Sexuality in the Therapeutic Relationship: An Interpretive Phenomenological Analysis of the Experiences of Gay Therapists.

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Abstract

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) clients have reported experiencing heterosexist/homophobic attitudes from heterosexual therapists, but this has seldom been discussed for gay therapists. Such experiences could impact the therapeutic process and a gay therapist's willingness to self-disclose their sexuality. Selfdisclosure of sexuality can be therapeutically beneficial for LGBTQ or heterosexual clients. Semi-structured interviews were conducted with seven gay male therapists and analyzed using Interpretative Phenomenological Analysis. Five themes emerged: affinity for working with LGBTQ clients, heterosexual males' resistance to the therapeutic process, the impact of homophobia within the therapeutic relationship, empathy through shared humanity, and utilizing therapist sexuality as a tool within the therapeutic relationship.

Keywords: Gay, LGBTQ, therapist, self-disclosure, homosexual, sexuality, heterosexism, homophobia.

Background

Homophobia and heterosexism are unfortunately both common (Barker, 2007; Ellis, 2007; Herek, 2009; Peel, 2001) and recognized to have a negative impact upon lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals' psychological wellbeing (Koh & Ross, 2006; Meyer, 1995; Pitts, Smith, Mitchell, & Patel, 2006). This negative social phenomenon has a pervasive negative influence in both day-to-day social encounters and less overt interactions, such as therapeutic practice with LGBTQ clients (Evans & Barker, 2010; Ryden & Loewenthal, 2001). It is therefore likely that similar attitudes could influence therapeutic relationships from the mirroring perspective of LGB therapists working with heterosexual clients.

Psychological therapeutic practices, such as those proposed by the ethos of counseling psychology, have moved away from the notion of how to "treat" clients, instead placing emphasis on how to "be with" them and just as importantly on "being-in-relation" to these clients (Strawbridge & Woolfe, 2010). Therefore, who a therapist is as a person is an integrative factor to all therapeutic relationships. It can be argued that one key element that impacts an individual's identity is his or her sexual orientation (Hicks & Milton, 2010).

This leads to the assumption that therapist sexuality can be a source of affinity or conflict within the therapeutic relationship, suggesting that the negative effects on therapeutic relationships that lesbian, gay, and bisexual (LGB) therapists are likely to experience, could disturb the therapist's ability and ease in being-in-relation to their clients (e.g., practices such as selfdisclosure).

Therapist self-disclosure could refer to any action that could reveal the sexuality of the therapist (Zur, 2011). Purposeful and verbal self-disclosure (as opposed to unavoidable and accidental, for example), has been deemed a relatively less employed therapeutic intervention. Hill and Knox (2002) found in their review of several studies examining therapist verbal behaviors that of all the interventions therapists employed, self-disclosure accounted for a mean of 3.5% of all therapeutic techniques utilized. Despite its less frequent use in relation to other therapeutic interventions, employment of self-disclosure was still described as one approximately 90% of therapists had previously used in their practice (Henretty & Levitt, 2010) and one that could foster a positive therapeutic relationship (Kolden, Klein, Wang, & Austin, 2011). Other benefits associated with purposeful self-disclosure included clients being more likely to want to see the therapist again, a better rating of the therapist (including their skills), increased reciprocal self-disclosure by the client, and normalizing of the client's experiences (Farber, 2006; Henretty & Levitt, 2010; VandeCreek & Andstadt, 1985). Potential drawbacks included; shifting the therapeutic focus away from the client, potentially confusing the client and altering therapeutic boundaries (Hill & Knox, 2002).

When discussing the experiences of any LGBTQ individual, whether therapist or client, it is worth considering society's attitude toward such sexual identities. There have been a number of positive developments in many Western countries for LGBTQ individuals, where public opinion has become more positive and discrimination based on sexuality is generally opposed (Herek, 2009). Despite these advances, anti-LGBTQ behaviors including victimization and hate crimes are still prevalent (Clarke, Ellis, Peel, & Riggs, 2010), with some brutal anti-gay campaigns occurring, for example, increasing discrimination of LGBTQ people in Russia (Rosenberg, 2013). A common but less aggressive discrimination occurs in the form of heterosexism, the assumption that heterosexuality is the only "normal" sexual orientation.

