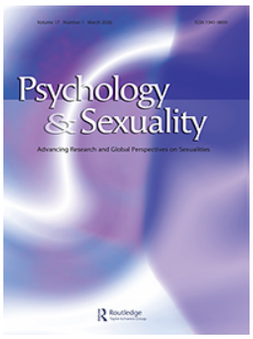

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Reflective functioning and mentalised affectivity among therapists working with LGBTQ+ patients: associations with the therapeutic alliance

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ABSTRACT

Psychotherapists' personal characteristics, including affirming attitudes and clinical skills when working with LGBTQ+ patients, may contribute to the development of a strong therapeutic alliance. Although therapists' mentalisation abilities have been associated with better alliance in general clinical settings, this association has not been specifically examined in work with LGBTQ+ patients. The present cross-sectional study investigated whether therapists' reflective functioning and mentalised affectivity were associated with therapist-rated working alliance with LGBTQ+ patients. Associations with sociodemographic and professional variables (i.e. age, sex assigned at birth, LGBTQ+ identity, and attendance at LGBTQ+ training) were also explored. The sample included 45 Italian psychologists and psychotherapists ($M_{age} = 40.87$, $SD = 10.18$) who reported clinical experience with LGBTQ+ patients. Results indicated that stronger working alliance was positively associated with therapists' certainty about mental states and greater ability to express emotions. No significant associations emerged for sociodemographic or professional variables. Moreover, expressing emotions mediated the association between certainty about mental states and working alliance. These findings suggest that therapists' capacity to understand mental states and express emotions may support the quality of the therapeutic relationship with LGBTQ+ patients. Training and supervision programmes may benefit from addressing these intrapersonal processes alongside culturally affirmative knowledge and skills.

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Mentalisation; reflective functioning; mentalised affectivity; working alliance; LGBTQ+ psychotherapy

Introduction

LGBTQ+[1] individuals consistently report higher levels of psychological distress and psychopathological symptoms than the general population (Cai et al., 2024; Jackman et al., 2016; Mahon et al., 2022; Marchi et al., 2023; Russell & Fish, 2016). These disparities are not inherent to diverse sexual orientation or gender identity but are largely explained by chronic exposure to

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minority-specific stressors. The Minority Stress Model (Hendricks & Testa, 2012; Meyer, 1995, 2003) provides a useful framework, distinguishing between distal stressors (e.g. discrimination, victimisation, systemic marginalisation) and proximal stressors (e.g. identity concealment, internalised stigma, and hypervigilance), whose cumulative impact increases vulnerability to mental health difficulties (Hoy-Ellis, 2023).

LGBTQ+ individuals face substantial structural and interpersonal barriers to accessing mental health services (Romanelli & Hudson, 2017). As a result, they show lower utilisation rates compared to heterosexual and cisgender populations (Alencar Albuquerque et al., 2016; Mezzalira et al., 2024, 2025), even though they are at heightened risk for mental health difficulties. Anticipation of stigma and concerns about unwelcoming interactions may further discourage engagement with care among sexual and gender minoritized individuals (Carone, Quintigliano, et al., 2025; Cruciani, Quintigliano, et al., 2025; Mezzalira, Carone, et al., 2025; Mezzalira, Cruciani, et al., 2025).

Mental health providers can also contribute, often unintentionally, to these barriers. Heteronormative and cisnormative assumptions, limited familiarity with LGBTQ+ lived experiences, and insufficient knowledge of population-specific risk and resilience factors may negatively affect the quality of care (Carone, Innocenzi, et al., 2025; Cruciani, Quintigliano, et al., 2024; Mezzalira, Carone, et al., 2025). These barriers may exacerbate distress and negatively affect the therapeutic relationship (McNamara & Wilson, 2020; Mezzalira, Quintigliano, et al., 2025; Rosati et al., 2022).

Positive attitudes, affirming interactions, and the demonstration of clinical competence in working with LGBTQ+ patients are key factors in the formation and maintenance of the therapeutic alliance, which constitutes a central component of the psychotherapeutic relationship. In contemporary pantheoretical perspectives, the therapeutic alliance is conceptualised as the collaborative relationship between patient and therapist, involving agreement on treatment goals, consensus on the tasks required to achieve them, and the development of an affective bond (Bordin, 1979; Martin et al., 2000). These three dimensions, that is, Goal, Task, and Bond, capture the shared evaluation of the therapeutic process and outcomes, the mutual understanding of the steps required to achieve them, and the personal attachment and trust that develop through ongoing therapeutic work (Bordin, 1979; Elvins & Green, 2008; Horvath & Greenberg, 1989). Empirical research has demonstrated that the therapeutic alliance is among the most robust and reliable predictors of psychotherapy outcome (Ardito & Rabellino, 2011; Eubanks et al., 2018; Lambert & Barley, 2001; Wampold & Imel, 2015), underscoring its role as a foundational mechanism of change across theoretical orientations (Del Re et al., 2021; Flückiger et al., 2018).

Only a few studies have quantitatively and qualitatively explored the role of therapeutic alliance in psychotherapies with LGBTQ+ individuals. Both quantitative and qualitative research has explored patient perspectives and identified therapist characteristics associated with stronger alliance, yet important gaps remain. For instance, Alessi and colleagues (2019) showed that more therapist's affirmative practices were associated with higher well-being in LGBQ patients, and that this association was mediated by patient-rated therapeutic alliance. Similarly, Davis and colleagues (Davis et al., 2022) reported significant positive associations between patient-reported psychotherapy inclusiveness and satisfaction, as well as perceived outcome, mediated by the therapeutic alliance. The contribution of a strong therapeutic alliance to patients' perceived therapy outcomes,

satisfaction, and well-being has been further acknowledged in qualitative research with LGBTQ+ patients (Berke et al., 2016; Rosati et al., 2022).

