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Identity-Focused Therapist Self-Disclosure in Matched Sexual/ Gender Minority Dyads: A Longitudinal Therapy Process-Outcome Study

Brian Thomas Neff

IDENTITY-FOCUSED THERAPIST SELF-DISCLOSURE IN MATCHED SEXUAL/GENDER MINORITY DYADS: A LONGITUDINAL THERAPY PROCESS-OUTCOME STUDY

by

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Abstract

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by

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Background: Therapist self-disclosure (TSD) is a controversial clinical intervention whose benefits and drawbacks remain contested. Notably, no prior research has differentiated explicitly between self-disclosures related to the therapist's core identities and those peripheral to identity, and qualitative studies suggest that identity-focused therapist self-disclosure (TSD-I) may be beneficial when therapist and patient share at least one marginalized identity. LGBTQ+ people, who experience significant health disparities and utilize psychotherapy more than their heterosexual and cisgender counterparts, could benefit particularly from TSD-I. The mental and physical health challenges facing LGBTQ+ individuals are predominantly explained through minority stress theory, which suggests that societal prejudice and discrimination contribute to heightened levels of rejection sensitivity, internalized LGBTQ+-negativity, and loneliness in the LGBTQ+ individual, which lead to deleterious health outcomes.

Objective: This longitudinal study investigates the effects of TSD-I on patient psychological functioning in therapy dyads matched by LGBTQ+ status. It explores two potential pathways through which TSD-I may affect patient psychological functioning: the therapeutic alliance (assessed as the "real relationship" between patient and therapist) and minority stress level. This

study also qualitatively analyzes participant written reflections to understand the meaning that LGBTQ+ patients make of TSD-I.

Method: A sample of 198 LGBTQ+ individuals, each receiving psychotherapy from an openly LGBTQ+ therapist, was recruited via therapist outreach, ads placed on social media sites and e-mail listservs, and posted flyers. Participants completed surveys at three time points, spaced on average eight weeks apart, measuring frequency and optimality of TSD (both identity-focused and general [GD]), minority stress processes, and psychological health. Path analysis was used to examine longitudinal mediation models. Emergent themes related to the therapeutic impact of TSD-I were identified using Interpretive Phenomenological Analysis (IPA) methodology.

Results: As hypothesized, longitudinal results revealed a significant indirect relation between TSD-I optimality at baseline and patient psychological functioning at T3, through real relationship and minority stress at T2. This indirect relationship remained significant after controlling for GD optimality, but only through the combined effects of both mediators and not each individually. Further, only TSD-I and not GD optimality at baseline significantly predicted better patient psychological functioning at T3 through the individual mediating pathway of minority stress at T2. Thematic analysis revealed that TSD-I can reduce loneliness, normalize life experience, and instill hope, among thirteen emergent themes, but also that it carries therapeutic risks.

Discussion: This study reveals that LGBTQ+ therapists do tend to disclose about their identities to their LGBTQ+ patients, that LGBTQ+ patients tend to rate disclosures as highly optimal, and that TSD-I appears to impact a patient's minority stress in ways that that GD does not. The path analyses suggest that TSD-I can be a beneficial therapeutic intervention but clinicians are wise to

approach it with caution, as the optimality of self-disclosure appears to influence treatment dynamics and patient mental health.

Keywords: Therapist self-disclosure, identity, sexual and gender minorities, LGBTQ, therapeutic alliance, real relationship, minority stress, internalized LGBTQ+-negativity, rejection sensitivity, loneliness, psychotherapy, psychopathology.

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Terminology

This paper defines the following sexual and gender identity terms in accordance with Division 44 (Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues) of the American Psychological Association (see e.g., APA Division 17 and Division 44, 2015):

*Asexual "*refers to a person who does not experience sexual attraction or has little interest in sexual activity" (p. 20).

Cisgender "refers to individuals who have a match between the sex they were assigned at birth, their bodies, and their gender identity" (p. 20).

Gender refers to "the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex. Behavior that is compatible with cultural expectations is referred to as gender-normative; behaviors that are viewed as incompatible with these expectations constitute gender non-conformity" (p. 20).

Gender expression refers to "an individual's presentation, including physical appearance, clothing choice and accessories, and behavior that communicates aspects of gender or gender role. Gender expression may or may not conform to a person's gender identity (p. 20).

Gender identity refers to "one's sense of oneself as male, female, or transgender" When one's gender identity and biological sex are not congruent, the individual may identify along the transgender spectrum (p. 21).

*Genderqueer "*refers to a person whose gender identity falls outside of the gender binary (i.e. identifies with neither or both genders). Genderqueers may also use the term 'gender fluid' as an identifier but typically reject the term 'transgender' because it implies a change from one gender category to another" (p. 21).

Pansexual "is most commonly used in the world outside academia as a sexual identity [and sexual orientation] term similar to 'bisexuality,' but more inclusive of trans people. It also shows an awareness of the implied gender binary in the term 'bisexual.' (p. 21).

Queer "is an umbrella term that individuals may use to describe a sexual orientation, gender identity, or gender expression that does not conform to dominant societal norms. Historically, it has been considered a derogatory or pejorative term and the term may continue to be used by some individuals with negative intentions. Still, many LGBT individuals today embrace the label in a neutral or positive manner. Some youth may adopt 'queer' as an identity term to avoid limiting themselves to the gender binaries of male and female or to the perceived restrictions imposed by lesbian, gay, and bisexual sexual orientations (p. 22).

Questioning "is an identity label for a person who is exploring their sexual orientation or gender identity, and is in a state of moratorium in terms of identity formation" (p. 22).

Sex refers to "a person's biological status and is typically categorized as male, female, or intersex (i.e., atypical combinations of features that usually distinguish male from female). There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia" (p. 22).

Sexual orientation refers to "the sex of those to whom one is sexually and romantically attracted. Categories of sexual orientation typically have included attraction to members of one's own sex (gay men or lesbians), attraction to members of the other sex (heterosexuals), and attraction to members of both sexes (bisexuals). Some people identify as pansexual or queer in terms of their sexual orientation, which means they define their sexual orientation outside of the gender binary of 'male' and 'female' only. While these categories continue to be widely used, research has suggested that sexual orientation does not always appear in such definable

categories and instead occurs on a continuum. In addition, some research indicates that sexual orientation is fluid for some people; this may be especially true for women" (p. 22).

Transgender "is an umbrella term that incorporates differences in gender identity wherein one's assigned biological sex doesn't match their felt identity. This umbrella term includes persons who do not feel they fit into a dichotomous sex structure through which they are identified as male or female. Individuals in this category may feel as if they are in the wrong gender, but this perception may not correlate with a desire for surgical or hormonal reassignment (p. 22).

CHAPTER ONE: INTRODUCTION

There is a longstanding and contentious debate among mental health professionals, rooted in polarized ethical and theoretical stances, around the clinical appropriateness and utility of therapist self-disclosure (TSD; Stricker & Fisher, 1990; Farber, 2006)—defined here as "any behavior or verbalization that reveals personal information to the patient about the clinician" (Dixon et al., 2001).[1] Consider the following starkly divergent positions:

> The doctor should be opaque to his [sic] patients, and, like a mirror, should show them nothing but what is shown to him (Freud, 1958/1912, p. 118).

> Valued change—growth—in patients is fostered when the therapist is a rather free individual functioning as a person with all of his feelings and fantasies as well as his wits. […] [Therapist] self-disclosure begets [patient] self-disclosure (Jourard, 1971, p. 140).

> Revelations of a personal nature…[are] breaks in the frame [that] serve to gratify pathological symbiotic and often parasitic needs within the therapist…[and] tend to lead to derivative deafness—failures to organize and understand the patient's derivative material around the relevant self-revealing intervention contexts (Langs, 1982, p. 470).

> Endeavor to normalize the shady side in any way possible. We therapists should be open to all our own dark, ignoble parts, and there are times when sharing them will enable patients to stop flagellating themselves for their own real or imaginary transgressions (Yalom, 2001, p. 224).

> Therapist self-disclosure puts pressure on the patient to also self-disclose without regard for his or her readiness to do so comfortably. (Simon, 1994, p. 514).

> In [Cognitive Behavioral Therapy], you don't want to be a blank screen. You want clients to accurately perceive you as a warm, authentic person who wants, and is capable, of helping them (Beck, 2020, p. 63).

[1] This paper uses "patient" and "client" interchangeably. It is inevitable, of course, that a therapist will inadvertently disclose certain aspects of their personhood through their office décor, physical appearance, dress, tone of voice, mannerisms, and other involuntary cues. This study concerns itself not with this indirect self-disclosure but rather with self-revealing behavior and speech that is conscious and intentional.

Empirical investigation into the merits of these conflicting stances has painted an incomplete and at times vexingly contradictory picture (Henretty & Levitt, 2010; Henretty et al., 2014). TSD has been found both to positively (VandeCreek & Angstadt, 1985; Lundeen & Schuldt, 1989) and negatively (Goodyear & Shumate, 1996; Cherbosque, 1987) affect patient perceptions of their therapist's expertness and trustworthiness, key components of the working alliance (Norcross, 2002). It has been shown both to bolster (Fox et al., 1984) and to have no effect on (Borrego et al., 1982) patient willingness to return to therapy. While one study reports that patients comparatively benefit from less intimate over more intimate TSD (Loeb & Curtis, 1984), another (Wetzel & Wright-Buckley, 1988) arrives at the opposite conclusion, while still others (e.g., Carter & Motta, 1988) find no differential effect.

We can say with relative confidence, report Henretty and Levitt (2010) in the most comprehensive meta-analytic research review to date, that on aggregate, therapists who self-disclose are perceived by patients as warmer (see, e.g., Nilsson et al., 1979; Fox et al., 1984) and more attractive or likable (Simonson & Bahr, 1974; Merluzzi et al., 1978); that moderate (versus low or high) TSD elicits greater patient self-disclosure (Powell, 1968; Mann & Murphy, 1975); that "immediate" TSD (of the therapist's experiences of the patient in the room and of the therapeutic process) is preferentially beneficial to "nonimmediate" TSD (of aspects of the therapist's life outside of the treatment; Hill et al. 1989; Ziv-Beiman et al., 2016); and that overall, TSD promotes net positive over negative patient responses (Bundza & Simonson, 1973; Peca-Baker & Friedlander, 1987; Lundeen & Schuldt, 1992).

These are tenuous conclusions, however, because historically TSD has been considered in binary and simplistic terms. For decades, researchers commonly made only one distinction between types of TSD: "immediate" (sometimes called "self-involving") and "non-immediate"

("self-disclosing"). The former includes countertransferential reactions ("I'm noticing a desire to comfort and protect you") and in vivo observations ("I feel that we've been more emotionally distant from each other lately"), while the latter involves any revelation of personal information outside the immediate therapy relationship (Hill et al., 1989).

Knox and Hill (2003) have offered the most usefully nuanced conceptualization of TSD, parsing it into further distinct subcategories (Hill et al., 1989). They propose that non-immediate TSD can take various forms: of *facts* (e.g., "I earned my PhD in counseling psychology"), *feelings* ("I also have felt anxious when I've been in situations like yours"), *insight* ("I tend to shut down when someone is angry at me because it reminds me of my own father's rage"), *strategy* ("When I enter crowded spaces and begin to feel panicked, I turn my attention to my breath"), *reassurance/support* ("I can empathize with your fear of public speaking because I have experienced that as well"), and *challenges* ("When I got divorced, I had to face my feelings of failure"). Few studies, however, have measured TSD granularly according to these subtypes (exceptions include Ain, 2011). Strikingly, no TSD taxonomy yet has proposed a distinction between disclosures related to the therapist's core identities—the racial, ethnic, sexual, gender, and other group affiliations that inform the therapist's essential personhood—and disclosures that are peripheral to identity. The present study addresses this significant gap in the literature.

Another explanation for the lack of TSD research consensus is that most investigators have failed to stratify their patient and therapist samples by demographic and other salient identity characteristics, implicitly presuming that all patients and therapeutic dyads will respond in similar ways to TSD (Henretty et al., 2014). But as Knox and colleagues (1997) discovered in their qualitative study of TSD in long-term treatment:

> Different types of clients seemed to react differently to TSD. Some of these clients were voracious in their desire for TSD, wishing their therapists had disclosed more often or even arranging to meet with a client of the same therapist to share information about the therapist. These clients seemed to want to merge in some way with their therapists. Other clients, however, were less desirous of disclosures, worrying at times that the disclosures blurred the boundaries of the relationship or distinctly stating that self-disclosures were inappropriate because they removed the focus from the client and were unprofessional in their revelations about the therapist (p. 292).

Along these lines, it is fair to presume that certain patients, and patient populations, would benefit more than others from TSD.

One such population may be LGBTQ+ individuals,[2] who are at substantially greater risk for mental health challenges (Plöderl & Tremblay, 2015; Hatzenbuehler et al., 2009; King et al., 2008; Meyer, 2003) and who utilize psychotherapeutic services at rates higher than the general population (Platt et al., 2018). Much contemporary research explains the relatively poor mental

[2] I have chosen LGBTQ+ as shorthand for the broadest possible collection of minoritized sexual and gender identities as defined by the National Institutes of Health (2020): "[Sexual and gender minority] populations include, but are not limited to, individuals who identify as lesbian, gay, bisexual, asexual, transgender, Two-Spirit, queer, and/or intersex. Individuals with same-sex or -gender attractions or behaviors and those with a difference in sex development are also included. These populations also encompass those who do not self-identify with one of these terms but whose sexual orientation, gender identity or expression, or reproductive development is characterized by non-binary constructs of sexual orientation, gender, and/or sex" (p. 3). LGBTQ+ refers to the manifold, fluid, and intersecting manifestations of non-heterosexual, non-cisgender identity; importantly, one can be simultaneously in the sexual majority and gender minority (e.g., a heterosexual, transgender woman), and vice versa (e.g., a bisexual, cisgender man).

and physical health of LGBTQ+ individuals through minority stress theory, which posits that cisheterosexist society inflicts persistent and pernicious structural violence onto them through prejudice, discrimination, stigma, and oppression (Katz-Wise & Hyde, 2012; Mays & Cochran, 2001; Meyer, 2003). LGBTQ+ people resultingly experience heightened levels of loneliness and alienation (Jacobs & Kane, 2012), as well as relational trauma rooted in shame (Bybee et al., 2009), internalized LGBTQ+-negativity (Israel et al., 2021), and rejection sensitivity (Pachankis et al., 2008) which are in turn implicated in higher levels of depression (Parra et al., 2016), anxiety (Timmins, 2020), substance use disorder (Lehavot & Simoni, 2011), and suicidality (Michaels et al., 2016), among other afflictions.

LGBTQ+ patients frequently seek out therapists who also openly identify as LGBTQ+ (an identity-based "dyad match"; Guthrie, 2006), and qualitative research (e.g., Satterly, 2006; Kronner, 2013) suggests that in such matched pairs, the therapist's self-disclosures around their lived experience as a fellow LGBTQ+ person can be therapeutic and transformative to the treatment—by improving the genuineness of the relationship, depathologizing and destigmatizing shame-fueled topics, increasing the therapist's perceived humanity and capacity to serve as a role model, and fostering an egalitarian treatment climate that promotes patient self-disclosure, all of which bolster the working alliance (Cabaj, 1996; Pixton, 2003; Hanson, 2005). It is suggested that TSD in LGBTQ+-matched dyads can offer a profoundly corrective emotional experience for the patient (Alexander & French, 1956) by providing hope and comfort, and offering concrete strategies for handling the manifold challenges of living that are unique to LGBTQ+ individuals (Satterly, 2006; Kronner, 2013). Conversely, LGBTQ+ therapists who remain staunchly opaque risk embarrassing or invalidating their LGBTQ+ patients, inhibiting

their patients' own disclosures, activating core schemas of alienation, and, paradoxically, creating a climate in which the focus shifts toward the therapist (Isay, 1991; Hanson, 2005).

However, TSD with any patient also presents a host of potential complications, including threats to the integrity of the treatment and at worst, ethical boundary violations (Barnett, 2011). Research has illuminated potential pitfalls of poorly executed TSD (Hanson, 2005; Farber, 2006; Audet, 2011). While too little disclosure (the "blank screen stance"[3]) can create a sterile and alienating treatment milieu devoid of empathic warmth, therapists who disclose too liberally or inappropriately (the "unboundaried stance") risk compromising the therapeutic frame by blurring the line between professional relationship and friendship, or even catalyzing a role reversal in which the patient assumes caretaking responsibility for the therapist (Audet, 2011). LGBTQ+ therapists may feel intuitively drawn to disclose more intimate aspects of their sexual or gender identities to their LGBTQ+ patients, but fearing these and other negative consequences, aware of the professional stigma around self-disclosure, and lacking empirical evidence to support their clinical intuition, they may err cautiously on the side of non-disclosure and thus forgo a potentially powerful therapeutic intervention.

We are still far from understanding why and how, and specifically for which patients, TSD is of benefit, if it is at all. There is ample reason to believe, however, that in dyads matched on one or more salient identities, TSD pertaining to those identities would have a substantively unique impact—one that is likely advantageous to the treatment if and only if the disclosures are optimally executed. This study, the first to this author's knowledge to examine *identity-focused*

[3] The "therapist as blank screen" metaphor, first invoked not by Freud, as conventionally believed, but by Jelliffe (1930), remains shorthand for the orthodox psychoanalytic stances of anonymity and neutrality that have been increasingly challenged by contemporary interpersonal, intersubjective, and relational thinkers (e.g., Renik, 1995).

therapist self-disclosure (TSD-I), regards "optimal" disclosure as aligned with the dynamics of the treatment relationship, delivered judiciously, and for purposeful therapeutic ends. Operationalized from the patient's perspective, optimal disclosure likely falls somewhere along the spectrum between the totally withholding blank screen and the extravagantly revealing, unboundaried stance; it meets the "Goldilocks test"—not too little, not too much, but rather just enough. For disclosure to be optimal, it must make the patient feel comfortable, be relevant to the patient's own issues, and be useful in advancing the patient's therapeutic goals—from the *patient's* perspective. (See Chapters 2 and 3 for further discussion of the operationalization of disclosure optimality.)

As rates of psychological distress spike across the general population amid the protracted COVID pandemic, LGBTQ+ individuals face especially acute vulnerability. As Phillips (2021) reports, the pandemic has exacerbated longstanding health inequities between sexual and gender minority individuals and their cisgender, heterosexual counterparts. For example, during the initial period of mandated COVID isolation, seven percent of gender-diverse individuals engaged in self-harm, compared to two percent in cis-gendered people. Prior to COVID, 34% of LGBTQ+ people reported "poor" or "extremely poor" mental health (a sobering statistic in its own right); one year into the pandemic, this had skyrocketed to 61%. Depression and anxiety increasingly and disproportionately affected non-straight and gender diverse (as well as ethnic minority) individuals. This disparity is troubling yet not surprising, as quarantining heightened the sense of loneliness and alienation that LGBTQ+ individuals long have suffered as a result of minority stress (Meyer, 2003; Beutel et al., 2017).

There perhaps has never been more urgency to empirically validate which psychotherapeutic interventions are most efficacious for LGBTQ+ people. To this author's

knowledge, the present study is the first process-outcome research that looks at a potentially beneficial intervention—identity-focused self-disclosure—using longitudinal data. It is predicated on the notion that LGBTQ+ patients have substantively unique needs in therapy that have been overlooked in the mainstream psychotherapy outcome literature (Pachankis & Safren, 2019). It does not presume, as many (perhaps most) researchers do, that interventions found to be effective or ineffective in the general patient population will be correspondingly so when applied to LGBTQ+ patients. In this way, this study aims to provide LGBTQ+ clinicians with actionable evidence that can guide their decisions about what and how to share aspects of their own sexual or gender identities in the treatment room.

Specifically, the purpose of this process-outcome study is to examine the effects of TSD-I on patient outcomes in dyads matched by LGBTQ+ identity. It further aims to investigate multiple potential pathways by which TSD-I impacts treatment outcomes. This study's core premise is that the psychotherapy experience—particularly when an LGBTQ+ individual is matched with an openly LGBTQ+ therapist—can provide a potent countervailing force against minority stress, the primary and predictable driver of psychopathology for LGBTQ+ individuals (Hoy-Ellis, 2021). Moreover, the therapist's act of self-disclosing around their sexual/gender identity—so long as it is done optimally—is likely to benefit the treatment by improving the "real relationship" component of the therapeutic alliance (Gelso et al, 2012; Horvath & Greenberg, 1989), as well as by salubriously counteracting and reducing the severity of component minority stress processes (Meyer, 1995, 2003), namely: the patient's rejection sensitivity stemming from stigma consciousness (Pachankis et al., 2008), internalized LGBTQ+-

negativity[4] (Berg et al., 2016; Testa et al., 2015), and the loneliness of identity concealment and minority alienation (Beutel et al., 2017).

An LGBTQ+ therapist who optimally self-discloses around their identity likely conveys the metamessage (Wachtel, 2014) that minoritized sexual/gender identities are natural expressions of humanity that warrant neither shame nor approbation, a stance which can serve to dissolve the patient's calcified scripts of internalized LGBTQ+-negativity. Such therapists likely convey that although there are indeed intolerant, even hateful victimizers in the world, there are many—therapist included—who not only accept but embrace all forms of sexual and gender expression, thereby likely lessening the patient's rejection sensitivity. And such optimally self-disclosing therapists likely convey that although alienation and isolation may have been the patient's dominant experience to date, there is nourishing connection to be had within the LGBTQ+ community; that the patient and therapist are "in it together," thus liberating the patient from the suffocating loneliness that defines so many LGBTQ+ people's lives (Jacobs & Kane, 2012). These premises are based both on existing qualitative research (e.g., Satterly, 2006), as well as this author's lived experience as a cisgender gay man who has been both patient of an openly gay therapist and therapist to patients whose primary therapeutic work centered on exploring their sexual and gender identities.

Hypotheses

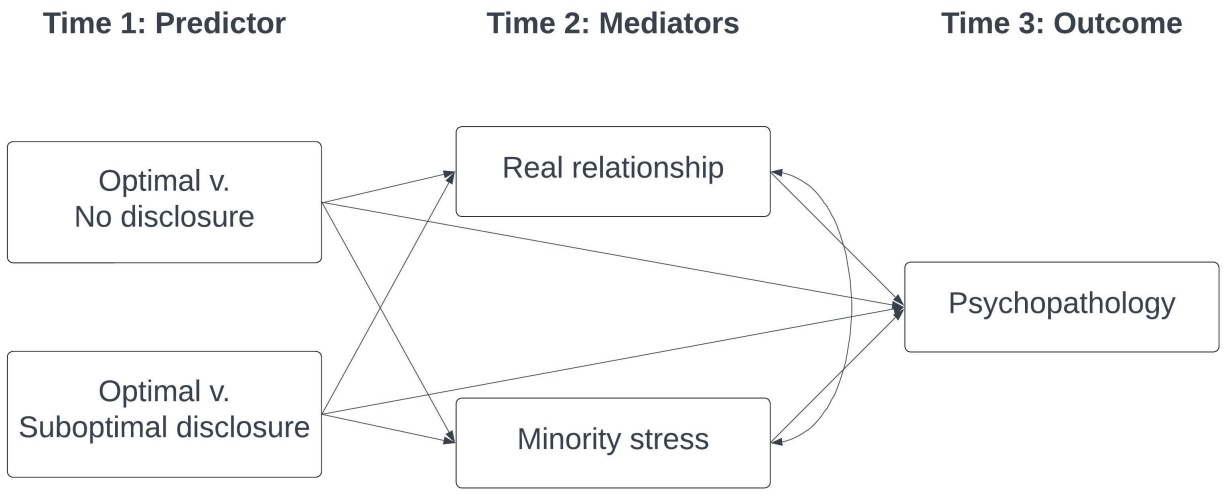
This study's primary hypotheses are as follows:

[4] "LGBTQ-negativity" is the internalization of societal stigma and shame towards one's minoritized sexual orientation and/or gender identity. It is used in this paper in place of the more frequently employed "internalized homonegativity" to reflect the wider range of sexual and gender minority identities represented in this study's population.

1. Patients whose therapists optimally self-disclose around their LGBTQ+ identity at baseline will show greater psychological functioning at study's end, as measured by symptoms of psychopathology, than those whose therapists suboptimally self-disclose or do not self-disclose at all. Suboptimal TSD-I will lead to worse patient outcomes than a total lack of self-disclosure. *(Null hypothesis: Self-disclosure does not influence symptoms of psychopathology.)*
2. Patients whose therapists optimally self-disclose around their LGBTQ+ identity at baseline will report a stronger therapeutic alliance at T2, as measured by the "real relationship," than those whose therapists self-disclose suboptimally or not at all. *(Null hypothesis: Self-disclosure does not influence the "real relationship.")*
3. Patients whose therapists optimally self-disclose around their LGBTQ+ identity at baseline, compared to those whose therapists self-disclose suboptimally or not at all, will manifest less reported minority stress at T2, namely (a) internalized LGBTQ+-negativity, (b) rejection sensitivity, and (c) loneliness. *(Null hypothesis: Self-disclosure does not influence minority stress processes.)*
4. The hypothesized positive relation between TSD-I optimality at baseline and patient psychological functioning at T3 will be partially mediated at T2 by both the "real relationship" and the patient's reported levels of minority stress (in the forms of rejection sensitivity, internalized LGBTQ+-negativity, and loneliness.) *(Null hypothesis: The relation between TSD-I and patient improvement will not be mediated by the "real relationship" or by levels of minority stress.)*

Figure 1

Hypothesized Longitudinal Mediation Model



CHAPTER TWO: LITERATURE REVIEW

The Health of LGBTQ+ Individuals

Throughout most of the twentieth century, LGBTQ+ individuals in the United States faced a grim choice: live openly and authentically at grave peril to their safety and livelihoods, or remain "in the shadows" (Odets, 2019), pantomiming as cisgender and straight or cloaking themselves in asexuality publicly while seeking intimacy in often shame- and terror-laden secrecy (Faderman, 2015). A homophobic psychoanalytic psychiatry establishment—from which mainstream society took its cue—branded homosexuals sick, certifying their psychopathology in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) first as a "sociopathic personality disturbance" (American Psychiatric Association [APA], 1952), then, in its second edition, as a "sexual deviation" (APA, 1968). "The classification of [sexual minority status] as mental illness," writes Uyeda (2021),

> was born from the legacy of multiple systems of power: the American legal system criminalized homosexual behavior; federal and state governments had not yet codified protections for queer and trans people seeking employment and housing; and an insistence on heteronormative gender roles stigmatized anyone who deviated from their role as a 'woman' or a 'man.'

In 1969, on the eve of the historic Stonewall riots that catalyzed the modern LGBTQ+ equality movement, 63% of Americans believed that homosexuals were "harmful to American life" (Motel, 2013), and the US was a country of anti-sodomy laws, gay bar ambushes, police harassment, rampant employment discrimination, including a federal civil service gay ban, forced lobotomies, and heinous hate crimes against gays and lesbians (Faderman, 2015; Sullivan, 1990; Klarman, 2013).

Although Freud (1960/1935) himself was remarkably tempered in his assessment of homosexuality, considering it merely a "variation of the sexual function,…nothing to be ashamed of, no vice, no degradation" (p. 423), his progeny spent the decades after his death militantly disavowing this progressive position. Rado (1940) declared homosexuality a "phobic avoidance of normative heterosexuality caused by early parenting deficits" (Drescher, 2008, p. 447); to Glover (1939), it was "the most advanced and organized form of sexual perversion" (p. 99). Socarides, who became the standard bearer for this band of "Neofreudian pathologizers" (Drescher, 2008), spoke breathlessly of the homosexual's "wild self-damaging tendencies" and "onslaughts of paranoid ideation" (quoted in Gold, p. 214), while Bergler (1956) reviled the "homosexual character" as an odious amalgam of "masochistic provocation and injustice-collecting; defensive malice; flippancy covering depression and guilt; hypernarcissism and hyper superciliousness;…and general unreliability, of a more or less psychopathic nature" (p. 49). The contemptuous moralism was thick and the purported empirical evidence supporting their claims was threadbare and methodologically corrupt: "shabby, shoddy, sleazy, pseudo-science…; moral, cultural, and religious value judgments cloaked in the language of science without any of the substance of science; assumptions plugged in at one end and drawn out unexamined and unchanged at the other end," as Franklin Kameny (2009), a founding leader of the contemporary gay rights movement, witheringly characterized it (p. 77).

In the psychoanalytic literature (e.g., Bieber, 1962), sexual minorities manifested pronounced mental illness only because they were sampled from psychiatric hospitals and prisons and carried preexisting psychological conditions independent of their sexual orientation, argued "homophile" activist groups like the Mattachine Society beginning in the 1960s (Meeker, 2001). Moreover, there was a growing body of overlooked or dismissed sexology research from

Kinsey (1948, 1953) and Hooker (1957) that showed no constitutional psychological differences between gay and straight individuals. Society was not justifiably stigmatizing gays and lesbians because they were pathological—if they were sick at all, it was because society was pathologizing them.

Enraged activists foisted this argument on successive conventions of the American Psychiatric Association (APA) in the early 1970s, disrupting proceedings to demand that science and not prejudice determine psychiatry's stance on human sexuality (Faderman, 2015). As Ron Gold attested in his 1973 APA address, "Stop it, You're Making Me Sick": "Nothing is more crippling than thinking that you're an emotional cripple, forever condemned to a personal status below those 'whole' people who run the world" (Ridinger, 2004, p. 215). And then, in a stunning about-face, relenting under the logical weight of the activists' arguments, the APA's Nomenclature Committee declared that a mental illness must cause subjective distress to be considered as such and that absent this distress, homosexuality per se (at least where it was "ego-syntonic") did not qualify as pathology (Drescher, 2008). "20,000,000 Gay People Cured!," one headline reported in wry jubilation (Bergeron & Kelly, 1974). Optimism ran high that a new dawn had arrived for the mental health of sexual minorities in America (Faderman, 2015).

