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PSYCHOLOGISTS IN TRAINING: DEVELOPING LGBTQ+ CULTURAL COMPETENCE IN TRAINEES

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PSYCHOLOGISTS IN TRAINING: DEVELOPING LGBTQ+ CULTURAL COMPETENCE

IN TRAINEES

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Abstract

Lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals search for counseling services at higher rates compared to their heterosexual peers. Unfortunately, LGBTQ+ people also report negative therapeutic experiences that are evident in higher dissatisfaction rates with counseling services. Perceived heterosexist bias, homophobia, and therapists' general lack of understanding and/or adequate training of gender and sexual diversity are some of the reasons why LGBTQ+ individuals may be wary of seeking medical or mental health services or why they forgo accessing services altogether (Dillon et al., 2004). Even though there is an emerging body of research stating a clear need to provide tailored, culturally appropriate, and LGBTQ+ affirmative psychological interventions to LGBTQ+ individuals, few studies have investigated the impact of therapist training in LGBTQ+-affirmative psychotherapy (Pepping et al., 2018). The purpose of this study was to evaluate the effectiveness of the Pride Healing Center (PHC) training program (a trauma-informed specialty clinic for the LGBTQ+ community at Long Island University-Post). This study used a comparison group design to explore if therapists who have undergone more hours of training in LGBTQ+- affirmative psychotherapy and had more clinical hours with LGBTQ+ clients report higher self-efficacy and changes in self-reported counselor competency and self-efficacy pre- and post-training. The results revealed significant increases in self-reported skills and knowledge between pre-test and post-test as a result of the cultural competency training that includes information about minority stress, unique barriers, and mental health needs of the LGBTQ+ population. The finding did not reveal any significant changes in counselor's perceived competency when assessing their clinical hours.

Psychologists in Training: Developing LGBTQ+ Cultural Competence in Trainees

This dissertation is a work of love for my LGBTQ+ community. As an openly queer therapist I have encountered many stories of harm perpetuated by medical and clinical providers. Whether it's an ignorant remark or a direct threat to our identities, it leaves a mark on the minds and hearts of queer folks and communicates detrimental messages. The message being that you do not belong, that you are different, that you are weird and abnormal. The message that you are the problem. The message that you are invisible or have no right to exist. The message that you are the one that should adapt to the world because the world will never accept you. My queer friends, colleagues, and clients recognize the importance of their wellbeing. But they have been hurt by the systems and people within those systems for way too long. My dissertation is a love letter to queer folks. It is a commitment to be and do better. The beautiful spectrum of queerness deserves safe, loving spaces. I am starting my work by committing to creating such spaces and educating myself and clinicians around me on how to uplift the voices of LGBTQ+ individuals.

The dissertation starts with the review of how LGBTQ+ individuals have been impacted by policies and laws, what role psychology and other institutions have played in perpetuating harmful stigmas, and the outcomes of that influence. I emphasize that, despite the progress made, sexual and gender minorities are still struggling under the weight of institutional barriers that are founded on heteronormativity and trans-negativity.

The following section expands upon that idea by offering alarming statistics of mental and physical health disparities such as higher risk of mood disorders, substance use, and other

problems experienced by queer individuals compared to their cisgender heterosexual counterparts. The section uses minority stress theory as a theoretical framework that highlights how discrimination, heteronormativity, and stigma exacerbate already existing risk factors, which makes LGBTQ+ populations especially vulnerable and in need of specialized high-quality care.

In the section about available care, I describe how the high need and demand for tailored care is not met by the available resources as most LGBTQ+ individuals report feeling dissatisfied with services received and mental health professionals admit they do not feel adequately prepared to provide affirmative care. Despite APA guidelines on the importance of affirmative service provision and recommendations by researchers and practitioners for additional training when working with LGBTQ+ individuals, there is a dearth of research about affirmative psychotherapy training.

In the following section, the principles of affirmative care are discussed. Affirmative psychotherapy is seen as a therapeutic stance that advocates and uplifts voices of LGBTQ+ individuals while actively denouncing systems of oppression. Affirmative psychotherapy is seen as a part of multicultural competence and is often measured by self-awareness, skills, attitudes, and knowledge.

I provide a brief overview of existing research on the effectiveness of affirmative training and its main components. Although it is evident that there is no uniform protocol that is followed by clinical practitioners, there are similarities in how training is conducted, which include the presence of didactic and experiential information, reflection on one's explicit and implicit biases, and clinical exposure.

Lastly, I described the affirmative therapy training model at the Pride Healing Center (PHC) at Long Island University Post. The (PHC) is a trauma-informed specialty clinic for the LGBTQ+ community that functions within the larger Psychological Services Center (PSC) at Long Island University-Post, a community mental health training clinic for the program's clinical psychology doctoral students. Since its inception in 2017, the PHC training model has gone through several iterations, adding didactic and experiential information and pre and post measures for beginning clinicians assessing the effectiveness of the training.

My aim is to evaluate the effectiveness of the Pride Healing Center training program by using a comparison group design to explore if therapists who have undergone more hours of training in LGBTQ+- affirmative psychotherapy and had more clinical hours with LGBTQ+ clients report higher self-efficacy and improvements in self-reported counselor competency and self-efficacy pre- and post-training. My hope is to use the results for strengthening the training to better assist LGBTQ+ clients. My study will add to the existing body of research of understanding the salient components of affirmative psychotherapy training when working with LGBTQ+ individuals.

History of Psychology and Queerness

Despite advancements in LGBTQ+ rights since the Stonewall riots in 1969 and the removal of homosexuality as a psychiatric disorder from the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (*DSM-*III)* in 1973, equality is far from being achieved. Over the past decade, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals in the U.S. have celebrated several social and legal victories such as increased social media and mainstream visibility, the Marriage Equality Act (2015), and, most recently, Title VII (2020). However, only five years ago, on June 12, 2016, the tragic shooting at the Pulse nightclub in Orlando took 49

queer lives and injured another 50. At the time, this hate crime has been called the worst mass shooting in U.S. history (Morris, 2016).

The aforementioned Title VII (a key provision of the Civil Rights Act of 1964 known as Title VII) was a landmark ruling because it banned job discrimination on the basis of sexual and gender identities. Banning bias against LGBTQ+ employees on a federal level in 2020 was a victory for LGBTQ+ individuals, yet a poignant and heartbreaking reality check accompanied it - the news of murders of two Black transgender individuals.

In a PBS interview by Courtney Vinopal (2020), Raquel Willis, a Black transgender activist, writer, and media strategist, says "It was a day of celebration, but it also was still a day of mourning for so many Black, queer and trans folks/ We should always carry an understanding that even with these winds of change…there's also the truth that queer and trans folks who are Black are literally being killed every day". In 2020 at least twenty-five transgender or gender-nonconforming individuals were murdered (Human Rights Campaign, 2020). Under the 45th president's administration, the changing political climate threatened some of the positive changes for LGBTQ+ individuals brought by the era of Barack Obama's presidency. Due to the reasons that the 45th president positioned himself as an active opponent of LGBTQ+ rights, he will not be named in this dissertation

In international and domestic politics, the 45th President took a strong anti-LGBTQ+ stance on a long list of issues (HRC, 2020):

Table 1
An incomplete but exhausting list of anti-LGBTQ policies set forth by the 45th President

The Equality Act	

Levels of the judicial system	• *Expressed opposition to non-discrimination protections for LGBTQ individuals in housing, employment, public spaces, education, jury services, credit and federal funding* • *Appointed anti-LGBTQ+ judges (as evident by anti-LGBTQ+ records by appointed Supreme Court Justices and federal nominees)*
Employment	• *Supported employment discrimination against LGBTQ+ folks* • *Banned transgender service members from the military* • *The Civil Rights Act: reversed Obama-era non-discrimination protections* • *Permitted federal contractors to use a religious exemption to fire LGBTQ+ employees*

Healthcare	
	• *Discriminated against people living with HIV by removing them from the military because of their status*
	• *Removed protections for LGBTQ+ folks by undermining Section 1557 Rule: prohibits discrimination based on race, color, national origin, sex, age, and disability in health programs and activities receiving federal financial assistance*
	• *Formed a Religious Discrimination Division (main goal was to defend physicians and other medical professionals who decide to refuse care to LGBTQ+ individuals)*
	• *Advocated for cutting over $1.35 billion from PEPFAR budget (the U.S.*

	government program that combats *AIDS abroad)*
Schools	
	• *Eliminated Obama-era guidance* *clarifying that schools must treat* *transgender students consistent with* *their gender identity* • *Refused to respond to civil complaints* *filed by transgender students* • *Suggested it is acceptable for schools* *to discriminate against LGBTQ+* *students* • *Eliminated language protecting* *LGBTQ+ children participating in the* *4-H program* • *Used Title IX to discriminate against* *trans students*
Housing	

LGBTQ+ families	• *Allowed emergency shelters to deny access to transgender and gender nonconforming people* • *Placed transgender incarcerated persons in the wrong prison* • *Allowed foster care programs to discriminate while accepting tax-payer funds,* • *Began refusing visas for same-sex partners of some diplomats and U.N. workers if they were not married* • *The child of a same-sex couple born abroad via surrogate would be considered "born out of wedlock", which makes it more difficult to obtain U.S. citizenship*
Visibility	• *Proposed a new definition that would narrowly define sex as either male or female, stopped the use of the word transgender in official reports*

International Politics	• *Eliminated information on LGBTQ+ rights, mentions, and representation on government websites, blocked questions regarding sexual orientation from consideration for the census*
	• *Refused to recognize LGBTQ+ people in National AIDS day Address*
	• *Refused asylum to LGBTQ+ seekers fleeing violence*
	• *Banned U.S. embassies across the world from flying the LGBTQ+ Pride Flag during Pride Month*
	• *Refused to condemn attacks on LGBTQ+ people in Chechnya*
	• *Refused to condemn a Brunei law that imposes barbaric punishments on LGBTQ+ people*

It is imperative that mental health providers understand the historical stigmatization of LGBTQ+ individuals in the U.S. It provides a contextual framework for pervasive discriminatory practices, institutionalized violence, negative biases, homophobia, and heteronormativity that

have permeated the contemporary lives of the queer community and given rise to continuous

backlash experienced by the community. It is evident that despite some progress towards

equality, the LGBTQ+ community still experiences both subtle and widespread violence, hate,

and discrimination that account for increased health and mental health disparities (Ramirez,

2020; Institute of Medicine, 2011).

 According to Morris (2016), "social movements, organizing around the acceptance and

rights of persons who might today identify as LGBTQ+ or queer, began as responses to centuries

of persecution by church, state and medical authorities" (p. 3). Palpable shifts in policies and

attitudes are primarily responsible for the queer community's mobilizing power that responded to

years of unequal mistreatment and violence. The legacy of stigmatization, criminalization, and

discrimination of LGBTQ+ people resulted in mistrust of government, medical providers, and

psychologists.

 The current obstacles to treatment, unique stressors, are informed by more than a century

of criminalization of sexual and gender minorities. The condemnation has been conveyed in both

subtle and widespread ways, including policies, media, language, psychology, and medical

warnings. LGBTQ+ individuals are exposed to stigma from an early age, which impacts their

experiences with the world around them, especially with health professionals (Institute of

Medicine, 2011). In the same vein, their heterosexual peers are socialized in the same

heteronormative environment and absorb messaging about the stigmatization of sexual and

gender minorities, which impacts their knowledge and attitudes toward LGBTQ+ people

(Institute of Medicine, 2011). Finally, institutions (mental health, law enforcement, legal entities,

etc.) have developed within the society that historically stigmatized the LGBTQ+ population

and, therefore, they inevitably grapple with a legacy of their inadequate ability to address the needs of sexual and gender minorities.

A comprehensive review of the history of the LGBTQ+ population is beyond the scope of this paper. This section will introduce principal leitmotifs that have played a role in forming the contemporary reality of LGBTQ+ health. Even though the historical context of LGBTQ+ health over the past 150 years in the U.S. is reviewed here, it is known that variant sexual and gender identities existed in the pre-colonial era. Western colonialism erased the wealth of knowledge and experiences of Indigenous people and supplanted the richness of those identities with standardized binary categories.

There were few formal mentions in Western history of LGBTQ+ people before the 19th century (Institute of Medicine, 2011). Starting in the 19th century, the usage of the word "homosexual" emerged when referring to queer individuals (Ramirez, 2020). Homosexuality was associated with mental and biological deficiencies and seen as an example of deviation from heteronormative, cisgender society. This approach criminalized and invalidated LGBTQ+ people's humanity and engendered an illness model where a "homosexual deficient individual" needed to adapt or adjust (Ramirez, 2020).

In 1868 Karl Maria Benkert coined the term "homosexuality" as the juxtaposition to normalcy (Herek & Garnets, 2007). The pathological clinical framework continued with Freud (1951), who, despite disagreeing that homosexuality was an illness, still labeled it as a less than optimal outcome for psychosexual development. American psychoanalysts broke away from Freud's views that bisexuality is innate and embraced the illness model by promulgating the stance that homosexuality is an attempt to gain sexual gratification because heterosexuality is too threatening (Herek & Garnets, 2007).

Before Freud's psychosexual theory gained popularity, there were religious and secular laws in the U.S. regulating and punishing nonprocreative sex acts outside of heterosexual marriage (Institute of Medicine, 2011). The U.S. sodomy laws existed until 1961, and their language and operational definitions of sexual behaviors varied from state to state. These laws were widely used to promote differential treatment of sexual minorities such as employment discrimination, interference with child custody, and immigration (Institute of Medicine, 2011). Repression of sexual and gender diversity is not surprising as "codes of heteronormativity were central tenets of the colonial project" (Picq, 2020). The psychology field created its own forms of LGBTQ+ oppression, such as the DSM that was first released in 1952 and listed homosexuality as "a sociopathic personality disturbance" (Drescher, 2015; Herek & Garnets, 2007). This classification was used as a justification for the discrimination of LGBTQ+ people. Any treatment options were reduced to ineffective attempts to change an LGBTQ+ person to fit a heteronormative cisgender world by encouraging them to admit that they are sick and to be willing to change using psychotherapy, hormone treatments, aversive conditioning with nausea-inducing drugs, lobotomy, electroshock, and castration (Institute of Medicine, 2011). In other words, LGBTQ+ individuals were recipients of consistent and harmful messages that there was something inherently wrong with them that had to be concealed if they wanted to survive; otherwise, they would be discriminated against and forced to change who they are.

Using this pathological framework in both legal and psychological realms, the view of homosexuality as problematic had calcified by the beginning of World War II (Institute of Medicine, 2011). An illness model had found its way to the U.S. military psychiatry screening and was a foundation for formal procedures for rejecting LGBTQ+ individuals. It was followed by a U.S. Senate committee solidifying on a national level that queer people were considered

unqualified for federal employment. In response to that, another Executive Order 10450 on April 27, 1953 was signed to dismiss all LGBTQ+ people from federal employment, civilian, and military (Institute of Medicine, 2011; Ramirez, 2020).

However, new empirical data emerged that disputed that homosexuality is an illness (Gonsiorek, 1991; Hooker, 1957; Kinsey et al., 1953; Ford & Beach, 1951), changed cultural views on the LGBTQ+ community, and began to challenge the pathological clinical framework. Only in 1973 did the American Psychiatric Association remove homosexuality as a diagnosis from the DSM (Minton, 2002; Ramirez, 2020). Shortly after, the Association of Lesbian and Gay Psychologists (ALGP) was formed to develop queer affirmative policy statements (Institute of Medicine, 2011).

 In 1979, the Harry Benjamin International Gender Dysphoria Association (the World Professional Association for Transgender Health, WPATH) defined standards of care to ensure and legitimize access to quality gender-affirming procedures. Even though there were significant legislative and policy changes, the impact of the pathological framework remained. Transgender and gender variant individuals continued to be exposed to oppressive clinical language and, most importantly, its consequences in the subsequent edition of DSM. The diagnosis was changed from transsexualism to gender identity disorder (GID) and then to gender dysphoria (GD). These clinical labels conceptualized gender nonconformity as a mental illness (Ramirez, 2020). In contrast, according to Knudson et al. (2010), a transgender movement emphasizes the controversial context of clinical labels and advocates for the recognition of gender diversity and the depathologizing of gender variance. According to Yep (2003), "heteronormativity reinforces pathology and violence against people who do not conform to the society's gender expectations," It is crucial to consider the insidious impact of binary heterosexual social, clinical and political

fabric. The illness model that propagated a pathological framework when working with LGBTQ+ individuals has a longstanding history in the U.S., and its deleterious impact persists. Thus, it is essential to conceptualize LGBTQ+ health within the historical perspective of the U.S.

This present study views unique stress and risk factors experienced by the LGBTQ+ community through the lens of acknowledging the detrimental impact of heteronormativity. For example, some literature tends to individualize the impact of oppression in describing health and mental health issues faced by LGBTQ+ individuals, promoting the idea that a change in individuals' behavior supersedes the systemic change. Downplaying institutional stigmatization may lead to circumventing the conversation that heteronormativity is the foundation of their victimization, resulting in poor mental health outcomes (Ramirez, 2020).

LGBTQ+ folx

According to the Gallup Daily tracking survey and the Gallup-Sharecare Well-Being Index survey 5.6% of U.S. adults identify as LGBT (2021). The most recent estimate is up from 4.5% in Gallup's previous update based on 2017 data (more than 11 million LGBTQ+ adults**)** and from 3.5% in 2012. The Gallup survey collected a random sample of 340,604 U.S. adults residing in all fifty states, but it did not include the LGBTQ+ youth.

According to Kann et al. (2018), approximately 15% of adolescents in the U.S. identify as LGB or questioning. The percentage of women identifying as LGBTQ+ has increased from 3.5% in 2012 to 5.1% in 2017, while the increase in queer men's percentage is less drastic, 3.4% in 2012 to 3.9% in 2017. Additionally, to a varying degree, LGBTQ+ identification has increased amongst all race and ethnic groups since 2012. Hispanic (4.3% to 6.1%) and Asian (3.5% to 4.9%) individuals who identify as LGBTQ+ have reported a significant increase from 2012 to

2017 compared to White (3.2% to 4%) and Black individuals (4.4% to 5%) whose increase was more subtle.

