Sex, Dishonesty, and Psychotherapy

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ABSTRACT

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Purpose: Honest disclosure about salient information is at the heart of the therapy process but sexual material has been found to be among the most frequently concealed types of content. Understanding why clients choose to be avoidant or explicitly dishonest about sexual topics may attune therapists to the types of concerns clients have when deciding whether or not to disclose this material, how non-disclosure or dishonesty about sex impacts therapy, and what would help clients be more honest about such material. This study directly queried clients who had been dishonest about four types of sexual content in order to learn how therapists can better promote honest disclosure about different domains of sex and sexuality.

Method: As part of a comprehensive study of client "secrets and lies," a sample of 798 outpatient therapy clients rated their dishonesty or honesty about four sexually related topics ("details of my sex life," "my sexual desires or fantasies," "my sexual orientation," and "times I have cheated on a partner") and completed measures about attitudes toward disclosure along with ratings of the therapeutic alliance. Follow-up samples of clients who stated that a sexual topic had been hardest to talk about in therapy answered multiple-choice and open-text questions about their motivations for being dishonest with the therapist, how it impacted them in terms of therapy progress and feelings about the decision, and what they believed the therapist could do to help them be more honest about this topic.

Results: Two types of sexual content – "details of my sex life" and "my sexual desires and fantasies" – were the most common topics of dishonesty across the whole sample. Dishonesty about sex tended to manifest in total avoidance of the topic in therapy. Approximately 80% of clients indicated that their motivation for dishonesty was to avoid shame or embarrassment, while smaller

numbers reported concerns about how the therapist would react to the disclosure. These clients cited worries about being stigmatized or judged, or felt unsure that the therapist would understand or be able to help; some referred to their belief that the therapy relationship could be jeopardized if they were more disclosing, a particularly salient theme for those who had been dishonest about sexual orientation and sexual fantasies. Based on a multiple choice format, a majority stated that their dishonesty about sexual issues had "no effect" but in an open-text format, a majority described more negative impacts, mainly the inability to address a relevant topic. A significant number of clients felt conflicted, guilty, or regretful about being dishonest, though some felt largely neutral; very few had positive feelings. When asked what would help facilitate honesty, about 80% of clients stated their wish for the therapist to "ask directly." Some differences occurred in terms of specific facilitators based on topic. For instance, clients who had concealed a more overtly sexual topic (e.g., "details of my sex life" and "my sexual desires or fantasies") wanted the therapist to normalize or provide a rationale for why it would be helpful to disclose; clients who concealed their sexual orientation wished for the therapist to display cultural competence and to ensure the safety of the relationship; and clients concealing infidelity were unsure if there was anything the therapist could do.

Limitations: The findings of this study may be limited in its generalizability due to a few key factors. First, the sample contained a majority of highly educated Caucasian female clients, which mirrors the therapy-seeking population but may not accurately reflect the concerns of male or minority clients. Second, it was comprised solely of individuals who were willing to speak more about their experience in therapy, while the follow-up samples contained respondents who identified that a sexual topic had been hardest to talk about in therapy. Finally, self-report data is by its very nature limited by the willingness of clients to answer accurately. As such, it is unclear how these data extend to the general or clinical population more broadly.

Conclusions: The concerns expressed by clients suggest that shame and the anticipation of a negative therapist reaction primarily motivate sexual dishonesty, and that direct inquiry by the therapist can help alleviate both of these interconnected worries by signaling that sex is a welcomed topic of disclosure. These findings also indicate the high prevalence of dishonesty about a spectrum of sexual topics and highlight the way that clients tend to avoid these discussions, which further supports the need for more active therapist intervention to frame the rationale and normalize honest discussion about clinically relevant sexual material.

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Dedication

To the 798 psychotherapy clients who were generous and courageous enough to share their experiences with me.

Introduction

This study aims to bring a greater understanding to an under-explored yet common occurrence in psychotherapy: client dishonesty about sexual material. Its goal is to use client narratives to elucidate a) the motivations for being dishonest about specific types of sexual content; b) the impact this dishonesty has on therapy; and c) clients' beliefs about what might facilitate honest disclosure about these intimate topics when it is relevant to do so. In addition, this work will contribute more specificity and depth to the existing literature by providing data about different types of sexual content that are withheld or lied about and exploring whether certain demographic, personality, and/or dyadic variables can distinguish clients who are honest or dishonest about sex.

Disclosure (or non-disclosure) about sex has had a prominent role in psychotherapy since its nascence, beginning quite notoriously with Freud's (1898) challenge to the then-prevailing dictum that a clinician had "no right to intrude upon his patient's sexual secrets and grossly injure their modesty" (p. 79) and his emergent belief that repressed sexuality play a significant role in virtually all neurotic illness and thus needed to be explored. The relationship between sexuality and emotional disorders is now considered more complex, but it is inevitable that therapists will be presented with all types of sexually-related material over the course of their careers, as psychologists are often the principal referral source for health care providers and physicians when clients present with sexual problems (Haboubi & Lincoln, 2003). These can range from inability to achieve orgasm to performance anxiety to discomfort with some aspect of their sex lives, their partners, their past, or the absence of a satisfying sex life at all. Prevalence data suggests that two-fifths of women and a third of men will report at least one manifest sexual problem to a physician (Dunn, Croft, & Hackett, 1998; McCabe et al., 2015), and half of patients diagnosed with a general psychiatric disorder also report suffering from a diagnosable sexual dysfunction (Wylie et al.,

2002). In addition to these comorbidities, sexual concerns are common symptoms of numerous mental disorders and are a frequent side effect of many psychotropic medications (Balon & Segraves, 2005).

However, many individuals experiencing sexual problems do not seek formal treatment for these concerns or struggle to disclose when they do. Either due to hesitancy to navigate sexual issues or because they have not identified their symptoms as linked to sexuality at all (Findlay, 2012), clients will frequently present to therapists with all types of other issues, including relationship problems, low well-being, or a general sense of life dissatisfaction, In a survey of couples in long-term heterosexual relationships, MacNeil and Byers (2005) found that 71% of women and 85% of men had one or more sexual concerns, but none reported seeking help specifically for these sexual issues; instead, they entered treatment for personal or marital problems, indicating how sexual complaints are typically intertwined with but often treated as secondary to other presenting problems or simply not discussed at all. Beyond the scope of sexual problems per se as a presenting concern, psychotherapy can be considered an appropriate and valuable setting for addressing a wide range of sexually-related topics, including sexual health, communication patterns, assertiveness with others, fantasies, fidelity, and the pursuit of pleasure as a way of enhancing life satisfaction and meaning (Butler, O'Donovan, & Shaw, 2009).

But open communication about sex is more often than not a challenging and imperfect enterprise, whether that dialogue is between children and their parents, romantic partners, or in the therapy room (Dilorio, Pluhar, & Belcher, 2003; Farber & Hall, 2002; Fisher, 1987). Even therapists, when they are psychotherapy clients themselves, find it hard to talk about sex. In Pope and Tabachnick's (1994) study of 476 client-therapists, the highest percentage of secrets concealed in treatment were about sexual issues (51%), while Martin's (2006) study of 109 psychology

graduate students found that the most prevalent material lied about in their personal therapy was about relationships (13%) and sexual behavior (7%).

It is no surprise then, while sexuality is a universal aspect of people's lives, the empirical literature indicates that sexual material is among one of the more frequent themes of client dishonesty or concealment in therapy (Baumann & Hill, 2016; Hill, Thompson, Cogar, & Denman, 1993; Martin, 2006; Norton, Feldman, & Tafoya, 1974; Pope & Tabachnick, 1994). When clients discuss sexual issues in therapy, they often do so only partially, leaving out information. In Farber and Sohn's (2007) survey of what clients disclose in therapy, some of the largest discrepancies between client ratings of salience (i.e., perceived importance of a topic) and extent of disclosure were found in the domain of sexual issues, including such topics as "the nature of my sexual experience," "my feelings about masturbation," and "concerns about sexual performance." As observed by clinical social worker Harvey Gochros (1986), "There is no area of human life cloaked in more secrecy, hypocrisy, inconsistently, ambiguous legality, ignorance, and emotionalism than sexuality" (p. 9).

Yet there has been scant empirical investigation related to clients' experience of being dishonest about sexual material in therapy, such as the motivations to conceal information about these topics, how it impacts treatment, and what would facilitate disclosure. Previous research on non-disclosure in therapy has tended to focus on a few key domains. These include classifying the most-common topics that have been lied about or kept secret in therapy (Farber & Hall, 2003; Hillet al., 1993; Kelly, 1998; Pope & Tabachnick, 1994) or to delineate any factors that are linked with non-disclosure, such as demographics, personality traits, or therapy-related variables (Farber, 2003; Fedde, 2009; Kelly & Yuan, 2009). More recent work has sought to deepen clinical knowledge about client dishonesty in therapy, including trying to identify the motives for concealing or lying about information, how the choice to not reveal to the therapist impacts clients in terms of feelings

and their sense of overall therapy process, and what clients believe helps increase honest disclosure in treatment (Blanchard & Farber, 2016; Blanchard, 2017; Baumann & Hill, 2009).

Altogether, these studies provide an important entry-point into the experience of client dishonesty more broadly, but this needs to be extended to dishonesty about sexual material. The purpose of this dissertation, then, is to clarify what is happening when clients choose to be dishonest about four types of sexual material – details of one's sex life, sexual desires or fantasies, infidelity, and sexual orientation. More specifically, the following questions are posed: How prevalent is dishonesty for each of those four sexually-related topics? What does dishonesty look like in terms of style? That is, are clients more likely to avoid certain topics entirely, or to address them but with a low degree of openness? Are there any factors (demographics, personality traits, or dyadic variables) that can distinguish between clients who are honest about specific types of sexual content as compared to those who are not? What motivates clients to be dishonest about sexual topics, and do these motivations differ depending on the type of content? What feelings does being dishonest evoke for clients? How does the choice to be dishonest impact therapy overall? Finally, what do clients believe would help facilitate honest disclosure about sexual topics?

Providing answers to each of these questions can improve clinical practice by attuning therapists to clients' experience of avoiding or being dishonest about salient sexual information. These data will help illuminate what types of concerns clients have about disclosing sexual material and help therapists provide more sensitive and effective clinical interventions.

Literature Review

Non-disclosure and dishonesty in therapy

Free and honest disclosure has been theorized as being at the core of psychotherapy since Freud delineated that clients should "be absolutely honest and never leave anything out because for

some reason or other it is unpleasant to tell it" (1913, p. 135). Presently, nearly all forms of psychotherapy highlight the value of client self-disclosure for treating psychological distress (Chaiken & Derlega, 1974; Stiles, 1995). Indeed, the fundamental structure of therapy is meant to create an atmosphere that encourages honest disclosure about one's most painful, intimate, and uncomfortable information. It is bounded by privacy and confidentiality, and takes place within the context of an attentive, positively regarding therapy relationship.

Nevertheless, clients find themselves frequently being dishonest in therapy about things that matter to them. Some may actively fabricate in order to deceive the therapist or enhance themselves in some manner (Gediman & Lieberman, 1996). Others will engage in secret-keeping (Kelly, 1998), avoid discussing their reactions to therapist interventions (Hill et al., 1993), downplay the extent to which they are suffering (Blanchard & Farber, 2016), or minimize discussion of personally relevant topics (Farber & Sohn, 2007). Even clients who report that it is "always better to disclose" still admit having some secrets (Baumann & Hill, 2016; Farber, Berano, & Capobianco, 2004).

The purpose of this literature review is to synthesize what is known about dishonesty about sexual content in psychotherapy. Because there is a dearth of empirical research in the topic area of sexual dishonesty as it applies to the unique setting of therapy, findings from the existing literature on dishonesty in therapy as a whole (that is, about any topic rather than about sexual content specifically) and from works about dishonesty or non-disclosure about sex in relevant settings, such as in a medical context or in other intimate relationships with peers and partners, will be incorporated to provide the basis for the questions this dissertation aims to address.

I will outline any known factors that are linked to dishonesty in therapy or dishonesty about sex in related settings, including demographics, individual tendencies toward disclosure or concealment of personal or distressing information with others, and dyadic variables (i.e., the therapeutic alliance). I will then highlight what has been found about the prevalence and style of

dishonesty about four types of sexual content in therapy, the motivations clients may have for being dishonest about sex, the impact of dishonesty on therapy (including the feelings that are evoked about the decision to be dishonest and its overall effect on therapy), and the possible clinical interventions that clients believe would yield more honesty.

Demographic factors.

While multiple studies have sought to identify demographic variables that are linked with non-disclosure, this has been a largely inconclusive effort. As such, I will briefly cover the mixed results that have been provided as to demographic factors that may be related to dishonesty in therapy and dishonesty about sex in particular.

Age. Though most research has found no significant association between age and disclosure (Farber, 2006), recent work by Blanchard and Farber (2016) indicated that younger clients were more likely to lie in therapy as compared to older clients, such that younger clients reported a greater number of lies across all topics.

As it relates to sexual material specifically, it has been shown that older adults find it difficult to discuss sexual concerns with healthcare professionals (Gott et al., 2004; Lindau et al., 2007). A review of the literature by Bauer et al. (2015) about the sexual experiences and sexual health of older adults (aged 65 and older) examined these themes more deeply and found that older adults are uncomfortable and hesitant to raise sexuality and sexual health issues due to negative perceptions of the healthcare professional's interest and attitudes, believing they won't understand, would be judgmental, or would have no interventions to offer. These clients also identified feelings of shame and embarrassment as motivations for non-disclosure – both about being sexually active and for having a sexual problem. They indicated that while they would not be comfortable raising the topic themselves, they would be willing to disclose openly if the healthcare professional were to inquire.

Gender (and gender roles). While the literature has been mixed on whether gender is a reliable predictor of overall non-disclosure in therapy, it seems there is a link – albeit weak – between these variables (Dindia & Allen, 1992), such that women disclose slightly more than men. Supporting this pattern, in their 2016 survey of 101 individual psychotherapy clients, Baumann and Hill found that men were more likely to conceal a secret than women.

Shifting the focus to dishonesty about sex more specifically, it is evident that both men and women likely encounter culturally based expectations around disclosure of sexual topics in psychotherapy. For women, research studies indicate that many may still feel silenced by gendered ideas about the appropriateness of talking openly about one's sexual self, desires, or problems. Women can experience talking about sex as taboo, leading to reluctance to address sexual material with others, even same-gendered peers (Hamilton & Armstrong, 2009; Muise, 2011). In an interview study of 95 diverse heterosexual women aged 20-68, Montemurro et al. (2014) found that women were uncomfortable talking about sex, identifying the fear of judgment if they expressed too much interest in sex, as well as the desire to save face. Women who were in more serious, intimate relationships with their romantic partners reported engaging in fewer discussions of sexuality with their close friends less frequently and with less detail, citing the desire to protect their sexual partner. For women, talking about sex may be deeply intertwined with their relationships and leads to a sensed need for privacy from even close others outside the relational dyad. As the authors highlight, for women, "Sexual selves may be private selves" (p. 150).

Discussion of sex can often be steeped in masculine language, which can have negative effects on men's willingness to disclose about certain aspects of sexual health. In a study of sexual health communication in 32 men aged 15-24, Knight et al. (2012) found that men engaged in sexual dialogue with others as a way of demonstrating masculinity. Their conversations about sexual health were centered on sexual encounters, which were classified as "guy talk"; the goals of this

were to project images of sexual dominance and virility. However, these attitudes were inversely linked with the frequency of discussions about health or illness, which is linked with men's reluctance to seek sexual health services for fear that engaging in this dialogue will be perceived as "feminine" or weak.

Thus, for men and women, avoidance of sexual material can result from differential attitudes and socialization about how they will be perceived by others, which can directly impact willingness to disclose in the therapy room. More needs to be known as to whether gender differentially impacts the discussion of specific sexual content. Because therapy is an inherently relational encounter, the relationship between gender and non-disclosure can perhaps be better considered as a dyadic experience. As such, more about the role of gender in the dyad as it relates to non-disclosure will be discussed in the section to follow on therapy or therapist variables.

Ethnicity. While the subject of ethnicity as it relates to disclosure has been the subject of a fair amount of clinical and theoretical literature, there is little empirical research that has been conducted, particularly in the area of dishonesty, about the effect of client ethnicity or race. One study by Morrison & Downey (2000) found that ethnic minority clients did not disclose suicidal ideation as frequently as non-minority peers at a university counseling center.

Personality traits.

Self-concealment. Self-concealment refers to a trait-like predisposition to actively conceal from others personal information that one perceives to be distressing or negative (Larson & Chastain, 1990). However, Larson, Chastain, Hoyt, and Ayzenberg (2015) have recently made a distinction as to the trait-like nature of the variable, noting that the conscious, dispositional use of self-concealment strategies (e.g., suppression, avoidance) can undergo state-like fluctuations over time and situations. More broadly, though, self-concealment refers to the active hiding of

information because of the perceived consequences rather than simply not volunteering it because the individual does not wish to or does not perceive it to be relevant.

The literature has found that the tendency to self-conceal has been linked with poorer outcomes in psychotherapy as well as to harmful effects on physical well-being and mental-health (Kelly & Achter, 1995; Pennebaker, 1985), including anxiety, depression, or increased suicidal behavior. Self-concealment has also been found to be inversely linked with social support and the willingness to seek out psychological services (Cepeda-Benito & Short, 1998; Friedlander, Nazem, Fiske, Nadorff, & Smith; 2012; Ichiyama et al., 1993). In his dissertation on how client concealment influences secret-keeping in therapy, Fedde (2009) found that high self-concealers were more likely to keep therapy-relevant secrets from their therapist, an association that has been reaffirmed by Blanchard and Farber's (2016) study of lies in psychotherapy. That is, as self-concealment scores increased, so too did clients' reported number of topics lied about. Altogether, these studies support the sense that client-rated self-concealment is associated with the tendency to be less disclosing in therapy, but it is unknown how this might manifest as it relates to disclosure about sex specifically.

This dissertation will explore an adaptation of the self-concealment construct by assessing the extent to which clients rate themselves as self-concealing in the therapy context. This was done to increase the level of specificity, as clients have already overcome a significant barrier by entering treatment but may still experience the need to keep secrets from the therapist.

Distress disclosure. Distress disclosure is defined by Kahn and Hessling (2001) as an individual's willingness to disclose distressing personal information to others. They theorize that distress disclosure represents a bipolar and unidimensional trait-like quality, with distress concealment (i.e., rare disclosure) at one end and distress disclosure (i.e., rare concealment) on the opposite end. The authors have found that the Distress Disclosure Index (DDI) inversely correlates with Larson and Chastain's (1990) Self-Concealment Scale (SCS). In their research examining the

relationship between trait distress disclosure and therapeutic outcomes, Kahn, Achter, and Shambaugh (2001) found that the DDI was a predictor of improvement in counseling, such that the self-reported tendency to disclose personal distress was associated with a significantly greater decrease in client-reported symptomatology and perceived stress over the course of counseling in comparison to participants who reported a tendency to conceal distress. Clients with high disclosure tendencies were also more likely to discuss content related to therapeutic goals during their individual therapy sessions, leading the authors to theorize that those who are low distress disclosures may be less likely or willing to participate in discussion of material that is important to clinical progress (Sloan & Kahn, 2005). Because of the relevancy of this trait-like personality variable to treatment process and progress, it is important to understand how it is related to clients' honesty or dishonesty about sexually-related material.

Dyadic or therapy-related variables.

Working alliance. Part of the therapeutic relationship is the degree to which therapist and client are in agreement on the tasks and goals of therapy itself, in addition to the emotional bond between them, a trio of factors known as the "working alliance" (Bordin, 1979). A weak therapeutic alliance is one of the most consistently identified factors related to client dishonesty. In a study exploring these variables, Kelly and Yuan (2009) found that clients who reported keeping a relevant secret showed significantly lower scores on the Working Alliance Inventory (WAI) even after controlling for client social desirability and therapist effects. The authors suggest this to mean that secret-keeping in therapy is either actively damaging to the therapeutic relationship or occurs when the relationship itself is already weak. A strong therapeutic alliance has been found to be an important contributor to overall rates of disclosure (Farber, 2003; Hall & Farber, 2001). Whenever clients feel they cannot be honest with their therapist, it is likely to represent, at least in part, a problem in the working alliance. Research has shown that having a good relationship with the

therapist is a critical factor in honest sexual discussion (Bauer et al. 2015). It may be that clients experience the need for the alliance to be sufficiently strong for them to honestly disclose about sexual content. But it is also possible that clients would become more hesitant to discuss what they perceive to be "taboo" content with a therapist that they view as a valuable figure. Nancy McWilliams (2004) notes that addressing sexual topics in therapy can become increasingly challenging as clients develop strong emotional reactions toward the therapist, leading to a concern that disclosure might jeopardize the relationship in some manner. More about the types of concerns clients have endorsed with regards to disclosing about sex with their therapist or as a function of the therapy process itself will be discussed in the Motives section to follow.

Demographics of the therapist. The role of demographics, such as age, gender, and ethnicity, in the therapeutic dyad can be a salient factor impacting disclosure. Work by Pattee and Farber (2008) found that women working with female therapists reported greater difficulty discussing intimate topics as compared to either men with female therapists or women with male therapists; women in this study also reported greater concern about how their disclosure might impact the therapist's feelings towards them. More recent findings by Blanchard and Farber (2016) across a large-scale sample of outpatient therapy clients found no differences in lying as a function of therapist gender or therapist-client gender match. However, there were significant demographic differences that were found in this study related to age and ethnicity. Results showed that therapist age group significantly affected the number of lies that clients reported; that is, clients with therapists between the (estimated) ages of 60-69 reported telling fewer lies than clients working with therapists in younger age brackets (22-29; 30-39; 40-49; 50-59) as well as clients working with therapists who were 70 or above. Additionally, clients who reported being a different race from their therapist reported lying about an average of 1.7 more topics than clients who were the same race as their therapist. Because this study was conducted across a broad spectrum of possible

content topics, it is not known whether there are any specific patterns that emerge related to dishonesty about sexual content with regards to the impact of therapist's demographics or the client match with the therapist.

Prevalence and style of dishonesty about sexual material

This section reviews the literature on sexual dishonesty or non-disclosure in psychotherapy in terms of prevalence and style – that is, how often information is not revealed to the therapist, minimized, or lied about. I will also discuss what types of sexual content have been investigated in each study in order to provide a basis for the current study's choice of four specific sexual topics.

In trying to define the prevalence of dishonesty about sexual material in therapy, there have been large-scale variations in estimates, not just with regard to frequency but also when attempting to clarify what "sexual" actually pertains to. The variation in the terms that each researcher uses – i.e., "secrets" (Pope & Tabachnick, 1994; Fedde, 2009) or "secret-keeping" (Kelly, 1998), concealed secrets (Baumann & Hill, 2016), "lies" (Blanchard & Farber, 2016), "things left unsaid," (Hill et al., 1993), or the extent to which a topic is discussed or not (Hall & Farber, 2001) – used to investigate dishonesty in therapy likely contributes to some of the difficulty in finding consistency among works. Additionally, the tendency to group all sexual content into one broad category can make it difficult to understand clients' experience of being dishonest about specific types of sexual material. It is likely that certain types of sexual content are more frequently the subject of dishonesty than others, but very little research exists in this domain to support this claim.

For example, early work in the 1970s by Yalom on secret-keeping among college students in an encounter group found that "sexual secrets" were among the three major categories of concealment in therapy (along with feelings of personal inadequacy and feelings of deep alienation from others). A later study by Hill et al. (1993) surveying individual therapy clients found that among a sample of 26 clients, "sexual secrets" were again the dominant area (27%). A larger-scale

survey by Pope and Tabachnick (1994) queried 476 clients who also happened to be therapists-in-training about "whether there had been anything important that they had kept secret and refused to disclose to any therapist and, if so, what the secret was." The authors hypothesized that the majority of participants would report keeping a major secret from the therapist, and that the majority of such secrets would pertain to "sexual issues." Indeed, as they surmised, 51% of all kept secrets involved "sexual issues."

A more recent survey of 205 current or former psychotherapy clients (Fedde, 2009) yielded similar findings, with the most frequently reported secrets kept from therapists being those related to sex (42.4%). In contrast, in a survey of 106 graduate students who had themselves been in therapy, Martin (2006) found that "sexual behavior" comprised only 7% of all reported lies. This differs starkly from Pope and Tabachnick's (1994) work despite also drawing from a fairly large, anonymous survey from similar mental health community samples (therapists and therapists-in-training). Most recently, Baumann and Hill (2016) found in their sample of 108 psychotherapy clients that sexual issues were again the most commonly held secrets from the therapist (38%).

Only a few studies (Blanchard & Farber, 2016; Farber & Sohn, 2007) have attempted to specify the types of sexual material that can be the subject of dishonesty rather than combining any and all possible content under the domain "sexual issues" or "sexual behavior." Farber and Sohn's (2007) study of a sample of 48 married individual psychotherapy clients used the 101 item Disclosure to Therapist Inventory III (DTI-III) to measure the extent of client disclosure and the saliency of disclosure on a range of moderate to high intimacy topics. The authors included eight specific items pertaining to sex, making it one of the first in-depth explorations of the specific types of sexual content that clients do not discuss in therapy. Those topics were as follows: "the nature of my sexual experience"; "my sexual fantasies"; "concerns about my sexual performance"; "my experiences of or feelings about masturbation"; "my sexual affairs, either while I was married or

while I was involved with someone who expected me to be faithful"; "the time I lost my virginity; what it meant to me"; "My interest in pornographic books, magazines, movies, videos, etc."; "my abortion(s) or the abortion(s) of my spouse/partner"; and "my experience of "sex play" with same-sex friends during childhood." These items were rated on a 5-point Likert scale for extent of disclosure (1 = "not at all," 5 = "thoroughly") and the salience of disclosure (1 = "minor," 5 = "great").

These items provide a sense of the scope as to what clients might disclose or not in therapy; however, when reporting their results, the authors ultimately grouped them together under a broader domain called "sexuality." Findings indicated that this theme was the least extensively discussed in therapy ($M = 2.35$, $SD = 1.04$) and was ranked by clients as being the least salient area of disclosure in therapy ($M = 2.49$, $SD = .098$) as compared to the other seven factors. While this supports the sense that sexual content is indeed quite difficult to discuss, a more thorough understanding as to why this was the case and how therapists might address the fact that clients are not discussing these themes and appear to consider them of low relevance. The authors went on to theorize that clients' lack of disclosure about this theme of sexuality is likely due to the experience of shame. This is a valuable preliminary finding as to the connection between shame and non-disclosure about sexual content, but more needs to be known as to the extent to which shame is involved for specific types of sexual content and whether there are additional motives that influence clients' choice to not disclose with their therapist.

More recent work by Blanchard and Farber (2016) on client dishonesty built on the topic list developed by Farber and Sohn (1997; 2007) and provided an exploratory insight into the specific types of sexual material that clients are dishonest about while also supporting previous estimates about sexual content being among the most prevalent area of dishonesty in therapy. In this survey, 547 outpatient therapy clients were prompted with a list of 58 possible topics and instructed to

select any and all that they had lied about in therapy. Their work found that 48% of clients reported having told at least one sex-related lie to their therapist. The table below presents those topics related to sexual material:

Table 1:
Prevalence of lies about sexual topics in psychotherapy in Blanchard & Farber (2016) (N = 547)

	Total Percent Reporting Lying
1. My sexual history	22%
2. My sexual fantasies or desires	17%
3. The state of my sex life these days	13%
4. My masturbation habits	13%
6. A sexual problem I have had	10%
8. Times I have cheated on a spouse or partner	10%
9. My use of pornography	9%

The high prevalence of dishonesty about sexual material resonates with other findings in the empirical literature, as noted above (Baumann & Hill, 2016; Hill et al., 1993; Martin, 2006; Pope & Tabachnick, 1994). Also notably, three of these topics – "my masturbation habits," "my use of pornography," and "times I have cheated on a spouse or partner" – were some of the "biggest" lies in the study. That is, when clients were asked to rate to what extent they had misrepresented the truth about these topics on a five-point scale, ranging from "a tiny bit" to "totally or extremely", these were some of the topics about which the highest proportion of clients reported either a "4" or "5" on this scale, indicating a significantly high degree of dishonesty. Of the 13% of the sample who indicated that they had lied about "my masturbation habits," 32% were a lot or totally dishonest (i.e., reported "4" or "5" on this scale); for those who had lied about "my use of pornography," this figure was 31%; and finally, of the 11% of clients who indicated lying about cheating on a partner or spouse, 29% did so with either near or total dishonesty. Clearly, for many

clients, this material is too difficult to discuss honestly – so much so that they are frequently concealing it entirely from the therapist.

Of note, Blanchard and Farber's (2016) work provides the first data about the style of dishonesty in therapy about sexual content, suggesting that certain types of sexually-related material (i.e., masturbation, infidelity) are more likely to be the subject of complete dishonesty. Still, more needs to be clarified about how the term dishonesty is operationalized, as it is not always clear how clients are interacting with these prompts. My work aims to build on this finding by specifically querying clients as to how dishonesty about sex manifested in their therapy. Were they more likely to not discuss a topic at all because they were avoiding it (passive dishonesty), or to discuss it but with a low degree of honesty (active dishonesty)?

Motives for dishonesty about sex

When clients are asked to report their motives for dishonesty in therapy, avoiding shame and embarrassment has often topped the list (Baumann & Hill, 2016; Blanchard & Farber, 2016; Hill et al., 1993; Kelly & Yuan, 2009). In their paper providing a theoretical overview of client lying, Newman and Strauss (2003) suggest that motivations for lying can be distilled into two domains: clients who lie because they are fearful of ashamed, and those who lie for more calculated, ulterior, and often external motives (to avoid consequences, to gain reward, etc.); the authors suggest that clinical interventions then should differ based on this conceptualization of clients' underlying motivation, as more consequence-driven motivations for lying are unlikely to be amenable to a clinical focus that emphasizes warmth and patience to undo shame. While it is my sense that it is helpful to elucidate clients' reasons for dishonesty through a more multifaceted lens rather than a dichotomous internal vs. external category, the linkage between tailoring clinical facilitators to motivations for dishonesty is a crucial one in the goal of increasing honest disclosure.

There is good evidence that client motives are contingent on the subject matter being concealed or distorted. Work by Hill et al. (1993) found that when the source of non-disclosure was related to events happening in therapy, as compared to personal secrets, the most common motive clients cited was not shame but the desire to avoid experiencing overwhelming emotions, such as frustration or feeling stuck, as well as worry about hurting the therapist's feelings. Meanwhile, Blanchard and Farber (2016)'s study of lying in outpatient therapy provided evidence that clients' motives for dishonesty are frequently directly linked with the subject matter itself that is being avoided, minimized, or lied about. In their sample of 547 therapy clients, the authors found that of the 106 lies that concerned aspects of the therapeutic relationship (e.g., "pretending to like my therapist's comments or suggestions," "not saying I want to end therapy," "pretending to find therapy more effective than I do"), the most common motivation was the desire to be polite and to avoid upsetting the therapist. In contrast, the 325 lies across all other topics were most commonly motivated by feelings of discomfort, not wanting to look bad, and the desire to avoid feelings of shame. Additionally, Blanchard's (2017) dissertation on the concealment of suicidal ideation in a sample of 107 outpatient psychotherapy clients found that while shame and embarrassment was a common barrier to disclosure, it was by and large considered to be a secondary concern to motivations that related to the fear of practical consequences that could occur as a result of disclosure (e.g., hospitalization, unwanted medication, others finding out), endorsed by nearly three-fourths of clients.