Since then, the pace of change in American society's acceptance and destigmatization of LGBTQ+ people has been exponential. Gay and lesbian people, and to a lesser extent bisexual, transgender, and other sexual and gender minority individuals, are now broadly represented across mainstream and social media platforms. The Supreme Court's 2003 *Loving v. Texas* ruling decriminalized same-sex sexual conduct, and in 2015 the Court affirmed the constitutionality of same-sex marriage in *Obergefell v. Hodges* (Klarman, 2012). Between 2001 and 2021, the percentage of Americans who believed that "gay and lesbian relations" are

"morally acceptable" jumped from 40 to 69 percent (Gallup, 2021). Today a record high 70% of Americans support same-sex marriage, up from 27% in 1996 (McCarthy, 2021), and a substantial majority of Americans across the political spectrum believes that discrimination based on sexual orientation or gender identity should be illegal (Kirzinger et al., 2020). To be sure, many parts of the country remain intolerant and dangerous places for LGBTQ+ individuals to live openly, and public sentiment remains far more conflicted over gender minorities (Morgan et al., 2020). The chilling wave of anti-LGBTQ+ bills that have passed state legislatures in recent years confirm that prejudice towards LGBTQ+ individuals remains a potent ploy in cynical political gamesmanship (Peele, 2023). Yet, still, there has never been more widespread belief that sexual orientation and gender identity exist along a complex spectrum and that cisgendered heterosexuality is no more "normal" than other forms of human expression.

Present-Day LGBTQ+ Health Disparities

It as confounding as it is disturbing, then, that by most estimates the mental and physical health of LGBTQ+ individuals have never been worse (Meyer et al., 2021; Ruth & Santacruz, 2017). LGBTQ+ people suffer profound disparities in nearly every major mental and physical health indicator compared to nonminority populations (Institute of Medicine [IOM], 2011). They have a greater probability of experiencing any mental health disorder, particularly mood and anxiety and substance use disorders (Bostwick, et al., 2014; Meyer, 2003; Cochran et al., 2003; Fredriksen-Goldsen et al., 2013). They have higher suicide attempt rates (Cochran & Mays, 2015; Gilman et al., 2001) and use mental health services more frequently than sexual and gender non-minorities (Cochran et al., 2003). They also experience comparatively greater physical health problems: higher rates of obesity (Matthews et al., 2016); of cardiovascular

disease, asthma, and lung cancer (Landers et al., 2011; Stall et al., 2016); of diabetes (Lick et al., 2013); and of early disability (Fredriksen-Goldsen et al., 2012).

A bevy of studies has broken down these disparities by identity group within the broader LGBTQ+ population. Gay men, for example, have been found to have a four times greater likelihood of mood disorder (Blosnich et al., 2016a; Lewis, 2009), higher rates of panic attacks and overall emotional distress (Cochran et al., 2003), and higher rates of substance abuse and suicide (USDHHS, 2000), as compared to heterosexual men. They also have comparatively greater difficulty accessing healthcare (CDC, 2013; Cochran & Mays, 2015), higher infection rates with HIV (Cochran et al., 2016) and other sexually transmitted infections (Eng & Butler, 1997), and a greater likelihood of daily cigarette smoking (Max et al., 2016a). Lesbian women, meanwhile, have been found to experience more mental distress (Cochran et al., 2016), generalized anxiety (Cochran et al., 2003), depression (Koh & Ross, 2006), and alcohol abuse (USDHHS, 2000) than heterosexual women. They have also comparatively greater likelihood of cigarette smoking (Conron et al., 2010) and of obesity, heart disease, diabetes, asthma, and high cholesterol (Blosnich et al., 2016a). Health research into transgender populations is still in its relative infancy, but Blosnich and colleagues (2016b) document high mental illness prevalence, including mood disorders, posttraumatic stress disorder, and suicidality. Compared to their cisgender peers, transgender people also report greater rates of being uninsured, and transgender men tend to postpone medical care more than any other population group (IOM, 2011).

Counterintuitively, a more accepting society has not produced a healthier LGBTQ+ population. Meyer and colleagues (2021) sought to test the conventional wisdom that "things are better today" by studying a broad array of stressors and health outcomes in three nationally representative, age-based cohorts of LGBTQ+ individuals. They dubbed these the "Pride"

cohort, born between 1956–1963; the "Visibility" cohort (1974–1981); and the "Equality" cohort (1990–1997). Entirely contrary to expectations, the researchers found that it was the "Equality" cohort—the youngest—who reported the highest number of everyday discrimination experiences. The younger two cohorts also reported greater internalized homonegativity than the oldest cohort, and the Equality cohort evidenced the greatest level of psychological distress and suicide attempts (30% prevalence, compared to four percent in the general population). Conclude Meyer et al. (2021):

> Contrary to our hypothesis, we found little evidence that social and legal improvements during the past 50 years in the status of sexual minority people have altered the experiences of sexual minority people in terms of exposure to minority stressors and resultant adverse mental health outcomes. Most tellingly, younger sexual minority people did not have less psychological distress or fewer suicide attempts than older sexual minority people. …We found that members of the younger cohort did not experience less minority stress than member of older cohorts…[and] it is notable that the younger sexual minority people experienced more extreme victimization in their shorter lifespan (p. 12).

Perhaps it is because the youngest LGBTQ+ individuals are more out and unreservedly visible than any previous generation that they are subject to more overt discriminatory aggressions; older LGBTQ+ people may still conceal their identities more guardedly. Meyer and colleagues' (2021) findings align with the predominant theory used to explain the stark health disparities between LGBTQ+ and cisgender, heterosexual individuals: minority stress theory (Meyer, 1995, 2003).

Minority Stress Theory

The minority stress model assimilates seminal theories from sociology, social psychology, and philosophy—intergroup relations theory (Allport, 1954), identity management theory (Goffman, 1963), identity theory (Hogg et al., 1995), and social (Aneshensel, 1992) and psychological (Lazarus, 1993) theories of stress (Hoy-Ellis, 2021)—to explain how the ruinous social determinants of prejudice, stigma, and discrimination interact to worsen the mental and physical health outcomes of minority groups (Dohrenwend, 2000; Bostwick et al., 2014). Meyer's minority stress framework (Meyer, 1995, 2003) is adapted specifically to LGBTQ+ populations. It is one of the few theories endorsed by the Health and Medicine Division of the National Academies (2011) and has amassed two decades of convincing, though at times mixed, evidence (e.g., Hatzenbuehler et al., 2010, 2013; White Hughto et al., 2015; Meyer, 1995; Lehavot & Simoni, 2011; Testa et al., 2015).

All humans experience and must adapt to the general stressors of life—job loss, illness, financial insecurity, and so on. Meyer's (1995, 2003) minority stress framework postulates that LGBTQ+ individuals experience additional stressors purely on account of their LGBTQ+ identities. The model begins with external, or distal, social stressors inflicted chronically and perniciously on the LGBTQ+ person, from discriminatory legislation (e.g., Florida's "Don't Say Gay" bill; Goldstein, 2022) to violent victimization (e.g., homophobic hate crimes). Beyond these blatant acts of prejudice, it is demoralizing and dehumanizing as a minoritized individual to live in a society that even tacitly endorses a narrow sliver of human expression as "normal" while marginalizing, dismissing, and ignoring other ways of being. We live in a culture in which there is "the institutional construction of dominant categories as normative, ahistorical, and revered as a social ideal," write Cragun and Sumerau (2015), and where "people…are

systematically socialized and encouraged to leave these categories unexplored, unquestioned, and taken for granted in the daily operations of oppression and privilege" (p. 822). Queer theory takes as a fundamental premise that institutionalized scripts of normality fundamentally toxify the identity narratives that LGBTQ+ people create for themselves, with often grave health implications (Muñoz, 1999; Jagose, 1996).

Research clearly demonstrates that LGBTQ+ individuals have comparatively higher rates of childhood maltreatment (Corliss et al., 2002) and lifetime trauma (Roberts et al., 2010). A meta-analysis by Lick and colleagues (2013) estimated that about 80 percent of sexual minority individuals have endured harassment because of their sexuality. Flores et al. (2020) determined in a national representative survey that LGBTQ+ individuals have about quadruple the chance of experiencing a physical or sexual assault. It is the cumulative and compounding impact of these micro- and macroaggressions, perpetrated expressly due to a target's LGBTQ+ identity, that endangers the individual's healthy development throughout the lifespan (Meyer, 1995, 2003).

LGBTQ+ people must perpetually "readjust" to this onslaught of regular and often unexpected minority stressors, according to minority stress theory, fostering a baseline state of hypervigilance (Meyer, 2003). When a person's stress-response systems are persistently aroused, their physiological and psychological resources are depleted and their risk of physical and mental illness increases (Nurius & Hoy Ellis, 2013). Meyer's (2003) model identifies three resultant and mutually exacerbating proximal stressors, which are internal responses to the distal stressors. First, the individual learns to expect victimization, becoming acutely stigma conscious and sensitive to real and potential rejection (Lewis et al., 2003; Mendoza-Denton et al., 2002). They both consciously and unconsciously internalize the dominant society's prejudicial attitudes (internalized LGBTQ+-negativity; Berg et al., 2016). This ultimately drives the LGBTQ+ person

to conceal their sexual/gender identity, either totally or selectively, as a means of physical and psychological self-preservation (Goffman, 1963; Meyer, 2003). Concealing one's authentic humanity has been characterized as one of the most profoundly lonely experiences a person can endure (Ratanashevorn & Brown, 2021), and thus loneliness serves as a useful proxy for measuring the detrimental effects of concealment.

Meyer (2003) argues that social connection to the greater LGBTQ+ community ameliorates the negative effects of minority stress and fosters resilience. One who identifies with and integrates into the minority group takes a major step away from concealment and establishes a new reference against which to compare oneself, potentially reducing stigma consciousness and internalized LGBTQ+-negativity (Meyer, 2003). Relationships with other LGBTQ+ people can enhance positive self-regard, provide robust coping resources, and generally buffer against the pernicious effects of minority stress (Hoy-Ellis, 2021; Thoits, 1995). This may help to explain why so many LGBTQ+ individuals seek out openly LGBTQ+ therapists for their mental healthcare (Guthrie, 2006): it is a powerful means of connecting with the broader LGBTQ+ community without requiring of the patient upfront willingness to be publicly open about, or even accepting of, their identity.

Minority Stress and LGBTQ+ Mental Health

There is robust evidence supporting minority stress theory as it applies to the LGBTQ+ population, though inconsistencies in study findings suggest that identity intersectionality influences how and to what degree minority stress processes impact psychopathology. That is, certain minority identities or permutations of identity make an individual more likely to suffer the deleterious effects of discriminatory stressors (Hoy-Ellis, 2021).

Discrimination

Discrimination has an unequivocally detrimental impact on the mental health of LGBTQ+ individuals. In a longitudinal population-based study, Bränström (2017) found that more frequent experiences of discrimination and threats of violence, combined with weak social support, led to worse mental health among LGB individuals. Parra and colleagues (2016) discovered flatter diurnal cortisol slopes (indicative of chronic stress), and consequently greater depression, in LGB subjects who had reported the most minority stressors. Pyra et al. (2014) found that sexual minority status independently predicted depression in their sample of 1811 women at risk of HIV, after controlling for age, substance use, history of violence, and socioeconomic status. Molina et al. (2015) reported that depression and alcoholism in bisexual women could be explained by the mediating factor of bi-negative stigma. Bisexual individuals seem particularly susceptible to poor mental health because, it is posited, they face "double discrimination" from both the gay/lesbian and heterosexual communities (Mongelli, 2018, p. 31). For example, in an analysis of data from over 200,000 Canadian adults who self-identified as lesbian, gay, bisexual, or heterosexual, the sexual minority respondents were more likely to say that they had stressful lives and weak community ties, and it was bisexual individuals who reported the greatest mood and anxiety symptoms and alcohol abuse (Pakula et al., 2016).

Rejection Sensitivity

Further, a rapidly growing research base supports associations between each component proximal stressor in Meyer's (2003) framework and deleterious LGBTQ+ mental health outcomes (Wittgens et al., 2022). Rejection sensitivity, defined here as "the anxious expectation of rejection coupled with a tendency to readily perceive and interpret rejection in the ambiguous interpersonal behavior of others," is one manifestation of stigma consciousness (Slimowicz et al.,

2020, p. 2). A meta-analysis of 75 studies demonstrated a moderate correlation between rejection sensitivity and poor mental health across all populations (Gao et al., 2017). Among LGBTQ+ individuals in particular, rejection sensitivity has been shown to predict social anxiety and depression in gay men. Feinstein et al. (2012), for example, showed significant associations in a sample of 467 gay men and lesbians between rejection sensitivity and depression and anxiety symptoms. In Cohen and colleagues' (2016) study of college-age gay and bisexual men, rejection sensitivity emerged as a risk factor for internalizing disorders, namely generalized anxiety, social anxiety, and posttraumatic stress symptomatology. Sattler and Christiansen (2017) determined that rejection sensitivity, along with experiences of victimization, predicted a broad array of mental health issues among German gay and bisexual men, including depression, phobic anxiety, paranoid ideation, somatization, obsessive-compulsive disorder, and psychoticism.

Internalized LGBTQ+-Negativity

Internalized LGBTQ+-negativity (ILN)—which broadly encompasses but is not limited to internalized homonegativity (IH) and transnegativity (IT)—is the extent to which heterosexist and cis-normative societal attitudes, especially stigma towards minority sexual and gender expression, become entrenched in an LGBTQ+ person's self-image. As one participant in Cody and Welch's (1997) study of rural gay men trenchantly captured the phenomenon: "I [came to believe I] was the embodiment of all those nasty things that have been said about gay people" (p. 60). ILN results in an intractable dilemma in which the pursuit of innate sexual and gender expression triggers guilt, shame, and poor self-esteem (Herek, 2000; Meyer & Dean, 1998; Shidlo, 1994). ILN manifests as self-deprecating attitudes, discomfort with revealing one's sexual/gender identity, disconnectedness from the LGBTQ+ community, and a global aversion to

same-sex sexual activity and nonconforming gender expression (Meyer & Dean, 1998). It has been emphasized that ILN is squarely the product of sociopolitical bias and stigma and not a pathological or irrational anxiety response, nor is it a temperament or personality trait divorced from contextual minority stress (Russell and Bohan, 2006; Russell, 2007). ILN can be understood as internally expressed or "introverted" responses to stigma and prejudice, as theorized by Allport (1954), whereby a minoritized individual identifies with, rather than rebels against, their aggressors.

Newcomb and Mustanski's (2010) metanalytic review of thirty-one studies found a significant relation between IH and both depression and anxiety, while Meyer (1995) identified IH as the minority stress component most predictive of guilt, suicidal ideation and behavior, demoralization, sex difficulties, and AIDS-related traumatic stress in a sample of 741 New York City gay men. DiPlacido (1998) revealed similar associations while studying a sample of lesbian women, identifying IH as a correlate of negative affect and alcohol consumption. Other studies have implicated IH in a range of other psychological problems, including self-injurious behavior (Liu et al., 2019), eating disorders (Williamson & Hartley, 1998; Williamson, 1999), and suicidality (Rofes, 1983; Hammelman, 1993).

There is comparatively less research into the impact of IT on the mental health of gender minorities, but Hoy-Ellis and colleagues (2017) identified IT as a significant risk factor for physical and mental health afflictions in a sample of middle-aged adults. Numerous studies report a significant positive direct association between IT and depression (Testa et al., 2015; Tebbe & Moradi, 2016; Brennan et al., 2017). Shame and alienation have been identified as components of IT that may explain its impact on depression as well as on anxiety (Scandurra et al., 2018). Three studies have found IT to be positively associated with anxiety (Testa et al.,

2015; Wilson, 2013; Timmins et al., 2017), one of which found IT to be indirectly positively related to anxiety via rumination (Timmins et al., 2017). All but one study (Sapareto, 2018) investigating the connection between IT and suicidality found positive correlations, with both ideation (Testa et al., 2017; Staples et al., 2018) and attempt (Perez-Brumer et al., 2015; Marshall et al., 2016).

Loneliness

Humans are social by nature, with a hardwired and largely universal need for interpersonal intimacy (Cacioppo & Patrick, 2008; Baumeister & Leary, 1995). When this need is not met, the common emotional response is loneliness, defined variously as "a subjective negative experience of feeling disconnected from others" (Eres et al., 2021, p. 358), "a mismatch between actual and desired relationships" (Elmer et al., 2021), and "a distressing feeling that accompanies the perception that one's social needs are not being met by the quantity or especially the quality of one's social relationships" (Hawkley & Cacioppo, 2010, p. 1). Importantly, though loneliness often corresponds to an objective state of social isolation, it does not have to. That is, loneliness arises when there is a mismatch between an individual's unique needs for connection and their actual experience of connection (Peplau & Perlman, 1982); it therefore can exist alongside abundant interpersonal contact (Findlay, 2003; Steptoe et al., 2013).

Loneliness manifests in two types: social and emotional (Hawkley et al., 2005, Weiss, 1973). Social loneliness is the sense that one lacks the fellowship and support of a fulfilling network of friends, family, and community ties. Emotional loneliness stems from feeling deprived of a primary attachment relationship, whether a partner, sibling, or best friend (Hawkley et al., 2005, Weiss, 1973). Loneliness is often a self-reinforcing phenomenon because it can exacerbate rejection sensitivity, encourage further social withdrawal and passivity, and

promote negative interpretations of ambiguous social cues as well as negative appraisals of self and others, all of which can elicit negative reactions from others and thus corrode an individual's relationships (Mund & Johnson, 2021; Segel-Karpas & Ayalon, 2020; Lieberz et al., 2021).

LGBTQ+ individuals are more prone to loneliness than their straight and cisgender counterparts (Gorczynski & Fasoli, 2022). For example, research has demonstrated that older LGB adults in North America (AARP Foundation, 2018; Angus Reid Institute, 2019; Hsieh & Liu, 2021) as well as the Netherlands (Fokkema & Kuyper, 2009; van Lisdonk & Kuyper, 2015) were more prone to experiencing loneliness and harbored greater fears of aging and dying alone compared to their non-LGB counterparts. Two studies with samples that spanned a broader age range identified a similar disparity in reported loneliness between LGBTQ+ and non-LGBTQ+ individuals (Doyle and Molix, 2016; Eres et al. 2021). Salway et al. (2020) report that among sexual minority men in Canada, 13 to 24 percent experience loneliness most or all of the time, and another cross-sectional study estimated that 34.7% of sexual minority individuals feel chronically lonely (Kneale, 2016).

Objective and subjective factors likely drive this preponderance of loneliness in LGBTQ+ people. They are less likely than heterosexual, cisgender individuals to be partnered or have children (Cahill et al., 2000; Ross et al., 2003; Shippy et al., 2004), and more likely to live alone (Adelman et al., 2006; Angus Reid Institute, 2019). Moreover, minority stress processes are known to hamper an individual's capacity to form and maintain gratifying relationships. Chronic experiences of discrimination and harassment tend to promote hypervigilant fear and expectations of rejection and thus can disincentivize socializing. Rejection sensitive individuals can take on defensive interpersonal postures like cool detachment or antagonism that repel potential friends and partners (Feinstein, 2020; Norona & Welsh, 2016; Zimmer-Gembeck et al.,

2016). ILN often fosters a belief that relationships with other LGBTQ+ people are inferior to those with cisgender heterosexual people, leading to avoidance of the LGBTQ+ community (Elmer et al., 2022; Cao et al., 2017; Doyle & Molix, 2015). Those who conceal their sexual orientation or adopt a conforming gender expression that is incongruent with their true identity often remain guarded and distant in their social interactions, foreclosing on the possibility of connection and intimacy, or they self-isolate to minimize the stress of being closeted (Newheiser & Barreto, 2014). Concealment may drive some LGBTQ+ couples to eschew public activity together, and the fear of discovery can strain the relationship (Knoble & Linville, 2010; Pepping et al., 2019). Those who conceal their identity can also present as less attractive potential friends and partners to those who live more openly (Frost & Meyer, 2009).

Loneliness has been found to exacerbate minority stress in a negative feedback loop, which suggests that it is perhaps a foundational subcomponent of the minority stress framework (Elmer et al., 2022; van Winkel et al., 2017; Segel-Karpas & Ayalon, 2020; Spithoven et al., 2017). Studies of American middle-aged and older sexual minorities have found connections between loneliness and IH (e.g., Jacobs & Kane, 2012; Kim & Fredriksen-Goldsen, 2016). Mereish and Poteat (2015) reported correlations between loneliness and IH, concealment, and marginalization in a study of American sexual minority adults, and Mereish et al. (2017) replicated this finding with an international sample. Jiang and colleagues (2019) found that among a group of Chinese gay men, those who were open about their sexual orientation felt less lonely than those who were not publicly out. Dutch researchers found that older LGB adults reporting high levels of actual or anticipated rejection tended to be lonelier, with minority stress explaining the variance in loneliness after controlling for health, self-esteem, partner status, and social network size (Kuyper & Fokkema, 2010; van Lisdonk & Kuyper, 2015). Finally,

in a sample of middle-aged and older LGB adults in the UK, perceived discrimination predicted loneliness at a six-month follow-up (Jackson et al., 2019).

There is a vast empirical literature that has implicated loneliness in a striking array of cognitive and emotional dysfunction. Loneliness has been found to contribute to Alzheimer's Disease (Wilson et al., 2007), cognitive decline (Gow et al., 2007; Tilvis et al., 2004), personality disorders and psychoses (DeNiro, 1995; Neeleman & Power, 1994), and diminished executive control (Cacioppo et al., 2000; Hawkley et al., 2009). In observational studies, it has been shown to predict increases in depression (Cacioppo et al., 2006a; Segrin, 1999; Heikkinen, 2004; Wei et al., 2005). Experiments that hypnotically induced loneliness found it to increase anxiety, perceived stress, anger, and fear of negative evaluation, and to diminish optimism and self-esteem (Cacioppo et al., 2006b).

Hawkley and Cacioppo (2010) postulate a loneliness model that comports well with minority stress theory (Meyer, 1995). They contend that perceived social isolation fosters a global view of the world as unsafe, triggering hypervigilant surveillance of the environment for social threat (i.e., rejection sensitivity) and producing predictable cognitive biases:

> Relative to nonlonely people, lonely individuals see the social world as a more threatening place, expect more negative social interactions, and remember more negative social information. Negative social expectations tend to elicit behaviors from others that confirm the lonely persons' expectations, thereby setting in motion a self-fulfilling prophecy in which lonely people actively distance themselves from would-be social partners even as they believe that the cause of the social distance is attributable to others and is beyond their own control. This self-reinforcing loneliness loop is accompanied by feelings of hostility, stress, pessimism, anxiety, and low self-esteem and represents a

> dispositional tendency that activates neurobiological and behavioral mechanisms that contribute to adverse health outcomes (p. 3–4).

As Hawkley and Cacioppo (2010) conclude, "These data suggest that a perceived sense of social connectedness serves as a scaffold for the self—damage the scaffold and the rest of the self begins to crumble" (p. 3).

Therapeutic Intervention for LGBTQ+ Individuals

The concept of LGBTQ+-affirmative therapeutic practice is barely two decades old, and the first comprehensive text mapping the evidence base for how treatment goals and delivery methods might be LGBTQ+-adapted was published only in 2019 (Pachankis & Safren, 2019). Still, although our understanding of the minority stress-driven pathways that drive health disparities between LGBTQ+ and non-LGBTQ+ populations has deepened substantially (Hatzenbuehler, 2009), clinicians by and large must use intuition and guesswork when attempting to implement this knowledge with patients. Indeed, barely any randomized controlled psychotherapy process-outcome trials stratify their samples based on LGBTQ+ identity (Chaudoir et al., 2017), and only one specifically LGBTQ+-affirmative therapy protocol has been evaluated via RCT (Pachankis et al., 2015). There is some evidence that adapting therapy practice for LGBTQ+ people may not even be necessary; several studies that have compared treatment effectiveness between LGBTQ+ and non-LGBTQ+ populations have demonstrated that existing modalities benefit both groups equally (and perhaps benefits LGBTQ+ patients *more*; Beard et al., 2017; Grafsky et al., 2011; Lefvor et al., 2017). Perhaps this is because minority stress processes have been found to activate universal psychopathological responses like emotional dysregulation (Hatzenbuehler, 2009). It may be that providing standard evidence-based care through an LGBTQ+-affirmative lens—avoiding cis- and heteronormative

assumptions, considering the well-documented developmental anomalies of LGBTQ+ people, and so on—is adaptation enough (American Psychological Association, 2012). Yet as Pachankis and Safren (2019) argue, through a moral justice perspective:

> Creating novel adaptations of evidence-based treatment for such frequent consumers of mental health services would be an important reparation for the field's historic perpetuation of psychologically, and sometimes physically harmful treatments. […] It is simply morally inexcusable that Western societies have been more successful at disseminating abusive conversion therapies than evidence-based alternatives for [sexual and gender minority] people (p. 10).

Even if wholly novel treatment approaches are not necessary for LGBTQ+ patients, there are increasing calls for process-outcome research that demonstrates which components of existing treatments facilitate or hamper outcomes for this population (Sullivan & Pachankis, 2018). One component that deserves such investigation, universal to all psychotherapy, is the extent to which the therapist self-discloses.

Theoretical Views on TSD

Classical Psychoanalytic Views on TSD

As with all discussions of therapeutic approach, we must begin with Freud (1912, 1913, 1915) and the classical analytic stance that he set forth in his guidelines for clinical practice, *Papers on Technique*, which to this day remain the North Star of analytic purity for many classically oriented practitioners (Couch, 2002). Freud believed that a proper transference neurosis could unfold only if the analyst remains a cypher to the analysand, a figure devoid of quotidian humanness—"opaque," "like a mirror"—so that the analysand's buried memories, fantasies, and other libidinal conflicts might be projected freely (Freud, 1912, p. 118). The more

"real" in personhood the analyst becomes to the patient, through for instance sharing their own life experiences or emotional reactions in and out of the consulting room (beyond the unavoidable betrayals of personal appearance and office décor), the more correspondingly dammed up the patient's unconscious would remain (Pulver, 1995). "Young and eager psycho-analysts will no doubt be tempted to bring their own individuality freely into the discussion, in order to carry the patient along with them and lift him over the barriers of his own narrow personality," Freud (1912) anticipates.

> It might be expected that it would be quite allowable and indeed useful, with a view to overcoming the patient's existing resistances, for the doctor to afford him a glimpse of his own mental defects and conflicts and, by giving him intimate information about his own life, enable him to put himself on equal footing. One confidence deserves another, and anyone who demands intimacy from someone else must be prepared to give it in return. But…[e]xperience does not speak in favor of an affective technique of this kind[, which] makes [the analysand] even more incapable of overcoming his deeper resistances, and in severer cases [he] finds the analysis of the doctor more interesting than his own" (p. 111).

To Freud, the sole role of the analyst is to interpret uncontaminated transference, and analyst disclosures risk distorting this transference field by overburdening the patient, shifting attention away from the patient's inner world, inhibiting fantasy, prompting overidentification with the analyst, and even seducing the patient (Farber, 2006; Aron, 2001; Hanly, 1998; Tillman, 1988).

Closely aligned with Freud's principle of anonymity is that of neutrality, which demands that the analyst convey neither too much investment nor too much indifference in the analysand. It asks him to sit equidistant from the patient's id, ego, and superego—"without memory or

desire," as Bion (1967) would later characterize it—seeking no particular outcome. Neutrality has been described as an amalgam of "professional commitment" and "benign understanding," an attitude that calls for the total repression of the analyst's own values and wishes (Pulver, 1995, p. 127). LaPlanche and Pontalis (1988) designate it one of analysis's "defining characteristics":

> The analyst must be *neutral* in respect of religious, ethical and social values—that is to say, he must not direct the treatment according to some ideal, and should abstain from counselling the patient; he must be *neutral* too as regards manifestations of transference (this rule usually being expressed by the maxim, 'Do not play the patient's game'); finally, he must be *neutral* towards the discourse of the patient: in other words, he must not, *a priori*, lend a special ear to particular parts of this discourse, or read particular meanings into it, according to his theoretical preconceptions (p. 270).

Freud does not invoke the word neutrality itself until 1915 in "Observations on Transference Love," where he forewarns that

> the experiment of letting oneself go a little way in tender feelings for the patient is not altogether without danger. Our control over ourselves is not so complete that we may not suddenly one day go further than we had intended. In my opinion, therefore, we ought not to give up the neutrality towards the patient, which we have acquired through keeping the counter-transference in check (Freud, 1915, p. 164).

Freud had established the notion of neutrality earlier in "Recommendations…," however, where he censures analysts' "therapeutic ambition" and "educative ambition," and discourages them from assigning concrete tasks to the patient (Freud, 1912, p. 115). Here Freud offers perhaps his most infamous technical analogy:

> I cannot advise my colleagues too urgently to model themselves during psycho-analytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully [sic] as possible (Freud, 1912, p. 115).

The surgeon metaphor, with all its attendant imagery of laser focus, all-business comportment, and sterile metal, did more than perhaps any other of Freud's technical exhortations to foster the perception that proper analysis was devoid of human warmth. Taken together, the classical stances of anonymity and neutrality have engendered a century of cutting caricatures, à la *New Yorker* cartoon, of the icy, unfeeling, detached, unempathetic, and aloof analyst (Gelso & Kanninen, 2017).

It must be noted, though, that Freud never intended these instructions to take on the rigid prescriptiveness of sacrosanct doctrine—he calls them "recommendations" and not commands or edicts, after all. "I must however make it clear," he qualifies,

> that what I am asserting is that this technique is the only one suited to my individuality; I do not venture to deny that a physician quite differently constituted might find himself driven to adopt a different attitude to his patients and to the task before him" (Freud, 1912, p. 111).

Freud was an avid experimentalist, concerned more with forging new psychic discoveries than effecting cure in his patients, as has been argued (Friedman, 2019). Thus, often he adapted his approach as a detective might when chasing a novel or unexpected lead (Thompson, 1994).

Indeed, it is well documented that Freud never placed as great a primacy on either anonymity or neutrality than the mid-twentieth century American training institutes' staunch obsession with them might suggest. He regularly lent books to patients, gave gifts, shared

personal photos, and even analyzed his friends and daughter Anna. According to Momigliano (1987):

> [Freud] seems to have had no objection to speaking perfectly freely on any subject proposed to him by the patients; indeed, he responded to all their varied remarks and questions patiently and perhaps with a certain pleasure, on the reality level—and everyone asked him many questions, as if they were eager to profit from their relations with Freud to obtain from him explanations of the theory and technique of psychoanalysis, but also know his personal opinions on political, artistic, and religious matters, his colleagues, friends and enemies and even his personal life (p. 382).

Freud, in other words, was less a blank screen than an open book.