This has been described as “mundane” in its nature due to its frequency and how it is often unchallenged (Peel, 2001).

LGBTQ individuals are likely to share experiences, such as minority stressors, based on mutual identification of LGBTQ sexuality. This mutual understanding is visible in the therapeutic context through a consistent report of LGBTQ clients’ preference for a therapist of the same sexual orientation (Haldeman, 2010; Hicks & Milton, 2010), even when discussing nonsexuality-related issues. This could be partially attributed to an LGB therapists’ probable gay affirmative approach (Davies, 1996; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). Liddle (1996, p. 396) stated such pairings are said to "increase the probability of a satisfactory therapy experience" and be linked to a longer lasting therapeutic relationship (Liddle, 1997) compared with LGB clients with heterosexual therapists, based on her participants (*n*=392) who had experience being clients and having seen a median of three therapists of various sexualities. This demonstrates that the societal context in which LGB therapists practice has influence upon their therapeutic relationships. Such affinities of LGB clients for LGB therapists could predict a similar preference held by LGB therapists, although there is no evidence of this in the current literature to the writers’ knowledge.

The compatibility between LGBTQ clients and therapists appears to correlate with the use of therapist self-disclosure in their therapeutic relationships. In Lea, Jones, and Huws’s (2010) Interpretative Phenomenological Analysis (IPA) study, participants (*n*=8) noted that their LGB clients could feel judged by heterosexual therapists. However self-disclosure of LGB therapists’ sexuality to remove assumptions that their sexuality was heterosexual could be both normalizing and demonstrate understanding. Atkinson, Brady, and Casas’s (1981) gay male participants (*n*=84) rated LGB therapists who self-disclosed sexuality more positively.

Purposeful self-disclosure with heterosexual clients also has limited discussion within the literature, although these appear to have mixed findings. Dean (2010) hypothesized that disclosure by sexual minority therapists would result in a negative rating of the LGB therapist by heterosexual clients. Using vignettes with participants (*n*=308), nonsignificant results were found. Lynne, Gauler, Ralph, and Hutchinson (2011), however, found that when heterosexual undergraduate students (*n*=238) answered questionnaires based on transcripts where a gay counselor self-disclosed his or her sexuality or instead made a reflective statement, the counselor was rated significantly more trustworthy when he or she self-disclosed sexuality. Haldeman (2010) revealed in his reflective piece that one of his female heterosexual clients benefited from his self-disclosure because it allowed her to work therapeutically with a male, despite having personal difficulties engaging with men in general. Martin (2005) on the other hand in his reflective paper believed that self-disclosure of his sexuality was not necessary for the majority of his therapeutic work due to having other ways to relate to his clients, such as being a son, a friend, or an outsider. Moore and Jenkins (2012) conducted an inductive thematic analysis of lesbian and gay counselors and psychotherapists (*n*=8) and their perceived benefits and costs to self-disclosure with heterosexual clients. They reported a common theme of these therapists' experiencing high levels of anxiety and vulnerability in relation to self-disclosure, fearing judgment and wanting to self-protect from potentially unaccepting and homophobic clients.

There is evidence that homophobia and heterosexism are still prevalent in today's society (discussed previously) and claims that heterosexism and/or homophobia can lead to therapeutic breakdown and negative effects for LGB clients (McHenry & Johnson, 1993; Ryden & Loewenthal, 2001). However, there is no known research exploring the experience of LGB therapists who are likely at some point to encounter some form of discrimination

based on their sexuality from clients and the impact this has on the therapeutic process, both for the therapist and the therapeutic relationship.

The aim of this study was to supplement the relatively limited research of LGB therapists' experiences of heterosexism and/or homophobia within the therapeutic relationship on themselves and the therapeutic process, while also examining the perceived differences between working with heterosexual and LGBTQ clients from the perspective of the therapist. Particular attention was also paid to the role of self-disclosure and how it is utilized with both LGBTQ and heterosexual clients.