Based on this data, it is evident that either due to an increase in disclosure rates or other variables, the LGBTQ+ population has been increasing every year, and it is prudent to conclude that there is an increasing need to address the unique health and mental health needs of the population. One would assume that mental health and medical providers would rise to the occasion and mobilize resources to accommodate the increasing demand for high-quality health and psychological services, yet the existing research shows a slightly different picture.

In addition to higher rates of health and mental health problems (Henry et al., 2020) that are exacerbated by minority stress, many LGBTQ+ people face discrimination, prejudicial treatment, and barriers in accessing services. Providers who do not wish to subject the LGBTQ+ population to discrimination and are committed to providing affirmative care are often unsure about the essential components of the best quality of care and feel ill-equipped in providing affirmative care (Dillon et al., 2004). Conversely, some providers have been perpetuating anti-LGBTQ+ stigmatization in their facilities, setting a precedent for LGBTQ+ people to be wary of seeking medical or mental health services or to forgo accessing services altogether (HEI, 2019).

On a national level, a Lambda Legal study (2010) investigated the refusal of care and barriers to healthcare services amidst LGBTQ+ individuals. Data gathered from 4916 surveyed individuals revealed exposure to alarming rates of discriminatory treatment practices and prejudicial policies. Transgender (73%) and LGB individuals (29%) reported believing that their LGBTQ+ status is a factor in being subjected to discriminatory treatment by medical personnel.

Refusal of medical services was another concern for 52% transgender and 9% of LGB participants. They reported a history of negative experiences such as being refused needed care,

healthcare professionals refusing to touch them or using excessive precautions, health care professionals using harsh or abusive language, being blamed for their health status, or health care professionals being physically rough or abusive. At least one of these occurrences were reported by nearly 56% of LGB and 70% of transgender and gender-nonconforming individuals and one or more of these experiences were reported by 70% of transgender and gender-nonconforming participants. About 8% of LGB and 27% transgender individuals stated that healthcare professionals refused care right after learning about their LGBTQ+ status. A little over 10% of LGB individuals recounted instances of medical personnel using harsh and abusive language toward them, and the number doubles for transgender individuals (20.5%). Health care professionals refused to touch or used excessive precautionary measures with 11% of LGB respondents, and nearly 12% experienced being blamed for their health concerns. That number increased for LGBTQ+ individuals living with HIV (25.7%). Even more disturbingly, nearly 8% of transgender individuals stated that they experienced physically rough or abusive treatment from a healthcare professional compared to 4.1% of LGB. In nearly every category, transgender and gender-nonconforming individuals were recipients of harsher treatment and subjected to the highest rates of discrimination that is two or three times more frequent than LGB respondents. People of color and/or low-income LGBTQ+ community members are at the highest risk of receiving discriminatory or neglectful treatment.

According to Marshal (2011), LGBTQ+ people have a higher prevalence of mental health problems such as depression, anxiety, suicidality compared to their heterosexual and cisgender counterparts. In their meta-analysis study, King (2008) revealed that in comparison to heterosexual peers, LGB individuals were 1.5 times more likely to have alcohol and other substance dependence in the past twelve months. According to Bockting et al. (2013), gender

non-conforming and transgender individuals are at the highest risk for poor mental health, struggling with high rates of depressive and anxiety disorders and suicidality. LGBTQ+ youth also face a unique set of challenges that result in significant health disparities such as higher risk of HIV and sexually transmitted diseases, substance use problems, bullying, and homelessness (Marshal et al., 2011).

Minority Stress Theory

Herek and Garnets (2007) postulated that a minority stress model, juxtaposed against the outdated, harmful illness model, would be the most prominent conceptual framework for understanding LGBTQ+ individuals' health trends. Meyer (2003) suggested that in addition to regular life stressors shared by most individuals, psychological problems experienced by LGBTQ+ people are enhanced by unique chronic stressors that occur due to their minority group status. The minority stress model states that sexual minority stress is unique, chronic, and socially based and has a significant impact on mental health (Cox et al., 2011; Meyer, 2003). Further, Meyer (2003) delineated distal and proximal stress processes such as experiences of discrimination, concealment or disclosure of sexual orientation, expectations of prejudice and discrimination, and internalized homonegativity.

A distal process is described as an objective stressor that is not predicated on a person's perspective, whereas a proximal process is considered to be a subjective stressor that is connected to an individual's standpoint. For instance, an actual experience of violence and discrimination, or enacted stigma are considered to be distal stress processes. However, perceived stigma (felt stigma), internalized homophobia, and concealment of one's sexual orientation or gender identity are seen as subjective stress processes.

LGBTQ+ individuals experience higher rates of anxiety, depression, and substance use as compared to their heterosexual peers. Through a minority stress lens, a higher risk for mental health and health issues is viewed as a result of the detrimental stress of discrimination and stigma idiosyncratic to LGBTQ+ individuals. It is important to note that even though the primary theoretical lens used in this paper is a minority stress model, there are multiple theoretical frameworks that could be used to conceptualize LGBTQ+ health.

According to the Institute of Medicine (2011), life-course, intersectional, and social-ecological perspectives are salient in informing research on LGBTQ+ health. In this paper, cohort and age differences, racial, ethnic, socioeconomic, and geographic diversity, as well as social circumstances, are acknowledged as simultaneous dimensions of inequality and important realms to consider in investigating LGBTQ+ health.

LGBTQ+ Health

Anxiety, Depression, Suicidality, and Substance Use

LGBTQ+ includes a wide spectrum of sexual and gender identities and expressions. Although, queer folks are usually regarded under the LGBTQ+ umbrella each subgroup is unique and thrives and struggles in its idiosyncratic way. Thus, it is important to note that some cited research addresses data on only lesbian, gay and bisexual (LGB) while other research specifically looks at transgender and gender expansive folks.

King et al. (2008) conducted a systematic review of the rates of mental disorder, substance misuse, suicide, suicidal ideation, and deliberate self-harm in LGB individuals. Through the methodical search of a myriad of databases such as Medline, PsycInfo, the Cochrane Library Database, the Applied Social Sciences Index and Abstracts, the International Bibliography of the Social Sciences, Sociological Abstracts, the Campbell Collaboration, and

Google and Google Scholar, they identified 13706 papers and later selected 25 studies that met their inclusion criteria.

The meta-analyses investigated the data on 214,344 heterosexual and 11,971 non-heterosexual people and found that sexual minorities have significant disadvantages in terms of mental health. LGB people are two times more likely to attempt suicide, the prevalence of depression and anxiety disorders, and alcohol dependence is 1.5 times higher than heterosexual peers. The results did not reveal a significant difference between sexes but noted that lesbian and bisexual women are at higher risk of substance dependence whereas gay and bisexual men have a higher prevalence of suicide attempts in their lifetime (King et al., 2008).

A more recent meta-analysis substantiated previous findings of LGB individuals being at an increased risk of mental health problems (Plöderl & Tremblay, 2015). Plöderl and Tremblay (2015) cautioned that previous research grouped LGBTQ+ individuals in one category, possibly dismissing subgroup differences, which inadvertently could have skewed the results. The authors aimed to update the existing data by exploring the most recent studies that added within-group differences such as gender, attraction, behavior, and identity. Using a PubMed search engine, the systematic review revealed 199 studies that met the criteria. Their results corroborated previous findings stating that both LGBTQ+ youth and adults from varying geographic areas are at elevated risk for depression, anxiety, suicide attempts, and substance-related issues. Sexual minorities have a higher prevalence of bipolar I, dysthymia or mania, and for any other mood disorder. An elevated risk for bulimia and anorexia is present for gay and bisexual men compared to bisexual and lesbian women. Bisexual individuals were found to be a higher risk subgroup in all of the studies.

LGBTQ+ Youth

The research reveals a similarly disturbing high prevalence of mental health problems experienced by LGBTQ+ youth. Marshal et al. (2011) conducted a meta-analysis aimed to investigate suicide and depression rates in sexual minority youth compared to heterosexual peers. The authors found that LGB adolescents are at significantly higher risk of suicidality and depression than their heterosexual counterparts. They conclude that elevated risk for suicidal ideation and attempts can be exacerbated by a variety of negative experiences such as discrimination and victimization.

It is difficult to provide a prevalence rate of transgender youth as the studies vary in their estimation. In 2016, the Williams Institute estimated that 0.7% of U.S. adolescents are transgender. In the most recent study by Johns et al. (2019), the results revealed that 1.8% of U.S. adolescents are transgender (Johns et al., 2019; Zucker, 2017). The variation in reported rates might be a result of an increase in prevalence or an increased willingness to disclose (Zucker, 2017).

There is a dearth of research dedicated to the mental health of transgender adolescents, but the few studies that exist demonstrate that they are at significant risk of mental health and health problems (Grossman & D'Augelli, 2007; Toomey et al., 2018; Thoma et al., 2019). Grossman and D'Augelli (2007) investigated suicide rates among transgender youth, noting that the previous research has primarily focused on LGB adolescents. These authors explored a connection of suicidality to four domains: the history of life-threatening behaviors, parental reactions to the youths' gender nonconformity and transgender identity, youths' body esteem, the differences between the transgender youth who had engaged in life-threatening behaviors and those who had not. The investigators studied a sample of 31 male-to-female and 24 female-to-

male adolescents (ages 15-21) using interviews and a battery of standard mental health measures and functioning as a primary assessment mode.

The results revealed that transgender youth are at high risk for suicidal ideation and life-threatening behaviors. Nearly 55% of the transgender youth reported life-threatening behaviors, 50% of the sample seriously considered taking their lives, and 25% reported suicide attempts. About half of the sample connected suicidal thoughts to their transgender identity. Other reported factors that significantly contributed to suicide attempts included past parental verbal and physical abuse and lower body esteem, primarily weight dissatisfaction and thoughts of how others evaluate the youths' bodies. Research corroborated previous studies by showcasing that sexual minority status is a key risk factor for life-threatening behaviors among transgender youth (Grossman & D'Augelli; 2007, Mathy, 2002).

In the most recent study, Thoma et al. (2019) explored suicide rates in transgender youth compared to their cisgender peers. Two thousand and twenty participants, 1148 of which were transgender adolescents between the ages of 14 to 18, were recruited to complete a cross-sectional online survey. The results revealed that transgender adolescents are at higher odds of all suicidality outcomes, including a high risk for suicidal ideation and attempt.

According to the Trevor Project's National Survey on LGBTQ+ Youth Mental Health 2020 that assessed over 40,000 respondents, LGBTQ+ youth are at higher risk for victimization, discrimination, suicide ideation, and life-threatening behaviors. Additionally, LGBTQ+ adolescents are at risk of bullying and harassment (Moe et al., 2015) and increased risk for early use of alcohol and other substances as well as unsafe high-risk sexual practices (CDC, 2012) and homelessness (Choukas-Bradley & Thomas, 2020).

Physical Health

HIV, STIs, Obesity, and Cancer

In terms of physical health, lesbian and bisexual young women are at a higher risk for unintended pregnancy, obesity, and breast cancer compared to their heterosexual peers (Graham et al., 2011). LGB adults report elevated levels of smoking, alcohol, and substance use compared to heterosexual counterparts (Institute of Medicine, 2011; Coulter et al., 2014).

There is little research about the physical and mental health of LGBTQ+ elderly. Some evidence suggests that long-term hormone use might result in adverse health outcomes for transgender elders. Testosterone therapy may increase the risk for ovarian cancer for transgender men, and feminizing hormones might contribute to prostate cancer for transgender women. In addition, even though HIV and AIDS impact older LGBTQ+ people, not enough prevention programs address their needs (Institute of Medicine, 2011).

According to a literature review done by Hafeez et al. (2017)**,** LGBTQ+ population's health is compromised due to exposure to negative consequences associated with unprotected high-risk sexual behaviors. LGBTQ+ youth have an increased prevalence of sexually transmitted diseases, and the rates of gonorrhea, chlamydia, and HIV are two times higher in sexually minority youth than heterosexual men. Data from the CDC (2014) shows that 83% of gay and bisexual men have a new diagnosis of HIV. An elevated risk of cancers such as prostate, testicular, anal, and colon in gay men and STDs like syphilis, human papillomavirus (HPV) infections, and hepatitis in men who have sex with men was hypothesized to be linked to a deficiency in culturally sensitive screening services. An elevated risk of breast, ovarian, and endometrial cancers was found in lesbians and bisexual women. The higher risk of obesity was revealed in lesbian women from the low SES African American community.

The most recent study by Henry et al. (2020) explored connections between health behaviors, physical health conditions, mental health, health insurance, and access to medical and health services among LGBTQ+ adults. In this study, 317 lesbian, gay, bisexual and transgender individuals (ages 18 and 66) completed an online survey and 41.6% of the sample reported having one or more health conditions (asthma 16.4%, arthritis/gout 5%, and thyroid disease 4.1%, cancer and diabetes 2.8%, epilepsy/seizures 1.6%, Hepatitis B or C 1.3%). The results were in line with the previous findings that unlike their heterosexual and cisgender peers, LGBTQ+ individuals have poorer health and experience higher risk for health disparities such as asthma, physical limitations, poor mental health disorders, suicidal ideation, and risky sexual behaviors (Fredriksen-Goldsen et al., 2014; Mckay, 2011). Prior studies highlighted that lesbian and bisexual women are at higher risk of cardiovascular disease (Fredriksen-Goldsen et al., 2014) and less likely to undergo routine care and cancer screening (Mckay, 2011; Mollon, 2012) more likely to be overweight and experience higher rates of asthma (Mollon, 2012) and arthritis (Simoni et al., 2016). Transgender individuals are at elevated risk for psychological stress, poor mental and physical health and disability (Fredriksen-Goldsen et al., 2014).

Risk Factors

Stigma, Violence, Heteronormativity, and Discrimination

LGBTQ+ individuals continue to be subjected to prejudice, violence, and discrimination. According to the 2020 Healthy People report, LGBTQ+ people are exposed to higher rates of health disparities, which can be traced to continuous discrimination, social stigma, and denial of civil and human rights. The LGBTQ+ community encompasses a diversity of genders and sexualities that are routinely grouped under the same category. It is imperative to state that each subgroup faces their own challenges that are often exacerbated by the intersectionality of

race/ethnicity, socioeconomic issues, immigration, and ability status. Notwithstanding idiosyncratic subgroup differences, they share common challenging experiences such as social stigma, discrimination, and negative stereotypes (Henry et al., 2020).

Mays and Cochran (2001) revealed that the poor mental health of LGBTQ+ individuals is correlated with experiences of discrimination. Holding a minority status may be connected to specific stressors and experiences of discrimination (Cole, 2009; Else-Quest & Hyde, 2016). Herek et al. (2007) suggest that LGBTQ+ people are exposed to the deleterious impact of institutionalized stigma, or heterosexism, in addition to discrimination and individual stigma. In today's world, "institutionalized heterosexuality constitutes the standard for legitimate, authentic, prescriptive, and ruling social, cultural, and sexual arrangements" (Yep, 2003, p.13) and is viewed as a norm.

When heteronormativity is considered the standard and the only acceptable form of sexuality, it can negatively impact individuals who fall outside the standardized category. Hatzenbuehler et al. (2010) investigated the relationship between living in states with discriminatory policies and the prevalence of psychiatric disorders in the LGBTQ+ population illustrates the insidious impact of heteronormativity. The authors used data from the National Epidemiologic Survey on Alcohol and Related Conditions (N=577), a longitudinal, nationally representative study of noninstitutionalized US adults. The results revealed that LGBTQ+ individuals living in areas that instituted bans on same-sex marriage suffered from increased mood disorders, generalized anxiety disorder, and psychiatric comorbidity, suggesting that the policies might have damaging consequences for mental health.

The experiences of LGBTQ+ individuals can be conceptualized as a self-perpetuating matrix where heteronormativity engenders hostile environments imbued with stigma for

members of LGBTQ+ groups, which in turn generates a corrosive impact that negatively impacts health outcomes for this population (Mink et al., 2014).

Using a sample of 662 LGBTQ+ adults, Herek (2008) investigated the prevalence of criminal victimization and related experiences based on the subject's sexual orientation. The results revealed that nearly 20% of interviewees experienced a person or property crime based on their sexual orientation, and about 50% experienced verbal harassment. More than one in ten respondents reported employment or housing discrimination. The risk of victimization varies within LGBTQ+ subgroups, with gay men more likely to experience criminal victimization and harassment than lesbians and bisexual individuals. The authors state that there is a connection between antigay victimization and increased psychological distress and that higher rates of psychological problems may be partially attributable to victimization.

According to Grant et al. (2011), in the National Gay and Lesbian Task Force and the National Center for Transgender Equality survey of N = 6,450 participants, 90% of transgender individuals reported experiencing harassment, mistreatment, or discrimination at work due to their gender identity, and 47% of transgender individuals reported being discriminated against in hiring, firing, and promotion. Discrimination, stigma, and negative attitudes that LGBTQ+ individuals are exposed to not only contribute to health disparities in the population, but may perpetuate the lack of adequate attention to LGBTQ+ needs and insufficient services. The damaging impact of the aforementioned adverse experiences was recognized on a national level when the Office of Disease Control and Health Promotion (ODCHP, 2020) identified LGBTQ+ individuals as an at-risk population and included the improvement of the health, safety, and well-being of LGBTQ+ individuals as a 10-year objective.

Among other objectives, ODCHP (2020) and the Joint Commission emphasize the importance of providing culturally competent sensitive care and recommend continual training for healthcare personnel to create inclusive and affirmative care environments. According to Bristol et al. (2018), health professionals often report little to no education or training on LGBTQ+ issues. The lack of training and educational opportunities is similar to mental health professionals and graduate students (Bristol et al., 2018).

According to Henry et al. (2020), higher self-esteem, possession of health insurance, and the ability to access care were associated with increased wellness behaviors, which in turn improves the physical health of LGBTQ+ individuals. They state that affordable insurance coverage, improving access to care, and adequately treating mental health in LGBTQ+ individuals could improve wellness behaviors.