Less is known about how therapists' individual characteristics may shape the therapeutic alliance with LGBTQ+ patients from the clinicians' perspective. One of the few quantitative studies addressing this issue is that of Carone, Innocenzi, et al. (2025), who examined working alliance in a sample of Italian therapists working with parents with minoritized sexual identities. Specifically, the authors investigated whether therapists' use of microaggressive questioning was associated with patient drop-out and alliance quality. Results showed that, among heterosexual therapists and those who had not attended LGBTQ+ training, greater reliance on microaggressive questions was indirectly associated with higher drop-out rates through lower working alliance. These findings suggest that therapists' personal and professional characteristics may meaningfully influence alliance formation in LGBTQ+ clinical contexts. Other qualitative works on therapists further highlighted that personal and professional therapist aspects, including their sexual orientation, being enjoyable, and the use of humour, validation, acceptance, empowerment, or affirmation, could affect therapeutic alliance with LGBTQ+ patients and, ultimately, therapeutic change (Israel et al., 2008; Porter et al., 2015).

Beyond these initial findings, empirical research has not yet systematically examined which intrapersonal capabilities of therapists may underlie alliance formation in clinical work with LGBTQ+ patients. In particular, while therapist attitudes and training have received some attention (Cruciani, Quintigliano, et al., 2024), less is known about the role of therapists' psychological processes that support relational attunement and emotional understanding within this specific clinical context. Although therapist-related variables appear to play a relevant role in shaping alliance quality, existing studies have primarily focused on observable characteristics or reported practices, leaving largely unexplored the internal psychological capacities that may sustain therapists' relational responsiveness. Within this broader framework, mentalisation appears to play a notable role (Babl et al., 2025; Folmo et al., 2021; Güvenç & Halfon, 2023). Mentalisation refers to the capacity to understand one's own and others' behaviours in terms of underlying mental states, such as emotions, intentions, beliefs, or desires, rather than attributing actions solely to observable events (Fonagy et al., 2002). In practical terms, a mentalising stance allows a therapist to consider, for example, that a patient's withdrawal in session may reflect shame or fear of rejection rather than lack of motivation. This capacity supports emotion regulation, fosters a coherent sense of self, and facilitates interpersonal functioning by helping individuals distinguish between internal experiences and external reality (Bateman & Fonagy, 2016). According to attachment theory, these mentalising skills emerge within secure early attachment relationships, shaped by caregivers' attuned mirroring and sensitive responsiveness to the child's needs (Fonagy et al., 2002). Within this framework, reflective functioning represents the measurable expression of mentalisation and refers to the degree to which individuals are able to apply this capacity when interpreting their own and others' mental states (Fonagy et al., 1998; Katznelson, 2014). In other words, while mentalisation describes the broader theoretical construct, reflective functioning is an operationalisation of mentalisation and captures how effectively this ability is enacted in specific contexts and can be empirically assessed. Empirical studies have shown consistent positive associations between therapeutic alliance and both patients' (Babl et al., 2025; Ekeblad et al., 2016) and therapists' (Reading et al., 2019)

reflective functioning. Although reflective functioning has been associated with therapeutic alliance in general clinical populations, it remains unclear whether this association extends to therapeutic work with LGBTQ+ patients, whose clinical contexts are often characterised by identity-related stress, stigma, and heightened sensitivity to relational safety. No studies, to our knowledge, have directly examined reflective functioning in therapists working specifically with LGBTQ+ individuals.

Within this broader framework, Jurist (2005, 2018) introduced the concept of mentalised affectivity, extending mentalisation theory to the domain of emotion regulation. Rather than conceptualising regulation as merely reducing emotional intensity, mentalised affectivity emphasises the capacity to identify, interpret, modulate, and express emotions in light of personal history and contextual meaning (Jurist, 2018). For example, recognising that anger towards a partner may also contain elements of fear or past experiences of rejection reflects mentalised engagement with affect. Mentalised affectivity thus relies on the capacity to reflect on one's own mental states and the contextual and developmental factors influencing emotional responses; this capacity enhances understanding of affective experiences and supports adaptive navigation of future emotional challenges, with protective effects on mental health (Cruciani, Fontana, et al., 2024; Cruciani, Lo Buglio, et al., 2025; Greenberg et al., 2017; Jurist et al., 2024; Liotti et al., 2021). Mentalised affectivity comprises three dimensions: the *identification* of emotions, which involves recognising and reflecting on affective states and their determinants; the *processing* of emotions, defined as the capacity to modulate and differentiate complex feelings; and the *expression* of emotions, whether directed inwardly or outwardly in a manner consistent with one's internal experience (Greenberg et al., 2017; Jurist, 2005, 2018). Despite Jurist's assertion that 'practicing as a therapist *must* include mentalizing' (Jurist, 2018, p. 130), to the best of our knowledge, no studies have yet empirically assessed mentalised affectivity capacities in a sample of therapists, leaving a significant gap in understanding how therapists' emotion regulation capacities may contribute to alliance formation, particularly in clinical contexts that require sensitivity to minority stress and identity-related experiences.

The present study

Taken together, existing literature underscores the centrality of therapeutic alliance in work with LGBTQ+ patients and suggests that therapist characteristics may influence alliance quality. However, no study has yet examined the role of therapists' reflective functioning and mentalised affectivity in this specific clinical context. Addressing this gap may clarify whether intrapersonal psychological capacities contribute to alliance formation beyond demographic or training-related factors. Given the scarcity of empirical research on this topic (Carone, Innocenzi, et al., 2025; Jurist, 2018; Reading et al., 2019), the present study preliminarily provided a comprehensive assessment of reflective functioning, mentalised affectivity and working alliance in therapists working with LGBTQ+ patients.

