Professional burnout in therapists working with LGBTQ+ patients: associations with defenses and reflective functioning

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ABSTRACT

This cross-sectional, questionnaire-based study examined the role of psychological (*i.e.*, defenses and reflective functioning) and contextual variables (*i.e*., LGBTQ+ identity, clinical experience, and LGBTQ+-specific training) in contributing to professional burnout among 51 Italian psychologists and psychotherapists (mean age 40.12, standard deviation [SD]=9.86) working with LGBTQ+ patients. Preliminary correlational analyses showed that mature defenses were negatively associated with emotional exhaustion and depersonalization, and positively with personal accomplishment. Conversely, immature defenses correlated positively with emotional exhaustion and depersonalization, and negatively with personal accomplishment. Neurotic defenses were linked specifically to reduced personal accomplishment. Lower certainty about mental states – an indicator of diminished reflective functioning – was also associated with higher burnout. In line with the study's main hypothesis, regression analyses revealed that lower overall defensive functioning (ODF), reduced certainty about mental states, and fewer years of clinical experience significantly predicted higher burnout levels. These findings underscore the importance of both intrapsychic resources and professional development in protecting therapists from burnout. Adaptive defenses and strong reflective functioning appear particularly protective in LGBTQ+ clinical contexts, where therapists often encounter emotionally complex, identity-related challenges. Therapists who can mentalize effectively and regulate internal responses through mature defenses may be better equipped to sustain therapeutic engagement and mitigate emotional exhaustion. These results suggest that clinical training and supervision should prioritize the enhancement of reflective capacity and adaptive defenses. Supporting these intrapsychic skills may be key to promoting therapist well-being and ensuring affirming, competent care for LGBTQ+ patients.

Key words: professional burnout, defenses, reflective functioning, LGBTQ+, psychotherapists, psychologists.

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Introduction

LGBTQ+[1] individuals are more likely to experience mental health issues than the general population, including depression, anxiety, suicide attempts, and drug-related disorders (Carone *et al.*, 2021; Hatchel *et al.*, 2021; Mezzalira *et al.*, 2025a; Moore *et al.*, 2021). Nevertheless, due to greater structural, interper-

[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.

sonal, and individual barriers, they access healthcare services – including mental health facilities – at a significant lower extent than cisgender heterosexual individuals (Alencar Albuquerque *et al.*, 2016; Mezzalira *et al.*, 2024; Scandurra *et al.*, 2019; Zeeman *et al.*, 2019). In accordance with the *minority stress model* (Meyer, 1995, 2003), positing that individuals with minoritized sexual and gender identities encounter unique stressors related to their marginalized status, barriers to care may include both proximal stressors, like internalized stigma and fear of rejection, and distal stressors, such as societal stigma, discrimination, microaggressions and structural inequalities (*e.g.*, discriminatory laws and policies).

In this vein, within clinical settings, practitioners may unintentionally perpetuate cis-heterosexist or monosexist biases, leading to discriminatory behaviors, inadequate diagnoses, and suboptimal care. Furthermore, a lack of training and limited cultural competence among mental health professionals exacerbates these challenges, reducing the likelihood that LGBTQ+ individuals will seek or continue treatment (Carone *et al.*, 2025). In a recent review, McNamara and Wilson (2020) showed that the psychotherapeutic experiences of lesbian, gay, or bisexual (LGB) patients can be shaped by factors such as sexual identity affirmation, adequate clinical and cultural knowledge of LGBTQ+ issues, and a positive therapeutic attitude. These contribute to positive encounters with mental health professionals. Conversely, experiences of discrimination by practitioners, pathologization of sexual orientation, insufficient clinical knowledge, and discomfort in addressing patients' sexuality can lead to negative psychotherapy outcomes. Similarly, Mezzalira and colleagues (2025a) reported that transgender and nonbinary (TNB) individuals undergoing psychotherapy identified a nurturing therapeutic alliance—characterized by an affirming stance and attention to intersectional stigma—as a crucial factor in fostering a positive therapeutic relationship. In contrast, experiences of micro- and macro-aggressions, inadequate trans-specific knowledge, and the pathologization of transgender and nonbinary identities were associated with negative encounters with mental health professionals. Moreover, TNB patients often report the burden of having to educate their therapists about their own identities, reflecting clinicians' limited trans-specific knowledge and training (Mezzalira *et al.*, 2025b; Mezzalira *et al.*, 2025d; Rosati *et al.*, 2022). Such challenges – frequently chronic and particularly salient for TNB individuals – can intensify experiences of invalidation and misunderstanding within therapy. From a psychoanalytic perspective, these encounters may also elicit clinicians' internal conflicts, uncertainties, and defensive reactions. As discussed in recent psychoanalytic work (Hansbury, 2017; Saketopoulou, 2020; Giovanardi *et al.*, 2025), therapists working with TNB patients are often called to engage with trans-related anxieties and countertransference processes that can shape the therapeutic relationship in subtle yet significant ways.

Data reported thus far highlight that therapists' personal and clinical characteristics significantly influence their therapeutic relationships with LGBTQ+ patients. Affirmative attitudes and competent clinical and cultural knowledge related to LGBTQ+ issues are associated with the creation of environments in which patients feel safe, respected, and valued. In contrast, ambiguous attitudes and limited knowledge often result in weaker therapeutic relationships and poorer clinical outcomes (Cruciani *et al.*, 2024b). Notably, while negative attitudes and deficits in clinical and cultural competence contribute to barriers in accessing healthcare, they may also adversely impact practitioners' well-being, particularly in terms of job satisfaction and professional burnout (Chaudhary & Bhaskar, 2016; Simionato & Simpson, 2018).