Building upon this literature, it is evident that dishonesty about sexual material in psychotherapy is likely to also be motivated by reasons that are specific to the content itself. However, it is also possible that dishonesty *within* the broader topic domain – that is, about different types of sexual material – might be motivated by certain specific underlying concerns. For example, a client may conceal details about infidelity in order to avoid being judged or disapproved of by the

therapist, while dishonesty about sexual fantasies may occur out of embarrassment or a sense that this material is not appropriate for therapy or perhaps irrelevant to their presenting concerns. Dishonesty about these separate topic areas within the overall domain of sexual content may also yield different emotional reactions and sense of consequences for clients, and would then likely require specifically tailored therapeutic interventions. Exploring clients' motives for being dishonest about specific types of sexual material will facilitate a better understanding of what leads to the choice to not disclose and help guide the choice of intervention accordingly.

What follows is a review of the literature exploring motives, or the types of reasons that clients provide for why they chose to be dishonest about sexual content. Much of this data has been derived from querying clients about their experience in the health care field more broadly, such as in a medical setting, as there is limited data about the motives for client dishonesty in psychotherapy about sex. While this section is divided into two types of client motives for dishonesty – personal characteristics of the client, and clients' feelings about the therapist, the therapeutic relationship, or therapy itself – in order to provide an organizing framework, it is important to note that clients can and often do have multiple, intersecting motivations for dishonesty about sexual content. For instance, a client whose culture of origin prohibited sexual education may be more likely to view the therapist as a judgmental figure or to view the disclosure of sexual material as an irrelevant distraction from their presenting concern.

Motives relating to client characteristics.

Shame. Shame has been consistently identified as a salient client motivation for keeping secrets in therapy (Kelly 1998; Hill et al., 1993) and is likely to be particularly relevant for the disclosure of sexual material. First, it is important to note that the literature suggests a distinction between shame as a transient, state-like emotional experience and the more trait-like variable of shame-proneness. Shame-prone persons tend to make more internal, global, and stable attributions

about self and others; they will self-blame for errors or transgressions with others, and hold negative self-concepts and self-esteem (Tangney et al., 1992). On the other hand, shame can also be experienced as an emotion after a specific incident that evokes a global, negative evaluation of self ("I am bad") associated with feelings of helplessness or inability to correct the perceived error. Afterwards, the individual may feel a sense of worthlessness, over-exposure, and the desire to hide from others (Lewis, 1971; Anolli & Pascucci, 2005).

However, previous studies on secret-keeping and disclosure have not always made a distinction as to whether shame is being conceptualized as a state or trait like variable when it is identified as a motivator for clients. In her work, Kelly (1998; Kelly & Yuan, 2009) found that shame was a salient motive for client secret-keeping that clients identified spontaneously in their open-text responses. However, it is not possible to know the extent to which these clients were shame-prone as a habitual way of being. Meanwhile, Baumann and Hill (2016) provided clients with a checklist of reasons based on Kelly's work and found that the item "I am too ashamed or embarrassed" was the most prevalent reason for concealed secrets endorsed by clients (75%). This also highlights the way in which embarrassment and shame are sometimes confounded both by clients and at times by researchers despite the literature that has sought to differentiate them. To my knowledge, only Farber and Hall (2002) have assessed the relationship between disclosure tendencies and shame-proneness using a validated measure. In their sample of 147 current psychotherapy clients, the authors found that patient shame scores were unrelated to total disclosure. The authors suggest it may be possible that shame as a state-like experience is more likely to be associated with non-disclosure rather than overall shame-proneness.

Shame-proneness as a trait variable is likely to be especially intensified for LGBTQ+ individuals, who – despite a growing awareness and acceptance of cultural minority groups – are still marginalized based on identity factors. These individuals frequently are subjected to negative

attitudes from others, including family members, peer groups, and within the broader legal and cultural landscape (Fahlstrom, 2016). In his recent review of the literature on shame and clinical process with LGBTQ individuals, Longhofer (2013) suggests that engagement with shame, especially where sexual desire is a topmost consideration or area of conflict, may be the most significant factor in establishing and maintaining the therapeutic alliance due to some clients' longstanding and culturally-reinforced history of being seen as "damaged, flawed, and rejected" (p. 298). This sense of shame is even more intensified for those who are concealing their sexual identity. Meyer (2003) found that concealment (and the attendant dishonesty it requires) is a significant aspect of mental health problems in gay individuals; while concealment around orientation can protect against negative feelings, possible stigmatization, or even more severe practical consequences (i.e., being disowned, fired from a job, or even physically attacked), it also amplifies shame in the long-term, fueling a cycle of chronic concealment and dishonesty.

Clients' non-disclosure of sexual material can also be fueled by acculturated shame or shame induced by one's family of origin. This can reflect a more stable belief that sex is bad or immoral and they are subsequently wrong for engaging and/or discussing, but it can also be shame that is more state-like rather than an underlying global attribution toward self across contexts. For example, shame could be evoked only in certain types of sexual experiences or only when it is related to having to disclose to others. Some clients may feel fully comfortable having sex with their partner but then become suffused with shame around the prospect of having to disclose to their therapist.

Therapists, too, may experience their own sense of shame about sexuality that is either state-like or trait-like, and this can be inadvertently expressed to the client through avoidance of the topic or reluctance to deepen conversations when they do emerge, prohibiting disclosure in the dyad. According to Hastings (1998), "sexuality is different from other issues because of the shame that is

elicited by open, nondefended conversation about sexual behavior. Most therapists don't have the opportunity to address sex in the way we address most other topics brought up by clients – free of our own shame (p. xi).

While clarifying between shame-proneness as a more general trait and shame as an emotional experience is beyond the scope of the current study as no measures assessing shame were included, it is important to know how often clients will endorse shame as a motivation for dishonesty about sexual content in therapy, both spontaneously and when presented with the opportunity to do so by selecting among a list of possible motives.

Stigma. Stigma has been defined by theorists as an attribute in a person that is seen as undesirable and making that person different from the rest of society (Lewis, 1995; Schmader & Lickel, 2006). This construct is said to contain two components: public stigma and self-stigma (Corrigan, 2004). Public stigma refers to negative, stereotypical beliefs held by the broader population about an identity or characteristic, and can be associated with negative internal reactions or actively discriminatory behaviors toward that person or group as. Self-stigma (also referred to as internalized stigma) has been conceptualized as the internalization of negative beliefs of others turned toward the self (Vogel, Wade, & Haake, 2006).

Shame, defined as an intense negative emotional experience resulting for a person who feels a sense of failure in regards to personal or others' standards, feeling responsible for that failure, and believing that failure reflects an inadequate or flawed self (Lewis, 2002), does share some conceptual overlap with self-stigma and is used somewhat interchangeably in the literature. However, individuals may be part of a stigmatized group and/or receive the attendant judgment that comes along with it but feel no sense of internal qualm about their own behavior. The extent to which stigmatized individuals blame themselves reflects their degree of shame. As such, it is useful to distinguish shame and stigma in the discussion of motivations for dishonesty about sex, because

while these experiences can and do frequently co-occur, particularly for clients with minority identities, they do not necessarily *always* co-occur. The construct of sexual stigma refers to the way in which minority sexual identifies have historically, culturally, and politically been viewed as invalid or lesser than as compared to heterosexuality. Regardless of whether these individuals personally believe society's negative views, all members of marginalized sexual identity groups are subject to awareness of societal stigmatization (Herek, Chopp, & Strohl, 2007).

Shifting from sexual identity to sexual practices more broadly, stigma about sex can be derived from one's family of origin as well as from culture, which can often communicate to clients that enjoyment of sex – let alone discussion of it – is taboo. This may be a factor for clients who report that sexual material is too private to disclose with another (or for therapists, too, who can experience trepidation around introducing the topic). Sexual behavior can have connotations about and connections to moral values, self-esteem, and emotions (Sanders & Robinson, 1979). For some cultures, sexual expression is so rare that individuals may not even discuss it with their partners; they "like to have sex but not talk about it" (Findlay, 2012). American culture tends to hold a paradoxical attitude toward sexuality. While popular culture is highly sexualized, within families, parents tend to dramatize the topic of sex and focus their efforts on controlling and deterring sexual behaviors (Schalet, 2011). Ultimately, though, such paradox culminates in an attitude toward sex that is fraught with conflict, whereby sex is an area of prominent focus and yet sensed to be problematic or prohibited.

Privacy. Clients may choose to not disclose about sexual content due to motivations to maintain privacy, which involves the belief certain information is by its very nature confidential and does not need to be or should not be shared with others. Vangelisti's (1994) work on the functions of family secrets cites five key underlying reasons for keeping secrets, four of which are more interpersonal and concern beliefs about what might happen if the information were to be revealed to

another person (i.e., the fear that a relationship would be altered by the revelation, wanting to avoid information being used against them, or worry that the disclosure itself would be challenging or badly received). Privacy, meanwhile, relates to a more intrapersonal sense that such information is not relevant to others.

In a qualitative study examining the reasons LGBTQ young adults did not disclose their sexual identity to a medical provider (Rossman, Salamanca, & Macapagal, 2018), a salient subtheme that emerged in the sample was Discretion, or patients' desire to maintain privacy about their identity as a motivation for non-disclosure. Framing this notion that sexuality is one's own personal information, one participant stated, "I feel like my sexuality is my business in what I do and who I do it with" (pg. 6). Maintaining privacy can be a motivation for clients who believe that open discussion of sex or sexuality is beyond the bounds of what is appropriate for therapy.

While not explicitly stated as being motivated by the need to maintain privacy per se, some of the reasons for client secret-keeping that have been identified in prior studies could be classified under this theme. For example, in Kelly (1998)'s sample, two of the 17 clients who endorsed keeping a relevant secret from their therapist cited "total secrecy" as their reason for doing so. Among the 23 clients who had kept a secret in Kelly & Yuan's (2009) sample, nine reported that their reason for doing so was that they would not tell anyone; using the themes derived in this study as part of a checklist of possible reasons for secret-keeping, Baumann and Hill (2016) found that nine clients also cited "I would not tell anyone" as a motive. It is difficult to know given the wording of these items what clients are thinking when they select it as a reason for secret-keeping, and more needs to be known in their own words whether their steadfast decision not to disclose is indeed motivated by the desire to maintain boundaries or the sense that this information is not necessary for others to have.

Loyalty. Some of the literature on client secret-keeping has identified that one of the reasons clients endorse for having a therapy-relevant secret is loyalty to another person. While it was mentioned spontaneously by only one individual in Kelly's (1998) sample of outpatient therapy clients and selected by two clients from a checklist of possible motives in Baumann and Hill's (2016) sample of 101 therapy clients, it is possible that for a topic like sex, which by its very nature is often related to another person, protecting one's partner could be a more relevant motive for non-disclosure. In particular, material related to infidelity may be more prone to non-disclosure, either to protect one's current partner or the affair partner.

Impression management. Research on the disclosure process in psychotherapy points towards clients' tendencies toward impression management. That is, clients often seek to present themselves in the most favorable light to others, which can manifest in the therapy relationship as non-disclosure of certain information if it would threaten their self-image in some manner (Goffman, 1959; Kelly, 2000). Some amount of non-disclosure about sexual material, then, may occur out of a desire to compartmentalize certain parts of themselves that feel messy, risky, or taboo.

Motives relating to the therapist or therapy.

The following section will cover those motivations for dishonesty about sex that are related to real or imagined features of the therapist as well as to the therapy process.

Client deference. Clients may believe that non-disclosure is important in order to preserve and maintain the therapeutic relationship. In his work on client deference, Rennie (1994) outlined two main reasons clients may choose to hold back information. First, clients view the therapist as a real person and want to avoid hurting the therapists' feelings or upsetting them. Second, clients try to avoid challenging the therapist's authority, believing that it is not their place to do so or fearing that doing so will jeopardize the relationship and/or the therapist's positive view of them. Indeed,

one of the reasons clients have cited keeping for relevant secret in therapy concerns the fear of revealing to the therapist how little progress had been made in therapy (Kelly, 1998; Kelly & Yuan, 2009; Baumann & Hill, 2006). Withholding of sexual material can be a way of managing the relationship with the therapist as well as maintaining some control over how the client wants to be seen within that relationship.

Fear of being judged by the therapist. Since many clients have been socialized to feel that sex is "private, shameful, and perhaps even evil" (Gochros, 1986, p. 11), the anticipation that the therapist could react negatively to such disclosures may play a role in limiting such discussion. This is likely to be even more intensified for clients presenting with sexual problems or any deviations from an internalized societal norms, who experience sexual stigma from the broader culture for not maintaining what is said to be the standard of "typical" behavior (Herek et al., 2007).

In a qualitative study of 21 therapy clients by Farber et al. (2004), almost half noted that the fear of a judgmental reaction from the therapist made disclosure difficult. The expectation of judgment may be intimately wound with clients' own internalized shame about sex and sexuality, which can lead to full-scale avoidance rather than risking having to sit with their own strongly negative reactions.

Fear of stigma is a recognized barrier to seeking mental health care in general (Hom, Stanley, & Joiner, 2015) and has been cited as a reason that clients do not disclose suicidality (Burton Denmark et al., 2012). While mental health practitioners are trained to be non-judgmental and empathetic, therapists are nevertheless seen as the having the potential to enact negative judgment. In the sample of 21 therapy clients interviewed by Farber et al. (2004), nine reported that the hardest aspect of disclosure was fear of the therapist's judgmental reaction. For instance, clients described reasons such as "It's harder to disclose when she [the therapist] makes a mountain out of a molehill" and "I don't want people to look at me differently based on what they know about me"

(p. 342). The first quote captures the way in which the therapist's actual overreaction can be counterproductive for disclosure, while the second shows how the therapist's anticipated reaction gets conflated with the sense of how people in general would react. In any case, the therapist's real judgmental responses or the imagined projection of how he or she might react negatively are both pathways through which disclosure can be curtailed.

Meanwhile, another salient theme in Rossman, Salamanca, and Macapagal's (2018) study about why LGBTQ young adults did not disclose sexual identity in a medical setting was Stigma, which contained any remark from patients that could be categorized as relating to concerns about receiving a negative reaction from the provider. For instance, patients worried that the provider might treat them differently or cited fearfulness about what the provider would say. This is consistent with work by Scrimshaw et al. (2013), which found that men who identify as bisexual were more likely than gay men to conceal their sexual orientation from others, including friends, family, and female partners due to concerns about being rejected. While these two studies do not extend their findings directly to psychotherapy, it is likely that these concerns hold true for some clients and motivate dishonesty about sexual content.

The fear of receiving negative feedback from one's therapist may not be entirely unfounded either, particularly for those clients who may present with sexual interests or identities that can be considered outside the bounds of heteronormativity. In a study of self-identified BDSM enthusiasts, Kolmes, Stock, and Moser (2006) found that over half reported experiencing "biased care" such as being lectured that BDSM was "unhealthy," needing to provide therapists with education on the topic due to the provider's lack of knowledge, or being told to discontinue kink activities in order to receive further treatment. Similarly, in a convenience sample survey of self-identified polyamorists, Weber (2002) found that 38% of clients who had been in therapy at some point did not disclose to

their therapist that they were consensually non-monogamous and 10% who had discussed it reported receiving a negative response.

Fear of being misunderstood by the therapist. For clients seeking psychotherapy for issues related to sexual identity, the "match" – that is, belonging to the same identity category – with the therapist can be a critical factor in regard to willingness to disclose (Burckell & Goldfried, 2006); thus, some clients may not feel comfortable disclosing unless they feel the therapist can truly understand and embrace their particular identity. In a study of older adults' disclosure about sexuality, Bauer et al. (2015) found that older gay men perceived health services to be heteronormative, which can have a negative impact on their relationship with providers; these clients reported finding healthcare services to be potentially unsafe, and indicated that they did not disclose their sexuality until they received indications that they would be accepted. This suggests that clients may hold off on making their identity known until they can test out how the therapist would react or feel toward them. Comfort disclosing sexual identity may also be affected by other factors, including gender, race, ethnicity, and age (Grov et al., 2006).

For those clients who do not feel that their sexual identity adheres to a traditional binary model, disclosure of sexual material can be all the more difficult, as they may expect that the therapist will not be able or perhaps even willing to understand them. The evolution of sexual identity has become increasingly fluid in modern culture; however, clients may feel an internalized pressure to conform to societal norms of the binary, or worry that they will have to educate the therapist on the nuances of their particular identity. Meanwhile, as discussed above, clients whose sexual interests or desires could be considered unconventional may avoid disclosure due to the concern that the therapist will not be interested or able to understand (Gochros, 1986).

Managing the course of therapy. In previous studies on secret-keeping in therapy, some of the reasons identified by clients for keeping a relevant secret from their therapist concerned the

sense that they had no time to address the topic or that they chose to do so because other things were more important to talk about (Kelly, 1998; Baumann & Hill, 2016). The latter reason was the third-most endorsed item in the Baumann and Hill (2016) study, behind shame or embarrassment and "I am not motivated to address the secret," which may also speak to a similar desire to control the course of therapy. Shifting to the revelation of previously-held secrets as a way of understanding clients' motivations, Baumann and Hill (2016) found that one of the most common reasons that clients ultimately chose to disclose a previously concealed secret was because they felt it was preventing them from making progress in therapy, indicating the way in which clients are keenly attuned to what feels relevant and important to share at any time. Thus, it may be that some clients choose not to disclose about sexual material because it does not feel meaningful to their progress.

For some clients, then, concealment of sexual material occurs as a function of wanting to direct the focus of treatment. Clients may not think that a particular sexually-related topic is especially significant or are uninterested in diverting precious therapy time from what they want to address. Others may only choose to disclose if it they feel a pressing enough need to do so. In their sample of 206 LGBTQ young adults, Rossman, Salamanca & Macapagal (2018) found that 10% chose not to disclose their sexual identity to their medical provider because they felt it was not relevant to their health. Some clients reported feeling that there was no need to disclose in that particular healthcare setting, while others felt more strongly that health and sexual identity had no relationship at all. It is possible that sex is perceived to be irrelevant in a therapeutic setting as well; for instance, sex may be an area of low or no concern for clients, or believed to be unnecessary to disclose unless there was a particular problem. More needs to be known about the types of reasons clients have for directing the course of therapy away from sexual content.

Confidentiality. It may be that this confidentiality concerns are less salient for adult individual therapy clients than they would be for adolescents, those in couples therapy, or for those

disclosing about topics like suicidality or substance use (which are more linked with legality issues or concerns about mandated reporting); additionally, these concerns do not come up in the literature on non-disclosure about sexual material. However, the data of the present study may provide evidence that certain sexual topics are avoided or lied about as a result of client concerns about confidentiality – for example, discussion of sexual fantasies or details of one's sexual life that are perceived to be taboo or, in some cases, illegal.

Effects of Dishonesty: Feelings, impact on self, and impact on therapy

Because to my knowledge there has not been empirical literature about clients' sense of how being dishonest about sexual material affected them and their therapy, the following section will focus on literature in a few related domains: clients' reported feelings about having disclosed to the therapist after a period of secret-keeping, and the impacts of concealment on the therapy process and on progress overall.

While some previous research has found that clients report experiencing primarily negative feelings after disclosing about challenging or intimate information (Farber, 2003; Hill et al., 1993), other findings been more mixed. In a study of 21 long-term therapy clients, Farber et al. (2004) found that while clients initially reported negative emotions before a disclosure – more specifically, shame and anticipatory fear of how the therapist will react – afterwards their feelings about having revealed became increasingly positive. The authors suggest that clients' approach to disclosure may be better understood as an interpersonal process in which clients actively weigh their felt need to disclose (i.e., their level of psychological distress and desire to relieve themselves of it) and the desire to avoid feeling ashamed or too vulnerable. The findings that clients often report conflicted feelings about the disclosure process are extended in recent work by Baumann and Hill (2016) investigating client motivations for concealing and revealing secrets in a sample of 115 therapy clients. Results showed that immediately post-disclosure, clients reported comparable levels of

positive and negative emotions, suggesting that the act of revealing can inspire some ambivalence for clients. However, over time, when clients were asked to reflect back on having revealed their secrets, they indicated higher levels of positive feelings and lower levels of negative feelings.

In both these studies, clients' overall sense about having disclosed was quite positive; all two clients in the Baumann and Hill (2016) sample indicated that they had benefitted from revealing their secret, suggesting that while the disclosure process itself can generate mixed feelings in clients, the overall choice to do so can lead to positive impacts, especially if the previously held, shame-inducing secret is received well by the therapist.

However, because these works focused solely on clients' reported feelings about having actually disclosed secrets to the therapist, it begs the question about how they might feel about the opposite experience: that is, choosing not to disclose certain information with the therapist. Additionally, since these studies did not directly link clients' reported feelings of revealing their secrets with the actual topics of their disclosure, I am specifically interested in knowing how clients felt about deciding to be dishonest with their therapist about sexual material.

In terms of the effects of non-disclosure on overall therapy progress, the literature has been mixed, speaking to both the complexity of the phenomenon as well as some challenges around methodology. Some work has found that client secret-keeping has a negative aspect on certain salient aspects of therapy, including ratings of client satisfaction and the working alliance (Farber et al., 2004; Fedde, 2009; Kahn & Hessling, 2001). Additionally, some findings in the literature suggest that having fewer secrets is related to less negative mood, higher self-concept, and overall well-being (Kahn et al., 2001).

Challenges to this perspective have come from Kelly (1998, 2000), whose self-presentational model argues that clients may actually benefit from some level of secret-keeping through the process of presenting a healthier, more favorable self-image that is then reflected back

to them through the therapist, leading to decreases in symptomatology. More recent work by Kelly and Yuan (2009) was not able to replicate this finding, showing instead that while secret-keeping was negatively related to the working alliance, it was not linked with symptom-change.

Kelly and McKillop (1996) make an important distinction about how the effect of revealing secrets can depend crucially on how the disclosure is received by the listener. They argue that the role of real or perceived feedback from the confidant can determine whether the act of revealing a secret has either a deleterious or helpful effect. Secret-keepers who are considering revealing encounters a complex dynamic in which they must weigh whether a confidant is likely to react positively to the revelation, or whether they are at risk for experiencing reactions like judgment, misunderstanding, or even rejection; in the latter case, it may be more beneficial to choose not to disclose. The current study can build empirically on this theoretical work by investigating why clients were motivated to be dishonest with their therapist and how they believe it affected their treatment overall, particularly for those clients who cited some aspect of the therapeutic relationship as being relevant to their choice not to disclose.

In an exploratory study of lying in psychotherapy, Martin (2006) found that in a sample of 40 clients who had lied to a therapist, 40% believed that lying had affected the therapeutic outcome, while 43% felt that it had not impacted outcome. The majority of participants who indicated that their therapy had been affected believed that that impact was negative, discussing in their open-text responses themes like being unable to address important issues in therapy or the feeling that therapy was compromised as a result. A few participants noted that they had terminated therapy early as a result of lying and the failure to develop a sufficient and workable connection with the therapist. Two participants in this study cited positive impacts of lying on therapy, such that they felt motivated to work harder after lying. While this work is helpful in providing some exploratory insight into the impact of lying on therapy process – particularly in terms of providing clients' own

words – it does not directly link the topics that clients lied about to outcome, which I believe misses an important opportunity to clarify more about the client's experience.

Overall, none of the studies addressed thus far have looked specifically at the consequences of non-disclosure about sexual material in therapy and how clients believe this may impact their therapy progress overall. The only relevant literature in this domain of sexual material concerns concealment of sexual identity. Here, too, the literature has been mixed as to the relationship between lower levels of concealment of one's sexual identity, greater disclosure about sexual identity, and beneficial mental health outcomes, with some studies finding a link (Beals, Peplau & Gable, 2009; Bybee, et al., 2009) and others finding no association (Basalm & Mohr, 2007) or a negative association (Frable, Wortman & Joseph, 1997). In work by Scrimshaw et al. (2013) about bisexual men in particular, while concealment was associated with lower levels of mental health, the converse was not true for greater levels of disclosure (i.e., disclosing one's bisexual identity was not linked with higher levels of mental health). Disclosure can sometimes be associated with negative feedback, and rejecting responses from others have been associated with adverse effects in the LGB population (Rosario, Scrimshaw, & Hunter, 2009). However, the act of concealing sexual identity from one's therapist has not been investigated as it relates to the impact on therapy process more specifically.

Given the varied patterns in the literature, one of the aims of this dissertation is to extend this line of inquiry and make it more specific to the topic of sexual material. How do clients feel about their choice to be dishonest about sexual topics, and do they believe it had an impact on their therapy overall? If so, what kind of impact did it have?

Facilitators of disclosure about sex in therapy

Few studies to my knowledge have investigated the types of clinical interventions that clients believe would help them be more honest about sexual content. Baumann and Hill (2016)

provide some preliminary evidence about facilitators of disclosure more generally, finding that the most common reasons clients reported for choosing to disclose a secret were trusting the therapist (83%), believing they could benefit from sharing the secret (76%), and feeling that keeping the secret was preventing them from making progress (65%). More generally, some research has found that clients report choosing to disclose material when it becomes too distressing not to (Stiles, 1995).

In his dissertation on the concealment of suicidal ideation, Blanchard (2017) directly queried clients as to what they believe would be helpful to foster increased disclosure on the topic of suicidality. These findings showed that a substantial portion (45%) felt that they would be more open if the therapist provided assurances about the practical consequences of disclosing suicidality, particularly with regards to hospitalization. This suggests that, as was the case with motives, the specific content of dishonesty is likely to be interrelated to the specific types of clinical interventions that clients need or desire. However, because no work has specifically examined what clients believe would help foster honesty about sexual material that they have previously withheld from the therapist, this dissertation aims to examine this topic in more depth.

Limitations of the existing research

There are a number of limitations of the previous literature on dishonesty about sexual content. First, little research has actually been conducted in this domain within the unique context of psychotherapy, particularly with regards to what motivates clients to conceal or lie about this information, how it impacts themselves and their therapy, and the ways in which therapists could facilitate increased honesty. Additionally, there have been no studies investigating the personality, demographic, and dyadic factors that influence non-disclosure of specific topics in therapy.

The existing literature on dishonesty in therapy has focused on outlining the types of material that clients are keeping secret, concealing, or lying about in therapy, often resulting in

lumping all sexually-related content into a single category such as "sexual secrets" (Hill et al., 1993), "sexual issues" (Pope & Tabachnick, 1994; Baumann & Hill, 2016) or "sexual behavior" (Martin, 2006). To my knowledge, only Blanchard and Farber's (2016) study of lying in psychotherapy made efforts to classify the specific types of sexual material that clients are lying about in therapy. However, it is difficult to know how clients in that study were primed by the term "lying," which can carry a more pejorative valence; this work aims to inquire about the phenomenon in a more neutral way in order to provide more generalizable data.

To that point, the variation in terms being used to assess dishonesty in therapy across studies has contributed to some challenges understanding how dishonesty actually manifests in terms of style. When terms such as client secret-keeping or concealment are used, it suggests that content areas or reactions are being fully withheld from the therapist. However, there are other styles in which dishonesty can present in therapy. Clients can avoid topics entirely, minimize discussion of personally salient topics (Farber & Sohn, 2007), purposefully mislead the therapist as to their actual reactions about interventions or therapy effectiveness (Blanchard & Farber (2016), or fabricate outright lies (Gediman & Liebeman, 1996). More needs to be known about both prevalence of dishonesty in therapy about specific types of sexual content and the style in which it occurs, and whether these differ at all depending on what kind of material is to be the subject (or lack thereof) of discussion.

There is little existing research, particularly qualitative research, querying clients about their experience of being dishonest in therapy about sexual material. Studies by Hill (1993), Blanchard and Farber (2016), and Blanchard (2017) have provided an important understanding that motivations for dishonesty likely differ based on the topic, but did not explore this specifically as it relates to sexual content. Baumann and Hill (2016) reported data about the feelings that were evoked for clients after being dishonest and reasons that clients *had* disclosed a relevant secret,

which provides some sense as to types of desired clinical interventions, but this study did not inquire about the actual content clients were speaking about when answering these questions. Additionally, this data was strictly quantitative, which limits the depth of understanding to some extent. Finally, work by Blanchard (2017) gave an in-depth understanding as to the impact of concealing in suicidal ideation in therapy and clients' desired facilitators for increased honesty, but it is likely that these findings differ substantially in the domain of dishonesty about sexual content. This dissertation aims to fill the gaps in understanding as to what motivates clients to be dishonest about specific types of sexual content, and to extend the literature further by providing the first known empirical evidence from clients about how dishonesty about sex impacted themselves and their therapy and what their therapist could have done to increase their honesty.

Purpose of the current study

The current study is designed to provide a comprehensive understanding of client dishonesty in therapy about four topics related to sexual material: "details of my sex life," "my sexual desires or fantasies," "times I have cheated on a partner or spouse," and "my sexual orientation."

As noted above, while previous literature has demonstrated that sexual material is among the most common type of dishonesty in psychotherapy, this has not been explored in great depth. It has not been well established what types of sexual content clients are likely to be dishonest about in therapy, and what this might look like in terms of style. It is also not clear whether there are any personality, demographic, or dyadic variables that differentiate between clients who are dishonest about sex and those who are honest. Knowing clients' motivations for being dishonest about specific types of sexual content can directly inform the way therapists conceptualize and intervene in these areas, Further, no study has asked clients to state in their own words what interventions they believe would be helpful in increasing honest disclosure about sexual material. Thus, this study poses the following research questions:

1) To what extent are clients honest and dishonest in psychotherapy about each of the following sexual topics – "details of my sex life," "my sexual desires or fantasies," "times I have cheated on a partner," and "sexual orientation"?
2) How does this dishonesty about sexually-related issues manifest in terms of style? That is, to what extent are clients *actively dishonest* about a topic (i.e., discussing it in therapy but with a low degree of honesty) and to what extent are they *passively dishonest*, excluding the topic from the dialogue entirely due to avoidance?
3) Which demographic variables (e.g., age, gender, ethnicity), specific tendencies toward disclosure or concealment (e.g., distress disclosure and self-concealment), and specific therapy variables (i.e., therapeutic alliance and demographics of the therapist) are related to whether clients rate themselves as being highly honest (that is, disclosing with either "a lot" or "complete" honesty) or dishonest (passively or actively) in psychotherapy about each type of sexual content?
4) What are clients' self-reported motives for being dishonest about each of the four sexual topics? Do these motives differ by the specific type of sexual content? Do these motives differ when compared to all other non-sexual topics?
5) What is the clinical impact of dishonesty about sexual material? More specifically, how do clients feel about their choice to be dishonest about each topic and how do they feel their dishonesty affected their therapy overall?
6) What is clients' sense of what their therapist could do to facilitate their ability to disclose more honestly about each type of sexual content? Do these desired clinical facilitators differ when compared to all other non-sexual topics?

Clinical Implications

Previous research has taken an atheoretical stance on dishonesty in psychotherapy. I believe that it is wholly within clients' prerogative to direct the course of treatment as they wish, and to only disclose what they are able and willing to at any given time. Thus, it is not my belief that dishonesty in therapy is altogether "bad" and that the goal is clients' fully honest disclosure; the process of disclosure is ultimately far more nuanced and complex, especially as it relates to topics like sex, infidelity, or sexual orientation.