Secondly, the study examined whether sociodemographic (e.g. age, sex assigned at birth, LGBTQ+ identity), clinical (e.g. training in LGBTQ+ affirmative practice), and personal variables (i.e. reflective functioning and mentalised affectivity) were associated with a more positive working alliance with LGBTQ+ patients. Based on previous research (Babl et al., 2025; Ekeblad et al., 2016; Reading et al., 2019), it was hypothesised that better reflective

functioning and mentalised affectivity would be associated with the construction of a more positive working alliance with LGBTQ+ patients. Additionally, based on previous empirical data on therapists' attitudes and interpersonal dynamics with LGBTQ+ patients (Cruciani, Quintigliano, et al., 2024; Mezzalira, Cruciani, et al., 2025), it was also hypothesised that therapist age, sex assigned at birth, LGBTQ+ identity, and prior participation in LGBTQ+-specific training might positively contribute to the development of the working alliance.

Lastly, according to Jurist (2018), who posits that mentalised affectivity represents a specific and developmentally advanced expression of reflective functioning, it is hypothesised that higher levels of therapists' reflective functioning would be associated with stronger working alliances with LGBTQ+ patients, and that this relationship would be mediated by mentalised affectivity. In particular, therapists with greater reflective functioning are expected to exhibit higher levels of mentalised affectivity, which in turn may enhance their emotional availability, flexibility, and capacity to co-construct a meaningful therapeutic relationship.

Materials and methods

Participants

A cross-sectional sample of 45 therapists participated in the study. The sample included licenced Italian mental health practitioners, specifically six clinical psychologists and 39 psychotherapists, all of whom reported prior clinical experience working with LGBTQ+ patients. Thirty-five participants were assigned female at birth and 10 were assigned male at birth. The mean age of the sample was 40.87 years (SD = 10.18). Detailed demographic and professional characteristics are presented in Table 1.

Procedure

Data were gathered through an online survey created using the Qualtrics platform. Recruitment took place between May 2024 and April 2025, utilising various strategies: the survey link was shared on social media (e.g. Facebook, Instagram) and distributed via targeted emails through mailing lists of leading Italian psychology and psychotherapy associations, within National Health System institutions, and through snowball sampling by word of mouth. To be eligible, participants had to: a) be licenced psychologists or psychotherapists currently or previously working with LGBTQ+ patients; b) be at least 18 years old; c) reside in Italy; and d) have fluent comprehension of Italian. Prior to participation, individuals were required to read and agree to an informed consent form. Anonymity and the right to withdraw from the study at any time without penalty were guaranteed. The study received ethical approval from the Ethical Committee of the University of Naples 'Federico II' (protocol no. 10/2024) and the Territorial Ethics Committee Lazio Area 2 (protocol no. 197.24 CET2 utv), adheres to the EU General Data Protection Regulation, and complies to the ethical principles of the Declaration of Helsinki (7th edition) for medical research involving human subjects.

Table 1. Sociodemographic characteristics and clinical activity information of the sample ($N = 45$).

Variables	Therapists ($N = 45$)
Sociodemographic characteristics	*M* (*SD*)
Age (years)	40.87 (10.18)
	n (%)
Age range	
<35 years	15 (33.33)
35–45 years	18 (40.00)
46–55 years	5 (11.11)
>55 years	7 (15.56)
Sex assigned at birth	
Female	35 (77.78)
Male	10 (22.22)
Other	0 (0)
Gender identity	
Cisgender women	33 (73.33)
Cisgender men	10 (22.22)
Transgender women	0 (0)
Transgender men	0 (0)
Nonbinary	2 (4.44)
Other	0 (0)
Sexual orientation	
Heterosexual	29 (64.44)
Gay	8 (17.78)
Lesbian	2 (4.44)
Bisexual	6 (13.33)
Other	0 (0)
LGBTQ+ identity	
Yes	16 (35.56)
No	29 (64.44)
Ethnicity	
White (Caucasic, European)	45 (100)
Black or Afro-American	0 (0)
Hispanic or Latin	0 (0)
Asian	0 (0)
Other	0 (0)
Marital status	
Single	12 (26.67)
In a relationship	9 (20.00)
Cohabiting partner	11 (24.44)
Married	12 (26.67)
Separated	0 (0)
Divorced	1 (2.22)
Widowed	0 (0)
Other	0 (0)
Geographic location	
Northern Italy	7 (15.56)
Central Italy	31 (68.89)
Southern Italy and the Islands	7 (15.56)
Educational level	6 (13.33)
Master's degree	39 (86.67)
Postgraduate school of psychotherapy	
Annual income	
<15.000€	9 (20.00)
15.001€-28.000€	18 (40.00)
28.001€-50.000€	12 (26.67)
>50.001€	6 (13.33)
Clinical activity information	*n* (%)

(*Continued*)

Table 1. (Continued).

Variables	Therapists ($N = 45$)
Professional experience	
<1 year	1 (2.22)
1–5 years	13 (28.89)
5–10 years	10 (22.22)
10–20 years	12 (26.67)
>20 years	9 (20.00)
Work context	
Public settings	4 (8.89)
Private practitioner	37 (82.22)
Both	4 (8.89)
Number of treated LGBTQ+ patients	
1–5	26 (57.78)
5–15	11 (24.44)
>15	8 (17.78)
Trainings on specific LGBTQ+ issues and needs	
Yes	25 (55.56)
No	20 (44.44)

Note. Percentages may not equal to 100, due to rounding. n = number of participants.

Measures

Sociodemographic and clinical activity information

Therapists' sociodemographic and clinical activity characteristics were collected through an ad hoc questionnaire. Sociodemographic information included: age, sex assigned at birth (i.e. female, male, or other), gender identity (i.e. cisgender woman, cisgender man, transgender woman, transgender man, nonbinary, and other), sexual orientation (i.e. heterosexual, gay, lesbian, bisexual, other), LGBTQ+ identity (i.e. yes, no), ethnicity (i.e. White [Caucasic, European], Black or Afro-American, Hispanic or Latin, Asian, and other), romantic relationship status (i.e. single, in a relationship, cohabiting partner, married, separated, divorced, widowed, and other), geographic location (i.e. Northern Italy, Central Italy, and Southern Italy and the islands of Sicily and Sardinia), educational level (i.e. Master's degree, postgraduate school of psychotherapy), and mean annual income (i.e. less than 15,000€, between 15,000€ and 28,000€, between 28,001 and 50,000€, more than 50,001€).