The concept of professional burnout encompasses a type of job-related stress due to prolonged exposure to chronic workplace pressures and tensions, particularly in emotionally demanding roles (Freudenberger, 1974). According to the model proposed by Maslach and colleagues (2001), professional burnout comprises three core dimensions: emotional exhaustion, characterized by feelings of being emotionally drained and depleted of emotional resources; depersonalization, defined as a detached, impersonal, or cynical response toward clients, patients, or colleagues – often accompanied by irritability, indifference, or negative attitudes; and a reduced sense of personal accomplishment, marked by diminished feelings of competence and achievement at work, often associated with perceived ineffectiveness and low productivity. Burnout can impair job performance and increase absenteeism (Bamber & McMahon, 2008; Bearse *et al.*, 2013) and negatively affect both mental and physical health of workers (Yang & Hayes, 2020). It is especially prevalent in helping professions, with a significant rate among therapists (O'Connor *et al.*, 2018; Van Hoy & Rzeszutek, 2022). Additionally, therapists' burnout can significantly undermine the quality of therapeutic processes and negatively affect patient outcomes: burned-out therapists may show difficulties in maintaining emotional engagement, leading to reduced empathy, poorer communication, and weakened therapeutic alliances (Maslach & Leiter, 2016; Shanafelt *et al.*, 2012). For patients, these issues can translate into lower satisfaction with care, slower therapeutic progress, or even premature termination of therapy (Delgadillo *et al.*, 2018; Morse *et al.*, 2012). In this context, research on therapist self-care and reflective supervision has highlighted the importance of structured support in maintaining emotional well-being and preventing burnout, particularly when clinicians work with clients with marginalized sexual or gender identities (Chui *et al.*, 2018; Hagler, 2020). By fostering reflective functioning, enhancing awareness of defensive processes, and providing space for processing countertransference reactions, these practices help therapists sustain engagement and effectiveness in challenging clinical work (Dictado &Torres-Harding, 2023).

Professional burnout is affected by a range of contextual and psychological factors specific to the therapist. For example, a review indicated that maladaptive coping strategies are associated with increased burnout among therapists (Simionato & Simpson, 2018). Given that emotional regulation includes both explicit and implicit processes (Gyurak *et al.*, 2011), growing evidence suggests that, beyond conscious, situation-based coping mechanisms, implicit and largely automatic processes such as defenses also play a critical role in the development of burnout in healthcare providers (*e.g.*, Fitzgerald-Yau & Egan, 2018).

Defenses are largely automatic and unconscious psychological processes that help individuals manage painful emotions, internal conflicts, and distressing experiences (American Psychiatric Association [APA], 2000; Cramer, 2015; Di Giuseppe & Perry, 2021). Defenses are best understood within the hierarchical framework conceptualized by Perry (1990) through the *Defense Mechanisms Rating Scale* (DMRS), which organizes defenses along a continuum from mature to immature (Vaillant *et al.*, 1986). Mature defenses, such as self-assertion, humor, and sublimation, are adaptive strategies that promote resilience,

self-reflection, and effective coping. Neurotic defenses, while less adaptive, still serve to protect psychological functioning by keeping internal conflicts outside of conscious awareness. At the opposite end of the spectrum, immature defenses like acting out and projective identification tend to distort reality and are linked to maladaptive behavior, low self-awareness, and interpersonal difficulties. Additionally, the DMRS allows for determining an overall defensive functioning (ODF) index of individuals' defensive maturity that can be used as an outcome measure (Di Giuseppe *et al.*, 2020; Prout *et al.*, 2022).

Although coping mechanisms and defenses differ in terms of their malleability – with defenses being generally more susceptible to modification within long-term therapeutic contexts than coping strategies – and in their association with psychopathological symptoms – with defenses typically being less directly linked to observable symptoms due to their more implicit nature – both constructs may be conceptualized as "adaptational processes" employed to navigate challenging circumstances and are highly interrelated (Di Giuseppe & Lingiardi, 2023; Silverman & Aafjes-van Doorn, 2023).

Several studies have examined the relation between defensive functioning and professional burnout in healthcare professionals (Di Giuseppe *et al.*, 2021; Elyasi *et al.*, 2020; Fitzgerald-Yau & Egan, 2018). However, to date, only one study has explored this relation specifically in psychotherapists, showing that higher reliance on mature defenses is negatively associated with emotional exhaustion and disengagement, while greater use of immature defenses is positively related to both dimensions of professional burnout (Bokowy, 2024). Despite the growing interest in therapists' defensive functioning (*e.g.*, Bokowy, 2024; Di Giuseppe *et al.*, 2024), no research has yet investigated the role of defenses in psychologists and psychotherapists working specifically with LGBTQ+ patients.