Still, the relationship between clients' felt ability to disclose what feels most relevant to them has been reliably linked with successful outcome (Farber et al., 2004), indicating that it is within the best interest of clinical practice to understand how to facilitate disclosure about sex when it is important to do so. Additionally, it is possible to argue that the topic of sexuality is relevant to all clients, as it touches core areas of identity, relationships, and well-being (Butler et al., 2009).

Thus, the main goals of this work are to better clarify the phenomenon of dishonesty about sexual material in therapy as a way of informing clinical practice. Gaining a thorough understanding of the challenges that clients encounter when considering whether or not to disclose about sexual topics can help therapists be more sensitively attuned within this often highly stigmatized, shame-prone area of disclosure so that they can accurately assess clients and provide treatment when relevant. Because this work provides an in-depth look at the conflicts underlying client dishonesty, and how these may manifest differentially depending on the type of sexual material being concealed, minimized, or lied about, clinicians can become better able to sensitively and reliably foster disclosure in these areas. By understanding the way in which dishonesty about sexual material affects therapy process and progress, clinicians can become better equipped to recognize the types of sexual content that should be targeted more thoroughly, and which clients may consider to be more secondary to other treatment goals. Finally, providing clients' own reports of the desired

therapeutic techniques that would help them more comfortably reveal has direct clinical implications for how to tailor the therapy process to be more effective in eliciting honest disclosure about different types of sexual content.

Method

This study is based on data collected by the Psychotherapy, Affirmation, and Disclosure Lab, which operates under the guidance of Dr. Barry Farber at Teachers College, Columbia University in the Department of Counseling and Clinical Psychology. The results analyzed in this study were collected using an online survey instrument designed to assess clients' experience of honesty and dishonesty in psychotherapy. After obtaining approval from the Institutional Review Board (IRB) at Teachers College, Columbia University, data were collected from June 2015 to March 2016. The posting message invited potential respondents to participate in a "survey about your psychotherapy experience." The survey was administered online with the aims of recruiting the largest and most diverse sample as possible, and to increase the likelihood of participants providing information about difficult yet salient topic material. It was hypothesized that using a private, anonymous format would yield more relevant data than in an in-person interview or any medium in which participants' identifying details were attached to their responses.

Participants

The survey included 798 respondents (186 male, 602 female, and 10 "other"; age range 18-78 years, M = 35.2 years, SD = 13.3) who were currently in psychotherapy (63%) or had been so within the past year (37%). The sample self-identified themselves as predominantly Caucasian (73%), with the rest identifying as African-American (7.3%), biracial or multiracial (7%), Asian / Asian-American (6.7%), Hispanic or Latino (5%), or American Indian (.6%). This sample reported high education levels, with 56% having a bachelor's degree or higher. Marital status in this sample

was primarily single or never married (61%). Median household income for the sample was $30,000-$60,000. Approximately 18% of participants reported being in the mental health field or training for it.

The median number of months in therapy was reported to be 14 (M = 27 months, SD = 37), with participants attending an average of three sessions a month. Respondents are or were seeing therapists who were primarily female (73.1%) and reportedly ranged in age from 22-70, with the majority of therapists being in the age ranges of 30 to 39 years old (26.4% of respondents), 40 to 49 years old (24.4%), or 50 to 59 years old (26.3%).

Respondents reported that the theoretical orientation of their treatment was cognitive-behavioral (37.8%), psychodynamic or psychoanalytic (14.3%), eclectic or integrative (9.1%), family or couples counseling (8.2%), humanistic or existential (5.4%), dialectical behavior therapy (4.2%) and "other" (17.3%). These participants were overwhelmingly in therapy of their own volition, with 86% indicating that they had begun treatment because "I wanted to" versus only 4% who were in mandated treatment and 8% who were pressured by another person. Clients who were currently in therapy reported that their duration in therapy ranged from one month to 30 years (M = 2.5 years, SD = 3.25 years. Clients who had completed treatment within the last 12 months reported their duration in therapy as ranging from one month to 25 years (M = 1.75 years, SD = 2.5 years).

Although this sample was somewhat younger, more highly educated, and more comprised of Caucasian females than the general population, it can be compared to the therapy-seeking population as reported by the National Survey on Drug Use and Health (2013). The current sample bears strong overall similarities in terms of gender and ethnicity to the national population of therapy users.

Among the 1,440 participants who began the survey, 798 participants (56%) completed it. A total of 247 individuals who began the survey discontinued after the demographics section.

Demographic analysis of the two groups – completers vs drop-outs – showed no statistically-significant differences on any demographic measure.

Sexual Dishonesty sample.

Of the 798 respondents in this survey, 47.7% (n = 381) endorsed that they had been dishonest about one or more of the following four sexual topics in therapy: "details of my sex life," my sexual desires or fantasies," "times I have cheated on a partner," and "my sexual orientation." The remaining 53.3% of the sample indicated that they had either been honest about all these topics or had selected them to be "irrelevant." Clients in the sexual dishonesty sample did not exhibit any significant demographic differences as compared to the overall sample. They were predominantly female (75%), in their thirties (mean age = 35 years), Caucasian (74%), single or never married (62%), and highly educated (55% with a bachelors degree or higher), working with female therapists (73%) across a range of modalities, including CBT (36%) and psychodynamic (14%).

Table 2 below displays the demographics of the overall sample and the sexual dishonesty subsample.

Table 2

Participant Demographics of Overall Sample (N = 798) and the Sexual Dishonesty Sample (n = 381)

Demographic	**Overall Sample**		**Sexual Dishonesty Sample**	
	% / M	SD		SD
Gender				
Female	75.4%		75.3%	
Male	23.3%		23.4%	
Other	1.3%		1.3%	
Race/Ethnicity				
Black / African-American	7.3%		6.6%	
Asian / Asian-American	6.7%		4.7%	
Hispanic / Latino/a	5.2%		7.1%	
White/Caucasian	73.1%		74%	
Biracial or multiracial	7%		5.8%	
American Indian / Alaska Native	.6%		0%	
Age (years)	35.2	13.3	35.0	13.5
Education Level				
Grade School	0.5%		0.3%	
High School or GED	9.7%		9.5%	
Some college	26.8%		28.9%	
Associate's Degree	6.6%		5.8%	
Bachelor's Degree	32.8%		32.6%	
Master's Degree	19.7%		18.2%	
PhD / MD / JD	3.9%		4.7%	
Marital Status				
Single or never married	61.1%		62.4%	
Married	21.2%		20.5%	
Separated	3.3%		3.2%	
Divorced	12.8%		12.1%	
Widowed	1.6%		1.8%	

Demographic	**Overall Sample**		**Sexual Dishonesty Sample**	
	% / M	SD		SD
Household Income				
$15,000 or less	20.3%		19.9%	
$15,000 – 30,000	20.2%		20.2%	
$30,000 – 60,000	24.2%		23.6%	
$60,000 – 100,000	15.3%		13.6%	
More than 100,000	10.7%		12.6%	
N/A	9.3%		9.9%	
Type of Psychotherapy				
CBT	37.8%		36.5%	
Psychodynamic or psychoanalytic	14.3%		13.9%	
Eclectic or integrative	9.1%		9.9%	
Addiction Counseling			2.9%	
Humanistic or existential	5.4%		6.6%	
DBT	4.2%		4.7%	
Family or couples counseling	8.2%		6.8%	
Other	17.3%		18.6%	
Therapist Gender				
Male	26.8%		26.8%	
Female	73.2%		73.2%	
Therapist Age				
22-29	6.4%		7.1%	
30-39	26.4%		24.7%	
40-49	24.4%		23.6%	
50-59	26.3%		28.9%	
60-69	14.0%		12.6%	
70 or above	2.4%		3.2%	
Duration in therapy (months)	26.8	37.0	29.1	38.6

Demographic	Overall Sample		Sexual Dishonesty Sample	
	% / M	SD		SD
Median	14.0		15.0	

Sexual Dishonesty subsamples for Research Questions 4-6.

The following subsamples refer to the respondents who, when presented with all the topics they had been dishonest or avoidant about in therapy, indicated that one of the following specific sexual topics had been "the hardest to talk about in your therapy." After selecting this topic, they were instructed to answer a series of open-text and multiple choice follow-up questions with this topic in mind, which pertained to their motives for being dishonest, perceived effect on overall therapy, feelings about having been dishonest, and possible facilitators of honesty.

"Details of my sex life."

Sixty-seven respondents elected to speak more about why "details of my sex life" had been the hardest topic to discuss in their therapy. Of that number, 12 respondents failed to complete all the follow-up questions and were removed from the analyses. The remaining 55 respondents comprise the "Details of my sex life" subsample analyzed for research questions 4-6.

The average age of the "sex life" subsample was 37.98 years (SD = 14.08), which is about three years older than the whole sample, and ranged from 19 to 72 years. Marital status was reported as single or never married (40%), married (38.1%), divorced (10.9%), separated (7.3%), or widowed (3.6%). The sample consisted of 43 females and 12 males. Respondents in this group reported their ethnicity as Caucasian (67.3%), Hispanic/Latino (9.0%), African-American (7.3%), Asian (3.6%), biracial/multiracial (3.6%), or American Indian (3.6%). This subsample reported similar levels of education as compared to the general sample, with 60% reporting a bachelors degree or higher, and 58% reporting a mean income level of $30,000 or higher. Common reasons

for entering therapy included depression (34.5%), anxiety (25.4%), trauma (16.3%), family/relationship problems (12.7%), financial/work problems (10.9%). Less common reasons included eating disorder (5.4%), bipolar disorder (3.6%), substance use, sexual orientation, and divorce (each endorsed by one respondent).

The respondents reported the orientation of their therapy as cognitive-behavioral therapy (CBT) (34.5%), other (18.1%), eclectic/integrative (14.5%), psychodynamic/psychoanalytic (12.7%), humanistic/existential (9.0%), family/couples (3.6%), dialectical behavior therapy (DBT) (1.8%), and addiction counseling (1.8%); two respondents did not provide data on their therapy orientation. They reported their duration in therapy as ranging from one month to seven years, six months, with the median time in therapy as one and a half years.

"My sexual desires or fantasies."

Fifty-three respondents elected to speak more about why "my sexual desires or fantasies" had been the hardest topic to discuss in their therapy. Of that number, nine respondents failed to complete all the follow-up questions and were removed from the analysis. The remaining 44 respondents comprise the "My sexual desires or fantasies" subsample analyzed for research questions 4-6.

The average age of the "sexual desires" subsample was 33.91 years (SD = 13.14), which is about two years younger than the whole sample, and ranged from 19 to 66 years. Marital status was reported as single or never married (68.1%), married (20.4%), divorced (9.0%), or widowed (2.3%). The sample consisted of 30 females, 13 males, and one identified "other." Respondents in this group reported their ethnicity as Caucasian (80%), biracial or multiracial (6.8%), Asian (4.5%), Hispanic/Latino (4.5%), African-American (2.3%), or other (2.3%). This subsample reported similar levels of education as compared to the general sample, with 61.4% reporting a bachelors degree or higher, and 41% reporting a mean income level of $30,000 or higher. Common reasons

for entering therapy included depression (36.3%), relationship issues (18.1%), anxiety (18.1%), trauma (15.9%), and eating disorders (13.6%). Less common reasons included bipolar disorder (6.8%), stress (6.8%), ADHD (6.8%), anger (4.5%), self-harm (reported by one respondent) and addiction (reported by one respondent).

The respondents reported the orientation of their therapy as cognitive-behavioral therapy (CBT) (29.5%) eclectic/integrative (18.1%), psychodynamic/psychoanalytic (15.9%), other (15.9%), humanistic/existential (4.5%), family/couples (4.5%), dialectical behavior therapy (DBT) (4.5%), and addiction counseling (2.3%); two respondents did not provide data on their therapy orientation. They reported their duration in therapy as ranging from one month to twenty years, with the median time in therapy as one year.

"My sexual orientation."

Sixteen respondents elected to speak more about why sexual orientation had been the hardest topic to discuss in their therapy. Of that number, two respondents failed to complete all the follow-up questions and were removed from the analysis. The remaining 14 respondents comprise the "My sexual orientation" subsample analyzed for research questions 4-6. The average age of the "sexual orientation" subsample was 34 years (SD = 14.8), which is about the same as the whole sample, and ranged from 19 to 72 years. Marital status was reported as single (71.4%) or divorced (28.6%). The sample consisted of five males and nine females. Respondents in this group reported their ethnicity as Caucasian (64.3%), Hispanic/Latino (14.2%), Black/African-American (7.1%), Asian (7.1%) and biracial or multiracial (7.1%). This subsample reported higher levels of education and lower income distribution than the general sample, with 61.5% reporting a bachelors degree or higher, and a median household income between $15,000-$30,000. Common reasons for entering therapy included depression (50%), anxiety and/or panic attacks (35.7%). Less common reasons included trauma (14.2%), insomnia (14.2%), bipolar disorder (reported by one respondent),

borderline personality disorder (reported by one respondent) and tic disorder (reported by one respondent). The respondents reported the orientation of their therapy as cognitive-behavioral therapy (CBT) (28.6%), other (21.4%), eclectic/integrative (14.3%), psychodynamic/psychoanalytic (14.3%) addiction counseling (14.3%), and dialectical behavior therapy (7.1%). They reported their duration in therapy as ranging from four months to five years, four months, with the median time in therapy as two and a half years.

"Times I have cheated on a partner."

Seven respondents elected to speak more about why "times I have cheated on a partner" had been the hardest topic to discuss in their therapy. The average age of the infidelity subsample was 38.3 years (SD = 9.53), which is three years older than the whole sample, and ranged from 25 to 46 years. Marital status was reported as married (42.8%), single (28.6%), separated (14.3%) or divorced (14.3%). The sample consisted of four males and three females. Respondents in this group reported their ethnicity as Caucasian (71.4%), Black/African-American (14.3%), and Asian (14.3%). This subsample reported higher levels of education and higher income distribution than the general sample, with 85.7% reporting a bachelors degree or higher, and 57.1% reporting a mean income level of $30,000 or higher. Common reasons for entering therapy included depression (28.6%) and anxiety and/or panic attacks (28.6%). Less common reasons included unspecified mental disorder and "divorce and work" (each reported by one respondent). The respondents reported the orientation of their therapy as cognitive-behavioral therapy (CBT) (42.9%), eclectic/integrative (14.3%), psychodynamic/psychoanalytic (14.3%), and addiction counseling (14.3%). They reported their duration in therapy as ranging from one month to nine years, six months, with the median time in therapy as two years.

Data Collection Procedures

Original data collection. The study received approval by the Teachers College IRB in April, 2015. Participants were recruited through postings to Craigslist, an online classified advertisement website reaching a community of over 700 localities in 70 countries worldwide. The survey was posted to Craigslist forums across both metropolitan and more rural areas of the United States and Canada in order to obtain a large and geographically diverse sample. The posting message invited respondents to share their experiences in a "survey on psychotherapy," and contained a link to the survey. All respondents could choose whether to enter into a drawing to win one of six $50 Amazon gift cards. Identities of respondents were protected by not requiring that respondents share their names. Those who chose to enter this drawing were provided a separate survey link in which they could enter their email addresses, ensuring protection of personal information by keeping personal information separate from their survey responses. Personal data was only linked to survey responses in the case of respondents who indicated they were interested in completing an in-person interview about their therapy experience, a later phase of the research project that is beyond the scope of the present study.

All survey information was secured in password-protected files that were only accessible by members of the study team. Any participant information was de-linked from survey responses after being processed by the study team. Respondents who completed the survey were provided the contact information of the principal investigator/faculty advisor on the study, Dr. Barry Farber, in case they had any questions or concerns. They were also given an email address that was checked regularly by members of the study team. Subjects who experienced distress while completing the survey were encouraged to contact Dr. Farber or the research team for assistance in finding local counseling services. No respondents contacted the team for this purpose.

Measures

The Difficult Disclosures Survey (DDS).

This online, anonymous self-report instrument was developed using Qualtrics software and is designed to yield both quantitative and qualitative data on clients' experience in psychotherapy about the following areas: prevalence of dishonesty; how dishonesty manifests in therapy in terms of whether it is passive (total avoidance of the topic) or active (discussing a topic but with a low degree of honesty); the demographic, personality, and/or dyadic variables that are related to whether a client is highly honest or dishonest (passively or actively) about each topic; the motives for being dishonest about a topic of their choice that was the hardest to discuss in therapy; the impact of dishonesty on therapy in terms of feelings that are evoked for clients and overall effect on progress; and the perceived facilitators that clients believe would increase honesty around their topic. The survey contained 107 items and has a median completion time of about 21 minutes. The dissertation herein will focus primarily on data about the following four sexually-related topics: "details of my sex life," "my sexual desires or fantasies, "times I have cheated on a partner," and "my sexual orientation."

First, respondents provide demographic information, including age, gender, ethnicity, household income, education, marital status, and whether they are in the mental health field or not; this section also asks respondents to indicate the demographics of their therapist, their reason for seeking therapy, the duration of their treatment, and the modality of therapy.

Then, in order to help respondents access memories of dishonesty, they are presented with a list of 33 topics and asked whether or not they have discussed them in therapy. These 33 topics were adapted from the Disclosure to Therapist Inventory IV (DTI-IV; Pattee & Farber, 2008) and Blanchard and Farber's (2016) exploratory survey on disclosure and lying in psychotherapy. Sample topics on the DDS include a wide range of potentially difficult areas of disclosure, including "Details of my sex life," "My use of drugs or alcohol," "How I struggle to control my moods," "Whether I think therapy is helping me," "Suicidal thoughts," and "My sexual orientation."

Respondents are then re-presented with a list of all the topics that they endorsed discussing in therapy and asked to rate their honesty for each topic on a 5-point Likert scale (1 = "not at all honest," 5 = "completely honest"). For those topics that respondents reported they *did not* discuss in therapy, they were asked to choose one of three reasons why this topic was not addressed and provided the following three options: "It does not apply to me," "I would discuss this but it has not come up," and "I purposely avoid this topic."

For the follow-up portion of the survey, respondents were re-presented with all the topics about which they had either reported a score of "1" or "2" on the Honesty scale or indicated they had avoided entirely and then asked to select the topic that was hardest to discuss in their therapy (see Figure 1 for a flowchart of this survey process). With this topic in mind, respondents answered forced-choice, multiple-choice and open-text questions about the circumstances, motivations, feelings, and perceived consequences of their dishonesty or avoidance, followed by a section about the possible facilitators of increased honesty. Answer choices for all follow-up questions were based on a review of the previous research and were most directly influenced by Kelly (2000), Blanchard and Farber (2016), and Baumann and Hill (2016). In this section, respondents also provided more information about their therapy experience, including demographic information about their therapist, the theoretical orientation of their therapy, and their reason for entering treatment.

In the follow-up section, respondents are first presented with an open-text box and encouraged to respond qualitatively to the prompt: "What makes it hard to be honest?" Then, clients are asked to select their motive(s) for being dishonest from a selection of six possible answers in response to the multiple-choice question "Which of these describes your reason for not being more honest?" Respondents could click all that applied from the following list of six choices: "practical consequences (e.g., legal problems, hospitalization)," "embarrassment or shame," "It would bring

up overwhelming emotions," "My therapist would be upset, hurt, or disappointed," "I didn't want this to distract from other topics," and "I doubt my therapist can help or understand," These motives were most directly informed by reducing the option choices from Blanchard and Farber (2016), as well as from a review of the literature (DePaulo et al., 1996; Hill et al., 1993; Newman & Strauss, 2003; Rennie, 1994; Regan & Hill, 1992).

Respondents are then asked a forced-choice item assessing their hypothetical attitude toward being more honest: "Is this a topic you would ever be more honest about?" They were instructed to select one response from the following four options: "Yes, but with a different therapist," "Yes, with my current therapist," "Yes, but only with family and friends," and "No, probably not with anyone." These options were developed by the two doctoral-level students who designed the survey, including the present author.

Respondents are also queried about what might facilitate increased honesty in their therapy using both open-text boxes and a multiple-choice question. Similarly to the motives section, participants are first presented with an open-text box and allowed to respond at length to the prompt: "How could your therapist make you feel more comfortable being honest about this? Please explain" in order to collect qualitative data on their desired therapeutic techniques or another imagined facilitators. Then, clients are presented with a multiple-choice item that instructs them to select as many possible options as they wished in response to the question, "Under what circumstances would you be more honest about this topic?" They were presented with eleven potential choices: "If I trusted my therapist more," "If my therapist was warmer," "If my therapist was more skillful," "If my therapist asked me about it directly," "If I knew this wouldn't ruin my relationship with my therapist," "If I knew that my therapist had a similar problem," "If my therapist understood my culture or class," "If I knew my therapist would not overreact," "If I felt like this was blocking my progress in therapy," or "Under no circumstances would I be more honest

about this topic." These response options were adapted from a review of the literature, including Baumann and Hill (2016), Blanchard and Farber (2016), and Farber et al. (2004).

Respondents are then asked to assess the potential effects of dishonesty by answering questions about how they felt after being dishonest and whether they perceived it having an impact on the therapy process. They were presented with the question, "Which of these describes your primary feeling about being avoidant or dishonest?" and instructed to pick one of 12 possible response choices: satisfied, safe, in control, true to myself, frustrated, guilty, worried, regretful, neutral, confused, unconcerned, and conflicted. The selected list of feelings was based on a review of the literature (Baumann & Hill, 2016; Blanchard & Farber, 2016; Farber et al., 2004).

Next, respondents are presented with an open-text box and allowed to respond at length to the prompt: "Can you tell us how not being honest affected your therapy?" in order to yield qualitative data on the impact of dishonesty on therapy. Finally, respondents encounter a similar question in multiple-choice format: "Has not being honest affected your therapy?" They are presented with three possible answer choices, from which they could select one: "It hurt my progress," "It helped my progress," or "No effect." These response choices were developed by the two doctoral-level students who designed the survey, including the present author. These answers were based in part on reducing the option choices from Blanchard and Farber (2016).

When assessing motives, facilitators, and impact on therapy, participants were first presented with open-text boxes to collect qualitative data so as not to bias any initial responses and to provide them the opportunity to speak at length before they encounter multiple-choice items, which were designed to act as a "check" on the qualitative data while also allowing for other salient themes to be developed.

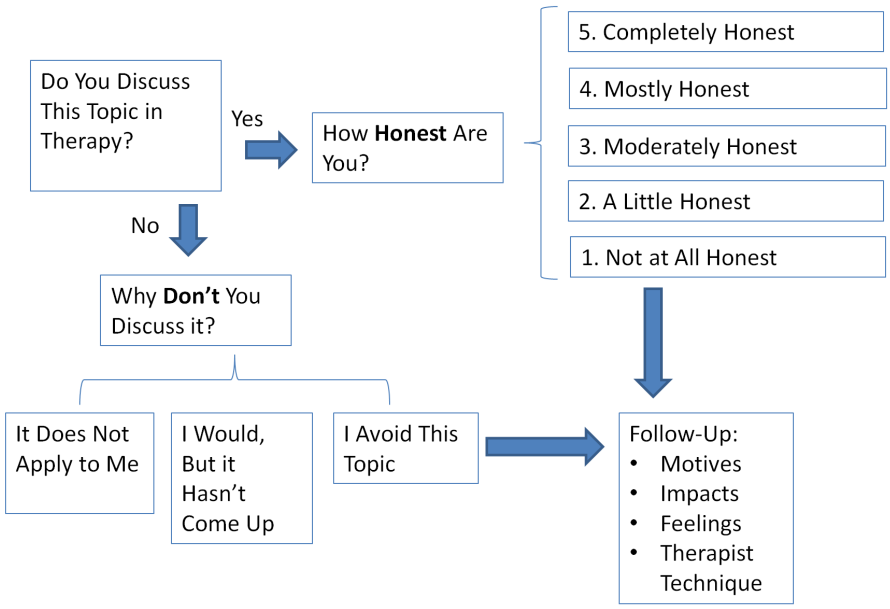


Figure 1: Design and Flow of the Difficult Disclosures Survey (DDS)

Items used in this analysis.

This dissertation will report data from the following domains on the Difficult Disclosures Survey:

- client and therapist demographics
- reason for entering treatment, therapy orientation, and duration of therapy
- prevalence of clients who indicated that they were either honest or dishonest about each of the four sexual topics ("details of my sex life," "my sexual desires or fantasies," "times I have cheated on a partner," "my sexual orientation")
- style in which dishonesty manifested (i.e., clients who indicated that they did not discuss a sexual topic because they were avoiding it as compared to those who addressed it but with a low degree of honesty)
- motives for being dishonest about a sexual topic (quantitative and qualitative responses)

- impacts of dishonesty on therapy about a sexual topic (quantitative and qualitative responses)
- feelings about being dishonest about a sexual topic (quantitative responses)
- perceived clinical facilitators of increased honesty about a sexual topic (quantitative and qualitative responses)

Of note, the sections on demographics, prevalence, and style of dishonesty about sexual content will be derived from the overall sample of participants (N = 798), since all participants rated all possible topics of dishonesty, while the sections on motives, impacts, feelings, and perceived facilitators will contain data only from the follow-up samples of participants – that is, those who indicated that a sexual topic had been hardest to talk about in their therapy. This dissertation will not include data on any other non-sexual topic of dishonesty when reporting about demographics, prevalence, or style of dishonesty. However, some comparisons to the overall sample will be provided in the quantitative results about motives and facilitators in order to provide a sense as to how these domains may differ based on topic of dishonesty. Data on hypothetical attitudes toward disclosure ("Is this a topic you would ever be more honest about?") was not included in the results section to follow.

Because this dissertation also includes a research question about the factors that may differ between clients who are honest about sexual content compared to those who are not, measures were also included to assess two personality traits that have been identified as potentially relevant (self-concealment and distress disclosure), as well as a measure of client ratings of the working alliance.

The Self-Concealment in Therapy Scale (SCS-T).

The SCS-T is an adaptation of the Self-Concealment Scale (Larson & Chastain, 1990), a 10-item measure of a person's predisposition to actively conceal distressing or negative personal information from others. The original SCS has been found to be a unidimensional and internally

consistent scale; a recent review of this measure across ninety-nine studies yielded an overall mean coefficient alpha of .87 (Larson et al., 2015).

The modified SCS-T retains the wording of the original 10-item scale but adapts the context to the psychotherapy setting. The original Self-Concealment Scale has been previously adapted for use in other settings, including for use specifically with parents, adolescents, and romantic partners, and was done so in this study with the permission of the author, Dale Larson. It is designed to capture the respondent's tendency to actively conceal distressing or negative personal information from his or her therapist. Items include "I have an important secret that I haven't shared with my therapist" and "I'm often afraid I'll reveal something I don't want to in therapy." The SCS-T is a 10-item self-report measure rated on a 5-point Likert scale (1 = "strongly disagree," 5 = "strongly agree"), with a minimum score of 10 and a maximum score of 50 points. Cronbach's alpha for the SCS-T used in the present study was .91. The mean score on the SCS-T was 24.56 (SD = 9.35). This is consistent with the initial development research for the Self-Concealment Scale, which found that the average score for a group of 306 adults was 26, with about 70% scoring between 19 and 33 (Larson & Chastain, 1990). There was a strong negative correlation between scores on the SCS-T and the Distress Disclosure Index (DDI; Kahn & Hessling, 2001), $r = -.33$, $p < .001$, which was meant to serve as a validity check; that is, respondents who reported a higher tendency to conceal to the therapist showed, on average, lower general willingness to disclose personally distressing information.

Distress Disclosure Index (DDI; Kahn & Hessling, 2001).

The DDI is a 12-item self-report measure of an individual's tendency to disclose personally distressing information. Items include "I am willing to tell others my distressing thoughts" and reverse-coded items such as "I prefer not to talk about my problems." Each item is rated on a 5-point Likert scale (1 = "strongly disagree," 5 = "strongly agree), with higher scores indicating a

greater tendency toward disclosure. According to the authors, distress disclosure is a largely stable, trait-like variable, and represents a general tendency that an individual brings into the therapy setting. Internal consistency of the DDI has been found to range from .92 to .95 (Kahn & Hessling, 2001); in the current sample, Cronbach's alpha was found to be .93.

Working Alliance Inventory – Short Form Revised (WAI-SR; Hatcher & Gillaspy, 2006).

The WAI-SR is a 12-item self-report measure of the alliance that has parallel forms for both clients and therapists. Only the client items were administered in this study. The items are based on Bordin's (1979) model of the therapeutic alliance, which is comprised of three interdependent components captured in the three subscales of the WAI-SR: Goals (the agreement between client and therapist on the goals of therapy), Tasks (the agreement between client and therapist on the tasks of therapy), and Bond (the strength of the reciprocal positive feelings between therapist and client). The WAI-SR yields a total alliance score and can also be analyzed based on the individual subscales. Items include "My therapist and I are working toward mutually agreed upon goals" (Goals subscale), "I feel the things I do in therapy will help me to accomplish the changes that I want" (Tasks subscale), and "My therapist and I respect each other" (Bond subscale). Each item is rated on a 5-point Likert scale (1 = "seldom," 5 = "always"). Reported internal consistency of the WAI-SR ranges from .85 to .92 (Hatcher & Gillaspy, 2006). In the current sample, Cronbach's alpha for the WAI-SR (total alliance score) was .94

Data Analysis Procedures

This data set comprises both quantitative and qualitative information about the motives, perceived impact (i.e., clients' feelings about being dishonest and their sense of its overall effect on therapy), and desired clinical techniques to facilitate increased honesty. Each of the aforementioned

domains used both multiple choice questions and open-text boxes so that clients could explain themselves at length. Additionally, quantitative data was collected in the form of client and therapist demographics, as well as psychometric scales that measure the therapeutic alliance, a modified version of a self-concealment scale designed to more specifically capture clients' tendency to self-conceal in therapy, and a measure of clients' tendency to disclose distressing experiences with others.

Given the complexity of these data, data analysis proceeded in a few separate steps. First, descriptive statistics were calculated to report the rates of prevalence and style of dishonesty using respondents' quantitative data. Respondents could rate their honesty for each of the four sexual topics if they had indicated discussing them in therapy, or provide information about whether they had chosen *not* to disclose a particular topic because they were avoiding it in therapy. Thus, prevalence data is provided about the extent to which respondents indicated being honest or dishonest about a particular sexual topic, as well as whether they tended to be *actively dishonest* (discussing topics but with a low degree of honesty) or *passively avoidant* in therapy about sexual details, fantasies, infidelity, and sexual orientation.

Because every participant in the survey rated their honesty (or lack thereof) on each possible topic, exploratory comparisons were conducted between those who were dishonest or avoidant about a sexual topic versus those who reported high honesty scores ("4" or a "5" on the honesty scale, indicating that they were "a lot" or "completely" honest about this material) in order to understand whether these groups – "high honesty" clients and "dishonest/avoidant" clients – differ in terms of demographic variables, disclosure tendencies, and/or ratings of the therapeutic alliance.