Clinical activity information regarded professional experience (i.e. less than 1 year, between 1 and 5 years, between 5 and 10 years, between 10 and 20 years, more than 20 years), work context (i.e. public settings, private practitioner, and both), number of treated LGBTQ+ patients (i.e. between 1 and 5, between 5 and 15, more than 15), and having received or attended educational trainings on specific LGBTQ+ issues and needs (i.e. yes, no).

Reflective functioning

Therapists' ability to reflect and understand one's own and other's behaviours in terms of beliefs, emotions, and mental states was measured through the Reflective Functioning Questionnaire (RFQ; Fonagy et al., 2016; Morandotti et al., 2018). The RFQ is an 8-item self-report questionnaire that requires participants to express their agreement for each item on a 7-point Likert scale ranging from 1 (*completely disagree*) to 7 (*completely agree*). The

measure provides two subscale scores: Certainty about mental states (e.g. 'I always know how I feel') and Uncertainty about mental states (e.g. 'Sometimes I do things without really knowing why').

Mentalised affectivity

Therapists' mentalised affectivity was measured using the Brief-Mentalised Affectivity Scale (B-MAS; Greenberg et al., 2021; Liotti et al., 2021). The B-MAS is a self-report instrument designed to assess a specific type of emotion regulation that involves reinterpreting, rather than merely adjusting, emotional experiences (Jurist, 2018). It consists of 12 items rated on a 7-point Likert scale, from 1 (*strongly disagree*) to 7 (*strongly agree*). The scale captures three core aspects of mentalised affectivity: *Identifying emotions*, which refers to the capacity to recognise and understand the meaning behind one's emotional states (e.g. 'I try to put effort into identifying my emotions'); *processing emotions*, which reflects the ability to regulate emotional intensity and integrate feelings within a broader interpersonal and affective context (e.g. 'When I am filled with a negative emotion, I know how to handle it'); and *expressing emotions*, which relates to the skill of conveying one's emotions effectively to others (e.g. 'If I feel something, I will convey it to others').

Working alliance

The construct of therapeutic alliance as conceptualised by Bordin (1979) was measured using the short version of the therapist-rated Working Alliance Inventory (WAI-T; Tracey & Kokotovic, 1989). The WAI-T is composed of 12 items rated on a 7-point Likert scale, from 1 (*never*) to 7 (*always*) assessing three dimensions of therapeutic alliance: *task*, which pertains to the shared understanding and endorsement of the strategies and interventions employed to facilitate therapeutic progress (e.g. 'My patient and I agree about the steps to be taken to improve his/her situation'), *goal*, which refers to a mutual understanding regarding the changes and modifications to be pursued during the therapeutic process (e.g. 'We have established a good understanding between us of the kind of changes that would be good for my patient'), and *bond*, which measures the close connection between patient and clinician, based on mutual trust, acceptance, and confidence (e.g. 'My patient and I have built a mutual trust'). Additionally, it is also possible to derive a global total score of therapeutic alliance. In the present study, therapists were asked to complete a questionnaire referring to the most recent LGBTQ+ patient they had treated or were currently treating in psychotherapy.

Data analysis

Analyses were conducted using the *jamovi* software (version 2.4.11) and the *GAMLj3* and *jAMM* statistical packages. First, preliminary descriptive analyses were conducted on sociodemographic data, clinical activity information, and study variables to offer an overall overview of the sample.

To explore possible associations among study variables, bivariate correlations (Pearson's *r*, two-tailed) were calculated among therapists' reflective functioning, mentalised affectivity, and working alliance. Additionally, to further identify which variables most effectively accounted for differences in therapists' working alliance with LGBTQ+ patients, a General Linear Model was run with the WAI-T total score as

a dependent variable, and therapists' reflective functioning (i.e. Certainty and Uncertainty) and mentalised affectivity (i.e. identifying, processing, and expressing emotions) as independent variables. Therapists' age, sex assigned at birth, LGBTQ+ identity, and attendance of professional trainings on specific LGBTQ+ issues and needs were included in the model as they have been found to influence therapists' attitudes and relational dynamics when working with LGBTQ+ patients (Cruciani, Quintigliano, et al., 2024).

To test the possible mediating role of mentalised affectivity in the association between reflective functioning and working alliance among therapists, a mediation model was developed, in which reflective functioning served as the independent variable, mentalised affectivity as the mediator, and working alliance as the dependent variable. The model was planned to be implemented according to the criteria proposed by Baron and Kenny (1986), which require that all variables included in the mediation model need to show significant associations with one another. Sociodemographic and clinical information variables that resulted significantly associated in the general linear model were included as covariates. Indirect, direct, and total effects were estimated, and significance was tested by computing 95% confidence intervals with Bootstrap percentiles method (5,000 resamples).

Results

Descriptives of therapists' sociodemographic and clinical activity information, reflective functioning, mentalised affectivity, and working alliance

In the present study, Cronbach's alphas for the employed measures were: $\alpha = 0.68$ for RFQ-Certainty; $\alpha = 0.82$ for RFQ-Uncertainty; $\alpha = 0.75$ for B-MAS identifying emotions; $\alpha = 0.65$ for B-MAS processing emotions; $\alpha = 0.85$ for B-MAS expressing emotions; $\alpha = 0.90$ for the WAI-T total score.

A full description of the sample's sociodemographic and clinical characteristics is presented in Table 1. All therapists identified as White and cisgender, with the exception of two participants who identified as nonbinary. Sixteen therapists reported an LGBTQ+ identity, primarily related to non-heterosexual sexual orientations. All participants had prior experience providing psychotherapy to at least one LGBTQ+ patient. Additionally, nearly half of the sample reported having attended specific LGBTQ+ training programmes.

