.

Another limit to this research is that not all participants discussed all of the same topics or themes, and some explored them in greater detail than others. It is possible that if each participant addressed each topic or theme more fully, the findings might have been slightly different. A number of participants noted that they had not given much previous thought to some of the questions asked of them, while others had thought more extensively about the issues and/or touched on them in previous publications. Therefore, the fact that participants may be at different stages of their thought processes regarding self-disclosure of their sexual identity, might limit the ability to generalize the findings. Also, it is worth noting that the somewhat controversial nature of the topic—coming out to heterosexual clients in the therapeutic milieu—may affect the degree to which therapists felt they could be open and honest about their self-disclosure practices of their sexual identity. Sexual minorities continue to experience scrutiny, homophobia, and heterosexism within society, which could possibly contribute to participants feeling the need to censor certain responses so as not cast lesbian therapists in a negative light or confirm stereotypes or prejudice.

In addition to the general limitations of this study, it is important to be transparent about the fact that I have my own personal biases. My interest in the issue of therapist self-disclosure of sexual identity stems mostly from my own experiences of being a white, lesbian clinician and having to think about and negotiate how, if, when, and to whom I disclose my sexual identity, what it means if I choose not to self-disclose, and from having an understanding of the difficulties of working as a therapist who has, in many respects, a “hidden identity.” While I made every effort to examine my own preconceptions and to analyze the research data in a thorough, objective manner, my experience as a lesbian working with the population may have influenced me in the research process.

Implications for Clinical Practice and Future Research

The current study sought to fill a gap in social work research with regard to how lesbian clinicians think about and practice self-disclosure of sexual identity with heterosexual clients. The findings of this research raise a number of themes and ideas that could be further explored or elaborated upon in future research. As mentioned previously, future research should explore the implications for both therapists and clients of therapist self-disclosure of sexual identity that reveals a difference in client-therapist sexual identity/orientation. The findings and literature revealed that lesbian therapists may make decisions regarding self-disclosure of sexual identity based, in part, upon their perceptions and assumptions about how a client will receive such information. This decision-making process may be informed by the therapist’s perception of client homophobia as well as the therapist’s internalized homophobia. A study exploring clients’ perceptions of their therapists and reactions to self-disclosures could shed light on

the degree to which heterosexual clients do or would harbor homophobic feelings toward their therapist. Further, the findings point to a continued need to combat and reduce homophobia and heterosexism within the field of social work as well as within the larger culture.

This current study, as well as future studies, could be beneficial in opening up dialogues between therapist-client and therapist-supervisor dyads in terms of the impact of homophobia and heterosexism on their relationships and clinical practice. It would behoove heterosexual supervisors to gain an understanding of the complicated nature of self-disclosure of sexual identity for lesbian and queer therapists and examine their own heterosexism and homophobia in order to help therapists—particularly newer therapists—navigate this terrain in an accepting and non-judgmental way. Hopefully, this study will encourage all clinicians to become more aware and reflective of their own self-disclosure practices in order to provide the best treatment to all clients and maintain cognizance of the potential impact of their disclosures and use of language.

Future research should explore therapist self-disclosure practices with children, adolescents, and families. A number of participants expressed differences in their self-disclosure practices based on the age of their client or based on the client system. Some participants were more apt to come out as lesbian to adolescent than adult clients, for example, while others maintained that they would not come out to children or adolescents. This is also a highly understudied area that deserves more attention, especially given the fact that more and more youth are coming out as queer at younger ages and more youth are being raised by lesbian, gay, bisexual, and transgender

caregivers. It is possible that, as with adults, coming out to youth and adolescents could have numerous therapeutic benefits.

Additionally, three participants worked a fair amount with transgender clients who identify as queer or straight. One participant asked me whether or not transgender clients who identify as heterosexual were included in my definition of “heterosexual clients.” Unfortunately, this question revealed my own bias and limited thinking in terms of the various representations of sexual identity. Also, the participants who worked with transgender clients expressed that they often had difficulty working with female-to-male transgender clients because they did not know how to help them learn to become men. It would certainly benefit all clinicians and transgender clients if clinicians gained greater knowledge and understanding of the issues that many transgender clients are grappling with in their process of gender and possibly sexual identity transitions. This area was not explored in great depth with participants but emerged as an area for future research and consideration. Additionally, future research on the unique and complicated self-disclosure issues that transgender and transsexual clinicians must negotiate, would be a significant contribution to the field of social work.