Chi-square analyses were implemented for all demographic variables excluding client age, which was measured on a continuous scale. The demographic variables are as follows: client gender, ethnicity, education level, and income; therapist gender and age (comprised by six age

groups: 20-29; 30-39; 40-49; 50-59; 60-69; 70 and above). T-tests were used for the variable of client age, as well as self-reported disclosure tendencies as measured by scores on the Self-Concealment to Therapist Scale (SCS-T) and Distress Disclosure Index (DDI) and ratings of the therapeutic alliance as measured by the Working Alliance Inventory (WAI-SR).

Finally, descriptive statistics are also reported for rates of responses on all multiple-choice follow-up items for motives, impact of dishonesty (including primary feelings about being dishonest and overall impact on therapy), and perceived facilitators of honesty. These data come from the four sexual dishonesty subsamples ("details of my sex life," "my sexual desires or fantasies," "my sexual orientation," and "times I have cheated on a partner") and thus contain only those participants who indicated that a sexual topic had been hardest to discuss in their therapy and elected to answer follow-up questions with their specific topic in mind.

Thematic analysis of the qualitative data

For the qualitative data, Braun and Clarke's (2006) approach to thematic analysis was chosen in order to examine themes relating to 1) client motives for dishonesty about each sexual topic, 2) client's sense of how being dishonest about sexual content impacted therapy overall, and 3) the possible facilitators that would help them be more honest with their therapist about this material. Thematic analysis (TA) was chosen for its theoretically flexible approach, which is consistent with the exploratory nature of the study and my lab's atheoretical stance toward the phenomenon of dishonesty, as well as the fact that very little literature exist specifically on dishonesty in therapy about sexual content.

In contrast to other qualitative methodologies like grounded theory, content analysis, or interpretive phenomenological analysis, thematic analysis is not tied to any preexisting theoretical framework. As described by Nowell et al. (2017), citing Braun and Clarke (2006), thematic analysis is a useful approach for "examining the perspectives of different research participants, highlighting

similarities and differences, and generating unanticipated insights" (p. 2). This makes thematic analysis well suited for the current mixed-methods, exploratory study, whose goal is provide a detailed overview of psychotherapy clients' experience of being dishonest about sexual material. More specifically, thematic analysis can capture a rich and comprehensive understanding of individual clients' subjective experience of being dishonest in psychotherapy about *specific* types of sexual content while also examining themes that are consistent across clients and across topics in order to inform therapeutic interventions about sex more broadly.

Of note, this data comes from four separate subsamples of the survey: that is, the individual clients who reported that one of the following four topics – "details of my sex life," "sexual desires or fantasies," "my sexual orientation," and "times I have cheated on a partner" – was the hardest to discuss in their therapy and went on to complete the follow-up portion of the survey with their selected topic in mind.

In order to conduct the thematic analysis, Braun and Clarke's six-step approach to thematic analysis (2006; 2012; 2013) was utilized. More specifically, this analysis proceeded from an inductive, semantic, and essentialist/realist approach[1] in order to provide a framework in which participants' experiences could unfold directly from the original data (inductive), where participants' written responses influenced the themes extracted rather than the researcher's preexisting theoretical stance (semantic), and where the goal of the work was to accurately and

[1] Because the construct of "essentialism" is associated with some degree of controversy, particularly as it has been used in gender studies/feminist theory to refer to attributions of a fixed, biological essence to gender that precludes the possibility of change, from here on I will refer to Braun and Clarke's use of the term in thematic analysis as "realism." Of note, these authors' backgrounds are in psychology, specifically the use of qualitative work in LGBTQ and feminist studies. Their use of the term "essentialist/realist" in epistemology is meant to reflect the researcher's ability to assume a direct relationship between language and meaning; words are reflctions of participant reality, thereby allowing the researcher to theorize about motives in a straightforward way. In contrast, a constructionist perspective states that meaning and experience are socially produced rather than emerging from within individuals (Burr, 995). Thematic analysis from a constructionist framework "cannot and does not seek to focus on motivation or individual psychologies," but rather aims to theorize about how sociocultural contexts contributed to and produce the individual accounts that are provided.

transparently reflect the individual client's experience using their words as evidence of their reality (realist approach). More about these parameters will be described below.

The data were analyzed by two doctoral-level researchers, including the present author, and reviewed by a third doctoral-level researcher who was involved in the development of the survey and has published about dishonesty in therapy. Members of the research team followed the steps outlined by Braun and Clarke (2006) to conduct the thematic analysis, with the final written report of themes evaluated by an experienced researcher in the field in the area of disclosure and non-disclosure in psychotherapy.

First, the data (i.e., clients' open-text responses across each area of interest) were read carefully in full length without coding in order for the researchers to familiarize themselves with the material. Second, all data were thoroughly and systematically read separately by each researcher, who then began produce a list of initial codes for each research question (motives, impact on process, and perceived facilitators of honesty). Each researcher coded responses on the basis of what appeared to be interesting or prominent in each client's words with the goal of comprehensively attending to all features of the data. Third, both members of the research team started the process of theme development by grouping codes together and searching for relationships between themes, initially working separately and then meeting together to discuss and compare themes. During this process, codes and themes were either differentiated further or grouped together according to shared features. The differentiation and merging of initial codes allowed for the development of a set of prominent themes and subthemes. Fourth, the data were systematically reviewed to ensure that a name and a clear definition for each theme were identified. Finally, themes were reviewed against the entire dataset to ensure that there was a good fit between the identified themes and the coded data, and that the themes told a representative and coherent story about the coded data. This process was repeated for each of the four sexual topics ("details of

my sex life," "my sexual desires or fantasies," "my sexual orientation," and "times I have cheated on a partner") within the three qualitative research questions for this study: motives for dishonesty, impact of dishonesty on therapy overall, and perceived facilitators of honesty.

Data analysis was an iterative process, allowing time for themes and subthemes to be identified until a structure was found that fit the data and captured the meaning of clients' experience by staying close to the text at every step. Themes were developed primarily at a semantic (surface-level) in order to identify the explicit meaning of the data (Boyatzis, 1998) and to stay close to the participants' words. The idea of a "theme" in qualitative analysis has been variously defined, but in essence it is "used as an attribute, descriptor, element, and concept. It contains codes that have a common point of reference and has a high degree of generality that unifies ideas regarding the subject of inquiry" (Vaismoradi et al., 2016, pg. 101)

Themes or patterns in the data can be identified in one of two ways within a thematic analysis approach: an inductive or "bottom-up way" (Frith & Gleeson, 2004) or in a theoretical, deductive, or top-down way (Boyatzis, 1998). This analysis utilized an inductive approach, in which the themes that are identified are linked to the data itself rather than guided by a preexisting theoretical approach. Inductive analysis is a process of coding the data in an exploratory, open-ended way without trying to fit it into a coding frame or using the researcher's analytic sense of what the data should yield (Braun & Clarke, 2013).

According to Braun and Clarke (2006), it is considered best practice to identify and make transparent the theoretical framework in which the analysis was conducted. The present analysis was conducted within a realist method, which aims to directly report the experiential reality of research participants. It is assumed that there is a unidirectional relationship between clients' words and the experiences that they are reporting, such that their language allows the researcher to capture and articulate motives, feelings, and meaning (Potter & Wetherell, 1987). However, according to

Ryan and Bernard (2003), even themes that are derived directly from the data in an inductive approach are inevitably influenced by researchers' existing theoretical understanding of the phenomenon under investigation (an a priori approach).As such, as per Braun and Clarke's recommendations (2006), it is important to explicate my own philosophical stance as a researcher in conducting this analysis as well as to account for any bias.

My aim as a researcher is to accurately represent my participants' experience and to take their words to be evidence of their reality. Accordingly, my methodology aims to reduce my influence as a researcher and to provide clients a free, unstructured opportunity to give their true perspectives; this is reflected in my choice of an anonymous online survey design and open-text qualitative questions. However, I recognize that my influence emerges nonetheless in my choice of topic, how I describe the constructs of interest, and my framing of questions. Moreover, my goal of describing some commonalities of experience across participants represents a form of constructed reality, as does my understanding that there is no single 'truth' to be found among participants as to why they are dishonest in therapy about sexual material.

With regards to my choice of a methodology, in which each research question (i.e., motives, impact on therapy, and perceived facilitators of honesty) was assessed using both open-text and multiple choice items, this mixed-methods approach was utilized as a way of giving clients as many opportunities as possible to expound upon their experience of being dishonest in therapy while also serving as a way for the qualitative and quantitative data to inform and enrich the other.

Reliability and rigor.

Because of the pure qualitative nature of thematic analysis, it has been argued that applying traditional, quantitative methods of proving reliability, such as assessing intercoder reliability, is not appropriate (Merriam, 2009; Vaismoradi, Turunen, & Bondas, 2013). According to Loffe and Yardley (2004), the reliability check does not necessarily establish that the codes are objective,

merely that two people can apply the same subjective perspective to the text. In the qualitative literature, the closest thing to reliability is the concept of "rigor," which is the product of the entire research process and "derives from the researcher's presence, the nature of the interaction between researcher and participants, the triangulation of data, the interpretation of perceptions, and rich, thick descriptions" (Merriam, 2009, pp. 165–166). Tracy (2010) also provides eight "big-tent" criteria for excellent qualitative research: (a) worthy topic (i.e., the topic is relevant, interesting, significant) (b) rich rigor (i.e., the study uses sufficient and appropriate data collection and analysis processes), (c) sincerity (i.e., the study is characterized by transparency about the methodology and the values or biases of the researcher) (d) credibility (the research is marked by thick description and concrete detail, multivocality, and triangulation or crystallization, which encourages researchers to gather multiple types of data and use multiple researchers), (e) resonance (the research contains evocative findings that are naturalistic and transferable) (f) significant contribution (conceptually, practically, methodologically), (g) ethics (i.e., the research considers procedural ethics), and (h) meaningful coherence (i.e., the study achieves what it states to be about and uses methods and procedures that fit its intended goals).

Within this study, the use of peer checking and the integration of multiple sources of data – i.e., the blending of quantitative and qualitative methodologies – is a way of achieving richly rigorous, resonant, and credible data. According to Tracy (2010), "Multiple types of data, researcher viewpoints, theoretical frames, and methods of analysis allow different facets of problems to be explored, increases scope, deepens understanding, and encourages consistent (re)interpretation" (pg. 843). Each member of the research team coded data and began the process of theme development separately so as to allow for independent thought. In cases of disagreement during the phase of theme differentiation and grouping, explanation and clarifying were used in order to reach a consensus that spoke to unifying features of the data while also allowing for less common voices to

be heard. Finally, all derived themes and the written report were overseen by an expert in the field in line with best practice recommendations for qualitative research (Denzin, 1978; Elliott, 1999).

Results

Research Question 1: To what extent are clients honest and dishonest in psychotherapy about each of the following sexual topics – "details of my sex life," "my sexual desires or fantasies," "times I have cheated on a partner," and "my sexual orientation"?

Frequencies and percentages of clients who were honest (i.e., those who scored a "4" or "5" on the Likert scale of honesty in therapy, indicating "a lot" or "complete" honesty) and dishonest (i.e., those who were purposefully avoidant about a topic or who scored a "1" or a "2" on the Likert scale of honesty in therapy, indicating that they were "not at all" or "a little" honest) about each of the four sexual topics are displayed in Table 3. Results showed that about a third of the sample was dishonest about "my sexual desires or fantasies" and "details of my sex life," which is comparable to previous research delineating sexual topics as among the most frequently lied about in therapy.

Of note, two of these topics – "my sexual desires or fantasies" and "details of my sex life" – were the top-most prevalent topics of dishonesty in the entire sample. For reference, the next highest topics of dishonesty were "suicidal thoughts," endorsed by 21.4% of all respondents, and "my real reactions to my therapist's comments," endorsed by 19.5%.

Table 3

Frequencies and Percentages of Overall Honesty and Dishonesty About Sexual Topics in Therapy (N = 798)

Topic	Number and (Percent) of overall sample reporting honesty	Number and (Percent) of overall sample reporting dishonesty
My sexual desires or fantasies	*n* = 94 (11.8)	*n* = 269 (33.7)
Details of my sex life	*n* = 166 (20.8)	*n* = 259 (32.5)
My sexual orientation	*n* = 267 (33.4)	*n* = 136 (17.0)
Times I have cheated on a partner	*n* = 110 (13.8)	*n* = 72 (9.0)

Note: Dishonesty defined as those who were purposefully avoidant about a topic or who scored a "1" or "2" on a 5-point scale of honesty where 1 = not at all honest and 2 = a little honest; honesty defined as those who scored a "4" or a "5" on the scale of dishonesty, where 4 = a lot and 5 = completely honest.

Research Question 2: How does this dishonesty about sexually-related issues manifest in terms of style? That is, to what extent are clients *actively dishonest* about a topic (i.e., discussing it in therapy but with a low degree of honesty) and to what extent are they *passively dishonest*, excluding the topic from the dialogue entirely due to avoidance?

Frequencies and percentages of clients who were actively dishonest (i.e., those who discussed the topic but with a low degree of honesty, as indicated by a score of "1" ["not at all honest] or 2" ["a little honest"] on the Likert scale of honesty in therapy) or passively dishonest (i.e., those who indicated that they *did not* discuss a topic in therapy because they were avoiding it entirely) about each of the four sexual topics are displayed in Table 4. Results showed that passive dishonesty (i.e., total avoidance) was most often the style of choice when it comes to dishonesty about sexual material in therapy as compared to broaching the topic but with a low degree of honesty. This pattern is especially prevalent with the two topics that are more explicitly focused on

sexual content ("my sexual desires or fantasies" and "details of my sex life"). This suggests that sexual material is very often left out of the dialogue entirely in therapy.

Table 4

Frequencies and Percentages of Active Versus Passive Dishonesty About Sexual Topics in Therapy (N = 798)

Topic	Percent of overall sample reporting active dishonesty (addressing a topic but with a low degree of honesty)	Percent of overall sample reporting passive dishonesty (purposefully avoiding a topic)
My sexual desires or fantasies	*n* = 31 (3.9)	*n* = 238 (29.8)
Details of my sex life	*n* = 50 (6.3)	*n* = 209 (26.2)
My sexual orientation	*n* = 58 (7.3)	*n* = 78 (9.8)
Times I have cheated on a partner	*n* = 20 (2.5)	*n* = 52 (6.5)

Note: Active dishonesty defined as those who scored a "1" or "2" on a 5-point scale of honesty where 1 = not at all honest and 2 = a little honest; Passive dishonesty defined as those who indicated being purposefully avoidant

Research Question 3: Which demographic variables (e.g., age, gender, ethnicity, education level, income), specific tendencies toward disclosure or concealment (e.g., distress disclosure and self-concealment), and specific therapy variables (i.e., demographic variables related to the therapist and ratings of the therapeutic alliance) are significantly related to high honesty and dishonesty in psychotherapy about each type of sexual content?

On the topic "details of my sex life," Chi-square analyses of the "high honesty" and "dishonest/avoidant" groups showed that the only significant demographic difference was in terms of client gender, such that females were more likely to be dishonest or avoidant, χ^2 (1) = 6.67, $p <$ .05. Therapist gender and age were both non-significant, χ^2 (1) = 1.58, p = .45; χ^2 (5) = 3.90, p = .56. For the variable of client age, a t-test comparison yielded non-significance, t (423) = 1.10, p = .27.

Results of independent t-tests showed statistically significant differences between the two groups in terms of ratings on the Self-Concealment to Therapist Scale (t [423] = -7.88, $p < .00$), Distress Disclosure Index (t [423] = 4.72, $p < .00$), and Working Alliance Inventory, (t [423] = 5.48, $p < .00$), such that those who were "dishonest/avoidant" had higher SCS-T scores, lower DDI scores, and lower WAI scores. This indicates a greater tendency to conceal information from the therapist about distressing or negative topics, feelings or behavior, a lower tendency to disclose to others more generally about personal information, and lower ratings of the therapeutic alliance, which includes ratings of the bond with the therapist and the agreement on tasks and goals. All mean scores and standard deviations for each topic are reported in Table 5.

On the topic "my sexual desires or fantasies," Chi-square analyses of the "high honesty" and "dishonest/avoidant" groups showed that there were significant demographic differences in terms of both client gender and therapist gender, such that female clients were more likely to be dishonest or avoidant, χ^2 (1) = 14.76, $p < .001$ and clients overall were more likely to be dishonest with a female therapist, χ^2 (1) = 11.67, $p < .001$. Therapist age was not significant, χ^2 (5) = 9.08, $p = .11$. A t-test of client age showed non-significance, t (361) = .38, $p = .107$. Results of independent t-tests showed statistically significant differences between the two groups in terms of ratings on the Self-Concealment to Therapist Scale (t[361] = -6.33, $p < .00$), Distress Disclosure Index (t [361] = 3.33, $p < .001$), and Working Alliance Inventory, (t [361] = 2.78, $p < .006$), such that those who were "dishonest/avoidant" had higher SCS-T scores, lower DDI scores, and lower WAI scores. This indicates that clients who were dishonest or avoidant about sexual desires or fantasies also had a greater tendency to conceal information from the therapist about distressing or negative topics, feelings or behavior, a lower tendency to disclose to others more generally about personal information, and lower ratings of the therapeutic alliance.

On the topic "my sexual orientation," Chi-square analyses of the "high honesty" and "dishonest/avoidant" groups showed no significant demographic differences for clients on the variables of gender, ethnicity, education level, or income and no demographic differences for therapist age and/or gender. T-tests showed no significant differences for client age, t (401) = .31, p = .75. Results of independent t-tests showed statistically significant differences between the two groups in terms of ratings on the Self-Concealment to Therapist Scale (t [401] = -7.14, p < .00), Distress Disclosure Index (t [401] = 3.54, p < .00), and Working Alliance Inventory, (t [401] = 5.71, p < .00), such that those who were "dishonest/avoidant" had higher SCS-T scores, lower DDI scores, and lower WAI scores. This indicates that clients who were dishonest or avoidant about sexual orientation also had a greater a greater tendency to conceal information from the therapist about distressing or negative topics, feelings or behavior, a lower tendency to disclose to others more generally about personal information, and lower ratings of the therapeutic alliance.

On the topic "times I have cheated on a partner," Chi-square analyses between the "high honesty" and "dishonest/avoidant" groups showed no significant demographic differences for clients on the variables of gender, ethnicity, education level, or income and no demographic differences for therapist age and/or gender. T-tests showed no significant differences for client age, t (180) = .58, p = .56. Results of independent t-tests showed statistically significant differences between the two groups in terms of ratings on the Self-Concealment to Therapist Scale (t [180] = -4.33, p < .00), Distress Disclosure Index (t [180] = 2.89, p < .004), and Working Alliance Inventory, (t [180] = 2.89, p < .004), such that those who were "dishonest/avoidant" had higher SCS-T scores, lower DDI scores, and lower WAI scores. This indicates that clients who were dishonest or avoidant about infidelity also had a greater tendency to conceal information from the therapist about distressing or negative topics, feelings or behavior, a lower tendency to disclose to others more generally about personal information, and lower ratings of the therapeutic alliance.

Table 5

Comparison of Mean Scores on Disclosure Tendencies and Ratings of the Therapeutic Alliance Among Those Who Were Honest or Dishonest About a Sexual Topic

		Distress Disclosure Inventory (DDI)		***Self-Concealment to Therapist Scale (SCS-T)***		***Working Alliance Inventory (WAI-SR)***	
		M (SD)	**t-score**	**M (SD)**	**t-score**	**M (SD)**	**t-score**
Details of my sex life	Honest (*n* = 166)	41.7 (10.1)	4.72*	19.9 (8.9)	-7.88*	65.9 (12.0)	5.48*
	Dishonest (*n* = 259)	36.8 (10.6)		26.9 (9.0)		59.3 (12.0)	
My sexual desires or fantasies	Honest (*n* = 94)	41.3 (10.1)	3.33**	19.3 (9.4)	-6.33*	64.8 (11.7)	2.77***
	Dishonest (*n* = 269)	37.2 (10.4)		26.2 (8.9)		60.7 (12.5)	
My sexual orientation	Honest (*n* = 267)	39.7 (10.1)	3.54*	21.8 (9.4)	-7.14*	64.2 (11.8)	5.70*
	Dishonest (*n* = 136)	35.9 (9.7)		28.8 (9.4)		56.8 (13.1)	
Times I have cheated on partner	Honest (*n* = 110)	40.3 (10.5)	2.89**	21.3 (9.9)	-4.33*	63.9 (12.4)	2.89**
	Dishonest (*n* = 72)	36.0 (8.4)		27.7 (9.3)		58.6 (11.6)	

Note: Overall N = 798. *$p < .05$; **$p < .01$; ***$p < .001$.

Research Question 4: What are clients' self-reported motives for being dishonest about each of the four sexual topics? Do these motives differ by the specific type of sexual content? Do these motives differ when compared to all other non-sexual topics? Results for this question were collected using both quantitative (multiple choice) data and qualitative (open-text) data to understand clients' motives for being dishonest about their sexual topic of choice.

Thematic Analysis of Open-Text Data for Research Question 4

Structure of the qualitative data. Qualitative data about motives for dishonesty for each of the four sexual topics – "details of my sex life," my sexual desires or fantasies," "my sexual orientation," and "times I have cheated on a partner" – was collected for research question 4 in response to an open-text question "What makes it hard to be honest about this topic?" Respondents could enter in as much text as they liked in order to describe what motivated their decision to be dishonest with the therapist about their selected topic.

For the 55 participants in the "details of my sex life" subsample, responses ranged from one words to 235 words that were developed into ten motives. For the 44 participants in the "my sexual desires in fantasies" subsample, responses ranged from two words to 83 words that were developed into 11 motives. For the 14 participants in the "my sexual orientation" subsample, answers ranged from four words to 114 words that were developed into nine motives. For the seven participants in the "times I have cheated on a partner" subsample, responses ranged from one word to 13 words that were developed into four motives.

Theme descriptions.

Four categories of motives were created from the data as a way of organizing the themes that clients discussed in their open-text responses. The frequency and percentage of clients reporting each motive category is presented in table 6.1. These categories are as follows: motives related to therapy or therapist, which contains four themes; motives related to beliefs about self or sexuality,

which contains three themes; motives related to the avoidance of emotional experience, which contains three themes; and motives related to avoiding real-world impacts, which contains two themes. The following sections describe each of the four categories of motives as well as the themes contained within, which total 12 distinct motives for dishonesty. All themes and the distribution of clients who reported each are presented in table 6.2, presented in order from most endorsed to least endorsed. Each theme is illustrated with relevant client quotes in order to stay close to the data.

Table 6.1
Categories of Motives for Dishonesty About Sexual Topics in Therapy: Frequency and Percentage of Clients Reporting

Categories	**Details of my sex life (*n* = 55)**	**My sexual desires or fantasies (*n* = 44)**	**My sexual orientation (*n* = 14)**	**Times I have cheated on a partner (*n* = 7)**
Motives related **to therapy or therapist** (e.g., to direct the course of therapy, to avoid therapist judgment or stigma, to protect therapist, because therapist can't help)	29 (52.7%)	30 (68.2%)	11 (78.6%)	1 (14.3%)
Motives related to the avoidance of **emotional experience** (e.g., shame, embarrassment, guilt, relationship of sex to past trauma, sadness, etc.)	43 (78.2%)	25 (56.8%)	6 (42.8%)	5 (71.4%)
Motives related to **beliefs about self or sexuality** (e.g., sex is private, hard to talk about, confusion about sexuality or sexual identity)	10 (18.1%)	7 (15.9%)	8 (57.1%)	1 (14.3%)
Motives related to avoiding **real-world impacts** (e.g., to protect a partner, confidentiality concerns)	4 (7.3%)	2 (4.5%)	3 (21.4%)	2 (28.6%)

Note. Sample percentages refer to proportion of clients within each topic who reported each category.

Motives related to therapy or therapist.

This category of motives for dishonesty consists of four themes relating to the therapy process or to the therapist, including wanting to direct the focus of therapy, concerns that the therapist wouldn't be able to help or couldn't understand, to avoid being judged or stigmatized by the therapist, and wanting to protect the therapist. Taken together, this was the most commonly reported category of motives for those who were dishonest about "my sexual desires or fantasies," endorsed by 68.2% of clients, and "my sexual orientation," endorsed by nearly 79% of clients. This category was also reported by over half (52.7%) of clients who had been dishonest about "details of my sex life." In contrast, only one client who had been dishonest about "times I have cheated on a partner" stated that this category of motives was relevant. Themes in this category reflect the worry that honest disclosure could have consequences for the therapeutic relationship – and more specifically, how the client might be seen in the therapist's eyes – as well as the belief that disclosing would not be helpful, either because of the therapist's competence level or due to sexual content not being what clients intended to focus on in their work.

To avoid judgment or stigma.

This theme was the most common motivator of dishonesty for clients in the "my sexual orientation" topic, mentioned spontaneously by nine clients, and the second-most common for clients in the "details of my sex life and "my sexual desires or fantasies" subsamples, endorsed by 20 and 21 clients, respectively. This theme was also endorsed by one client in the "times I cheated on a partner" subsample. Responses in this theme indicated that clients were dishonest about sexual content because they did not want their therapist to think differently of them, judge them as abnormal or strange, or tell them to change their behavior.

"To avoid judgment or stigma" it is distinct from the theme of "shame, embarrassment, or guilt" in that the client makes specific reference to the therapist in their responses. Additionally, it is

not possible to make the leap to state that these clients always felt ashamed or embarrassed of their sexual behavior. While these themes do often overlap to some extent, for other clients there was not enough evidence to say that they felt negatively or conflicted about their own sexual behavior or sexuality; however, all clients within this theme *do* state their awareness of how they would be perceived by the therapist as impacting their decision not to disclose. In the words of one client who was concealing what she deemed to be a "taboo desire," "I was afraid of being judged for something I myself didn't understand just because I would thought of as either a 'hormonal teenager' or maybe 'emotionally unstable' when I knew both those were untrue." In line with this difficulty around disclosing what are felt to be untoward sexual desires, one client described how her fantasies as "very bad and dishonest" and that the therapist would "think I'm crazy and a stalker." Another young female client discussed how a prior negative experience in therapy with a provider who insinuated that her history of sexual abuse had been her fault led her to feel unable to address her present-day sex life with her current therapist, fearing she would receive a similarly insensitive response again.

Client responses in this theme did not always refer to actual judgmental or stigmatizing experiences with the therapist as motivating their non-disclosure; for some, the therapist was more so viewed as a representation of a stigmatizing society; for instance, one client felt that "my sex life is not socially acceptable, thus until I truly trust a therapist I refuse to bring it up." In this case, her belief that her disclosure would be seen as taboo by anyone impacted how she imagined her therapist could react, precluding her from being more honest until she could be certain that the therapist's stance would be welcoming.

Further reflecting the way societal stigma can be generalized to the therapy space, a client cited that she was dishonest about her sexual orientation because "people, even therapists, can be very judgmental. Many people won't accept you if they know you are LGBTQ. I don't know how

my therapist feels about LGBTQ people." Without any evidence to ascertain that the therapist felt positively toward the LGBTQ community, this client was unable to disclose for fear that the therapist – like so many others – would be rejecting of her.

Additionally, fears of judgment or stigmatization seemed to occur for clients both within the context of a weaker therapeutic relationship that did not appear able to handle the disclosure, as well as within what was characterized to be a good relationship that the client wanted to maintain. For instance, a client struggling with her sexuality due to identifying as a Christian kept her orientation hidden from her therapist because "She's a Christian counselor and I know that her stance is that it's 'wrong.' I know that she accepts me…but I don't want her to think badly of me." Another felt certain that while her therapist would be accepting of her intimacy issues with her husband, her own belief about this "stigmatized" topic would "make me feel judged, even though I really truly don't think he would be judging me, but I would be projecting what I was feeling onto him."

Within this theme, a few clients also made mention that they did not discuss their topic because they knew the therapist would disapprove and would suggest they address their behavior, such as the client who had been dishonest about an infidelity because she did not want therapist "pressure me to change." This theme more broadly reflects the societal taboos that prohibit discussion of sexual content and are manifested within the therapeutic relationship, either because of the therapist's behavior directly or because of how the therapist is viewed transferentially.

To direct the focus of therapy.

Clients who endorsed this theme – nine in "details of my sex life," ten in "my sexual desires or fantasies," and two in "my sexual orientation" – indicated that the rationale for their dishonesty involved wanting to maintain control over the content of their therapy. They felt that disclosing sexual content would either distract from other topics that they deemed to be more relevant or that they were more inclined to deal with. One client expressed that, despite her deep feelings of pain

and conflict about being dishonest about her sexual orientation, "There are really more pressing concerns of current depression and anxiety, plus I'm living at home with parents who have essentially shoved me back into the closet, so I'm not seeing anyone." While this client would indeed have liked to discuss further, she felt obliged to focus on more immediate concerns. Other clients provided reasons that spoke to their sense that sexual content was not a problem at all: "Being LGBTQ was not why I was in therapy," said one client. Others suggested that there was no reason to speak about sex: "My sex life is pretty nonexistent so there is no need to speak of it. If I were sexually active, I still wouldn't share about it unless there was something seriously wrong." This quote also captures a related experience in which some clients only felt they would disclose in therapy about sex if it was problematic. Finally, some clients went even further to state that certain sexual topics were not relevant to therapy. Distinguishing between sexual fantasies and sexual content more broadly, a client stated that her dishonesty was because "My feelings about sex are relevant; my fetishes are not, and so I tend to skirt around that sort of thing." Clients responding within this theme wanted to keep the therapist's focus on what they characterized as their presenting problem or a more important concern, or did not feel that there was a therapeutic rationale to disclose about sexual content.

Therapist wouldn't understand or be able to help.

Respondents who described this theme as motivating their dishonesty – nine in "details of my sex life," seven in "my sexual desires or fantasies," and six in "my sexual orientation" – expressed their concern about the therapist's ability to handle their disclosures or provide useful feedback or guidance. For some, this was due to a sense of being too different from the therapist, either demographically or in terms of a sexual identity or preference, such as the gay-identified male client working with a heterosexual female therapist who described how he was "worried about being misunderstood due to difference in sexual orientation between self and therapist." One female

client noted simply, “He’s a man” as the motive for her dishonesty about the details of her sex life. Some clients who expressed this motive cited that their choice to be dishonest had to do with their therapist’s attitude more globally, suggesting that they might disclose more openly with another therapist who had a different demeanor or could intervene more sensitively. One client remarked that his therapist was “somewhat arrogant and self-absorbed;” another had the sense that “my therapist doesn’t want to hear or believe” about his sexual fantasies. These clients indicated that the therapist didn’t seem able or willing to take in their disclosures. Others cited actual techniques on the part of the therapist that shut down disclosure, such as the client who identified as a lesbian whose Christina therapist would repeatedly ask her why she didn’t have a boyfriend; another client characterized her therapist by saying “she did not particularly welcome attempts to talk about sex and her comments were not particularly enlightening when we did.” Finally, some clients spoke to this theme by doubting that the therapist could even do anything useful in this area: “Some fantasies are just fantasies. There is no reason to share sex fantasies as there’s nothing my therapist can help with. What good would it do? What’s the end goal?” Altogether, this theme captures clients’ belief that disclosure would be more harmful than helpful, or simply useless, and that often this was due to the therapist themselves.

To protect the therapist.