Available Care

Demand and Satisfaction Rates

Mental health and health disparities, chronic stress, and discrimination of LGBTQ+ people provide clear evidence for the urgent need for culturally competent affirmative mental health services. Nevertheless, the question is: Are psychologists adequately prepared to provide inclusive and sensitive services? According to Murphy et al. (2002), 56% of surveyed psychologists reported working with at least one LGBTQ+ client. Cochran et al. (2003) reported that lesbian and gay individuals seek psychological services at a higher rate compared to their heterosexual counterparts. According to Palma and Stanley (2002) despite higher utilization rates of therapy, LGBTQ+ people report a high rate of dissatisfaction with clinical services.

Lesbian, gay, and bisexual transgender individuals report perceived heterosexist bias, homophobia, and a lack of knowledge about sexual orientation and gender identity as barriers to

psychological treatment. Dillon et al. (2004) highlighted that graduate students report feeling inadequately prepared to integrate an LGBTQ+ affirmative stance in counseling. Inadequate training and knowledge might result in diminished self-efficacy, which impairs the provision of high-quality services. The possible source of dissatisfaction could be the lack of competent LGBTQ+ training in graduate students.

Sherry et al. (2005) aimed to evaluate current training in APA-accredited clinical and counseling doctoral programs. They surveyed training directors at 204 APA-accredited programs in the United States with the final response rate of 51%. The LGB specific Multicultural Competency Checklist was a primary mode of assessing representation, curriculum, practice and supervision, research, student and faculty competency, and physical environment. The focus on whether lesbian, gay and bisexual issues were covered in multicultural and sexuality courses, practica, and clinical supervision.

Sherry et al. (2005) looked at faculty members' research interests and the presence of organizational support for LGB individuals (specific LGB organizations or support groups on campus). The results showed that 67.6% of doctoral programs require a multicultural course, and 61% offer an advanced course in multicultural issues. Further, 71% of programs reported including LGB issues in the course.

Their results also showed that 89.5% of programs reported that graduate students work with LGB clients during their training years, and 94.3% reported that LGB issues are addressed both in practicum and supervision experiences. 88.6% of programs report having at least one visible LGB faculty member, graduate student, and/or support staff members, and nearly 90 percent reported housing active university LGB student organizations. Even though 30.5% of training directors appraised their integration of LGB issues as exemplary, only 17.1% of

programs provide yearly/end of program evaluations on students' LGB competencies, and only 21% of programs focus on LGB issues separate from the required multicultural course.

According to Riggs and Fell (2010), in Australia, psychology students are likely to graduate without exposure to LGBTQ+ training and might not be aware of the need for continuing their education. This finding is being echoed by studies showcasing the link between a lack of skills and preparedness when working with LGBTQ+ clients, discrimination against clients, and inadequate graduate training.

A 2018 survey taken with the American Hospital Association shows that there are 6,146 registered hospitals, 5,198 community hospitals, 2,937 not-for-profit hospitals, and 1,296 for-profit hospitals in the U.S. (Fast Facts on U.S. Hospitals, 2020.). The Healthcare Equality Index of 2019 is a national LGBTQ+ benchmarking tool that looks through healthcare facilities' policies and procedures concerning the inclusion of LGBTQ+ patients, visitors, and employees. Even though 680 healthcare facilities participated in the survey, only 406 met the standards out of 1,680 facilities evaluated (Healthcare Equality Index, 2019). The ranking from about a thousand hospitals showed that many do not have LGBTQ+-inclusive patient and employment non-discrimination policies.

It is clear that providers on individual and organizational levels may feel unprepared to provide high-quality care to address the LGBTQ+ population's unique needs. Increasing demand for affirmative health and mental health care must be met with high quality treatment.

Ethics

In 2000, the American Psychological Association (APA) recognized the importance of providing support for affirmative service provision to LGB clients and issued 20 guidelines for psychotherapy with LGB clients (APA, 2000; APA, 2012).

The guidelines include the following:

- Therapists' understanding the effects of stigma

- Renouncing an illness model ("understand that lesbian, gay, and bisexual orientations are not mental illnesses") and forms of therapy that call for changing sexual and gender identities

- Recognizing their attitudes and knowledge, and seeking consultation if needed

- Appreciating differences in issues concerning gender and sexual identities

- Recognizing the unique experiences of bisexual individuals

- Respecting the importance of LGB relationships and understanding of family dynamics

- Understanding the issues of diversity including intersectionality, religion, ability, and age

- Understanding the impact of HIV/AIDS on the lives of lesbian, gay, and bisexual individuals and communities

- Encouraging psychologists to consider the impact of socioeconomic status on the psychological well-being of lesbian, gay, and bisexual clients (p.1).

The APA recommends psychologists should commit to including LGB issues in professional education and training and are encouraged to pursue continuing education, training, and consultation to enhance their understanding of LGB issues. In the research realm, psychologists should commit to disseminating research on sexual orientation and related issues and to being mindful of the potential misuse or misrepresentation of research findings (APA, 2012).

Pachankis (2014) built on the APA guidelines and provided more detailed clinical principles and techniques when working with LGB individuals such as working to: normalize the adverse impact of minority stress, facilitate emotion awareness, regulation, and acceptance, reduce avoidance, empower assertive communication, restructure minority stress cognitions and validate

sexual minority individuals' unique strengths. It is noteworthy that despite the importance of the APA (2012) guidelines and the principles by Pachankis (2014), transgender and gender variant individuals are not included in the recommendations of either.

Hence, in 2015, APA released the guidelines for psychological practice with transgender and gender-nonconforming people (TGNC) to assist psychologists in providing culturally competent, developmentally appropriate, and trans-affirmative psychological practice with TGNC people. These guidelines (2015) include psychologists' understanding of a non-binary construct; a person's gender identity may not align with their sex assigned at birth and this is a different yet interrelated construct to sexual orientation. Understanding of intersectionality, understanding of their knowledge and attitudes about TGNC folks, and their impact on the provided care, recognizing the impact of stigma, discrimination, and violence and institutional barriers on TGNC individuals are all considered ethical duties of psychologists. Psychologists ought to commit to promoting social changes that ameliorate the negative impact of stigma on TGNC mental health while recognizing that mental health concerns may or may not be related to TGNC gender identity.

According to APA (2015), psychologists should understand the unique developmental needs of TGNC individuals and the challenges that come with each developmental stage. The guidelines include psychologists recognizing the importance of social support or trans-affirmative care, understanding the romantic relationships dynamic and parenting, and family variations. Psychologists should commit to promoting an interdisciplinary approach and emphasize respect for the welfare and rights of TGNC participants in research. Last, but not least, the guidelines highlight the importance of preparing trainees in psychology to work competently with TGNC people.

Weir and Piquette (2018) stated that it is imperative to be supportive and knowledgeable about the transgender community. Knowledge about sexual orientation issues faced by LGBTQ+ individuals, community resources, and institutional barriers are essential in providing support. Another form of support includes advocacy for TGNC individuals that includes but not limited to the promotion of social justice, usage of transgender affirmative language, awareness, discussion of historical stigmatization and knowledge about the pathological clinical framework used within the assessment and diagnosis stage (Weir & Piquette, 2018). The TGNC community faces unprecedented rates of violence and hate crimes, and it is vital to be aware of the contemporary sociopolitical impact on transgender and gender-variant individuals.

Affirmative Therapy

Even though the legacy of oppressive, discriminatory treatment towards LGBTQ+ in psychology persists in forms of prejudice and heteronormative beliefs, the mental health field has started its journey of moving away from oppressive heritage and has become invested in affirmative counseling. One of the tenets of cultural competency, affirmative therapy (AT) has been widely discussed in the literature. Described as a stance rather than a theoretical framework, confusion about its definition and components, as well as about how to implement it, still persists. Few empirical studies have investigated AT's components, and most research describes AT as a therapeutic principle-based approach, a therapeutic stance rather than a specific intervention (Langridge, 2007; Harrison, 2000).

Minority stress theory provided a conceptual framework for understanding LGBTQ+ health that shifted the treatment focus toward an affirmative approach (Johnson, 2012). According to Harrison's (2000) literature review, gay affirmative therapy included a nonpathological view of homosexuality and knowledge of LGBTQ+ history, stressors, barriers,

and developmental stages. Similar to other authors (Morrow, 2000; Tozer & McClanahan, 1999; Dillon & Worthington, 2003), Harrison described an affirmative therapist as someone who continuously challenges oppression within oneself and others while advocating for social change.

Affirmative therapy with LGBTQ+ individuals can be defined as "the integration of knowledge and awareness by the therapist of the unique developmental and cultural aspects of LGBTQ+ individuals, the therapist's self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy skills at all stages of the therapeutic process" (Bieschke et al., 2007, p. 408). Davies (1996) adds that AP is a therapeutic approach that "affirms an LGB identity as an equally positive human experience and expression to heterosexual identity" (p. 25).

According to Bieschke, there are three essential components for affirmative therapy: therapist competence, therapist affirmation of LGBTQ+ culture, and therapist openness in attending to sexual orientation and identity issues. In 1998, Appleby and Anastas delineated the following fundamental principles of affirmative psychotherapy: not assuming heteronormativity, believing that homophobia in the client and society is the problem, accepting and advocating for LGB identities, decreasing internalized homophobia, having theoretical knowledge about LGBTQ+ individuals and their unique stressors, and enhancing personal and professional self-awareness. Several researchers add proactive work in dismantling heterosexist, homophobic and transphobic systems while celebrating and advocating for the validity of identities of LGBTQ+ individuals as another salient element of affirmative therapy (Dillon & Worthington, 2003; Kort, 2008; Morrow, 1999; Tozer & McClanahan, 1999; Worthington et al., 2001). According to Tozer and McClanahan (1999), a therapist no longer assumes a neutral blank state stance but

rather actively confronts and therapeutically counteracts homophobic messages that are often internalized by LGB individuals.

According to Langdridge (2007), there are two types of affirmative therapy: ethically affirmative, but less developed therapy, and strong, more developed affirmative therapy. In the ethically affirmative approach, LGBTQ+ identities and their experiences are valued similarly to heterosexual ones, while unique stressors are acknowledged. The latter, a more "radical" affirmative therapy type, entails acceptance and positive affirmation that directly targets the impact of heterosexism. McCarrick et al. (2020) echoed these findings by adding political advocacy of LGB rights and disclosure of the therapist's sexual orientation to the affirmative approach. According to the authors, therapists must minimize shame, sadness, and anxiety associated with clients' internalized homophobia.

Ramirez (2020) reviewed the existing literature on affirmative therapy and identified common components of LGBTQ+-affirming therapy. They listed therapists' self-awareness about heteronormative privilege as a key element in becoming an affirmative therapist. Ramirez (2020) emphasized the need for ongoing training and research and highlighted the importance of addressing the pathologization and stigmatization of LGBTQ+ identities. A caution was also added for therapists to be especially careful when it comes to misdiagnosing while being aware of intersectionality and accumulating stressors of race, gender, social class.

Wandrekar and Nigudkar (2019) summarized research by stating that affirmative therapy entails therapist's self-work, attitudes, knowledge, ethics, and process skills. Their study examined the impact of queer affirmative cognitive behavior therapy on mental health outcomes of group participants (N=71) in Mumbai, India. The sample included 78% cisgender-gay men, with low representation of lesbian, bisexual women and transgender and gender nonconforming

individuals. The free, open group for queer individuals was held over one year and included 12 monthly sessions. The authors analyzed participants' feedback, which revealed they enjoyed the group and found it to be a safe space. The participants reported an improvement in mental health, reduction of distress, reduction of feelings of isolation, and acquisition of knowledge and skills specific to stressors experienced by LGBTQ+ people. This study showcases the importance of creating a safe affirming space and the associated positive changes in mental health. However, it is important to interpret the results with caution as the authors did not control for confounding variables. The group efficacy could have been impacted by a combination of factors such as peer support, safe space, cognitive behavioral therapy, and affirmative stance, which was not assessed as a separate variable. In addition, the group consisted of mostly cisgender gay men and the sample is not as inclusive to generalize the results to the rest of LGBTQ+ community.

Kort (2008) identified that understanding and combating heterosexism and homophobia in addition to recognizing heterosexual privilege and homo-avoidant attitudes are the most salient components of affirmative practice. The authors delineated major principles of gay affirmative work, which include: inclusive language and terminology, queer-friendly counseling setups, knowledge about diversity and queer resources, emphasis on confidentiality, counselors' self-awareness of their biases, avoiding assumptions about clients, addressing misinformation and misconceptions of clients, and working on internalized homophobia and self-acceptance (Kort, 2008; Wandrekar & Nigudkar, 2019).

Palma and Stanely (2002) identified positive outcomes of affirmative therapy for lesbian, gay, and bisexual clients. They emphasized that authentic affirmation of a client's LGB identity enhances the individuals' comfort level, which could lead to increased engagement in therapy. The authors cautioned that every client is aware of nonverbal cues, and that it is imperative to

showcase the therapist's comfort level and openness to LGB identities. In a study by Dorland and Fischer (2001), LGB participants had more confidence in and were more likely to return to therapists whose language was free of heterosexist bias. They also showcased that LGBTQ+ clients were more likely to self-disclose to therapists whose language appeared less biased.

Training components

Multicultural Competence: Definition and Components

In 2017, the American Psychological Association highlighted an ethical duty of psychologists to enhance their cultural competence by being aware and respectful of cultural, individual, and role differences: "Cultural, individual, and role differences are defined as consisting of age, gender, gender identifies, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status" (APA, 2017).

Competent and culturally sensitive psychological services and research are contingent on the psychologist's cultural knowledge and skills (APA, 2017). According to APA (2017), psychologists should engage in continuous training to enhance their cultural competence when they are doing research or working with a new client population.

It is noteworthy that research on developing cultural competence extends beyond psychology and exists in nursing, mental health, education, social work, and medical fields (Benuto et al., 2020), which results in a variety of operational definitions and constructs. Multicultural counseling competence is an ongoing process that involves counselors' awareness of their own cultural values, biases, and position in power structures and the impact of these factors on relationships with clients, and the ability to develop and implement culturally appropriate interventions (Sue, 1982).

According to Tervalon and Murray-Garcia (1998), "cultural competence in clinical practice is best defined not by a discrete endpoint but as a commitment and lifelong process that individuals enter on an ongoing basis with patients, communities, colleagues, and with themselves" (p. 118). In other words, from a psychology perspective, cultural competence represents an ongoing learning process that encompasses self-awareness, knowledge, and skills (Benuto et al., 2020; Dunn, 2002; Sue et al., 1982).

Benuto et al. (2020) defines self-awareness as a combination of an individual's beliefs about cultural groups that are different from theirs and awareness of their own culture. At the same time, knowledge and skills are defined as a specific skill set like knowledge about cultural groups and interpersonal and intervention abilities, respectively.

Sue's definition (1982) can be expanded by adding to an individual's cultural competencies a focus on programs, agencies and institutions, also known as "systems of care" (Benuto et al., 2020).

Training in Multicultural Competence

There is a clear need to provide tailored multiculturally competent treatment, which means there is an increasing need to provide comprehensive training in multicultural issues in clinical training programs. As mentioned earlier, nearly 67% of APA-accredited programs require a multicultural training course (Sherry et al., 2005).

In a systematic review of the literature, Benuto et al. (2018) assessed 1230 studies dedicated to exploring training models and examining cultural competency training outcomes with clinical psychologists in the USA and Canada. A total of seventeen training outcome studies met their inclusion criteria of studies that empirically examined the cultural competency of clinical and counseling psychologists. This study aimed to gather available empirical research

using clearly defined, systematic methods to obtain answers to the following specific questions: 1) What research methodologies are used to examine the effects of cultural competency training? 2) How are psychologists trained to be culturally competent, including the specific goals of cultural competency training? 3) How are training outcomes assessed (i.e., what is the expected outcome of cultural competency training)? 4) What are the outcomes of cultural competency training?

Benuto et al. (2018) identified six dissertations and eleven peer-reviewed journal articles with three being exclusively qualitative studies (years of publication ranging from 1984 to 2014). A quantitative methodology was used in 82% of the studies, and half of the studies used a between-group design with a control group, while only two studies used RCTs. Participants included mostly graduate students (88%), and the sample sizes varied from nine to sixty-seven respondents. Most studies had predominantly White and only White participants, and only two studies included an ethnically diverse sample.

The findings showed that training is usually a combination of lectures, discussion, case scenarios, cultural immersion, role-play, contact with diverse individuals, self-reflection, journaling, and service-learning, covering topics such as discrimination, worldviews, cultural identity, general concepts about culture, and biases (Benuto et al., 2018). The Multicultural Competency Inventory, the Multicultural Awareness, Knowledge, and Skills Survey, and the White Racial Identity Attitude Scale were the most frequently used assessment measures of skills, knowledge, and awareness. Despite the multitude of training strategies, they found that cultural competency training increased knowledge, yet no consistent changes across attitudes and awareness were found. The authors echoed previous findings (Lie et al., 2011) by highlighting a deficit of studies investigating the client's experience as a training outcome. Also, Benuto et al.

(2018) emphasized that even though there is an increase in research on cultural competency training, there is no clear understanding of the training themselves. This study is the only one to date that explored the cultural competency training among psychologists. The first systematic review (Lie et al., 2011) that focused on the impact of cultural competency training on patient outcomes included seven studies and showcased positive relations between the two. However, only two studies included mental health professionals which might impact the generalizability of the results. The existing research on cultural competency consists mostly of meta-analyses studies that did not use rigorous designs, focus on psychologists nor examine the durability of training outcomes via longitudinal research (Benuto et al., 2018).

In another mixed-method study, Benuto et al. (2019) investigated the cultural competency training experiences of clinical and counseling psychologists using qualitative interviews (N=9) and surveys (N=142). The findings echoed previous results (Benuto et al., 2018) in confirming that mostly psychologists tend to get their training using a diversity course (85%), supervised clinical experience with diverse populations (83%), didactic training about cultural competency (82%) and exploring personal biases (76%). Some participants stated that their cultural training included experiential activities (67%) and cultural immersion (38%).

Alvarez and Domenech Rodríguez (2020) investigated whether the type of undergraduate multicultural psychology class (online and face-to-face) resulted in shifts in the cultural competence domains of self-awareness, knowledge, and skills in students (N=155). The results suggested that in-person students had more favorable movement than online students on specific measures of ethnocultural empathy and color-blind racial attitudes. However, changes in "multicultural domains can be possible through mirroring gold standard courses in multicultural psychology regardless of the teaching modality" (p. 3). The authors suggested that an adherence

to the tripartite model (knowledge, awareness, and skills) (Sue, 1992) and the instructor's competence were the possible contributing factors to positive changes. However, it remains to be seen what the "gold standard" training approaches are.