Therapists' reflective functioning, mentalised affectivity, and working alliance scores are presented in Table 2. Regarding reflective functioning, both Certainty and Uncertainty scores were slightly below the normative mean of nonclinical participants reported by Fonagy et al. (2016), although they fell within one standard deviation of the mean. With respect to mentalised affectivity, therapists reported similar scores on Identifying emotions, higher scores on Processing emotions, and lower scores on Expressing emotions compared with the normative data reported by Liotti et al. (2021). Working alliance scores with LGBTQ+ patients were comparable to those previously reported by Carone, Innocenzi, et al. (2025) in an Italian sample of therapists working with parents with minoritized sexual identities.

Table 2. Reflective functioning, mentalised affectivity and working alliance scores of the therapist sample ($N = 45$).

			Range		95% CI	
Variables	Mean	SD	Min	Max	LL	UL
Reflective functioning						
Certainty about mental states	1.38	0.68	0.00	2.67	1.17	1.58
Uncertainty about mental states	0.56	0.23	0.00	1.00	0.49	0.63
Mentalized affectivity						
Identifying emotions	5.83	1.01	3.50	7.00	5.53	6.14
Processing emotions	5.30	0.76	3.50	6.50	5.07	5.53
Expressing emotions	4.63	1.21	1.50	7.00	4.26	4.99
Working alliance						
Task	5.57	0.92	2.50	7.00	5.30	5.85
Goal	5.54	1.06	2.75	7.00	5.23	5.86
Bond	5.54	0.77	3.50	6.75	5.31	5.78
Total score	5.59	0.81	2.92	6.83	5.34	5.83

Note. CI = Confidence intervals. LL = Lower limit. UL = Upper limit. SD = Standard deviation.

Correlations between study variables and factors associated with working alliance

Table 3 presents the full correlation matrix. Total working alliance and the Bond subscale were positively and significantly associated with therapists' Certainty about mental states, as well as with Identifying, Processing, and Expressing emotions. The Task subscale was positively associated with Certainty about mental states and Expressing emotions, whereas the Goal subscale was positively associated with Identifying emotions. No significant associations emerged between working alliance and Uncertainty about mental states. Notably, higher Certainty scores were associated with higher Expressing emotions scores, whereas higher Uncertainty scores were associated with higher Identifying and Processing emotions scores.

The general linear model with total working alliance as the dependent variable was significant ($p = .001$) and explained 38% of the variance. To maintain conciseness, only significant effects are described below; full model estimates are reported in Table 4. Higher Certainty about mental states and higher Expressing emotions scores were associated with stronger working alliance.

Table 3. Correlations between therapists' reflective functioning, mentalised affectivity and working alliance ($N = 45$).

	1.	2.	3.	4.	5.	6.	7.	8.	9.
Reflective functioning									
1. Certainty about mental states	1								
2. Uncertainty about mental states	0.02	1							
Mentalized affectivity									
3. Identifying emotions	0.22	0.46**	1						
4. Processing emotions	0.21	0.30*	0.43**	1					
5. Expressing emotions	0.37*	−0.15	0.36*	0.20	1				
Working alliance									
6. Task	0.56***	0.03	0.27	0.28	0.43**	1			
7. Goal	0.54***	0.02	0.33*	0.18	0.52***	0.88***	1		
8. Bond	0.44**	0.07	0.39**	0.38*	0.49***	0.67***	0.57***	1	
9. Total score	0.54***	−0.01	0.36*	0.31*	0.53***	0.92***	0.90***	0.82***	1

Note. *$p < 0.05$. **$p < 0.01$. ***$p < 0.001$.

Table 4. Factors associated with therapists' working alliance with LGBTQ+ patients ($N = 45$).

Outcome: Working alliance		β	SE	CI LL	CI UL	p
Age		−0.04	0.01	−0.02	0.02	0.783
Sex assigned at birth		0.21	0.29	−0.42	0.76	0.564
LGBTQ+ identity		0.05	0.28	−0.53	0.61	0.885
LGBTQ+ trainings		0.40	0.22	−0.13	0.76	0.156
Certainty about mental states		0.40	0.16	0.16	0.80	0.004
Uncertainty about mental states		−0.07	0.55	−1.36	0.85	0.647
Identifying emotions		0.10	0.13	−0.19	0.35	0.563
Processing emotions		0.16	0.16	−0.15	0.49	0.281
Expressing emotions		0.34	0.10	0.02	0.43	0.034
R^2 adjusted (explained variance)	0.378					

Note. SE = standardised error; CI = Confidence intervals; LL = lower limit; UL = upper limit.

Direct and indirect associations between reflective functioning and working alliance through mentalised affectivity

Following the recommendations of Baron and Kenny (1986), a mediation model was tested, with Expressing emotions as the mediator, Certainty about mental states as the independent variable, and total working alliance as the dependent variable. The model is presented in Figure 1 and Table 5. Certainty showed a significant direct effect on working alliance, as well as a significant indirect effect through Expressing emotions.

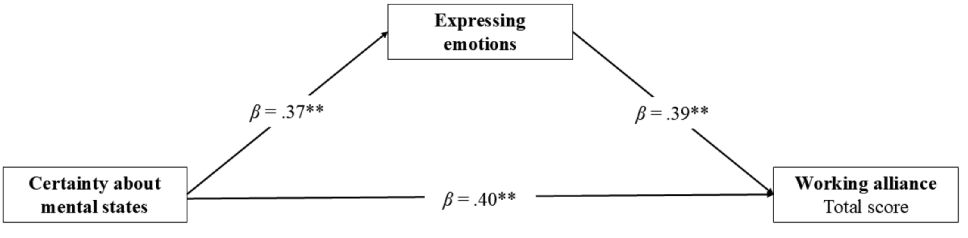

Figure 1. Graphical representation of the mediation model assessing the direct and indirect effects of therapists' reflective functioning certainty about mental states on working alliance with LGBTQ+ patients through mentalised affectivity expressing emotions ($N = 45$).