Although this theme was quite scarce, only endorsed by two clients in the “my sexual desires or fantasies” subsample, it was distinct enough an experience to justify its own separate theme. One client described her sense that “the therapist would be uncomfortable” if she were to disclose about her desires, which she deemed to be “not common or considered normal.” Another felt quite certain that “My therapist doesn’t want to know that! I really think she prefers not having those details.” These clients highlight a separate experience from other themes in this category in

which the client's desire is to prevent *the therapist* from having a negative experience rather than themselves.

Motives related to the avoidance of emotional experience.

This category of motives for dishonesty consists of three themes relating to clients' seeking to avoid a particular emotional experience that they perceived would occur as a result of disclosure, including embarrassment, shame, guilt, sadness, or other overwhelming feelings. Taken together, this was the most commonly reported category of motives for those who had been dishonest about "details of my sex life," endorsed by 78.2% of clients, and "times I have cheated on a partner," endorsed by 71.4% of clients. This category was also reported by 56.8% of clients who had been dishonest about "my sexual desires or fantasies," and 42.8% of clients in the "my sexual orientation" subsample. While some research (e.g., Miller & Tangney, 1994; Burton Denmark et al., 2012) has sought to distinguish "shame" from "embarrassment" and "guilt," it was not possible to reliably separate these responses in the current sample, as clients tended to use them interchangeably or without providing more detail. Thus, a combined embarrassment shame, and guilt theme was used. This category also includes a broader theme that encompasses other or unspecified emotional impacts that clients referred to in their responses, which were either too vaguely worded to assign to the embarrassment, shame, or guilt category (i.e., "disclosing would make me feel too emotional") or contained other feelings, such as sadness, pain, or discomfort. Finally, this category also included clients who believed that disclosure would trigger unspecified feelings because of the relationship of sexual content to past trauma, which they deemed to be an unwanted experience. Themes in this category reflect clients' sense that disclosing more openly would lead to a sequelae of difficult or painful emotional experiences that they wished to avoid.

Shame, embarrassment, or guilt.

Above and beyond, the desire to avoid feelings of shame, embarrassment, or guilt was the most common motivator for all topics other than "my sexual orientation." It was endorsed by 38 clients in the "details of my sex life" subsample, 25 who had been dishonest about "my sexual desires and fantasies," six in the "my sexual orientation" subsample, and five clients who had been dishonest about "times I have cheated on a partner." Clients were open and consistent in their spontaneous disclosure of these emotions, though they tended to use them interchangeably or, often, all together. For instance, one client stated that her inability to discuss the details of her sexual experience stemmed from "Embarrassment, shame that my experience is bad or not normal, guilt over bad decisions I have made." Clients could be self-critical in their responses, such as one who made reference to herself as "a weirdo," stating that she felt "really embarrassed of seeing myself as a sexual being in-general." Another client who had avoided discussing "my sexual desires or fantasies" disclosed how her feelings of shame ran so deep that she had never approached this conversation with anyone:

> "I feel vulnerable and foolish. I've never discussed this with anybody, including my spouse. I would be exposing myself. I hold myself back from this topic. My doctor is accepting of anything I say, but shame would keep me from revealing myself."

Included within this theme are clients who reflected on the way in which their culture of upbringing infused negative emotions into the prospect of disclosing about sex, suffusing them with a sense of internalized shame: "My parents are extremely conservative and always made me feel bad and guilty about exploring one's sexuality," said one female client. Another described her attitude that talking openly about sex would be "too personal, maybe because my mother said it was wrong to talk about it."

Shame was distinguished from the theme "to avoid judgment or stigma," because while stigma and shame can and often do overlap, responses within this theme (i.e., "shame,

embarrassment, or guilt") focused more on clients' personal negative evaluations that they have internalized rather than on anticipated reactions from others. Indeed, while some clients endorsed both sources of motivation as being salient – that is, wanting to avoid internal feelings of shame as well as to prevent negative reactions from the therapist – others reported they felt quite secure in their sexual identity, sex life, or desires but nevertheless did not want to be appraised negatively by others, most often the therapist.

Many clients within this theme were quite brief in their responses, stating very simply: "It's embarrassing," "this is too shameful," or "it makes me uncomfortable," a pattern of responding that could in its own way reflect clients' feelings of embarrassment or shame such that they were unable to discuss in more depth without generating intense emotions.

Of note, clients who had been dishonest about infidelity were most likely to cite the emotion of guilt, either alongside shame or on its own, than in any other category (only four out of forty in "details of my sex life," one in "my sexual desires or fantasies," and one in "my sexual orientation). These respondents were especially tight-lipped in their descriptions, with one client stating succinctly "guilt" and another who reflected, "Myself and my behavior doesn't let me to tell anything about this." Overall, clients within this theme were acutely aware of the need to avoid disclosing about a sexual topic because it would generate an intolerable feeling that they were bad, abnormal, or a disappointment to others.

Other or unspecified emotional experience.

This theme – described by seven respondents in "details of my sex life," three in "my sexual desires or fantasies," and one in "times I have cheated on a partner – includes motives that refer to emotional experiences clients sought to avoid as a result of disclosure other than shame, guilt, or embarrassment. Because these reported feelings did not overlap among multiple clients, there was not enough evidence to support creating any additional themes. For instance, one client who had not

disclosed with his therapist about infidelity admitted that it was because "I feel sad that I did that to someone I loved." Another client felt that she could not discuss more openly about her sex life in therapy because "it hurts me as a women to say that I have been rejected and insulted by husband who made my sex life a very bad experience," capturing a type of emotional pain that could very well be shame, or at least include the experience of shame, but which was not supported by the client's words and so stands alone as a separate theme. Additionally, this theme was used for statements in which clients mentioned some type of emotional impact as a reason for dishonesty, but the precise nature of the emotion was worded generally. For example, one client described how discussing sexual desires or fantasies would be "too emotional," while another felt that addressing her sex life more fully would cause "too much pain; don't want to make insecurities worse." Another referred to a vague sense of being "uneasy about this topic, even with my own partner." All of these responses suggest some type of emotional discomfort or overwhelm but one which was not described fully enough to situate it within a more specific theme.

Relationship of the topic to past trauma.

This theme – endorsed by five clients in "details of my sex life," two in "my sexual desires or fantasies," and one in "my sexual orientation – describes those clients who stated that the experience of past trauma motivated their reticence to be honest about a sexual topic in therapy. One client captured the way in which trauma foreclosed her ability to be more open, stating, "This is an area that has been particularly traumatic and it would be too hard to discuss." Two clients felt conflicted about the way in which their abuse history reflected in their present day sex life: "I feel like my sexuality had been influenced so much by the abuse I suffered. My preference sexually reflects that torture. It makes me feel like I have been broken by them." Another said simply, "The abuse I grew up with still affects me sexually as an adult." These clients expressed a the complex pain of having to encounter traumatic memories each time they thought about exploring their sex

life, and the way in which it could feel more manageable to avoid these topics especially if they were not already introduced into the dialogue. Indeed, as one client added, "When she [the therapist] doesn't ask, I talk myself out of bringing it up."

Motives related to beliefs about self or sexuality.

This category of motives for dishonesty consists of three themes relating to clients' perception of self and identity. These perceptions include clients' belief that disclosure about sex was inappropriate or not feasible due to their self-assessment as a private person or because sex was deemed to be a highly personal matter, as well as the sense that disclosure would be too complicated or challenging due to lack of clarity around sexual identity and/or preferences; this category also includes a theme for those clients who stated that sex or sexuality was difficult to talk about but did not provide any more details as to why that was the case.

Taken together, this was the second-most commonly reported category of motives for those who were dishonest about "my sexual orientation," endorsed by 57.1% of clients. This category was also reported by nearly 20% of clients who had been dishonest about "details of my sex life" and 16% of clients who had been dishonest about "my sexual desires or fantasies." Only one client endorsed this category in the "times I have cheated on a partner" subsample. Themes in this category reflect clients' personal belief that disclosure about sexual content would be difficult or, for some, even impossible, due to a felt need for privacy, as a result of confusion about sexuality, or due to an unspecified sense that sex was hard to talk about or explain.

Confusion about sexuality.

Respondents who endorsed this theme – four in "my sexual orientation" and three in "my sexual desires or fantasies" – described being "not sure" about their sexual orientation or sexual preferences, or discussed not having the language to even describe sexual material. Clients described a sense of being "clueless" or "confused" in regards to the topic they had been dishonest

about, such as one client who had been celibate for almost nine years and felt “unsure of where I am sexually at this point. I have little sexual experiences so I tend to be clueless about sexual desires in the first place.” Capturing some of the difficulty around how to speak about sex, one client said, “I'm never sure how to say some things.” The three clients who had avoided discussing their sexual orientation with the therapist stated that it was due to their own confusion about how they identified. “I’m not sure of my sexual orientation,” described one female client, highlighting succinctly the way in which internal confusion can function as a barrier to disclosure.

To maintain privacy.

Clients who endorsed this theme – eight in “details of my sex life,” three in “my sexual desires or fantasies,” and one in “my sexual orientation” – deemed sexual content too personal or private to share with the therapist. Some cited their need for privacy as a characterological trait, such as one client who said, "Because I’m a shy person and I feel that’s nobody’s business” and another who felt “I am a bit of a prude. It makes me uncomfortable to talk about sex honestly.” Others gave responses that suggested their feeling that sex or sexuality should be considered a fundamentally private matter, either to be kept to oneself or exclusively within the context of a sexual relationship. “My sexual desire and fantasies are incredibly personal to me,” said one client, noting that she would only be able to share this material with her best friends or a sexual partner, and that even such a disclosure would be uncomfortable. Another pointed out that sexual content “seems too personal to share with someone with whom I have a profoundly asexual relationship.” Clients who endorsed this theme were distinguished from those who believed that the topic of sex was irrelevant to therapy, as those who expressed a need for privacy were not saying that the topic did not matter to their therapy, but rather, that they experienced a characterological or personal barrier around disclosing.

Hard to talk about.

Clients who endorsed this theme – two in "my sexual orientation" and one each in "details of my sex life" and "my sexual desires or fantasies" – indicated that they were dishonest because the topic was too difficult to talk about or explain, but did not include sufficient reasons to explain *why* it was so challenging. I imagine that this non-reason reason could encompass a range of underlying motives – shame, embarrassment, confusion, fear of judgment – but there was not enough explicit evidence provided in their text to support being included in another category. For example, one client who had concealed their sexual orientation from the therapist stated simply "It's hard to explain," while another who had been dishonest about "my sexual desires or fantasies" described "difficulties explaining what or why I have these feelings/thoughts." Clients who endorsed this theme seem to be suggesting that the verbal expression of sexual content was problematic.

This theme is differentiated from "To maintain privacy" because these clients did not provide enough evidence in their responses to say that they are characterologically boundaried about disclosure or believed the topic should be left out of therapy, but they do suggest that this particular topic presents difficulty to them; it is also different from "confusion about sexuality" because these clients did not state that they were internally fraught in any way yet nevertheless experienced some challenges around explaining themselves. Without more detail, these responses could not be subsumed under another category and thus are included within "Hard to talk about."

***Motives related to avoiding real-world impacts*.**

This category of motives for dishonesty consists of two themes relating to clients' real-world concerns about disclosure. These reflect practical consequences that could occur as a result of being honest about their topic of choice that clients sought to avoid, such as damaging one's relationship with their partner or, conversely, to protect oneself from a partner, the worry about sensitive information being leaked, or the fear that disclosing about a taboo or illegal sexual topic could lead

to unwanted involuntary commitment. This was the least commonly selected category of themes for every subsample other than "times I have cheated on a partner," in which this was endorsed by two out of seven clients (28.6%). Three out of 14 clients (21.4%) who had been dishonest about "my sexual orientation" endorsed a motive within this category. In comparison, only a few clients across the two more overtly sexual topics – four in "details of my sex life" (7.3%) and two in "my sexual desires or fantasies" (4.5%) – felt that dishonesty was motivated by the desire to protect against external consequences. Overall, themes in this category refer to actual, real-life events that could occur in the client's external life as a result of disclosure, which they believe would bring about undesirable consequences.

To protect one's partner.

Clients who endorsed this theme – three in "details of my sex life" and two in "times I have cheated on a partner" – highlighted in their responses the fact that disclosure about sex is an inherently relational prospect, and that dishonesty was utilized as a means to show respect for a partner's privacy, control how they would be seen in the therapist's eyes, or to avoid the feeling that they were blaming their partner for issues. One client described a difficult conflict in which she longed to discuss more about the "details of my sex life" with her therapist, but felt obliged not to: "This is between a man and a wife and I don't want to bring a third party in. I do not want to say anything that would bring shame to my husband." Another client who had entered therapy to address difficulties with her son, which involved joint sessions between her and her husband, expressed that she wanted to remain judicious and not "unfairly show therapist one side only." The theme of protecting one's partner was most prevalent for those who had been dishonest about infidelity, with one client stating simply that his dishonesty had been motivated by "loyalty," and another revealing that she "want[ed] to keep in for myself and the person I was with when I

cheated." Protecting one's partner, in this sense, could relate to either the original partner or the affair partner.

Concerns about practical consequences.

While representing a limited theme, the small number of clients – three in "my sexual orientation," two in "my sexual desires or fantasies," and one in "details of my sex life" – whose fears related to real-world concerns described a few distinct types of unwanted experiences that stood in the way of more honest disclosure. Two out of three clients who had been dishonest about this theme in the "my sexual orientation" subsample cited concerns about the confidentiality and how the therapist would protect sensitive information. For instance, a self-described "closet bisexual" wanted "absolute assurance regarding confidential data entry" before he would consider addressing this topic. Another female client embroiled in divorce proceedings expressed a "confidentiality concern about ex-husband getting this information." In contrast, the three clients who had been dishonest about more overtly sexual material within the "details of my sex life" and "my sexual desires or fantasies" subsamples expressed worry that even addressing their topic might result in the therapist having to take unwanted action. One client described a desire "that is extremely taboo; I might be put into an asylum or something." Another mentioned the prospect of "civil commitment," stating simply that the content being withheld was "illegal." While it is difficult to assess the veracity of these concerns without knowing more about the nature of what was being concealed, it seems that for a small minority of clients, disclosure is assumed to inevitably require a severe, highly punitive reaction from the therapist.

Table 6.2

Motives of Dishonesty in Therapy: Frequency of Clients' Open-Text Themes (With Sample Quotes) in Response to "What makes it hard to be honest about this topic?" for All Sexual Topics

Themes	**Details of my sex life (*n* = 55)**	**My sexual desires or fantasies (*n* = 44)**	**My sexual orientation (*n* = 14)**	**Times I have cheated on a partner (*n* = 7)**
Shame, embarrassment, or guilt "I have struggled with defining what healthy sexuality is due to guilt and shame tied to it in my upbringing" "I don't feel comfortable talking about it because I'm ashamed and embarrassed"	38	23	5	5
Fear of judgment or stigma "It has to deal with problems – and the stigma related to sexual problems." "My therapist would think less of me." "People, even therapists, can be very judgmental. I don't know how my therapist feels about LGBTQ people."	20	21	9	2
Therapist wouldn't understand or be able to help "worried about being misunderstood due to difference in sexual orientation between self and therapist" "Alternative sexuality that I don't think she would understand" "My therapist did not particularly welcome attempts to talk about sex and her comments were not particularly enlightening"	9	7	6	0

Themes	Details of my sex life (*n* = 55)	My sexual desires or fantasies (*n* = 44)	My sexual orientation (*n* = 14)	Times I have cheated on a partner (*n* = 7)
Directing the focus of therapy "It wasn't a primary reason for why I was in therapy and there was always so much else I wanted to discuss" "If I were sexually active, I still wouldn't share about it unless there was something seriously wrong." "My feelings about sex are relevant; my fetishes are not, and so I tend to skirt around that sort of thing."	9	11	2	0
Confusion about sexuality "I am not sure where I am sexually at this point" "I'm not sure about my sexual orientation"	0	3	4	0
To maintain privacy "Because I'm a shy person and I feel that's nobody's business" "I have no interest in discussing this for myself or others"	8	4	1	0
Relationship of the topic to past trauma *"*It relates to previous abuse therefore I do not like to discuss it." "the abuse I grew up with still affects me sexually as an adult"	5	2	1	0
Other or unspecified emotional impact "too emotional" "I feel sad I did that to someone I loved" "discomfort"	7	3	0	1

Themes	Details of my sex life (*n* = 55)	My sexual desires or fantasies (*n* = 44)	My sexual orientation (*n* = 14)	Times I have cheated on a partner (*n* = 7)
To protect one's partner "Another party is involved, and the therapist has worked with both of us together, so I don't want to unfairly show therapist one side only." "I want to keep in for myself and the person I was with when I cheated"	3	0	0	2
To protect the therapist "to protect my therapist" "I don't want to make her uncomfortable."	0	2	0	0
Concerns about practical consequences "I might be put into an asylum or something" "confidentiality concern about ex-husband getting this information"	1	2	3	0
Hard to talk about "it's hard to explain" "difficulties explaining what or why I have these feelings/thoughts"	1	1	2	0

Note. Example quotations taken from survey responses. Respondents could provide as many motives as were relevant.

Multiple Choice Results for Research Question 4.

In addition to the open-text item querying clients' motivations for dishonesty, a multiple-choice item addressing research question 4 provided focused options they could select in response to a similar question: "Which of these describes your reason for not being more honest?" Respondents could choose as many options applied to them out of the six possible answer choices.

Frequencies and percentages of clients' reported motives for being dishonest about each of the four sexual topics – "details of my sex life," "my sexual desires or fantasies," my sexual orientation," and "times I have cheated on a partner" – are reported in Tables 6.3. Also included in table 6.3 are the frequencies and percentages of clients' reported multiple-choice motives for being dishonest across every non-sexual topic (that is, including all 54 other non-sexual topics) to see if there was a difference between motivations for dishonesty as it related to sexual vs. non-sexual content. Totals do not sum to 100% as respondents could choose as many motives as were relevant.

Results showed that "embarrassment or shame" was the predominant motive across all topics, both sexual and non-sexual. However, for the four sex-related topics, this motive was reported at a higher rate as compared to the general non-sexual topic population; approximately 80% of each sexual subsample cited "embarrassment or shame" as a motivating factor for dishonesty as compared to 58.4% across all other topics.

While far less frequent a motive as compared to "embarrassment or shame," about 20-40% of respondents endorsed motives for dishonesty about a sexual topic that were related to the therapist – either "I doubt my therapist can help or understand" or "My therapist would be upset, hurt, or disappointed" – making these the second-most frequently selected motive behind "embarrassment or shame" for each of the four sexual topics.

While again far less frequent of a motive as compared to "embarrassment or shame," about 14-22% of clients who were dishonest about all four topics of sexual material indicated that it was a

function of wanting to keep therapy focused on other topics by selecting the response "I didn't want this to distract from other topics." However, this motive appeared to be a more relevant concern for those who had been dishonest about a non-sexual topic, selected by a full quarter of respondents.

Some differences also emerged within sexual topics as to what possible unwanted therapist response was most salient to clients when they opted to be dishonest. On the topics of sexual orientation and infidelity, clients endorsed "my therapist would be upset, hurt, or disappointed" at a much higher rate (0-9% vs. 28%) as compared to the more overtly sexual topics ("details of my sex life" and "sexual desires or fantasies"). Additionally, the two groups who were dishonest about "my sexual fantasies" and "my sexual orientation" endorsed the motive "I doubt my therapist could help or understand" at a higher rate (32 and 43%, respectively) as compared to the other sexual topics (20% for "details of my sex life" and none for "times I have cheated on a partner") and across all other non-sexual topics (24%).

As indicated, across all other non-sexual topics, the primary motive for dishonesty was also "embarrassment or shame," though this was far more prevalent for those who were specifically dishonest about any sexual topic. The second highest motivation for dishonesty behind "embarrassment or shame" across all other non-sexual topics was "practical consequences" (such as unwanted hospitalization, changes to medications, legal problems, confidentiality concerns, etc.), endorsed by a full quarter of respondents. By contrast, very few respondents in any of the four sexual subsamples endorsed "practical consequences" as a motivating factor for dishonesty.

While it is not possible to do a direct comparison of these multiple choice results, in which categories were chosen *a priori*, with the qualitative themes that were derived "in vivo" from clients' open-text responses, there are some areas of overlap. Notably, both methods indicate that dishonesty about sexual content was overwhelmingly motivated by the desire to avoid feelings of embarrassment or shame. Clients endorsed these motives spontaneously in their open-text at high

rates, and tended to do so even more frequently in the multiple choice format. Motivations that had to do with concerns about the therapist (reflected in the multiple choice options “I doubt my therapist can help or understand” and “My therapist would be upset, hurt, or disappointed” and coded under the open-text themes “Therapist can’t help or understand” or “To avoid judgment or stigma”) and to maintain control over the focus of therapy (multiple choice item “I didn’t want to distract from other topics” and the open-text theme “To direct the focus of therapy”) were also quite prevalent in both methodologies. Of note, these motives related to therapy or the therapist were reported more often in both methodologies for those clients who had been dishonest about “my sexual orientation” and “my sexual desires or fantasies” in comparison to those clients in the other two categories. Similarly, comparison across both methods shows that practical consequences were of low relevance when clients were choosing to be dishonest about any type of sexual content in therapy.

Table 6.3

Motives for Dishonesty: Frequency and Percentage of Multiple-Choice Responses to "Which of these describes your reason for not being honest?" With Comparison Between Sexual and Non-Sexual Topics

Reported Motivation	**Details of my sex life (n = 55)**	**My sexual desires or fantasies (n = 44)**	**My sexual orientation (n = 14)**	**Times I cheated on a partner (n = 7)**	**Non-sexual topics (n = 500)**
	n / %	*n / %*	*n / %*	*n / %*	*n / %*
Embarrassment or shame	45 (81.8)	36 (81.8)	11 (78.6)	6 (85.7)	292 (58.4)
I doubt my therapist can help or understand	11 (20)	14 (31.8)	6 (42.9)	0	119 (24.4)
My therapist would be upset, hurt, or disappointed	0	4 (9.0)	4 (28.6)	2 (28.6)	91 (21.0)
It would bring up overwhelming emotions for me	8 (14.5)	2 (4.5)	3 (21.4)	0	105 (21.8)
I didn't want this to distract from other topics	8 (14.5)	10 (22.7)	2 (14.3)	0	121 (25.0)
Practical consequences	1 (1.8)	2 (4.5)	0	2 (28.6)	122 (25.4)

Research Question 5: What is the impact of dishonesty about sexual material? More specifically, how do clients feel about their choice to be dishonest about each topic and how do they feel their dishonesty affected their therapy overall? Results for this question were collected using quantitative (multiple choice) data to assess clients' feelings about being dishonest and both quantitative (multiple choice) and qualitative (open-text) data to understand clients' sense of how being dishonest affected therapy overall.

Thematic Analysis of Open-Text Data for Research Question 5.

Structure of the qualitative data.

Qualitative data about impact on progress for each of the four sexual topics – "details of my sex life," my sexual desires or fantasies," "my sexual orientation," and "times I have cheated on a

partner" – was collected for research question 5 from participants' responses to an open-text question "Can you tell us how not being honest affected your therapy?" Participants could enter in as much text as they liked in order to describe the impact of being dishonest on their therapy.

For the 55 participants in the "details of my sex life" subsample, open-ended responses ranged from two words to 83 words. For the 44 participants in the "my sexual desires in fantasies" subsample, responses ranged from two words to 50 words. For the 14 participants in the "my sexual orientation" subsample, answers ranged from three words to 116 words. For the seven participants in the "times I have cheated on a partner" subsample, responses ranged from three words to 14 words. Every client response was coded into one theme that summarized overall impact; as such, responses total to 100%. Frequencies and percentages of clients endorsing each theme with regards to perceived impact of dishonesty about a sexual topic are reported in table 7.1.

Theme and sub-theme descriptions.

Across respondents, three broader themes about the impact of dishonesty were synthesized from the data: "negative effect on therapy," "no effect on therapy," "positive effect on therapy." Two of the three themes ("negative effect on therapy" and "no effect on therapy") contained three subthemes. Because so few respondents endorsed a "positive effect," it did not contain any subthemes. The following sections describe each theme and subtheme (when applicable) that clients reported using relevant quotes in order to stay as close to the data as possible.

Negative effect on therapy.

A majority of clients across the three topics "details of my sex life" (35 of 55 clients; 63.6%), "my sexual desires or fantasies" (23 of 44 clients; 52.3%), and "my sexual orientation" (nine of 14 clients; 64.3%) reported some type of negative effect as a result of dishonesty in therapy, comprising the theme "negative effect on therapy." In contrast, only two of seven clients in the "times I have cheated on a partner" subsample felt that dishonesty had impacted them or their

therapy progress negatively. “Negative effect on therapy” encompasses three different subthemes that describe in more depth the dimensions of therapy that clients felt were negatively impacted by dishonesty: their ability to progress as a result of feeling unable to address therapy-relevant concerns, their relationship with the therapist, and their emotional experience.

Negative effect on progress, relevant problem not addressed.

Clients most often reported negative effects in the form of being unable to address a relevant problem as a result of being dishonest, which directly impacted their sense of overall progress. Within the theme of “negative effect on therapy,” this subtheme was described by 21 of 35 clients in “details of my sex life,” 12 of 23 clients in “my sexual desires or fantasies,” and five of nine clients in “my sexual orientation.” Of note, not a single client who had been dishonest about “times I have cheated on a partner” endorsed this subtheme.

Within this subtheme, clients described two types of experiences that occurred as a result of dishonesty about a sexual topic: being unable to make progress on that sexual topic specifically and/or being unable to make progress on a *related* topic. For instance, some clients described the way in which dishonesty about their topic of choice was problematic because it was indeed a problem they needed to work on: “I have not solved problems related to my sex life,” said one client who had been dishonest about “details of my sex life,” while another who had been dishonest about “my sexual desires or fantasies” said that they had been unable to get help “with my shame around sex.” A third client felt that “I might have a sexual addiction that I need to get over with therapy.”

Meanwhile, other clients highlighted how being dishonest about one topic made it so that they felt a decreased ability to be honest in other areas: “Not being honest about details of my sex life prevents me from being honest about others topics, or realizing other topics, such as gender confusion,” said one client, while another who had been dishonest about “details of my sex life”

said, “It took me a long time to come around to realizations about my alcohol dependence. I could have gotten to this point quicker.”

Capturing the way that sex is directly and often inextricably intertwined with other topics, one client illustrated how they had to monitor themselves in other subject areas because of how they were being dishonest about their sexual orientation: “My therapist doesn't know about something central to my life and relationships. I always have to filter what I say and that detracts from open and honest therapy.” These quotes illustrate the way in which clients felt that dishonesty about a sexual topic curtailed their ability to make progress in therapy by preventing disclosure in manners both direct and indirect. For instance, dishonesty in one topic can block progress in that area, but it can also be intimately connected to a spectrum of other areas, undermining open disclosure across the therapeutic process.

Negative impact on therapeutic relationship.

Respondents in this theme cited a range of negative impacts to the therapeutic relationship that occurred as a result of being dishonest about a sexual topic, including lessening trust in the dyad and promoting the sense that the therapist was not able to understand them fully and was thus less able to provide help. Within the theme of “negative effect on therapy,” this subtheme theme was reported by five of 35 clients in “details of my sex life,” six of 23 in “my sexual desires or fantasies,” and three of nine in “my sexual orientation,” This theme was not endorsed by any client who had been dishonest about “times I have cheated on a partner.”

Reflecting on the way dishonesty impacted the working alliance, one client who had been dishonest about “sexual desires or fantasies” said:

> I suppose it has hurt my progress. I feel like I’ve tiptoed around the topic with my therapist. I think she would have a fuller understanding of how I relate to my spouse if she knew this and could help me more.

Another client spoke to the sense of inauthenticity that arose as a result of being dishonest about "my sexual desires or fantasies" and how it impacted the therapist's ability to really understand him: "He [therapist] doesn't know who I truly am." Meanwhile, in a succinct encapsulation of how dishonesty can weaken the therapeutic bond, one client noted, "It has left some trust out." Expounding on this subtheme in more depth, one client who had been dishonest about "my sexual orientation" discussed the pain of withholding from her therapist and how it unfortunately reinforced her deep-seated challenges being open with others:

> It's more than just this topic that I've been honest but still holding back some...it's like I want the naked truth to come out, so I can actually address the issue, feel the feelings, and move on. But I took off the issue's shirt, pants, and shoes, but left on its underwear and socks. It's never all the way uncovered because I'm too ashamed. But I know in theory that I need to trust my therapist because I've kind of got trust issues anyway, and it would be really great to feel like at least one person could be trusted. So no work really gets done if I don't really bring the issues to the table.

Overall, respondents who endorsed this subtheme felt that dishonesty interfered with their ability to do the work of therapy by interfering with one of the central mechanisms of change: the therapeutic relationship.

Negative emotional impact.

Respondents in this theme described a variety of negative emotional impacts that occurred as a result of being dishonest about a sexual topic, including feelings of guilt and shame, fear, and inauthenticity; a few clients spoke to a more general experience of "feeling bad" or "heavy."

Within the theme of "negative effect on therapy," this subtheme was reported by nine of 35 clients in "details of my sex life," five of 23 in "my sexual desires or fantasies," one of nine in "my sexual orientation," and two in "times I have cheated on a partner." One client who had been

dishonest about “my sexual desires or fantasies” said, “I don’t like hiding anything, because the very fact of me feeling shame about something tells me that I need to talk about it.” Another client described how “If I’m not fully honest, I’m not authentic,” highlighting how dishonesty caused this client to feel negatively in their sense of identity. Capturing a more vague sense of unease that dishonesty can cause, particularly as it relates to the belief that therapy is a place to be honest, one client who had avoided discussing “my sexual orientation” felt that doing so “left me with a heavy feeling around conversations regarding relationships because I haven't been as open as I should be.” The two clients who endorsed this theme in the “times I have cheated on a partner” subsample – the only two who noted any negative impact – stated that dishonesty increased their feelings of guilt or shame: “I feel guilt and ashamed,” said one client, while another noted that dishonesty about this topic “hurt progress, perpetuates shame.”

No effect on therapy.

A smaller though still significant portion of clients across each topic – except for “times I have cheated on a partner,” for which this was the most predominant theme reported (four of seven clients; 57.1%) – indicated that being dishonest had “no effect on therapy.” For the remaining three topics, this theme was endorsed by 19 of 55 clients in “details of my sex life” (34.5%), 19 of 44 clients in “my sexual desires or fantasies (43.2%), and five of 14 clients in “my sexual orientation” (35.7%). “No effect on therapy” encompasses three different subthemes: dishonesty had no effect on therapy because this topic was not relevant to treatment; dishonesty had no effect on therapy overall, but it still would have been helpful to be able to discuss this topic more openly; and finally, dishonesty had not yet had an effect on therapy but could become problematic in the future. Fewer clients endorsed the latter two subthemes, but they provide an important counterpoint to those who stated that dishonesty about a sexual topic had not been relevant to therapy.

No effect, not relevant.

Within the theme of "no effect on therapy," the majority of clients indicated that dishonesty about their sexual topic of choice had not impacted their treatment because it was not relevant. This theme was described by 16 of 19 clients in "details of my sex life," 13 of 19 clients in "my sexual desires or fantasies," four of five clients in "my sexual orientation," and all four clients in "times I have cheated on a partner."