This represents a critical gap, considering that psychotherapy with LGBTQ+ individuals often involves complex identity dynamics, high emotional intensity, and topics related to marginalization (Hatzenbuehler *et al.*, 2024; Mezzalira *et al.*, 2025a), which may place greater emotional demands on the therapist. In this context, the therapist's defensive functioning may be especially relevant, as patients' identity-related experiences or defenses may unconsciously activate parallel defenses in the clinician (Di Giuseppe *et al.*, 2024). Moreover, prior work suggests that patients may interiorize aspects of the therapist's defensive functioning over the course of treatment (Di Giuseppe *et al.*, 2024), influencing both the therapeutic alliance and clinical outcomes. Thus, when therapists rely predominantly on maladaptive defenses, this can significantly impair both the quality of the therapeutic experience and the therapist's own psychological well-being (Carone *et al.*, 2025).

In a similar way, professional burnout appears to be linked to individuals' mentalizing abilities, that is, the capacity to understand and interpret one's own and others' behavior as driven by underlying mental states, such as emotions, intentions, desires, beliefs, goals, and needs, whether these are expressed implicitly or explicitly (Fonagy *et al.*, 2002). Mentalization plays a crucial role in regulating emotions and fostering a cohesive sense of identity, supporting interpersonal functioning by enabling individuals to make sense of their own and others' mental states and differentiate between internal experiences and external reality (Bateman & Fonagy, 2016). Attachment theory suggests that mentalization abilities develop in the context of optimal (*i.e.*, secure) primary attachment relationships, as a function of caregivers' mirroring ability and responsiveness to the child's needs (Fonagy *et al.*, 2002). From this perspective, reflective functioning has been proposed as an operationalization of mentalization (Fonagy *et al.*, 1998), a cognitive ability through which individuals apply their mentalization processes in different situations (Katznelson, 2014). Reflective functioning has been linked to professional burnout among different professions (Dexter & Wall, 2021; Safiye *et al.*, 2022), including therapists (Brugnera *et al.*, 2023), showing that lower levels of mentalizing abilities are associated with higher rates of professional burnout.

Despite growing evidence that therapists' individual characteristics – such as clinical knowledge, defenses, and reflective functioning – can significantly influence both therapeutic processes and their own psychological well-being, particularly in relation to professional burnout (Lingiardi *et al.*, 2018), no study to date has specifically examined these factors in therapists working with LGBTQ+ patients. This represents a critical gap in the literature, especially given that LGBTQ+ individuals continue to encounter structural and interpersonal barriers to accessing affirming mental health care (Cruciani et al., 2024b; Mezzalira et al., 2025a). Therefore, gaining a deeper understanding of how therapists' mental functioning relates to professional burnout is essential for enhancing both practitioner well-being and therapeutic outcomes within this marginalized population.

The present study

Given the limited research on therapists' defenses and mentalizing capacities (Cologon *et al.*, 2017; Di Giuseppe *et al.*, 2024; Reading *et al.*, 2019), particularly in relation to professional burnout (Bokowy, 2024), the present study preliminarily provided a comprehensive assessment of defensive functioning, reflective functioning, and professional burnout among licensed psychologists and psychotherapists working with LGBTQ+ patients. The study aimed at investigating the role of psychological (*i.e.*, defenses and reflective functioning) and contextual variables (*i.e.*, LGBTQ+ identity, clinical experience, and LGBTQ+-specific training) in contributing to professional burnout. Based on previous research (Bokowy, 2024; Brugnera *et al.*, 2023; Dexter & Wall, 2021; Di Benedetto & Swadling, 2014; Malinowski, 2013; Safiye *et al.*, 2022), it was hypothesized that less adaptive defenses and lower mentalizing abilities would be associated with higher burnout levels. Additionally, it was also hypothesized that lower burnout levels would be found among therapists holding an LGBTQ+ identity, higher clinical experience, and who have attended previous training on specific LGBTQ+ issues, as these have been identified as protective factors that can enhance perceived self-confidence and affirming practices when working with LGBTQ+ patients (Cruciani *et al.*, 2024b).

Materials and Methods

Participants

A cross-sectional sample of 51 participants was recruited. Participants (41 assigned female at birth, 10 assigned male at birth, mean age 40.12±9.86 years) were licensed Italian clinical psychologists (n=9) and psychotherapists (n=42) having treated or still treating LGBTQ+ patients in their clinical activity. Table 1 displays the complete participants' characteristics.

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Table 1. Sociodemographic characteristics and clinical activity information of the sample (n=51; mean age 40.12; SD=9.86).

Variables	n (%)
Sociodemographic characteristics	
Sex assigned at birth	
Female	41 (80.39)
Male	10 (19.61)
Other	0 (0)
Gender identity	
Cisgender women	39 (76.47)
Cisgender men	10 (19.61)
Transgender women	0 (0)
Transgender men	0 (0)
Nonbinary	2 (3.92)
Other	0 (0)
Sexual orientation	
Gay/Lesbian	10 (19.61)
Heterosexual	33 (64.71)
Bisexual	8 (15.69)
Other	0 (0)
LGBTQ+ identity	
Yes	18 (35.29)
No	33 (64.71)
Ethnicity	
White (Caucasic, European)	51 (100)
Black or Afro-American	0 (0)
Hispanic or Latin	0 (0)
Asian	0 (0)
Other	0 (0)
Marital status	
Single	14 (27.45)
In a relationship	10 (19.61)
Cohabiting partner	13 (25.49)
Married	13 (25.49)
Separated	0 (0)
Divorced	1 (1.96)
Widowed	0 (0)
Other	0 (0)
Geographic location	
Northern Italy	8 (15.69)
Central Italy	34 (66.67)
Southern Italy and the Islands	9 (17.65)
Educational level	
Master’s degree	9 (17.65)
Postgraduate school of psychotherapy	42 (82.35)
Annual income	
<15.000€	11 (21.57)
15.001€-28.000€	19 (37.25)
28.001€-50.000€	15 (29.41)
>50.001€	6 (11.77)
Clinical activity information	
Professional experience	
<1 year	1 (1.96)
1-5 years	15 (29.41)
5-10 years	13 (25.49)
10-20 years	13 (25.49)
>20 years	9 (17.65)
Work context	
Public settings	6 (11.76)
Private practitioner	41 (80.39)
Both	4 (7.84)
Number of treated LGBTQ+ patients	
1-5	30 (58.82)
5-15	12 (23.53)
>15	9 (17.65)
Trainings on specific LGBTQ+ issues and needs	
Yes	28 (54.90)
No	23 (45.10)