Analyst anonymity, asserts Kernberg (2016), was a "questionable development in psychoanalytic thinking in the 1950s" that reflected the unfortunate "authoritarian pressures within psychoanalytic education, and the related institutionally fostered idealization of the training analyst, who should not show any usual personal human characteristic to the patient" (p. 287). Similarly, Eagle (2011) posits that "when classical orthodoxy was predominant [mid-century],…many younger analysts, wary of being seen as not truly analytic by permitting so-called transference gratification, adopted an austere stance that was close to…a caricature of analytic neutrality" (p. 197). Gelso and Kanninen (2017) suggest that rigid adherence to a somber and astringent practice protocol of total anonymity bore a "neurotic appeal" to the insecure neophyte analyst, whose own humanity had been crushed by his paternalistic and monolithic training culture and who hungered for a power and superiority of his own. "Emotional aloofness or coldness in the face of the patient's misery," they posit, "may allow the therapist to feel strong while also righteous because he or she is behaving as the rules say he or

she should" (Gelso & Kanninen, 2017, p. 331; cf. Greenberg, 1986). Freud's attempt to codify clinical practice with some degree of clarity and precision had the unintended consequence of inculcating in generations of analysts a myopically rigid mindset. "What to Freud might have been temporary or ad hoc measures," writes Roazen (1992), "became, in the hands of some devoted followers, unchangeable rituals" (p. 128).

Anonymity became one such unchangeable ritual, and twentieth century neo-Freudians castigated an analyst's voluntary self-disclosure as the gravest of errors. Langs (1975), for example, has argued that anonymity is *the* inviolable boundary and its upholding the most crucial factor in any psychoanalytic treatment. Etchegoyen (1991) finds self-disclosure wholly inappropriate because an analysis not solely based on patient-derived material is not a true analysis. Epstein (1995) asserts that self-disclosing inappropriately demystifies the analyst and takes the burden of the therapeutic work off the patient. Hanly (1998), among others, argues that however well intentioned, analysts are inevitably blind to their true motivations for disclosing and likely do so to gratify their own unconscious narcissistic needs, to rescue the patient from doing the grueling work of analysis, or to enliven a boring treatment. As Aron (2001), a relationalist, concedes, "deliberate self-revelations are always highly ambiguous and are enormously complicated. Our own psychologies are as complicated as our patients' and our unconsciouses no less deep" (p. 88; Farber, 2006).

The Subversive Minority of Disclosing Classical Analysts

From the start, a small but notable minority of classical analysts comprised a culture of subversion in orthodox practice, pushing the boundaries of what the analyst might reveal to the patient. The most infamous of these iconoclasts was Sandor Ferenczi, the "enfant terrible" of psychoanalysis (Peeters, 2020), who espoused an "active technique" that assigned "commands

and prohibitions" to more directively guide and accelerate the patient's healing (Farber, 2006, p. 118). To Ferenczi (1932), anonymity and neutrality were anathema to the treatment because "any kind of secrecy, whether positive or negative…makes the patient distrustful; he detects from little gestures…the presence of affects, but cannot gauge their…importance" (p. 11). Indeed, aloofness and withholding on the part of the analyst "[risk] reviving the very traumas and affective failures that brought patients into therapy in the first place" (Farber, 2006, p. 118; Aron, 2001; Dupont, 1988). Moreover, believed Ferenczi, patients may read kindness or acceptance into a blank screen stance and thereby censor negative feelings towards the analyst, which may in turn cause the analyst to disavow their own true feelings towards the analysand, resulting in a "culture of denial, separation, and misunderstanding" (Farber, 2006, p. 118).

As an antidote, Ferenczi (1932) proposed a radical new paradigm of "mutual analysis" in which "the tears of doctor and patient mingle in a sublimated communion, which perhaps finds its analogy only in the mother-child relationship. And this is the healing agent [that]…surrounds the personality…with a new aura of vitality and optimism" (p. 65). Mutual analysis was predicated on the notion that when an analyst exposes his own humanity, warts and all, the therapeutic relationship is infused with greater trust and the patient gains access to previously repressed and unassimilated parts of themselves (Aron, 2001; Dupont, 1988). Patients find it easier to expose their deepest vulnerabilities after witnessing the analyst do so, Ferenczi believed, and the treatment can morph into a co-healing, co-mingling of shared humanity. "Certain phases of mutual analysis represent the complete renunciation of all…authority on both sides," Ferenczi reflected. Patient and analyst "give the impression of two equally terrified children who compare their experiences, and because of their common fate understand each other completely and instinctively try to comfort each other" (Ferenczi, 1933, p. 156).

At the time, critics of Ferenczi's approach (not least Freud himself) argued that total self-disclosure is not only impossible but irresponsibly self-serving and harmful. Complete analyst transparency obliterates the boundaried holding environment necessary to shore up vulnerable patients' ego strength, they contended; it would make patients feel profoundly unsafe, stoking fears of sexual seduction and provoking destabilizing regressions (Farber, 2006). Ferenczi himself came to disavow his iconoclastic approach ("Mutual analysis: only as a last resort!" he ultimately lamented) as he discovered with great distress that there were indeed unintended consequences of analyst-patient mutuality, namely a toxic stew of resentment, frustration, humiliation, and stalled progress (Ferenczi, 1932, p. 115). But Ferenczi must be credited as first to emphasize the centrality of the therapeutic relationship to the treatment. Moreover, he laid the conceptual groundwork for short-term dynamic and humanistic therapies as well as the "relational turn" in psychoanalysis of the late 1970s (Farber, 2006).

Contemporary Relational Psychoanalytic Views on TSD

The defining characteristic of contemporary relational psychoanalysis, as Mills (2012) puts it,

> is that it approximates the way real relationships are naturally formed in patients' external lives, including the rawness, tension, and negotiability of the lived encounter, with the exception that the process falls under analytic sensibility. This is why the relationalists demand we be malleable in the treatment frame rather than apply a rigid, orthodox, or authoritarian procedure, because malleability is necessary in order to cater to the unique contingencies of each dyad; this necessitates abolishing any illusory fixed notions of practice that can be formulaically applied to all situations (p. 113).

Blum (2016) concurs that "the role of the analyst has evolved from that of a neutral detached observer and interpreter. Besides being a transference object," he writes, "the analyst is now considered to be a real object, a new object, and a fully participating observer in the analytic process…whose personal influence…has supplanted the now antiquated model of the analyst as impartial interpreter while remaining a blank screen" (p. 41). This shift towards emphasizing the personhood of the therapist and the primacy of the cocreated dyadic relationship traces its roots to the object relations theorists of the mid-twentieth century.

Klein, though a proponent of analytic neutrality and anonymity, greatly influenced current relational views on self-disclosure when she displaced drives with the object (person) as the center of psychic life. If the purpose of drives was to connect individuals interpersonally, as Klein believed, the analyst could no longer be seen as an entirely neutral observer (Klein, 1975). Kleinians argued against therapist self-disclosure on the premise that any disclosed material likely belongs to the patient themselves, split off and projected using primitive defenses, and that disclosing it preempts the patient's ability to take ownership over that which they have disowned. Still, as Farber (2006) argues, "in recasting analysts as susceptible to a patient's intrapsychic conflicts and desires, Klein opened the formerly closed clinical system and laid the foundation for later perspectives that emphasized the value of focusing on the mutually influential nature of patient and therapist interactions" (p. 123).

Winnicott and Fairbairn are two other British object relations theorists who took a more liberal view on therapist self-disclosure. "There is no such thing as a baby," Winnicott (1947/1964) famously proposed, but rather a nursing couple that exists in a symbiotic holding environment designed to meet the infant's needs (p. 88). To Winnicott, the analyst is charged with recreating this type of environment in treatment and, in a mutual interplay, giving the

patient the psychic nurturance that the parent did not. It was not interpretation but rather this "presentation of missing parental provisions" that effected cure (Farber, 2006, p. 124). Winnicott was convinced that schizophrenic and other seriously disturbed individuals could not tolerate a fully withholding and distant analyst and thus he endorsed a moderate degree of therapist self-disclosure with them. He also believed that an empathic and caring stance was preferable to the blank screen, though he cautioned against self-disclosure with less disturbed patients because these intrusions, he believed, could impinge on the treatment (Farber, 2006).

For his part, Fairbairn (1946) vociferously rejected Freud's drive paradigm and held that the "libido is not primarily pleasure-seeking, but object-seeking" (p. 30). An early interpersonalist, he believed that it was not interpretation primarily but rather the personal relationship between therapist and patient that cured and thus he underscored the need for a healthy rapport in any successful treatment. Although Fairbairn remained silent on self-disclosure, one can infer from his theoretical stance that a certain amount is appropriate and that it should be exquisitely attuned to the unique needs of each dyad. For one patient with an emotionally neglectful mother, a withholding stance may rekindle trauma; for another with insatiable narcissistic gratification needs, withholding may be just what the treatment demands (Farber, 2006).

Across the Atlantic, Sullivan's interpersonal school had taken root, with its emphasis on analyst participant-observation and the primacy of environmental context in personality formation. Because Sullivan believed it is one's interpersonal ecosystem that predominantly shapes functioning, he ranked the personal relationship between therapist and patient as most impactful on progress. Sullivan was against strict neutrality and detachment. He enrolled the analyst as a true co-participant and endorsed self-disclosure as an inevitable component of that

role. He, as well as contemporaries Fromm-Reichmann (1952) and Thompson (Proceedings of the Association for the Advancement of Psychotherapy, 1956), believed that the analyst should lay bare their own in vivo involvement in the work by acknowledging errors and oversights, divulging negative countertransferential reactions, and so on (Sullivan, 1953; Papouchis, 1990; Farber, 2006).

Most contemporary analysts, influenced by these object relations and interpersonal pioneers, have significantly softened around the classical self-disclosure prohibition, though as Moroda (1997) notes, few are willing to endorse the practice unconditionally. Aron (2001) marvels at the "incredible transformation" within the field of psychoanalysis: "the analyst's self-disclosure [is now] a subject worthy of investigation[; soon] textbooks on psychoanalysis will undoubtedly contain chapters on self-disclosure, and institutes will have courses and clinical case seminars devoted to this subject" (p. 221). This shift in attitude toward self-disclosure was inevitable given the very nature of relational thinking. Intersubjectivity is the sine qua non of relational analysis, which "views the patient-analyst relationship as continually established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other" (Aron, 1991, p. 35). There are profound implications to this dynamic, Aron (1991) writes, "for it means that as resistances are analyzed, patients not only expose more of their own unconscious but also gain awareness of hitherto unnoticed, dissociated, or repressed aspects of the psychology of their analysts" (p. 35). Echoing Singer (1977), who was first to posit that all interpretations are essentially self-revelatory and that analytic anonymity is wishful thinking, Aron (1991) states:

> I believe that patients, even very disturbed, withdrawn, or narcissistic patients, are always accommodating to the interpersonal reality of the analyst's character and of the analytic

> relationship. Patients tune in, consciously and unconsciously, to the analyst's attitudes and feelings toward them… (p. 36).

Analysts, in other words—even staunchly old guard, blank screen interpreters—are *always* self-disclosing; as Orange and Stolorow (1998) assert, "even withholding is a form of communication" (p. 532). "Self-revelation is not an option; it is an inevitability," Aron (1991) argues, but he warns that "it is never so clearcut precisely what the analyst is revealing and how the revelation is interpreted by the patient, so complex [are] the dynamics of two comingling unconsciouses" (p. 40). Greenberg (1995) similarly introspects that "I am not necessarily in a privileged position to know, much less to reveal, everything that I think and feel" (p. 197).

Moreover, Aron (1991) contends that patient-therapist interactions must be viewed in light of burgeoning infant research, which has identified as a significant developmental milestone the baby's capacity to recognize their mother as an autonomous subject with a differentiated inner world. In therapy, intersubjectivity involves the patient coming to recognize the analyst as precisely the same. "Just as psychoanalytic theory has focused on the mother exclusively as the object of the infant's needs while ignoring the subjectivity of the mother," Aron (1991) writes, "so, too, psychoanalysis has considered analysts only as objects while neglecting the subjectivity of analysts as they are experienced by the patient" (p. 32). Aron (1991) argues that this must change; and indeed it had already begun to, as by his time of his writing, mainstream analysts no longer viewed their countertransferential reactions as contaminants but rather as a lode of insights into the patient's psychic functioning. Aron (1991) therefore advocates for an open, transparent, radical focus on how the patient makes sense of the analyst's subjectivity, conducted with an intensity and frequency that is meaningful but not so high as to overshadow the primary focus on the patient's intrapsychic world. Aron (1991) also

warns against "imposing [one's] subjectivity" on the patient in too heavy-handed a manner, advocating for self-disclosure that allows the patient "the opportunity to search out, uncover, and find the analyst as a separate subject, in their own way and at their own rate" (p. 42).

Renik (1995, 1998, 1999) is arguably the relationalist who has most influentially shifted opinions on self-disclosure within the analytic establishment. There has been a "leveling [of] the clinical analytic playing field" and an "evolution towards less self-importance and more candid self-exposure by the analysts," he writes, which to some degree reflects a broader cultural movement towards equality and democratization but which also confirms that "a collaborative treatment relationship…yields better results" (Renik, 1999, p. 523). To Renik (1999), the patient has a fundamental "need to know about the person with whom he or she is actually dealing" and so is already playing a game of "Guess What's on My Mind" with their analyst—this game only intensifies the more withholding the analyst is. "A reticent analyst looms large," he remarks, "occupying center stage as a mysterious object of interest" (p. 525). Therefore Renik's (1999) advice to analysts is to "play one's cards face up" because, paradoxically, this shifts the attention back *toward* the patient.

Further, Renik (1995) calls for the patient to provide constructive feedback on the analyst's self-disclosures:

> We know that when a patient tries to say everything that comes to mind, an analyst is able to point out things the patient overlooked. Similarly, when an analyst tries to make his or her analytic activity as comprehensible as possible, a patient is able to point out things the analyst overlooked (pp. 485-488).

Here, Renik (1995) highlights the co-creation of the dyadic experience so central to the relational paradigm and supports Aron's (1991) notion that self-disclosure opens access to rich analytic

material that otherwise might not arise in the patient alone. “The benefit of an analyst’s willingness to self-disclose,” Renik (1999) writes:

> is that it establishes the analyst’s fallible view of his or her own participation in the analysis as an appropriate subject for collaborative investigation—something analyst and patient can and should talk about explicitly together. This makes it possible for the patient to open up analytic opportunities by calling to the analyst’s attention aspects of the analyst’s functioning of which the analyst would otherwise not be aware (p. 31).

There are subtle parallels between this exchange of subjectivities and the more extreme mutual analysis practiced and later abandoned by Ferenczi.

To critics who would suggest that such free-flowing disclosure can foster rapaciousness in the patient for ever more disclosure, Renik (1999) counters that “my willingness to self-disclose elicits in my patients neither an insatiable curiosity about me, nor a wish to learn my opinions so that they can be taken as received wisdom” (p. 528). But Renik goes further than Aron in arguing that therapist self-disclosure catalyzes patient self-disclosure, and that conversely, a withholding stance encourages the patient to shut down defensively:

> If the analyst is unwilling to pursue an explicit exchange of views with the patient, as needed, then the patient concludes that the analyst is not really interested in receiving active consultation. When a patient calls an analyst’s attention to aspects of his or her participation in treatment that the patient feels are significant, even problematic, and the analyst, instead of saying what he or she thinks about the patient’s observations, encourages the patient toward further self-reflection, the patient learns that offering his or her observations will not be interpersonally consequential, and the patient becomes much less interested and willing to offer them. I find that when an analyst does not operate

> according to an ethic of self-disclosure, the analyst, despite claims to the contrary, discourages free confrontation and questioning by the patient. The analyst's unwillingness to make his or her own views available conveys to the patient that the analyst wishes to protect him- or herself by avoiding scrutiny. Usually the patient complies (p. 530).

Notably, both Aron and Renik refer primarily to the type of self-disclosures that contemporary researchers refer to as "immediate," those related specifically to the here-and-now process between patient and therapist. Other contemporary relational writers (e.g., Fosha, 2000; Zeddies, 2000) show more tempered support for therapist self-disclosure, ranging from "permissive tolerance" to "explicit endorsement" of some elements (Farber, 2006, p. 126), so long as the disclosures are judicious and driven by the dyad's particular needs (Orange & Stolorow, 1998). In sum, as Gelso and Hayes (1998) conclude, "it is safe to say that self-disclosure is no longer a dirty word in psychoanalysis…. Analytic therapists…are surely less disclosing than their humanistic and feminist cousins, but are just as surely more open to the possible benefits of 'controlled disclosures' than they were in times past" (pp. 181-182).

Humanistic and Existential Views on TSD

Humanistic therapists work with an appreciation for the uniqueness of each client's worldview and life experience, viewing problems-in-living as the result of the client's compromised self-awareness and inauthenticity that has stalled their innate growth trajectory. The aim of humanistic therapy is not primarily to unearth drive-derived conflicts, explore transference distortions, or analyze maladaptive thought patterns, but rather to "help clients cultivate the capacity for choice" in the service of self-actualization and to explore the inevitable "limits, ambiguities, and risks" inherent in this capacity (Schneider & Krug, 2010, p. 31; May,

1981; Tillich, 1952). Existential therapy, closely related though distinct, places a greater focus on meaning-making with the client around universal human anxieties: despair, loneliness, uncertainty, suffering, loss, and ultimately death itself (Yalom, 1980). Both humanistic and existential therapists grapple with how to help clients find their power and autonomy to craft a meaningful life, and they do so with a mindset of radical egalitarianism. The therapist is not an omnipotent authority in this paradigm, but rather a fellow human on the same messy and poignant journey (Bugental, 1987).

Unsurprisingly, then, humanistic-existential therapists regard self-disclosure as a natural outgrowth of this egalitarianism. Disclosing to a struggling client about one's own human experience aligns with Bugental's (1965) call for therapist authenticity, Kaiser's (1965) emphasis on therapist openness, and Truax and Carkhuff's (1967) encouragement of therapist genuineness. Kaslow et al. (1979) write of how therapist self-disclosure can demystify the therapy experience.

It was Jourard, however, who most vociferously urged therapists to replace the blank screen with the open book. Jourard (1971) believed that healthy mental functioning stems from an inclination and capacity to expose one's true self to the world, to drop culturally-conditioned, defensive façades and roles, and to reveal one's bare, authentic humanity.

> Authentic being means being oneself, honestly, in one's relations with his fellows. It means taking the first step at dropping pretense, defenses, and duplicity. It means an end to "playing it cool," an end to using one's behavior as a gambit designed to disarm the other fellow, to get him to reveal himself before you disclose yourself to him. This invitation is fraught with risk, indeed, it may inspire terror in some. Yet…while simple honesty with others (and thus to oneself) may produce scars, it is likely to be an effective preventive of both mental illness and certain kinds of physical sickness (p. 133).

If psychotherapy is to facilitate for the client the practicing of such authenticity, then the therapist, Jourard (1971) believed, must be willing to model it:

> It fascinates me to think of psychotherapy as a situation where the therapist, a "redeemed" or rehabilitated dissembler, invites his patient to try the manly [sic] rigors of the authentic way. The patient is most likely to accept the invitation, it has seemed to me, when the therapist is a role model of uncontrived honesty. … The patient then wants to make himself known, and proceeds to do so. In this defenseless state, the interpretations, suggestions, and advice of the therapist then have maximum, growth-yielding impact on him (p. 132).

To Jourard, therapist disclosure was perhaps the most potent catalyst for patient disclosure.

Jourard is an outlier among his peers in the intensity of his views; generally, humanistic therapists have been more tempered in the amount and type of disclosures they are willing to endorse. For example, it commonly has been presumed that Rogers (1951), the progenitor of client-centered humanistic therapy grounded in unconditional positive regard, was frequently self-disclosing to clients as a means of promoting genuineness and openness (Carew, 2009; Audet & Everall, 2010). This is a misconception, however. As Myers (2020) discovered in an exhaustive analysis of recorded sessions, Rogers was exceedingly sparse in his disclosures; out of 8,668 in-session responses examined, only 21 (0.24%) had an element of self-revelation.

Bugental (1987) highlights four scenarios in which the therapeutic focus might productively shift toward the therapist and warrant some degree of self-disclosure: when the patient's resistances lead to preoccupation with the therapist as a defense against looking inward; when the therapy is nearing termination and the patient needs to work through feelings

towards the therapist before ending; when the dyad is stuck in an impasse or enmeshed in an enactment and the therapist must openly investigate their role in it; and finally, when the therapist has unavoidable personal circumstances (pregnancy, serious illness, surgery) that necessitate frank discussion. However, Bugental (1987) proposes guardrails on disclosure under all these circumstances. First, "strict honesty is required[, which] means that there should be no distortion in the information given to patients," he forewarns (p. 143). Second, Bugental (1987) advises that disclosures of one's immediate reactions to the patient and the unfolding dyadic process are preferable to disclosures of matters outside the treatment. Finally, he says, therapists should heed caution before disclosing "hostile, resentful, punitive, erotic, seductive, and competitive feelings in relation to the patient," which are not entirely taboo but which should occur only after careful consideration of the therapist's own "needs, motives, and intentions" (Bugental, 1987, p. 144).

Feminist Views on TSD

Perhaps no therapeutic tradition is grounded more essentially in radical egalitarianism between patient and therapist than the feminist. From its inception, feminist theorists have argued that therapist self-disclosure can be a critical curative agent in the treatment—it empowers clients, they argue, by dismantling staid and misogynistic archetypes of the omniscient, authoritarian, controlling (and at feminist theory's inception, usually male) therapist and the helpless, neurotic, out-of-control (usually female) patient (Greenspan, 1986; Lerman, 1976; Rawlings & Carter, 1977). Indeed, it has been argued that a psychotherapy-shopping client has an inalienable consumer right to know a potential therapist's political stances, identity politics, biases, and personal values (Brown & Walker, 1990).

Feminist therapy has been conceptualized less in traditional doctor-patient terms, and more as a "consciousness-raising group of two" (Kravetz, 1976). The pioneering feminist psychotherapists of the 1960s and 1970s saw psychological illness as largely reflective of dominant sexist culture, and the mental health treatment industry as oppressively reifying patriarchal control over women. Research (e.g., Broverman et al., 1970) had begun to reveal that psychological professionals held double standards for what constituted "normalcy" in women as compared to men. Moreover, labeling women as mentally ill was seen as an insidious strategy to subjugate women into accepting their status quo subservience (Chesler, 1972).

Psychoanalysis of women, feminist therapists believed, always had been less a medical and more a political endeavor, and thus feminist therapy was an act of political defiance, with necessary implications on the power dynamic between therapist and patient. "The absence of equality between women and men in social, political, economic, educational, and other spheres requires that therapists take a stance of political action and advocacy, and that such a stance be explicitly integrated into the work of therapy," write Brown and Walker (1990).

> The…norms for practice…include the importance of developing an egalitarian relationship between client and therapist as a model for the overall development of such relationships in the client's life and the rendering of close attention to the impact of all the various forms of oppression and discrimination experienced by clients, including but not limited to racism, classism, heterosexism, homophobia, ageism, able-bodiedism, and fat oppression (p. 138).

The feminist therapy tradition has done perhaps more than any other to establish thoughtfully considered ethical guidelines around self-disclosing to clients—including strategies to avoid

inappropriate role reversals, blurred boundaries, and the fostering of a cult-like adoration of the therapist (Committee on Women in Psychology, 1985; 1987).

Cognitive Behavioral Views on TSD

Like analytic relationalists, existential humanists, and feminists, cognitive behavioral therapists regard psychotherapy as a co-created endeavor between two relatively equal human beings, where one happens to have useful expertise and insight to offer the other. There has been surprisingly little written about self-disclosure in the Cognitive Behavioral Therapy (CBT) literature, but there is consensus that it comports with the fundamentals of both cognitive and behavioral theory and can powerfully benefit the patient (Goldfried et al., 2003). Behavioral therapist Lazarus (1985) contends that "selective self-disclosure often enhances the therapeutic relationship and provides valuable when using modeling and behavior rehearsal techniques"; he offers the example of a therapist who successfully treated a claustrophobic client by divulging his own strategies for coping with anxiety in constrained spaces (p. 1419). This, Lazarus (1985) concludes, showed "the hallmarks of good behavior therapy," namely "rapport, empathy, identification, specificity, and practice" (p. 1419).

Similarly, echoing Bandura's (1986) seminal social learning theory, Goldfried and Davison (1994) assert that CBT therapists should strive to serve as models for their clients. Taking this modeling role seriously often involves self-disclosing:

> The therapist should be aware continually of his [sic] impact on the client, making every effort to model behavior, attitudes, and emotions likely to enhance therapeutic progress. For example, it is not uncommon for clients to describe problems that are part of the therapist's own personal experience. By disclosing the way he himself changed his thinking or behavior with positive consequences, that therapist can often use his own life

experiences to help facilitate the client's behavior change (Goldfried & Davison, 1994, p. 60).

Other CBT practitioners (e.g., Kohlenberg & Tsai, 1991) encourage therapists to hold a mirror up to the client by revealing their personal experience of the client's behavior, with the purpose of encouraging adaptive and discouraging maladaptive behavior. McCullough (2003) advocates for the therapist to divulge personal reactions and feelings so as to maintain a "disciplined personal involvement" in the treatment (p. 188). Dryden (1990), a rational-emotive therapist, argues that a patient can internalize new ways of coping when they hear their therapist disclose how they themselves have coped with similar problems. As Bandura (1986) writes, individuals "who lack confidence in their ability and hold themselves in low self-esteem…are especially prone to adopt the behavior of successful models," especially those whom they respect as having authority and competence (p. 208).

Empirical Investigation of TSD

Conflicting Definitions and Taxonomies

As discussed, it is challenging to make clear-cut conclusions regarding the effects of TSD on patients' therapy experiences and outcomes because in the extant research, investigators have employed a mélange of TSD definitions, measurements, and taxonomies, rarely stratifying patients by salient demographic groups or specifying with useful precision which disclosure subtypes they are investigating (Farber, 2006). Most studies have looked at verbal disclosures only, i.e., the "words therapists use to consciously and purposefully communicate private information about themselves to their patients" (Farber, 2006, p. 134; Simon, 1988). Thus, body language, facial expressions, dress style, office décor, and other "unintentional" disclosures have remained unexplored. Cozby (1973) defined TSD as "any information about himself [sic] which

Person A communicates verbally to Person B" (arguably too expansive a definition to be useful), and parsed TSD into three dimensions: amount, duration, and intimacy level. Weiner (1983) offered a more refined conceptualization, highlighting the importance of purposefulness and genuineness on the part of the therapist, and delineated numerous topics on which a therapist might speak freely: personal history, feelings, opinions, attitudes, associations, fantasies, and experiences. Other scholars have proffered useful differentiations that are more similar than distinct: between self-disclosing presentations of facts versus self-involving (also called "immediate") presentations of in-the-moment emotional reactions (Knox & Hill, 2003; Robitschek & McCarthy, 1991; Watkins & Schneider, 1989); between "intrapersonal" disclosures, "wherein the therapist reveals information about his or her personal life outside of therapy," and "interpersonal," which concerns the dyadic relationship (Nilsson et al., 1979); and between "factual" self-disclosures and countertransferential disclosures (Bridges, 2001). Countertransference disclosure has been defined by Wilkenson & Gabbard (1993) as "a form of clinical honesty that focuses on the therapist's experience of the patient in the here-and-now of the session" (p. 282).

Still other writers have distinguished between self-disclosures that are positive and negative in valence (e.g., Hoffman & Spencer, 1977), between TSD that is similar and dissimilar to the patient's experiences or emotional responses (e.g., Murphy & Strong, 1972), and between TSD that is independent of patient material or "reciprocal" in nature (i.e., tit-for-tat disclosure that matches the patient's disclosure; Barrett & Berman, 2001). Farber (2006) integrates this "dizzying array of definitions" into two overarching categories: "factual self-disclosure" about the therapist's life and personhood that may vary across manifold dimensions of intimacy, valence, amount, and so on; and "self-involving"/"immediacy"/"countertransferential"

disclosures of "the therapist's…immediate or past feelings or experiences in response to a patient's feelings or experiences," which can vary in emotional intensity, relevance to the patient's direct statements, and other distinctions (pp. 135–136). The most comprehensive TSD taxonomy to date, elucidated earlier, is Knox & Hill's (2003), which I have employed in the present study.

Prevalence of TSD

Numerous studies using a variety of methods (client reports, transcript analysis, etc.) have attempted to pinpoint just how common an occurrence TSD is in the real world of clinical practice. Unsurprisingly, it is difficult to estimate this with precision given the discussed definitional ambiguity and the likelihood that therapists underreport their disclosures due to perceived stigma surrounding the practice. Farber (2006) reviewed the literature and has concluded that TSD occurs with "moderate" frequency, though he notes that some scholars estimate it to be far rarer and that it is safe to conclude other techniques are more common. In Mathews's (1988) sample, 62% of therapists said they disclose occasionally and about 26% reported "almost never" disclosing to patients. Berg-Cross (1984) reported low to moderate disclosure frequency among polled therapists, while Anderson and Mandell (1989) and Edwards and Murdock (1994) reported moderate disclosure frequency. Marriage and family therapists tend to report higher self-disclosure levels, with over 70% reporting at least occasional TSD (e.g., Brock, 1987; Pope et al., 1987).

Patient surveys show comparable rates of TSD. Fifty-eight percent of respondents to Ramsdell and Ramsdell's (1993) survey reported having received at least one therapist self-disclosure, with six percent reporting ten or more self-disclosures over the course of treatment. Hill and Knox (2002) examined transcribed sessions and noted between one and 13 percent of all

interventions were self-disclosures. Concludes Farber (2006), "it appears that most therapists—probably in the 65-75% range—occasionally self-disclose personal (factual) information to their patients, although the absolute frequency of this behavior is relatively low" (p. 137). Farber (2006) also cautions that because many of the above cited studies failed to specify what constitutes "occasional" or "frequent" self-disclosure, interpreting these findings is a murky business.

Content of TSD

Numerous studies have investigated *what* exactly therapists do disclose to their patients. Lane and colleagues (2001) identified theoretical orientation, beliefs about therapy's efficacy, and contrition for mistakes as the most common divulsions, whereas the therapist's dreams, personal issues, and attraction to the patient as least. In Lane's (2001) estimation, what drives these common disclosure topics is the therapist's desire to impart hope on the client and to repair ruptures. Surveyed therapists revealed that the disclosures they found most curative were

> feelings of admiration for patients, attitudes toward child-rearing, emotional reactions to patients, opinions regarding patients' prognoses, reactions to patient's expressive style, feelings that are similar to those of patients, apologies for mistakes, and strategies for coping with stress. Thus, disclosures perceived as most advancing treatment aims can be seen as providing the patient accurate feedback, positive regard, an enhanced sense of the universality of his or her [sic] concerns, or opportunities for modeling appropriate behavior. (Farber, 2006, p. 138).