When expanding upon this theme, clients reported that dishonesty about sex had been irrelevant to therapy for one of two reasons: they felt that they had still been able to make progress in treatment overall despite having some area of dishonesty, or they felt that sexual material was ultimately irrelevant to therapy in general. (Of note, clients who had been dishonest about "times I have cheated on a partner" were least likely to expound further as to why specifically dishonesty did not have an impact on therapy, stating simply "Hasn't affected it" and "Not at all.") Some clients referenced their presenting problem as needing to be a more salient focus of their treatment, as in the words of one client who had been dishonest about their sexual orientation: "My anxiety/insomnia/panic attacks are more related to work and other external stressors. While my sexual orientation and relationship is a source of stress, it is one that I have coped with successfully outside of therapy." Within this vein, one client who had been dishonest about "my sexual desires or fantasies" stated, "It isn't one of my main problems, so it hasn't come up," while another who had been dishonest about "details of my sex life" felt that "The main issues I need to get over deal with my father so this isn't important."

Clients who had been dishonest about "my sexual desires or fantasies" were more likely than those who had been dishonest about another type of material to state that this was, in the words of one client, a "largely irrelevant topic." Another added, "I don't think it really did [affect therapy]. I'm honest about other details of my sexuality," highlighting the distinction this client made between desires and the broader domain of sexuality, with desires felt to be less treatment-relevant.

Meanwhile, clients who had been dishonest about "details of my sex life" and "my sexual orientation" more often noted specifically in their responses that these topics were important to them, but that they felt the need to direct the course of their therapy to other, more time-sensitive and salient material.

No effect overall but would have been helpful to talk about.

While a smaller subtheme overall, this response captures the few clients who felt that while therapy had been productive overall, they believed it still would have been helpful to discuss the sexual topic about which they had been dishonest. Within the broader theme of "no effect on therapy," this subtheme was described by two of nineteen clients who had been dishonest about "details of my sex life," three who had been dishonest about "my sexual desires or fantasies," and one who had been dishonest about sexual orientation. No client who had been dishonest about "times I have cheated on a partner" endorsed this subtheme.

One client who in the "my sexual orientation" subsample noted the nuance involved in assessing the effect of dishonesty on therapy, stating: "It was not the primary issue for my therapy, although I think it still could have/could be important to talk about. So although I think it stalled a little progress, the therapy continued." A client who had been dishonest about "my sexual desires or fantasies" added another dimension to this issue, namely the struggle to find time to disclose all relevant material and the way in which some clients weigh what is most important to them to discuss: "I think there could be important findings in discussion of this topic for me, but there is so much more to work on at this time that it doesn't seem like the highest priority."

No effect yet but could become problematic in the future.

While again another small subtheme, this response highlights the view of clients who felt that dishonesty – assessed at this moment in time – had not affected therapy, it could become an issue in the future. These clients seemed attuned to the way in which dishonesty could shift over

time. Within the broader theme of "no effect on therapy," this subtheme was described by one of nineteen clients who had been dishonest about "details of my sex life" and three who had been dishonest about "my sexual desires or fantasies." No client who had been dishonest about "my sexual orientation" or "times I have cheated on a partner" endorsed this subtheme.

One client who had been dishonest about "my sexual desires or fantasies" felt that while dishonesty had not yet been negatively impactful, "If I had a partner I think this would be different," highlighting the way in which the effect of dishonesty can fluctuate based on relational context, making what was once a less salient topic more relevant. Another client, reflecting on the choice to be dishonest about "details of my sex life" due to an interest in alternative forms of sexuality, including BDSM, stated:

> In the majority of cases, my sex life isn't relevant. When it has been, the emotional details are more important than the physical so I've been able to skirt around the physical details where necessary. If I did start having issues related to my sex life, I would face a conflict between whether to try to bridge the gap or not.

This quote also captures the way in which dishonesty about even a specific type of sexual content can be a nuanced prospect; for instance, the above client made a distinction between "emotional details" and the physical, such that one is felt to be more relevant and therapy-appropriate than the other.

Positive effect on therapy.

Very few participants overall made reference to any positive effects on therapy as a result of being dishonest. For those that did, dishonesty for the most part was felt to be helpful in that it allowed focus to be kept on other topics. In the words of one client, who had been dishonest about "my sexual desires or fantasies," "It allowed me to progress in other areas." Consistent with that theme, another client who had been dishonest about "details of my sex life" stated, "Focus was kept

on working toward my next steps in other departments." In this respect, dishonesty was used as a tool to manage therapy in a way that seemed to be beneficial for these clients. However, this theme was endorsed by just one client in the "details of my sex life" subsample and two in the "my sexual desires or fantasies" subsample, making it far less prevalent a theme with regards to the effect of dishonesty on therapy as compared to those who felt that dishonesty had had a negative impact or no impact on therapy.

For one client, who chose to speak more about "times I have cheated on a partner," dishonesty functioned as an important protective mechanism: "It has helped me cope without fear of being judged." This was the only occurrence of such a theme across all sexual dishonesty subsamples. Not a single client indicated a positive effect as a result of being dishonest about "my sexual orientation."

Multiple Choice Results for Research Question 5.

Impact on therapy.

A forced-choice multiple-choice question addressing research question 5 asked participants, "Has not being honest affected your therapy?" and gave them three possible answer choices: "It hurt my progress," "It helped my progress," and "no effect." Frequencies and percentages of clients' perceived impact of dishonesty about a sexual topic on overall therapy are reported in table 7.2.

Results indicated that clients' perception of the effect of dishonesty depended on the type of material that had been difficult to discuss honestly. Clients who selected "my sexual orientation" as the hardest to discuss in their therapy reported negative impacts on treatment progress at a higher rate (57%) as compared to the other three topics. Conversely, clients who selected "times I have cheated on a partner" as the hardest to discuss in their therapy reported the most minimal impacts on their treatment progress as compared to the other three topics.

For the two topics that were more overtly sexual in nature – "details of my sex life" and "my sexual desires or fantasies" – clients were more likely to indicate a negative effect on treatment when they were being dishonest about sexual details as compared to sexual desires (44% vs. 39%).

Of note, almost no respondents indicated that being dishonest had had a positive effect on their treatment overall; only a single client in the "my sexual desires or fantasies" category selected this choice. While respondents may have frequently felt that being dishonest about a sexual topic had minimal impacts on their therapy, it was a rare occurrence for them to feel that their choice to withhold or lie about information was actually beneficial to their treatment overall.

Participants reporting dishonesty about all other topics (other than the four sexual topics) were also asked the same question about the impact of dishonesty on therapy. Results are shown in table 7.2, and indicate that the two samples showed generally similar patterns of responses whether the topic of dishonesty was sexual or non-sexual. Of note, however, participants who indicated being dishonest about "sexual orientation" tended to report a slightly more negative effect on treatment, while those who had been dishonest about infidelity were more likely to indicate that this had "no effect" on their treatment overall as compared to the broader sample or in comparison to the other sexual topics.

While exact comparisons between the multiple choice and open-text data are not possible because of the differences in methodology – that is, responses for the multiple-choice item were chosen *a priori* and specifically assessed the impact of dishonesty on *progress*, whereas themes for the open-text data were developed in vivo from respondents' words in response to a question about impact on therapy such that clients could interpret the question as they wanted – some broad similarities can be seen as to the patterns that emerged across items. In comparing clients' qualitative responses to multiple choice data, results show that clients are more likely to expound upon negative impacts to therapy when given an open-ended opportunity to do so.

While over half of clients in the "details of my sex life" and "my sexual desires or fantasies subsamples and two-thirds of clients who had been dishonest about "times I have cheated on a partner" indicated that dishonesty had "no effect" on their overall treatment progress when forced to pick a multiple choice response, many of these respondents – particularly those who were not in the infidelity group – described in their open-text responses other types of negative impacts, including experiencing negative feelings, feeling less close to the therapist, or feeling less able to make headway on other related topics. This was especially salient for those who had been dishonest about "details of my sex life," for whom approximately 64% of clients reported some form of negative effect in their qualitative data as compared to 44% in their multiple choice assessment of progress; additionally, over half of clients who had been dishonest about "my sexual desires or fantasies" noted qualitatively that this had a negative effect, most often in the form of preventing disclosure about a relevant topic, in comparison to 39% who reported in their multiple choice data that dishonesty "hurt my progress."

In contrast, for those who had been dishonest about "times I have cheated on a partner," the multiple-choice and open-text data accorded fully, with 28% indicating some negative effect on therapy – more specifically, by causing negative emotional responses such as guilt and shame – and the rest citing that dishonesty had no effect. Similarly, clients who had been dishonest about "my sexual orientation" were largely in agreement that this had had a negative effect in a more general sense and on treatment progress directly, with 64% identifying some form of negative effect in their open-text responses and 57% citing "it hurt my progress" in their multiple-choice data.

Feelings about dishonesty.

Secondly, a multiple-choice item addressing research question 5 asked respondents "How did you feel after being dishonest" about their topic of choice and instructed them to select one feeling from a list of 12 multiple choice options presenting negative, neutral, positive, and

conflicted feelings (three of each valence). Results indicate that clients experience different feelings about being dishonest with their therapist depending on the specific type of sexual material. Frequencies and percentages of all feelings reported after being dishonest about each sexual topic are reported in table 7.3.

While about a quarter of respondents described being neutral or unconcerned about being dishonest about the details of their sex life, most often these clients indicated negative or conflicted feelings (67%); only four selected positive feelings such as “safe” or “in control,” and none indicated being “satisfied” with their choice to be dishonest.

In comparison, those clients who had been dishonest about their sexual fantasies reported positive feelings about doing so at a higher rate, with a full quarter selecting options such as “safe,” “in control,” or “true to myself.” Again, though, none selected being “satisfied” about being dishonest. Nearly 48% of these clients selected negative or conflicted feelings, while another 23% felt “neutral” or “unconcerned” about being dishonest.

While representing smaller subsamples, the topics of “my sexual orientation” and “times I have cheated on a partner” also showed some distinct themes in terms of primary emotions about being dishonest. Most frequently, clients who were concealing their sexual orientation felt conflicted or confused about doing so (46%), with a smaller handful reporting negative emotions (15%), positive emotions (2%), or neutral (23%). Meanwhile, those who had been dishonest about infidelity were more likely to report feeling either “neutral” or “unconcerned” (43%) or positive emotions (29%) like “safe” and “satisfied.” On this topic, respondents were least likely to report feeling conflicted or negative emotions as compared to the other sexual topics.

Table 7.1

Impact of Dishonesty on Therapy: Frequency and Percentage of Open-Text Themes (With Sample Quotes) in Response to "Can you tell us how not being honest affected your therapy?" for All Sexual Topics

Themes	Details of my sex life (*n* = 55)	My sexual desires or fantasies (*n* = 44)	My sexual orientation (*n* = 14)	Times I have cheated on a partner (*n* = 7)
Negative effect on progress, relevant problem not addressed "I talk about my marriage problems without mentioning the most important one." "Sex is closely related to my trauma history, which is the primary reason I'm in therapy." "It left an important part of my anxiety untouched."	21 (38.2%)	12 (27.3%)	5 (35.7%)	0
Negative effect on therapeutic relationship "There's no bonding." "It fuels my desire to be seen as doing the 'right' thing in the eyes of my therapist." "He doesn't know who I truly am."	5 (9.1%)	6 (13.6%)	3 (21.4%)	0
Negative emotional experience "It made me feel bad and derailed some of the progress I was making. It consumed me for a while and I was not able to focus." "It perpetuates guilt and shame." "It leaves me with a heavy feeling because I haven't been as open as I should be."	9 (16.4%)	5 (11.4%)	1 (7.1%)	2 (28.6%)
No effect, not relevant "No effect, it's just something that I do not discuss."	16 (29.0%)	13 (29.5%)	4 (28.6%)	4 (57.1%)

Themes	Details of my sex life (*n* = 55)	My sexual desires or fantasies (*n* = 44)	My sexual orientation (*n* = 14)	Times I have cheated on a partner (*n* = 7)
"The therapy was not about my sexual self as much as about the rest of me. In that, that area, therapy helped enormously."				
No effect yet but could become problematic in the future "I do feel like the lack of discussion about this will block my progress in therapy in the long run."	1 (1.8%)	3 (6.8%)	0	0
No effect overall but would have been helpful to talk about "I feel as though I may have made some progress with having more healthy views on sexuality if I would have discussed it, but I do not feel as though it affected my overall progress in other issues."	2 (3.6%)	3 (6.8%)	1 (7.1%)	0
Positive effect "It has helped me cope without fear of being judged." "It allows me to focus on more important, direct issues affecting my life."	1 (1.8%)	2 (4.5%)	0	1 (14.3%)

Note. Example quotations taken from survey responses. Sample percentages refer to proportion of participants within each topic ("details of my sex life," "my sexual desires or fantasies," "my sexual orientation," and "times I have cheated on a partner") who reported each theme.

Table 7.2

Impact of Dishonesty on Therapy Progress: Frequency of Multiple-Choice Responses to "Has not being honest affected your therapy?" with Comparison Between Sexual and Non-Sexual Topics

Impact on progress	Details of my sex life (n = 55)	My sexual desires or fantasies (n = 44)	My sexual orientation (n = 14)	Times I have cheated on a partner (n = 7)	All other non-sexual topics (n = 500)
No effect	56%	61%	43%	72%	55%
It hurt my progress	44%	39%	57%	28%	40%
It helped my progress	0%	2%	0%	0%	5%

Table 7.3

Feelings About Dishonesty: Frequency of Multiple choice Responses to "How did you feel after being dishonest?" for All Sexual Topics

	Details of my sex life (n = 55)	**My sexual desires or fantasies (n = 44)**	**My sexual orientation (n = 14)**	**Times I have cheated on a partner (n = 7)**
Primary Feeling				
	n (%)	*n (%)*	*n (%)*	*n (%)*
Conflicted	15 (27.2)	8 (18.2)	7 (50)	1 (14.3)
Confused	3 (5.4)	4 (9.1)	1 (7.1)	0
Frustrated	11 (20)	3 (6.8)	1 (7.1)	0
Guilty	4 (7.2)	6 (13.6)	1 (7.1)	1 (14.3)
Regretful	4 (7.2)	1 (2.2)	0	0
Worried	0	0	0	0
In control	1 (1.8)	3 (6.8)	0	0
Safe	3 (5.4)	5 (11.4)	2 (14.2)	1 (14.3)
Satisfied	0	0	0	1 (14.3)
True to myself	0	3 (6.8)	0	0
Unconcerned	7 (12.7)	4 (9.1)	1 (7.1)	1 (14.3)
Neutral	8 (14.5)	6 (13.6)	1 (7.1)	2 (28.6)

Research Question 6: What do clients feel their therapist could do to facilitate their ability to disclose more honestly about each type of sexual content? Do these facilitators differ when compared to all other non-sexual topics? Results for this question were collected using quantitative (multiple choice) data and qualitative (open-text) data to assess what clients believe might facilitate increased honesty on a sexual topic.

Thematic Analysis of Open-Text Data for Research Question 6.

Structure of the qualitative data. Qualitative data about clinical facilitators for each of the four sexual topics – "details of my sex life," my sexual desires or fantasies," "my sexual orientation," and "times I have cheated on a partner" – was collected for research question 6 in response to an open-text question "How could your therapist make you feel more comfortable being honest about this?" Respondents could enter in as much text as they liked in order to describe what might have facilitated more honest disclosure on their topic of choice.

For the 55 participants in the "details of my sex life" subsample, open-ended responses ranged from one word to 102 words that were developed into 12 themes. For the 44 participants in the "my sexual desires in fantasies" subsample, responses ranged from two words to 93 words that were developed into 11 themes. For the 14 participants in the "my sexual orientation" subsample, answers ranged from five words to 216 words that were developed into eight themes. For the seven participants in the "times I have cheated on a partner" subsample, responses ranged from one word to nine words that were developed into three themes.

Overall, across all topics, the open-text data yielded 13 themes that clients reported to be perceived facilitators of increased honesty and three additional themes comprising clients who stated that there was nothing the therapist could do to help, those who were unsure of what the therapist could do, or who provided no facilitator. The open-text themes, as well as frequencies and percentages (i.e., the number of clients who cited each facilitator), are reported in table 8.1.

Theme Descriptions.

The following sections describe each of the 13 themes that clients reported in their open-text data. Of note, some facilitators were only relevant for one topic. These themes are illustrated using relevant client quotes in order to stay as close to the data as possible.

If therapist initiated the conversation.

Above and beyond, this was the most desired facilitator for increased honesty for clients who had been dishonest about the two most overtly sexual topics: "Details of my sex life" and "my sexual desires or fantasies," endorsed by 17 and 14 respondents, respectively. An additional four of the fourteen clients who had been dishonest about "my sexual orientation" also cited this as being a relevant facilitator. No client in the "times I have cheated on a partner" indicated that this theme would be helpful.

Within this theme, clients spontaneously offered a range of techniques the therapist could implement, all centering around a main idea that the therapist's initiation of the topic relieved the client of the burden of doing so and signaled that the therapist was open and accepting of such material. About half of these clients explicitly stated "ask directly," with some offering even more specific ways that the therapist could do so. One client who struggled around having the language to describe her sexual experience wanted the therapist to "ask very specific questions using the words I have trouble with," while another wished his therapist had circled back to the topic to see if his feelings had changed: "If she would have brought it up again after the first time it came up I think I could have talked some more about it." A few clients noted that it would helpful for the therapist to bring the topic up more gradually or generally: "Bring it up in smaller parts, not just 'tell me about your sexual relationship,'" said one client, while another wanted the therapist to "talk more about sex in sessions in general or maybe introduce it by saying, 'We haven't talked much about your sexual health. How are you feeling about this?'" For a significant number of clients across sexual

topics, the therapist bringing sexual material directly into the therapeutic dialogue would be enough to overcome their avoidance or discomfort and address this content more fully.

If therapist displayed being open and non-judgmental.

This theme encompasses the second-most desired facilitator for clients who had been dishonest about "details of my sex life," "my sexual desires or fantasies," and "times I have cheated on a partner," and the most relevant facilitator for those clients in the "my sexual orientation" subsample. Clients within this theme, particularly the 15 who had been dishonest about more overtly sexual content such as fantasies they deemed to be taboo or a sexual problems they felt to be shameful, spontaneously provided the response "be non-judgmental" or "be more accepting."

Relatedly, the six clients who had been dishonest about "my sexual orientation" believed it would be facilitative for their therapists to explicitly state having an open stance toward the LGBTQ community. One client who reported feeling insecure about his sexuality and how it is perceived by others wanted the therapist to "explicitly communicate an affirming position. Validate that it is a topic that is okay to discuss," highlighting the way in which the therapist modeling acceptance for the client can pave the way for increased disclosure. Another framed a similar desire to know how her therapist felt about the topic so that it was clear she was accepting of clients who identified as a minority sexual orientation: "Discuss the topic with me in general terms so I know where she stands on it. If she could assure me no judgment, I would be open about it." The therapist's open disclosure of their beliefs seemed to be a way to create safety for these clients, ensuring they would not receive stigma or judgment about their sexuality.

For those clients who had been dishonest about "times I have cheated on a partner," two of seven stated that the therapist "listening and offering comfort while I explain the situation" and "giving me moral support" would be helpful, targeting their deep sense of guilt and shame. They wanted to know that, in some sense, the therapist condoned their actions, or at the very least did not

seek to judge them punitively. Of note, this was the only actual facilitator provided by clients in the infidelity subsample, the rest of whom stated that there was nothing the therapist could do to help.

Therapist could not do anything.

Twenty-two clients – six who had been dishonest about "details of my sex life," eleven within "my sexual desires or fantasies," one in the "my sexual orientation" subsample, and two from "times I have cheated on a partner" – stated that there was nothing the therapist could do to help them disclose. This theme comprises a range of reasons, including those who felt that non-disclosure was their own internal problem to cope with rather than anything that could be ameliorated by the therapeutic relationship, those who believed the topic was too taboo or too private to discuss outside of a sexual relationship, or those who stated simply and without any additional detail that the therapist could not do anything to facilitate honesty. Within this, some clients made note of how their therapist's openness and acceptance was appreciated but not enough to diminish their shame: "The problem is me and not the therapeutic process. My doctor is accepting of anything I say, but shame would keep me from revealing myself." Another added, "It's not so much to do with them as it is with me and how I was raised. I don't think I'd ever be comfortable discussing sex with someone other than a romantic/sexual partner."

These responses reflect clients' belief that – despite the therapist's best efforts – they are ultimately responsible for their choice not to disclose. Clients who had been dishonest about sexual desires or fantasies were more likely to make reference to disclosure being "impossible; it's too taboo" or to say that "it would require a sense of informality we wouldn't have," which may be reflective of the notion that sexual fantasies are felt to be even more stigmatized and thus off-limits from the therapist. Meanwhile, this theme was the most prevalent among clients concealing infidelity, comprising responses such as "It's not about them; therefore it doesn't matter what they do," "can't, and "there is nothing the therapist can do." These clients did not see any need for the

therapist to intervene and could not imagine any way in which disclosure would occur more openly around this topic.

If therapist demonstrated competence/knowledge about the topic.

This theme includes those clients – four in the "details of my sex life" subsample, three from "my sexual desires or fantasies," and three who had been dishonest about "my sexual orientation" – who wanted the therapist to openly address their training, knowledge base, or prior experience having dealt with relevant sexual material before they would disclose. One client who had minimized discussion around his sexual orientation wanted his therapist to "demonstrate having done personal research, so it is not my job to educate her;" he described his frustration about feeling obligated to explain the more concrete, factual details of his sex life to his therapist so she could understand where he was coming from, which ultimately prevented him from being able to explore his feelings more fully because it was time-consuming and burdensome. Similarly, a client who was concealing her interest in BDSM wanted her therapist to "educate herself about kink" so that she did not have to provide context to her therapist in order to avoid being misunderstood; again, this client described how having to explain herself felt like a waste of time and extra effort. Another client made reference to needing the therapist to display "cultural competence" toward those with less sexual experience, as she felt that society – including her therapist – was biased in its reflection of how much sexual activity is normal. Another client wanted the therapist to "demonstrate past experience with clients that have similar issues" as a way of making them feel more comfortable addressing an area of sexuality that felt "traumatic and embarrassing." For these clients, knowing that the therapist had knowledge or experience about their topic was a way of creating safety and communicating that they would be able to be helped because the therapist understood them.

If therapist normalized client experience.

Nine clients – six from the "details of my sex life" subsample and three from "my sexual desires or fantasies" – reported that they would be more honest if the therapist assured them that the content of their disclosures were normal and natural. To some extent these clients wanted a way of dealing with the shame or embarrassment that might be generated by being more open about sexual material, which were some of the most prevailing motivations for dishonesty across all sexual topics. One client who was raised in a culture where talking about sex was taboo and who described being dishonest about her sex life because she was not sexually active wished that her therapist would "tell me what I am experiencing is normal and that there are a lot of people in the world who are celibate. If I knew this was common, either by choice or by circumstance, I would feel more comfortable." Another wanted "reassurance that fantasies and desire are natural and personal (so long as they do not cause harm)." These clients, who reported struggling with feeling abnormal or that their desires were uncommon, would be more honest if the therapist took steps to defuse that sense of stigma.

If therapist provided rationale about why topic was relevant to treatment.

Seven respondents – two in the "details of my sex life" subsample and five in "my sexual desires or fantasies" – stated that it would have been facilitative for their therapist to describe how discussing sexual content would be relevant and/or helpful to them in their therapy. One client noted that he did not believe sexual desires were not a problem per se in their therapy, but that his therapist could "bring this up as a part of discussions of adult adjustment to the world of relationships with my wife and others." Consistent with the high number of clients who cited that their motive for being dishonest was because sexual content was too private, taboo, or just simply irrelevant to treatment, this perceived facilitator seems to encompass those who needed to understand just how disclosing would be relevant or beneficial to their therapy, to themselves, or their relationships.

If the therapeutic relationship was stronger or more trusting.

Eleven participants – three in the "details of my sex life" subsample, five in "my sexual desires or fantasies," and three in "my sexual orientation" – described perceived facilitators that were related to the therapeutic relationship, including clients who wanted to feel an increased sense of trust with the therapist and those who cited a therapeutic attitude that would need to change before they could be more comfortable disclosing.

Within this theme, all three clients who had been dishonest about "details of my sex life" directly referenced trust in their responses, which did not come up in any of the other sexual topics. One client hesitated to discuss the intimate details of her marriage with her therapist: "I don't feel like I really know my therapist. I need to trust him more." Another wanted to find "a female therapist that I could trust" due to the type of sexual content she was concealing, which was tied to feelings of rejection from her husband," highlighting the way that demographic variables, sexual content, and trust can be intertwined to impact disclosure.

In contrast, clients in the "my sexual desires or fantasies" and "my sexual orientation" subsamples were more likely to cite therapist demeanors that they wanted adjusted in order to strengthen the relationship and promote disclosure. One client who had been dishonest about "my sexual orientation" wanted her therapist to "develop a better rapport with me rather than being so clinical," while another who was concealing what she felt to be a shameful sexual fantasy wished her therapist would stop "looking at me with a blank stare." A third client wished her therapist would "make herself more approachable. She usually would just listen and rarely gave any feedback or response," which she felt curtailed her ability to disclose more fully and ultimately "stalled" his progress in therapy.

The difference between this theme and "if therapist normalized client experience" and "if therapist displayed being open and non-judgmental" is that the latter two delineate specific

behaviors the therapist could engage in or attitudes they could demonstrate toward sexual content specifically, whereas this theme speaks to a more fundamental need for closeness, trust, or better rapport in the therapeutic relationship overall.

Therapist demographic differences.

Four clients – two each in "details of my sex life" and "my sexual orientation" – cited that differences between themselves and the therapist demographically would need to be addressed within the dyad or ameliorated by seeking out a new therapist in order for disclosure to occur. One female client who was concealing material related to her sex life said simply, "I'd disclose if he wasn't a man." A male client in his twenties who experienced confusion about his sexual identity due to a proclivity for seeking out diverse types of pornography felt that working with a therapist in his seventies presented "a big issue. The generational differences make it difficult to discuss certain things." Another female client who identified as a lesbian reported feeling uncomfortable and unable to progress with her Christian therapist, who would repeatedly ask her if she had a boyfriend. These clients' responses give the sense that increased honesty around their topic of choice could only occur within the context of a different therapeutic relationship, one in which demographic variables that felt highly relevant to the client were matched by the therapist.

If therapist provided assurances about confidentiality.

A few clients across each sexual topic, save for "times I have cheated on a partner," explicitly referenced concerns about confidentiality needing to be addressed before they would disclose. One client who identified as a "closet bisexual" stated that he would need "a firm vow of silence. I know they keep notes on everything and possibly record the sessions." Another expressed his worry that the therapist would "get it all wrong in her notes, leaving out parts and adding things I did not say." Finally, one client who had been dishonest about an "illegal" sexual desire believed he would be arrested if he disclosed. While it is difficult to know for certain the nature of what these

clients were concealing from their therapist, it does seem evident that they felt it would be facilitative for their therapist to explain more fully about confidentiality, including the process of record-keeping and the parameters of mandated reporting. These concerns may also speak to a lack of trust in the therapeutic relationship, but there was not enough evidence in these clients' responses to ascertain whether that was the case.

Not sure or I don't know.

Thirteen respondents, comprising eight clients who had been dishonest about "details of my sex life," two in the "times I have cheated on a partner" subsample, and two who had been dishonest about "my sexual desires or fantasies" – said that they did not know or were unsure what their therapist could do to foster honesty. Their responses were limited to phrases such as "unsure" and "I don't know." While these respondents did not provide any ideas of what their therapist could do, it is possible that some may have been expressing feelings in line with the theme "Therapist can't do anything." However, because responses within this theme category are all extremely sparse, there was no ground during the coding process to ascertain what these clients meant when they state they "don't know" what the therapist could do.

Miscellaneous facilitators.

Three clients in the "details of my sex life" subsample and three in "my sexual desires in fantasies" provided therapeutic facilitators that could be considered miscellaneous because they provided content that was not applicable for more than one respondent and, for the most part, could not be implemented therapeutically. These clients' answers included, "If I was attracted to them [the therapist]," "If he left the room," and "Get me drunk," which allude to a felt sense of impossibility around addressing their topic of dishonesty more fully. Also likely outside of the bounds of therapy-appropriate disclosures, two clients stated their wish for the therapist to share his or her own sexual fantasies. In the words of one client, "He'd have to share something personal about himself that

involved his sexual thrills. A back and forth conversation about sexuality is more open." Despite not being therapeutically feasible, the latter responses seems to speak to a desire for increased openness on the part of the therapist.

If this topic was more of a problem.

Only two clients – both of whom reported dishonesty about "details of my sex life" – reported in their responses that this area would have to more of a problem in their lives before they would feel comfortable addressing it. One client, stating that sexual content was far too private or embarrassing to discuss with the therapist, felt that she would be more inclined to do so "if I had more actual sexual dysfunction in my marriage." Another felt fairly certain she would never discuss the lack of intimacy in her relationship due to shame and stigma, but spontaneously added, "But perhaps if it was disrupting the therapy process, I would." The low prevalence of this theme is notable, as it seems to reflect clients' belief that sexual content was indeed considered to be relevant to themselves and their therapy even if they were not experiencing a sexual problem per se.

If therapist directly addressed shame or embarrassment.

While shame or embarrassment was a highly prevalent theme when assessing client' motivations for being dishonest about sexual content, only two client across all four sexual topics spontaneously stated that they wished for the therapist to directly address those feelings as a way of facilitating increased honesty. In the words of one client who had been dishonest about "my sexual orientation" due to experiencing confusion around their identity: "Talk about why I'm ashamed." This theme does overlap to some extent with "If the therapist initiated the conversation" as it is likely that intervening at the level of shame or embarrassment requires the therapist to identify these feelings and bring them into the dialogue. Additionally, a few clients made note that while shame was indeed a critical factor in their choice to be dishonest, they felt it had more to do with their own internal struggle rather than anything the therapist was doing or could do differently, such as a client

who wrote: “I feel shame and guilt and fear of judgment; however, she has never once shown any signs of judgment and has been open and caring about it.” As such, these responses were coded under the theme “Therapist can’t do anything to help.”

Multiple Choice Results for Research Question 6.

Quantitative data was collected in response to the multiple choice question “Under what circumstances would you be more honest about this topic?” Respondents could choose as many options applied out of the ten possible answer choices. Frequencies and percentages of clients’ desired facilitators for each four sexual topic – “details of my sex life,” “my sexual desires or fantasies,” my sexual orientation,” and “times I have cheated on a partner” – are reported in Table 8.2. Also included for comparison in table 8.2 are the frequencies and percentages of clients’ reported multiple-choice desired facilitators across every non-sexual topic (that is, including all 54 other non-sexual topics). Of note, because respondents could select as many choices out of the 10 options as they felt applicable in terms of possible facilitators, the results do not sum to 100% but instead represent the portion of clients who selected a specific response.

Results showed that across all topics – both sexual and non-sexual – the response choice “if my therapist asked me about it directly” emerged as a top facilitator for respondents, selected by 28-77% of clients depending on the specific topic. Respondents in the “my sexual orientation” category were most willing to disclose more if they were simply asked by the therapist, with over three-quarters selecting this option. For the two most overtly sexual topics, “details of my sex life” and “my sexual desires or fantasies,” wanting to be asked directly by the therapist was chosen as a facilitator by over half of the subsample of respondents that were queried, as compared to the 44% who selected this response across all other non-sexual topics. Meanwhile, respondents in the infidelity group were somewhat less likely to select this option, with two out of seven clients indicating it would be a helpful facilitator for disclosure.