Method

Qualitative Approach

Interpretative Phenomenological Analysis was adopted for the current study. The phenomenological philosophical approach places emphasis upon the lived experiences of the participant (Smith, 1996; Smith, Flowers, & Larkin, 2009). This approach was chosen because the literature in this particular research area was deemed still in its infancy and so a ground-up exploration of participants' experience was thought likely to be helpful in developing a clearer understanding of the experiences of LGB therapists.

Within this approach it is understood that researcher interpretations are not free from bias and therefore the research represents "double hermeneutics," meaning that the process takes into account not only how participants are making sense of their lived experiences but also how the investigator is attempting to understand how the participants' were attempting to understand and communicate their recalled experience in the present moment (Eger, 1999).

Recruitment & Participants

Three routes were used to recruit participants: (1) an advertisement was placed on "Counselling Psychologists UK" and "Counselling Psychology and Psychotherapy Training" Facebook pages, (2) an advertisement was delivered through the West Midlands branch of The British Psychological Society, and (3) direct emails were sent to potential participants known through networking.

Seven participants took part in this study (n=7) (Table 1). The first of the inclusion criteria potential participants had to meet was that they were male and identified as gay or homosexual. This was to ensure a homogenous sample that adheres to the qualitative paradigm proposed by using an IPA method (Smith et al., 2009). Other inclusion criteria included: (1) either accredited counseling psychologists, clinical psychologists, counselors, psychotherapists, or counseling psychologists in training; (2) had experience of working therapeutically with heterosexual clients; or (3) had experience of working therapeutically with LGBT or queer clients.

TABLE 1 Participant Demographic Information

Characteristic	Information
Job title, role, and country training took place	4 × counselling psychologist. Trained to provide psychotherapy. UK. 1 × clinical psychologist. Trained to provide psychotherapy. UK. 1 × counsellor. Trained to provide psychotherapy. UK. 1 × counsellor and counselling psychologist in training. Trained to provide psychotherapy. UK. 1 × mental health nurse and counselling psychologist in training. Trained to provide mental health support. Training to provide psychotherapy. UK.
Age	1 × 21–30 years 1 × 31–40 years 3 × 41–50 years 1 × 51–60 years 1 × 61–70 years
Ethnicity	3 × White British 2 × White European 1 × Black British African-Caribbean 1 × Mixed White and Black British African-Caribbean
Years practising talking/psychological therapies	Range 6–35 years

Trainee counseling psychologists were included in the sample because U.K. training courses in counseling psychology require a minimum of a certificate in counseling and more than 100 hours therapeutic experience to train (e.g., The University of Wolverhampton, 2013) and so would have a sufficient level of self-awareness to utilize in the interviews. Institutional ethical approval was sought and granted before any participant contact commenced.

Interview Development and Procedures

The interview schedule was based on a review of related literature and informed by the first investigator's (JP) own experience of identifying as a gay male and a counseling psychologist in training at the time. Questions were also created to facilitate and encourage participants to verbally explore their relevant experiences and their meaning. The interview topics consisted of five areas: opening questions, sexuality and identity, working with clients of differing sexualities, optional vignettes, and concluding questions.

Participants were also given the option to choose their own pseudonyms to ensure anonymity. They were also assured that any information that could allude to participant identification was removed from the transcript. All participants gave written consent for the interviews to be conducted and data used for publication. Interviews and engagement with participants was conducted in accordance to *Code of Ethics and Conduct* published by the British Psychological Society (2009). All interviews were audio recorded and later transcribed. Interviews took place at the convenience of the participants for a period of approximately one hour (interviews ranged from 30 to 90 minutes).

Data Analysis

Data analysis was conducted in accordance with the processes suggested by Smith et al. (2009) by the first author (JP). An idiographic approach was adopted, analyzing each transcript individually to produce detailed accounts. This resulted in a descriptive core of comments, with a clear phenomenological focus, while also making connections, interpretations, and interlinking concepts within each transcript. These notes then formed the foundation of emergent themes that aimed to encapsulate the meaning of the participants'

accounts and entwine them with the interpretation and understanding reported by the investigator.