Percentages may not equal 100, due to rounding; M, mean; SD, standard deviation.

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Procedure

Data were collected via a web-based survey developed using the Qualtrics online platform. Participant recruitment occurred between May 2024 and April 2025 through multiple channels, including the dissemination of the survey link on social media platforms, targeted email invitations distributed via mailing lists of the major Italian associations of psychology and psychotherapy, outreach through various institutions within the National Health System, and snowball sampling via word-of-mouth. Inclusion criteria for participation were: i) working as a licensed psychologist/psychotherapist with LGBTQ+ patients; ii) being at least 18 years old; iii) living in Italy; and iv) understanding Italian fluently. Before completing the survey, participants were asked to read and accept an informed consent form. Participants were also assured that the survey would be anonymous and that they could withdraw at any time with no consequences. The research received ethical approval from the University of Naples "Federico II" (protocol number: 10/2024; date of approval: 15 May 2024) and by the University of Rome "Tor Vergata" (protocol number: 197.24 CET2 utv; date of approval: 25 July 2024) and complies with the EU General Data Protection Regulation.

Measures

Sociodemographic and clinical activity information

An *ad-hoc* questionnaire was developed to collect sociodemographic characteristics of the sample. Information collected 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.*, gay/lesbian, heterosexual, bisexual, and other), LGBTQ+ identity (*i.e.*, yes, no), ethnicity (*i.e.*, White [Caucasic, European], Black or Afro-American, Hispanic or Latin, Asian, and other), 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). Regarding clinical activity, information collected included 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 attended professional trainings on specific LGBTQ+ issues and needs (*i.e.*, yes, no).

Defenses

The Defense Mechanisms Rating Scales-Self-Report-30 (DMRS-SR-30; Prout *et al.*, 2022) was employed to assess psychotherapists' defenses. The DMRS-SR-30 consists of 30 items that assess how frequently participants use specific defense mechanisms to manage emotions or stressful situations, rated on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*very often*). The DMRS-SR-30 measures 28 defenses, articulated among seven defensive levels, organized hierarchically. *High Adaptive* defenses (level 7) involve mature strategies to handle issues and redirect negative emotions into productive activities (*i.e.*, affiliation, altruism, anticipation, humor, self-assertion, observation, sublimation, and suppression). *Obsessional* defenses (level 6) include mechanisms to handle discomfort and avoid negative emotions (*i.e.*, undoing, intellectualization, and isolation of affect). *Neurotic* defenses (level 5) are recruited to unconsciously divide negative emotions from thoughts (*i.e.*, repression, dissociation, reaction formation, and displacement). *Minor Image-Distortion* defenses (level 4) include subtle reality distortions to temporarily obtrude stressful thoughts out of consciousness (*i.e.*, omnipotence, idealization, and devaluation). *Disavowal* defenses (level 3) reject threatening aspects of reality (*i.e.*, autistic fantasy, projection, rationalization, and denial). *Major Image-Distortion* defenses (level 2) are characterized by severe reality distortions (*i.e.*, splitting object-image, splitting self-image, and projective identification). Lastly, *Action* defenses (level 1) are the least adaptive defenses, which include impulsive behaviors not addressing underpinning conflicts or negative emotions (*i.e.*, acting out, help-rejecting complaining, and passive aggression). In addition to the individual defenses and the seven defensive levels, the DMRS-SR-30 also provides scores for three defensive categories (*i.e.*, mature, neurotic, and immature) as well as and ODF. In the present study, individual defenses, defensive levels, and categories, as well as the ODF were considered. Cronbach's α was .85 for the ODF.

Reflective functioning

The Reflective Functioning Questionnaire (RFQ; Fonagy *et al.*, 2016; Morandotti *et al.*, 2018) is an 8-item self-report measure of reflective functioning assessing individuals' ability in understanding and interpreting their own and others' behaviors in terms of mental states. Participants were asked to express their agreement with each item on a 7-point Likert scale ranging from 1 (*completely disagree*) to 7 (*completely agree*). It is possible to derive two subscale scores: Certainty and Uncertainty about mental states. In the present study, Cronbach's α was 0.71 for the RFQ-Certainty and 0.89 for the RFQ-Uncertainty subscales.