Finally, future research much also attempt to include greater racial and geographic diversity among participants. Most studies and literature on therapist self-disclosure—including self-disclosure of sexual identity—represent a very small percentage of clinicians of color or do not include clinicians of color at all. Female sexual minorities of color are members of at least three marginalized groups: “one related to their ethnicity, another to their sexual orientation, and the third to their biological sex” (Ritter & Terndrup, 2002, p. 189). The “triple discrimination” female sexual minorities of color

face have an impact on racial/ethnic minority lesbians (Green, 1994), and would likely impact the self-disclosure practices of lesbian therapists of color when working with heterosexual clients. The self-disclosure practices of lesbian therapists of color might also differ depending on the racial/ethnic identity make-up of both therapist and client.

Conclusions

My hope for the utility of this study is that it will fill a gap in the current social work research, while also contribute to the clinical practice knowledge base for lesbian therapists who work with both heterosexual and queer clients, as well as therapists of all sexual identities or orientations. This study will hopefully mark the beginning of a larger, more in-depth exploration into the complex issues lesbian and queer therapists face in their negotiation of self-disclosure of their sexual identity to heterosexual clients. It is important to consider when, how, why, and to whom information about a therapist's sexual identity is revealed or communicated to clients and to understand the impact of such disclosure or non-disclosure on therapists, clients, and the therapeutic alliance. Additionally, the impact of heterosexism and homophobia on clinicians, clients, and clinical research must not be ignored. If all clinicians strive to understand the dynamics of heterosexism and homophobia within the therapeutic milieu and the larger culture, and be reflective of and attuned to the biases we bring to it, we may—as a therapeutic community—work toward minimizing and confronting heterosexist bias and improving our clinical practice for clients and clinicians alike.

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Appendix A

Human Subjects Review Committee Approval Letter

December 18, 2007

Molly Thomas

Dear Molly,

Your revised materials have been reviewed and they are fine. All is in order and we are therefore happy to give final approval to this most interesting study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. It will be most interesting to learn more about this issue from people on the front line.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Luba Faulk Feigenberg, Research Advisor

Appendix B

Recruitment Letter

Dear Friends and Colleagues,

As you may know, I am currently a candidate for a Masters of Social Work degree from the Smith College School for Social Work. I am writing to request your assistance in completing my master's degree thesis research; whether or not you qualify to participate in my study, you may know someone who does! The purpose of my study is to explore the ways in which lesbian identified clinicians think about and/or practice self-disclosure of their sexual identity in a clinical setting with heterosexual clients. While there is a growing body of literature that addresses therapist self-disclosure issues among social workers in general, there has been very little inquiry into therapist self-disclosure practices of queer social workers or of self-disclosures of a queer identity. My study is designed to give voice to lesbian social workers and to make a contribution towards filling this gap, but I need your help in order to complete it!

I am writing to invite your participation and solicit your help in identifying other eligible persons you know who might be willing to participate. In order to qualify for the study, you must be a biologically female, lesbian-identified therapist who is a licensed social worker of any theoretical background. You must have experience practicing in a clinical setting in which self-disclosure of sexual identity is permitted and you must currently be practicing social work. Additionally, you must reside in New England or the New York City area and have English language fluency.

Qualified participants will be asked to provide certain demographic information in written form, as well as participate in an interview that will last approximately 60 to 90 minutes. In the demographic questionnaire you will be asked some general information about yourself and the population you serve. In the interview, you will be asked questions regarding your sexual identity, your thinking about the use of self-disclosure of your sexual identity within the clinical setting, your practice of self-disclosure of your sexual identity, and the thoughts, feelings and experiences that have influenced and shaped your current thinking and practice. The interview will allow for you to elaborate on any of the questions and/or insert any additional comments you may have on the subject at the end of the interview. Any information obtained from you will be kept completely confidential and all names and other identifying information will be changed.

If you are interested in being part of this study or have any questions or concerns, please contact me directly. To help me recruit others, I am asking that you forward this information to any practicing social workers you know—coworkers, colleagues, friends, family, etc.—who might be willing to participate.

Thank you in advance for helping to make this meaningful project a success. Please feel free to contact me with any questions or concerns.

Appendix C

Informed Consent

Dear Potential Research Participant,

My name is Molly Thomas, and I am currently enrolled in a Master's Degree program in Social Work at Smith College School for Social Work in Northampton, Massachusetts. I am conducting a study that aims to explore the ways in which lesbian identified clinicians who work with heterosexual clients think about and/or practice self-disclosure of their sexual identity in a clinical setting. Data obtained in this study will be used in my Master's thesis, and for future presentation and publication on the topic.

Your participation is requested because of your unique perspective as a lesbian therapist working with adult heterosexual clients. If you are interested in participating in this study, you must be a biologically female, lesbian-identified, licensed clinical social worker doing therapy. You may be a clinician of any theoretical background and may have practiced therapy as a licensed clinical social worker for any length of time. You may practice in public or private settings but must have experience practicing therapy in a setting in which self-disclosure of sexual identity is permitted. Further, you must have experience working with adult heterosexual clients, although not necessarily exclusively. You may be of any racial or ethnic group, age, religious or political affiliation, and you must reside in New England or the New York City area and have English language fluency.