Results showed that the psychologists' overall satisfaction with the training experiences was contingent on the quality of supervision and training (Benuto et al., 2019). Other studies demonstrated that multicultural training results in increased multicultural competence, specifically a sense of self-efficacy, knowledge, and positive attitudes (Israel et al., 2008; Constantine et al., 2001; Chao et al., 2010).

Multicultural Competence with LGBTQ+ individuals

The need to provide culturally attuned treatment has resulted in increasing demand for multicultural training, which is the only effective framework for working with diverse communities. Can effective multicultural competency training be tailored toward working with the LGBTQ+ community? And, what are the best methods of increasing these competencies in clinical psychologists who work with LGBTQ+ populations?

Cultural competency is seen as a frontline strategy for targeting health disparities (Douglas, 2018; CDC, 2014). According to Sawning et al. (2017), inadequate training for mental health providers may be a contributing factor to increased LGBTQ+ health disparities. Therefore, it is imperative that mental health providers prioritize multicultural competence training when working with LGBTQ+ individuals. Biaggio et al. (2003) highlights the importance of including LGB affirmative practices in the curriculum of clinical and counseling training programs. This is echoed by Godfrey et al. (2006) who suggest that the way to incorporate multicultural training when working with queer individuals is to include LGB counseling competency in

training curricula focused on the three major components of competency: knowledge, awareness, and skills.

Kocarek and Pelling (2003) suggest that an LGBTQ+ multicultural training can be provided in the form of role-plays. Their model comprises three levels of role-playing in triads: counselor, client, and as an observer. Kocarek and Pelling (2003) stated that this approach enhances clinical and empathy skills (Rutter et al., 2008). Israel and Selvidge (2003) suggested that assessing LGB competencies by utilizing graded portfolios and creating a scale assessing attitudes concerning LGBTQ+ clients may improve multicultural training. Garbers et al. (2017) advocated for using online webinars as a way to garner relevant resources and increase knowledge about LGBTQ+ issues for medical providers. Using a cultural competency checklist and apps created by the National Association of School Nurses and available online (https://www.nasn.org/nasn-resources/practicetopics/cultural-competency), medical providers can assess their level of expertise with the LGBTQ+ community. The authors highlight the utility of webinars presented online (e.g., the National LGBTQ+ Health Education Center at www.LGBTQ+healtheducation.org and http://www.glma.org).

Frick et al. (2017) conducted a qualitative study where a convenience sample of 24 women and 3 men (N=27) were asked to watch the movies "For the Bible Tells Me So" (Karslake, 2007) and "Normal" (Busch et al., 2003). They then assessed if those films influenced respondents' perceptions of LGBTQ+ individuals. The participants included twenty-four self-identified White individuals, one African-American individual, one Hispanic individual, and one Latin individual (age range 23-56). The majority of the sample were graduate students from counseling (N=19) programs, followed by social work (N=4), psychology (N=3), and college student personnel (N=1) programs. The investigators used a series of open-ended questions in a

semi-structured questionnaire on students' thoughts, feelings, and reactions about LGBTQ+ clients, therapy with queer individuals, and overall reactions to the films (before and after viewing each film). In addition, participants submitted reflection journals at the end of each week and a final reflection summary paper at the end of the course. The authors used consensual qualitative research (CQR) methodology to decode the data. The study ensured its rigor by taking a series of steps to address credibility, dependability, transferability, and confirmability.

The findings demonstrated that experiential learning, such as watching and discussing movies about LGBTQ+ experiences, enhances students' self-awareness and beliefs about culturally diverse clients (Frick et al., 2017). The results demonstrate that observing films helped students by eliciting reactions about themselves and others, expanded their cognitive learning into affective learning, and increased their empathy for the LGBTQ+ communities. The use of class discussions and reflective journals also improved awareness and sensitivity.

However, we need to be cautious when interpreting the results of this study, as the convenience sample lacked diversity. In addition, this study doesn't focus specifically on psychology trainees, which might impact the generalizability of the results. The question of which aspect of the experiential learning (class discussion, watching a movie, reflection journals, and processing) was the most salient remained unanswered.

Other research sheds light on what factors impact prejudice and multicultural competence. For example, Satcher and Schumacker (2009) revealed that such variables as age, church attendance, not having exposure to LGBTQ+ individuals (friends or family members), not having attended training on LGBTQ+ issues, and political conservatism were predictors of homoprejudice in therapists. The authors used a sample of heterosexual counselors (n = 571) and 79% of the sample were White, 17% were African American, and 4% classified their race as

other (e.g., Asian, Native American, biracial) while the majority (70%) had master's degrees, 5% were currently in master's degree counselor education programs, and 25% had postgraduate degrees. Using logistic regression analysis, they indicated that the aforementioned variables contribute to the counselors high modern homonegativity scores.

In their exploratory study of psychologists (N=14), Israel et al. (2008) reported a similar finding stating that with more knowledge comes a positive change in attitudes. Isbell's study (2019) used a sample of 57 healthcare students and proposed that postsecondary education, training, religion, past experience with a relationship with LGBTQ+ impact cultural competency in healthcare professionals. These findings were supported by other studies showcasing the importance of educational experience (Sawning et al., 2017; Bristol et al., 2018).

Even though the research field continues to witness an increasing emphasis on multicultural competence training, there is a dearth of data on the impact of such training on trainees and professionals. Bonvicini (2017) also underscores a gap between "an explosion of research specific to LGBTQ+ healthcare" and the reality of deficiency of multicultural LGBTQ+ training (p.4). Hence this dissertation project aims to analyze the effectiveness of existing affirmative training with the ultimate goal of using it as a resource for future programs when considering implementing affirmative multicultural training.

In summary, the existing research on LGBTQ+ competent training is in line with the literature on multicultural competence training. The studies reviewed found that the utilization of didactic materials, supervision, personal reflections, online training, and self-reflection increased competence and positively impacted skills, knowledge, and attitudes. However, it is noteworthy that some literature alludes to social desirability components and preexisting positive beliefs towards the LGBTQ+ community, which might skew the results by revealing a positive change.

It is clear that more sophisticated psychometric measures are required to address these confounding variables and to quantify the outcomes of various training programs.

Existing LGBTQ+-affirmative psychotherapy training

Several studies (Bidell, 2013; Rudolph, 1989; Rutter et al., 2008) posit that training in providing LGBTQ+-affirmative psychotherapy improves therapists attitudes, knowledge and skills as measured by a decrease in homo-negativity and trans-negativity, improved ability to form a therapeutic alliance and conduct appropriate assessment with the population. Despite the widely advocated importance of providing affirmative care there is no uniform training protocol for therapists. However, the existing research shows that there are similarities in existing training and highlights important themes that should be included in LGBTQ+-affirmative psychotherapy curriculum.

This section describes several recent studies that provided the review of their training models that resulted in positive change in attitudes, skills and knowledge amongst therapists.

Pepping et al. (2018) reported skills, knowledge and attitudes of 96 mental health professionals in relation to working with LGBTQ+ population (Age range 22 - 70; 80 females, 16 males, 72.9% heterosexual, 22% identified as LGBTQ+ individuals, 67.7% licensed psychologists, 14.6 % social workers and 2% psychiatrist or medical practitioners, the remaining percent is mental health professionals) were assessed before and after the LGBTQ+ affirmative training. The researchers used the Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI; Dillon & Worthington, 2003), Therapist self-efficacy working with transgender Individuals, the Modern Homo-negativity and Trans-negativity Scales

(Morrison & Morrison, 2003), the Acceptance and Action Questionnaire-Stigma scale that measures psychological flexibility (Levin et al., 2014) and the Consumer Satisfaction Questionnaire (Larsen et al., 1979) that measured the satisfaction of services received.

Pepping et al. (2018) conducted 7.5 hours of training that focused on didactic materials, use of videos and experiential components such as group discussion and reflection exercises. Clinical psychologists developed the workshop using existing theoretical and empirical research on LGBTQ+-affirmative psychotherapy such as minority stress theory (Meyers, 1995), CBT and compassion focused therapies for sexual and gender minorities (Martell et al., 2004; Pepping et al., 2017), and APA professional guidelines and standards of care (American Psychological Association, 2012).

The workshop started with introductory information on LGBTQ+ terminology, physical and mental health of sexual and gender minorities which was analyzed from a minority stress theory lens. The second segment was dedicated to exploration of potential implicit and explicit biases, learning about how to assist during the coming out process, strengthen social support, address internalized stigma and intersectionality of identities. During the third and fourth sections of the training, the participants learned concrete skills about working with same-sex couples and working with transgender clients with the emphasis on gender dysphoria, assessment and intervention.

Despite its limitations - such as an absence of control group, no measure of strength of religious beliefs, the length of the workshop and the lack of variability in work in different settings and gender imbalances - the study provided strong support that the training in LGBTQ+ affirmative care improved therapists' skills, knowledge and attitudes. The researchers identified

that demographic factors as well as religious affiliation did not impact the results, which led

them to suggest that the training itself was helpful (Pepping et al., 2018).

In another study in Romania conducted by Lelutiu-Weinberger and Pachankis (2017),

researchers conducted a two-day workshop for mental health professionals addressing stigma

and discrimination of LGBTQ+ individuals. The training utilized the U.S. empirical and

theoretical data, which was adapted for a Romanian cultural context, which included unique

structural stigma such as the absence of legal protection against employment or housing

discrimination. The participants (N=54: 90%, Female, 73% Heterosexual, 87% clinical

psychologists) completed pre and post measures to assess the effectiveness of the training. The

measures included demographic questionnaires and the U.S. adapted scales assessing attitudes,

skills and knowledge. The workshop was divided into three modules and included both didactic

information and interactive case discussions. Participants were trained in learning about

LGBTQ+ identities and unique stressors, LGBTQ+ disparities and health needs, and LGBTQ+-

affirmative therapeutic principles and techniques. Researchers recognized that in order to assess

the long-term impact of this workshop a randomized control trial is needed. The findings

supported previous research studies stating that the training increased perceived LGBTQ+

competence.

In a more recent study, medical professionals were asked to complete the LGBTQ+

cultural competency training, Curriculum for Oncologists on LGBTQ+ populations

to Optimize Relevance and Skills (COLORS) (Seay, 2019). Forty-four oncologists completed

pre and post measures measuring their skills, knowledge and attitudes towards LGBTQ+

individuals. COLORS is a web-based training program that includes didactic and interactive

information spread over four 30-minute modules. They cover general topics, such as sexual

orientation and gender identity terminology and oncology-focused topics that include hormone therapy considerations for transgender patients undergoing cancer treatment and fertility with LGBTQ+ patients in the context of cancer care. The training was based on Campinha-Bacote's (2002) model of cultural competence in health care delivery that includes cultural awareness, cultural knowledge, skill, encounters, and desire. Similar to other aforementioned studies, the findings revealed a significant improvement in perceived LGBTQ+ competence.

Coulter et al. (2020) reviewed the impact of LGBTQ+-focused training on skills and attitudes of pre-service teachers who work with high school students. The researchers conducted a non-randomized pre-test-post-test design with eighty-eight participants (88% cisgender women, 13% cisgender men, 90% non-Hispanic White, 96% heterosexual, 74% Catholic) comparing two intervention groups (service-based and didactic based) to a control group who did not receive an LGBTQ+ training. The service-based group was required to complete 3 hours of pre-placement training on working with LGBTQ+ high school students and 9 hours of service-based placement at local gender and sexuality alliances.

Didactic based group members attended a three-hour training session with members of local non-for-profit LGBTQ+ youth serving organizations. They covered personal introductions (including gender pronouns), personal gender reflection, how to create inclusive high schools and understanding, identifying, and responding to LGBTQ+ bullying. The findings revealed that the service-based intervention group significantly increased in self-efficacy and active listening and empathetic skills when compared to the control group. However, neither didactic nor intervention group had different outcomes regarding attitudes compared to control group.

Across several studies it is evident that researchers implementing LGBTQ+ affirmative training favor a combination of didactic and experiential information such as vignettes, case

discussion and reflection questions. Most training focuses on basic information about LGBTQ+ populations, such as mental health disparities and unique challenges within each specific population under the LGBTQ+ umbrella. Most training includes reflection segments where participants are asked to evaluate their biases and think about how they could improve their work with the population. Lastly, each field has a specialized segment covering their line of work like oncology, work with students or clinical principles in therapy.

The development of the of PHC and its history

The Pride Healing Center (PHC) is a trauma-informed specialty clinic for the LGBTQ+ community that was opened on January 20, 2017. The PHC functions within the larger Psychological Services Center (PSC) at Long Island University-Post, a community mental health training clinic for the program's clinical psychology doctoral students (Egbert & DePalo, 2021).

The PHC is a student-created and student-run clinic. Doctoral student clinicians volunteer to take on clinical and administrative responsibilities of the PHC in addition to their standard academic and externship hours. In addition to clinical and supervision hours, administrative tasks (mandatory paperwork, progress notes, treatment planning), these responsibilities encompass the 20-hour required PHC training and one-hour weekly peer consultation group (Egbert & DePalo, 2021).

Student leaders and the Trauma Response and Research Team at Long Island University Post procured local and national experts on LGBTQ+ cultural competency to ensure that the PHC provide high-quality affirmative psychological services to LGBTQ+ individuals.

Since 2017, the PHC has trained 50 Graduate Student Therapists (GSTs), not including the upcoming cohort 2020-2021 of 12 GSTs, and has delivered services to nearly 30 members of

the LGBTQ+ community and their families. The PHC served 29 individuals, two couples, one family, and ran two groups (PHC Parents and a creative arts space).

Services provided

LIU Post's clinical psychology doctoral program offers a dual-orientation training in both cognitive-behavioral therapy and psychodynamic psychotherapy. Doctoral students undergo comprehensive theoretical training in both modalities and receive CBT and Psychodynamic supervision from a faculty and community supervisor. After assiduous research of best practices, the founder of the PHC, Dr. Rae Egbert, included Acceptance Commitment Therapy to the list of therapeutic modalities as it was found to be effective when addressing complex trauma and unique issues faced by gender and sexual minorities (Egbert & DePalo, 2021).
PHC clients seek therapeutic services for a plethora of presenting issues such as depressive disorders, anxiety disorders, trauma, dating and family conflict, gender dysphoria, eating disorders, high-risk behaviors, chronic suicidality, self-harm, substance abuse, and eating disorders.

GSTs provide individual, couples, and family therapies. In addition, the PHC has a strong commitment to supporting and advocating for individuals seeking to undergo gender-affirming medical or hormonal treatments. GSTs are trained in providing affirming in-depth assessments and writing transition letters required for medical interventions.

Training program and elements

In the past four years, the PHC training curriculum has undergone several iterations. The PHC training model relies heavily on the best practices research and feedback of GSTs. PHC training modules are reviewed each year and modified according to students' feedback and new relevant information. From its inception, the goal of the PHC was to offer culturally-informed and sensitive LGBTQ+ care. Dr. Egbert designed a comprehensive virtual training program for GSTs to become acquainted with relevant mental health concerns, minority stress theory, unique barriers that each community faces, and treatment options and issues (Egbert & DePalo, 2021).

Table 2
Pride Healing Center: The Developmental History

	2017	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Approach	A mixed media approach (e.g. webinars, books, articles, websites, etc.) 10-15 hours, followed a	✓ ✓	✓ 15-20 hours, followed a self-directed model (Added: an option to complete the training as an independent	✓ ✓ Added: self-directed AND in-person training	✓ Added: case conceptualization presentation letter writing workshop

	self-directed model		study or group study) Introduction/Issues facing the LGBTQ+ Community, LGBTQ+ Youth, Lesbian, Gay, and Bisexual Adults, Transgender Youth and Adults, and Special Topics	full-day in-person training covering role-plays, exploring heteronormative and cisgender bias, and self-reflection	
Resources	Fenway Institute's National LGBTQ+ Health Education Center	✓	✓	✓	**Module 3, Replacing-Behavioral Healthcare for Lesbian, Gay, and Bisexual People** +What more is there to say about LGBTQ+ issues? (7min)

	The National LGBTQ+ Health Education Center				https://youtu.be/olPn5xr0L08 +Ongoing Challenges in the Fight Against HIV/AIDS (3min) https://youtu.be/TxTomXd21Oo **Module 3, Replacing- Best Practices in Behavioral Health for Sexual Minority Women** +Caring for Sexual Minority Women (Fenway, 2020) **Module 4, Replacing- Behavioral Healthcare for Transgender Adults** +Behavioral Health Care

					for Transgender Adults (Fenway, 2020)
Work	Webinars (e.g., Sexual Orientation, Gender Identity, and Mental Health in Children and Adolescents (1 hr). Articles (e.g., APA Guidelines for Psychological Practice With	Added: Weekly Consultations Lunch and Learn events	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓ ✓

	Lesbian, Gay, and Bisexual Clients)				
Measures	Demographic form SOCCS LGBTQ+ knowledge assessment based on the assigned training modules	✓ GST freeform self-reflections	✓ Measure of Attitudes Towards Lesbian, Gay, Bisexual, and Transgender Clients Added post-test reflection questions, a new method of assessing GSTs knowledge.	✓ ✓ LGBTQ+ DOCSS Gender Expression Attitudes Scale	✓ ✓ ✓

Phase One: 2017

The training's original format used a mixed media approach (e.g., webinars, books, articles, websites, etc.). The 10-15 hours of self-directed training asked GSTs to familiarize themselves with the information and complete the modules before beginning their clinical practice at PHC. GSTs could be considered PHC clinicians and allowed to see clients only if the training was completed in its entirety. The first cohort consisted of five GSTs, and they had fewer clinical hours, least access to resources, and received the least amount of training (Egbert & DePalo, 2021).