The other members of the research team (LHW) and (DC) also made credibility checks to ensure and confirm that the analytical interpretations were grounded in the data and that no important potential emergent themes had been overlooked. Any oversights that were highlighted by either (LHW) or (DC) resulted in another read through and coding for each of the transcripts to incorporate this potential data trend into the emergent themes created.

Reflexivity

The interviews were all conducted by (JP), who identifies as a gay man and who accepts this identity as part of a minority group. He was in the second and final year of his training as a counseling psychologist when the study was conducted, having worked therapeutically in an adult mental health services and predominantly within child and family mental health services. He described his preferred therapeutic style as an integration of humanistic and psychodynamic orientations. JP had worked with both heterosexual and LGBTQ clients, but he had never self-disclosed his sexuality in a therapeutic relationship. He had, however, on a number of occasions experienced heterosexist attitudes, had a few experiences of indirect homophobic attitudes, and frequently encountered the assumption that he himself was heterosexual, from his clients.

The investigator (JP) had personal insight into the impact differing sexualities could have on therapeutic relationships. The limited published works in the area of differing sexualities in the therapeutic relationship led to the conception of this research. Therefore, he only had a

few of his own personal assumptions and loosely related published works to provide insight into potential discussions that could occur in interviews.

Findings

Through the process of analysis, we found five major themes: an affinity for working with LGBTQ clients, heterosexual males' resistance to the therapeutic process, the impact of homophobia within the therapeutic relationship, empathy through shared humanity, and utilizing therapist sexuality as a tool within the therapeutic relationship (Table 2). These themes will now be discussed using grammatically corrected extracts to enhance readability.

An affinity for working with LGBTQ clients

All participants, regularly throughout the interviews, presented a preference in discussing their experiences of working with LGBTQ clients; this preference also translated into a tangible theme of an increased affinity and ability to relate to LGBTQ clients. There were emotional situations and personal experiences, which were also likely shared between gay

TABLE 2 Showing the Themes Derived From the IPA Analysis of the Therapists Accounts

Major Themes
1) An Affinity for working with LGBTQ clients.
2) Heterosexual males' resistance to the therapeutic process.
3) The impact of homophobia within the therapeutic relationship.
4) Empathy through shared humanity.
5) Utilising therapist sexuality as a tool within the therapeutic relationship.

therapist and LGBTQ client. It appeared that this could not only feed into compatibility for working with LGBTQ client:

> *There is a stronger desire, to free them and not just in terms of their sexuality but whatever it is that they might be coming from . . . the minute I get presented with a gay person or a lesbian person or a trans person or someone who identifies as queer or you know rejects binary gender systems, I have a desire to create a world in the therapy room that can, allow them to grow because I doubt many other situations that they come into allow them to do that because of oppression and stigma. (Harrison)*

There is a strong sense that both gay therapist and LGBTQ clients share certain experiences, this translated into a motivation to compensate for negative experiences which the gay therapist had "insiders knowledge" about, by creating a therapeutic space which could be more productive for the client to reach self-actualization. One potential method to this was through self-disclosure:

> *I think it can lead to a deeper communication I've certainly experienced that in the past. . . I worked with a guy for probably six or seven sessions . . . and it was just so natural to share that I was gay too and it just kind of meant we didn't have to beat around the bush. (Mark)*

This natural effect almost appeared like an unspoken understanding that both individuals were connected through their shared experience of identifying as part of the same minority. This seemed to also lead to a certain congruence in communication where both therapist and client could "get to the point," in a sense removing a barrier that could appear by exploring meanings behind the client's perspective, which may not be that conducive to therapeutic outcome.

Heterosexual males' resistance to the therapeutic process

Highlighted throughout all the interviews was reference toward heterosexual men as a source of comparison and often difference in the participants' self-appraisals and how some of these differences could create a barrier in therapy:

> *One of the things that is really interesting about working with (straight) men, is that social norms and expectations of what it means to be a proper man [said emphatically] that heteronormative masculine thing is so present, so much there really I see it all the time. (Mark)*

The gender roles placed upon heterosexual males appeared to be a crucial difference that presented itself between the gay therapist and the heterosexual male client. These were found present within the therapeutic relationship between heterosexual males and gay therapists:

> *I just think you start in a different place . . . straight men I've worked with in therapy say, "you're not making me cry," "I'm not doing that," so I'll reply, "fine what do you want to do here ... if you don't want to cry that's up to you I'm not going to sit here and force you to do anything". . . all the time ensuring that they're feeling safe enough to let go with you. (Adam)*

It was presented by all participants that what heterosexual male clients expected from entering into a therapeutic relationship comes into conflict with the identity they have of themselves and what is perceived as acceptable for a heterosexual male. This key difference between the heterosexual client and gay therapist was not only present due to differing gender norms but also the qualities most therapists are likely to represent, for example, verbalizing difficult issues and expressing emotions. There does, however, appear to be something threatening about the position the gay therapist plays in these interactions:

> *There is a fear of being penetrated and obviously I don't mean that literally, but the idea of being penetrated by another man, is a very anxiety provoking thing it kind of switches roles, and then if you're a gay man it adds something even more difficult for them to experience . . . therapy is all about that relationship evolvement and someone allowing you to get inside of them in terms of their emotions and experiences, and I've had lots of therapy experiences where that has been the block, especially with straight men. (Harrison)*

A proposed fundamental component of talking therapies could be the exploration of personal and private aspects of one's life. This was reported by the participants as being unorthodox and uncomfortable for many heterosexual male clients, contributing to a relational barrier between therapist and client. This was in part attributed to gender roles and to potential stigmatization against gay males.

The impact of homophobia within the therapeutic relationship.

It was reported that all the therapists had at some point experienced heterosexist or homophobic attitudes from clients, said both directly and indirectly. These comments were described as having an impact upon the therapist and could be described as hurtful:

> *Well I do feel sad, if I've been working with somebody and because of an aspect of me well it is a rejection in a sense isn't it? And they're actually saying, "part of you is not acceptable to me," now that is not very nice. (Adam)*

Essentially, such attitudes from clients would hold the therapist in a negative light if their sexuality was known, which could be information only known by the therapist, this could result in an internal dialogue:

> *Even though the comment is quite harmless there's a little moment of surprise that people still hold on to these ideas ... and I suppose the feeling was, one of those little moments of surprise . . . where you feel a bit puzzled, I didn't see this coming what the hell do I do with this now? Do I laugh and agree? Or do I ignore it? At the time I chose to ignore it. (Craig)*

On a therapeutic level, a therapist's focus could shift from the client's frame of reference to their own and their own understanding of sexuality. To the point where in Craig's case he felt unsure on how to respond, even considering colluding with the client's heterosexist/homophobic attitude, at the expense of his own beliefs. It could also be expected for such an incident to have more long-term impact on the therapeutic process:

> *I can have a kind of massive over sense of responsibility for making things alright for (clients) and so when clients have said, negative things or insinuated things or sometimes even if they just use the word "gay" to mean bad in a room with me it will kind of reduce that feeling of responsibility . . . I find that I kind of move back, almost in a punishing way which isn't very therapeutic. (Harrison)*

On a relational level, such attitudes originating from clients could lead to the therapist employing unconscious defenses to deal with these situations. An unfortunate consequence of such a reaction could be the therapist being unable to fully act in the best interest of the client. Harrison and Andrew even commented on how such incidents could remind them of earlier abusive memories of homophobia, explaining why these defenses were employed. It was also discussed that should gay therapists find the attitudes too distressing, they themselves could choose to end the relationship:

> *I would say "go on give him another therapist" you know, do I really need to put myself through that then through their experience ... I'm not putting myself in these*

> *situations . . . because I feel eventually those beliefs rub off on me . . . someone can be very erosive about someone's self-concept. (Alex)*

In what could be deemed as an act of personal protection, a therapist like Alex could end the therapeutic relationship and be unable to maintain the ideal conditions of such a relationship due to attitudes held by the client. It could be understood that their sexual orientation is an aspect of the therapist, which could have been a reason for stigmatization in the past. If a homophobic attitude were to be present within the client this could potentially lead to relationship break down. Adam described that if this were to occur he would still act in the client's best interest regardless.