Professional burnout

The Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981; Sirigatti *et al.*, 1988) is a self-report questionnaire measuring work-related psychological and physical symptoms characterizing burnout. Participants were required to answer 22 items measuring their frequency on a 7-point Likert scale ranging from 0 (*never*) to 6 (*every day*). Respondents were explicitly instructed to complete the questionnaire while reflecting on the most recent LGBTQ+ patient they had worked with, or to select one they were currently treating. Three subscales can be derived from this measure: *Emotional Exhaustion*, marked by a lack of energy to face the workday, often accompanied by feelings of emptiness, apathy, and detachment from work; *Depersonalization*, a form of professional disengagement characterized by emotional detachment, irritability, and indifference leading to withdrawal from work and undervaluing the needs of those being helped; and *Personal Accomplishment*, which assesses personal's sense of competence, efficiency, and accomplishment in completing work tasks successfully. An additional MBI total score was further calculated by merging the three subscales (scores for the Personal Accomplishment scale were reversed), with higher scores indicating higher levels of burnout. In the present study, scores for Emotional Exhaustion, Depersonalization, and Personal Accomplishment, as well as the MBI total score, were considered. Cronbach's α for the MBI total score was .85.

Data Analysis

Analyses were conducted using the jamovi software (version 2.4.11) and the GAMLj3 statistical package. To provide a general sample description, preliminary descriptive analyses were first

run on sociodemographic and clinical activity information, as well as on study variables. Additionally, bivariate correlations (Pearson's r, two-tailed) were calculated to explore possible associations between psychotherapists' defenses, reflective functioning, and burnout. To identify the variables that best explained variations in participants' burnout, a general linear model was implemented with the MBI total score as a dependent variable, and ODF, RFQ-Certainty, and RFQ-Uncertainty as independent variables. Participants' LGBTQ+ identity, clinical experience, and attendance of professional trainings on specific LGBTQ+ issues and needs were also included in the model as they were shown to affect therapists' satisfaction in working with LGBTQ+ patients (Cruciani *et al.*, 2024b).

Results

Descriptives of therapists' defenses, reflective functioning, and burnout

A full description of the sample's defenses, reflective functioning, and burnout scores is reported in Table 2. It is worth noting that, regarding individual defenses, the highest mean scores

Table 2. Defenses, reflective functioning, and burnout scores of the sample (n=51).

Variables	Mean	SD	Range Min	Range Max	95% CI LL	95% CI UL
Defenses						
Individual defenses						
Acting out	1.51	1.72	0.00	6.52	1.03	1.99
Help-rejecting complain	2.64	2.17	0.00	8.11	2.03	3.25
Passive aggression	0.79	0.90	0.00	3.03	0.54	1.04
Splitting object image	2.02	2.10	0.00	11.11	1.43	2.61
Splitting self-image	1.78	2.60	0.00	9.64	1.05	2.51
Projective identification	1.77	2.15	0.00	10.71	1.17	2.38
Autistic fantasy	1.37	1.98	0.00	7.14	0.81	1.92
Projection	1.83	1.98	0.00	8.33	1.27	2.39
Rationalization	2.76	2.91	0.00	11.11	1.94	3.57
Denial	1.27	1.83	0.00	8.79	0.76	1.79
Omnipotence	1.86	1.95	0.00	6.45	1.32	2.41
Idealization	3.04	2.06	0.00	6.90	2.46	3.62
Devaluation	2.27	2.00	0.00	6.45	1.71	2.84
Repression	1.88	2.06	0.00	6.45	1.30	2.46
Dissociation	2.53	1.59	0.00	5.75	2.08	2.98
Reaction formation	3.58	2.14	0.00	8.08	2.98	4.19
Displacement	3.43	1.95	0.00	8.70	2.88	3.98
Undoing	3.18	2.13	0.00	7.79	2.58	3.77
Intellectualization	1.91	1.92	0.00	8.79	1.37	2.45
Isolation of affect	2.26	2.40	0.00	11.11	1.58	2.93
Affiliation	7.15	2.36	0.00	16.67	6.20	8.10
Altruism	9.28	2.56	2.30	22.22	8.28	10.28
Anticipation	6.29	2.53	0.00	11.11	5.57	7.00
Humor	4.22	2.74	0.00	10.71	3.45	5.00
Self-assertion	8.68	2.99	0.00	15.69	7.84	9.52
Self-observation	9.57	2.72	4.92	16.67	8.81	10.34
Sublimation	6.04	2.54	1.65	11.76	5.33	6.76
Suppression	5.10	2.56	0.00	12.50	4.38	5.81
Defensive levels						
High adaptive	56.32	11.96	33.06	87.50	52.96	59.69
Obsessional	7.35	3.81	0.00	17.58	6.28	8.42
Neurotic	11.42	3.80	3.57	19.67	10.35	12.49
Minor image distortion	7.18	3.95	0.00	16.67	6.07	8.29
Disavowal	7.22	4.49	0.00	17.86	5.96	8.48
Major image distortion	5.57	3.87	0.00	16.09	4.48	6.66
Action	4.94	3.53	0.00	11.06	3.95	5.94
Defensive categories						
Mature	56.32	11.96	33.06	87.50	52.96	59.69
Neurotic	18.76	5.51	3.57	32.97	17.21	20.31
Immature	24.91	9.70	3.92	42.15	22.19	27.64
ODF	**5.62**	**0.45**	**4.82**	**6.58**	**5.49**	**5.75**
Reflective functioning						
Certainty about mental states	1.38	0.66	0.00	2.67	1.20	1.57
Uncertainty about mental states	0.55	0.23	0.00	1.00	0.48	0.61
Professional burnout						
Emotional exhaustion	1.82	1.08	0.11	4.22	1.52	2.12
Depersonalization	1.31	0.81	020	3.40	1.08	1.54
Personal accomplishment	4.79	0.59	3.00	5.75	4.62	4.95
Total score	1.48	0.66	0.59	3.05	1.30	1.67

CI, confidence intervals; SD, standard deviation; LL, lower limit; UL, upper limit; ODF, overall defensive functioning.

are observed for the eight mechanisms composing the high adaptive defensive level (*i.e.*, affiliation, altruism, anticipation, humor, self-assertion, observation, sublimation, and suppression), suggesting a prominent use of mature defenses among therapists included in the sample. This observation is further sustained by the mean score observed for the ODF.