The key resources included the Fenway Institute's National LGBTQ+ Health Education Center and the National LGBTQ+ Health Education Center. Carefully selected one-hour webinars covered the following topics: Sexual Orientation; Gender Identity, and Mental Health in Children and Adolescents; Behavioral Healthcare for Lesbian, Gay, and Bisexual People; and Mental Health Care and Assessment of Transgender Adults. GSTs were given a choice to select one additional video from the list: Structural Stigma and the Health of Lesbian, Gay, and Bisexual Populations, Providing Care for Addictions in the LGBTQ+ Community, or Same-Sex Domestic Violence: Considerations, Suggestions, and Resources.

GSTs were asked to read three of the five following articles and clinical reports: APA Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients; APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People; Lesbian and Gay Parenting; Human Rights Campaign – National Coming Out Day Youth Report; Human Rights Campaign – Supporting and Caring for our Gender Expansive Youth Report. In addition to webinars and articles, GSTs were asked to review three of the five websites: hrc.org, thetrevorproject.org, wpath.org, transequality.org, transpeoplespeak.org.

Phase Two 2017-2018

A similar format of the training program with slight modifications was used with the 2017-2018 cohort. There were six GSTs in the second 2017-2018 cohort. Based on the feedback collected from the first cohort, more in-depth experiential and reflective training were in demand. Therefore, weekly consultation meetings with the founder, Dr. Egbert, and Lunch and Learns with Pride Healing Center were included. *Lunch and Learns* featured local and national experts in LGBTQ+ care for 90-minute didactic and skills seminars (Egbert & DePalo, 2021).

Phase Three 2018-2019

In 2018 the training curriculum was revised again. The second cohort's feedback was analyzed, and appropriate adjustments were made to address the needs of clinical psychology trainees. In addition, the modules were reviewed to add the most up-to-date information. The new training added information on institutional barriers to treatment for gender and sexual minorities, practices on facilitating the exploration of one's own privilege and bias, and additional resources for assessing/evaluating/treating gender and sexual minorities.

The 2018-2019 training curriculum was divided into five modules: Introduction/Issues facing the LGBTQ+ Community, LGBTQ+ Youth, Lesbian, Gay, and Bisexual Adults, Transgender Youth and Adults, and Special Topics. Dr. Egbert added two new components: an option to complete the training as an independent study or group study and post-test reflection questions, a new method of assessing GSTs knowledge.

Phase Four 2019-2020

Based on the feedback collected from the 2018-2019 cohort, the new changes were implemented. The training modules added both self-directed and in-person training. The modules

still accounted for 10-15 hours of self-directed study but added a full-day in-person training covering role-plays, exploring heteronormative and cisgender bias, and self-reflection.

Phase Five 2020-2021

The training curriculum for the 2020-2021 cohort has been reviewed to add two experiential training days, one at the beginning of the year before self-directed study and one after the completion of the study. The first in-person training included a review of PHC history and data and case conceptualization of a prior PHC case. The second in-person training included a self-reflection of one's biases, individual gender journey explorations, role plays, and a workshop on letter writing.

The research aims for this study

This was designed to evaluate the PHC training program's effectiveness and to explore the most salient components of the training curriculum. The impact of PHC training on GSTs skills, knowledge, and self-efficacy was measured by self-report inventories. Specifically, this research project explored changes in competencies from the beginning of the training year to the end of the year for all trainees of the PHC as well as differences between clinicians who had more face-to-face clinical hours and supervision.

The current study differed from the existing body of research in several ways. The PHC has been successfully functioning for nearly four years, and in that time, the training model was attuned to the needs of GSTs, which allowed comprehensive training based on clinicians' feedback. The existing data from four years gives us a glimpse into potential differences in clinicians preparedness based on clinical and supervision hours and on didactic and experiential components. This study's results may be helpful to future clinicians as they are considering

implementing affirmative psychological services in their practice and ultimately helpful for LGBTQ+ clients who, as mentioned above, need high-quality affirmative mental health services.

Therefore, it was hypothesized that face-to-face clinical hours, didactic, and experiential training components will enhance GSTs skills, knowledge, and attitudes. It was suggested that increased skills level, improved attitudes would result in an enhanced sense of self-efficacy in GSTs and positive experiences of clients.

The research questions:

1. Are there a significant change in self-reported skills, knowledge, and attitudes from pre-test to post-test?

2. Are there a significant difference between GSTs who have more clinical hours with LGBTQ+ clients than those with fewer hours?

3. If the entire PHC training model is considered to be effective, can it be determined which is the most salient component of the training?

Hypotheses:

1. It is hypothesized that, given the literature review, there will be a significant increase in self-reported skills, attitudes, and knowledge between pre-test and post-test as a result of the cultural competence training that includes information about minority stress, unique barriers, and mental health needs of LGBTQ+ population.

2. It is hypothesized that clinicians' perceived skills, attitudes, and knowledge will be enhanced with more therapeutic contact with LGBTQ+ clients as well as supervision hours devoted to those clients.

3. Hypothesis 3 will explore the most salient component of the PHC training and be

   identified by analyzing GSTs feedback from 2017 to 2021.

Methods

Participants

This study was conducted amongst graduate student therapists at Long Island University

Post, Clinical Psychology, Psy.D. program. In order to be included in the study the participants

had to be current 2nd year graduate Psy.D. students from Long Island University Post who

selected to become a PHC clinician for a full training year or doctoral students who have

completed the training. Graduate Student Therapists (GSTs; N=50) have been trained in a 10-

20-hour comprehensive, multi-media training program (including videos, webinars, books, and

articles) to increase multicultural competence in working with sexual and gender minorities. The

email that included a consent form and a demographic survey information was sent out to current

and former GSTs to ascertain their interest in participating in the study. The study included a

convenience sample of students who selected this extra curriculum training and who returned a

signed consent and the demographic sheet (N=33). Of these participants, N=25 self-identified as

primarily white, N=1 as White Latina, N=4 as Asian (one South Asian), N=2 as Black and one as

both white and Native American. N= 24 participants identified as heterosexual, and N= 2

participants were bisexual, N=5 lesbian, gay, queer and N=2 pansexual. N=3 participants were

nonbinary with N = 24 cisgender women and N=6 cisgender men. The participants ranged in age

from 23 to 37.

Exclusion Criteria

Participants who either did not complete the PHC training or those who completed the training but did not provide consent to use their data were not included in the study.

Design

The proposed quantitative study will be conducting a one group pre-posttest design with established pre- and post- training data that was collected at the end of each training years using the following self-report measures of LGBTQ competence: The Sexual Orientation Counselor Competency Scale and the Measure of Attitudes Towards Lesbian, Gay, Bisexual, and Transgender Clients, and GST freeform self-reflections.

Procedure

The study used existing pre and post training data from the years 2017-2021. Current and past GSTs were contacted with information about the purpose of the study and asked to provide informed consent to use their previously collected data (see Appendices A and C). To ensure the confidentiality of the study the researcher assigned an identification number to each subject to avoid interfering with the results. The data from GSTs (N=33) were analyzed and pre and post scores compared to each other. LGBTQ+ competence was assessed using self-report measures that consisted of GSTs perceived skills, knowledge, and skills.

Power Analyses

Hypothesis 1: In order to have meaningful and interpretable outcomes, a power analysis was conducted using G-power. A sample size of 27 was recommended to complete this analysis. This was determined utilizing an effect size of 0.30 and power of 0.80.

Hypothesis 2: In order to have meaningful and interpretable outcomes, a power analysis was conducted using G-power. A sample size of 62 was recommended to complete this analysis. This was determined utilizing an effect size of 0.30 and power of 0.80.

Measures:

1. **Demographic Form:**
   GSTs were asked to provide demographic information about themselves that included
   age, sexual orientation, gender identity and race (Appendix B).

2. **LGBTQ+ DOCSS (Bidell, 2017):** The LGBTQ+-DOCCS is an 18-item self-assessment
   measure of clinical competency that uses a Likert scale (1-7, strongly disagree to strongly
   agree). Scores range from 18 to 126 with higher scores indicating less bias and more
   clinical readiness and knowledge in relation to working with LGBTQ+ clients. It consists
   of three subscales: Clinical Preparedness (the clinician's training and experience),
   Attitudes (the clinician's bias and prejudice), and Knowledge (assesses the clinician's
   awareness of health and mental health disparities LGBTQ+ clients) (Appendix D)**.**

3. **The Gender Expression Attitudes Scale (Santos, Goldstein, & Tracey, 2017):** The
   GEATS is a 24-item self-assessment measure of attitudes towards counseling transgender
   clients utilizing a Likert scale (1-5, strongly disagree to strongly agree). The measure
   comprises three factor scales with no total score: Emphasis on Assigned Sex Expression
   (nine items describing approaches akin to reparative or conversion types of therapy),
   Affirmation of Gender Expression in All Forms (six items capturing attitudes that affirm
   diverse forms of gender expression), and Generalized Emphasis on Gender Binary
   Expression (nine items capturing the gender binary attitudes). Beliefs that gender
   differences are not amenable to change (gender immutability) and that gender differences

are due to genetic or innate differences (gender essentialism) show positive relation to

Emphasis on Assigned Sex Expression and negative association with the Affirmation of

Gender Expression in All Forms subscale. Higher score on Affirmation of Gender

Expression in All Forms showcases openness to work with transgender clients,

understanding of gender continuum and unique needs of transgender clients (Appendix

E)

4. **GST freeform self-reflections:**

5. GSTs were asked to provide answers to open-ended questions and were informed that

    their responses will be used to inform the training and clinic experience for the next

    cohort. GSTs constructive feedback focused on initial training (7 items), clinic

    experience (4 items), continuing education (3 items), overall experience (7 items). GSTs

    asked about their feedback on most helpful and least helpful components of the training

    as well as the continuing education (Appendix F).

6. **Sexual Orientation Counselor Competency Scale (Bidell, 2005):** The purpose of the

    Sexual Orientation Counselor Competency Scale (SOCCS) is to measure a therapist's

    perceived competencies for working with LGB clients. The SOCCS is theoretically

    grounded in the tripartite multicultural psychology model and consists of 29 questions

    with three subscales: (1) Skills, which includes 11 items focused on LGBTQ+ affirmative

    clinical work; (2) Attitudinal Awareness, which includes 10 items examining self-

    awareness of LGBTQ+ biases and stigmatization; and, (3) Knowledge, which consists of

    eight items assessing knowledge of LGBTQ+ psychosocial issues. The scale is a self-

    reported measure for mental health professionals. GSTs rated each item on a seven-point

Likert scale ranging from "Not true at all" to "Totally True." Higher scores are indicative

of higher level of competencies (Appendix G).

7. **Clinical Exposure:** In addition to completing PHC measures, GSTs were asked for a

monthly summary of their clinical and supervision hours pertaining to PHC clients only.

Data Analyses

This study used a quantitative research methodology and data from the current study was

analyzed using IBM SPSS Statistics software v. 25.0 (2017). Independent sample t-test were

conducted in order to explore Hypothesis 1, which states that there will be a significant change in

GSTs skills, attitudes, and knowledge after PHC training that includes didactic, experiential

training and exposure to LGBTQ+ clients. Hypothesis 2 explores components of the training

more closely by stating that more clinical hours with LGBTQ+ clients result in increased

multicultural competency. A repeated two-way ANOVA was performed to compare groups of

students with PHC clients who did not get exposure to clinical work. Three groups were

compared to each other: minimal clinical exposure (under 20 clinical hours), moderate clinical

exposure (under 40 clinical hours), and maximum clinical exposure (more than 40 clinical

hours). Hypothesis 3 was explored using self-report narrative measures. The most salient

components of the PHC training were identified by analyzing GSTs feedback from 2017 to 2021.

Hedges' g was calculated as a measure of effect size when comparing means for each

measure. Additionally, Cronbach's alpha was run in order to demonstrate internal consistency of

the measures used.

Results

A total of 50 Graduate Student Therapists completed the PHC training over the past five years and were asked to participate in the study. Thirty-two GSTs agreed to participate (64% of sample). However, it is noteworthy that the unequal number of measures were completed by participants. For example, out of thirty-two GSTs N=19 completed SOCCS measure, N=19 completed DOCCS, N=27 completed Measures of Attitudes, and N=19 completed GEATS. There were 6 cisgender male participants and 23 cisgender female participants, and 3 nonbinary participants, with participants ranging in age from 23 to 37 ($M = 27.66$, $SD = 3.92$) years.

Table 3

Demographic Information

	N=32	%
Age		
Mean (SD)	27.66	3.92
Range	23.00 - 37.00	
Gender Identity		
Cisman	6	18.8%
Ciswoman	23	71.9%
Nonbinary	3	9.4%
Sexual Orientation		
Bisexual	2	6.2%
Gay	2	6.2%
Hetero	23	71.9%
Lesbian/Queer	1	3.1%
Pansexual	2	6.2%
Queer	2	6.2%
Race		

	N=32	%
Asian	3	9.4%
Black	2	6.2%
Indigenous/White	1	3.1%
Latina -White	1	3.1%
South Asian	1	3.1%
White	24	75.0%

Figure 1

Information on Completed Measures
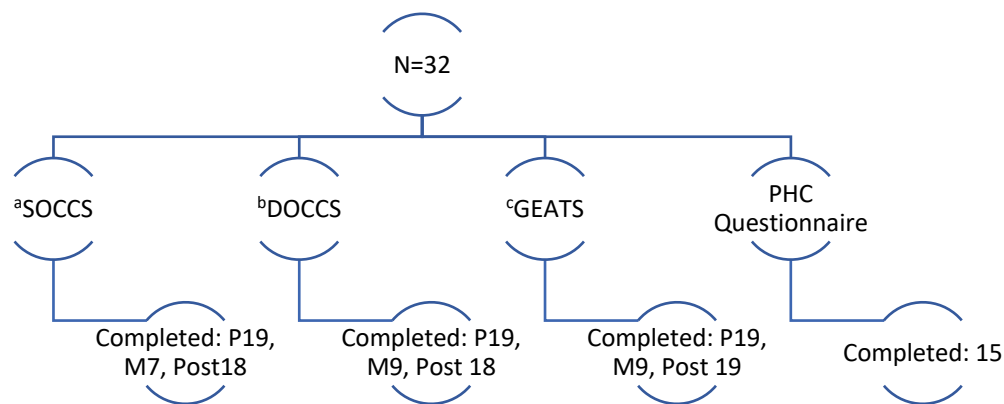
Note. P. – Pre-Measures, M. – Mid Year Measures, Post – End of the Year

[a]*SOCCS - Sexual Orientation Counselor Competency Scale*

[b]*DOCCS - The* Lesbian, Gay, *Bisexual, and Transgender Development of Clinical Skills* Scale

[c]*GEATS - The Gender Expression Attitudes Scale*

Research Question 1.

Comparing Pre and Post scores on Sexual Orientation Counselor Competency Scale (SOCCS)

Total Scores on Sexual Orientation Counselor Competency Scale

An independent sample *t*-test was utilized to address the first research question: if there will be a significant change in GSTs skills, attitudes, and knowledge after PHC training that

includes didactic and experiential training. Results indicated a significant difference in pre

training and the end of the year scores in Graduate Student Therapists (N=18), such that there

was a large increase in overall competency (post training) scores (M = 5.47, SD = 0.44, range = -

0.14-1.14) compared to pre-trainings scores (M = 5.17, SD = 0.53, range = 4.45-6.14),

$t(17)$=3.94, p = 0.001 (see Table 4).

This difference represents a large effect size (Hedges' g = .95). We can be 95% confident

that the true difference between scores in these two groups is between 0.37 and 1.52. Internal

consistency reliability was found to be acceptable for responses on this measure (Chronbach's α

= .85).

Figure 2

SOCCS Total Score from Pre to Post (N=18)
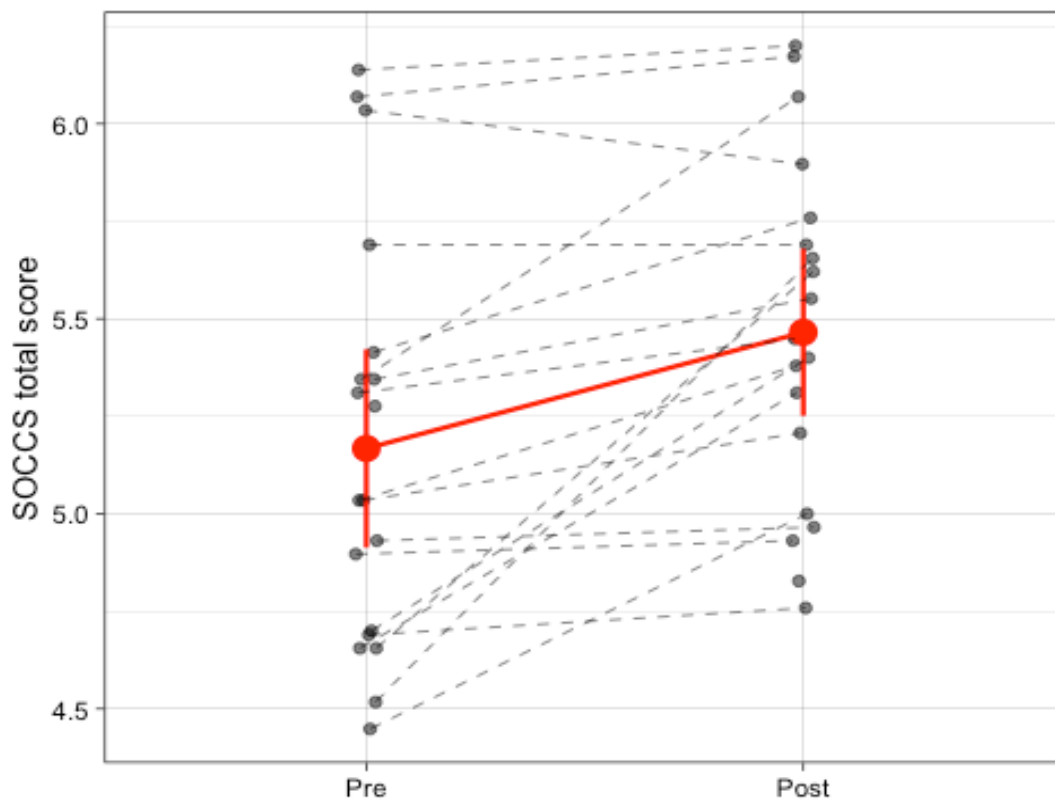
Table 4

Descriptive statistics for Total competency scores, as measured by SOCCS (N=18)

SOCCS	N	M	SD	Range
Pre Total	19	5.17	0.53	4.45 - 6.14
Post Total	18	5.47	0.44	-0.14 - 1.14

Skills Subscale of SOCCS

Results indicated a significant difference in reported skills before the training and at the end of the year in Graduate Student Therapists (N=32), such that there was an increase in overall skills (M = 3.55, SD = 0.69, range = 2.27 - 4.91) compared to the beginning of the year (M = 3.20, SD = 0.90, range = 1.91 - 5.36), $t(17)$=2.23, p = 0.040 (see Table 5).