Other studies (e.g., Berg-Cross, 1984, Edwards & Murdock, 1994; Robitschek & McCarthy, 1991) have found professional disclosures to be more frequent than personal/sexual matters, though remarkably, Borys and Pope (1989) found a full 40% of therapists had disclosed personal

troubles to a patient. It is important to emphasize that none of the above studies examined TSD in the context of matched-identity dyads, though.

Reasons for and Patient Perceptions of TSD

Lane and colleagues (2001) also inquired about why therapists choose to disclose to patients. Their therapist subjects most commonly reported disclosing to bolster the alliance, to normalize their patient's lived experiences, to illuminate fresh and more adaptive ways of thinking and acting, and to reduce the patient's sense of loneliness and alienation. Knox and Hill (2003), echoing Jourard (1971), additionally posit that therapists disclose to foster reciprocal disclosure from the patient. Other surveys (e.g., Geller & Farber, 1997; Edwards & Murdock, 1994) have identified further motivations for TSD: to increase perceived similarity between patient and therapist, to model helpful or adaptive behaviors, and simply to gratify the patient's desire for therapist openness. Knox et al. (1997) found that clients generally agree that TSD can have these beneficial treatment effects, as did Hanson (2005), who found that patients "valued their therapists' disclosures because they contributed towards a real relationship, which included (1) a sense of connection, intimacy, closeness or warmth; (2) trust, safety, or a decrease in alienation; (3) a sense of being deeply understood, welcomed or cared about; (4) an opportunity to identify with the therapist; and (5) a sense that the therapist would take responsibility for mistakes" (p. 98–99).

Of course, therapists also make strategic decisions about when not to disclose to patients. Lane et al. (2001)'s sample identified numerous reasons to withhold self-revelation: for example, when the therapist senses that disclosure would foster role confusion, muddy the transference, inappropriately veer focus from patient to therapist, interrupt the patient's flow of material, or appear unprofessional. Other researchers (e.g., Simon, 1990, Geller & Farber, 1997) have noted

additional reasons therapists choose not to disclose, including concerns that it would unfairly burden or overstimulate the patient and that it would primarily gratify the therapist's narcissistic needs for attention or support. Indeed, clients have been found to validate these concerns. Hanson's (2005) research indicates that patients perceive TSD to be unhelpful when it damages the alliance, forces the patient to manage the relationship, invalidates the patient, inhibits the patient's own disclosure, and when it creates a power dynamic that is either too egalitarian or not egalitarian enough.

In a qualitative study, Audet (2011) investigated why clients perceive TSD to be optimal or suboptimal. Participants characterized optimal or helpful disclosures as "infrequent, low-to-moderately intimate, similar to their experiences, or responsive to their needs and the emerging therapeutic relationship." They tended to agree that prior to disclosing, their therapists came off as "formal," "rigid," "impersonal," "authoritative," and "clinical," and they reported feeling like "a case to be analyzed" or a "guinea pig being experimented on." After receiving therapist disclosures, clients perceived deeper humanity in their therapists and experienced sessions as "one human being [talking] to another," both "on equal footing" (p. 93). Audet's (2011) subjects identified suboptimal or unhelpful disclosures, by contrast, as "too frequent, repetitive, lengthy with superfluous detail, incongruent with their issue or personal values, or poorly attuned to their needs or the therapeutic context" (p. 92). One participant, for instance, noted that "after a while it became, 'Mhmm. Mhmm.' And I'd be off thinking about other things. Eventually she'd get to the end of the story" (p. 95). Another characterized the post-disclosure relationship as having devolved into "parent-child" dynamics, "like I was the therapist and she was the patient getting everything off her chest," with "moments when it seemed like my therapist was crazier than I was" (p. 95). The Identity-Focused Therapist Self Disclosure Questionnaire (TSDQ-I), created

for the present study to operationalize disclosure optimality, draws heavily on the themes that emerged from Audet's (2011) research, namely how patients perceive the appropriateness of disclosure frequency, their comfort or discomfort with disclosures, the extent to which disclosures relate to their own problems, and the overall helpfulness of disclosures to their treatment.

Effects of TSD on Treatment Outcome

Research examining the direct impact of TSD on psychotherapy outcome is limited in three respects: there is not a lot of it, much is of an analogue variety by which independent raters assess session transcripts (both real and invented), and few studies look at outcomes that are distal (i.e., the patient's long-term psychological functioning) as opposed to proximal (the patient's immediate experiences in and directly after therapy). Regarding proximal effects, TSD has been found largely to be beneficial to the client. In an early literature review, Hill and Knox (2002) found that patients rated TSD as very beneficial and that TSD promoted higher "experiencing" levels in the client (i.e., deeper engagement with feelings). They further discovered that helpfulness ratings and experiencing levels were higher when the therapist made disclosures that sought to reassure rather than to challenge the client. Hill and Knox (2002) found that on average, TSD fostered insight in the client and encouraged the client to regard their therapist as more human, which in turn bolstered the real relationship between the two. This humanizing effect also tended to reassure clients and lessen feelings of abnormality, which promoted more client honesty and openness in a salubrious feedback loop.

In their review, Henretty and Levitt (2010) confirmed that the evidence favors self-disclosure over nondisclosure. They concluded that TSD positively impacts clients, who show stronger attraction to self-disclosing therapists and perceive the latter as warmer than

nondisclosing therapists. Clients also tend to self-disclose more often to therapists who also self-disclose, they determined. Henretty and colleagues (2014) later found that a disclosing stance benefited patients more than a nondisclosing one (and promoted patient perceptions of the therapist as professional), particularly when the disclosures illuminated similarities between patient and therapist and concerned "extratherapy" experiences (i.e., the therapist's life outside the consulting room). Interestingly, the researchers determined that disclosures of a negative valence were more beneficial than nondisclosure or disclosures of a positive valence (Henretty et al., 2014). Perhaps this is because it is negatively-valenced more than positively-valenced disclosures that promote an aura of fallible humanness in the therapist.

Concerning ultimate patient outcomes, though, the effects of TSD are far less clear. At least six correlational studies found no connection between TSD frequency and long-term outcome as evaluated by either patient, therapist, or third party (Ziv-Beiman, 2017; Beutler & Mitchell, 1981; Williams & Chambless, 1990; Coady, 1991; Hill et al., 1998). Moreover, Braswell et al. (1985) found that TSD frequency was negatively associated with therapists' ratings of client progress, though this latter study examined CBT treatments in children and thus cannot be generalized easily to the general population. Kelly and Rodriguez's (2007) empirical investigation revealed no significant connection between TSD frequency and symptomatic change or therapist/patient assessment of alliance (though this study relied solely on therapist ratings and looked at factual disclosures only). It should be emphasized, however, that disclosure frequency does not imply optimality. These studies, whose independent variable is frequency alone, do not differentiate between disclosure delivered judiciously and experienced by the client as helpful from disclosure that is handled ineptly and experienced as unhelpful. Moreover, all the

above studies used "vague and inconsistent" TSD definitions and measurement strategies, as Hill and Knox (2002) note (p. 260).

Numerous researchers have demonstrated that TSD positively influences patient outcomes. Ramsdell and Ramsdell (1993) surveyed former therapy clients who had undergone at least six therapy sessions and these subjects reported that in retrospect, TSD had had a beneficial effect on their treatment. Barrett and Berman (2001) designed an experiment (apparently the only of its kind in the literature) in which they manipulated the level of TSD that training clinicians offered their patients and examined the differential effects on treatment process. In this study, patients who received more reciprocal disclosures from their therapists (i.e., disclosures given in mirrored response to patient material) showed greater symptom improvement and felt more affection for their therapists, though they did not disclose more often themselves or report higher dyad intimacy than patients who had received lower amounts of TSD. "It is very difficult to assess the impact of a single statement, one perhaps given weeks or months ago, on treatment outcome," write Knox and Hill (2003, p. 532). This reality calls for research, like the present study, in which a more comprehensive and holistic assessment of TSD quality (optimality rather than simply frequency) is used to predict treatment outcome.

TSD and LGBTQ+-Matched Dyads

The sparse research on TSD within LGBTQ+-matched therapeutic dyads is largely qualitative, predominantly looks at gay men, and has focused almost exclusively on the therapist's binary choice between whether or not, and how, to come out to patients. There has been little empirical consideration of the manifold types of disclosure within Hill and Knox's (2003) framework (feelings, challenges, strategies, etc.) beyond divulging the fact of the therapist's sexual identity. (Indeed, apparently no research has looked at the disclosure of gender

identity). As noted earlier, the present study proposes a discrete category of rich and varied *identity-focused* TSD, which encompasses far more than simply revealing the bare fact of one's identity. Moreover, no identified studies examine the impact of TSD on ultimate treatment outcome on LGBTQ+-matched dyads through longitudinal design.

It has been shown that gay clients in particular seek a treatment dynamic of emotional security and affirmation and want assurances that their therapist will not inflict further homophobia or intolerance on them. They therefore tend to want to know if their therapist is similarly orientated (Cole & Drescher, 2006; Russell, 2006, Satterly, 2006; Henretty & Levitt, 2010). Research demonstrates that in matched dyads of gay men TSD can lessen internalized homophobia, shame, and self-hatred (Cornett, 1993; Henretty & Levitt, 2010; Kronner & Northcut, 2015). There is also evidence that gay men respond more sensitively to paternal than maternal support (or rejection), and so it is especially meaningful when a gay client receives identity-focused self-disclosure from a gay male therapist (Mohr & Fassinger, 2003; Thomas, 2008). Qualitative and survey studies that have examined TSD within gay-matched dyads consistently show that patients characterize TSD as "central to therapeutic bonding, reducing client anxiety that otherwise inhibited disclosures, and affirming gay sexuality and self-esteem" (Danzer, 2019, p. 75). Kronner and Northcut (2015), for instance, found that clients deemed 73% of their therapist's sexuality-related disclosures as positive (24% were neutral, while only 3% were deemed negative). Jeffrey & Tweed (2015) found that clients tended to disclose reciprocally when their therapists disclosed around sexuality, and Kronner (2013) found that clients with such therapists were more forgiving of their therapists' errors.

Because sexual orientation and gender identity are easier to keep private than other types of identity (e.g., race), an LGBTQ+ therapist must make considered decisions about when and

how (and to which patients) to reveal that they are LGBTQ+ (Moore & Jenkins, 2012). Some even have argued that informed consent requires a therapist to divulge their identities to any client, LGBTQ+ or not (e.g., Dean, 2010; Thomas 2008), and that the therapist's very credibility is at stake in the decision (Hearn & West-Olatunji, 2015). All agree that the choice to disclose or not to disclose will have significant implications on the therapeutic relationship and the communication patterns that unfold throughout treatment, particularly in matched dyads (e.g., Hearn & West-Olatunji, 2015; Guthrie, 2006) and especially when the patient has expressly sought out a therapist whom they know or suspect to be LGBTQ+ (Bashan, 2004; Dean, 2010; Liddle, 1997).

The therapist's disclosure decision is further impacted by the reality that the LGBTQ+ community is relatively small; even in large cities, it is common for patients and therapists to cross paths at social events, bars, parties, and other meeting places. Remaining reticent on one's own LGBTQ+ identity and then encountering a client under such real-world circumstances can put the therapist in an awkward position and perhaps stoke feelings of mistrust and betrayal in the client. Therefore, to sidestep such a treatment complication, many LGBTQ+ therapists seek to preemptively come out to their LGBTQ+ patients (Danzer, 2019).

Indeed, the literature identifies many potentially detrimental effects of nondisclosure. When an LGBTQ+ therapist remains closeted to their LGBTQ+ patient, it can arouse in the patient feelings of stress (Harris, 2015), loneliness, and isolation (Carroll et al., 2011). It can convey implicit heterosexism (Carroll et al., 2011), project internalized LGBTQ+-negativity (Hearn & West-Olatunji, 2015; Danzer, 2019) and shame (Dean, 2010; Farber 2006; Harris, 2015) onto the patient, inculcate in the patient a fear of impending judgement or rejection, and,

as a proverbial elephant in the room, it can divert attention away from the patient's therapeutic work (Harris, 2015).

Studies of openly LGBTQ+ clinicians consistently show that most have disclosed their sexual or gender identity at some point, that they choose to be out to certain clients over others, and that they are generally confused about the precise impact of disclosure on patients—though they tend to believe it is more helpful than not for an LGBTQ+ client to know their therapist's orientation (Harris, 2015; Houston, 1997; Carroll et al., 2011; Thomas, 2018; Satterly, 2006). Therapists frequently frame identity disclosure as serving a vital function of role-modeling and social justice in a community that has a dearth of role-models and ample injustice (Carroll et al., 2011; Hearn & West-Olatunji, 2015), or as a means of challenging homophobic stereotypes and opening dialogue about experiences of oppression (Thomas, 2008). Satterly (2006) found that in matched dyads, therapist disclosure of sexual orientation can increase patient disclosures, heighten empathy toward the therapist, and stimulate spontaneity, openness, flexibility, confidence, intimacy, and the patient's commitment to the work. Importantly, Satterly (2006) also found that these disclosure benefits arise more often when the therapist is secure and grounded in their sexual identity. Perhaps if the therapist harbors a fragile sense of self or unresolved internalized LGBTQ+-negativity, coming out may project onto the patient these unwanted states and set the work backwards. As Danzer (2019) writes, incorporating insights gleaned from studies conducted by Carrol et al. (2011), Harris (2015), Satterly (2006), Thomas (2008), Hearn and West-Olatunji (2015), and Lea et al. (2010):

> LGBTQ therapists thinking through the possibility of [disclosing their orientation] must consider the impacts of their own and the client's internalized homophobia and projections, whether they may be over-identifying with the client, the relevance of

> [disclosure] to treatment, and the foreseeable impacts of [disclosure] on the therapeutic relationship, the balance between therapeutic neutrality and authenticity, and the intersection between social and professional identity. Thus, [disclosure] risks meeting the therapist's own needs, giving the impression of flaunting one's sexuality, sending simplistic "it's okay to be gay" messages, and near-abruptly disconfirming client presumptions in a way that can damage the relationship (p. 74).

In sum, there are clear pitfalls to disclosure that even seasoned therapists with strong clinical instincts must weigh before self-disclosing to their LGBTQ+ patients.

Research Gap

The theoretical and empirical literature gives us ample reason to suspect that some patients may benefit—perhaps greatly—from TSD under certain circumstances. Clinical intuition and qualitative research (e.g., Satterly, 2006) suggest that one such circumstance is when both patient and therapist identify as LGBTQ+ and when the therapist discloses meaningful, personal information related expressly to their shared identity. To this author's knowledge, no extant study examines the effect on ultimate treatment outcome of such identity-focused self-disclosure in LGBTQ+-matched dyads. Moreover, the qualitative and survey research on LGBTQ+ therapy tends to focus only on the narrowest of therapist disclosure behavior: coming out to a client or remaining in the closet. By contrast, the present study defines identity-focused therapist self-disclosure substantially more broadly, considers only what the patient considers to be helpful or "optimal" disclosure (eliminating the impact of self-aggrandizement bias when asking therapists to assess their own disclosure skill), and tracks patients over time to investigate how TSD-I may impact symptomatology. It is therefore a novel addition to the voluminous self-disclosure literature.

CHAPTER THREE: METHOD

Overview of Research Methods

Participants and Procedure

Recruitment

Between December 2022 and July 2023, I recruited 262 LGBTQ+ U.S. and Canadian residents aged 18 to 78 to participate in a study about "what therapy/counseling is like when the client and the therapist are both LGBTQ+." Individuals met eligibility criteria if they (1) were 18 years of age or older and fluent in English; (2) lacked a psychotic disorder diagnosis; (3) identified as LGBTQ+[5]; (4) were currently, and had been for at least two months, in a one-on-one psychotherapy/counseling treatment with a licensed (or training-for-licensure) clinician working in a recognized mental health field and theoretical modality; and (5) knew for certain that their therapist also identifies as LGBTQ+, whether their therapist divulged this directly or they learned secondhand through a referral source, internet searching, or other means. This study received CUNY Integrated IRB approval on October 20, 2022 (Protocol #2022-0623).

I adhered to recruitment best practices (Dillman, Smyth, & Christian, 2014) and employed a variety of outreach approaches. I mailed about 800 patient recruitment request letters via postal and e-mail to therapists who openly list their LGBTQ+ identities on mental health clinician databases. Additionally, I placed advertisements on professional listservs, social media sites (e.g., Instagram, Reddit) and in national LGBTQ+ print publications including *The Advocate* and *Out in New*

[5] Defined for prospective participants as lesbian, gay, bisexual, queer, asexual, pansexual, polysexual, or any other sexual minority identity, and/or transgender, nonbinary, genderfluid, genderqueer, agender, or any other gender minority identity.

Jersey.[6] I also posted flyers on bulletin boards at organizations like Callen-Lorde Community Health Center in New York City and the Los Angeles LGBT Center. Of the final sample, 82 participants learned of the study directly from their therapists (41.4%); 46 (23.2%) from friends, family, or colleagues; 29 (14.6%) from an email or listserv advertisement, 20 (10.1%) from a social media posting, 16 (8.1%) from a posted flyer, and five (2.5%) from print advertisements. Appendix A presents selected outreach materials. Lag between data waves was on average 8.08 weeks between baseline and T2, and 7.37 weeks between T2 and T3. I administered surveys using Qualtrics (Qualtrics, 2018).

Data Integrity

All 262 enrolled participants passed a rigorous fraud detection process to filter out data generated by automated bots and bad faith responders, an increasingly pernicious threat to online survey-based research (Pozzar et al., 2020). I employed multiple data quality assurance measures, including a CAPTCHA[7] at the start of each survey, four attention check questions spaced throughout, duplicate demographic questions at survey's end, and IP address location checks. Additionally, I scrutinized responses to similar questions for inconsistency. I de-enrolled any participant if they failed one or more data integrity checks.

[6] I directed prospective participants via URL and QR code to a dedicated website (www.TherapyStudy.com) which described the study's premise, basic inclusion criteria, participation requirements, potential benefits of participating, and remuneration of $25 in Amazon gift cards. A link on this website opened the baseline survey, which began with a screening questionnaire that filtered out participants who did not meet inclusion criteria.

[7] A CAPTCHA, or "Completely Automated Public Turing Test to Tell Computers and Humans Apart," presents a visual puzzle that humans can easily complete, but computers cannot.

Attrition

Of the 262 enrolled participants, 24 (9.2%) completed only the baseline survey and ten (3.8%) completed all but the T3 survey, for a total attrition rate of 13 percent. Participants lost to attrition did not differ significantly from those who completed all survey rounds on any major study variable at T1. Namely, they did not differ on amount of identity-focused therapist self-disclosure (TSD-I) [$t(260) = -0.30$, $p = .77$], TSD-I optimality [$t(241) = 1.46$, $p = .15$], amount of general disclosure (GD) [$t(260) = 1.47$, $p = .14$], GD optimality [$t(240) = 1.48$, $p = .14$], real relationship [$t(260) = -0.63$, $p = .53$], internalized LGBTQ+-negativity [$t(260) = -0.19$, $p = .85$], rejection sensitivity [$t(260) = 0.04$, $p = .97$], loneliness [$t(260) = 0.54$, $p = .59$], composite minority stress [$t(260) = 0.26$, $p = .79$], or psychopathology [$t(260) = 1.60$, $p = .11$]. Attrition subjects were, however, more likely to be from the geographic West than from the Northeast [$\chi^2(5) = 19.35$, $p = .00$]; less likely to know their therapist's racial identity [$\chi^2(3) = 21.70$, $p < .001$]; more likely to be retired than unemployed [$\chi^2(7) = 16.31$, $p = .02$]; more likely to be married than unmarried and cohabiting with a partner [$\chi^2(8) = 18.45$, $p = .02$]; more likely to identify as lesbian or gay than queer [$\chi^2(8) = 16.94$, $p = .03$]; more likely to identify as cisgender [$\chi^2(1) = 6.28$, $p = .01$]; less likely to have a mood disorder [$\chi^2(1) = 4.82$, $p = .03$]; more likely to see a therapist who holds a bachelors' degree [$\chi^2(3) = 54.94$, $p < .001$]; and more likely to have been in therapy for between one and two years [$\chi^2(4) = 74.96$, $p < .001$].

Measures

All the following measures were administered at all three time points.

Identity-Focused Therapist Self-Disclosure (TSD-I)

To measure the prevalence and impact of TSD-I, a construct with no prior literature base, I administered the Identity-Focused Therapist Self Disclosure Questionnaire (TSDQ-I), a modified

version of the Therapist Self Disclosure Questionnaire–Client Form (TSDQ-C) developed by Ain and Gelso (Ain, 2011; Ain & Gelso, 2008, 2011) and adapted by this author with permission (Gelso & Ain, personal communication, April 26, 2022).[8] The TSDQ-C, which does not concentrate on identity-focused disclosures in particular, asks the respondent to consider through description and example each subtype in Knox and Hill's (2003) taxonomy (disclosures of facts, feelings, reassurance/support, strategies, challenges, and insight), then rate on three-point Likert-type scales the amount of disclosure they have received from their therapist (*not at all*, *some*, *a lot*) and their feelings about this amount (*not enough*, *just right*, *too much*). The respondent also writes, if applicable, one example of each type of disclosure that has occurred in their therapy. The TSDQ-C ends with four broad questions about the amount and perceived appropriateness of the therapist's overall disclosure patterns.

To create the TSDQ-I, I modified all descriptions, examples, and questions to focus exclusively on disclosures related to the therapist's sexual and/or gender identity (e.g., "A therapist might disclose feelings they have about their LGBTQ+ identity. *Example:* "I was relieved when my parents reacted supportively when I came out as bisexual"). I expanded all Likert scales from three to five points to provide greater granularity of response data, and made minor edits to Ain and Gelso's (2008, 2011) original text to improve clarity and concision. I added two additional questions to capture perceived self-disclosure optimality: "How do you tend to feel when your therapist self-discloses in this way?" [*very uncomfortable* to *very comfortable*]; and "Which best describes how this self-disclosure has impacted your therapy?" [*It's been very harmful to my therapy* to *It's been very helpful to my therapy*]. As on the TSDQ-C, the final TSDQ-I section asks

[8] The TSDQ-I was piloted with members of the City College of New York's Clinical Psychology Doctoral Program's "Queer and Allies" student group, who provided feedback on the face validity and clarity of the measure. Their feedback was incorporated into the TSDQ-I's final revision.

the respondent to rate the optimality of their therapist's TSD-I overall. To allow for analysis of the specific effects of identity-focused disclosure, I also asked participants to assess the optimality of their therapist's general disclosures (GD), with instruction to "consider only self-disclosure that is completely unrelated to LGBTQ+ identity." Appendix B presents the TSDQ-I.

The TSDQ-I produces data about patient-perceived frequency and optimality of their therapist's identity-focused disclosures. Frequency is captured by the answer to "How often does your therapist self-disclose…," as well as the patient's estimate of the total number of self-disclosures their therapist has made. Participants receive a global optimality score, which is the sum of responses to all concluding "overall" items except those about frequency (because disclosure frequency, in and of itself, is independent of a patient's subjective experience of that disclosure).

Higher global optimality scores indicate higher optimality of TSD. The lowest possible optimality score (= 4) results when a respondent reports that (a) their therapist's self-disclosure has been *much less than [they'd] prefer* or *much more than [they'd] prefer* (item score = 1)[9]; (b) the self-disclosures have made the respondent feel *very uncomfortable* (item score = 1); (c) the therapist's self-disclosures have been *not at all related* to the respondent's problems (item score = 1); and (d) the self-disclosures have been *very harmful to [their] therapy* (item score = 1). By contrast, the highest possible optimality score (= 18) results when a respondent reports that (a) the amount of their therapist's self-disclosure has been *just right* (item score = 3); (b) the self-disclosures have made the respondent feel *very comfortable* (item score = 5); (c) the therapist's self-disclosures have been *extremely related* to the respondent's problems (item score = 5); and (d) the self-disclosures have been *very helpful to [their] therapy* (item score = 5).

[9] I recoded the 5-point scale on this question such that the extreme ends (*much less*, *much more*) both transform to a value of 1; the middle value (*just right*) remains 3, and intermediate values between the middle and the extremes receive a value of 2.

Therapeutic Alliance: The "Real Relationship"

A decisive component of the therapeutic alliance, shown empirically to positively impact patient outcomes, is the "real relationship" between therapist and patient (Gelso, 2009, 2011; Gelso et al., 2012). The real relationship is conceptualized as a combination of the patient's and therapist's "realistic perceptions and experiences of [each other], uncontaminated by transference" (realism), and the extent to which patient and therapist connect "in a way that is non-phony and authentic, even as each plays out the roles they must take" (genuineness; Gelso and Kline, 2019, p. 143). Higher realism and genuineness within the dyad indicate a stronger therapeutic alliance via the real relationship.

I administered the Real Relationship Inventory–Client Version (RRI-C; Kelley et al., 2010), a 24-item questionnaire that asks the respondent to evaluate the amount of genuineness or realism in their relationship with their therapist. Item examples include "I am able to communicate my moment-to-moment inner experience to my therapist" (genuineness) and "I am able to separate out my realistic perceptions of my therapist from my unrealistic perceptions" (realism). Items focus variously on the client, the therapist, or their relationship, and the respondent rates each item on a 5-point Likert scale (from *strongly disagree* to *strongly agree*). For the purposes of this study and with the original author's endorsement (Kelley, personal communication, April 26, 2022), I made pronoun modifications to certain questions (substituting "their" for "his or her," for instance) to encompass a broader range of gender identities. Moreover, I changed all tenses from past to present, as this study concerns itself with current and not past psychotherapy treatments. Global RRI-C scores, tabulated by summing all realism and genuineness item scores, range from 24 to 120, with higher scores indicating greater therapeutic alliance via the real relationship.

The RRI-C is psychometrically sound, demonstrating acceptable internal consistency and retest reliability across numerous studies (Fuertes et al., 2007; Marmarosh et al., 2009; Kelley et al., 2010), and the realism and genuineness subscales have shown high interrelation (r = .80). Convergent, discriminant, and construct validity are likewise robust when the RRI-C is compared to related measures of working alliance, observing ego, and attachment patterns (Fuertes et al., 2007; Eugster & Wampold, 1996; Kelley et al., 2010). Other studies have demonstrated that the RRI-C predicts positive therapy outcomes as expected (Marmarosh et al., 2009; Lo Coco et al., 2011). Appendix C presents the RRI-C.

Minority Stress

I computed a composite minority stress score for each participant at each time point by summing the scores from the following validated instruments that measure component minority stress processes.

Rejection Sensitivity. According to Meyer's (2003) minority stress framework and ample empirical data (e.g., Pachankis et al., 2008), LGBTQ+ individuals are subjected to chronic discriminatory affronts and tend to become highly stigma conscious and consequently sensitive to rejection. I measured rejection sensitivity (RS) using the LGBTQ-Related Rejection Sensitivity Scale (LGBTQ-RSS), a more identity-inclusive adaptation of the Gay-Related Rejection Sensitivity Scale (G-RSS) by Pachankis and colleagues (Pachankis, Goldfried, & Ramrattan, 2008). The LGBTQ-RSS asks the respondent to consider 11 hypothetical, potentially discriminatory scenarios (e.g., "You go to a party and you and your partner are the only LGBTQ+ people there. No one seems interested in talking to you."). The respondent ranks on a six-point Likert scale how concerned or anxious they would be in such a scenario, and how likely they believe their sexual orientation and/or gender identity would have contributed to the hypothetical rejection. A weighted score for each item multiplies the concerned/anxious and likelihood ratings, and the

average of these weighted scores provides the respondent's global RS score. Inter-item correlations for the G-RSS are high, and moderate correlations with related measures (including internalized homophobia, interpersonal sensitivity, assertiveness, fear of negative evaluation, and perceived gay discrimination) support the G-RSS's discriminant validity (Pachankis, Goldfried, & Ramrattan, 2008, p. 313). Appendix D presents the LGBTQ-RSS.

Internalized LGBTQ+-Negativity. Currie and colleagues (2004) developed the Short Internalized Homonegativity Scale (SIHS) to improve upon existing measures of internalized homonegativity (IH; e.g., Homosexual Attitudes Inventory [Nungesser, 1983], Internalized Homonegativity Inventory [Mayfield, 2001], and Reactions to Homosexuality Scale [RHS; Ross & Rosser, 1996]) that had shown relatively weak reliability and validity and were increasingly seen as anachronistic given sweeping contemporary changes in attitudes toward LGBTQ+ persons. Currie et al. (2004) began with the RHS (the strongest of those existing measures, in their estimation), a 26-item survey comprised of four subscales: "Public Identification as Gay" (sample item: "I would prefer to be more heterosexual"); "Perception of Stigma Associated With Being Gay" ("Discrimination against gay people is still common"); "Social Comfort With Gay Men" ("I feel comfortable in gay bars"); and "Moral and Religious Acceptability With Being Gay" ("Homosexuality is as natural as heterosexuality"). The authors eliminated the "Perception of Stigma…" questions due to lack of convergent validity, then added ten additional items to improve internal consistency of the other subscales. Exploratory and confirmatory factor analysis resulted in a final 12-item measure comprised of three factors: "Public Identification as Gay" (which measures fear that people will find out, and desire to control who knows, about one's sexual orientation, as well as discomfort with discussing homosexuality); "Sexual Comfort with Gay Men" (which measures the prevalence of stereotypic beliefs about gay relationships, sexual encounters, and public displays of sexuality); and "Social Comfort with Gay Men" (a new dimension of IH which

measures discomfort around social interactions with gay men). The authors found internal consistency reliabilities around .70 and concluded that "it is appropriate to total the scores of the 12-item measure as a single measure of internalized homonegativity" (Currie et al., 2004, p. 1065).

The SIHS, while capturing contemporary experiences of IH more robustly than older measures, is limited in that it was written for and psychometrically tested on gay men only. For the present study, with input from the original authors (Currie, personal communication, April 28, 2022), I altered wording to be inclusive of a broader range of sexual and gender minority identities. For example, I modified "Social situations with gay men make me feel uncomfortable" to "Social situations with LGBTQ+ people make me feel uncomfortable." Appendix E presents the LGBTQ+-adapted SIHS.[10]

Loneliness. To measure the concealment component of Meyer's (2003) minority stress model, I administered the UCLA Loneliness Scale (Version 3), a 20-item measure that captures the respondent's subjective feelings of loneliness and social isolation. Since its first publication (Russell et al., 1978), the authors have modified the scale twice for syntactic clarity and to include reverse scored items. Subjects read statements (e.g., "There is no one I can turn to" and "My social relationships are superficial") and rate whether they feel *often*, *sometimes*, *rarely*, or *never* each way. Russell (1996) reports that this instrument demonstrates high reliability, with internal consistency coefficients between .89 and .94, as well as a strong test-retest reliability (r = .73).