Associations between study variables

Bivariate correlations between participants' defenses, reflective functioning, and levels of professional burnout revealed several significant patterns. Greater use of mature defenses was associated with lower levels of professional burnout – specifically, reduced emotional exhaustion and depersonalization, and increased personal accomplishment – as well as with higher levels of reflective functioning, certainty about mental states. In contrast, greater use of immature defenses was linked to higher levels of burnout, particularly increased emotional exhaustion and depersonalization, and lower reflective functioning certainty. Additionally, higher reliance on neurotic defenses was associated with lower personal accomplishment and reduced certainty about mental states. Finally, higher certainty about mental states was itself associated with lower levels of professional burnout, including lower emotional exhaustion and depersonalization, and greater personal accomplishment. Table 3 shows bivariate associations in detail.

Factors associated with professional burnout

The general linear model with the total score of professional burnout as a dependent variable was significant (p<.001) and explained 41% of the observed variance. For the sake of brevity, only statistical effects are reported below, while Table 4 displays full model estimates. More specifically, lower overall defensive functioning and certainty about mental states were associated with higher levels of professional burnout. Moreover, professional experience was a significant covariate, with younger therapists reporting greater burnout.

Table 3. Correlations between therapists' defenses (levels, categories, and ODF), reflective functioning, and burnout subscales (n=51).

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
Defenses																	
Defensive levels																	
High adaptive	1																
Obsessional	$-.51^{***}$	1															
Neurotic	$-.36^{*}$	.05	1														
Minor image distortion	$-.59^{***}$	-.04	.06	1													
Disavowal	$-.52^{***}$	$.31^{*}$	–.13	.25	1												
Major image distortion	$-.52^{***}$	.11	.26	.13	–.08	1											
Action	$-.56^{***}$	.14	–.10	$.41^{**}$	.11	.22	1										
Defensive categories																	
Mature	1	$-.51^{***}$	$-.36^{*}$	$-.59^{***}$	$-.52^{***}$	$-.52^{***}$	$-.56^{***}$	1									
Neurotic	$-.60^{***}$	$.73^{***}$	$.72^{***}$	.01	.12	.26	.03	$-.60^{***}$	1								
Immature	$-.89^{***}$	.22	.03	$.72^{***}$	$.57^{***}$	$.49^{***}$	$.67^{***}$	$-.89^{***}$	.17	1							
ODF	**$.95^{***}$**	**$-.32^{*}$**	**–.20**	**$-.61^{***}$**	**$-.49^{***}$**	**$-.59^{***}$**	**$-.71^{***}$**	**$.95^{***}$**	**$-.36^{*}$**	**$-.97^{***}$**	**1**						
Reflective functioning																	
Certainty	$.58^{***}$	$-.31^{*}$	–.22	$-.40^{**}$	$-.40^{**}$	–.11	$-.32^{*}$	$.58^{***}$	$-.36^{**}$	$-.50^{***}$	$.52^{***}$	1					
Uncertainty	.12	–.03	–.07	–.07	.05	–.17	–.12	.12	–.07	–.12	.14	.07	1				
Professional burnout																	
Emotional exhaustion	$-.44^{***}$	.06	.01	.23	$.33^{*}$	$.34^{*}$	$.36^{*}$	$-.44^{**}$	.05	$.51^{***}$	$-.51^{***}$	$-.41^{**}$	.06	1			
Depersonalization	$-.39^{**}$	.12	–.16	$.34^{*}$	$.33^{*}$	.22	$.32^{*}$	$-.39^{**}$	–.03	$.49^{***}$	$-.45^{***}$	$-.31^{*}$	.08	$.46^{***}$	1		
Personal accomplishment	$.37^{**}$	$-.31^{*}$	$-.40^{**}$	–.06	–.17	–.20	.01	$.37^{**}$	$-.49^{***}$	–.18	.26	$.50^{***}$	.07	$-.41^{**}$	–.23	1	
Total score	$-.52^{***}$	.18	.09	.27	$.36^{**}$	$.35^{*}$	$.32^{*}$	$-.52^{***}$	.18	$.53^{***}$	$-.55^{***}$	$-.52^{***}$	.04	$.92^{***}$	$.65^{***}$	$-.65^{***}$	1

ODF, overall defense functioning; *p<.05; **p<.01; ***p<.001.

Table 4. Factors associated with therapists' professional burnout (n=51).

Outcome: professional burnout	β	SE	95% CI		p
			LL	UL	
Overall defensive functioning	–.47	0.19	–1.08	–0.30	<.001
RFQ-Certainty about mental states	–.27	0.16	–0.53	–0.01	.043
RFQ-Uncertainty about mental states	.13	0.32	–0.27	1.03	.243
LGBTQ+ identity	.03	0.16	–0.30	0.35	.898
Professional experience	–.28	0.07	–0.30	–0.03	.016
LGBTQ+ training	–.26	0.16	–0.48	0.14	.278
R^2 adjusted (explained variance) 0.407					

SE, standardized error; CI, confidence intervals; LL, lower limit; UL, upper limit; RFQ, Reflective Functioning Questionnaire.