Empathy through Shared Humanity

Although evidence of affinities and differences have been demonstrated regarding the dynamics of sexual orientation of therapist and client, an underlying understanding was that as a therapist, regardless of sexual orientation, there was an ability to empathize and work therapeutically with clients of any sexuality:

> *(When working with) let's say a heterosexual man . . . I seem to be able to make a relationship with these people whether they have come from the army or are a biker. (Andrew)*

As a therapist, where the therapeutic relationship is of utmost importance, all participants noted how they were able to form this therapeutic alliance with the people they were working with. Although sexual orientation was a factor and an important one, it was still only one

aspect of what it means to be an individual; more broadly by being human there are a number of ways to relate to one another:

> *I forget people are different you know you see people as human beings, I think I don't see people as a straight person or a gay person it's people are human beings and you see that first. (Craig)*

The emotional connection that could take place between therapist and client could almost go beyond the interactions that could be linked to sexual orientation. Andrew and Jeffrey also voiced how therapists cannot relate to every aspect of a client's experiences, but they can empathize and perhaps relate in other ways that are common to the human experience:

> *The world is set up to be straight and I know far more straight people than I know gay people either professionally or personal my world is full of straight people, and if I couldn't empathize with them I probably wouldn't be able to live in the world. I think there are lots of similarities between gay people and straight people by virtue of being a person. (Harrison)*

Ultimately there are many ways a gay therapist can connect to his clients, and sexuality does have an impact on that. More importantly, there are other similarities and shared understandings which can connect two individuals together within a therapeutic relationship.

Utilising therapist sexuality as a tool within the therapeutic relationship.

Through the interviews the topic of self-disclosure of sexuality was explored with all participants, and it became clear that such a disclosure in the therapeutic relationship was a multifaceted intervention that could be used to communicate personal qualities such as congruence:

> *I remember one client where it became very clear that I needed to be authentic with this person or I knew they would never trust me again and I said, "I think it's important for you to know that I'm gay" and he said "I have to go" ... I said to him "of course you would like to leave but I would much rather that you stayed" . . . he returned and he said, "I don't know what all that was about," and I gave him lots more opportunity to scrape around this, but that had an effect and most good healing relationships need authenticity. (Andrew)*

There was a strong link between gay therapists' use of self-disclosure as a way of being congruent with some of their clients. Being gay in Andrew's experience represented some safety for some clients and self-disclosure was a way of utilizing that safety:

> *I was working with a woman who had been quite severely abused and it involved Eye Movement Desensitization and Reprocessing therapy, and I was aware that I was sitting nearer to her and that she was uncomfortable so I said, "are you uncomfortable?" and she said "I am a bit" . . . and I said "would it help if you knew that I was gay?" and she said, "I think it would really," and this wasn't psychodynamic work, it wasn't about transference so in that situation it seemed the ethical and right and even good creative work really. (Andrew)*

One's sexuality in this example was a tool to help Andrew create a safe space from the client's perspective to continue therapeutic work. There was not the claim that this intervention could be used to address all deep-rooted issues, but it did allow the therapist to increase the comfort of the client to work on other difficulties.

A general consensus throughout all the interviews was that, if given the choice, each participant would prefer his or her own sexual orientation to be open and known without need for discussion with clients; this, however, was discussed as an unrealistic preference. This led

to the topic of priority within the therapeutic relationship whereby the needs of the client always took precedence:

> *Even when they've challenged me or been very critical, about me or the possibility that I might be gay I still haven't disclosed because I've thought that's about me and not about them . . . and sometimes it isn't about my right to educate people that are coming to me with distress about their values about gay people, bi people or lesbian people. (Harrison)*

In line with the desire for sexuality to be open and unquestioned also came the passion to make people aware of prejudices. However, this could conflict with the fundamental rule of placing the client's needs first. It was deemed just as important to choose when not to self-disclose:

> *I think there is something about holding the space and allowing the client to make you into what they need you to be without knocking all of that down and saying, "actually I'm gay." (Mark)*

The use of sexuality is a powerful tool and the use of such an intervention is equally important as choosing not to self-disclose. Mark, Jeffrey, Craig, and Harrison voiced how sometimes to be in the best service of their clients required them to not self-disclose so as to allow the client to project needed perceptions of the therapist on to them.