Table 5. Mediation model estimates of direct and indirect effects of therapists' reflective functioning certainty about mental states on working alliance with LGBTQ+ patients through mentalised affectivity expressing emotions ($N = 45$).

Type	Effect	Estimate	SE	95% CI (LL)	95% CI (UL)	β	p
Indirect	Certainty about mental states ⇒ Expressing emotions ⇒ Working alliance	0.17	0.08	0.02	0.37	0.14	0.042
Component	Certainty about mental states ⇒ Expressing emotions	0.65	0.25	0.13	1.20	0.47	0.008
	Expressing emotions ⇒ Working alliance	0.26	0.08	0.05	0.43	0.39	0.001
Direct	Certainty about mental states ⇒ Working alliance	0.48	0.15	0.18	0.80	0.40	0.001
Total	Certainty about mental states ⇒ Working alliance	0.65	0.15	0.33	0.96	0.54	<0.001

Note. No covariates were inserted in the present model in accordance with non-significant effects of age, sex assigned at birth, LGBTQ+ identity, and LGBTQ+ trainings resulted from the general linear model. *$p < 0.05$; **$p < 0.01$; ***$p < 0.001$. Confidence intervals computed with method: Bootstrap percentiles; Betas are completely standardised effect sizes.

Discussion

The present study investigated the role of therapists' sociodemographic, professional, and personal variables as possible factors associated with the construction of a positive therapeutic alliance with LGBTQ+ patients. Partially supporting the initial hypotheses, higher Certainty about mental states and Expressing emotions scores were associated with higher levels of therapeutic alliance; on the contrary, neither sociodemographic nor professional variables were significant associated with therapeutic alliance. Additionally, the association between reflective functioning and therapeutic alliance was significantly mediated by mentalised affectivity, with higher certainty about mental states being associated with higher emotion expression and, ultimately, a stronger alliance. These results highlight the role of intrapsychic therapists' processes in enhancing the relation quality within the context of LGBTQ+ clinical work. These findings are in line with the broader literature on the therapist effect, which emphasises that individual therapist characteristics contribute significantly to therapeutic outcomes (Heinonen & Nissen-Lie, 2020). Importantly, within this framework, the quality of the therapeutic alliance itself is considered a key process influenced by therapist effects, as therapists' personal capacities can affect the extent to which patients feel understood, supported, and collaboratively engaged in the therapeutic process (Ackerman & Hilsenroth, 2001, 2003; Del Re et al., 2021).

In the field of psychotherapy with LGBTQ+ patients, this issue could be particularly relevant. Therapeutic work with LGBTQ+ patients requires therapists not only to foster a collaborative and affirming therapeutic alliance but also to actively engage with their own internal experiences (Lingiardi & McWilliams, 2025). In this vein, processing personal internal responses, including unconscious biases, values, or emotional responses, becomes a central part of the therapeutic process, which can be challenging for therapists working with LGBTQ+ patients (Giovanardi et al., 2025; Hatzenbuehler et al., 2024). In particular, therapists' reflective functioning and mentalised affectivity may play a central role in understanding both their own reactions and those of their patients, ultimately supporting the co-construction of a meaningful and effective therapeutic relationship.

We hypothesised that higher levels of therapists' reflective functioning would be associated with a more positive working alliance with LGBTQ+ patients. Results showed that therapists with higher certainty about mental states were better able to understand and interpret both their own and their patients' internal experiences, thereby supporting a collaborative and trusting therapeutic relationship. In the context of the RFQ, Certainty about mental states refers to the extent to which individuals perceive mental states as understandable, interpretable, and meaningfully linked to behaviour, whereas Uncertainty reflects difficulties in recognising or making sense of one's own and others' internal experiences. In clinical work with LGBTQ+ patients, higher Certainty may manifest as the therapist's ability to read and consider how experiences of minority stress, identity negotiation, or internalised stigma shape a patient's emotional and relational responses, while remaining open to revising initial interpretations. Conversely, elevated Uncertainty may be reflected in difficulties identifying the emotional meaning of identity-related disclosures or in relying predominantly on observable behaviour without integrating underlying subjective experiences. In this vein, findings from the present study are consistent with previous research linking therapists' reflective functioning to improved

working alliance (Reading et al., 2019). Clinical work with LGBTQ+ is often characterised by complex narratives of identity development, perceived or internalised stigma, and minority stress (Berke et al., 2016; Mezzalira, Carone, et al., 2025; Moradi & Budge, 2018). In this context, higher reflective functioning may support therapists' capacity to sustain an open, flexible, and non-defensive stance within the therapeutic relationship, which can buffer the possible negative effect of therapists' unconscious personal biases (Brugnera et al., 2021; Cruciani, Tracchegiani, et al., 2025; Fonagy et al., 2002).

In fact, therapists with stronger reflective functioning may be better able to hold in mind both their own internal reactions and those of their patients, facilitating a more accurate understanding of emotional meanings and relational dynamics as they unfold in session (Bateman & Fonagy, 2016; Fonagy & Bateman, 2006). This reflective stance may be particularly relevant for the therapeutic alliance, as it has the potential to promote emotional attunement, validation, and sensitivity to identity-related experiences, ultimately strengthening the affective bond and supporting shared understanding of therapeutic goals and tasks. Conversely, lower reflective functioning may increase the risk of reduced sensitivity to implicit cues, or an overreliance on observable behaviour at the expense of underlying mental states (Katznelson, 2014). In the context of LGBTQ+ psychotherapy, such difficulties may undermine patients' sense of being understood and affirmed, affecting in a negative way alliance quality in a clinical setting where relational safety and mental flexibility are especially central (Israel et al., 2008).