This difference represents a medium effect size (Hedges' g = .54). We can be 95% confident that the true difference between scores in these two groups is between 0.02 and 1.04. Internal consistency reliability was found to be acceptable for responses on this measure (Chronbach's α = .84).

Figure 3
SOCCS Skills Score from Pre to Post (N=18)
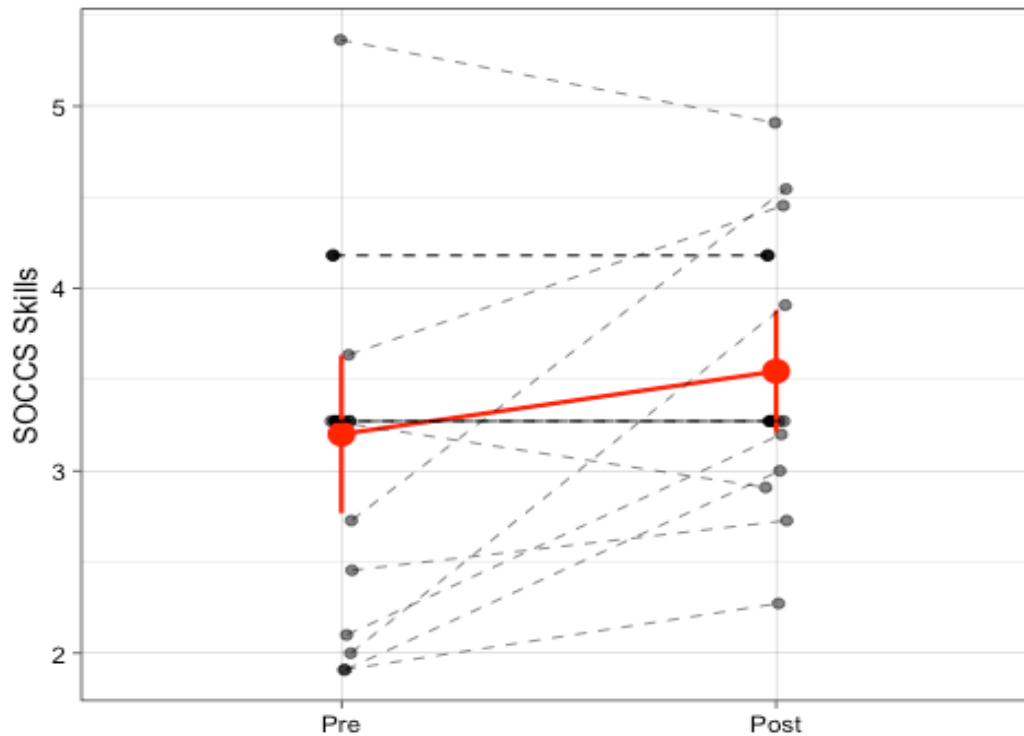
Table 5

Descriptive statistics for Skills scores, as measured by SOCCS (N=18)

SOCCS	*N*	*M*	*SD*	Range
Pre Skills	19	3.20	0.90	1.91 - 5.36
Post Skills	18	3.55	0.69	2.27 - 4.91

Note. Pre = before the summer training, Post = at the end of the year

Attitudes Subscale of the SOCCS

This difference represents a small effect size (Hedges' g = .05). We can be 95% confident that the true difference between scores in these two groups is between -0.52 and 0.43. Internal

consistency reliability was found to be acceptable for responses on this measure (Chronbach's α = .57).

Results indicated no significant difference in pre training and the end of the year attitudes in Graduate Student Therapists (N=32), such that there was no change in overall pre-attitude (*M* = 6.96, *SD* = 0.10, range = 6.60 - 7.00) and post-attitudes (*M* = 6.94, *SD* = 0.11, range = -0.30 - 0.20), t(17) = 0.2, *p* = 0.842 (see Table 6).

Figure 4

SOCCS Attitudes Score from Pre to Post (N=18)
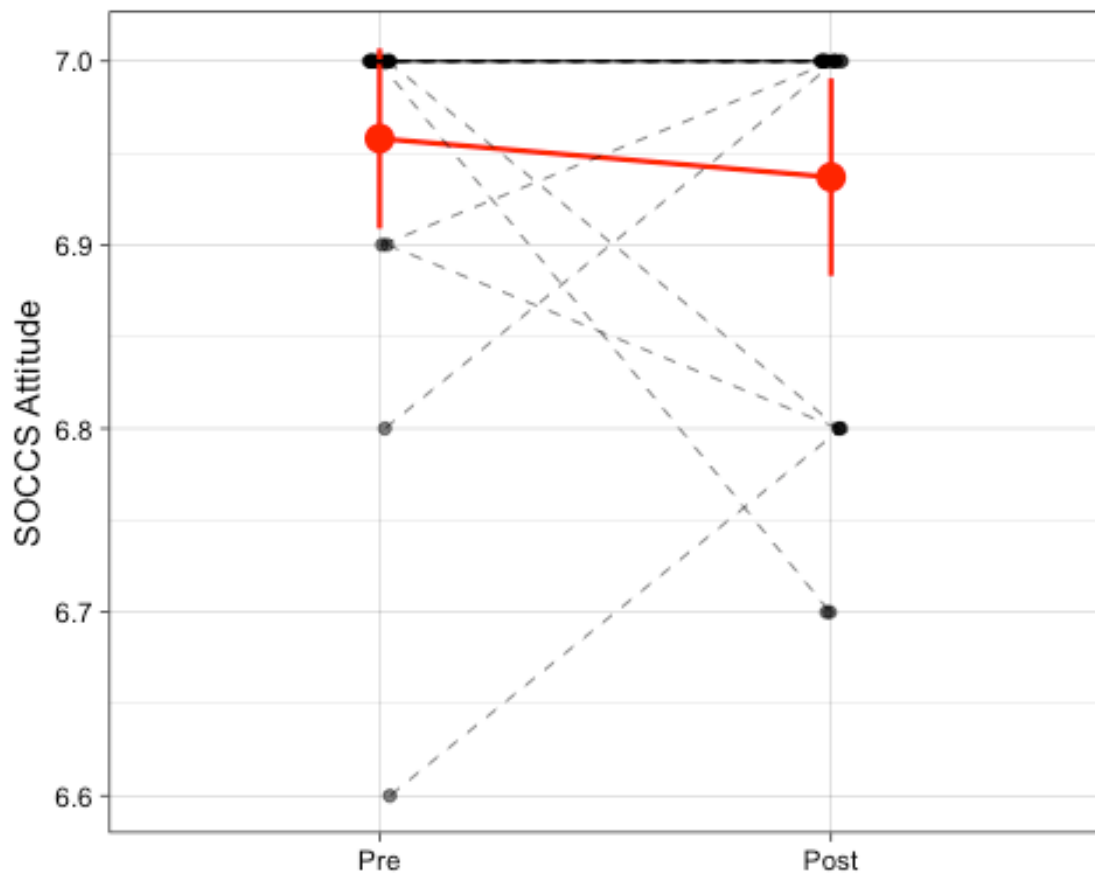
Table 6

Descriptive statistics for Attitudes scores, as measured by SOCCS (N=18)

SOCCS	N	M	SD	Range
Pre Attitudes	19	6.96	0.10	6.60 - 7.00
Post Attitudes	18	6.94	0.11	-0.30 - 0.20

Note. Pre = before the summer training, Post = at the end of the year

Knowledge Subscale of the SOCCS

Results revealed significant differences in pre training and the end of the year Knowledge in Graduate Student Therapists (N=32), such that there was a large increase in post knowledge scores ($M = 5.36$, $SD = 0.76$, range = 4.50 - 6.50) compared to pre-knowledge scores ($M = 5.12$, $SD = 0.66$, range = 4.50 - 6.00), $t(17)=2.22$, $p = 0.040$ (see Table 7).

This difference represents a medium effect size (Hedges' $g = .54$). We can be 95% confident that the true difference between scores in these two groups is between 0.02 and 1.04. Internal consistency reliability was found to be acceptable for responses on this measure (Chronbach's $\alpha = .69$).

Figure 5

*SOCCS Knowledge Score from Pre to Post (N=18)*
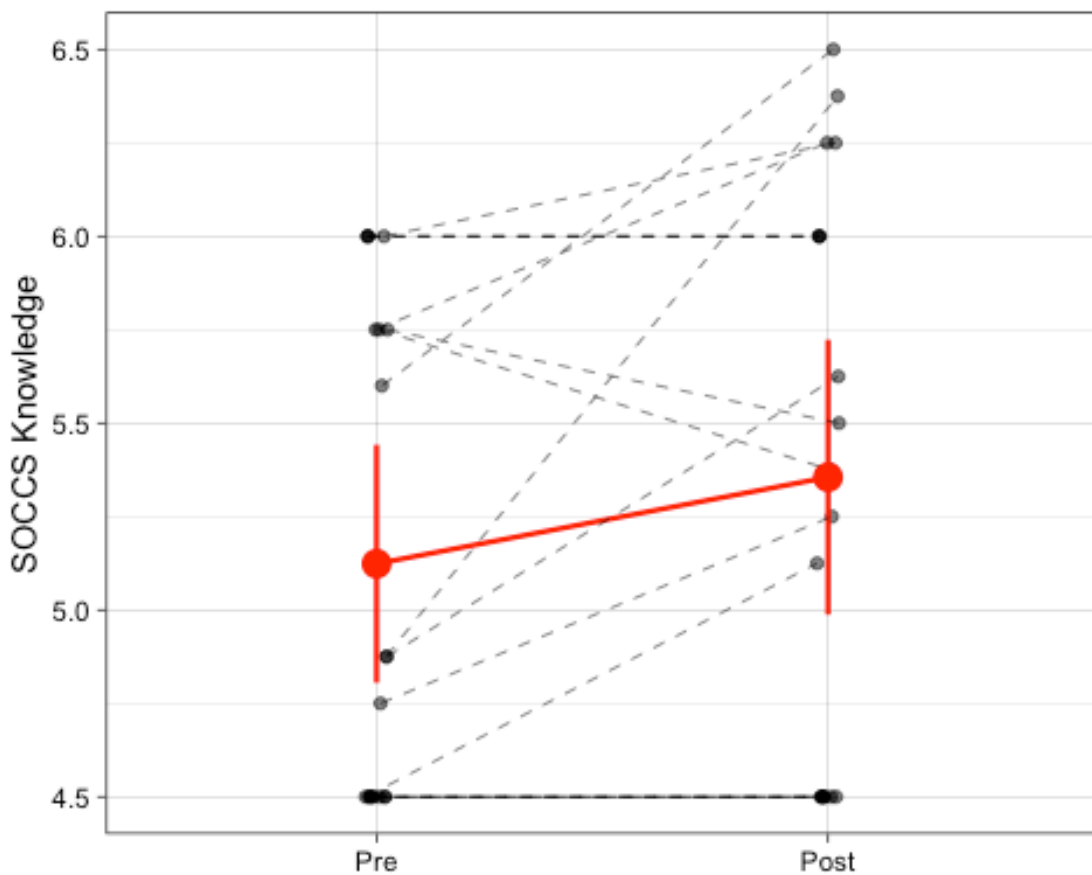
Table 7

Descriptive statistics for Knowledge scores, as measured by SOCCS (N=18)

SOCCS	*N*	*M*	*SD*	Range
Pre Knowledge	19	5.12	0.66	4.50 - 6.00
Post Knowledge	18	5.36	0.76	4.50 - 6.50

Note. Pre = before the summer training, Post = at the end of the year

Comparing Pre and Post scores on LGBTQ+ DOCSS Scale

Total Scores on **LGBTQ+ DOCSS**

Results indicated a significant difference in pre training and the end of the year total DOCCS scores in Graduate Student Therapists (N=32), such that there was a large increase in post total scores (*M* = 5.55, *SD* = 0.61, range = 3.89 - 6.70) compared to pre-total scores (*M* = 4.98, *SD* = 0.50, range = 4.00 - 5.78), $t(18)$=5.31, $p < 0.001$ (see Table 8).

This difference represents a large effect size (Hedges' g = 1.25). We can be 95% confident that the true difference between scores in these two groups is between 0.63 and 1.86. Internal consistency reliability was found to be acceptable for responses on this measure (Chronbach's α = .83).

Figure 6

DOCSS Total Score from Pre to Post (N=19)
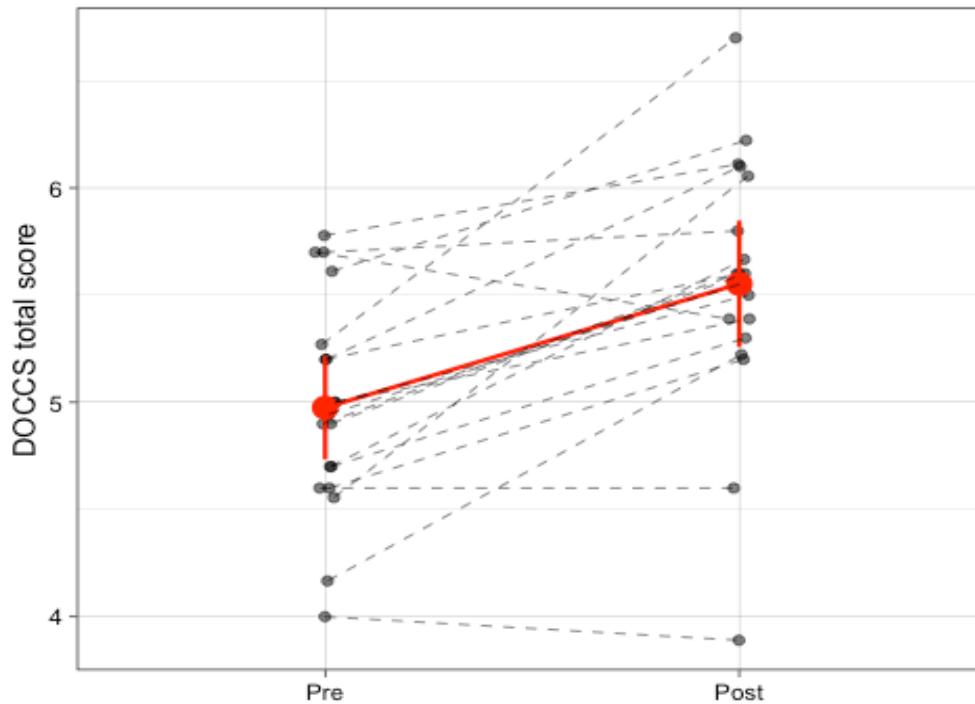
Table 8

Descriptive statistics for Knowledge scores, as measured by DOCCS (N=19)

DOCCS	N	M	SD	Range
Pre Total	19	4.98	0.50	4.00 - 5.78
Post Total	18	5.55	0.61	3.89 - 6.70

Note. Pre = before the summer training, Post = at the end of the academic year

Preparedness Subscale of the DOCCS

Results indicated a significant difference in skills before and after the in Graduate Student Therapists (N=32), such that there was a large increase in post Preparedness scores (M = 3.66, SD = 1.15, range = 1.30 - 6.40) compared to pre-Preparedness scores (M = 2.71, SD = 0.93, range = 1.29 - 4.40), $t(18)$=4.27, p < 0.001 (see Table 9).

This difference represents a large effect size (Hedges' $g = 1.01$). We can be 95% confident that the true difference between scores in these two groups is between 0.43 and 1.56. Internal consistency reliability was found to be acceptable for responses on this measure (Chronbach's $\alpha = .85$).

Figure 7

DOCSS Preparedness Score from Pre to Post (N=19)
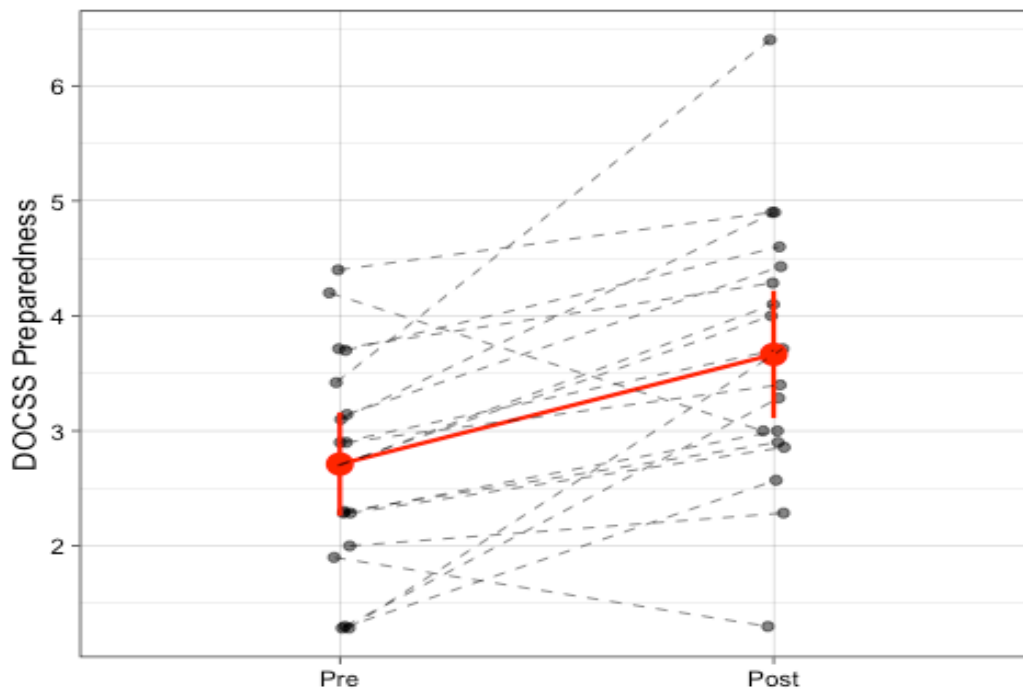
Table 9

Descriptive statistics for Preparedness scores, as measured by DOCCS (N=19)

DOCCS	N	M	SD	Range
Pre Preparedness	19	2.71	0.93	1.29 - 4.40
Post Preparedness	18	3.66	1.15	1.30 - 6.40

Note. Pre = before the summer training, Post = at the end of the year

Attitudes Subscale of the DOCCS

This difference represents a medium effect size (Hedges' g = .48). We can be 95% confident that the true difference between scores in these two groups is between -0.01 and 0.96. Internal consistency reliability was found to be acceptable for responses on this measure (Chronbach's α = .52).