Across the entire sample, another highly ranking response that respondents felt would facilitate increased honesty on their topic of choice was "if this was blocking my progress in therapy." With the exception of the "my sexual orientation" subsample, for whom this choice was less prevalent, approximately 33-57% of respondents across all sexual and non-sexual topics indicated that they would be more honest if they had a sense that not doing so was negatively impacting their therapy. Respondents in the infidelity group were most likely to endorse this choice, selected by four out of seven clients.

In examining themes that emerge within specific sexual topics, there were some differences in terms of desired clinical facilitators depending on the material about which clients were being dishonest. Over a third of respondents in the "details of my sex life" subsample selected the response choice "If my therapist had a similar problem," making it the second-highest most desired facilitator; in comparison, this response was chosen by only 6-15% across all other sexual topics and by about quarter of respondents across the compilation of non-sexual topics.

Meanwhile, concerns about whether disclosure would negatively impact the therapeutic relationship were most salient for the two topics "my sexual desires or fantasies" and "my sexual orientation," with the response choice "If I knew this wouldn't ruin my relationship with my therapist" selected by 36% and 46% of respondents in these categories, respectively. As comparison, this response was selected by 18% of respondents across all non-sexual topics, only 10% of respondents in the "details of my sex life" group, and none in the infidelity group.

When comparing respondents' desired facilitators to increase honesty about sexual material as compared to non-sexual material, one key difference emerged between these groups. Respondents who were dishonest about a non-sexual topic were more likely to select the choice "If I knew my therapist wouldn't overreact;" it was the second-most selected response across all non-

sexual topics, endorsed by 30% of participants as compared to about 6-15% of participants who were dishonest about a sexual topic.

For the most part, very few respondents indicated that there was nothing the therapist could do to facilitate increased honesty; only 12% selected "Under NO circumstances would I be more honest" in the general topics group and 0-11% for the sexual topics, with individuals in the "my sexual desires or fantasies" group being the most likely to select this choice, making it one of the lowest ranked choices across all respondents.

Because responses for the multiple choice item were selected *a priori,* they cannot be directly compared with the themes that were developed from the respondents' in vivo answers during the process of thematic analysis. However, there are some areas of overlap that emerge across methods. One of the most commonly endorsed facilitators of increased honesty in the open-text data was "If therapist initiated the conversation," which maps on to the multiple choice response "If my therapist asked me about it directly." In particular, this was the desired intervention across both methods of inquiry for the more overtly sexual topics ("details of my sex life" and "my sexual desires or fantasies"). However, while a majority clients in the "my sexual orientation" subsample went on to select "If the therapist asked me about it directly" from the multiple choice responses, they were more likely to state in their open-text responses that the therapist's demonstration of being open and non-judgmental was their top-most facilitator.

Another salient theme that clients endorsed in their open-text responses – particularly those in the "my sexual orientation" subsample – was "If the therapist demonstrated competence/knowledge about the topic;" while no multiple choice answers map on directly to that language, there are some similarities that can be seen in the rates of clients who endorsed the responses "If my therapist understood my culture or class" and "If I knew my therapist had a similar problem." Another relationally-oriented theme in the open-text data was "If the therapeutic

relationship were stronger or more trusting," which can be compared to the multiple choice response "If I trusted my therapist more," though clients in the multiple choice were more likely to select this from a list of options than they were to offer it spontaneously.

Of note, very few clients wrote in their open-text responses that they would be more open if they felt that dishonesty was blocking their progress. In comparison, it was one of the more highly selected multiple choice items across all subsamples other than "my sexual orientation." Meanwhile, more clients were likely to say in their open-text data that "the therapist can't do anything to help" than ultimately selected the multiple choice response "Under NO circumstances would I be more honest." However, many clients within this open-text theme described an internal struggle around whether and how to be more honest rather than a total disinclination to do so, which may account for some of the discrepancy.

Additionally, nearly all answer choices in the multiple choice item were endorsed by higher percentages than in the open-text. This is due to the fact that respondents could select as many answers as were relevant to them on the multiple choice, and thus almost all reported more themes than they did in their open-text responses.

Table 8.1

Perceived Facilitators of Honesty in Therapy: Frequency of Open-Text Themes (With Sample Quotes) in Response to "How could your therapist make you feel more comfortable being honest about this?" for All Sexual Topics

Themes	Details of my sex life (*n* = 55)	My sexual desires or fantasies (*n* = 44)	My sexual orientation (*n* = 14)	Times I have cheated on a partner (*n* = 7)
If therapist initiated the conversation "Ask whether I have concerns in this area." "Maybe if we broached the topic little by little." "If she would have brought it up again after the first time it came up."	17 (30.9%)	14 (31.8%)	4 (28.6%)	0
If therapist displayed being open and non-judgmental "Explicitly communicating an affirming position." "Be non-judgmental."	6 (10.9%)	9 (20.4%)	6 (42.9%)	2 (28.6%)
If therapist demonstrated competence/knowledge about the topic "Demonstrate past experience with clients that have similar issues." "Demonstrate having done personal research, so it is not my job to educate her." "Cultural competence."	4 (7.3%)	3 (6.8%)	3 (21.4%)	0
Therapist could not do anything "The problem is me, not the therapeutic process." "I don't think I'd be comfortable discussing sex with someone other than a partner."	6 (10.9%)	11 (25%)	1 (7.1%)	4 (57.1%)
If therapist normalized client experience "By not making it a big deal" "If I knew it was common/normal"	6 (10.9%)	3 (6.8%)	0	0
If therapist provided rationale about why topic was relevant to treatment "Explain to me why it was a relevant/helpful topic to share." "Bring this up as a part of discussions of adult adjustment to the world of relationships with my wife and others"	2 (3.6%)	5 (11.4%)	0	0

Themes	Details of my sex life (*n* = 55)	My sexual desires or fantasies (*n* = 44)	My sexual orientation (*n* = 14)	Times I have cheated on a partner (*n* = 7)
If the therapeutic relationship was stronger or more trusting "I don't feel like I really know my therapist. I need to trust him more." "Maybe if she reacted more to things, as opposed to nodding and listening."	3 (5.4%)	5 (11.4%)	3 (21.4%)	0
If the therapist was demographically different "If he wasn't a man." "I know she is a Christian but I am a lesbian."	2 (3.6%)	0	2 (14.3%)	0
If therapist provided assurances about confidentiality "absolute assurance regarding confidentiality data entry"	1 (1.8%)	1 (2.3%)	2 (14.3%)	0
Not sure or I don't know "unsure"	8 (14.5%)	2 (4.5%)	0	2 (28.6%)
Miscellaneous facilitators "I think I just need some more time to be comfortable talking about it"	3 (5.4%)	3 (6.8%)	0	0
If this topic was more of a problem "Perhaps if it was disrupting the therapy process, I would" "If I had more actual sexual dysfunction in my marriage"	2 (3.6%)	0	0	0
If therapist directly addressed embarrassment or shame "Talk about why I'm ashamed." "Explain that there's nothing to be embarrassed about."	0	1 (2.3%)	1 (7.1%)	0

Note. Example quotations taken from survey responses. Sample percentages refer to proportion of participants within each topic who reported each theme. Respondents could provide as many facilitators as were relevant; as such, frequencies do not total to 100%.

Table 8.2

Perceived Facilitators of Honesty: Frequency and Percentage of Multiple-choice Responses to "Under which circumstances would you be more honest about this topic?" with Comparison Between Sexual and Non-Sexual Topics

Perceived Facilitator	**Details of my sex life (n = 55)**	**My sexual desires or fantasies (n = 44)**	**My sexual orientation (n = 14)**	**Times I have cheated on a partner (n = 7)**	**All other non-sexual topics (n = 500)**
	n (%)	*n (%)*	*n (%)*	*n (%)*	*n (%)*
If my therapist asked me about it directly	29 (52.7)	25 (56.8)	11 (78.6)	2 (28.6)	222 (44.4)
If I felt like this was blocking my progress in therapy	18 (32.7)	14 (31.8)	3 (21.4)	4 (57.1)	150 (30.0)
If I trusted my therapist more	8 (14.5)	12 (27.3)	5 (35.7)	1 (14.3)	134 (26.8)
If my therapist was warmer	9 (16.4)	7 (15.9)	3 (21.4)	1 (14.3)	78 (15.6)
If I knew this wouldn't ruin my relationship with my therapist	6 (10.9)	16 (36.4)	6 (42.8)	0	91 (18.2)
If I knew my therapist wouldn't overreact	3 (5.4)	7 (15.9)	2 (14.2)	1	153 (30.6)
If my therapist was more skillful	4 (7.2)	4 (9.1)	1 (7.1)	0	85 (17.0)
If my therapist understood my culture or class	6 (10.9)	5 (11.4)	4 (28.6)	0	59 (11.8)
If I knew my therapist had a similar problem	20 (36.4)	6 (13.6)	3 (21.4)	1 (14.3)	127 (25.4)
Under NO circumstances would I be more honest	2 (3.6)	5 (11.4)	0	1 (14.3)	62 (12.4)

Note: Respondents could select as many answer choices as were relevant; as such, results do not total to 100%.

Discussion

The purpose of this exploratory, mixed-methods study was to understand the experience of psychotherapy clients who had been dishonest about varied types of sexual content with their therapist. Given that nearly half of all clients in this large-scale survey (N = 798) reported being dishonest in therapy about at least one or more sexual topics, this work contributes to the existing body of literature that has found sexual content to be among the most frequent area of non-disclosure; it also and lends more depth to understanding this salient clinical phenomenon by querying clients directly about their choice to be dishonest about a broad range of sexual material. A follow-up sample of clients who indicated that one of four sexual topics – "details of my sex life," "my sexual desires or fantasies," "times I have cheated on a partner," and "my sexual orientation" – was the hardest to discuss in their therapy answered open-text and multiple-choice questions about their motives for being dishonest, the consequences it had to their therapy and how they felt about it personally, and what clinical tools or approaches would help them disclose more honestly.

The major findings of this study are as follows: Psychotherapy clients tend to be dishonest about a wide spectrum of sexual topics at very high rates, and they do so primarily by avoiding discussion of such material with their therapist. Clients stated reasons for being dishonest are most commonly to avoid feelings of shame or embarrassment and concerns about how the therapist might react to disclosure, but most believe they would be more honest about each type of sexual content if the therapist asked directly or if they felt dishonesty was blocking their progress. Finally, clients' sense of whether dishonesty impacts their therapy is primarily topic-dependent; however, very few believe that dishonesty has any type of positive impact. Clients who have been dishonest about their sexual orientation or their sex life are more likely to

endorse negative effects, primarily the inability to address other relevant content, while those who are dishonest about infidelity and sexual fantasies are more likely to state that this had no effect overall. Overall, this study suggests that while dishonesty about sexual content is a frequent occurrence in psychotherapy, therapists can help address client concerns by being more active about introducing these topics, linking discussion to treatment goals, and making efforts within the therapeutic relationship to normalize and defuse negative emotions around content that tends to be highly stigmatized. The balance of the discussion to follow will review each of these study findings as they relate to the existing literature and provide implications for clinical intervention.

Dishonesty about sexual content is highly prevalent and often manifests through total omission from therapy

Consistent with previous studies that have found sexual material to be among – if not the most – frequent area of non-disclosure or dishonesty in psychotherapy (Baumann & Hill, 2016; Blanchard & Farber, 2016; Hill et al., 1993; Martin, 2006; Pope & Tabachnick, 1994), clients in this study reported a high prevalence of dishonesty in therapy about all types of sexual content, with two topics ("details of my sex life" and "my sexual desires and fantasies") being the most highly endorsed areas of dishonesty across the whole survey. Over half of the entire sample of 798 psychotherapy clients indicated having been dishonest about one or more sexual topics; of note, this rate of prevalence is nearly exactly the same as the results of Blanchard and Farber (2016), which queried clients about whether they had lied at any point in therapy about a range of sexual content. Of note, the four topics were chosen to reflect a broad domain of sexually-possible topics that clients might discuss in therapy; their inclusion in this study is not intended to suggest that they are all equally important or salient for clients. Rather, they are meant to

represent a consolidation of the nine sexual topics studied in Blanchard and Farber (2016) while still encompassing a wide scope of potentially relevant material.

The overlap of this study with Blanchard and Farber (2016) suggests that, even when assessed using different sample sizes, methods of inquiry, and definitions, a large portion of clients believe that honest discussion of sexual material is especially difficult in therapy. In particular, content that is felt to be most overtly sexual - that is, concerning one's actual sexual experience or fantasies – appears to be especially challenging for clients to engage with openly or sometimes even at all.

Indeed, this study found that dishonesty about sexual content tended to manifest in terms of total avoidance of the topic rather than addressing it but with a low degree of honesty. This lends a new dimension to previous research in the domain of dishonesty and disclosure, which has provided information about the extent of client "lies" (Blanchard & Farber, 2016) or asked about the extent to which clients do or do not discuss certain topics (Farber & Hall, 2002). By providing data on the proportion of clients who are admittedly dishonest in regard to a given topic because they are *deliberately* avoiding it, this study illuminates the way in which dishonesty about sex often occurs very passively. It also allows for a comparison among sexually-related topics. For instance, the data here reveal that clients were nearly equally likely to avoid the topic of "my sexual orientation" as they were to discuss it but with a low degree of honesty; in comparison, the rates of avoidance as compared to those who might discuss a topic but with a low degree of honesty are triple for "times I have cheated on a partner" and nearly tenfold for "my sexual desires or fantasies." It is likely that the area of sexual orientation is more frequently assessed by clinicians, yielding at least some information, while more "taboo" topics such as infidelity or sexual fantasies are avoided by therapists and clients alike. These data

suggest that some material is more likely to be routinely and totally avoided by clients, which thus shifts more of the initiative to the therapist to foster open dialogue.

Gender, higher tendencies toward self-concealment, and lower ratings of the working alliance are related to dishonesty in therapy about sex

Demographic differences were found for the two more overtly sexual topics – "details of my sex life" and "my sexual desires or fantasies" – such that female clients were more likely to be dishonest or avoidant in these domains as compared to the non-significant findings for all demographics for the topics of "my sexual orientation" and "times I have cheated on a partner;" additionally, clients of both genders were more likely to be dishonest with a female therapist about sexual desires.

Across all four topics, there were clear differences in variables related to personality and to the therapeutic alliance: that is, on each topic of sexual dishonesty, clients reported higher scores on a measure assessing the tendency to conceal from the therapist about distressing or negative topics, feelings, or behaviors (an adapted construct from Larson & Chastain's [1990] Self-Concealment Scale); lower scores when assessing the tendency to disclose distressing information to others more generally; and lower ratings of the therapeutic alliance, which included ratings of the bond with the therapist and agreement on tasks and goals of therapy.

The findings about demographics in this work are to some extent consistent with how mixed these findings have been across the literature. In terms of gender, some work has found a weak link between gender and general non-disclosure, such that women disclose slightly more than men (Dindia & Allen, 1992) or that men are more likely to keep secrets in therapy (Baumann & Hill, 2016). Previous work by Pattee and Farber (2004) found that gender was not a significant factor with regard to either extent or content of disclosure in therapy, but Farber and

Hall (2002) found that women were more likely to disclose about their sexual experiences with their therapist than male clients. The results here reflect the opposite pattern, such that female clients reported a higher rate of dishonesty about "my sexual desire or fantasies" and "details of my sex life." It may be that the wording of these topics, which pertained to specificities of one's sex life or sexual fantasies, yielded different reactions from clients in the Farber and Hall (2002) study, which queried about "The nature of my sexual experiences" and seven other sexually-related topics.

Some work has suggested that gender differences or similarities within the dyad offer a more reliable link to disclosure, with work by Pattee and Farber (2004) finding that female clients working with female therapists reported greater difficulty addressing intimate topics than either men with female therapists or women with male therapists. The finding in the present study that clients – both male and female – are more likely to be dishonest with female therapists about the topic of "my sexual desires or fantasies," but not for any of the other three topics, provides a new dimension to the gender dyad disclosure research; it suggests that content may intersect with gender, such that something as private and oftentimes taboo as sexual fantasies could be seen as inappropriate or especially shameful to share with a female therapist. Clients may project notions of prudishness on the therapist, worry about being viewed by the therapist as having prurient interests, or be unclear about whether the topic is "allowed" in therapy. Notably, recent work by Blanchard and Farber (2016) did not yield any differences across all potential topics of lying as a function of client gender, therapist gender, or therapist-client gender match; however, that study did not provide detail about specific topics, and it may be that sexual content in particular is experienced differently within the dyad. The mixed nature of the findings across studies underscores the extraordinary complexity of assessing the impact of identity factors –

particularly the way in which they align or do not align with the therapist's own identity – given that both clients and therapists may identify more strongly or less strongly with certain aspects of self. Still, the findings of this work emphasize the value of exploring different facets of identity within the therapeutic dyad to understand how they relate to sexual identity, attraction, and expression.

Results about the non-significance of age as it relates to dishonesty are consistent with most of the previous literature (Farber, 2006), with the exception of the results from Blanchard and Farber (2016), which found that younger clients lied about more topics in psychotherapy than older clients. The differences here could be accounted for by the fact that the current study focused on single topics at a time rather than comparing age differences across all possible topics of dishonesty as in Blanchard and Farber (2016). It may also be that younger clients do not have any particular marked discomfort about the domain of sexual topics specifically as compared to all other topics, but this was beyond the scope of the present study.

This study indicated that there was a significant relationship between dishonesty about each sexual topic and lower ratings of one's tendency to disclose distress to others more generally (as measured by the Distress Disclosure Index) as well as higher ratings of self-concealment within the therapeutic relationship (as measured by the Self-Concealment to Therapist Scale) as compared to those who had been honest about each sexual topic.
These findings are consistent with the previous literature, which has shown that clients who describe themselves as high self-concealers are also more likely to keep therapy-relevant secrets (Blanchard & Farber, 2016; Fedde, 2009) and to report negative effects on treatment (Love & Farber, 2017). As a caveat, though, these results are correlational, such that it is not possible to assert the causality or directionality of the relationship or whether these variables are uniquely

related to the prospect of disclosure about sexual content. It may be that high self-concealers and/or low distress disclosers would feel less comfortable discussing any type of intimate content, not just sexually-related material. Indeed, previous work by Love and Farber (2017) found that high self-concealers were more likely to be dishonest or avoidant across all topics as compared to those who described themselves as low concealers. It should also be noted that dishonesty can be viewed as both a state and a trait like variable; some clients are more likely than others to be characterologically withholding, minimizing, or to lie overtly no matter what the content, but some topics may also be considered to be especially difficult, even for those who generally view themselves as honest disclosers.

This study provides more evidence as to the value of incorporating variables related to attitudes about disclosure into treatment since they are clearly linked with lower honesty about therapeutic content. Assessing clients' tendencies to be forthcoming about negative or distressing personal information, and the extent to which they habitually conceal from others, can be an important way to tailor therapy more effectively to client comfort level and attitudes toward disclosure, particularly as it relates to the discussion of sexual content. Further, because more work needs to be done to understand the extent to which these variables function in a more state or trait-like manner (Larson et al., 2015), ongoing check-ins about the clients' felt ability to disclose can be highly beneficial in facilitating increased honesty.

Finally, the finding herein that dishonesty about each sexual topic was correlated with weaker ratings of the therapeutic alliance accords with the finding by Hall and Farber (2001) and Farber's (2003) review of the literature, which highlighted a strong therapeutic alliance as being one of the critical factors associated with client disclosure. This suggests that dishonesty about sexual content specifically is negatively associated with one's sense of being able to work

productively with the therapist; because these results are correlational, though, it is not possible to state in which direction this relationship occurs. It could be that clients who already feel themselves to be in a weaker relationship may be more likely to be dishonest in therapy, particularly about content that is as sensitive as sexual topics; but the reverse could also be true, in that clients who are dishonest about a sexual topic may then feel the therapeutic relationship and/or the ability to make progress to be impacted as a result. More work needs to be done to establish causality between these variables, as well as to link them more reliably to the previously discussed demographic and personality variables in order to build a more comprehensive and potentially predictive model of client dishonesty.

Avoiding shame and concerns about therapist judgment are the most commonly endorsed motivators for dishonesty about sex

Across both qualitative and quantitative methodologies, clients endorsed wanting to avoid feelings of "shame or embarrassment" as a key motivator for dishonesty, which is consistent with previous studies that have identified the important and often predominant role that shame has in clients' choice to be keep secrets from their therapist (Hill et al., 1993; Kelly, 1998). The effect of shame is even more pronounced for dishonesty about sexual content; for each of the four topics, it was endorsed by approximately 80% of clients, as compared to 58.4% for all non-sexual topics.

The avoidance of shame or embarrassment may also be linked to another theme that developed in both methods of inquiry about clients' motivations for being dishonest: concerns about the therapist and how the therapist would react to their disclosure about sex. The most common therapist-related theme was clients' fear that the therapist would see them differently or

even be judgmental, and this apprehension co-occurred for many clients with the desire to avoid a negative emotional experience such as shame.

Another theme within the domain of therapy-related motives was clients' worry that the therapist would not be able to understand their specific experience or would not be able to help, either due to the sense they were too different from the therapist (demographically or in terms of sexual identity) or that the therapist was not competent to deal helpfully with sexual content. In particular, those clients who had been dishonest about their sexual orientation were more likely to endorse therapist-related motives for dishonesty as compared to the other three sexual topics; while this was a small sample (n = 14) who had already indicated that sexual orientation was the hardest topic to talk about in their therapy, these clients' active consideration of the therapist or the therapeutic relationship can frame the sense of wariness – particularly for those who may already be experiencing confusion about their identity, stigma, or rejection – that therapy will become a shame-inducing atmosphere, whether this manifests overtly or even inadvertently.

A smaller minority of clients indicated that their choice to be dishonest was in order to control the direction of therapy, reporting that sexual content was not what they wanted to focus on or was irrelevant to them. This suggests that some clients will consider the discussion of sex to be less important or even unnecessary to address in their treatment, and that they may find it a more efficacious use of their time to divert the therapy space to address other topics or concerns. This finding can also speak to the way in which some clients are attuned to the time-limited nature of therapy, such that it is not always feasible to address everything that is on one's mind and that some choices have to be made about what feels most pertinent.

Across both open-text and multiple choice responses, very few clients reported being motivated by trying to avoid practical or real world consequences (e.g., hospitalization; job loss).

This provides support to the emerging findings that clients' motivations for dishonesty differ depending on the topic of material, as avoiding practical or real-world consequences was the main finding in Blanchard's (2017) study about concealment of suicidal ideation but was not especially salient in the present study regarding motives for dishonesty about sexual content. Clients' motivations in this domain appear to be more focused on the avoidance of negative internal experiences and to manage the therapeutic relationship, including how they are seen in the eyes of therapist and whether disclosure will be helpful.

Clients feel conflicted about the impact of dishonesty on therapy and themselves

On the whole, clients were mixed about how dishonesty about a sexual topic affected themselves or their therapy. Their overall assessment appeared to be dependent on topic, as those who had struggled to disclose about sexual orientation were more likely to endorse negative impacts, while clients who had been dishonest about infidelity or sexual desires tended to state that it had no effect. Consistently across both methods of inquiry (multiple choice and open-text), very few clients reported that being dishonest about a sexual topic had a positive impact on themselves or their therapy, suggesting that clients do not find it helpful when they feel they cannot be as honest as they wish about sexual-related issues.

In their multiple choice responses, clients were more likely to cite that being dishonest about a sexual topic had "no effect" on their progress. This finding suggests that the majority of clients believe that overall, they are still able to make progress in therapy despite some areas of dishonesty. In their open-text themes, clients who expanded on the sense that being dishonest had no effect stated that it was because a sexual topic was not a key focus of their treatment, and thus they felt a certain degree of compartmentalizing was not problematic. This finding is consistent with previous literature that suggests that clients may continue to conceal some

material as long as they believe that progress is still being made and the burden of not disclosing is not too high (Baumann & Hill, 2016). In a similar fashion, Blanchard's (2017) study of suicide concealers in therapy found that for many, dishonesty had "no effect" on treatment, though a majority did note feeling "conflicted."

In the open-text data, the most commonly stated type of negative impact was the inability to address a related topic due to dishonesty about a sexual topic. This highlights the way that dishonesty in one domain can "seep into" other areas of content that clients feel are important to discuss, creating a felt inability to navigate something salient.

It is likely that more negative impacts emerged in the qualitative data as compared to a forced-choice inquiry instructing clients to think about their overall treatment when answering because the open-text allows clients to think about therapy in a more nuanced and complex way, and that even when therapy is felt to be proceeding in a helpful way overall, clients still experience some negative consequences to dishonesty. It could also be that some clients are rationalizing the lack of impact on progress to help defuse the discomfort that can be experienced when non-disclosing about something that is felt to be important.

When querying clients about their feelings with regard to being dishonest, the most commonly endorsed feeling across all sexual topics was "conflicted" or "unconcerned/neutral." A smaller portion of clients identified negative feelings such as "frustration," "regret," and "guilt." Very few clients endorsed positive feelings, and if they did, it was either feelings of being "safe" or "in control." Only a single client described being "satisfied" about the choice to be dishonest, which lends support to the sense that clients generally do not feel it is ideal to be dishonest but will do so if it is felt to be necessary. The high proportion of clients who cited being "conflicted" frames the difficult circumstances of non-disclosure, such that clients often

wish they could discuss sexual issues more openly but feel doing so will lead to shame or therapist judgment.

It is important to note when discussing the impact of dishonesty on therapy around sexual topics that this sample was comprised of clients who had already indicated that a sexual topic was hardest to talk about in their therapy, which undoubtedly affects their responses when they are considering this particular question. Assessing the impact of dishonesty at a single point in time is also complicated because its effects can change over time, and what might feel less distressing to a client in one session may feel more so as time goes on, or vice versa. Still, the themes suggest that many clients find dishonesty about sex impactful to themselves, whether in terms of experiencing mixed or negative feelings or finding that it forces them to be more withholding about other salient information.

Clients believe that the therapist asking directly would facilitate more disclosure about sexual content

Across both quantitative and qualitative methods, the most frequently desired intervention to increase honest disclosure about sex was the wish for the therapist to "ask directly." While this finding is consistent with the data on non-sexual topics, it was more pronounced for all sexual topics other than infidelity, ranging from half to nearly 80% of clients as compared to 44% for all non-sexual topics. This indicates that clients want to relieved of the burden of initiating the conversation about sexual content, which could also be a way of lessening concerns about perceived therapist judgment or stigma or the worry about experiencing shame; that is, if the therapist is the one to introduce this material, it signals a degree of comfort and willingness to engage that can promote safety to proceed in the client and can normalize what is often considered to be taboo material. Clients also provided other therapist suggestions,

including wishing that the therapist would return to the topic repeatedly or wanting the therapist to link the topic to other client concerns. These findings frame the way in which honest disclosure is an ongoing and dynamic process, such that what may feel uncomfortable or less relevant to a client at one moment can become easier over time, making therapists' regular inquiry a way of providing clients' allowance to engage when it feels safe to do so.

Consistent with previous research that has highlighted how clients often engage in a process of actively weighing whether or not to disclose depending on whether they feel it would be beneficial, this study showed that clients felt they would be more open about sexual content if they felt dishonesty was blocking their progress. According to Kelly and McKillop (2006), the "key factor in deciding to reveal secrets is whether that confidant is able to offer new insights or perspectives on a problematic secret" (pg. 458). It may be that the therapist linking the discussion of sex to clients' stated goals or presenting problems could be a useful way of facilitating more discussion, particularly in light of the approximately 30% of clients who reported in their open-text data that dishonesty about a sexual topic negatively impacted their ability to address another relevant topic.

When it comes to facilitating honesty about specific topics of sexual content, the data show that clients who had been dishonest about "my sexual desires or fantasies" and "my sexual orientation" were more likely than other groups to highlight the need to know that the therapeutic relationship would be secure even if they disclosed. Because these two topics are often particularly stigmatized, ensuring the safety and continuity of the therapeutic relationship may be all the more important. Clients who had been dishonest about "details of my sex life" and "my sexual desires or fantasies" expressed the need for normalization, highlighting the way that overtly sexual content can be considered out of bounds for therapy and may require active

intervention on the part of the therapist to make this material safer and more visible. Meanwhile, clients who had been dishonest about infidelity were most likely to feel that the therapist could not do anything to help, or were unsure of any options that might be facilitative. This suggests the way in which infidelity – uniquely from the other sexual topics – can be felt to be especially taboo, or so private, that clients do not feel they wish to be more open. However, it should also be noted that this was an especially small sample (n = 7), which in itself can underscore the difficulty of being honest about this domain.

As a final note, the construct of dishonesty was chosen for this study because it was believed to best capture a broad array of terms, including concealment, lying, and non-disclosure. These have all been used in the previous studies to capture a similar type of client behavior in therapy: keeping something private that they are not ready or able to navigate. While the word "dishonesty" can be viewed as critical or pejorative, it was intended to be the best approximation when seeking to describe and understand the function of these behaviors oriented around making the client less known to the therapist. There is no consensus word by psychologists, philosophers, or linguists that fully captures the fluid interplay of what clients do to keep hidden their sense of truth from others. Though it might feel like concealment and overt lies are distinct, and at times they can be, for the most part they are rather permeable. Future studies can make greater effort to clarify whether there are more pure instances of avoiding versus lying to understand whether there are clinical differences in how they are handled to facilitate disclosure.

Clinical Implications

This study brings to light how frequently sexual content is omitted from therapy by clients, often due to reasons related to shame and concerns about how the therapist would handle

such disclosure. Because clients can be conflicted or ambivalent about discussing sex, it can be helpful for therapists to signal their own openness to this content by bringing it up directly, providing a rationale for why disclosure could be helpful, and to explain more fully about the disclosure process to clients so they can anticipate the sequelae of emotions that can be evoked. For example, previous research has found that there is often delayed relief associated with secret-telling (Baumann & Hill, 2016; Farber et al., 2004; Kelly & McKillop, 2006); informing clients that they may feel more intensely leading up to and in the immediate aftermath of discussing before they feel a sense of relief, authenticity, or pride about disclosing. In this way, clients can begin to address the topic without having to delve fully into the content itself, developing their level of comfort and safety.

It can also be useful to engage in a process of weighing the cost-benefit analysis of disclosure versus non-disclosure about sexual material. While clients may be anxious about the prospect of disclosure, it may be more emotionally burdensome or negatively impactful to progress to maintain areas of dishonesty. The results of this study found that the main type of negative impact identified by clients as a result of being dishonest about sex was the inability to address a relevant topic, suggesting a sort of "domino effect" of dishonesty and highlighting how sex is intimately related to an array of other content.