At the same time, it is important to acknowledge that reflective functioning may become clinically problematic when it takes the form of excessive or inaccurate mental state attributions. For example, Brugnera and colleagues (Brugnera et al., 2023) found moderate evidence that higher certainty about mental states predicted subsequent burnout symptoms among psychotherapists. The authors suggested that therapists with higher mentalising capacities may become more emotionally engaged with their patients, a core therapeutic factor that, if unmodulated, can increase the risk of overidentification with clients and their distress. From a mentalisation perspective, such overinvolvement may reflect forms of hypermentalization, characterised by excessive or biased certainty about mental states that is insufficiently grounded in ongoing relational evidence, potentially leading to misinterpretations and reduced relational attunement (Sharp & Vanwoerden, 2015). Nevertheless, in the present study, therapists' levels of Certainty about mental states were comparable to those reported in other nonclinical samples (Fonagy et al., 2016); this result may suggest that the reflective functioning observed in our sample reflects a balanced and adaptive mentalising stance rather than a tendency towards over-mentalisation. This supports the interpretation that therapists' reflective functioning in the present study is likely to contribute to alliance formation by fostering accurate, flexible, and emotionally attuned engagement with LGBTQ+ patients.

Regarding our hypothesis, higher levels of therapists' mentalised affectivity were expected to be associated with a more positive working alliance with LGBTQ+ patients. Results showed that the expressing emotion dimension, in particular, was significantly associated with higher therapist-reported alliance scores. Expressing emotions refers to the capacity to convey affective states in a way that is mentally grounded, regulated, and congruent with one's internal experience (Fonagy et al., 2002; Jurist, 2018). In psychotherapy with LGBTQ+ patients, whose therapeutic encounters often require careful negotiation of emotional disclosure, trust, and

relational boundaries as affected by prior experiences with invalidation or discrimination (Cruciani, Quintigliano, et al., 2024), therapists' ability to express affect in a measured and mentally grounded way may foster transparency, emotional availability, and relational authenticity. Such expressive capacity likely strengthens the affective bond component of the working alliance by signalling presence, validation, and emotional attunement, while simultaneously supporting emotional regulation and preventing both withdrawal and over-involvement. In this vein, therapists' emotional expression appears not as a loss of professional neutrality, but as a mentalised use of affect that actively contributes to the co-construction of a stable therapeutic alliance. These observations are in line with previous meta-analytic findings (Peluso & Freund, 2018) that demonstrated a significant positive association between therapist's expression of emotions and therapeutic outcomes.

Nevertheless, Fonagy and colleagues (2002) emphasised that expressing emotion can also be directed inwardly, through an internal process of acknowledging and reflecting on one's emotional experience while remaining emotionally activated, rather than necessarily translating affect into outward behaviour. From this perspective, expressing emotions inwardly may represent a particularly valuable resource for therapists, functioning as a reflective tool for recognising and processing internal emotional responses elicited during clinical work with LGBTQ+ patients. This capacity may help therapists become aware of countertransferential reactions related to themes of identity, stigma, power, or vulnerability, as well as of more implicit emotional responses that might otherwise remain outside awareness (Giovanardi et al., 2025; Sabin et al., 2015). When such emotional experiences are not mentalised and owned, they may subtly affect clinical interventions, relational positioning, or affective availability, potentially undermining therapeutic alliance quality. By contrast, the inward expression of emotion may allow therapists to manage and clarify their affective responses without acting on them, supporting emotional regulation, responsive therapeutic stance, and, ultimately, a positive alliance.

Regarding the hypothesis that therapists' mentalised affectivity would mediate the association between reflective functioning and therapeutic alliance with LGBTQ+ patients, results showed that therapists' higher certainty about mental states was associated with a stronger alliance through higher emotion expression. The association between reflective functioning and emotion regulation has been discussed in the developmental model proposed by Fonagy and colleagues (1997), which conceptualises these capacities as emerging through a bidirectional and interdependent process. Early in development, caregivers' mentalising capacities support the co-regulation of the child's emotional states, fostering both the gradual development of mentalisation and the acquisition of increasingly autonomous emotion regulation abilities (Fonagy & Target, 2011; Fonagy et al., 1997). Through repeated experiences of sensitive, reflective interactions, emotional states become experienced as meaningful, predictable, and manageable, allowing for the formation of differentiated internal representations of affect that support later self-regulation (Fonagy et al., 2002).

The development of emotion regulation thus involves a shift from primarily relying on interpersonal co-regulation to progressively achieving self-directed, independent regulation of one's emotions (Fonagy & Target, 2011). In adulthood, this developmental pathway appears to be further elaborated through more complex forms of affective awareness and regulation. In this regard, Schwarzer and colleagues

(Schwarzer et al., 2021) highlighted the role of mentalised affectivity as a fundamental process through which individuals make sense of affective states and their meanings in light of their autobiographic memories. From this perspective, the capacity to mentalise emotions in adulthood seems to rely on a well-established ability to attend to and reflect upon one's own internal experiences, that is, self-directed mentalising, suggesting a functional continuity between reflective functioning and mentalised affectivity. Empirical evidence supporting this conceptual link comes from studies showing that emotion regulation abilities mediate the association between mentalisation and different forms of psychopathology, including interpersonal problems (Euler et al., 2021) and borderline traits (Sharp et al., 2011). Taken together, these findings, along with results from the present study, support a theoretical and empirical rationale for conceptualising mentalised affectivity as a process that may operate downstream of reflective functioning. This may translating mentalising capacities into adaptive emotional regulation within relational contexts, ultimately affecting therapeutic alliance. By supporting therapists' capacity to regulate and make sense of their own emotional responses, mentalised affectivity may facilitate attuned, validating, and flexible relational exchanges, thereby enhancing alliance quality with LGBTQ+ patients.