[10] I additionally administered the Transgender Identity Scale (TIS; Bockting et al., 2020) only to those participants who identified at baseline as non-cisgender. I provided instructions to "replace the word 'transgender' in the following questions, if appropriate, with your own non-cisgender identity (non-binary, genderfluid, genderqueer, etc.)." I eliminated the TIS from the minority stress composite score, however, after unsolicited and thematically consistent participant feedback indicated that the measure does not adequately capture the lived experience of non-cisgender individuals who identify other than transgender (e.g., nonbinary, agender, etc.).

Convergent and construct validity are likewise robust, as the scale correlates strongly with other loneliness instruments as well as with measures of interpersonal relationship quality and general well-being. Appendix F presents the UCLA Loneliness Scale.

Psychopathology

This study's outcome of interest is the participant's psychological functioning, i.e., level of psychopathology, at T3. I measured this with the Outcome Questionnaire–45.2 (OQ45), a robust and routinely administered instrument that captures an individual's psychosocial health across three domains—symptom distress, interpersonal relations, and social integration (Beckstead et al., 2003). Respondents endorse each of 45 items (e.g., I feel no interest in things"; "I have frequent arguments") along a 5-point Likert scale from *never* to *almost always*. Numerous studies have confirmed the OQ45's psychometric strength (Lambert et al., 1999; Boswell et al., 2013). Its internal consistency is very strong (Cronbach's alpha = .93), as is its test-retest reliability (.84), and it correlates closely with related measures including the Beck Depression Inventory and clinician-generated Global Assessment of Functioning ratings (Boswell et al., 2013; Mueller et al., 1998). Appendix G presents the OQ45.

Covariates

At baseline, I assessed and coded numerous covariates related to the participant's sociodemographic identity, mental health, and therapy treatment.

Age. I asked participants to enter their age in years and assigned them to the following age bands: *18-24*, *25-34*, *35-44*, *45-54*, *55-64*, and *65 and older*.

Geographic region. I asked participants to provide their full home address and assigned them to the following geographic regions: *Northeast*, *Midwest*, *West*, *South*, and *Canada*.

Race and ethnicity. I assessed race for both participant and therapist by asking, "Please choose one or more races that you consider yourself to be [that your therapist/counselor considers

themselves to be].” Responses options were *American Indian or Alaska Native*, *Asian*, *Black or African American*, *Native Hawaiian or other Pacific Islander*, *White*, *mixed race*, and *I do not [My therapist does not] identify racially*.[11] Because about 79% of participants and 71% of therapists identified as White, I recoded responses dichotomously as *White* and *non-White*. I captured participant and therapist ethnicity with the question, “Are you [Is your therapist] of Spanish, Hispanic, or Latino origin?”; response options were *yes* and *no*. I created dyad match variables to identify respondents who shared a racial and/or ethnic identity with their therapist, coded respectively as *racially unmatched* and *racially matched*, and *ethnically unmatched* and *ethnically matched*.

Education, employment, and income. I assessed participant education by asking “What is the highest level of education you have completed?”; response options were *some high school or less*, *high school diploma or GED*, *some college but no degree*, *associates or technical degree*, *bachelor’s degree*, and *graduate or professional degree*. I assessed participant employment with the item, “What is your current employment status?” and respondents could select any of the following that applied: *full-time work*, *part-time work*, *full-time student*, *part-time student*, *unemployed*, and *retired*. I recoded participants who selected any combination of work and student options as *combination of work and student*. I prompted participants, “Please indicate your household income in 2021 before taxes” and responses ranged from *less than $10,000* to *$150,000 or more*.

Relationship status. I asked participants, “What is your relationship status?”; response options were *I am single*, *I am currently dating but do not live with a romantic partner*, *I live with my romantic partner(s) but am not married*, *I am married*, *I am separated from a spouse(s) or*

[11] Many covariate questions included response options of “Other,” “I prefer not to say,” and/or “I do not know,” which are not listed here for the sake of brevity.

domestic partner(s), *I am divorced*, and *I am widowed*. Because nearly 70% of participants reported some form of romantic relationship, I recoded responses dichotomously as *single* and *in a relationship*.

Religion. I assessed participant religion with the question, "What religion or spiritual tradition(s) do you follow, if any?" and respondents could select any of the following that applied: *atheist or agnostic*, *Buddhism*, *Evangelical Protestant*, *Greek Orthodox*, *Hinduism*, *Islam*, *Judaism*, *other Protestant*, *Roman Catholic*, *pagan*, *spiritual*, and *combination of beliefs*. Because 51% of participants identified as atheist or agnostic, I recoded responses dichotomously as *no faith tradition* and *follows faith tradition*.

Sex, gender, and sexual orientation. I assessed birth sex with the question, "What sex were you assigned at birth?" and response options were *male*, *female*, and *intersex*. I assessed patient sexual orientation with the item, "When you think about sex, do you primarily think of yourself as:" and response options were *lesbian*, *gay*, *bisexual*, *queer*, *asexual*, *pansexual*, *polysexual*, *questioning*, and *straight/heterosexual*. I assessed therapist sexual orientation with the item, "To the best of your knowledge, which best describes your therapist's/counselor's sexual orientation?" and response options were identical except for the exclusion of *questioning* and addition of *I'm not sure what my therapist's/counselor's sexual orientation is*. I assessed participant gender identity with the item, "When you think about gender, do you primarily think of yourself as:" and response options were *cisgender*, *transgender*, *nonbinary*, *genderfluid*, *genderqueer*, *agender*, and *questioning*. I assessed therapist gender identity with the item, "To the best of your knowledge, which best describes your therapist's/counselor's gender identity?" and response options were identical except for the exclusion of *questioning* and the addition of *I'm not sure what my therapist's/counselor's gender identity is*. I recoded both gender identity questions as *cisgender* and *non-cisgender* (for therapist gender identity, a third category was added for *unknown*).

I created therapy "dyad match" variables, conceptualized as follows. "Sexual orientation match" refers to dyads in which patient and therapist share the same sexual orientation (e.g., lesbian patient and lesbian therapist). "Exact gender identity match" refers to dyads in which patient and therapist share a specific gender identity (e.g., transgender patient and transgender therapist, or cisgender patient and cisgender therapist). "Any noncisgender identity match" refers to dyads in which patient and therapist share *any* noncisgender identity, though not necessarily the same one (e.g., transgender patient and nonbinary therapist). "At least one identity match" refers to dyads in which patient and therapist share the same sexual orientation *and/or* identify as noncisgender. Finally, "double match" refers to dyads in which patient and therapist share the same sexual orientation and also identify as noncisgender. I dichotomously coded all dyad match variables as *unmatched* or *matched*.

Mental health diagnoses. I asked participants, "Have you ever received any of the following mental health diagnoses?" and instructed them to select all that apply from the following list: *depression*, *anxiety*, *obsessive-compulsive disorder*, *post-traumatic stress disorder*, *eating disorder*, *substance use disorder*, *personality disorder*, *autism spectrum disorder*, *attention deficit hyperactivity disorder*, and *I have not been diagnosed with a mental health disorder*. Depression and anxiety were both recoded as *mood and anxiety disorders*.

Therapy treatment. I asked participants to characterize their therapy treatment as follows. I captured therapy length with the item, "For approximately how long have you been seeing your current therapist/counselor?"; response options were *one year or less*, *between 1 and 2 years*, *between 2 and 3 years*, and *more than 3 years*. I assessed therapist education with the question, "What are your therapist's/counselor's educational credentials?"; response options were *bachelor's degree*, *master's degree*, and *doctoral degree*. I asked participants to specify their therapist's mental health field with the item, "What type of mental health professional is your therapist/counselor?";

response options were *clinical or counseling psychologist*, *clinical social worker*, *marriage and family therapist*, *mental health counselor*, *clinical alcohol and drug abuse counselor*, *psychiatric or mental health nurse practitioner*, and *psychiatrist*. I captured therapy modality with the question, "Which best describes the type of therapy that are you in?"; response options were *psychodynamic/psychoanalytic*, *cognitive-behavioral therapy*, *humanistic/existential*, *dialectical behavior therapy*, *My therapist uses an equal blend of two or more of these approaches*, and *My therapist uses a different therapy approach that doesn't fit any of the above descriptions* (the first four response options included brief descriptions of each respective modality).

Analyses

Missing Data

Of the participants who completed all three survey rounds ($N = 228$), only 18 (7.9%) reported at baseline that their therapist had never self-disclosed about their LGBTQ+ identity (a noteworthy finding which will be discussed further in Chapter 5). Because these participants did not constitute a large enough subgroup from which to draw meaningful comparisons or conclusions, and because they only answered disclosure optimality questions at T3 (At baseline and T2, Qualtrics displayed these questions only to participants who reported at least some therapist disclosure), I excluded these 18 participants from the final analysis. (Because they did rate the optimality of their therapists' *lack* of disclosure at T3, I conducted a supplemental cross-sectional analysis of these 18 participants, discussed below). Independent samples *t* tests revealed that this excluded group differed from the analytic sample in only two respects: Individuals whose therapists never self-disclosed about identity reported significantly worse real relationship across all time points [e.g., $t(226) = -2.74$, $p = .01$ at T2], as well as significantly less rejection sensitivity at T1 [$t(226) = -2.47$, $p = .01$] and T3 [$t(226) = -2.33$, $p = .02$], than did those whose therapists self-disclosed about identity at least sometimes. Expectedly, participants whose therapists never

disclosed about identity at baseline also self-disclosed significantly less about matters unrelated to identity across all time points [e.g., $t(226) = -3.31$, $p < .001$ at T1].

There were an additional 11 participants who reported at T1 that their therapists did disclose at least sometimes about LGBTQ+ identity—but also reported that their therapists never disclosed about non-identity-related matters (for the reason noted above, they did not assess GD optimality, a covariate, at baseline). Given that the data for these participants was missing not at random (MNAR), I made the decision to exclude these 11 individuals from analysis as well, despite the loss of data. Of note, GD optimality scores were notably correlated with TSD-I optimality scores ($r = .46$, $p < .001$). Independent samples t tests revealed that this subgroup did not differ from the rest of the sample on any major variable of interest.[12] In effect, I refined this study's population to be LGBTQ+ therapy patients whose therapists disclose at least sometimes about identity, as well as more generally (the overwhelming majority of respondents). I eliminated one final participant because they did not complete the rejection sensitivity measure at T2, resulting in a final analytic sample with no missing data of $N = 198$ (see Figure 2).

Disclosure Optimality Groups

Disclosure optimality scores (on a scale from 4 to 18) were strongly negatively skewed at T1 (TSD-I: $M = 15.82$, $SD = 2.14$; GD: $M = 15.38$, $SD = 2.38$) and across time points. That is, participants overwhelmingly and consistently rated their therapists' disclosures as highly optimal. Given this score distribution, creating optimal and suboptimal disclosure groups of roughly equal size was impossible because selecting a cut-off score to distinguish optimal from suboptimal disclosure would have been arbitrary and conceptually meaningless. I therefore decided to treat

[12] Regarding covariates, chi squared tests of independence detected significant differences between this subgroup and the rest of the sample in participant education level, income, religious affiliation, non-cisgender dyad identity match, and OCD diagnosis.

disclosure optimality as a continuous variable and to test the influence of disclosure optimality level, instead of the difference between distinct optimal/suboptimal groups.

Covariates

I conducted ANOVAs to identify covariates for real relationship and minority stress at T2, and psychopathology at T3. I detected significant between-group differences in real relationship at T2 for gender identity (both participant and therapist), any noncisgender identity match, dyad double match, PTSD diagnosis, and therapy length. I detected significant between-group differences in minority stress at T2 for employment, income, OCD diagnosis, relationship status, religion, and participant sexual orientation. I detected significant between-group differences in psychopathology at T3 for age band, dyad sexual orientation match, employment, education (both participant and therapist), therapy frequency, and diagnoses of mood disorder, OCD, PTSD, and personality disorder, as well as no (versus any) diagnosis. I added the above covariates as controls to the final models at the appropriate time points. I excluded from analysis covariates for which I found no between-group differences for any variable: birth sex, dyad gender identity exact match, geographic region, race and ethnicity (both participant and therapist), racial/ethnic dyad match, therapist profession and sexual orientation, and therapy modality.

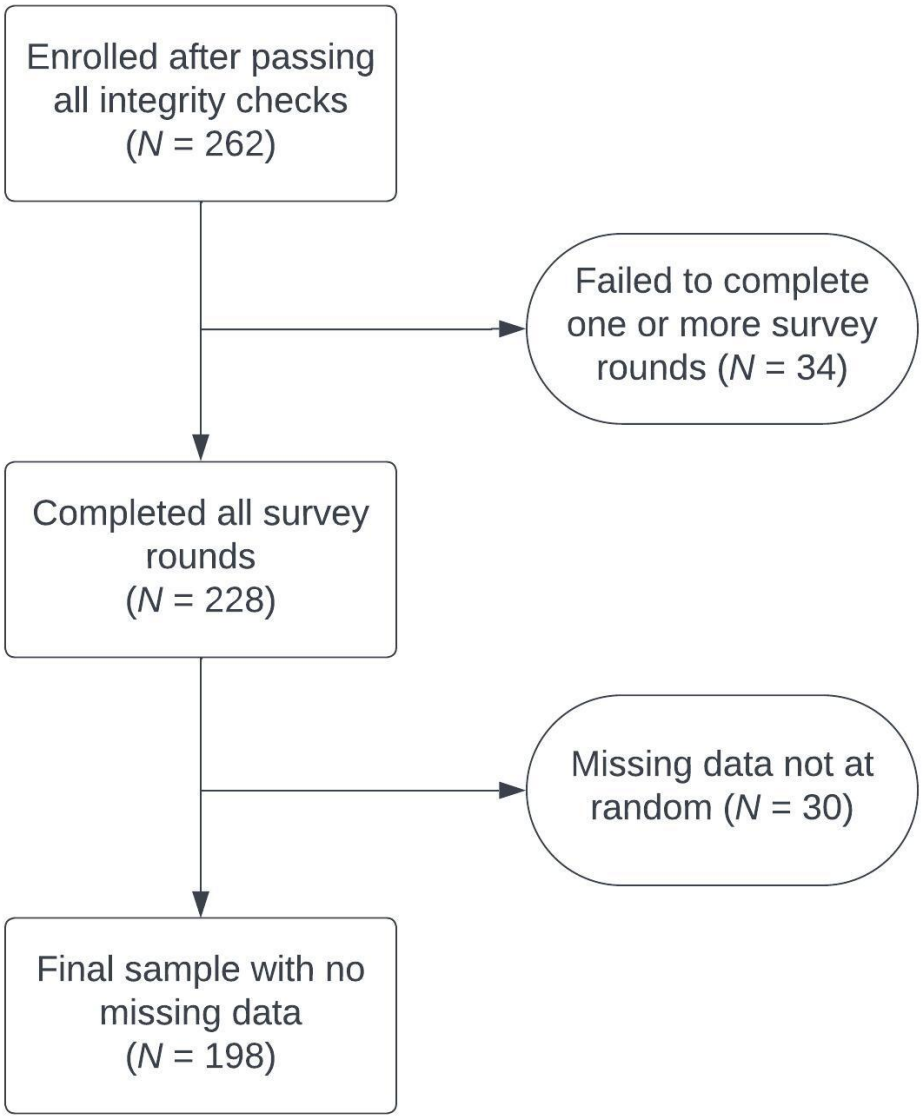
Primary Analyses

I computed change between T1 and T3 for all major study variables, and employed Pearson correlations to examine bivariate relations. I coded qualitative data for topics, concepts, categories, and emergent themes, then systematically analyzed it using frequency tabulations and Interpretative Phenomenological Analysis (IPA) methodology to identify essential meanings in participants' subjective disclosure experiences. I conducted all preliminary quantitative analyses (descriptive statistics, correlations) in SPSS Version 29 (IBM Corp., 2022), and analyzed all longitudinal mediation models in Mplus Version 8.3 (Muthén & Muthén, 1998-2017) placing disclosure

optimality at baseline, real relationship and minority stress at T2, and psychological functioning (psychopathology) at T3. Mplus is one of several software options available for investigating mediation models and functions equivalently to the PROCESS macro but with added flexibility. I tested models using Maximum Likelihood estimation with 10,000 bootstrap draws based on code provided and annotated by Stride and colleagues (2015). Although fit statistics are often interpreted for path models investigated in Mplus, and although they were generated for the models under investigation, they will not be interpreted because the models themselves should be interpreted as saturated (i.e., just-identified). That is, adding additional model paths would not change model estimates (Muthén, Muthén, and Asparouhov, 2017).

Figure 2

Study Participants Flow Diagram



CHAPTER FOUR: RESULTS

Descriptive Statistics

As reported in Table 1, at baseline participants were LGBTQ+-identifying residents of the United States and Canada in their early thirties, on average.[13] The majority were female, White, and non-single (in some form of romantic relationship); worked full- or part-time, held a graduate or professional degree, and earned a median annual income of about $70,000. Most participants identified as atheist/agnostic, queer, and non-cisgender. The majority had been diagnosed with a mood or anxiety disorder and had been in therapy at least once a week, for less than one year, in an integrative or eclectic treatment with a licensed master's-level clinical social worker. Participants' therapists were majority White, queer, and cisgender. Most therapist-patient dyads were matched on race and at least one minoritized sexual orientation and/or noncisgender identity. Specifically, nearly half of the dyads were exactly matched on a minoritized sexual orientation (e.g., lesbian patient and lesbian therapist) or gender identity (e.g., transgender patient and transgender therapist). About one-third were matched broadly on any noncisgender identity (e.g., nonbinary patient and transgender therapist), and about one-fifth were double matched on both sexual orientation and a noncisgender identity. Table 2 presents descriptive statistics for major study variables.

Bivariate Relations

Table 3 presents the bivariate relations among major study variables. The following are notable associations that emerged from the data.

Component Minority Stress Processes

Individuals with greater LGBTQ+-negativity also reported greater rejection sensitivity, though the association was weak and existed at T1 only ($r = .15$, $p < .05$). Changes in LGBTQ+-negativity and rejection sensitivity over time were weakly associated ($r = .14$, $p < .05$), such that

[13] Participants were from thirty-two US states and four Canadian provinces.

Table 1

Sociodemographic Characteristics of Participants at Baseline

		M (SD) or % (N)
Age:		33.4 (10.04)
Sex assigned at birth:	Female	74.2 (147)
Geographic region:	Northeast	33.3 (66)
	West	25.8 (51)
	Midwest	18.2 (36)
	South	8.6 (17)
	Canada	12.6 (25)
Race:	White	79.3 (157)
	Asian	7.6 (15)
	Black	2.5 (5)
	Mixed	4.0 (8)
Ethnicity:	Not Hispanic/Latino	87.4 (173)
Relationship status:	Single	31.8 (63)
	Cohabiting and unmarried	23.2 (46)
	Married	19.2 (38)
	Dating and not cohabiting	17.7 (35)
	Other	8.1 (16)
Education:	Graduate or professional	51.5 (102)
	Bachelor's	31.3 (62)
	Less than bachelor's	17.2 (34)
Employment:	Full- or part-time work	72.7 (144)
	Combination work/student	10.1 (20)
	Full- or part-time student	9.6 (19)
	Unemployed or retired	7.6 (15)
Household income:		7.12 (3.85)
Religion:	Agnostic/atheist	51.0 (101)
	Faith tradition/spiritual	48.0 (95)
Sexual orientation:	Queer	46.0 (91)
	Lesbian or gay	26.8 (53)
	Bisexual	13.6 (27)
	Other	13.6 (27)
Gender identity:	Cisgender	35.9 (71)
	Nonbinary	20.2 (40)
	Transgender	20.2 (40)
	Genderqueer	9.6 (19)
	Other	13.6 (27)
Diagnoses:	Mood or anxiety disorder	82.3 (163)
	PTSD	33.8 (67)
	No diagnosis	10.1 (20)
	OCD	9.6 (19)
	Eating disorder	8.6 (17)
	ADHD	7.6 (15)
	Substance use disorder	4.5 (9)
	Other	10.6 (21)
Therapist's education:	Master's degree	66.7 (132)
	Don't know	18.2 (36)
	Doctoral degree	12.6 (25)
	Bachelor's degree	2.5 (5)

Table 1 (continued).

		M (SD) or % *(n)*
Therapist's profession:	Clinical social worker	42.4 (84)
	Mental health counselor	16.7 (33)
	Clinical or counseling psychologist	13.6 (27)
	Marriage and family therapist	10.6 (21)
	Other	8.1 (16)
	Don't know	8.6 (17)
Therapy modality:	Integrative/eclectic	34.8 (69)
	Cognitive behavioral (CBT)	18.2 (36)
	Psychodynamic/psychoanalytic	15.2 (30)
	Humanistic/existential	6.1 (12)
	Dialectical behavioral (DBT)	3.0 (6)
	Other	22.7 (45)
Time in therapy:	One year or less	32.8 (65)
	Between one and two years	28.8 (57)
	Between two and three years	17.7 (35)
	More than three years	20.7 (41)
Frequency of therapy:	Once a week or more	50.5 (100)
Therapist's race:	White	71.2 (141)
	Not sure	10.6 (21)
	Asian	8.6 (17)
	Black	4.0 (8)
	Mixed	2.5 (5)
Therapist's ethnicity:	Not Hispanic/Latino	64.6 (128)
Therapist's sexual orientation:	Queer	38.9 (77)
	Lesbian or gay	36.9 (73)
	Bisexual	9.6 (19)
	Not sure	8.6 (17)
	Other	6.1 (12)
Therapist's gender identity:	Cisgender	56.6 (112)
	Nonbinary	16.2 (32)
	Transgender	12.6 (25)
	Genderqueer	5.1 (10)
	Other	3.5 (7)
	Not sure	6.1 (12)
Dyad matching:	Matched on race	66.2 (131)
	Matched on sexual orientation	43.9 (87)
	Matched exactly on gender identity	44.4 (88)
	Matched on any noncisgender identity	33.3 (66)
	Matched on at least one LGBTQ+ identity	61.6 (122)
	Double matched	19.7 (39)

Note. N = 198. Age is reported in years. Relationship status: "Other" includes *divorced* and *separated*. Household income: *Less than $10,000* (1) to *$150,000 or more* (12), with (7) = *$60,000 to $69,999.* Sexual orientation: "Other" includes *pansexual*, *asexual*, *sapphic*, and *questioning*. Gender identity: "Other" includes *genderfluid*, *agender*, *transsexual*, *transmasculine nonbinary,* and *questioning*. Diagnoses: Percentages sum to greater than 100% due to comorbidity. "Other" includes *autism spectrum disorder*, *personality disorder, and dissociative identity disorder*. Therapist's profession: "Other" includes *psychiatrist*. Therapy modality: "Other" includes *internal family systems*, *EMDR*, and *Gestalt*. Therapist's sexual orientation: "Other" includes *pansexual* and *asexual*. Therapist's gender identity: "Other" includes *trans-spectrum*. Dyad matched on sexual orientation: e.g., lesbian patient and lesbian therapist. Dyad matched exactly on gender identity: e.g., transgender patient and transgender therapist. Dyad matched on any noncisgender identity: e.g., transgender patient and nonbinary therapist. Dyad matched on at least one LGBTQ+ identity: patient and therapist share same sexual orientation and/or any noncisgender identity. Double matched: patient and therapist share same sexual orientation, and both identify as noncisgender.

Table 2

Descriptive Statistics for Major Study Variables

			Normality Statistics		
	N	*M (SD)*	Skewness	Kurtosis	Range
TSD-I frequency (T1)	198	2.95 (.82)	0.43	-0.57	2 – 5
TSD-I frequency (T3)	198	3.16 (.83)	0.38	-0.09	1 – 5
TSD-I frequency change	198	0.21 (.89)	-0.08	1.71	-3 – 3
TSD-I optimality (T1)	198	15.82 (2.14)	-1.32	1.82	8 – 18
TSD-I optimality (T3)	198	15.59 (1.99)	-1.03	1.46	7 – 18
TSD-I optimality change	198	-0.24 (1.93)	-0.04	2.45	-8 – 7
GD frequency (T1)	198	3.12 (.84)	0.56	-0.08	2 – 5
GD frequency (T3)	198	3.16 (.87)	0.20	-0.16	1 – 5
GD frequency change	198	0.04 (.85)	0.23	0.76	-2 – 3
GD optimality (T1)	198	15.38 (2.38)	-0.90	0.97	5 – 18
GD optimality (T3)	198	14.91 (2.59)	-0.98	0.84	5 – 18
GD optimality change	198	-0.46 (1.85)	-0.37	0.76	-7 – 4
Real relationship (T1)	198	103.54 (10.90)	-1.31	3.85	45 – 120
Real relationship (T3)	198	101.86 (10.73)	-0.62	0.72	62 – 120
Real relationship change	198	-1.68 (7.78)	1.16	12.95	-30 – 53
LGBTQ-negativity (T1)	198	31.19 (9.22)	0.60	1.13	12 – 68
LGBTQ-negativity (T3)	198	31.67 (8.79)	0.59	1.37	12 – 70
LGBTQ-negativity change	198	0.48 (5.40)	-0.72	2.64	-25 – 17
Rejection sensitivity (T1)	198	13.17 (6.68)	0.70	0.29	1.45 – 35.45
Rejection sensitivity (T3)	198	12.35 (6.68)	0.92	0.91	1.27 – 36.00
Rejection sensitivity change	198	-0.82 (4.41)	-0.22	0.34	-15.09 – 10.45
Loneliness (T1)	198	27.10 (13.41)	0.12	-0.83	2 – 55
Loneliness (T3)	198	26.25 (14.17)	0.11	-0.83	0 – 59
Loneliness change	198	-0.85 (7.30)	-0.09	2.29	-29 – 29
Minority stress (T1)	198	71.45 (21.52)	0.29	0.37	22.73 – 150.00
Minority stress (T3)	198	70.27 (21.37)	0.20	0.69	18.00 – 161.00
Minority stress change	198	-1.18 (11.20)	-0.57	0.79	-45.09 – 21.73
Psychopathology (T1)	198	69.77 (21.99)	0.10	-0.51	20 – 124
Psychopathology (T3)	198	65.89 (23.81)	0.33	-0.40	13 – 134
Psychopathology change	198	-3.88 (12.86)	-0.21	2.33	-52 – 46

Note. All change variables refer to change between T1 and T3. Higher TSD-I and GD frequency scores indicate greater reported amount of therapist disclosure (identity and general, respectively), on a scale from 1 to 5. Higher TSD-I and GD optimality scores indicate greater reported optimality of therapist disclosure (identity and general, respectively), on a scale from 4 to 18. Higher real relationship scores indicate stronger therapeutic alliance via real relationship, on a scale from 24 to 120. Higher LGBTQ-negativity scores indicate greater internalization of societal stigma around minority sexual orientation and gender identity, on a score from 13 to 91. Higher rejection sensitivity scores indicate greater tendency to expect, perceive, and emotionally respond to rejection, on a scale from 0 to 36. Higher loneliness scores indicate greater reported feelings of disconnection and isolation, on a scale from 20 to 80. Higher composite minority stress scores indicate greater aggregate experiences of LGBTQ-negativity, rejection sensitivity, and loneliness, on a scale from 33 to 207. Higher psychopathology scores indicate more compromised psychological functioning in the areas of symptom distress (subjective emotional discomfort), interpersonal relations (e.g., conflict with others), and social role (workplace/school/home difficulties), on a scale from 0 to 180.