Dishonesty is always contextual, depending on a number of factors not limited to: the clients' presenting concerns, their diagnostic history, the length of therapy, the modality of therapy, the agreement on goals, and the quality of the interaction between therapist and client. While some of these variables were not fully assessed here, this study did find that client dishonesty can signal something important about the therapeutic relationship. The data reveals two types of patterns with regards to the alliance. First, some clients do not feel comfortable discussing sexual

content with their therapist because the bond is felt to be weak and the therapist is perceived as being unable to be useful. Second, other clients feel blocked from disclosing because they worry it will impact the way the therapist sees them or cares for them. The therapeutic alliance is undoubtedly critical in facilitating disclosure (Farber, 2006); however, because it is something that is valued by the client, fears about jeopardizing it can motivate dishonesty such that disclosure can become more difficult as time goes on. For therapists, addressing the alliance – both in terms of the bond itself as well as the tasks and goals of therapy – can be a way of facilitating open discussion. For instance, when appropriate, therapists can relate the discussion of sex to the client's presenting problems or goals for therapy. They can explicitly affirm that the therapeutic bond can tolerate disclosure of sensitive information, or work to strengthen a weaker bond so that more disclosure can occur.

While it was also beyond the scope of this study, it is possible that therapeutic modality impacted the findings herein. A substantial number of clients reported being in cognitive behavioral therapy (CBT), which is typically more time-limited and focused. Such topics as sexual fantasies or details of one's sex life could have been considered beyond the scope of a solution-oriented treatment. While psychoanalytic or interpersonally oriented therapists may view the topic of sexual material – especially sexual fantasies – to be more salient, it is not necessarily beyond the purview of a more structured therapy. Yet it is important to note the way in which the therapeutic contract (i.e., time-limited or present-focused versus more exploratory) inevitably shapes the types and amounts of content that can be discussed, and clients often have a keen eye as to what they feel is most relevant for them to focus on.

It is important to note that when discussing about the notion of dishonesty, is not meant to suggest that the aim of psychotherapy is to help clients "come clean," such that they have fully

revealed about every aspect of their lives and feelings; this is likely to be true about most topics, and especially as it relates to sex, which is an ongoing part of clients' lives and relationships. The idea of the truth is iterative, something that the therapeutic dyad can come close to but never totally achieve. Honest disclosure is an ongoing, dynamic construct that can fluctuate over time and requires attunement on behalf of the therapist, willingness on the part of the client, and patience for both members of the dyad.

Finally, because one of the most salient findings of this study was clients' wish that therapists initiate discussion of sexual material, therapists should do their best to ensure that they are well trained and able to handle disclosures about various types of sexual content. Yet many psychologists have not had formal training or supervision in sexual health concerns and, as a result, find themselves discussing sensitive sexual issues without sufficient background or, conversely, not asking about sexual health (Haboubi & Lincoln, 2003; Reissing & Guilio, 2010). Research has found a link between increased clinical training in supervision in the domain of sexuality and therapists' reported comfort level and willingness to engage in these discussions with patients (Harris & Hays, 2008), indicating the value of seeking out continuing education and supervision about sexual issues.

Because clients frequently take their cues from therapists, and may also use any opportunity to avoid addressing a sensitive, difficult topic, therapists' silence around or mishandling of a sexual topic can shut down future disclosures. To ensure a greater ability to initiate and engage fully in these topics of conversation, it is critical that therapists reflect on their own willingness (or lack thereof) to receive sexual content. Reflecting on their own sexual identity issues and personal history about sex can allow therapists to be more aware of blind spots or areas of bias, in turn helping them develop appropriate boundaries, and the awareness of when it is necessary

to refer a client out when a presenting issue or problem is beyond the scope of their competence (Hastings, 1998). It is notable, too, that the majority of the clinical and empirical literature on sex and marital therapy is from a heterosexual, Western, and dyadic position, which can manifest in a lack of understanding about how to adapt these treatments to more diverse populations, further supporting the need for ongoing continuing education and supervision. Discussion of sex and sexuality can be challenging for both clients and therapist alike, sparking all types of societal taboos, prohibitions from personal history, and worries about how the disclosure will be received; and yet, as this data shows, clients often wish they could be more open and many would do so if given more implicit or even explicit permission from the therapist.

Limitations and Future Directions

There are some key limitations about this study's methodology that should be noted. First, the survey from which these data were derived represents a select sample of individuals who were motivated to answer questions about their experience in therapy and how honest or dishonest they had been across a range of topics. Additionally, the subsamples in the present analysis who elected to answer follow-up questions about sex are an especially self-selected group because they indicated that a sexual topic was hardest to discuss in their therapy and were willing to speak more in depth about the choice to be dishonest with their therapist. These respondents may also not be generalizable to a wider population of therapy-seeking clients because they acknowledged that discussing sexual issues was a particular problem for them. Relatedly, because this dissertation is part of a larger study on dishonesty in psychotherapy that was not primarily focused on sex or sexuality, the subsamples of participants who answered follow-up questions about one of the four sexual topics vary broadly in terms of how relevant the topic of sex was to them and their therapy. As such, the respondents herein do not necessarily

provide an accurate representation of the type of client who might seek psychotherapy for a sexual issue; indeed, many respondents indicated that sex was outside the purview of what they were in therapy to focus on.

The results of this study could be overdetermined to some extent, such that the individuals who answered follow-up questions asserted that sex was the hardest topic to discuss in their therapy. This framing makes it nearly inevitable that a large portion would see dishonesty as having a negative impact on therapy. It is also possible that shame or embarrassment being a main motivation for dishonesty would not hold true for the 500 clients that picked another topic as being most difficult to discuss in their therapy; for those clients, dishonesty about sex could have occurred because it simply did not feel relevant rather than it being shame-inducing.

While this study provides an entry-point into some of the major themes that are relevant when psychotherapy clients choose not to disclose about sexual content, more work is needed to clarify and extend these findings. For instance, the sample sizes of two of the topics within this study – "my sexual orientation" and "times I have cheated on a partner" – were fairly small (<15), making it difficult to generalize. It is possible that the low number of clients willing to discuss more about orientation or infidelity captures the challenge of disclosing openly in this domain when clients have already been withholding, but without more data to speak to this, it would be important for future studies to acquire a larger group in order to better understand clients' motivations for concealment, its impact on therapy overall, and any possible facilitators of increased honesty. It should also be mentioned that the wording of the topic "details of my sex life" may have been confusing for some respondents, as there could be a valuable distinction to be made between clients' openness to discussing their sex lives more generally as opposed to

specific "details." As such, priming respondents with the wording "details of my sex life" could have impacted how they answered follow-up questions.

Another important limitation concerns the use of the online survey technique. While an anonymous, online survey format was selected in order to increase the likelihood that respondents would feel more comfortable and willing to disclose intimate information, it is possible that respondents were distorting or concealing certain aspects. As was noted in a previous study by Fedde (2009), any work concerning the topic of secrecy in therapy should be interpreted in light of the fact that no measures, even measures completed anonymously with full promises of confidentiality, can fully account for an individual's tendency to conceal; he argued that if clients have actively chosen not to disclose to the therapist, arguably a trusted figure, it is possible that they may be equally – if not more – unwilling to disclose to an unknown researcher. Self-report data by its very nature has limitations, and it could be useful to augment any self-report inquiry with an interview portion to account for any tendency to minimize or secret-keep.

Additionally, this study did not utilize random sampling methods; respondents were recruited to the survey via Craigslist advertisements. As a result, I cannot claim that my sample is representative of the therapy-using population, or more specifically, of the population of clients for whom a sexual topic is relevant. While the sample does contain a broad age range, it is composed primarily of highly educated Caucasian females. Though these demographics are similar to the distribution of the therapy-using population in the United States, the findings reported here may not be generalizable to the experiences of men or minorities. Further, the demographics section in this study did not contain a question pertaining to sexual identity, so there is no known information about how this important variable might have factored into the present analysis and findings. Future research should aim to understand how and to what extent

an individual's sexual identity shapes their experience of being honest and dishonest about sexual content in therapy. It is also unknown the extent to which these results would generalize to other therapy-seeking populations – i.e., outside of the United States. More work needs to be known about clients' non-disclosure of sexual content in other cultures and countries, where attitudes about sex and sexuality can differ greatly from the United States.

Of note, this data was collected in 2015-2016, and given the historical context, the discussion of sexual content may have greater salience now. The discussion of sexual identity and expression has become increasingly fluid and open with younger generations, and in the era of the MeToo movement, it would be important to know how sociocultural variables impact disclosure in therapy or make certain content more or less likely to be addressed. As stated before, dishonesty is inevitably contextual, which begs the question: how does culture (political, geographical) and different intersections of identity facilitate or restrict people talking about their sexual lives, and how does this manifest in the therapy dyad?

A useful question for further research is the extent to which therapists feel comfortable and competent when discussing sexual topics, including sexual orientation, infidelity, sexual problems, and healthy sexual functioning. Research has indicated that training on human sexuality in graduate programs is sparse in terms of coursework and adequate supervision. It is likely unless clinicians actively seek out continuing education post-graduation, they will be inadequately equipped to address treat these areas appropriately. Because a dominant theme in this work was clients' desire to have the therapist initiate conversation about sexual topics – either by asking direct questions or by signaling their comfort with the topic more generally – it is important to conduct empirical research with a representative sample of psychotherapists in order to clarify attitudes toward sexuality and the discussion of sexual content in treatment.

Many respondents in this study indicated that a fear of how the therapist might react (i.e., with judgment or misunderstanding) contributed to their choice to be dishonest about relevant content, and while this may be an overestimation on the clients' part as to how the therapist would react, it is also crucial to understand whether the therapist's discomfort, anxiety, or personal biases are indeed playing a role in the conflict around disclosure. Therapy is always a relational endeavor, and future work should extend the topic of disclosure about sex in psychotherapy to the other side of the dyad to understand how therapists facilitate and engage in discussions with clients.

References

Anolli, L., & Pascucci, P. (2005). Guilt and guilt-proneness, shame and shame-proneness in Indian and Italian young adults. *Personality and Individual Differences*, *39*(4), 763-773.

Armstrong, D., Gosling, A., Weinman, J., & Marteau, T. (1997). The place of inter-rater reliability in qualitative research: an empirical study. *Sociology*, *31*(3), 597-606.

Bauer, M., Haesler, E., & Fetherstonhaugh, D. (2016). Let's talk about sex: older people's views on the recognition of sexuality and sexual health in the health-care setting. *Health Expectations*, *19*(6), 1237-1250.

Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: a comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology*, *54*(3), 306.

Balon, R., & Segraves, R. T. (2005). *Handbook of sexual dysfunction*. CRC Press.

Baumann, E. C., & Hill, C. E. (2016). Client concealment and disclosure of secrets in outpatient psychotherapy. *Counselling Psychology Quarterly*, *29*(1), 53-75.

Beals, K. P., Peplau, L. A., & Gable, S. L. (2009). Stigma management and well-being: The role of perceived social support, emotional processing, and suppression. *Personality and Social Psychology Bulletin*, *35*(7), 867-879.

Berry, M. D., & Lezos, A. N. (2017). Inclusive sex therapy practices: a qualitative study of the techniques sex therapists use when working with diverse sexual populations. Sexual and Relationship Therapy, 32(1), 2-21.

Blanchard, M., & Farber, B. A. (2016). Lying in psychotherapy: Why and what clients don't tell their therapist about therapy and their relationship. *Counselling Psychology Quarterly*, *29*(1), 90-112.

Blanchard, M. (2017). Concealment of suicidal ideation in psychotherapy. Columbia University Academic Commons, https//doi.org/10.7916/D8G73S5P.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice*, *16*(3), 252.

Boyatzis, R. E. (1998). Transforming qualitative information: Thematic analysis and code development. Thousand Oaks, CA: Sage.

Burckell, L. A., & Goldfried, M. R. (2006). Therapist qualities preferred by sexual-minority individuals. *Psychotherapy: Theory, research, practice, training*, *43*(1), 32.

Burton Denmark, A., Hess, E., & Becker, M. S. (2012). College students' reasons for concealing suicidal ideation. *Journal of College Student Psychotherapy*, *26*(2), 83-98.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., Clarke, V., & Terry, G. (2012). Thematic analysis. *APA handbook of research methods in psychology*, *2*, 57-71.

Burr, V. (1995). An introduction to social constructionism. London: Routledge.

Butler, C., O'Donovan, A., & Shaw, E. (Eds.). (2009). *Sex, sexuality and therapeutic practice: A manual for therapists and trainers*. Routledge.

Bybee, J. A., Sullivan, E. L., Zielonka, E., & Moes, E. (2009). Are gay men in worse mental health than heterosexual men? The role of age, shame and guilt, and coming-out. *Journal of Adult Development*, *16*(3), 144-154.

Chaikin, A. L., & Derlega, V. J. (1974). Variables affecting the appropriateness of self-disclosure. *Journal of Consulting and Clinical Psychology*, *42*(4), 588.

Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counseling Psychology*, *45*(1), 58.

Clarke, V., & Braun, V. (2014). Thematic analysis. In *Encyclopedia of critical psychology* (pp. 1947-1952). Springer New York.

Cornett, C. (Ed.). (1993). *Affirmative dynamic psychotherapy with gay men*. Jason Aronson, Incorporated.

Corbett, K., Dimen, M., Goldner, V., & Harris, A. (2014). Talking sex, talking gender—A roundtable. Studies in Gender and Sexuality, 15(4), 295-317.

Cruz, C., Greenwald, E., & Sandil, R. (2017). Let's talk about sex: Integrating sex positivity in counseling psychology practice. *The Counseling Psychologist*, *45*(4), 547-569.

DePaulo, B. M., Kashy, D. A., Kirkendol, S. E., Wyer, M. M., & Epstein, J. A. (1996). Lying in everyday life. *Journal of personality and social psychology*, *70* (5), 979.

Dindia, K., & Allen, M. (1992). Sex differences in self-disclosure: a meta-analysis

Dilorio, C., Pluhar, E., & Belcher, L. (2003). Parent-child communication about sexuality: A review of the literature from 1980–2002. *Journal of HIV/AIDS Prevention & Education for Adolescents & Children*, *5*(3-4), 7-32.

Downs, A. (2006). The velvet rage: Overcoming the pain of growing up gay in a straight man's world. Cambridge, MA: DeCapo Lifelong.

Dunn, K. M., Croft, P. R., & Hackett, G. I. (1998). Sexual problems: a study of the prevalence and need for health care in the general population. *Family Practice*, *15*(6), 519-524.

Elliott, R., Fischer, C. T. and Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*, 215–229.

Evans, M., & Barker, M. (2010). How do you see me? Coming out in counselling. *British Journal of Guidance & Counselling*, *38*(4), 375-391.

Farber, B. A., & Sohn, A. E. (2007). Patterns of self-disclosure in psychotherapy and marriage. *Psychotherapy: Theory, Research, Practice, Training*, *44*(2), 226.

Fahlström, E. (2016). Sexual preferences, shame, psychological and physical health: What's the relationship? (Bachelor's thesis). Retrieved from http://lup.lub.lu.se/luur/download?func=downloadFile&recordOId=8561317&fileOId=8561368

Farber, B. A. (2003). Patient self-disclosure: A review of the research. *Journal of clinical psychology*, *59*(5), 589-600.

Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients' Perceptions of the Process and Consequences of Self-Disclosure in Psychotherapy. *Journal of Counseling Psychology*, *51*(3), 340.

Farber, B. A., & Hall, D. (2002). Disclosure to therapists: What is and is not discussed in psychotherapy. Journal of clinical psychology, 58(4), 359-370.

Farber, B. A., & Sohn, A. E. (2007). Patterns of self-disclosure in psychotherapy and marriage. *Psychotherapy: Theory, Research, Practice, Training*, *44*(2), 226.

Fedde, F. (2009). *Secret keeping and working alliance: The impact of concealment on the therapeutic process and the development of a solid client-therapist relationship*. The University of Memphis. Retrieved from ProQuest Digital Dissertations. (AAT 3400158)

Findlay, R. (2012). Talking about sex: Narrative approaches to discussing sex life in therapy. *International Journal of Narrative Therapy & Community Work*, (2), 11.

Fisher, T.D. (1987) Family communication and the sexual behavior and attitudes of college students. *Journal of Youth and Adolescents* 16, no. 5 (1987): 481-495.

Frable, D. E., Wortman, C., & Joseph, J. (1997). Predicting self-esteem, well-being, and distress in a cohort of gay men: The importance of cultural stigma, personal visibility, community networks, and positive identity. *Journal of personality*, *65*(3), 599-624.

Freud, S. (1962). Sexuality in the aetiology of the neuroses. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume III (1893-1899): Early Psycho-Analytic Publications* (pp. 259-285).

Friedlander, A., Nazem, S., Fiske, A., Nadorff, M. R., & Smith, M. D. (2012). Self-concealment and suicidal behaviors. *Suicide and Life-Threatening Behavior*, *42*, 332–340.

Gediman, H. K., & Lieberman, J. S. (1996). *The many faces of deceit: Omissions, lies, and disguise in psychotherapy*. Jason Aronson, Incorporated.

Gilbert, P., & Andrews, B. (Eds.). (1998). *Shame: Interpersonal behavior, psychopathology, and culture*. Oxford University Press on Demand.

Goffman, E. (1959). *The presentation of self in everyday life.* New York: Random House.

Gochros, H. L. (1986). Overcoming client resistances to talking about sex. *Journal of social work & human sexuality*, *4*(1-2), 7-15.

Gott, M., Hinchliff, S., & Galena, E. (2004). General practitioner attitudes to discussing sexual health issues with older people. *Social science & medicine*, *58*(11), 2093-2103.

Grov, C., Bimbi, D. S., NaníN, J. E., & Parsons, J. T. (2006). Race, ethnicity, gender, and generational factors associated with the coming-out process among gay, lesbian, and bisexual individuals. *Journal of sex research*, *43*(2), 115-121.

Haboubi, N. H. J., & Lincoln, N. (2003). Views of health professionals on discussing sexual issues with patients. Disability and rehabilitation, 25(6), 291-296.

Hall, D. A., & Farber, B. A. (2001). Patterns of patient disclosure in psychotherapy. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *29*(2), 213-230.

Hamilton, L., & Armstrong, E. A. (2009). Gendered sexuality in young adulthood: Double binds and flawed options. *Gender & Society*, *23*(5), 589-616.

Harris, S. M. and Hays, K. W. (2008), Family Therapist Comfort with and Willingness to Discuss Client Sexuality. Journal of Marital and Family Therapy, 34: 239–250. doi:10.1111/j.1752-0606.2008.00066.x

Hastings, A. S. (1998). *Treating sexual shame: A new map for overcoming dysfunction, abuse, and addiction*. Jason Aronson, Incorporated.

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, *16*(1), 12-25.

Herek, G. M., Chopp, R., & Strohl, D. (2007). Sexual stigma: Putting sexual minority health issues in context. In *The health of sexual minorities* (pp. 171-208). Springer, Boston, MA.

Hill, C. E., Thompson, B. J., Cogar, M. C., & Denman, D. W. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert processes. *Journal of Counseling Psychology*, *40*(3), 278.

Hom, M. A., Stanley, I. H., & Joiner Jr, T. E. (2015). Evaluating factors and interventions that influence help-seeking and mental health service utilization among suicidal individuals: a review of the literature. *Clinical psychology review*, *40*, 28-39.

Ichiyama, M. A., Colbert, D., Laramore, H., Heim, M., Carone, K., & Schmidt, J. (1993). Self-concealment and correlates of adjustment in college students. *Journal of College Student Psychotherapy*, *7*(4), 55–68.

Kahn, J. H., & Hessling, R. M. (2001). Measuring the tendency to conceal versus disclose psychological distress. *Journal of Social and Clinical Psychology*, *20*(1), 41-65.
Kaslow, N. J. (2004). Competencies in professional psychology. *American Psychologist*, *59*(8), 774.

Kahn, J. H., Achter, J. A., & Shambaugh, E. J. (2001). Client distress disclosure, characteristics at intake, and outcome in brief counseling. *Journal of Counseling Psychology*, *48*(2), 203-211.

Kahn, J. H., Lamb, D. H., Champion, C. D., Eberle, J. A., & Schoen, K. A. (2002). Disclosing versus concealing distressing information: Linking self-reported tendencies to situational behavior. *Journal of Research in Personality*, *36*(5), 531-538.

Kelly, A. E. (1998). Clients' secret keeping in outpatient therapy. Journal of Counseling Psychology, 45(1), 50.

Kelly, A. E. (1999). Revealing personal secrets. *Current Directions in Psychological Science*, *8*(4), 105-109.

Kelly, A. E., & McKillop, K. J. (1996). Consequences of revealing personal secrets. *Psychological Bulletin*, *120*(3), 450.

Kelly, A. E., & Achter, J. A. (1995). Self-concealment and attitudes toward counseling in university students. *Journal of Counseling Psychology*, *42*(1), 40.

Kelly, A. E. (2000). Helping construct desirable identities: a self-presentational view of psychotherapy. *Psychological Bulletin*, *126*(4), 475.

Kelly, A. E., & Yuan, K. H. (2009). Clients' secret keeping and the working alliance in adult outpatient therapy. *Psychotherapy: Theory, Research, Practice, Training*, *46*(2), 193.

Knight, R., Shoveller, J. A., Oliffe, J. L., Gilbert, M., Frank, B., & Ogilvie, G.

(2012). Masculinities,'guy talk'and 'manning up': a discourse analysis of how young men talk about sexual health. *Sociology of health & illness*, *34*(8), 1246-1261.

Kolmes, K., Stock, W., & Moser, C. (2006). Investigating bias in psychotherapy with BDSM clients. *Journal of Homosexuality*, *50*(2-3), 301-324.

Larson, D. G., & Chastain, R. L. (1990). Self-concealment: Conceptualization, measurement, and health implications. *Journal of Social and Clinical psychology*, *9*(4), 439-455. Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'muircheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *New England Journal of Medicine*, *357*(8), 762-774.

Larson, D. G., Chastain, R. L., Hoyt, W. T., & Ayzenberg, R. (2015). Self-concealment: Integrative review and working model. *Journal of Social and Clinical Psychology*, *34*(8), 705-774.

Lewis, H. B. (1971). Shame and guilt in neurosis. *Psychoanalytic review*, *58*(3), 419.

Lewis, M. (1995). *Shame: The exposed self*. Simon and Schuster.

Longhofer, J. L. (2013). Shame in the clinical process with LGBTQ clients. *Clinical social work journal*, *41*(3), 297-301.

Love, M., & Farber, B. A. (2017). Let's not talk about sex. *Journal of clinical psychology*, *73*(11), 1489-1498.

Love, M., & Farber, B. A. (2017). Honesty in psychotherapy: Results of an online survey comparing high vs. low self-concealers. *Psychotherapy Research*, 1-14.

MacNeil, S., & Byers, E. S. (2005). Dyadic assessment of sexual self-disclosure and sexual satisfaction in heterosexual dating couples. *Journal of Social and Personal Relationships*, *22*(2), 169-181.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review.

Martin, L. E. (2006). Lying in psychotherapy: Results of an exploratory study (Doctoral dissertation). Retrieved from ProQuest dissertations and Theses database. (UMI No. 3253137).

McCabe, M. P., Sharlip, I. D., Lewis, R., Atalla, E., Balon, R., Fisher, A. D., & Segraves, R. T. (2016). Incidence and prevalence of sexual dysfunction in women and men: a consensus statement from the Fourth International Consultation on Sexual Medicine 2015. *The journal of sexual medicine*, *13*(2), 144-152.

McWilliams, N. (2004). Psychoanalytic psychotherapy: A practitioner's guide. Guilford Press.

Mereish, E. H., & Poteat, V. P. (2015). A relational model of sexual minority mental and physical health: The negative effects of shame on relationships, loneliness, and health. *Journal of Counseling Psychology*, *62*(3), 425.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, *129*(5), 674.

Miller, R. S., & Tangney, J. P. (1994). Differentiating embarrassment and shame. *Journal of Social and Clinical Psychology*, *13*(3), 273-287.

Montemurro, B., Bartasavich, J., & Wintermute, L. (2015). Let's (not) talk about sex: The gender of sexual discourse. *Sexuality & Culture*, *19*(1), 139-156.

Muise, A. (2011). Women's sex blogs: Challenging dominant discourses of heterosexual desire. *Feminism & Psychology*, *21*(3), 411-419.

Newman, C.F., & Strauss, J. L. (2003). When clients are untruthful: Implications for the therapeutic alliance, case conceptualization, and intervention. *Journal of Cognitive Psychotherapy: An International Quarterly, 17,* 241-252.

Norton, R., Feldman, C., & Tafoya, D. (1974). Risk parameters across types of secrets. *Journal of Counseling Psychology*, *21*(5), 450.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. Psychological Bulletin, 133, 328-345.

Pattee, D., & Farber, B. A. (2008). Patients' experiences of self-disclosure in psychotherapy: The effects of gender and gender role identification. *Psychotherapy Research*, *18*(3), 306-315.

Pennebaker, J. W. (1985). Traumatic experience and psychosomatic disease: Exploring the roles of behavioural inhibition, obsession, and confiding. *Canadian Psychology/Psychologie canadienne*, *26*(2), 82.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, *52*(2), 126.

Pope, K. S., & Tabachnick, B. G. (1993). Therapists' anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice*, *24*(2), 142.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.

Regan, A.M., & Hill, C.E. (1992). Investigation of what clients and counselors do not say in brief therapy. *Journal of Counseling Psychology, 39,* 168-174.

Reissing, E. D., & Giulio, G. D. (2010). Practicing clinical psychologists' provision of sexual health care services. Professional Psychology: Research and Practice, 41(1), 57.

Rennie, D. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology, 41*, 427-437.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2009). Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: critical role of disclosure reactions. *Psychology of Addictive Behaviors*, *23*(1), 175.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field methods*, *15*(1), 85-109.

Sanders, J. S., & Robinson, W. L. (1979). Talking and not talking about sex: Male and female vocabularies. *Journal of Communication*, *29*(2), 22-30.

Schalet, A. T. (2011). Beyond abstinence and risk: A new paradigm for adolescent sexual health. *Women's Health Issues*, *21*(3), S5-S7.

Schrimshaw, E. W., Siegel, K., Downing Jr, M. J., & Parsons, J. T. (2013). Disclosure and concealment of sexual orientation and the mental health of non-gay-identified, behaviorally bisexual men. *Journal of consulting and clinical psychology*, *81*(1), 141.

Schmader, T., & Lickel, B. (2006). Stigma and Shame: Emotional Responses to the Stereotypic Actions of One's Ethnic Ingroup. In S. Levin & C. van Laar (Eds.), *The Claremont symposium on Applied Social Psychology. Stigma and group inequality: Social psychological perspectives* (pp. 261-285). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.

Sloan, A. E, & Kahn, J. H. (2005). Client self-disclosure as a predictor of short-term outcome In brief psychotherapy. *Journal of College Student Psychotherapy*, *19*(3), 25–39.

Stiles, W. B. (1995). Disclosure as a speech act: Is it psychotherapeutic to disclose?.

Syed, M., & Nelson, S. C. (2015). Guidelines for establishing reliability when coding narrative data. *Emerging Adulthood*, *3*(6), 375-387.

Tangney, J. P., Wagner, P., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of abnormal psychology*, *101*(3), 469.

Tangney, J. P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behaviour research and therapy*, *34*(9), 741-754.

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative inquiry*, *16*(10), 837-851.

Vaismoradi, M., Jones, J., Turunen, H., & Snelgrove, S. (2016). Theme development in qualitative content analysis and thematic analysis. *Journal of Nursing Education and Practice*, *6*(5), 100.

Vaismoradi, M., Turunen, H., Bondas, T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nursing & Health Sciences. 2013; 15(3): 398-405.

Vogel, D. L.,Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*, 325—337.

Weber, A. (2002). Survey results: Who are we? And other interesting impressions. *Loving More Magazine*, *30*(4).

Willig, C. (Ed.) (1999) Applied Discourse Analysis: Social and Psychological Interventions. Buckingham: Open University Press.

Wylie, K. R., Steward, D., Seivewright, N., Smith, D., & Walters, S. (2002). Prevalence of sexual dysfunction in three psychiatric outpatient settings: A drug misuse service, an alcohol misuse service and a general adult psychiatry clinic. *Sexual and relationship therapy*, *17*(2), 149-160.

Yalom, I.D. (1970). *The theory and practice of group psychotherapy*. New York: Basic Books.

APPENDIX: CONSENT FORM

INFORMED CONSENT

You are being asked to take part in a research study about the client experience of psychotherapy. This study will consist of a single survey, which will take about 10-20 minutes to complete. There will also be an opportunity to follow up on the survey with a phone interview. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What this study is about: The purpose of this study is to learn more about what psychotherapy is like for the client and how to improve that experience. Principally, we are interested in what topics clients feel they cannot be open with their therapist about and how that affects therapy.

What we will ask you to do: If you agree to be in this study, you will complete a survey about your psychotherapy experience. The survey will take about 10-20 minutes to complete all parts. This will include demographic questions, questions about your therapist, reasons you entered therapy, and feelings about therapy and your therapist. We will also be asking you whether there are subjects you did not feel comfortable sharing with your therapist. These topics may involve very personal and sensitive information. You are free to skip any question(s) that you do not wish to answer.

Benefits: There are no direct benefits to you. However, your answers will be important in improving the psychotherapy experience and training future clinicians.

Risks/Discomforts: The principal risk involved in this study is that sharing of personal or sensitive information may bring up difficult topics or uncomfortable feelings. Taking part in this study is completely voluntary. You may choose to skip any questions you do not want to answer. If you decide to take part in this study, you are free to withdraw at any time with no penalty to you or loss of benefits to which you are otherwise entitled.

Compensation: As a thank you for your time, we will be offering entry into a lottery. Six survey takers will win a $50 Amazon gift card. At the end of the survey, we will ask for your email address for the lottery. This information will only be used for the lottery and will not be linked to your responses if you are not interested in being contacted for the follow-up interview.

Opportunity for follow-up: We will be conducting follow up research on the major themes of the survey. This will consist of a single in-person interview lasting 30 minutes to an hour about the topics you described in your survey. If you are interested in being contacted to take part in the follow-up, you will be asked to provide your contact information at the end of the survey. This is voluntary and will not affect your odds of winning in the lottery if you choose not to take part. If you do choose to enter this information, your survey answers are no longer anonymous because they will be linked to your contact information. However, all personal information will be kept confidential.

Your answers are confidential: Precautions have been taken to keep your information confidential. The records of this study will be kept private. Research records will be kept in a locked file; only the researchers will have access to the records. All identifying information will be removed from any future use of the material in articles or other publications.

How the results will be used: Data from the survey and/or interview may be reported in professional publications and conferences. We plan to report group results, such as, "the most common reasons for lying to one's therapist include..." We will de-identify all quotations in order to protect your confidentiality. By participating in this project, you will be helping to advance knowledge in the field of psychology, particularly in regard to professional training.

If you have questions: If at any point you have questions or concerns regarding this research, you can contact the principal investigator, Barry Farber, at ColumbiaTherapySurvey@gmail.com or by phone at 212-678-3267. This study has been reviewed and cleared by the Teachers College, Columbia University Institutional Review Board (IRB). If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact the IRB at (212) 678-4105.

We thank you for your time and consideration. If you are 18 years or older and have ever been in psychotherapy, you may consent and begin the survey on the next page.

Statement of Consent: ***I have read the above information, and have received answers to any questions I asked. I consent to take part in this study by clicking "Next" and beginning the survey.***

With great appreciation,

Dr. Farber's Psychotherapy Lab
Teachers College, Columbia University