Results indicated no significant difference in pre training attitudes and the end of the year attitudes in Graduate Student Therapists (N=32), such that there was no change in post Attitudes scores (*M* = 6.93, *SD* = 0.10, range = 6.70 - 7.00) compared to pre-Attitudes scores (*M* = 6.77, *SD* = 0.35, range = 5.70 - 7.00), *t*(18)=2.04, *p* = 0.056 (see Table 10).

Figure 8

DOCSS Attitudes Score from Pre to Post (N=19)
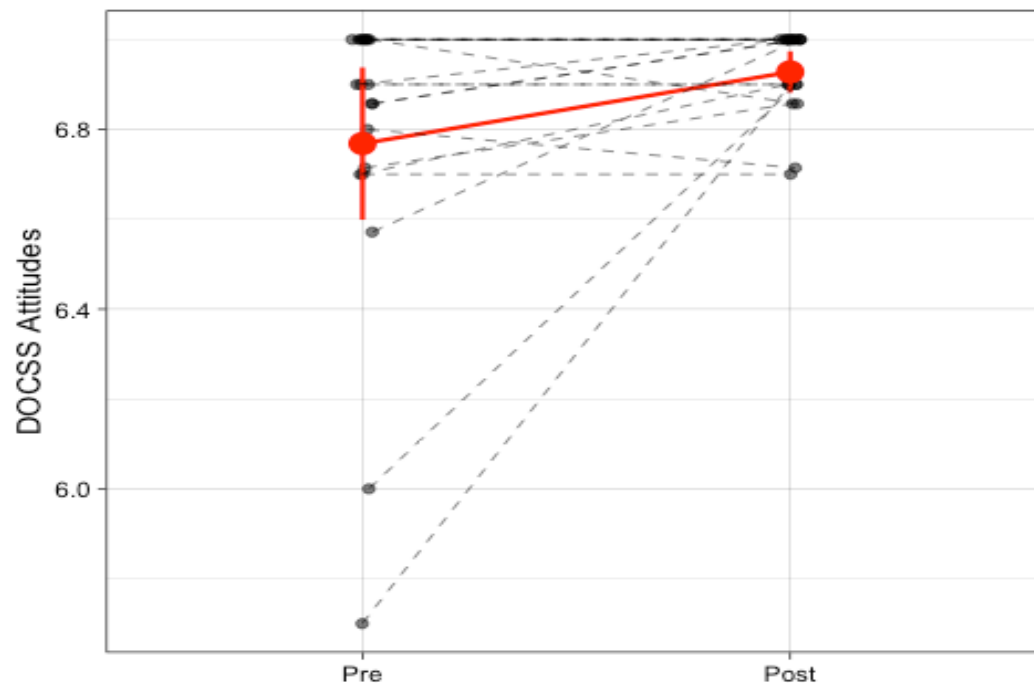
Table 10

Descriptive statistics for Attitudes scores, as measured by DOCCS (N=19)

DOCCS	N	M	SD	Range
Pre Attitudes	19	6.77	0.35	5.70 - 7.00
Post Attitudes	18	6.93	0.10	6.70 - 7.00

Note. Pre = before the summer training, Post = at the end of the year

Knowledge Subscale of the DOCCS

Results revealed a significant difference in pre training and the end of the year Knowledge scores for Graduate Student Therapists (N=32), such that there was a large increase in post Knowledge scores ($M = 6.29$, $SD = 0.61$, range = 5.00 - 7.00) compared to pre-Knowledge scores ($M = 5.54$, $SD = 0.91$, range = 3.50 - 7.00), $t(18)=5.62$, $p < 0.001$ (see Table 11).

This difference represents a large effect size (Hedges' $g = 1.33$). We can be 95% confident that the true difference between scores in these two groups is between 0.68 and 1.95. Internal consistency reliability was found to be acceptable for responses on this measure (Chronbach's $\alpha = .69$).

Figure 9

DOCSS Knowledge Score from Pre to Post (N=19)
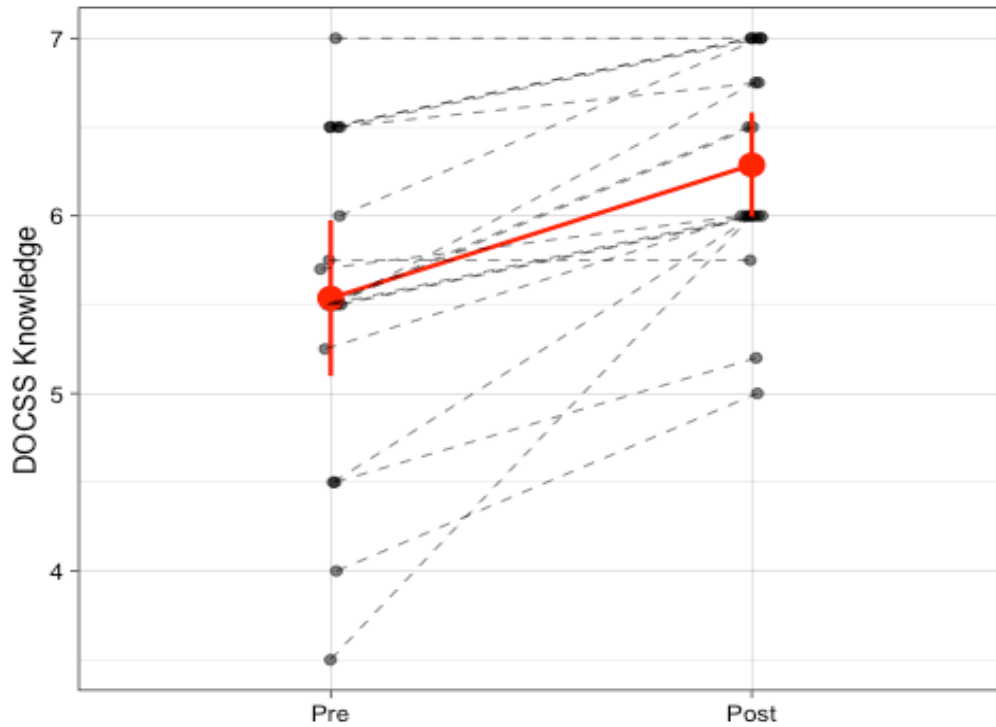
Table 11

Descriptive statistics for Knowledge scores, as measured by DOCCS (N=19)

DOCCS	N	M	SD	Range
Pre Knowledge	19	5.54	0.91	3.50 - 7.00
Post Knowledge	18	6.29	0.61	5.00 - 7.00

Note. Pre = before the summer training, Post = at the end of the year

Comparing Pre and Post scores on The Gender Expression Attitudes Scale (GEATS)

Factor 1. Emphasis on Assigned Sex Expression

Results revealed no significant differences in pre-training and the end of the year beliefs about the efficacy and validity of reparative/conversion like therapy for Graduate Student Therapists (N=32). However, it is noteworthy that the overall trend was a decrease in most people that is indicative of rejection of emphasis on assigned sex expression $t(18)=1.06$, $p = 0.304$ (see Table 12).

This difference represents a small effect size (Hedges' $g = 0.25$). We can be 95% confident that the true difference between scores in these two groups is between -0.71 and 0.22.

Factor 2. Affirmation of Gender Expression in All Forms

Results revealed no significant differences in pre-training and the end of the year affirmation of gender expressions in Graduate Student Therapists (N=32). However, it is noteworthy that the overall trend was an increase in most people in their post assessment compared to pre-scores. That is indicative of increased affirmation of gender expression in all forms, $t(18)=1.3$, $p = 0.210$ (see Table 12).

This difference represents a small effect size (Hedges' $g = 0.31$). We can be 95% confident that the true difference between scores in these two groups is between -0.17 and 0.78.

Factor 3. Generalized Emphasis on Gender Binary Expression

Results revealed no significant differences in pre-training and the end of the year beliefs about the importance of binary expression in Graduate Student Therapists (N=32). However, it is noteworthy that the overall trend was a decrease in most people that is indicative of rejection of emphasis of gender binary, $t(18)=.063$, $p = 0.537$ (see Table 12).

This difference represents a small effect size (Hedges' $g = 0.15$). We can be 95% confident that the true difference between scores in these two groups is between -0.61 and 0.32.

Table 12

Descriptive statistics for scores on the Gender Expression Attitudes Scale (N=29)

Factor	N	M	SD	Range
[a]Pre Factor1	19	10.53	2.61	9.00 - 18.00
Post Factor1	19	10.00	1.63	9.00 - 14.00
[b]Pre Factor2	19	27.42	3.11	21.00 - 30.00
Post Factor2	19	28.32	2.58	22.00 - 30.00
[c]Pre Factor3	19	12.37	5.36	5.00 - 29.00
Post Factor3	19	11.42	4.36	9.00 - 27.00

Note. [a]Factor 1 - Emphasis on Assigned Sex Expression; [b]Factor 2 - Affirmation of Gender Expression in All Forms; [c]Factor 3 - Generalized Emphasis on Gender Binary Expression

Figure 10

Facet Plot GEATS Factor 1,2, and 3 from Pre to Post scores (N=19)
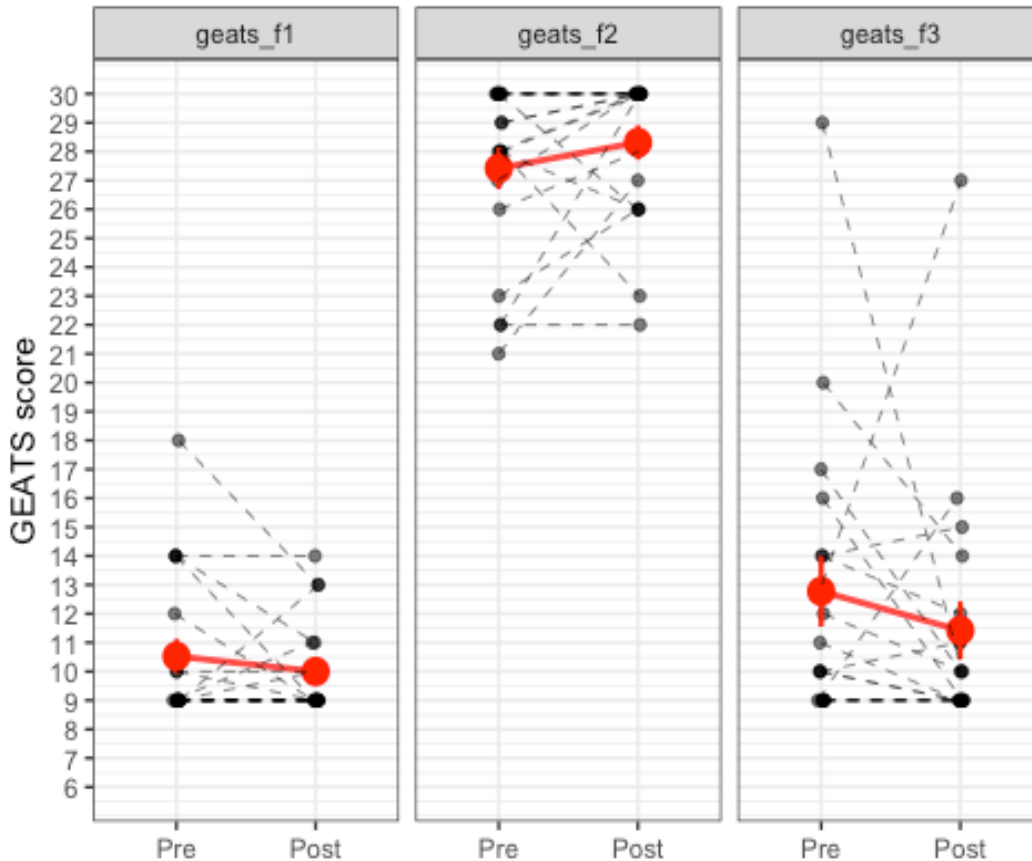
Research Question 2.

      A repeated two-way ANOVA was utilized to address the second research question whether more clinical hours with LGBTQ+ clients (low under 20 hours, moderate 20-40 hours, and high above 40 hours) result in increased multicultural competency as measured by self-reported skills, knowledge, and attitudes. Results revealed no significant interaction in pre and post skills, attitudes, and knowledge and how many clinical hours GSTs had in neither SOCCS, DOCCS or GEATS. The significant differences in total pre and post scores and pre and post skills and knowledge scores were not dependent on the number of clinical hours.

Table 13

Descriptive statistics for low, moderate, and high clinical hours groups (N=32)

Hours Group	*M*	*SD*	Min	Q25	Median	Q75	Max
low (n = 8)	11.75	3.99	6	8.75	11.5	15	18
moderate (n =8)	33.87	4.65	23	32.50	36.0	37	38
high (n = 16)	56.87	14.84	41	48.75	52.5	58	102

Type II Analysis of Variance for SOCCS

The results of the two-way repeated measures ANOVA revealed that there was a significant main effect of time (changes in pre and post scores) $F(1, 15.5) =14.6$, $p > .001$. Participants' total score improved from the beginning of the year (mean=5.48) to the end of the year (mean=5.64).

Post-hoc analysis with Tukey adjustment found that reported higher levels of total competency after training, *Mdiff = 0.315, SE = .1, t(15.7) = 3.14, p = .006.*

Results indicated no main effect for hours $F(2,16.9) = 0.80$, $p = 0.44$ and no significant interaction between clinical hours and time $F(2, 15.6) = 0.58$, $p = .057$ such that GST improved their scores regardless of their clinical exposure (see Table 14).

Figure 11

SOCCS Total Scores from Pre to Post by Hour interaction (N=32)
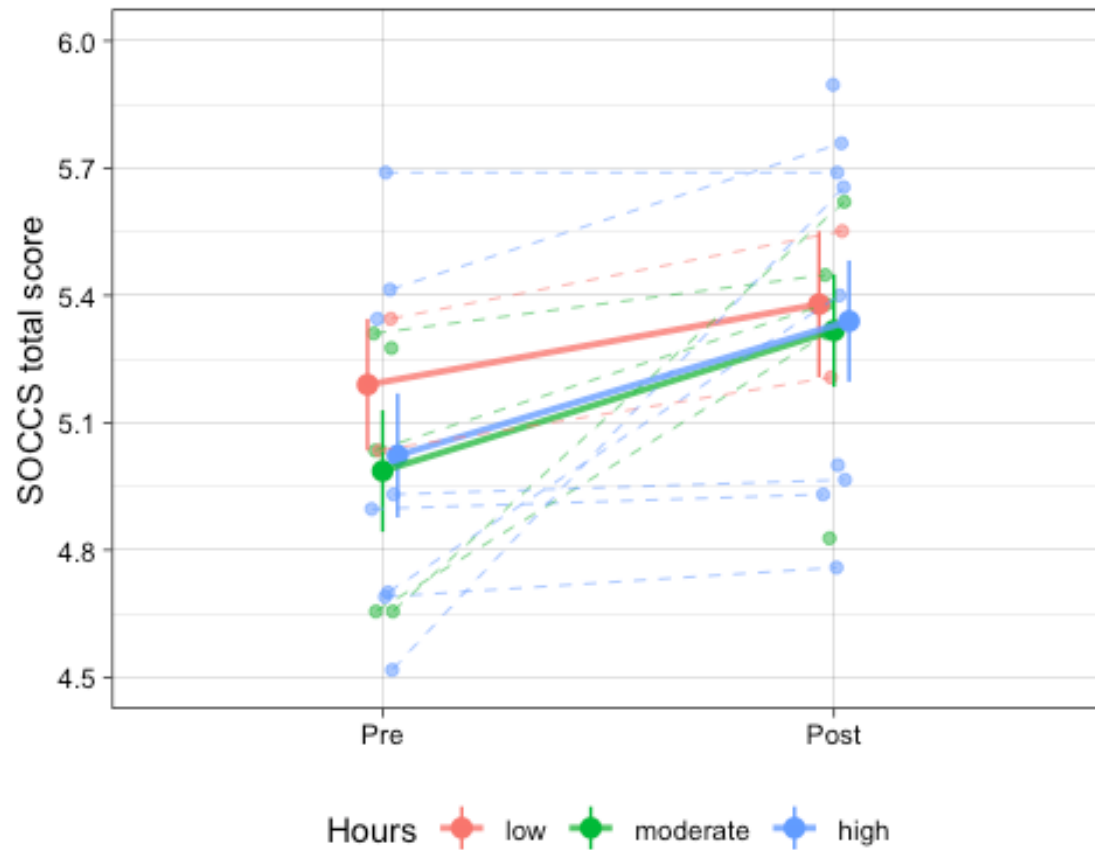
Table 14

 A repeated two-way ANOVA for SOCCS Total scores (N=32)

SOCCS Total	df	Mean Square	F	*p*
Time (Pre/Post)	1	0.99	14.6	0.001
Hours	2	0.05	0.84	0.44
Time X Hours	2	0.04	0.58	0.56

More specifically GSTs skills $F(1,15.7) = 4.6$, $p = 0.4$ and knowledge $F(1,15.4) = 4.5$, $p = 0.44$ have improved from the beginning of the year to the end of the year regardless of the clinical exposure (see Table 15 and 16). The results of the two-way repeated measures ANOVA revealed that there was no significant main effect for attitude in neither pre-post measures $F(1, 16.0) = 0.26$, $p = 0.6$ nor when interacting with clinical hours $F(2, 16.2) = 0.33$, $p = 0.72$ (see Table 17).