Table 3

Bivariate Relations Between Major Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
1. TSD-I freq. (T1)	—																												
2. TSD-I freq. (T3)	**.42*****	—																											
3. TSD-I freq. Δ	**-.52*****	**.55*****	—																										
4. TSD-I opt. (T1)	**.32*****	.14	**-.17***	—																									
5. TSD-I opt. (T3)	**.19****	**.34*****	**.14***	**.56*****	—																								
6. TSD-I opt. Δ	**-.16***	**.19****	**.33*****	**-.53*****	**.41*****	—																							
7. GD freq. (T1)	**.28*****	**.17***	-.10	-.11	.03	**.15***	—																						
8. GD freq. (T3)	**.35*****	**.41*****	.06	-.03	.10	.14	**.51*****	—																					
9. GD freq. Δ	.08	**.25*****	**.16***	.08	.07	-.01	**-.46*****	**.53*****	—																				
10. GD opt. (T1)	.04	.01	-.04	**.46*****	**.49*****	-.01	.08	-.02	-.11	—																			
11. GD opt. (T3)	.05	.03	-.02	**.50*****	**.58*****	.04	-.05	.06	.11	**.73*****	—																		
12. GD opt. Δ	.02	.04	.02	.11	**.18***	.06	**-.18***	.11	**.29*****	**-.27*****	**.47*****	—																	
13. RR (T1)	.09	.07	-.02	**.39*****	**.37*****	-.06	.04	.00	-.04	**.46*****	**.41*****	-.02	—																
14. RR (T3)	.11	**.16***	.04	**.44*****	**.52*****	.05	.03	.00	-.03	**.49*****	**.56*****	**.16***	**.74*****	—														
15. RR Δ	.04	.13	.08	.06	**.20*****	**.14***	-.02	.00	.02	.03	**.21****	**.25*****	**-.38*****	**.34*****	—														
16. LGB-neg. (T1)	-.03	.02	.04	**-.14***	-.09	.07	.01	.05	.03	-.13	-.12	.01	-.14	**-.25*****	**-.16***	—													
17. LGB-neg. (T3)	-.04	-.01	.02	-.12	-.08	.05	-.01	.04	.05	-.06	-.09	-.05	**-.15***	**-.28*****	**-.17***	**.82*****	—												
18. LGB-neg. Δ	-.01	-.05	-.03	.05	.02	-.03	-.03	-.01	.02	.13	.05	-.09	-.01	-.02	-.01	**-.37*****	**.23****	—											
19. RS (T1)	-.03	.04	.07	-.04	.05	.09	.01	.01	-.01	-.08	-.01	.09	-.02	.02	.06	**.15***	.08	-.11	—										
20. RS (T3)	-.01	.10	.10	-.03	.06	.09	.01	.04	.03	-.05	-.02	.03	-.05	.01	.07	.07	.06	-.02	**.78*****	—									
21. RS Δ	.03	.08	.05	.00	.01	.01	-.01	.05	.06	.04	-.03	-.08	-.03	-.03	.01	-.12	-.04	**.14***	**-.33*****	**.33*****	—								
22. Loneliness (T1)	-.03	-.05	-.02	-.09	.10	**.20****	.06	-.08	-.14	.02	-.04	-.08	**-.27*****	**-.22****	.07	**.50*****	**.46*****	-.10	.07	.02	-.08	—							
23. Loneliness (T3)	-.03	-.02	.01	**-.16***	.03	**.21****	.07	-.03	-.10	-.01	-.10	-.14	**-.29*****	**-.30*****	.00	**.49*****	**.51*****	-.01	.03	.00	-.04	**.86*****	—						
24. Loneliness Δ	.00	.06	.05	**.15***	-.11	.05	.02	.08	.06	-.05	-.14	-.13	-.07	**-.17***	-.14	.03	.14	**.17***	-.06	-.02	.05	**-.17***	**.36*****	—					
25. MS (T1)	-.04	-.01	.03	-.13	.04	**.18***	.05	-.03	-.08	-.07	-.08	-.02	**-.24*****	**-.24****	.00	**.79*****	**.67*****	**-.26*****	**.42*****	**.28*****	**-.20****	**.86*****	**.76*****	**-.11*****	—				
26. MS (T3)	-.04	.01	.05	**-.17***	.01	**.19****	.05	.01	-.04	-.04	-.11	-.10	**-.27*****	**-.31*****	-.05	**.68*****	**.77*****	.08	**.30*****	**.34*****	.06	**.77*****	**.87*****	**.29*****	**.86*****	—			
27. MS Δ	.01	.04	.04	-.08	-.06	.03	.00	.07	.07	.05	-.07	**-.16***	-.06	-.13	-.09	**-.21****	**.18****	**.65*****	**-.22****	.10	**.50*****	**-.19****	**.21****	**.76*****	**-.27*****	**.25*****	—		
28. Psych. (T1)	.07	.06	-.01	-.08	.01	.10	**.15***	.08	-.06	-.04	-.08	-.07	**-.32*****	**-.29*****	.05	**.40*****	**.41*****	-.02	.11	.03	-.12	**.70*****	**.71*****	.09	**.64*****	**.65*****	.00	—	
29. Psych. (T3)	.01	.13	.12	-.13	.04	**.18***	.10	.07	-.03	-.02	-.11	-.13	**-.30*****	**-.32*****	-.02	**.34*****	**.41*****	.08	.10	.08	-.03	**.61*****	**.76*****	**.36*****	**.56*****	**.70*****	**.26*****	**.85*****	—
30. Psych. Δ	-.10	.14	**.22****	-.11	.05	**.17***	-.07	-.01	.05	.03	-.06	-.12	-.02	-.11	-.12	-.05	.06	**.18***	.00	.09	.14	-.08	**.19****	**.53*****	-.07	**.18***	**.48*****	**-.15***	**.41*****

All change (Δ) variables refer to difference in means between T1 and T3. TSD-I = identity disclosure; GD = general disclosure; RR = real relationship; LGB-neg. = LGBTQ-negativity; RS = rejection sensitivity; MS = minority stress; Psych. = psychopathology; freq. = frequency; opt. = optimality. *, $p < .05$; **, $p < .01$; ***, $p < .00$

both minority stress processes increased or decreased in tandem. In a moderately strong correlation, individuals with greater LGBTQ+-negativity were lonelier at both T1 ($r = .50$, $p < .001$) and T3 ($r = .51$, $p < .001$). No significant relationship existed between rejection sensitivity and loneliness.

Self-Disclosure Frequency and Optimality

Therapists remained consistent across time in the amount they disclosed; disclosure frequencies at T1 and T3 were moderately positively correlated for both identity ($r = .42$, $p < .001$) and general disclosures ($r = .51$, $p < .001$). Therapists tended to disclose as often about identity as they did more generally; identity and general disclosure frequencies were positively though weakly associated at both T1 ($r = .28$, $p < .001$) and T3 ($r = .35$, $p < .001$). Individuals remained consistent across time in their perceptions of therapist disclosure, as there was a moderate positive association between T1 and T3 identity disclosure optimality ($r = .56$, $p < .001$) and a strong positive association between T1 and T3 general disclosure optimality ($r = .73$, $p < .001$). Further, individuals experienced identity and general disclosure as similarly optimal, with TSD-I and GD optimality ratings moderately positively correlated at both T1 ($r = .46$, $p < .001$) and T3 ($r = .58$, $p < .001$).

Individuals with more frequently disclosing therapists rated disclosures as more optimal than did individuals with less frequently disclosing therapists—but only when disclosure was related to identity. Specifically, there were weak associations between frequency and optimality of identity disclosure at T1 ($r = .32$, $p < .001$) and T3 ($r = .34$, $p < .001$), but no significant relationship emerged between frequency and optimality of general disclosure. There was a weak positive association between frequency change and optimality change, both for TSD-I ($r = .33$, p

< .001) and GD (r = .29, p < .001). That is, individuals whose therapists increased either type of disclosure frequency over time rated the disclosure increasingly optimal.

Self-Disclosure Frequency/Optimality and Real Relationship

Individuals whose therapists disclosed more often about identity reported better real relationship, but this weak positive association between real relationship and TSD-I frequency existed at T3 only (r = .16, p < .05). No such relationship at any time point existed between general disclosure frequency and real relationship. Individuals who reported better real relationship rated disclosure as more optimal; real relationship and TSD-I optimality were moderately positively associated at T1 (r = .39, p < .001) and T3 (r = .52, p < .001), and there was a similar association for GD optimality (T1: r = .46, p < .001; T3: r = .56, p < .001).

Self-Disclosure Frequency/Optimality and Minority Stress

Participants whose therapists disclosed more optimally about identity at baseline reported less overall minority stress (r = -.17, p < .05) at T3 in a weak correlation. Regarding component minority stress processes, participants whose therapists disclosed more optimally about identity at baseline reported less internalized LGBTQ+-negativity (r = -.14, p < .05) as well as less loneliness (r = -.16, p < .05) at baseline, though these relationships were weak. No significant relationships existed between TSD-I optimality and rejection sensitivity, between general disclosure optimality and minority stress, or between disclosure frequency (either general or identity) and minority stress.

Real Relationship and Minority Stress

Individuals with stronger real relationship reported less minority stress, in a weak association, at both T1 (r = -.24, p < .001) and T3 (r = -.31, p < .001). Regarding component minority stress processes, at T3 individuals reporting stronger real relationship also reported less

LGBTQ+-negativity (r = -.28, p < .001). Similarly, stronger real relationship at T1 was associated with lower LGBTQ+-negativity at T3 (r = -.15, p < .05), and lower LGBTQ+-negativity at T1 was associated with stronger real relationship at T3 (r = -.25, p < .001). Individuals with stronger real relationship also reported less loneliness at both T1 (r = -.27, p < .001) and T3 (r = -.30, p < .001). No significant relationship was found between real relationship and rejection sensitivity.

Self-Disclosure Frequency/Optimality and Psychopathology

There was a weak positive association between general disclosure frequency and psychopathology at T1 only (r = .15, p < .05), such that participants with greater psychopathology tended to have therapists who disclosed more often about matters unrelated to LGBTQ+ identity at baseline. Psychopathology was not significantly related to identity disclosure frequency or to disclosure optimality (either identity or general).

Real Relationship and Psychopathology

Real relationship was weakly negatively related to psychopathology, such that at both T1 and T3 (r = -.32, p < .001), individuals reporting stronger real relationship reported less psychopathology.

Minority Stress and Psychopathology

Individuals reporting greater minority stress also reported greater psychopathology, with the association strong at T3 (r = .70, p < .001) and slightly less so at T1 (r = .64, p < .001). Moreover, minority stress and psychopathology followed similar trajectories over time, as individuals reporting increased minority stress between T1 and T3 tended also to report increased psychopathology (r = .48, p < .001). Component minority stress processes and psychopathology were significantly related as follows. Individuals reporting greater LGBTQ+-negativity also reported lower psychological functioning at both T1 (r = .40, p < .001) and T3 (r

= .41, $p < .001$). A similar and much stronger relationship existed between loneliness and psychopathology at T1 ($r = .70$, $p < .001$) and T3 ($r = .76$, $p < .001$). Psychopathology tended to increase in tandem with LGBTQ+-negativity ($r = .18$, $p < .05$) and with loneliness ($r = .53$, $p < .001$), with the latter association stronger than the former. No significant relationship existed between rejection sensitivity and psychopathology.

Supplemental Analyses of Excluded Participants

As discussed, I opted to treat disclosure optimality as a continuous variable and to exclude from the primary analysis the subset of 18 participants who reported at baseline that their therapist had never disclosed about LGBTQ+ identity, as they did not constitute a large enough group to make statistically meaningful comparisons. At T3, I asked all participants to rate the optimality of their therapists' *lack* of self-disclosure, if applicable. Tables 4 and 5 present supplemental descriptive statistics and bivariate correlations, at T3, of this "no identity disclosure at baseline" subgroup. Of note, however: only six of these 18 participants remained consistent in reporting no identity disclosure across time. By T3, a full 12 of these participants reported some amount of identity disclosure. It is likely that after completing the first survey round, participants were primed to reflect on and notice identity disclosure more attentively. It is also possible that some therapists introduced identity disclosure into the treatment of their own volition, perhaps because their patients shared that they were participating in a study about it. (There was one anomalous participant, not included in this supplemental analysis, who had reported "frequent" identity disclosure at T1 but by T3 reported no identity disclosure since the previous survey.) Because of the small sample size and the longitudinal variation in reported disclosure frequency, these data should be interpreted cautiously, as pilot findings that might inform future research studies that recruit larger numbers of subjects who experience no therapist disclosure.

Table 4

Descriptive Statistics at T3 for Excluded Participants Reporting No TSD-I at Baseline (N = 18)

			Normality Statistics		
	N	*M (SD)*	Skewness	Kurtosis	Range
TSD-I frequency (T3)	18	2.06 (.94)	0.36	-0.82	1 – 4
TSD-I optimality (T3)	18	13.28 (2.40)	-0.14	-0.53	9 – 18
GD frequency (T3)	18	2.28 (.75)	0.41	0.47	1 – 4
GD optimality (T3)	18	13.28 (3.12)	-0.24	-1.01	8 – 18
Real relationship (T1)	18	97.00 (13.24)	-1.18	1.16	64 – 111
Real relationship (T3)	18	96.28 (12.79)	-1.03	1.07	65 – 114
Real relationship change	18	-0.72 (7.80)	-0.42	-0.24	-16 – 13
LGBTQ-negativity (T1)	18	31.33 (11.02)	0.70	1.54	13 – 60
LGBTQ-negativity (T3)	18	31.89 (8.76)	0.62	0.98	20 – 54
LGBTQ-negativity change	18	0.56 (4.79)	0.03	-1.18	-7 – 8
Rejection sensitivity (T1)	18	9.06 (5.19)	0.12	-1.12	1.73 – 17.36
Rejection sensitivity (T3)	18	8.39 (4.52)	0.18	-0.31	1.00 – 17.82
Rejection sensitivity change	18	-0.67 (2.94)	-0.70	2.27	-8.36 – 5.45
Loneliness (T1)	18	26.50 (13.83)	0.30	0.13	1 – 57
Loneliness (T3)	18	23.78 (10.96)	-0.62	-0.10	1 – 39
Loneliness change	18	-2.72 (10.95)	-0.50	0.92	-29 – 18
Minority stress (T1)	18	66.89 (21.48)	0.13	-0.30	25.18 – 108.73
Minority stress (T3)	18	64.06 (16.38)	-0.64	0.24	28.64 – 90.45
Minority stress change	18	-2.83 (13.58)	-0.04	-0.05	-29.27 – 22.18
Psychopathology (T1)	18	66.72 (19.21)	-0.06	-0.47	32 – 102
Psychopathology (T3)	18	61.39 (18.73)	1.10	2.23	32 – 113
Psychopathology change	18	-5.33 (12.09)	-0.87	1.18	-32 – 11

Note. All change variables refer to change between T1 and T3. Higher frequency scores indicate greater reported amount of therapist disclosure on a scale from 1 to 5 (3 = *sometimes*). Higher optimality scores indicate greater reported optimality of therapist disclosure (identity and general, respectively), on a scale from 4 to 18. Higher real relationship scores indicate stronger therapeutic alliance via real relationship, on a scale from 24 to 120. Higher LGBTQ+-negativity scores indicate greater internalization of societal stigma around minority sexual orientation and gender identity, on a score from 13 to 91. Higher rejection sensitivity scores indicate greater tendency to expect, perceive, and emotionally respond to rejection, on a scale from 0 to 36. Higher loneliness scores indicate greater reported feelings of disconnection and isolation, on a scale from 20 to 80. Higher composite minority stress scores indicate greater aggregate experiences of LGBTQ+-negativity, rejection sensitivity, and loneliness, on a scale from 33 to 207. Higher psychopathology scores indicate more compromised psychological functioning in the areas of symptom distress (subjective emotional discomfort), interpersonal relations (e.g., conflict with others), and social role (workplace/school/home difficulties), on a scale from 0 to 180.

Table 5

Bivariate Relations Between Study Variables at T3 for Participants Reporting No TSD-I at Baseline (N = 18)

	1	2	3	4	5	6	7	8	9	10
1. TSD-I frequency	—									
2. TSD-I optimality	**.49***	—								
3. GD frequency	.39	.02	—							
4. GD optimality	.42	**.83*****	.12	—						
5. Real relationship	.29	**.61****	-.15	**.69****	—					
6. LGBTQ-negativity	-.02	.29	-.45	.12	.09	—				
7. Rejection sensitivity	.01	.07	.23	.16	-.09	-.09	—			
8. Loneliness	-.21	.16	-.41	-.21	-.12	.34	-.06	—		
9. Minority stress	-.14	.28	-.45	-.03	-.05	**.74*****	.19	**.83*****	—	
10. Psychopathology	-.26	-.08	-.31	-.34	-.28	**.49***	.02	**.68****	**.73*****	—

Note. $N = 18$. All variables are measured at T3. TSD-I = identity disclosure; GD = general disclosure. *, $p < .05$; **, $p < .01$; ***, $p < .001$

Disclosure Subtypes

At baseline, I asked participants to assess the frequency and optimality of each of Knox and Hill's (2003) therapist self-disclosure subtypes. Although these data are peripheral to the study's primary focus (i.e., overall disclosure patterns), they nonetheless provide an intriguing glimpse into what, specifically, therapists are disclosing in the consulting room, and how patients tend to perceive these types of disclosure. Table 6 presents the frequency and optimality ratings of TSD-I disaggregated by subtype.

Table 6

Frequency and Optimality of Identity-Focused Therapist Self-Disclosure Subtypes

			Normality Statistics		
	N	*M (SD)*	Skewness	Kurtosis	Range
Frequency					
Facts	198	2.78 (.88)	0.31	0.04	1 – 5
Feelings	198	2.23 (.90)	0.45	0.08	1 – 5
Reassurance/support	198	2.49 (1.11)	0.35	-0.41	1 – 5
Challenges	198	1.98 (.93)	0.46	-0.92	1 – 5
Strategies	198	2.23 (1.06)	0.38	-0.69	1 – 5
Insight	198	2.01 (1.01)	0.66	-0.46	1 – 5
Optimality					
Facts	188	11.96 (1.32)	-1.42	1.72	7 – 13
Feelings	154	11.50 (1.59)	-0.96	0.20	6 – 13
Reassurance/support	154	11.68 (1.53)	-1.00	0.01	7 – 13
Challenges	121	11.46 (1.64)	-0.91	-0.05	7 – 13
Strategies	133	11.68 (1.56)	-1.17	0.83	6 – 13
Insight	119	11.50 (1.66)	-0.82	-0.39	7 – 13

Note. Higher frequency scores indicate greater reported amount of identity-focused therapist disclosure, on a scale from 1 to 5. Higher optimality scores indicate greater reported optimality of identity-focused therapist disclosure, on a scale from 3 to 13. For the sake of survey brevity, to minimize attrition, the subtype optimality measure omitted the question "How much have your therapist's self-disclosures…related to you and your problems?"

Paired-samples *t* tests revealed that participants reported significantly higher frequency of factual identity disclosure than of any other subtype: more than feelings [$t(197) = 8.76$, $p < .001$], reassurance/support [$t(197) = 3.54$, $p < .001$], challenges [$t(197) = 12.12$, $p < .001$], strategies [$t(197) = 6.59$, $p < .001$], and insight [$t(197) = 9.88$, $p < .001$]. Moreover, therapists reportedly disclosed about challenges related to LGBTQ+ identity with the least frequency of any subtype, significantly less often than disclosure of feelings [$t(197) = 4.21$, $p < .001$], reassurance/support [$t(197) = 7.32$, $p < .001$], and strategies [$t(197) = 3.43$, $p < .001$]. Disclosure of identity-related insight was also relatively less common, significantly less frequent than disclosure of reassurance/support [$t(197) = 6.46$, $p < .001$] and strategies [$t(197) = 2.91$, $p < .001$]. Finally, therapists disclosed feelings about LGBTQ+ identity significantly more often than insight [$t(197) = 2.99$, $p = .00$] but less often than reassurance/support [$t(197) = -3.47$, $p < .001$], and they disclosed the latter significantly more often than strategies [$t(197) = 3.38$, $p < .001$]. Participants rated the optimality of factual identity disclosure significantly higher than any other subtype: higher than feelings [$t(150) = 3.87$, $p < .001$], reassurance/support [$t(147) = 2.47$, $p = .02$], challenges [$t(119) = 4.82$, $p < .001$], strategies [$t(128) = 2.54$, $p = .01$], and insight [$t(115) = 3.53$, $p < .001$]. Further, participants rated the optimality of disclosure about identity-related challenges as significantly lower than the optimality of feelings [$t(108) = 2.48$, $p = .02$], reassurance/support [$t(111) = 3.11$, $p = .00$], and strategies [$t(98) = 2.55$, $p = .01$] disclosures.

Qualitative Data

At baseline, participants provided written examples of their therapist's disclosures of facts, feelings, reassurance/support, challenges, strategies, and insight. Their responses provide a compelling set of qualitative data that illuminates what identity disclosures LGBTQ+ therapists do tend to make to their LGBTQ+ patients, as well as the utility and meaning of these disclosures from the patient's perspective. Table 7 reports the relative frequency of disclosure topics, and Table 8 presents the themes

that emerged, through Interpretive Phenomenological Analysis (IPA), about the impact of identity disclosure on the patient. IPA is a qualitative research approach that aims to understand the nuanced meaning people make of their lived experience, through detailed scrutiny of their written or verbal accounts (Smith et al., 2009). Participants' free response answers were coded for content and subjective meaning, and the data was analyzed holistically according to IPA methodology for emergent patterns and themes. It should be noted that because responses were limited (answers were optional and many participants declined to provide written reflections), these findings should be viewed as preliminary and a foundation upon which a future in-depth qualitative study, investigating what makes TSD-I optimal from the patient perspective, might be based.

Participants identified a variety of reasons why therapist disclosure has beneficially impacted their mental health and treatment progress. Responses revealed that identity disclosure can (1) strengthen the patient's feelings of connection and positive attachment to their therapist, bolstering the alliance; (2) increase the patient's comfort with opening up honestly and vulnerably in session, especially around issues that are difficult to speak about; (3) contribute to creating a safe space in which the patient feels accepted and not judged; (4) promote in the patient a deep sense of being seen, heard, witnessed, and understood; (5) alleviate the patient's anxiety that they need to educate their therapist about LGBTQ+ issues in order to be understood; (6) foster in the patient feelings of validation and affirmation; (7) promote in the patient a sense that their life experiences are normal, understandable, and relatable; (8) reduce the patient's sense of loneliness, isolation, and alienation; (9) soothe, comfort, reassure, and support the patient; (10) convey to the patient empathic or sympathetic understanding, and especially a sense of shared emotional experience; (11) cultivate in the patient optimism, hope, and positive expectations for future; (12) provide the patient with new ways of looking at self, others, and

Table 7

Relative Frequency of Reported TSD-I Content

Disclosure topic	Frequency	%
LGBTQ+ identity/identities (naming, developing, speaking broadly about)	125	16.0
Romantic relationships	106	13.6
Minority stress experiences (discrimination, stigma, invisibility, bullying, alienation, etc.)	78	10.0
LGBTQ+ community (seeking, building, navigating)	71	9.1
Overall emotional experience of being LGBTQ+, esp. shared emotional experience	56	7.2
Family of origin relationships	54	6.9
Coming out	44	5.6
Life/experiences as LGBTQ+ (non-specific)	30	3.8
Gender transition (surgery, changing name, etc.)	27	3.5
Relationship/family structure (marriage, partners, nonmonogomy, children, etc.)	25	3.2
Dating	24	3.1
Intersecting minority identities (sexuality/gender and race, ethnicity, autism, disability, etc.)	24	3.1
Navigating a cis-heteronormative world (broadly)	23	2.9
Career/professional life	22	2.8
Pronouns (naming, discussing)	21	2.7
Body image/gender dysphoria	14	1.8
Relationships with friends and acquaintances	13	1.7
Expression of gender (masculinity and femininity)	13	1.7
Self-acceptance and self-affirmation	12	1.5
How others perceive/react to you	12	1.5
Religion/spirituality	11	1.4
Childhood experiences	10	1.3
Sexual experiences	10	1.3
Relaxation, emotional regulation, self-care practices	10	1.3
Offering patient LGBTQ-related resources that have been personally useful	9	1.2
Living authentically	8	1.0
Trauma (experiences of, healing from)	7	0.9
Masking identity/passing/“code switching”	7	0.9
Parenting	6	0.8
Political stances (esp. around LGBTQ+ issues)	6	0.8
Navigating medical systems	6	0.8
Defining and understanding queer identity	3	0.4
AIDS epidemic	3	0.4

Table 7 (continued).

Disclosure topic	Frequency	%
LGBTQ+ popular culture	3	0.4
Setting boundaries	3	0.4
Patient's immediate impact on therapist's feelings (including countertransference)	2	0.3
Self-image	2	0.3
Substance abuse	2	0.3
Therapist's choice of their own LGBTQ+ therapist	2	0.3
First realization of being LGBTQ+	1	0.1
Serving/helping others	1	0.1
Offering an identity-related personal item as a transitional object	1	0.1

Note. Frequency reflects the total number of instances that each theme was identified across all disclosure subtypes. I coded each participant disclosure reflection with only the most specific and salient themes. For example, I did not double-code a disclosure example specifically about *defining and understanding queer identity* as the broader theme of *LGBTQ+ identity/identities*, or one specifically about *body image/gender dysmorphia* as the broader theme of *expression of gender*; moreover, I coded a disclosure about *religion/spirituality* that only peripherally mentioned childhood as *religion/spirituality* and not *childhood experiences* as well. Percentage (%) reflects the percentage of total theme identifications (N = 782).

the world; and (13) model ways that the patient might handle challenges and problems outside of therapy. Table 8 also presents representative quotes from participants that illustrate these themes.

Very few participants recalled instances when their therapist's disclosures had a negative impact on their treatment, though the survey did not prompt for reflections on this specifically. One respondent (A. W., age 41) commented that their therapist's perpetual positivity when disclosing did not serve him well: "My therapist tends to disclose positive experiences but not negative experiences, which probably prolonged the amount of time it took for me to trust him and relate to him," he wrote. This participant also indicated that his therapist's disclosures could make him feel inadequate:

> My therapist has talked about his thriving friendships and social life, which I don't have. In the short term, this was triggering and threatening but over time it may have been helpful for me to form a connection with someone whose experience has been so dramatically different than mine.

Another participant recounted her discomfort after encountering her therapist's candid online postings:

> A lot [of disclosure] has been on her social media and website blog. Which is fine to a degree, but sometimes she's revealed more than I would like to know about her life, such as when she shared that her sex drive increased after she discovered that she is lesbian." (O. S., age 26)

Participants also revealed that offering concrete strategies or advice to patients based on the therapist's own life experience carries risks. "My therapist often gives me strategies," writes R. A. (age 38), "but it is sometimes frustrating because she is more outgoing than me and at times her ideas are just not gonna work with how I roll." Writes another respondent, J. B. (age 33), "She told me some boundaries she has for herself and how she talks to partners about STIs. It wasn't helpful though, because I have my own strategies already and don't necessarily agree with hers. They just wouldn't work for me and my relationships." Finally, the data suggest that disclosure risks creating role confusion in the dyad, as another participant highlighted:

> At first when my therapist began disclosing, it did not seem like any kind of problem. But eventually I became aware, upon contemplation, of how it could impede our therapy…, because it would a bit unclear as to why he was making these statements. Once in a while I would wonder if I was becoming *his* therapist in some way. He often told me that he thought I should think about applying to the Jungian Institute in southern California and becoming a therapist myself. I was, of course, flattered, but it left me wondering if he was seeking something from me that I felt unqualified to give him. (K. K, age 78)[14]

As I will discuss in Chapter 5, future qualitative research should focus more expressly on investigating the pitfalls and hazards of disclosure.

[14] None of these participants shared whether or not they broached their feelings about the suboptimal disclosure with their therapist. The patient's choice to address or avoid addressing suboptimal disclosure is a topic for further qualitative study.

Table 8

Impact of TSD-I on Patients: Emergent Themes

Disclosure Impact Theme	Representative quote(s)
Increases sense of connection to therapist; promotes alliance *Disclosure strengthens the patient's feelings of connection and positive attachment to their therapist, bolstering the alliance*	"She shared insights about her relationships, and it made me feel more connected to her." (J. B., age 33) "My therapist once said something about the age she was when she came out. I appreciate hearing these details because they help me paint a better picture for where my therapist is coming from." (M. L., age 26)
Helps patient to feel more comfortable opening up to therapist, especially about challenging topics *Disclosure increases the patient's comfort with opening up honestly and vulnerably in session, especially around issues that are difficult to speak about*	"I was discussing relationship problems as a gay man, how it impacts my self-concept, and how it intersects with personal trauma. My therapist told me he heard echoes of his own experience—it was first time he disclosed his identity—and it helped me feel comfortable and relaxed. I opened up more and began to cry more in sessions." (M. S., age 33) "My therapist discussed her experience with being queer and from a religious household in our first session. Since I share a similar background, it helped me feel more comfortable exploring my religious trauma." (S. R., age 26)

Table 8 (continued).

Disclosure Impact Theme	Representative quote(s)
Increases sense of nonjudgmental acceptance and therapeutic safety *Disclosure contributes to creating a safe space in which the patient feels accepted and not judged*	"[After my therapist self-disclosed], I felt safer disclosing specific aspects of the gay community with him (e.g., poppers, bathhouses) because I did not feel like he was going to judge me or over-emphasize sexual risk behaviors." (M. S., age 33) "To make me feel more comfortable and validate my experience, he [let] me know that he had a same-sex marriage that had its own conflicts. It was extremely helpful to feel less judged and guarded. That he would understand dynamics better of same sex relationships." (A. L., age 43)
Promotes relief from burden of educating therapist *Disclosure alleviates the patient's anxiety that they need to educate their therapist about LGBTQ+ issues in order to be understood*	"My therapist acknowledged his trans identity in our initial consultation, and that was a defining factor in my decision to see them. It's helpful to me to know that I won't have to explain gender and sexuality basics." (J. A., age 32) "When I talk about my experiences as a queer non-binary person she doesn't need subtext as to what I'm talking about. She knows the culture and I am aware of this through her having queer friends of her own, although she doesn't disclose her personal life as often." (E. R., age 27)

Table 8 (continued).

Disclosure Impact Theme	Representative quote(s)
Increases feelings of being understood *Disclosure promotes in the patient a deep sense of being seen, heard, witnessed, and understood*	"When discussing transphobic interactions that I have experienced, my therapist sometimes inserts 'As a non-binary person, I understand how you feel,' or otherwise slips their gender identity into a response in a way that reassures me they truly empathize with my experience." (R. B., age 24) "I asked about her identity and she told me she was married to a woman. That was probably a few months into seeing her. Later I asked if she was bisexual, and she said she was not. I wanted to know so I could know how much of my experience she could understand." (Y. F., age 31)
Provides validation and affirmation *Disclosure fosters in the patient feelings of validation and affirmation*	"He has said he remembers what it was like to grow up feeling like he didn't fit in, same as what I experienced, and I never had anyone validate my own experience like that." (T. K., age 58) "When I was discussing struggles with making queer friends in a new city, it was really affirming to hear my therapist discuss how she has navigated this." (S. B., age 32)

Table 8 (continued).

Disclosure Impact Theme	Representative quote(s)
Normalizes life experience *Disclosure promotes in the patient a sense that their life experiences are normal, understandable, and relatable*	"When I said I personally felt unable to come out to my family, Jamie used our similar background as Asian people to say that was normal to be hesitant to come out to family especially if they come from a culture like in Asia where it is taboo to talk about homosexuality." (N. V., age 25) "My therapist has provided normalizing statements about experiences of doubt related to being in a relationship with a masc-presenting person as a femme person. In other words, when I endorsed insecurities about not being 'queer enough,' my therapist normalized these experiences from her perspective as a bisexual person." (A. F., age 32)
Reduces feelings of loneliness *Disclosure reduces the patient's sense of loneliness, isolation, and alienation*	"I can recall on a few occasions when I would describe my general struggles with existing as a non-binary person, and my therapist would briefly chime in with similar experiences that made me feel like I was less alone." (S. H., age 39) "I don't know anyone else who identifies as nonbinary, everyone in my life identifies as binary. I was able to ask my therapist about their experience as a nonbinary person. We talked openly about genitalia issues for example. I felt so much less isolated. I have a peer now." (A. S., age 43)

Table 8 (continued).

Disclosure Impact Theme	Representative quote(s)
Provides comforting reassurance *Disclosure soothes, comforts, reassures, and supports the patient, as well as dispels anxiety or fear*	"My therapist self-disclosed the experiences of making mistakes as a new queer parent and how they learned to accept the reality of making mistakes witch offered me reassurance and support as I prepare to become a new queer parent myself." (A. B., age 45) "My therapist reassured me with one of their experiences when I was nervous about how some of my friends would react to my own sexuality. She related in feeling anxiety and nervousness when approaching the topic, but reassured me that many people are openminded and if I was friends with them already, they would be understanding." (A. P., age 21)
Conveys empathy *Disclosure conveys to the patient empathic or sympathetic understanding, and a sense of shared emotional experience*	"It probably comes up at least once every two sessions that my counselor is part of the rainbow community, personally understands and can empathize with oppression on the basis of sexual orientation, etc." (T. F., age 33) "My therapist has described their own concerns with living in a body of marginalized identities, and how they think that has impacted their being understood, in order to sympathize with my experiences." (H. K., age 21)

Table 8 (continued).