Discussion

The present study investigated the role of psychological and contextual variables – including defenses, reflective functioning, LGBTQ+ identity, clinical experience, and LGBTQ+-specific training – in contributing to professional burnout among psychologists and psychotherapists working with LGBTQ+ patients. Consistent with our hypotheses, lower ODF, diminished certainty about mental states, and fewer years of clinical experience significantly predicted higher levels of burnout. These findings highlight the central role of intrapsychic self-regulation in buffering therapists against emotional exhaustion, depersonalization, and reduced personal accomplishment within the context of LGBTQ+ clinical work.

Before examining these results in depth, it is important to note that participants reported a predominant reliance on highly adaptive (mature) defenses. Defenses such as humor, sublimation, altruism, and anticipation are essential tools for transforming internal stress into constructive engagement, especially when therapists face the emotionally complex material often presented in LGBTQ+ clinical contexts. These mature defenses facilitate psychological integration, enable flexible affect regulation, and preserve therapeutic functioning – particularly important when clinicians are exposed to patient narratives involving trauma, discrimination, and identity-related challenges (Di Giuseppe *et al.*, 2022; Rice & Hoffman, 2014).

In this vein, working with LGBTQ+ patients requires therapists to offer not only containment and affirmation but also to process their own internal responses, including unconscious biases, values, or emotional reactivity (Giovanardi *et al.*, 2025; Hatzenbuehler *et al.*, 2024). Under such conditions, mature defenses can support therapists in managing these internal dynamics while maintaining therapeutic attunement. For example, the anticipatory capacity to foresee and emotionally prepare for potential ruptures – rooted in the defense of anticipation – may help prevent disengagement and support relational repair. This becomes particularly salient for therapists who themselves identify as LGBTQ+. As found in 35% of the present sample, the resonance between therapists' and patients' lived experiences can evoke personal memories or unresolved conflicts. In such cases, defensive maturity – especially mechanisms like altruism – may enable clinicians to channel personal experience into empathic understanding and relational depth. This transformation of vulnerability into therapeutic purpose may foster meaning, mitigate emotional depletion, and strengthen the therapeutic alliance.

Conversely, immature defenses can seriously compromise both clinical efficacy and therapist well-being. Prior research has linked immature defenses to negative attitudes toward LGBTQ+ individuals (Ciocca *et al.*, 2015) and, within the therapeutic space, such defenses risk perpetuating invalidating or distancing dynamics. For instance, passive aggression may manifest as subtle microaggressions, eroding the therapist's ability to empathically engage and increasing emotional strain (Carone *et al.*, 2025). Similarly, splitting may interfere with the therapist's capacity to integrate complex patient material, reinforcing depersonalization and undermining therapeutic presence.

Reflective functioning emerged as another significant psychological predictor of burnout, particularly the dimension of certainty about mental states. Therapists with lower certainty were more vulnerable to burnout, suggesting that difficulties in mentalizing may compromise their ability to understand and manage emotionally charged material. These results align with existing research linking reflective functioning to enhanced emotional resilience and professional well-being (Brugnera *et al.*, 2021; Fonagy *et al.*, 2002). Within LGBTQ+ clinical work – often characterized by nuanced narratives of identity, stigma, and trauma – higher reflective functioning enables therapists to process their own internal reactions, maintain perspective, and sustain therapeutic openness. Therapists with lower reflective functioning may become overly focused on behavioral content, missing implicit emotional cues, and diminishing the depth of their clinical engagement. This more surface-level processing not only hinders therapeutic effectiveness but can also exacerbate feelings of ineffectiveness and emotional exhaustion – key features of burnout.

Importantly, while some evidence (Brugnera *et al.*, 2023) has suggested that excessive certainty about mental states may be linked to increased burnout over time – possibly due to over-identification – this was not supported by the current findings. It is plausible that in a sample characterized by generally high defensive maturity, reflective functioning enhances rather than depletes the therapist's capacity to manage emotional labor. This finding emphasizes the value of psychological integration, where emotional openness is met with effective internal regulation.

Clinical experience also played a significant role in predicting burnout. As therapists gain experience, they typically report greater self-efficacy, lower anxiety, and more sophisticated clinical reasoning (Rønnestad & Skovholt, 2003). These competencies may directly buffer against burnout. Indirectly, experience is often accompanied by greater exposure to supervision, personal therapy, and ongoing training – all of which may strengthen both mentalization and defensive functioning. Thus, professional development appears to support both the technical and emotional aspects of clinical work, enhancing resilience in the face of stress. Interestingly, LGBTQ+ identity and LGBTQ+-specific training were not significant predictors of burnout. This may reflect the proximal importance of intrapsychic processes such as defensive maturity and reflective functioning in mediating clinician distress. However, this does not diminish the potential long-term benefits of training (Carone *et al.*, 2025), particularly when such programs include components aimed at enhancing self-awareness, managing countertransference, and navigating sociocultural dynamics with sensitivity.