Discussion

This study has contributed to the extant literature in this area in a number of ways: It has provided some insight into the experiences of gay male therapists working with both heterosexual and LGBTQ clients; discussed the experiences that homophobic and/or

expressed heterosexist attitudes can have in the therapeutic process from the perspective of the gay therapist; and, through the accounts presented, given further insight into the use and purpose of self-disclosing sexual orientation to a client.

A common message portrayed was that the pairing of a gay therapist with a client of the same sexual orientation would be perceived as a positive occurrence for the participants in this study. Such a perception could be interpreted to potentially lead to beneficial inferences for the therapeutic relationship, which accords with previous findings (Atkinson et al., 1981; Israel et al., 2008; Liddle, 1996). Previous positive therapeutic outcomes reported in this literature had been related partially to LGB clients having a perceived preference for LGB therapists (Isay, 1991; Liddle, 1997; McDermott, Tyndall, & Lichtenberg, 1989) and potential shared experiences (Lea et al., 2010).

This IPA study found that the participant's mirrored this positive perception. This preference shared some commonalities with Lea et al.'s (2010) study whereby the participants understood negative experiences their clients likely experienced due to living in a "heternormative" culture. This translated into the participants sometimes self-disclosing their sexual orientation, resulting in greater rapport and strengthening the therapeutic relationship. This affinity to LGBTQ clients could be explained partly by the notion of in-group bias whereby clients being members of an LGBTQ group have positive feelings toward other members of this group, which can result in preferential treatment and a sense of safety that the other member of this group will not discriminate against them (Anderson & Klatzky, 1987; Brewer & Brown, 1998).

This study reports, a more candid and truthful communication between gay therapist and LGBTQ client following self-disclosure. This could be linked to certain subcultural social norms (Yinger, 1960) that individuals of a shared sexual orientation may hold, for example, candid communication.

It became clear through participant accounts that heterosexual males as clients were a source of comparison and difference, sometimes resulting in a barrier to the therapeutic relationship formation. Relevant reflection by Haldeman (2010) discussed his enjoyment of working with heterosexual men; however, this pleasure partly derived from their differences and a shift in power to the gay male, which did not usually occur in day-to-day life. Participants in this study loosely explained these "differences" through the recognition of different gender role pressures. Mahalik et al. (1998) referred to gender roles as *"specific behaviors that men and women enact congruent with the socially constructed ideals of masculinity and femininity"* (p. 247, emphasis added) and it could be theorized that heterosexual males could be more defensive in therapeutic settings due to male gender-role conflict (O'Neil, Helms, Gable, David, & Wrightsman, 1986) and a need to avoid behaviors associated with feminine roles such as expressing emotions or affection to other men, which are likely to be expected as part of the therapeutic experience (Schaub & Williams, 2007).

Discussion of the impact of homophobia within the therapeutic relationship was an area this study was greatly interested in; due to the distinct lack of research into the impact of homophobia in a therapeutic relationship experienced by the therapist. Based on related literature, it was hypothesized that homophobic attitudes would infiltrate into some therapeutic relationships (Evans & Barker, 2010; Herek, 2006; Ryden & Loewenthal, 2001). Relatable work from Mohr (2002) suggested that heterosexual therapists with a more positive attitude towards LGB people tended to result in more positive and affirmative therapeutic relationships with LGB clients, whereas those with more negative attitudes appeared to be less attentive to their needs and have a negative impact. This IPA study goes on to add to this research deficit to state that the participants did indeed experience homophobic attitudes in the therapy room and these had some negative effects both on the therapist and the therapeutic relationship.

It was reported that although therapists understood it was their duty to be nonjudgmental of their clients, and witnessing such attitudes (in their clients) was part of their professional identity; it did cause them sadness, cause them to lose focus on the client's frame of reference, and sometimes even become slightly defensive, choosing to detach somewhat on an interpersonal level, and hence could potentially damage the therapeutic relationship. One potential explanation for such defense/coping mechanisms could be an attempt to avoid internalizing such homophobic attitudes (Sophie, 1987).