Disclosure Impact Theme	Representative quote(s)
Instills hope *Disclosure cultivates in the patient optimism, hope, and positive expectations for future*	"When discussing my own transition, my therapist used his own personal experience to make me feel better about my dysphoria and also give me encouragement. He has been transitioning for almost 35 years. Sharing what he went through to get there and how it has changed over the years made me feel like I wasn't alone, valid for my feelings, and it gave me hope." (H. S., age 27) "We have shared our frustrations over needing to explain things to cis people and bureaucracy not being trans-friendly. In particular, every time I've needed to advocate for a bathroom at work my therapist has shared his frustration/other stories which is very helpful in making me feel not alone in the situation and like it is something that can be dealt with." (K. P., age 30)
Offers helpful new perspectives, especially influencing self-understanding *Disclosure provides the patient with new ways of looking at self, others, and the world*	"When discussing my sexual history, it was very comforting to have my therapist disclose his queer identity and his queer experiences. This helped me view my sexual trauma in a different light." (A. O., age 24)

Table 8 (continued).

Disclosure Impact Theme	Representative quote(s)
Offers helpful new perspectives, especially influencing self-understanding (cont.)	"My therapist also reflected back their own experiences in queer relationship structures (i.e. non-hierarchical polyamory) which helped me create reframes in my own relationships." (O. A., age 32) "My therapist has given me plenty of insight into how as adults we both can give hope to others through our experiences—even just having lived as long as we have, given the high suicide rates amongst LGBTQ+ youth." (H. S., age 27)
Models approaches to handling challenges *Disclosure models ways that the patient might handle challenges and problems outside of therapy*	"I had concerns about my singing voice when going on testosterone and he shared tips/tidbits from his experience with his singing voice when he transitioned and what may or may not happen, which was helpful in working out the best way to handle that (speech therapist, voice lessons, etc.) and, largely due to conversations like that, I ended up starting voice lessons and joining a choir which has been immensely helpful." (K. P., age 30)

Table 8 (continued).

Disclosure Impact Theme	Representative quote(s)
Models approaches to handling challenges (cont.)	"When I was struggling with reconciling my negative relationship with my parents with the fact that I still need them for financial support, my therapist disclosed that they were in a similar position when they were younger and this lead to a conversation on what my options are both in terms of interactions with parents but also in terms of how I could make steps towards being less financially dependent on them (many of which I have now successfully done!"). (C. R., age 24) "She told me about presentation, that to queer people, clothes are not male or female, they're just clothes. So when she goes shopping, she tells her kids to pick clothes they like, no matter what section of the store it's from. This strategy helped my confidence tremendously and allowed me to feel free to wear the clothing I like (menswear) even though I am a woman. It helped to break me out of the binary box and stop trying to fit into women's clothes and instead pick something more affirming and comfortable to my body." (M. H., age 36)

Note. Some participant responses have been lightly copyedited for clarity.

Mediation Models

Model results, presented in Table 9 and Figure 3, should be partially interpreted considering obtained power as well as the correlation between general and identity disclosure optimality. For the 198-participant sample, obtained power using the Schoemann, Boulton, and Short tool (2017) is .75 for a model that considers parallel mediators with a single predictor (i.e., without including either general disclosure optimality or any identified covariates). Notably, the software is unable to take covariates into consideration when estimating power, which is especially noteworthy for covariates that are highly correlated with the predictor of interest. Although estimating power obtained for the more complex model is prohibitively technical, the nature of regression allows for the understanding that a larger sample would be necessary when including both general and identity disclosure optimality in the model, as well as additional covariates, to account for the smaller effect size.

As reported in Table 9 and Figure 3, I considered results from three models: one larger model investigating the influence of identity disclosure optimality while controlling for general disclosure optimality alongside other covariates, and two smaller models—one investigating the influence of identity disclosure optimality while excluding general disclosure optimality, and the other investigating general disclosure optimality while excluding identity disclosure optimality. In the larger model (Model 3 in Table 9 and Figure 3), general and identity disclosure optimality are significantly correlated as expected (standardized coefficient, for comparison with correlation, is .46, *SE* .07., $p < .001$). In this model, neither specific indirect effect was significant, indicating insufficient evidence that identity disclosure optimality has an indirect influence on psychopathology through either real relationship or minority stress when also accounting for general disclosure optimality. The total indirect effect, however, was significant, giving evidence that, taken together and when also taking general disclosure

optimality into account, identity disclosure optimality has an indirect influence on psychopathology through both real relationship and minority stress.

In the model omitting general disclosure optimality (Model 1 in Table 9 and Figure 3), both specific indirect effects as well as the total indirect effect were significant. This indicates that, when ignoring the influence of general disclosure optimality, there is evidence of an indirect effect of identity disclosure optimality on psychopathology through both real relationship and minority stress, as well as through the two combined. In the model omitting identity disclosure optimality (Model 2 in Table 9 and Figure 3), however, the specific indirect effect of general disclosure optimality through real relationship was significant, along with the total indirect effect, but the specific indirect effect through minority stress was non-significant. This indicates that there was no evidence of an indirect effect of general disclosure optimality on psychopathology through minority stress, and likely indicates that the significance of the total effect is largely driven by the significant indirect effect through real relationship.

It is of interest whether disclosure frequency has an impact on treatment outcomes, and if so, whether frequency acts through the same mediating influences of real relationship and minority stress. The bivariate relations (see Table 3) suggest that frequency in and of itself has an insignificant effect: there was only a weak positive association, at T3 only, between identity disclosure frequency and real relationship and no association between the latter and general disclosure frequency; a weak positive association, at T1 only, between general disclosure frequency and psychopathology and no relation between the latter and identity disclosure frequency; and no association at all between either identity or general disclosure frequency and any minority stress process. Though I considered a number of further models, e.g., specifying disclosure frequency as the predictor variable and controlling for optimality, the above data suggest that such models would not produce notable results.

Table 9

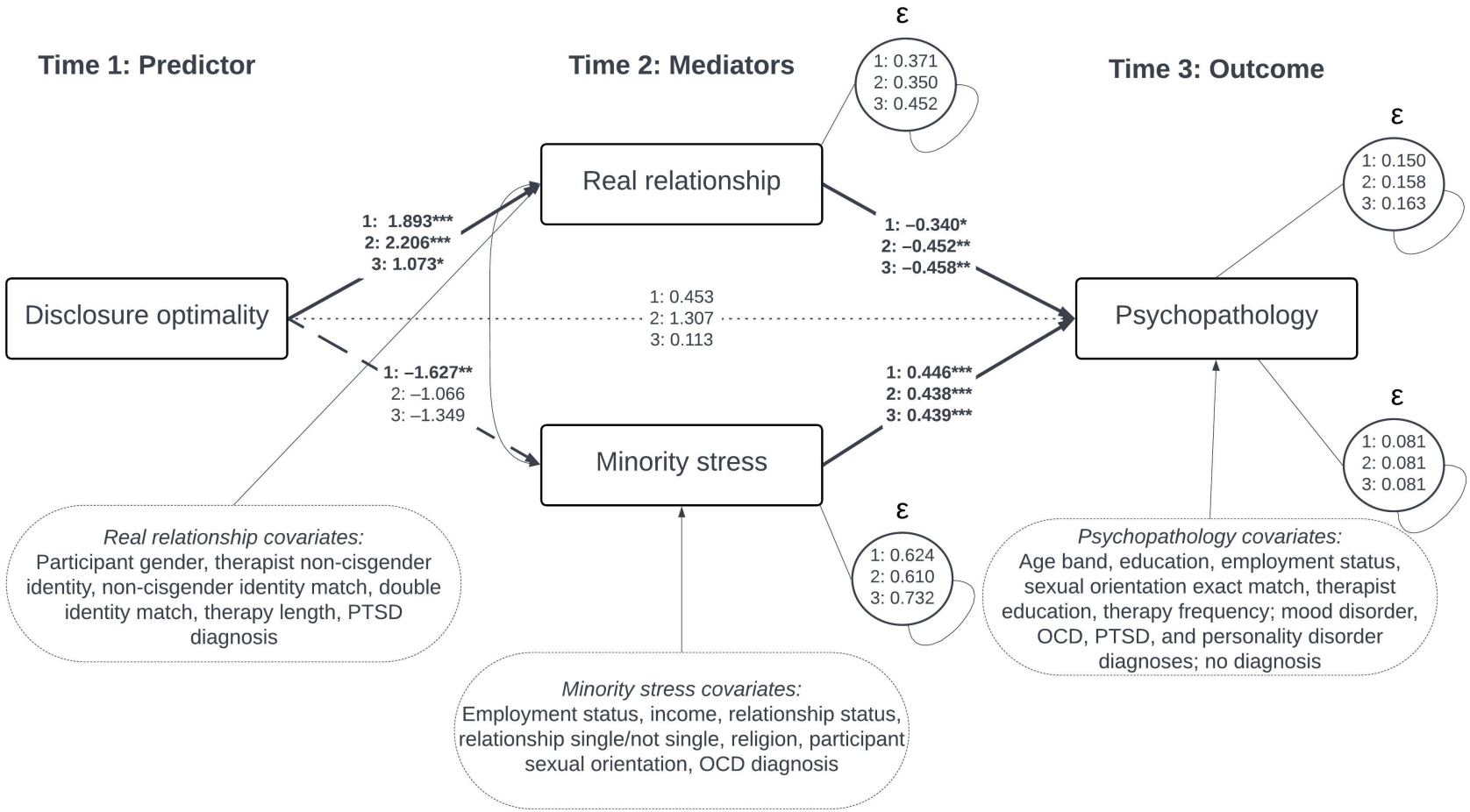
Mediation Analysis of the Relation Between Disclosure Optimality and Psychopathology via Real Relationship and Minority Stress

	Model 1: TSD-I [a]			Model 2: GD [b]			Model 3: TSD-I controlling for GD [c]		
	b	*SE*	*p*	*b*	*SE*	*p*	*b*	*SE*	*p*
Direct effects									
Optimality → Real relationship	**1.893**	0.371	.000	**2.206**	0.350	.000	**1.073**	0.452	.018
Optimality → Minority stress	**–1.627**	0.624	.009	–1.066	0.610	.081	–1.349	0.732	.066
Optimality → Psychopathology	0.453	0.837	.588	1.307	0.709	.066	0.113	0.910	.901
Real relationship → Psychopathology	**–0.340**	0.150	.023	**–0.452**	0.158	.004	**–0.458**	0.163	.005
Minority stress → Psychopathology	**0.446**	0.081	.000	**0.438**	0.081	.000	**0.439**	0.081	.000
Indirect effects									
Optimality → Real relationship → Psychopathology	**–0.643**	0.313	.040	**–0.997**	0.401	.013	–0.491	0.275	.074
Optimality → Minority stress → Psychopathology	**–0.726**	0.321	.024	–0.467	0.297	.116	–0.591	0.353	.094
Optimality → Both mediators → Psychopathology	**–1.369**	0.452	.002	**–1.464**	0.493	.003	**–1.083**	0.491	**.**027
Total effects									
Optimality → Psychopathology	–0.916	0.810	.258	–0.158	0.707	.823	–0.969	0.907	.285

Note. N = 198. Presented are unstandardized coefficients (*b*), standard errors (*SE*), and *p* values (*p*). Coefficients in **bold** indicate $p < .05$. Disclosure optimality is measured at T1, real relationship and minority stress is measured at T2, and psychopathology is measured at T3. [a] Model 1 examines the effect of identity-focused disclosure (TSD-I) at T1 on psychopathology at T3 without including the effects of general disclosure (GD). [b] Model 2 examines the effect of GD at T1 on psychopathology at T3 without including the effects of TSD-I. [c] Model 3 examines the effect of TSD-I at T1 on psychopathology at T3, controlling for the effects of GD.

Figure 3

Mediation Analysis of the Relation Between Disclosure Optimality and Psychopathology via Real Relationship and Minority Stress



Note. Models are indicated by number. Model 1 examines the effect of identity-focused disclosure (TSD-I) at T1 on psychopathology at T3 without including the effects of general disclosure (GD). Model 2 examines the effect of GD at T1 on psychopathology at T3 without including the effects of TSD-I. Model 3 examines the effect of TSD-I at T1 on psychopathology at T3, controlling for the effects of GD. Solid lines indicate significant direct effects for all three models. Dashed line indicates significant direct effect for Model 1 only. Dotted line indicates no significant direct effect.

CHAPTER 5: DISCUSSION

This longitudinal study reveals important insights about frequency, patient perceptions, and impact of therapist self-disclosure on psychotherapy process and outcome in LGBTQ+-matched dyads. There are numerous notable findings. First, an LGBTQ+ therapist is much more likely than not to disclose to an LGBTQ+ patient detailed aspects of their own lived LGBTQ+ experience, as well as more generally. Participants reported over forty distinct disclosure topics, from the therapist's romantic relationships and coming out process, to their gender transition and even sexual experiences. Remarkably, only 7.9% of the enrolled sample reported at baseline that their therapist had never made an identity-focused disclosure, comprising a subgroup that was too small to generate statistically meaningful comparisons. As Farber (2006) has argued, in interview and survey-based research studies, therapists are likely to downplay the frequency with which they self-disclose to patients, or to deny that they self-disclose altogether, reflecting a longstanding uneasiness with a clinical intervention that many mental health professionals were trained to eschew and still regard disapprovingly. This study offers a window into what really goes on in the consulting room when patient and therapist are matched on sexual orientation and/or gender minority status.

Second, LGBTQ+ patients overwhelmingly tend to regard their LGBTQ+ therapists' disclosures (about identity and more generally) as highly optimal, as demonstrated by the strong negative skew in this sample's optimality scores. That is, patients rate the amount of disclosure in their treatments as more ideal than not, they are more comfortable than not with the disclosure, they tend to find it more relevant than not to their own problems, and overall they believe it to be more beneficial than not to their therapy progress. Notably, patients whose therapists disclose more frequently, compared to those whose therapists disclose less frequently, tend to rate the disclosure as more optimal—but only when it relates

to identity. This suggests that there is something uniquely impactful about identity disclosures, compared to general disclosures, that LGBTQ+ patients find therapeutic.

As expected, the data reveal that the therapeutic alliance—defined here as real relationship—has a significant direct effect on a patient's psychological functioning. Specifically, in all three models, stronger real relationship in the dyad at T2 significantly and consistently predicted lower patient psychopathology at T3. Moreover, also as expected, a patient's minority stress level has a significant direct effect on their psychological functioning. Higher minority stress at T2, captured here as a composite of internalized LGBTQ+-negativity, rejection sensitivity, and loneliness, significantly and consistently predicted greater psychopathology at T3 in all models.

It is through these two mediating variables—real relationship and minority stress—that therapist disclosure appears to impact patient mental health. The data indicate that it is not frequency of disclosure in and of itself that influences treatment and patient psychological functioning, but rather the clinical skill with which disclosure is executed, i.e., the optimality of the disclosure. In short, the therapist's choice of when, what, and how to disclose matters greatly in the consulting room. It is not to be treated cavalierly. Optimality of disclosure, whether identity-focused or general, does not have a direct effect on patient psychological functioning. It does, however, appear to influence patient psychological functioning by strengthening or weakening the real relationship (in the case of both identity and general disclosure), and by increasing or reducing the level of minority stress the patient experiences (in the case of identity disclosure alone). These factors, in turn, directly influence patient psychological functioning over time.

The data supported the first hypothesis, that patients whose therapists more optimally disclose about their LGBTQ+ identity would manifest better psychological functioning at study's end than those whose therapists disclose less optimally. The data also supported hypothesis two, which posited that

patients whose therapists more optimally disclose about identity would report stronger real relationship than those whose therapists disclose less optimally. The data additionally supported the third hypothesis —that patients whose therapists more optimally disclose about identity would manifest lower minority stress than those whose therapists disclose less optimally. Finally, the positive relation between optimal identity disclosure and patient psychological functioning, as hypothesized, was present only in its indirect influence through both real relationship and minority stress, though the data revealed important nuances to this indirect path. Both real relationship and minority stress, individually and combined, mediated the relation between identity disclosure optimality and patient psychological functioning. The indirect relation between *general* disclosure optimality and patient psychological functioning, though, was individually mediated only by real relationship (and by both mediators combined). Finally, the indirect relation between identity disclosure optimality and patient psychological functioning, after controlling for general disclosure optimality, remained significant for both mediators combined, but not for each individually.

In the longitudinal path analyses, disclosure optimality temporally preceded real relationship and minority stress, which in turn preceded psychopathology. This design, as well as the fact that I controlled for a wide array of sociodemographic and other covariates, bolsters the proposition that disclosure optimality potentially may have some causal impact on psychopathology over the course of a therapy treatment. One distinction warrants emphasis: disclosure optimality predicted minority stress only in Model 1, which disregarded general disclosure and examined the impact of identity disclosure alone. The qualitative data reveal at least thirteen reasons why optimal *identity* disclosure might be uniquely capable of reducing a patient's minority stress: it can normalize experience, offer validation and nonjudgmental acceptance, provide hope and comfort, and reduce loneliness, among other salubrious effects, in a way that general disclosure simply cannot.

It makes intuitive sense that a patient whose therapist is inept, inappropriate, or generally unskilled at the delicate intervention of self-disclosure would experience moments of misattunement and possibly more serious relationship rupture, and that the therapeutic alliance would degrade accordingly. Conversely, a patient whose therapist navigates self-disclosure with clinical acumen, disclosing judiciously and relevantly in amounts the patient deems appropriate and comfortable, would experience their therapist as more real and genuine, the defining components of the real relationship. Less straightforward, perhaps, is how the optimality of the therapist's identity disclosures directly influences the patient's minority stress levels, and this deserves further consideration and empirical study.

Identity disclosures can reveal much about the therapist's state of, and journey towards, self-acceptance and self-actualization. They can demonstrate the hope and possibility that one's minoritized sexual/gender identity might be woven into one's self-concept fully, authentically, vulnerably, and wholeheartedly; in psychoanalytic terms, that it might be integrated ego syntonically (Janssen, 2016). Many LGBTQ+ patients experience painful self-alienation precisely because they have not integrated their sexual/gender identity in such a manner. It remains an ego dystonic source of shame and confusion, like a foreign body that has been rejected by the psyche. As one participant, B. L. (age 26), attests, "Once [my therapist] recognized my own discomfort in my gender identity, she told me that for years she also struggled to feel wholly like herself. But then she told me how she learned to accept her own gender identity, and how from there, things felt better and better for her." Therapist identity disclosure thus appears to be a potent tool in helping to reduce a patient's internalized LGBTQ+-negativity.

In the world at large, sharing aspects of one's LGBTQ+ identity can be a profoundly risky venture, even in progressive urban enclaves. Every LGBTQ+ individual—this author included—has experienced the shaming sting of stigma, discrimination, harassment, rejection, or outright violence after a miscalculated moment of vulnerable self-revelation. These minority stress experiences can cultivate a

reflexive state of hypervigilant, self-protective, rejection-sensitive silence that often extends into the therapeutic consulting room, particularly at the beginning of a treatment. Indeed, a theme that emerged frequently in the qualitative data is the patient's fear of judgement, and the power of therapist identity disclosure to relax that fear. Shared one participant, C. R. (age 24):

> My therapist self-disclosed that they are nonmonogamous while I was trying to navigate a complicated relationship situation with more than one partner, which made me feel significantly more comfortable with openly discussing being polyamorous/the details of my relationship dynamics without worrying about being judged for the assumed infidelity, promiscuity, or any of the other stereotypes about polyamory.

Another participant, A. L. (age 43), reported that his therapist's identity disclosures "made [him] feel more comfortable and validated [his] experience," and that knowing more about his therapist's experiences with same sex relationships "was extremely helpful [in making him] feel less judged and guarded." Identity disclosures, particularly in direct response to the patient's own disclosures (which are always acts of courage, in that they risk potential rejection by the therapist), can establish a holding environment of non-judgmental safety and acceptance that, over time, can reduce the patient's baseline rejection sensitivity.

By far, the study variable most strongly correlated with psychopathology is loneliness, which is both reinforcing of and exacerbated by the other minority stress processes. Loneliness also underlies most of the themes that emerged in the qualitative data. It is perhaps an existential, ineffable loneliness that generates the patient's ache to be seen, heard, witnessed, and understood; to be validated and affirmed; to be soothed, comforted, reassured, and supported; and to be guided through the complexities of living in a cis- and heteronormative society—all identified as beneficial impacts of identity disclosure. Loneliness often fuels the patient's desire for deep connection with their therapist,

and loneliness is the inevitable byproduct of believing that one's life experiences are abnormal, one's emotions unrelatable. Therapy's healing power, as has long been recognized, rests largely in its provision of basic human connection. It is an antidote to isolation.

Strengths and Limitations

This study has several limitations that restrict the interpretation of its results. Path analysis offers a powerful statistical approach to detecting the influence of variables on each other and the direction and strength of that influence. It does not, however, itself allow for conclusions about causality (Streiner, 2005). The three-time-point longitudinal design, in which the predictor variable preceded the proposed mediators, which in turn preceded the outcome of interest, is a strength of this study and supports the proposition that disclosure optimality may have some causal impact on patient psychopathology, but this cannot be asserted definitively because the models could not control for all possible influences on psychopathology. A patient's mental health is influenced not only by therapist interventions, of course, but by a dizzying array of other variables: psychopharmacological medication, the quality of romantic and social relationships, professional satisfaction, childhood adversity, and many more. If any of these or other unmeasured potential confounds had been added to the models, the indirect effect of disclosure on psychopathology may have been rendered insignificant, and it could have been any combination of these other variables that in fact caused the observed psychopathology irrespective of disclosure. Indeed, a fully causal model investigating disclosure optimality on patient psychopathology would require experimentally manipulating disclosure optimality with real patients, an ethically dubious research design.

As elaborated earlier, this study's population focus was narrowed to LGBTQ+ therapy patients whose therapists do disclose, about identity and more generally, at least sometimes. The comparative effect of total non-disclosure—the uncompromising "blank screen" stance—remains to be examined

empirically. Although the data do suggest that some identity disclosure is more beneficial to the treatment than none at all—e.g., greater frequency of identity disclosure was associated with higher optimality scores; patients whose therapists increased their identity disclosure frequency reported significantly increased optimality of that disclosure—a much larger number of subjects reporting no disclosure would need to be recruited as a comparison group to study total non-disclosure robustly. This poses significant recruitment challenges, to be addressed below.

The present study's sample was predominantly White, high income/education, young, cisgender female, and queer-identifying.[15] This reflects the lamentable lack of diversity among mental health providers and patients, due to deeply entrenched disparities in access to training and care (American Psychological Association, 2022; Barksdale et al., 2022). This also limits the generalizability of the study's findings and leaves questions about the nuanced influences of race, ethnicity, class, age, sexual orientation, and gender identity on disclosure dynamics within the therapeutic dyad. Importantly, no significant between-group racial or ethnic differences were detected across any major study variable, and indeed few other particulars of identity and social location were found to have a significant effect at baseline on either identity or general disclosure optimality ratings. As exceptions, participants earning over $100,000 annually, and those between 45 and 54 years old, rated their therapists' disclosures at baseline as significantly more optimal than those earning less or in other age brackets. A more diverse,

[15] I made every effort to recruit as diverse a subject pool as possible across race, ethnicity, socioeconomic location, and so on. Among the databases that informed therapist outreach, for example, were those of the National Queer and Trans Therapists of Color Network, a "healing justice organization that works to transform mental health for queer and trans people of color" (www.https://nqttcn.com), and Inclusive Therapists, a community of practitioners working for "equitable access to radically affirming and culturally responsive mental health care" (https://www.inclusivetherapists.com).

and larger, participant pool may have revealed further important distinctions between how disclosure is perceived by patients of varying identities.

Due to logistical exigencies, I restricted participant recruitment to seven months and the lag between data collection waves was between seven and eight weeks on average for each participant. That recruitment window resulted in a final analytic sample, after attrition and missing data exclusion, that was large enough to produce obtained power of .75, just shy of the .80 initially sought. More participants, as always, would have been preferable. Moreover, longer time gaps between survey rounds, to capture more pronounced therapeutic progress and symptomalogical change, may have strengthened this study.

Further, I employed the construct of loneliness as a proxy for the minority stress component of concealment. This is because loneliness has been found to be associated strongly with concealment (e.g., Mereish & Poteat, 2015) and existing measures of concealment (e.g., the Sexual Orientation Concealment Scale [Jackson & Mohr, 2016] and the Nebraska Outness Scale [Meidlinger & Hope, 2014]) were developed for and psychometrically tested only on sexual, and not gender, minorities. It would have been preferable to have utilized a psychometrically robust measure that captured concealment experiences explicitly, one that is applicable to the widest range of LGBTQ+ identities.

Finally, this study's results may reflect biases inherent in the methodology and sample. I made concerted efforts to recruit a participant pool that reflects the broad population of LGBTQ+ therapy patients. It could be, though, that individuals who are more likely to enroll in a publicly-advertised research study differ in some fundamental way from those who would not—in personality, temperament, attitude towards therapy, or other important aspects. Similarly, the therapists who agreed to inform their own patients about this study may differ from the therapists who did not respond to

recruitment solicitations, in some capacity that also impacts the amount that they disclose and the skill with which they do so.

I measured this study's constructs with online questionnaires, which are always prone to self-report biases, for example the tendency for participants to provide socially desirable answers or to recall their experiences inaccurately (Althubaiti, 2016). Of particular concern, patients in LGBTQ+-matched dyads may have trouble distinguishing identity disclosure from general disclosure, exacerbating the difficulty in statistically isolating the effects of each. For instance: Has a gay therapist who tells his gay patient about an upcoming trip to Puerto Vallarta—a well-known and notoriously freewheeling travel destination for gay men—simply disclosed that he is taking a vacation? Or has he revealed something fundamental about his (perhaps freewheeling) identity? This ambiguity makes teasing apart the isolated impact of identity disclosure challenging without a significantly larger sample, given the small effect size of disclosure optimality and high correlation between general and identity disclosure optimality ratings.

Self-Report Bias in Psychotherapy Research: Unique Considerations

Self-report bias poses idiosyncratic challenges for therapy process-outcome research (McLeod, 2001; Truijens et al., 2023). The validity of any self-report measure that asks the patient to evaluate a facet of their therapy (e.g., disclosure optimality) as it pertains to treatment efficacy depends on whether (a) that facet indeed contributes to efficacy, conceptually and theoretically; (b) the patient is an accurate judge of their own therapy experience; and (c) the measure's rating scale has comparable meaning across patients. Two facets of disclosure optimality captured by the TSDQ-I should be considered with this in mind: the patient's feelings toward disclosure amount, and their comfort with that amount.

In the TSDQ-I, each participant was asked to specify the amount of identity disclosure they had experienced in their treatment and to assess that amount as being less than preferable, more than

preferable, or just right. Ostensibly, it seems optimal for a therapist to disclose in quantities that the patient perceives as "just right"—it reflects, as introduced earlier, the familiar "Goldilocks" principle that extremes are more destabilizing and deleterious than a homeostatic middle ground. Biologists invoke Goldilocks to explain the metabolic balancing act that allows an organism to thrive in its environment (Somero, 2022); economists use it to describe an exemplar economy—stable and moderately growing, neither too hot with inflation nor too cold in recession (Krugman, 2022); and developmental psychologists dub an infant's tendency to attend only to stimuli somewhere between overly simple and overly complex the "Goldilocks effect" (Kidd et al., 2014). The Goldilocks principle applies to so many natural and social phenomena that it has become something of a truism.

Yet there are clinical scenarios in which a certain disclosure amount, however ideal the patient deems it, may conflict with therapeutic progress. Disclosure may fuel unexamined enactments within the dyad that do not serve the treatment (Bromberg, 2003). Consider, for example, a borderline-organized patient who heartily approves of his therapist's liberal self-revelations but unconsciously does so because it reenacts his covertly incestuous (Love, 1991) relationship with an unboundaried, alcoholic mother who spilled her deepest secrets to him when inebriated. Likewise, a patient in the throes of an erotic transference may rate her therapist's abundant disclosure as "just right," while in clinical reality the disclosure is merely cementing a fantasy bond (Firestone, 1985) and perhaps making the transference more difficult to identify and explore. In both cases, better treatment outcomes likely would result from less frequent disclosure, which these patients surely would rate as "too little" but would nonetheless render the disclosure objectively more optimal. It may be that future psychometric testing of the TSDQ-I will find the "rate this disclosure amount" item to be problematic enough to reword or replace. However, viewing *any* therapy self-report measure through a psychodynamic lens arguably renders many if not most items at least somewhat problematic. The presupposition of self-report

measures, of course, is that humans are by and large accurate accountants of their experience. The foundation of analytic thought, by contrast, is that patients often are *not* accurate reporters of their experience, as much of it remains dammed up in the unconscious.

Relatedly, the TSDQ-I asks patients to rate their comfort level with the amount of therapist disclosure they experience in treatment. Disclosure optimality is presumed to increase as comfort level does because comfort is inextricably tied to a sense of safety, which decades of research has shown to be a prerequisite of effective psychotherapy, one that predicts treatment improvement and outcome (e.g., Siegel & Hilsenroth, 2013; Norcross & Lambert, 2019; Beck et al., 2016; Friedlander et al., 2008). Podolan et al. (2023) propose that this is because the holding environment of therapy is analogous to that of early childhood, and safety is a prerequisite of healthy development. Early psychoanalytic theorists were first to propose various safety-seeking survival processes—Adler's (1912) "safeguarding tendencies," Anna Freud's (1936) "defense mechanisms," Sullivan's (1953) "security operations"—and contemporary empirical research has found lack of safety in childhood to be significantly associated with later psychopathology (Cassidy & Shaver, 2016; Gilbert, 2006; Shore, 2003).

Bromberg (2006), however, contrarily argues that therapy should be "safe but not too safe"—that is, the treatment environment should hum with an energy of optimal arousal, in which the patient feels secure enough to confront difficult psychic material without becoming overwhelmingly dysregulated, yet not so comfortable that the difficult work of therapy can be sidestepped (p. 4). (Here again, the Goldilocks principle rears its head.) Mason (2015) calls this a climate of "safe uncertainty," which allows for risk taking and experiencing what Winnicott (1971) termed "optimal frustrations and tolerable disappointments." Along these lines, we may be misguided to assign the highest optimality score in the TSDQ-I to the "very comfortable" response option.