Limitations

This study presents several limitations that warrant consideration. First, the reliance on self-report measures introduces potential biases related to self-presentation and social desirability. Future studies should incorporate observer-rated or clinician-report instruments, such as coded session transcripts, which may capture dynamic defense use and reflective functioning in vivo. This would allow for a more ecologically valid understanding of how therapists respond to emotionally charged clinical material emerging during sessions with LGBTQ+ patients.

Second, although participants were instructed to reflect on their most recent LGBTQ+ patient when completing burnout measures, the study did not assess the reasons for the patient's therapy. Without this information, it is difficult to determine how specific patient characteristics may have influenced therapists' emotional responses or burnout risk. Third, the cross-sectional design precludes causal inference. Longitudinal studies are needed to determine whether deficits in reflective functioning and defensive maturity predict subsequent increases in burnout over time or whether burnout symptoms themselves erode these intrapsychic capacities. Fourth, the relatively small sample size and use

of volunteer sampling limit the generalizability of findings. It is possible that therapists experiencing higher levels of burnout – or more maladaptive defensive functioning – were less likely to participate, introducing a self-selection bias. Moreover, the sample's demographic homogeneity, composed almost entirely of cisgender, White, Italian therapists, further constrains the cultural and contextual generalizability of the results. Such limited variability may have also reduced the range of key psychological variables (*e.g.*, defensive functioning or burnout), potentially hindering the detection of more subtle mechanisms. Future research should aim to overcome these limitations by recruiting larger and more diverse samples – both in terms of sociodemographic and cultural characteristics – and by conducting cross-national studies that can better capture variability in therapists' experiences and well-being across different sociocultural contexts.

Conclusions

This study offers a novel and clinically relevant contribution to the literature on therapists' defenses (see also Bokowy, 2024; Di Giuseppe *et al.*, 2024), providing the first comprehensive investigations into the role of defenses in therapists working with LGBTQ+ patients. Findings underscore the significance of psychological self-regulation – particularly through defensive maturity and reflective functioning – as key protective factors against professional burnout.

Given the complex sociocultural and emotional terrain that often characterizes work with LGBTQ+ patients, therapists are frequently confronted with identity-related material that activates personal sensitivities and systemic tensions. When internal resources are insufficient, clinicians may risk detachment, emotional exhaustion, or subtle invalidating responses. However, reflective functioning allows for a nuanced understanding of these interactions, while mature defenses regulate therapists' affective states, thereby preserving the therapeutic alliance. For example, when a therapist is met with prolonged silence following a discussion of sensitive identity material, those with high reflective functioning may interpret this as an expression of shame or ambivalence, rather than a personal failure. Similarly, mature defenses help modulate emotional reactions, reducing the likelihood of withdrawal or misattunement. These mechanisms are essential for sustaining therapeutic presence and protecting both patient and therapist from relational strain.

This study also supports the broader importance of addressing therapist burnout, particularly in clinical work with marginalized populations. Burnout can compromise empathy, authenticity, and clinical attunement – factors critical to effective psychotherapy (Delgadillo *et al.*, 2018; Yang & Hayes, 2020). LGBTQ+ patients, already vulnerable to societal invalidation, may be especially sensitive to subtle signs of therapist disengagement or emotional distancing. In such contexts, burnout not only threatens therapists' well-being, but it also risks reproducing the very forms of marginalization that therapy is meant to heal.

Several clinical implications emerge. Training and supervision should prioritize the cultivation of reflective functioning and adaptive defensive strategies, not only as markers of clinical sophistication but as vital tools for emotional sustainability during sessions with LGBTQ+ patients. Similarly, supervision and personal therapy can offer protected spaces for processing countertransferential reactions (Giovanardi *et al.*, 2025) and bolstering resilience. Mental health organizations and institutions must also recognize therapist well-being as a systemic priority, acknowledging that clinician functioning is foundational to the delivery of competent and affirming mental health care, especially for LGBTQ+ populations facing ongoing barriers to access. Additionally, these findings carry potential implications also for clinical training and supervision. Programs aimed at enhancing therapists' competence with LGBTQ+ patients should go beyond didactic instruction to include interactive and experiential components that foster deeper self-reflection and emotional awareness (Baiocco *et al.*, 2022; Mezzalira *et al.*, 2025c; Pezzella *et al.*, 2023). Psychodynamic approaches are particularly suited to promoting reflective functioning and adaptive defensive processes, enabling therapists to recognize and work through biases, defenses, and countertransference reactions related to gender and sexuality. To advance this goal, curricula should incorporate case discussions, role-plays, and focus groups that help clinicians translate theory into practice and confront implicit biases, as well as the direct involvement of LGBTQ+ individuals through testimonies and co-facilitated workshops (Damery *et al.*, 2025; Sekoni *et al.*, 2017). Such integrative, relationally oriented training may enhance cultural competence while also buffering against burnout by strengthening therapists' reflective functioning and awareness of their defensive functioning while working with LGBTQ+ patients.

In this vein, future research could benefit from adopting mixed-methods or longitudinal designs to capture the dynamic interplay between defensive functioning, reflective capacities, and burnout over time. Qualitative interviews, in particular, may provide rich insights into the subjective experiences of therapists, illuminating how they interpret and make sense of emotional depletion, professional fulfillment, and the challenges of working with LGBTQ+ patients. Such approaches would deepen understanding of the mechanisms underlying therapist well-being, while also informing targeted interventions to support clinicians' protective factors and clinical effectiveness.

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