If you choose to participate you will be asked to provide certain demographic information in written form, as well as participate in an interview that will last approximately 60 to 90 minutes. In the demographic questionnaire you will be asked some general information about yourself and the population you serve. In the interview, you will be asked questions regarding your sexual identity, your thinking about the use of self-disclosure of your sexual identity within the clinical setting, your practice of self-disclosure of your sexual identity, and the thoughts, feelings and experiences that have influenced and shaped your current thinking and practice. The interview will allow for you to elaborate on any of the questions and/or insert any additional comments you may have on the subject at the end of the interview.

The interviews will be recorded and transcribed. Any information will be kept completely confidential. The data will be coded and your name, your agency or location of practice and other identifying information will be changed. Quotes may be used in the reporting, but identifying data within the quotes will be removed or deleted. Everything pertaining to you will be locked and stored in a safe place and will be destroyed after three years, consistent with Federal regulations.

It is my hope that this data will be illuminating in terms of the implications this study has for clinical practice of both queer and heterosexual therapists. The interview process may be beneficial to you in that it is giving you a chance to discuss and clarify your own

experiences, thoughts and clinical practices. Unfortunately, however, I am not able to offer financial remuneration for your participation.

Some of the information asked of you in the interview may be personal, although the risks associated with participating in this study are minimal. Participation in this study is completely voluntary. You may decline to be involved with this study at any time without repercussion or loss of services. You may stop the interview at any point and you may decline to answer any interview question(s) for any reason. If you wish to withdraw your participation, you may do so at any time prior to April 1, 2008 and your data will be destroyed.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Researcher	Date

If you have any further questions about this study, participation, rights of participants, or this consent form, please feel free to contact me or the Chair of the Human Subjects Review Committee at 413.585.7974. Please keep this a copy of this consent form for your records.

Thank you for your time, and I look forward to having you as a participant in this study.

Sincerely,

Molly Thomas
Family Advocacy Center
2 Medical Center Drive, Suite 205
Springfield, MA 01199
413.794.4987
mthomas@email.smith.edu

Appendix D

Data Collection Instrument

Demographic Questionnaire

Age:

Sexual identity:

Racial/ethnic identity:

Relationship status:

Do you have children?:

State of residence:

Location or setting of employment (i.e. agency, private practice, etc.):

Client population with whom you work:

Theoretical orientation(s) (e.g. psychodynamic, relational, existential, etc.):

To what degree are you “out” in your personal (friends, family, community) and professional (colleagues, supervisors, professional networks) lives?

Type of degree(s) currently held:

Year(s) received degree(s):

Type(s) of license(s) currently held:

Year(s) received licensure(s):

Years of professional social work experience:

If in private practice, years in practice:

Average number of hours per week spent in private practice:

Approximate percentage of heterosexual clients you have worked with in your career:

Approximate percentage of heterosexual clients with whom you currently work:

Approximate percentage of LGBTQ clients you have worked with in your career:

Approximate percentage of LGBTQ clients with whom you currently work:

Do you receive regular clinical supervision?:

Interview Guide

1. Can you talk about your belief of the use of self in the therapeutic relationship and your approach to therapist self-disclosure in general (of any kind)? What about with regard to self-disclosure of your sexual identity/orientation?
2. Can you talk about your decision-making process of disclosing or not disclosing your sexual identity to straight clients?
 - a) What are your motivations and rationales for coming out to straight clients and/or not disclosing your sexual identity?
 - b) What do you perceive to be the risks and benefits to yourself, your clients, and the therapeutic alliance/process associated with disclosing or not disclosing your sexual identity?
 - c) How is information about your sexual identity communicated or revealed to straight-identified clients (e.g. verbal, non-verbal, in response to a direct question, etc.)?
3. From your perspective, what impact have disclosures and/or non-disclosures of your sexual identity had on your personal and professional identities and overall sense of self? What impact have they had on your straight clients and on the therapeutic alliance (i.e. have they helped or hindered the process)?
4. How have factors such as your work environment, degree of outness, and aspects of your social identity (e.g. race, sexual identity, gender, class, religion, age, etc.) shaped your thinking around and practice of self-disclosure of your sexual identity?
5. How and to what extent have issues of oppression (e.g. internalized and externalized homophobia & heterosexism, racism, sexism, etc.) been present or played out within the therapeutic relationship with straight clients? How have you addressed/dealt with them and what impact have they had on you personally?
6. Is there anything else regarding self-disclosure that you would like to add?