It is my contention, however, that there is valuable, productive unsafety in therapy—and toxic unsafety. The distinction between the two deserves further theorizing, but discomfort with a therapist's inept disclosures surely would fall into the latter category. For unsafety within the treatment to be useful, it must live inside an intact therapeutic frame that is, in a sense, "meta-safe," a safe holding environment for the unsafety. Most LGBTQ+ patients enter therapy with a history of traumatic attachment bonds, and as Bowlby (1988) contends, the therapist's essential job is to create a safe, secure base from which (and *only* from which) the patient "can explore the various unhappy and painful aspects of his [sic] life" (p. 156).[16] Disclosures that make the patient uncomfortable privilege the therapist's material over the patient's and render the dyadic relationship insecure to such an extent that the unsafety lives in a different, nontherapeutic holding environment altogether.

Future Directions

As mentioned, research into the comparative effects of non-disclosure in LGBTQ+-matched dyads is warranted. There is a significant challenge in recruitment for such a study, as clinicians who abide by a pure stance of anonymity tend to be psychoanalytically oriented and are relatively unlikely to divulge to an LGBTQ+ patient even the basic fact of their sexual orientation/gender identity. Total non-disclosure surely would be experienced differently by a patient who knows for certain that their therapist does share LGBTQ+ identity (through online sleuthing for example), than by one who has suspicion, but no concrete evidence, that their therapist is withholding. Moreover, psychoanalytically-minded therapists are unlikely to advertise a research study to their patients; numerous analysts I contacted while recruiting politely declined and explained that doing so would be a break in the analytic frame. That

[16] Indeed, a secure patient-therapist attachment bond has been shown empirically to strengthen the therapeutic alliance (Parish & Eagle, 2003), promote more thorough examination of difficult patient material (Mallinckrodt et al., 2005), and stimulate a corrective emotional experience for the patient (Skourteli & Lennie, 2011).

only 18 subjects reported total non-disclosure is partly a reflection of the dearth of analysts in the dyads. Indeed, only 15.2% of the sample reported that their treatment was exclusively psychoanalytic or psychodynamic, irrespective of their therapist's education and training. Further, there is one item on the TSDQ-I that requires thoughtful wording modification for patients reporting no disclosure. The item, "Overall, how much have your therapist's self-disclosures related to you and your problems?" is irrelevant as written to those whose therapists don't disclose. Interjecting "(or lack of self-disclosures)" into the existing item, though, appears logically problematic. A revised question, "Overall, how much do you think your therapist's *lack* of self-disclosure relates to your therapy needs?" perhaps is an apt replacement. This modification, like the entire measure, would need psychometric testing.

The present study provides a foundation upon which a more comprehensive qualitative investigation of disclosure optimality, from the perspective of the LGBTQ+ therapy patient, should be built. "Optimality" of disclosure is a highly subjective construct that needs to be operationalized based on empirical evidence and not intuition or common sense assumptions. Prior qualitative research had identified numerous qualities that might make disclosure optimal (e.g., comfort level, relevance to the patient's problems), and I made a concerted effort to create an optimality measure, the TSDQ-I, that captured these qualities. The prior research is limited in amount and scope, however. The subjects who provided the most thoughtful and nuanced free response answers to this study's baseline survey perhaps could be recruited to participate in extended interviews about their therapy experiences, which could form the basis of a robust phenomenological analysis of optimality that examines disclosure's risks and pitfalls as much as its benefits. The findings from that study subsequently could inform revisions to the TSDQ-I, which should be psychometrically tested.

Clinical Implications

The clinical intuition of most LGBTQ+ therapists in the United States and Canada seems to favor disclosure over non-disclosure; overall, this is likely to the benefit of LGBTQ+ patients. The potential negative consequences of poorly executed disclosure, though, are very real. As this study demonstrates, therapists are wise to feel confused or conflicted over what, when, and how to disclose, as the skill and sophistication with which they do so contributes to strengthening or weakening the alliance, increasing or decreasing a patient's minority stress, and ultimately bolstering or degrading their mental health. This study might stimulate in LGBTQ+ therapists more nuanced, sober consideration of how they are sharing their minoritized identity, their very personhood, with their LGBTQ+ patients. It might also provide preliminary guideposts, to be further investigated, for what "optimal" disclosure really is.

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Appendix A

Selected Outreach Materials

Subject Recruitment: Therapist Outreach Letter

Dear [Name]:

I am a PhD Candidate in Clinical Psychology at The City College of New York (CUNY) and with my co-investigator and advisor Dr. Elliot Jurist, PhD, I am conducting an IRB-approved dissertation study researching the psychotherapy dynamic when both client and therapist identify as LGBTQ+. To carry out this investigation, I am recruiting 500 LGBTQ+-identifying therapy patients/clients to complete three online surveys over the course of three months.

I am writing to ask for your help in connecting to study participants. **Would you please consider informing your clients and professional network of this study?**

Individuals are eligible to participate if they (a) are 18 years or older and speak English fluently; (b) identify as LGBTQ+; and (c) have been in one-on-one therapy/counseling for at least two months with a licensed (or working towards licensure) mental health clinician who also identifies as LGBTQ+. **Participants will receive up to $25 compensation in Amazon Gift Certificates, after a data quality audit. All data is anonymized and confidential and participants can withdraw at any time without explanation.**

Enclosed are copies of a flyer you might post and circulate that describes the study and directs interested individuals to its dedicated website, **www.TherapyStudy.com**, where they can learn more and begin participation.

I believe the potential impact of this research will make your efforts to help recruit subjects worthwhile, as I anticipate that this study's findings will inform mental health treatment best practices and fill a valuable gap in our understanding of how therapy can best serve LGBTQ+ individuals.

I would be pleased to discuss this study further with you by phone (212.650.6393, ext. 9047) or email (bneff000@citymail.cuny.edu) and answer any questions you might have. This study has received approval by the CUNY Institutional Review Board, #2022-0623.

Again, your help in recruiting LGBTQ+ therapy clients who meet the eligibility requirements above is so very valuable and I greatly appreciate it.

Sincerely,

Brian Neff, MA, MALD, PhD Candidate

The City College of New York, CUNY

Subject Recruitment: Posted Flyer

LGBTQ+ and in therapy?

We are conducting a research study on what therapy/counseling is like when the client and the therapist are both LGBTQ+.

YOU'RE ELIGIBLE TO PARTICIPATE IF:

- You're at least 18 years old
- You identify as LGBTQ+
- You've been in 1-on-1 therapy/counseling for at least 2 months
- Your therapist/counselor also identifies as LGBTQ+

You will be asked to fill out 3 confidential online surveys over 12 weeks

You will be compensated with **$25 in Amazon eGift Certificates** upon completion

Interested in participating? Begin at:

www.TherapyStudy.com

Or scan:

If you have questions, contact Brian Neff, MA, MALD, PhD Candidate, at:
bneff000@citymail.cuny.edu or 212.650.6393 ext. 9047

This study has been approved by the CUNY Institutional Review Board, #2022-0623.

Subject Recruitment: Website

- you're at least 18 years old
- you identify as part of the LGBTQ+ community
- you've been in one-on-one therapy/counseling for at least two months
- your therapist/counselor also identifies as LGBTQ+

Interested? CLICK HERE TO BEGIN

You will be asked to fill out 3 online surveys over 3 months	You will be compensated with $25 in Amazon Gift Cards upon completion (pending a data audit)
Your survey responses will be completely anonymous and confidential	You may withdraw your participation at any time for any reason

By participating, you will be contributing to research that may improve LGBTQ+ mental healthcare.

Want more information first?

Enter your email here and someone from our team will reach out to you.

Email

Submit

This study is being conducted by Brian Neff, MA, MALD, PhD Candidate in Clinical Psychology at The City College of New York, under the advisement of Dr. Elliot Jurist, PhD, PhD, and has received CUNY Institutional Review Board approval (#2022-0623).

160 Convent Avenue, New York, New York 10031, United States

(212) 650-6393, ext. 9047

Appendix B

Identity-focused Therapist Self-Disclosure Questionnaire (TSDQ-I)*

Instructions: Now we'd like to ask you some questions about your therapy experience. A therapist who is LGBTQ+ may choose to self-disclose details about their own LGBTQ+ identity to a client—particularly when the client is also LGBTQ+. Clients may find these therapist self-disclosures either helpful or unhelpful. The following screens present different types of self-disclosures that an LGBTQ+ therapist might make to a client about their own LGBTQ+ identity. Each type is first defined, then examples are presented to illustrate what a therapist might say if they were making that type of self-disclosure. These examples are only some of the many ways that a therapist might make each type of self-disclosure. Please think carefully about ways that your current therapist may have self-disclosed to you about their own LGBTQ+ identity. Rate how often your therapist has made each type of self-disclosure, then rate how you feel about this amount of self-disclosure. Finally, if applicable, for each type of self-disclosure please provide one real example of how your therapist self-disclosed to you if you can think of one.

* adapted from Ain, 2011

A therapist might disclose to a client factual information about their LGBTQ+ identity.

Examples: "I identify as a lesbian."

"I came out when I was sixteen years old."

How often does your therapist self-disclose factual information about their LGBTQ+ identity?

Never	Rarely	Sometimes	Often	Very often

How do you rate this amount of self-disclosure?

It's much less than I'd prefer	It's somewhat less than I'd prefer	It's just enough	It's somewhat more than I'd prefer	It's much more than I'd prefer

How do you tend to feel when your therapist self-discloses in this way?

Very uncomfortable	Somewhat uncomfortable	Neither comfortable nor uncomfortable	Somewhat comfortable	Very comfortable

Which best describes how this self-disclosure has impacted your therapy?

It's been very harmful to my therapy	It's been somewhat harmful to my therapy	It's been neither harmful nor helpful to my therapy	It's been somewhat helpful to my therapy	It's been very helpful to my therapy

If you can think of one, please provide a brief example of when your therapist self-disclosed factual information about their LGBTQ+ identity: *[Free response]*

A therapist might disclose <u>feelings</u> they have about their LGBTQ+ identity, by using specific words to describe their emotional experience being LGBTQ+.

Examples: "At times I've felt scared that I'll always be discriminated against as a trans queer person."

"I was relieved when my parents reacted supportively when I came out as bisexual."

How often does your therapist self-disclose <u>feelings</u> about their LGBTQ+ identity?

Never	Rarely	Sometimes	Often	Very often

How do you rate this amount of self-disclosure?

It's much less than I'd prefer	It's somewhat less than I'd prefer	It's just enough	It's somewhat more than I'd prefer	It's much more than I'd prefer

How do you tend to feel when your therapist self-discloses in this way?

Very uncomfortable	Somewhat uncomfortable	Neither comfortable nor uncomfortable	Somewhat comfortable	Very comfortable

Which best describes how this self-disclosure has impacted your therapy?

It's been very harmful to my therapy	It's been somewhat harmful to my therapy	It's been neither harmful nor helpful to my therapy	It's been somewhat helpful to my therapy	It's been very helpful to my therapy

If you can think of one, please provide a brief example of when your therapist self-disclosed <u>feelings</u> about their LGBTQ+ identity: *[Free response]*

A therapist might disclose personal experiences they've had as an LGBTQ+ person, intending to reassure or support a client.

Examples: "I also had anxiety before telling my co-workers that I am transitioning. They reacted so much better than I expected."

"Once I realized that I could surround myself with accepting people, I started to feel more hopeful."

How often does your therapist self-disclose personal experiences they've had as an LGBTQ+ person, intending to offer reassurance or support?

Never | Rarely | Sometimes | Often | Very often

How do you rate this amount of self-disclosure?

It's much less than I'd prefer | It's somewhat less than I'd prefer | It's just enough | It's somewhat more than I'd prefer | It's much more than I'd prefer

How do you tend to feel when your therapist self-discloses in this way?

Very uncomfortable | Somewhat uncomfortable | Neither comfortable nor uncomfortable | Somewhat comfortable | Very comfortable

Which best describes how this self-disclosure has impacted your therapy?

It's been very harmful to my therapy | It's been somewhat harmful to my therapy | It's been neither harmful nor helpful to my therapy | It's been somewhat helpful to my therapy | It's been very helpful to my therapy

If you can think of one, please provide a brief example of when your therapist self-disclosed around their LGBTQ+ identity to offer you reassurance or support: *[Free response]*

A therapist might disclose challenges or personal struggles that they've faced as an LGBTQ+ person.

Examples: "To be honest, I also struggle with feeling inadequate when I look at all the muscular gay men on Instagram."

"I never know how to respond when people tell me: 'You're not bisexual, you're gay and just won't admit it.'"

How often does your therapist self-disclose challenges that they've faced as an LGBTQ+ person?

Never | Rarely | Sometimes | Often | Very often

How do you rate this amount of self-disclosure?

It's much less than I'd prefer | It's somewhat less than I'd prefer | It's just enough | It's somewhat more than I'd prefer | It's much more than I'd prefer

How do you tend to feel when your therapist self-discloses in this way?

Very uncomfortable | Somewhat uncomfortable | Neither comfortable nor uncomfortable | Somewhat comfortable | Very comfortable

Which best describes how this self-disclosure has impacted your therapy?

It's been very harmful to my therapy | It's been somewhat harmful to my therapy | It's been neither harmful nor helpful to my therapy | It's been somewhat helpful to my therapy | It's been very helpful to my therapy

If you can think of one, please provide a brief example of when your therapist self-disclosed a challenge that they've faced as an LGBTQ+ person: *[Free response]*

A therapist might disclose strategies they've used to cope with challenges they've faced as an LGBTQ+ person.

Examples: "When there was an anti-gay hate crime in my own building, I looked for a new apartment through a 'Queer-friendly Housing' mailing list."

"I'm always up front on the very first date that I am nonbinary and bisexual."

How often does your therapist self-disclose strategies they've used as an LGBTQ+ person?

Never	Rarely	Sometimes	Often	Very often

How do you rate this amount of self-disclosure?

It's much less than I'd prefer	It's somewhat less than I'd prefer	It's just enough	It's somewhat more than I'd prefer	It's much more than I'd prefer

How do you tend to feel when your therapist self-discloses in this way?

Very uncomfortable	Somewhat uncomfortable	Neither comfortable nor uncomfortable	Somewhat comfortable	Very comfortable

Which best describes how this self-disclosure has impacted your therapy?

It's been very harmful to my therapy	It's been somewhat harmful to my therapy	It's been neither harmful nor helpful to my therapy	It's been somewhat helpful to my therapy	It's been very helpful to my therapy

If you can think of one, please provide a brief example of when your therapist self-disclosed a strategy they've used as an LGBTQ+ person: *[Free response]*

Finally, a therapist might disclose <u>insight</u> they have gained—for example, things that they have learned about themselves—as an LGBTQ+ person.

Examples: "I came to realize that I was depressed not because I am gay, but because I was in the closet and living inauthentically."

"I think I avoided intimacy for a long time because deep down I was afraid of bringing a boyfriend home to meet my family."

How often does your therapist self-disclose <u>insight</u> they have gained as an LGBTQ+ person?

Never	Rarely	Sometimes	Often	Very often

How do you rate this amount of self-disclosure?

It's much less than I'd prefer	It's somewhat less than I'd prefer	It's just enough	It's somewhat more than I'd prefer	It's much more than I'd prefer

How do you tend to feel when your therapist self-discloses in this way?

Very uncomfortable	Somewhat uncomfortable	Neither comfortable nor uncomfortable	Somewhat comfortable	Very comfortable

Which best describes how this self-disclosure has impacted your therapy?

It's been very harmful to my therapy	It's been somewhat harmful to my therapy	It's been neither harmful nor helpful to my therapy	It's been somewhat helpful to my therapy	It's been very helpful to my therapy

If you can think of one, please provide a brief example of when your therapist self-disclosed <u>insight</u> they've gained as an LGBTQ+ person: *[Free response]*

<u>Overall</u>, how often does your therapist self-disclose about their LGBTQ+ identity?

Never	Rarely	Sometimes	Often	Very often

<u>Overall</u>, how do you rate this amount of self-disclosure?

It's much less than I'd prefer	It's somewhat less than I'd prefer	It's just enough	It's somewhat more than I'd prefer	It's much more than I'd prefer

<u>Overall</u>, how do you tend to feel when your therapist self-discloses about their LGBTQ+ identity?

Very uncomfortable	Somewhat uncomfortable	Neither comfortable nor uncomfortable	Somewhat comfortable	Very comfortable

<u>Overall</u>, how much have your therapist's self-disclosures about their LGBTQ+ identity related to you and your problems?

Not at all	Slightly	Moderately	Very	Extremely

Which best describes how your therapist's self-disclosure about their LGBTQ+ identity has impacted your therapy <u>overall</u>?

It's been very harmful to my therapy	It's been somewhat harmful to my therapy	It's been neither harmful nor helpful to my therapy	It's been somewhat helpful to my therapy	It's been very helpful to my therapy

<u>Overall</u>, how many self-disclosures would you say your therapist has made about their LGBTQ+ identity? (Just give your best estimate.)

A therapist also may self-disclose information that is completely unrelated to their LGBTQ+ identity.

Examples:

"I earned a PhD in counseling psychology."

"I was angry when my parents divorced."

"I know how hard losing a loved one can be."

"I've had difficulty caring less about what people think of me."

"When I feel overwhelmed with work, I try to prioritize my tasks."

"I realized that my perfectionism is a defense against feeling inadequate."

Also, some therapists choose to self-disclose their immediate, in-the-moment experience of the client and/or the therapy session.

Examples:

"I feel some tension between us today."

"As you're speaking, I'm suddenly feeling very protective of you."

For the following questions, please consider only the self-disclosures your therapist has made that are completely unrelated to their LGBTQ+ identity.

<u>Overall</u>, how often does your therapist self-disclose *<u>completely unrelated to their LGBTQ+ identity</u>?*

Never	Rarely	Sometimes	Often	Very often

<u>Overall</u>, how do you rate this amount of self-disclosure? *(Remember, consider only self-disclosure that is completely unrelated to LGBTQ+ identity.)*

It's much less than I'd prefer	It's somewhat less than I'd prefer	It's just enough	It's somewhat more than I'd prefer	It's much more than I'd prefer

<u>Overall</u>, how do you tend to feel when your therapist self-discloses? *(Remember, consider only self-disclosure that is completely unrelated to LGBTQ+ identity.)*

Very uncomfortable	Somewhat uncomfortable	Neither comfortable nor uncomfortable	Somewhat comfortable	Very comfortable

<u>Overall</u>, how much have your therapist's self-disclosures related to you and your problems? *(Remember, consider only self-disclosure that is completely unrelated to LGBTQ+ identity.)*

Not at all	Slightly	Moderately	Very	Extremely

Which best describes how your therapist's self-disclosure has impacted your therapy <u>overall</u>? *(Remember, consider only self-disclosure that is completely unrelated to LGBTQ+ identity.)*

It's been very harmful to my therapy	It's been somewhat harmful to my therapy	It's been neither harmful nor helpful to my therapy	It's been somewhat helpful to my therapy	It's been very helpful to my therapy

<u>Overall</u>, how many self-disclosures would you say your therapist has made in total? (Just give your best estimate.)

Scoring: The global self-disclosure optimality score ranges from 4 to 18, where a higher score indicates greater optimality. It is calculated by summing the scores for the following items,: (a) <u>Overall</u>, how do you rate this amount of self-disclosure? (*It's much less than I'd prefer* and *It's much more than I'd prefer* = 1; *It's somewhat less than I'd prefer* and *It's somewhat more than I'd prefer* = 2; *It's just right* = 3); (b) <u>Overall</u>, how do you tend to feel when your therapist self-discloses? (*Very Uncomfortable* = 1 to *Very Comfortable* = 5); (c) <u>Overall</u>, how much have your therapist's self-disclosures related to you and your problems? (*Not at all* = 1 to *Extremely* = 5); and (d) Which best describes how your therapist's self-disclosure has impacted your therapy <u>overall</u>? (*It's been very harmful to my therapy* = 1 to *It's been very helpful to my therapy* = 5).

Appendix C

Real Relationship Inventory–Client Version (RRI-C)*

Instructions: Please use the following scale to evaluate your perceptions of yourself, your therapist, and your relationship with your therapist, placing your rating in the space next to the item.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

____ 1. I am able to be myself with my therapist.

____ 2. My therapist and I have a realistic perception of our relationship.

____ 3. I hold back significant parts of myself.

____ 4. I appreciate being able to express my feelings in therapy.

____ 5. My therapist likes the real me.

____ 6. It is difficult to accept who my therapist really is.

____ 7. I am open and honest with my therapist.

____ 8. My therapist's perceptions of me seem colored by his or her own issues.

____ 9. The relationship between my therapist and me is strengthened by our understanding of one another.

____ 10. My therapist seems genuinely connected to me.

____ 11. I am able to communicate my moment-to-moment inner experience to my therapist.

____ 12. My therapist holds back his/her genuine self.

____ 13. I appreciate my therapist's limitations and strengths.

____ 14. We do not really know each other realistically.

* Kelley et al., 2010

____ 15. My therapist and I are able to be authentic in our relationship.

____ 16. I am able to see myself realistically in therapy.

____ 17. My therapist and I have an honest relationship.

____ 18. I am able to separate out my realistic perceptions of my therapist from my unrealistic perceptions.

____ 19. My therapist and I have expressed a deep and genuine caring for one another.

____ 20. I have a realistic understanding of my therapist as a person.

____ 21. My therapist does not see me as I really am.

____ 22. I feel there is a significant holding back in our relationship.

____ 23. My therapist's perceptions of me are accurate.

____ 24. It is difficult for me to express what I truly felt about my therapist.

Scoring: The following items are reverse scored: 3, 6, 8, 12, 14, 21, 22, and 24. The global Real Relationship score is calculated by the sum of all item scores, where a higher score indicates stronger therapeutic alliance via the real relationship. The Genuineness subscore is calculated by summing the scores for items 1, 3, 4, 7, 10, 11, 12, 15, 17, 19, 22, and 24. The Realism subscore is calculated by summing the scores for items 2, 5, 6, 8, 9, 13, 14, 16, 18, 20, 21, and 23.

Appendix D

LGBTQ+-Related Rejection Sensitivity Scale*

Instructions: Please read the following descriptions of situations and answer the two questions that follow each one. Imagine each situation as vividly as you can, as if you were actually there:

1. You bring a LGBTQ+ partner to a family reunion. Two of your old-fashioned aunts don't come talk to you even though they see you.	How **concerned or anxious** would you be that they don't talk to you because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that they didn't talk to you because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**
2. A 3-year old child of a distant relative is crawling on your lap. The child's mom comes to take the child away.	How **concerned or anxious** would you be that the mom took him away because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that the mom took him away because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**

* Pachankis et al., 2008

3. You've been dating someone for a few years now and you receive a wedding invitation to a straight cisgender friend's wedding. The invite was addressed only to you, not you and a guest.	How **concerned or anxious** would you be that the invite was addressed only to you because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that the invite was addressed only to you because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**
4. You go to a job interview and the interviewer asks if you are married. You say that you and your LGBTQ+ partner have been together for 5 years. You later find out that you don't get the job.	How **concerned or anxious** would you be that you didn't get the job because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that you didn't get the job because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**

5. You go get an STD checkup, and the man taking your sexual history is rude towards you.	How **concerned or anxious** would you be that he is rude towards you because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that he is rude towards you because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**
6. You bring someone you are dating to a fancy restaurant of straight, cisgender patrons, and you are seated away from everyone else in a back corner of the restaurant.	How **concerned or anxious** would you be that you were seated there because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that you were seated there because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**

7. You and your LGBTQ+ partner are on a road trip and decide to check into a hotel in a rural town. The sign out front says there are vacancies. The two of you go inside, and the woman at the front desk says that there are no rooms left.	How **concerned or anxious** would you be that she lied to you because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that she lied to you because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**
8. You go to a party and you and your partner are the only LGBTQ+ people there. No one seems interested in talking to you.	How **concerned or anxious** would you be that no one talks to you because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that no one talked to you because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**

9. You are in a locker room in a straight gym. One person nearby moves to another area to change clothes.	How **concerned or anxious** would you be that he moved to another area to change because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that he moved to another area to change because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**
10. Your colleagues are celebrating a co-worker's birthday at a restaurant. You are not invited.	How **concerned or anxious** would you be that they did not invite you because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that they did not invite you because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**

11. Only you and a group of straight men are on a subway train late at night. They look in your direction and laugh.	How **concerned or anxious** would you be that they would be laughing at you because of your LGBTQ+ identity? (circle one) **Very Unconcerned** 1 2 3 4 5 6 **Very Concerned** How **likely** is it that they would be laughing at you because of your LGBTQ+ identity? (circle one) **Very Unlikely** 1 2 3 4 5 6 **Very Likely**

Scoring: For each item, multiply the anxiety score by the likelihood score to get an individual rejection sensitivity score for each item. Take the average of the 11 individual rejection sensitivity scores.

Appendix E

Short Internalized Homonegativity Scale (SIHS)—LGBTQ+-Adapted*

Instructions: Now, please indicate the degree to which you agree or disagree with each of the following items. Use the following scale:

Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree/Disagree	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

____ 1. I am comfortable about people finding out about my LGBTQ+ identity.

____ 2. It is important to me to control who knows about my LGBTQ+ identity.

____ 3. I feel comfortable discussing my LGBTQ+ identity in a public situation.

____ 4. Even if I could change my LGBTQ+ identity, I wouldn't.

____ 5. I feel comfortable being seen in public with someone who obviously is LGBTQ+.

____ 6. Most LGBTQ+ people cannot sustain a long-term committed relationship.

____ 7. Most LGBTQ+ people prefer anonymous sexual encounters.

____ 8. LGBTQ+ people tend to flaunt their sexual orientation/gender identity inappropriately.

____ 9. LGBTQ+ people are generally more promiscuous than straight, cisgender people.

____ 10. I often feel intimidated while at LGBTQ+ venues.

____ 11. Social situations with LGBTQ+ people make me feel uncomfortable.

____ 12. I feel comfortable in LGBTQ+ bars.

____ 13. Making an advance to a romantic interest is difficult for me.

Scoring: Items 1, 3, 4, 5, and 12 are reverse scored. The global score is calculated by summing all item scores, where a higher score indicates greater internalized LGBTQ+-negativity.

* Currie et al., 2004

Appendix F

UCLA Loneliness Scale*

Instructions: Please indicate how often each of the statements below is descriptive of you using the following scale:

I often feel this way	I sometimes feel this way	I rarely feel this way	I never feel this way
3	2	1	0

____ 1. I am unhappy doing so many things alone.
____ 2. I have nobody to talk to.
____ 3. I cannot tolerate being so alone.
____ 4. I lack companionship.
____ 5. I feel as if nobody really understands me.
____ 6. I find myself waiting for people to call or write.
____ 7. There is no one I can turn to.
____ 8. I am no longer close to anyone.
____ 9. My interests and ideas are not shared by those around me.
____ 10. I feel left out.
____ 11. I feel completely alone.
____ 12. I am unable to reach out and communicate with those around me.
____ 13. My social relationships are superficial.
____ 14. I feel starved for company.
____ 15. No one really knows me well.
____ 16. I feel isolated from others.
____ 17. I am unhappy being so withdrawn.
____ 18. It is difficult for me to make friends.
____ 19. I feel shut out and excluded by others.
____ 20. People are around me but not with me.

Scoring: Sum all item scores, where a higher score indicates greater subjective feelings of loneliness.

* Russell et al., 1978

Appendix G

Outcome Questionnaire (OQ®-45.2)*

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and choose the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Use the following categories:

Never	Rarely	Sometimes	Frequently	Almost Always
0	1	2	3	4

____ 1. I get along well with others.

____ 2. I tire quickly.

____ 3. I feel no interest in things.

____ 4. I feel stressed at work/school.

____ 5. I blame myself for things.

____ 6. I feel irritated.

____ 7. I feel unhappy in my marriage/significant relationship.

____ 8. I have thoughts of ending my life.

____ 9. I feel weak.

____ 10. I feel fearful.

____ 11. After heavy drinking, I need a drink the next morning to get going.

(If you do not drink, mark "Never")

____ 12. I find my work/school satisfying.

____ 13. I am a happy person.

* Lambert & Burlingame, 1996

____ 14. I work/study too much.

____ 15. I feel worthless.

____ 16. I am concerned about family troubles.

____ 17. I have an unfulfilling sex life.

____ 18. I feel lonely.

____ 19. I have frequent arguments.

____ 20. I feel loved and wanted.

____ 21. I enjoy my spare time.

____ 22. I have difficulty concentrating.

____ 23. I feel hopeless about the future.

____ 24. I like myself.

____ 25. Disturbing thoughts come into my mind that I cannot get rid of.

____ 26. I feel annoyed by people who criticize my drinking (or drug use).

(If not applicable, mark "Never")

____ 27. I have an upset stomach.

____ 28. I am not working/studying as well as I used to.

____ 29. My heart pounds too much.

____ 30. I have trouble getting along with friends and close acquaintances.

____ 31. I am satisfied with my life.

____ 32. I have trouble at work/school because of drinking or drug use.

(If not applicable, mark "Never")

____ 33. I feel that something bad is going to happen.

____ 34. I have sore muscles.

____ 35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.

____ 36. I feel nervous.

____ 37. I feel my love relationships are full and complete.

____ 38. I feel that I am not doing well at work/school.

____ 39. I have too many disagreements at work/school.

____ 40. I feel something is wrong with my mind.

____ 41. I have trouble falling asleep or staying asleep.

____ 42. I feel blue.

____ 43. I am satisfied with my relationships with others.

____ 44. I feel angry enough at work/school to do something I might regret.

____ 45. I have headaches.

Scoring: Items 1, 12, 13, 20, 21, 24, 31, 37, and 43 are reverse coded. The Total score is calculated by summing all individual items. Total scores (≥ 64) reflect increased distress related to experiencing a high number of symptoms, interpersonal difficulties, and decreased satisfaction and quality of life. The Symptom Distress subscore is calculated by summing scores for items 2, 3, 5, 6, 8, 9, 10, 11, 13, 15, 21, 22, 23, 24, 25, 27, 29, 31, 33, 34, 35, 36, 40, 41, 42, and 45. Symptom Distress subscores (≥ 37) indicate subjective discomfort related to intrapsychic symptoms of depression, stress, and anxiety. The Interpersonal Relations subscore is calculated by summing scores for items 1, 7, 16, 17, 18, 19, 20, 26, 30, 37, and 43. Interpersonal Relations subscores (≥ 16) reflect problems in interpersonal relations. The Social Role subscore is calculated by summing scores for items 4, 12, 14, 21, 28, 32, 38, 39, and 44. Social Role subscores (≥ 13) indicate dissatisfaction, conflict, distress, and inadequacy in performance of tasks related to employment, school, family roles and leisure life.