For what concern the hypothesis that sociodemographic and professional variables would be associated with the construction of a positive therapeutic alliance with LGBTQ+ patients, results showed that age, sex assigned at birth, LGBTQ+ identity, and prior LGBTQ+ training were not significantly associated with therapeutic alliance in the present sample. Although these variables are often considered relevant in shaping therapists' attitudes and competencies when working with LGBTQ+ patients (Cruciani, Quintigliano, et al., 2024), the present findings suggest that demographic characteristics and formal exposure alone may be insufficient to account for variations in alliance quality. One possible explanation is that relational processes underpinning the therapeutic alliance rely more strongly on clinicians' intrapsychic and relational capacities, such as mentalisation, than on static personal attributes or categorical identities (Ackerman & Hilsenroth, 2001, 2003).

From this perspective, factors such as age or sex assigned at birth may exert indirect or context-dependent influences that are less relevant than proximal relational skills during therapeutic exchanges. Similarly, identifying as LGBTQ+ or having received LGBTQ+-specific training may foster awareness and affirmative attitudes, but may not translate into stronger alliances without the ability to mentalise flexibly, regulate emotional responses, and remain attuned to patients' subjective experiences. This interpretation aligns with research suggesting that affirming knowledge and shared identity, though valuable, do not substitute for the ongoing relational work required to sustain therapeutic engagement, particularly in clinical contexts characterised by heterogeneity of identities, lived experiences, and interpersonal needs within LGBTQ+ populations (Alessi et al., 2019; Jennings & Sprankle, 2024; Lelutiu-Weinberger et al., 2023).

Limitations

Several limitations should be considered when interpreting the present findings. The reliance on self-report measures may have introduced biases related to self-perception and social desirability and may not fully capture in-session relational processes; future

studies should adopt multi-method approaches, including observer- or patient-rated measures, to better assess therapeutic dynamics with LGBTQ+ patients. Additionally, future studies would benefit from the integration of both therapists' and patients' perspectives on working alliance, as the actual experience of LGBTQ+ patients may provide a more nuanced understanding of underlying mechanisms of effective therapeutic work.

Moreover, the cross-sectional design prevents causal conclusions regarding the directionality of associations among reflective functioning, mentalised affectivity, and therapeutic alliance, highlighting the need for longitudinal research. The lack of detailed information on patient-specific characteristics further limits understanding of how clinical complexity or minority stress may have affected therapists' emotional responses and alliance perceptions. Finally, the relatively small and sociodemographically homogeneous sample, predominantly composed of cisgender Italian therapists, restricts the generalisability of the findings. This could be possibly due to non-random sampling strategies adopted in the present study. Replication in larger and more diverse samples is needed to better account for cultural, gender, and contextual variability in LGBTQ+ clinical work.

Conclusions

This study contributes to the literature on therapist factors by highlighting the central role of intrapsychic processes in shaping the quality of the therapeutic alliance in LGBTQ+ clinical work. Focusing on reflective functioning and mentalised affectivity, the findings indicate that alliance quality is not simply a function of demographic characteristics, shared identity, or formal training, but is fostered by therapists' capacity to mentalise, regulate, and engage with their own emotional experiences within the therapeutic relationship. Reflective functioning appears to provide a foundational capacity for managing emotionally salient clinical material, while mentalised affectivity, particularly the ability to express emotions, including inwardly directed ones, may represent a key mechanism through which mentalising is translated into relational effectiveness.

Therapists who can recognise and work through their emotional responses, including subtle countertransferential reactions elicited by LGBTQ+ clinical material, may be better able to maintain openness, emotional presence, and responsiveness, thereby strengthening the therapeutic alliance (Giovanardi et al., 2025). Conversely, difficulties in mentalising and emotion regulation may increase the risk of misattunement or emotional distancing, with potential implications for alliance quality and engagement (Carone, Innocenzi, et al., 2025).

These findings also have implications for training and supervision. Working alliance could be affected by therapists' clinical knowledge and attitudes regarding specific mental health needs of LGBTQ+ patients, as well as by intrapsychic factors, as observed in the present study. Programmes aimed at enhancing competence in LGBTQ+ clinical work should move beyond exclusively didactic or identity-focused approaches and emphasise the integration of formal educational training and the cultivation of reflective functioning and emotion mentalisation through interactive and experiential components (Baiocco et al., 2022; Pezzella et al., 2023). Supervision and personal therapy may further support therapists in processing countertransference and emotionally charged reactions, promoting sustained relational engagement (Chui et al., 2018; Moe & Thimm, 2021). Overall, strengthening

therapists' mentalising and emotion regulation capacities may represent a promising avenue for enhancing therapeutic alliance in LGBTQ+ psychotherapy, warranting further investigation through longitudinal and multi-method research designs.

Note

1. The acronym LGBTQ+ will be used to refer to people who identify as lesbian, gay, bisexual, transgender, queer, and other minoritized sexual and gender identities.

Author contributions

Conceptualisation: Gianluca Cruciani, Jacopo Tracchegiani, and Nicola Carone; Literature search and data analysis: Gianluca Cruciani, Jacopo Tracchegiani, Maria Quintigliano, Selene Mezzalira, and Cristiano Scandurra; Writing – original draft preparation: Gianluca Cruciani and Jacopo Tracchegiani; Writing – review and editing: Maria Quintigliano, Selene Mezzalira, Cristiano Scandurra, and Nicola Carone; Funding acquisition: Cristiano Scandurra and Nicola Carone; Supervision: Nicola Carone.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

Research data supporting the findings of the current study are available upon reasonable request to the corresponding author.

Ethics statement

This study received ethical approval from the Ethical Committee of the University of Naples 'Federico II' (protocol no. 10/2024) and the Territorial Ethics Committee Lazio Area 2 (protocol no. 197.24 CET2 utv).

Patient consent statement

Informed consent was obtained from the participants of this study.

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