Lea et al.'s (2010) study discussed the complexity of self-disclosure of sexuality. This study further explored the deeper meanings gay therapists associate with their self-disclosures. Self-disclosure was employed to communicate understanding and experience associated with identifying as gay while being gay affirmative (Davies, 1996), demonstrating that claiming a LGBTQ identity as a valid and healthy choice. Comparisons between selfdisclosure of their sexual orientation and being congruent with their clients to foster their therapeutic relationship (Rogers, 1957) were made.

Homophobic and/or heterosexist attitudes reported in this study by the participants provides further insight into the works of Moore and Jenkins (2012), suggesting why gay and lesbian therapists in their study could feel anxious and vulnerable regarding the option of self-disclosure to heterosexual clients. This study suggests that due to the experiences that our participants had of such attitudes, that a potential expectation of 'rejection' is warranted with some clients.

Recommendations

It is hoped that through publication and dissemination that this information can be more widely received to provide further insight into therapeutic intricacies for LGB therapists. Perhaps qualified practitioners can utilize this information in their practice, and trainees may find it useful to be considered for training purposes and in modern LGBTQ texts.

A key limitation and strength resulted from using a small homogenous sample. A limitation would be found in the transferability of this study to other LGB therapists in general (Pringle, Drummond, McLafferty, & Hendry, 2011). As the aim of this study was to investigate at a deeper experiential level (Smith et al., 2009) a small homogenous sample was necessary to achieve this and so should be viewed as placing privilege upon the individual participant experience. It would however be hypothesized that many of the reported themes regarding homophobia and heterosexism would be transferable to other LGB therapists.

In regards to further studies Dean (2010) and Lynne et al. (2011) quantitatively investigated the impact of LGB therapist self-disclosure on heterosexual clients, both from the perspective of heterosexual clients. This suggests that similar quantitative studies would be required, from the perspective of the LGB therapist, who may have deeper understanding and knowledge on the impacts of the therapeutic relationships from their own practice based evidence. It would also be fitting to investigate qualitatively the self-disclosures reported from LGB therapists from the perspective of heterosexual clients.

Conclusion

This IPA study was cultivated to investigate the experiences of gay male therapists in relation to their sexuality in the therapeutic relationship. Previous studies report that LGB clients can have a preference for therapists of the same sexuality; this study's participants shared this preference. The LGB therapists within this study also reported self-disclosing their sexuality to both LGBTQ and heterosexual clients. Self-disclosure was more frequently used with LGBTQ clients as a method to communicate qualities such as congruence, understanding, and normalizing. Participants also utilized such self-disclosure with heterosexual clients, which could facilitate therapeutic change in the clients and even represent safety. Therapists in this study recited experiencing homophobic attitudes from some of their clients producing a "barrier" to the therapeutic relationship, furthermore working with heterosexual male clients was said to involve a resistance to the therapeutic process from some heterosexual males. Ultimately the most important factors to gay male therapists in this study however were holding their clients' needs as top priority and relating through a shared humanity, regardless of sexual orientation. This study provides a rich experiential perspective on the topic and further quantitative investigation would be appropriate.

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Appendix 1

Interview Schedule

Opening questions and background information

1) How many years have you been practising therapy?
2) What is your current place of work and client group?
3) What therapeutic orientation(s) do you work in?
4) Approximately how many gay clients have you worked with and what context did this work take place?

Sexuality and Identity

5) Could you describe to me the steps you took to 'come out' and how the whole situation took place?

- What emotions and thoughts did the experience bring up for you?
- What impact do you think coming out had on you as a person?
- What impact do you think being 'out' has on you as a therapist?
- How comfortable do you feel with your sexuality?

6) Have you ever disclosed your sexuality in a therapeutic relationship?

- What was the purpose of this and its impact?

Working with clients of different sexualities

7) What differences (if any) have you experienced between working with gay clients and straight clients?

8) Would you be more likely to self-disclose to a client of certain sexuality? Or any particular characteristics?
9) Are there any differences between relating and/or being empathic to straight and LGBTQ clients?

Conclusion

10) Considering the areas we discussed today, are there any questions you think I should have asked, which I didn't?