Table 15

A repeated two-way ANOVA for SOCCS Skills scores (N=32)

SOCCS Skills	df	Mean Square	F	*p*
Time (Pre/Post)	1	1.16	4.65	0.04
Hours	2	0.08	0.34	0.71
Time X Hours	2	0.11	0.45	0.64

Table 16

A repeated two-way ANOVA for SOCCS Knowledge scores (N=32)

SOCCS Knowledge	df	Mean Square	F	*p*
Time (Pre/Post)	1	0.513	4.56	0.04
Hours	2	0.166	1.47	0.25

	2	0.70	0.62	0.54
Time X Hours				

Table 17

A repeated two-way ANOVA for SOCCS Attitudes scores (N=32)

SOCCS Attitude	df	Mean Square	F	*p*
Time (Pre/Post)	1	0.002	0.26	0.61
Hours	2	0.01	0.69	0.51
Time X Hours	2	0.002	0.33	0.72

Type II Analysis of Variance for DOCCS

The results of the two-way repeated measures ANOVA revealed that there was a significant main effect of time (changes in pre and post scores) $F(1, 16) = 25.1$, $p < .001$. Participants' total score improved from the beginning of the year to the end of the year (see Table 18).

Results indicated no main effect for hours $F(2, 16) = 0.06$, $p = 0.9$ and no significant interaction between clinical hours and time $F(2, 16) = 0.04$, $p = .9$ such that GSTs improved their scores regardless of their clinical exposure (see Table 18).

Post-hoc analysis with Tukey adjustment found that reported higher levels of total competency after training, *Mdiff = 0.59, SE = .13, t(16) = 4.35, p = .0005.*

Table 18

A repeated two-way ANOVA for DOCCS Total scores (N=32)

DOCCS Total	df	Mean Square	F	*p*
Time (Pre/Post)	1	3.17	25.1	0.0001
Hours	2	0.008	0.06	0.9
Time X Hours	2	0.005	0.04	0.9

Figure 12

DOCCS Total Scores from Pre to Post by Hour interaction (N=32)
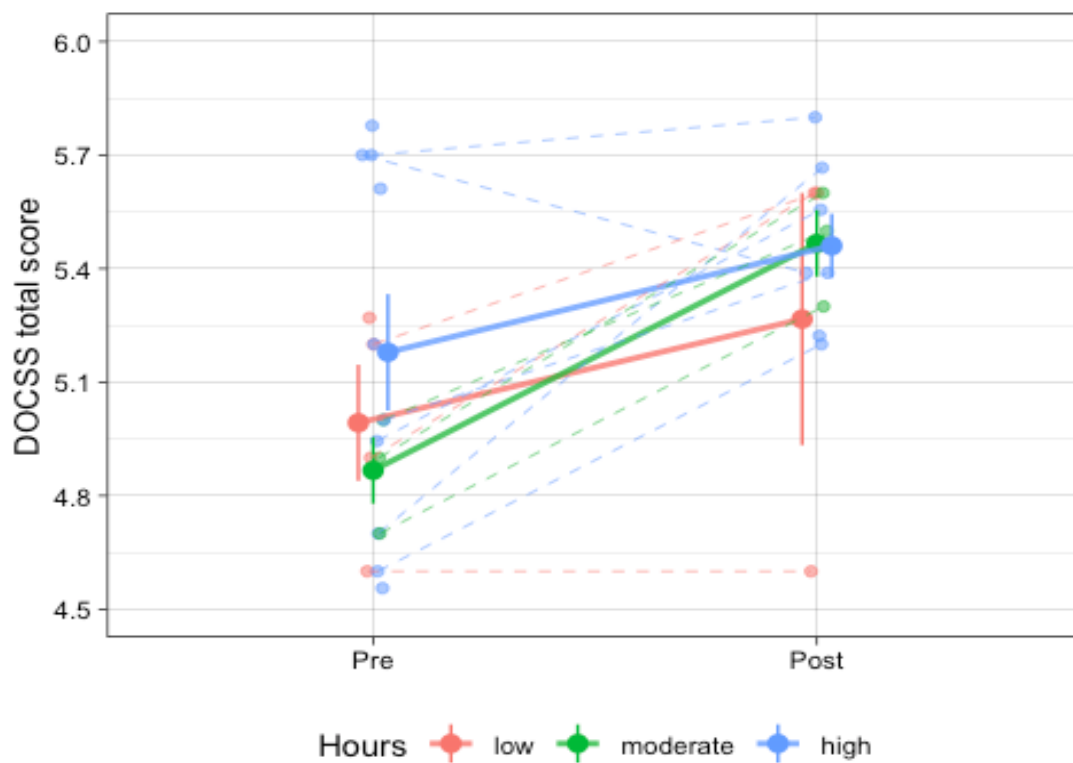
More specifically GSTs skills ($F(1,16) = 16.8$, $p < 0.001$) and knowledge ($F(1,16) = 28.3$, $p < 0.001$) have improved from the beginning of the year to the end of the year regardless of the clinical exposure. The results of the two-way repeated measures ANOVA revealed that there was no significant main effect for attitude in neither pre-post measures $F(1, 16.0) = 4.2$, $p = 0.06$ nor when interacting with clinical hours $F(2, 16) = 1.3$, $p = 0.3$.

Figure 13

All DOCSS Scores from Pre to Post by Hour interaction (N=32) Facet Plot
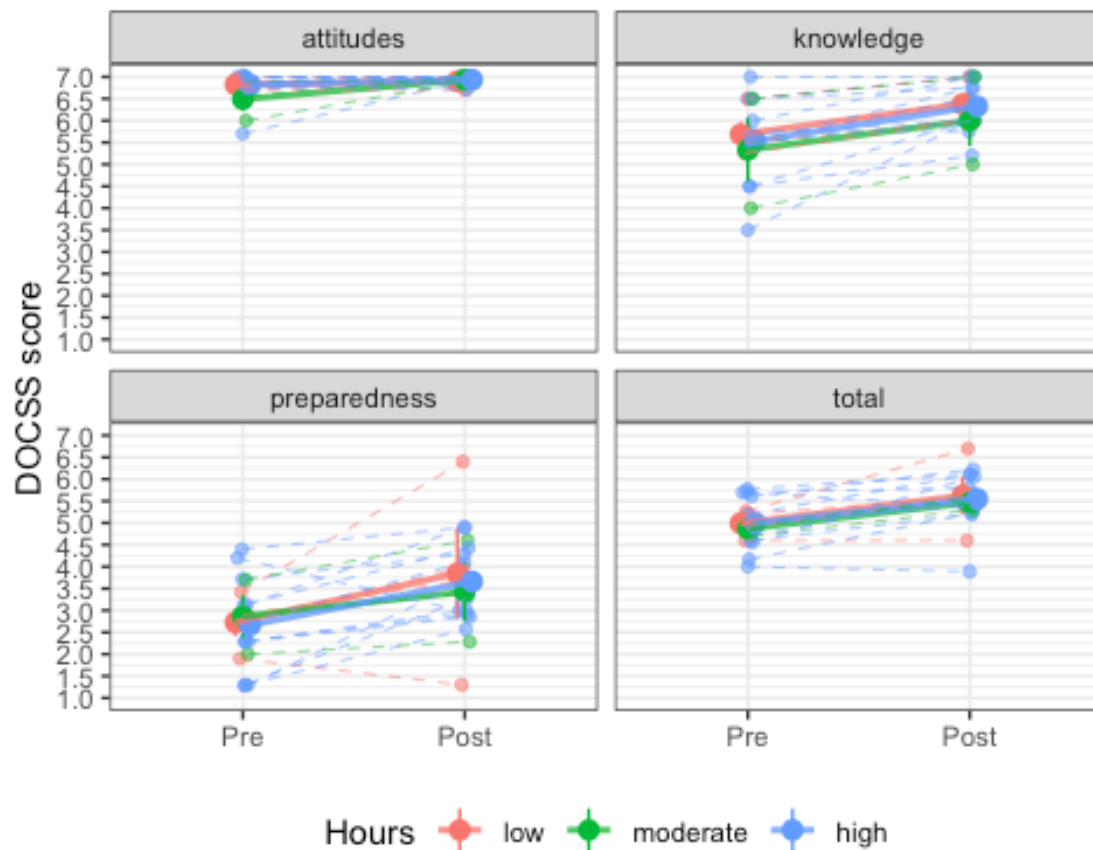
Type II Analysis of Variance for GEATS

The results of the two-way repeated measures ANOVA revealed that there was no significant main effect of time (changes in pre and post scores) $F(1, 16) = 25.1$, $p < .001$. and no

significant interaction between clinical hours and GSTs gender essentialism and gender

immutability (see Table 19).

Table 19

A repeated two-way ANOVA for GEATS (N=32)

GEATS	df	Mean Square	F	*p*
Factor 1 Time (Pre/Post)	1	2.63	1.4	0.24
Hours	2	3.8	2.06	0.15
Time X Hours	2	6.4	3.4	0.06

GEATS	df	Mean Square	F	*p*
Factor 2 Time (Pre/Post)	1	7.6	1.7	0.2
Hours	2	10.3	2.4	0.12
Time X Hours	2	6.3	1.5	0.25

GEATS	df	Mean Square	F	*p*
Factor 3	1	8.5	0.35	0.5

Time (Pre/Post)				
Hours	2	25.3	1.04	0.4
Time X Hours	2	0.5	0.02	0.9

Figure 14

All GEATS Scores from Pre to Post by Hour interaction (N=32) Facet Plot
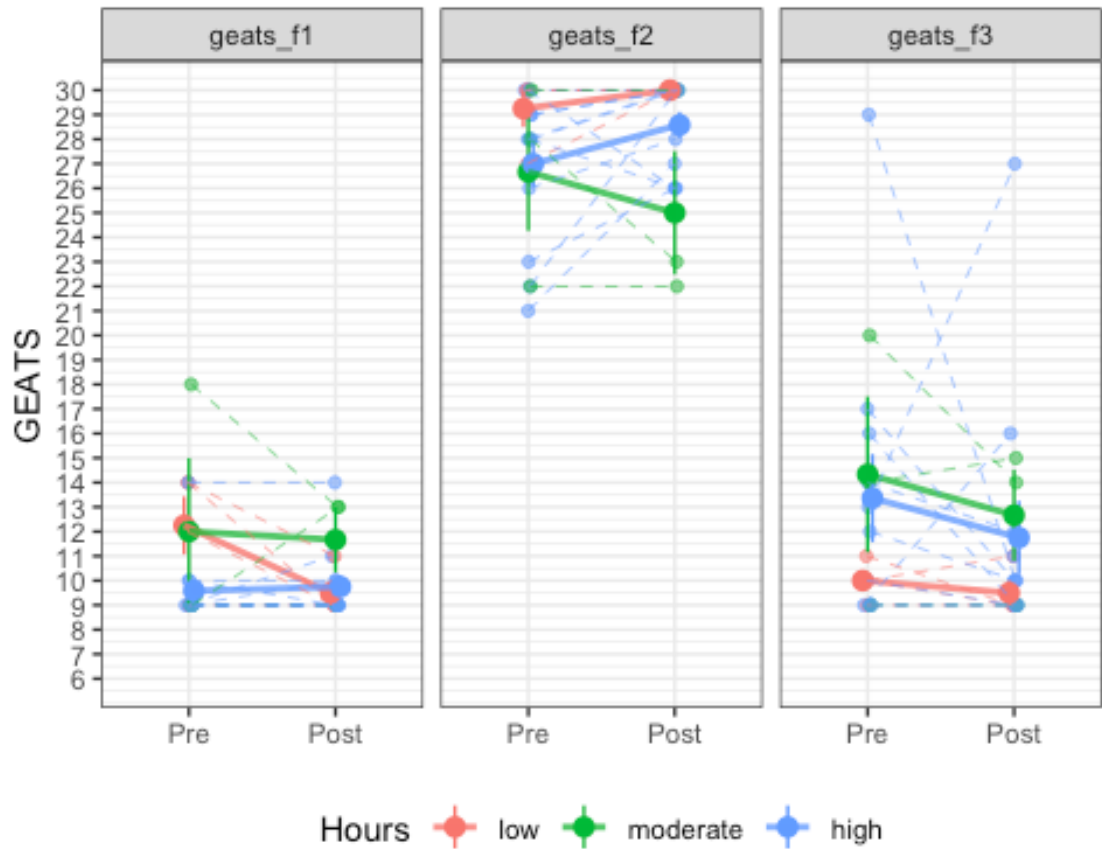
Research Question 3

 PHC experience questionnaires (N=15) were reviewed in order to identify common themes in relation to most and least helpful components of the PHC training model. The student experience was assessed in four domains: their reflections on initial training, experiences at the clinic and the usefulness of the training, their interest in continuing education and overall experience.

In the first portion, students shared their initial thoughts about completing the 20-hour self-directed training prior to the start in PHC and any changes that occurred throughout the year. They were asked to identify the most enjoyable and least enjoyable and helpful components of the training as well as were provided with an opportunity to suggest any changes to the training.

Most students report positive experiences with the training describing it as comprehensive ("*I felt the training was comprehensive and educational*", "*enriching and relevant*") However, despite the positive feedback the common theme of the training being overwhelming and tedious emerged *("I was eager to learn more about LGBTQ+ related issues, but somewhat discouraged by the amount of time the training would require", "The readings were a bit tedious. The webinars were also really long and often not very engaging", "the training being very data heavy, with not a lot of clinical significance", "I thought it was a daunting task, given that it would be 20 hours and a lot of readings. It felt like doing more mindless schoolwork and less about learning"*). Students found it difficult to motivate themselves to do a self-paced review of didactic material during the summer *("Twenty hours was difficult to accurately appreciate before actually beginning the training, and while I found having the entire summer to complete it was of course more than ample time, the self-directed nature of it required discipline and dedication to complete, especially when the time period when*

it is to be done (summer after first year) consists of free time sandwiched between two years of nonstop academic demands. That being said, I think completing the training within that period of time has the peripheral benefit of ensuring that those who complete it are demonstrating serious dedication to learning about and working with the LGBTQ+ community"). Some other comments included the information being dry and dense, which results in the disengagement from the material. Another roadblock to effective learning was difficulty making the information relevant to the new clinicians who reported being worried about seeing patients for the first time. They expressed a desire for more clinical material to be included in the didactic material. Folks who already had some clinical experience described the training as a more of a refresher rather than an in-depth overview of their area of interest.

Although, students uniformly agreed on the importance of covering general information about LGBTQ+ individuals such as health and mental health statistics, they expressed interest in the training being more experiential and clinically relevant. Some students found information to be repetitive and missing some of the important information for example on polyamory and asexuality. In terms of the delivery of the training, the majority of the students expressed a wish to have a training in person or a hybrid training rather than a self-paced review during the summer ("*In person is probably a more effective way of learning, but the logistics are obviously difficult", "I personally prefer more face-to-face training seminars. However, I think that due to the timing (since it was in the summer), it made the most sense to have the self-directed training session. Moving forward, I think it would make sense to shorten the self-directed training and add in a face-to-face training session"*). Some students reported enjoying reflection responses at the end of each module, yet the majority stated that they would appreciate the opportunity to process the information in a group setting for better understanding and retention. In addition,

some students felt that their reflection questions were repetitive and not tailored to a specific

module, which made it difficult for them to engage critically with the material. Students enjoyed

when the dense information was provided in graphs and diagrams rather than lengthy articles.

Although, almost uniformly, students favored webinars and personal stories of LGBTQ+ folks,

they expressed that some of the videos are too lengthy and difficult to watch *("The webinars*

were probably most efficiently balanced with the density, accessibility, and breadth of

information. Again, while it may be helpful for nuanced understandings and questions, the

question-and-answer segments at the end of the webinars was not conducive to my particular

learning style", "I most enjoyed the webinar videos which were in most of the sections. I least

enjoyed the question-and-answer segments at the end of them", "Certain shorter videos were

okay. The hour-long video on Social Determinants of Health or something like that was so

boring and felt like a waste of time. There was another video put together by graduate students I

think that was also long and incredibly boring").

As students reflected on the usefulness of the training during their clinical year, they

unanimously agreed that peer consultation and supervision were the most helpful part of their

training *("PHC peer consultation was a highlight of my time at the PSC. Talking about cases*

and receiving peer support was an incredible experience", "The team meeting was a highlight of

my experience at the PSC. Being surrounded by passionate brilliant clinicians who are

committed to providing affirming therapy was an inspiration", "I found the team meeting to be a

great opportunity to process and discuss difficult client interactions, as well as positive client

dynamics, with peers and the PHC leader", "I found it very enriching to my overall experience

at the PSC to attend these meetings. It was invaluable to hear about my peers' experience with

clients, the challenges they faced, and their insights into one another's cases"). Students

appreciated the opportunity to discuss their cases, process difficult interactions with peers and receive feedback and support. Some students spoke about the dilemma of wanting to be a part of continuing education lessons but not wanting to give up their peer consultation time. The majority of students spoke about the importance of good supervision. In the last section dedicated to continuing education, participants emphasized that they are interested in ongoing learning and stressed the need for supervision and more classes to get to that goal.

As students reflected on their overall experience, most of them expressed interest in working with marginalized communities and that the experience was fulfilling because they were given specialized training to do so. Based on the responses, all of the participants who entered the training had a strong commitment to provide high quality care to vulnerable populations and unlearn their implicit and explicit biases to reduce heteronormativity and increase their competence.

In summary it seems that the didactic portion has been helpful but overall, too dense for participants to truly enjoy or retain the material. Students preferred a hybrid model or some in person training component to process the information. That might explain why the ongoing peer consultation was favored unanimously by all participants. During the peer consultation participants were able to address their questions specific to their cases and make the information learned during the training more relevant.

Discussion

To address the first research question, pre and post scores on skills, attitudes, and knowledge as measured by SOCCS and DOCCS, and pre and post scores on range of gender immutability and essentialism as measured by GEATS were assessed across a sample of 32 doctoral psychology student therapists at Long Island University Post. To address the second

research question, changes in LGBTQ+ competency (skills, attitudes, and knowledge) were assessed in relation to clinical hours of the sample of GSTs. To address the third research question, a narrative summary of self-reported data was developed.

It was hypothesized that the PHC training would have a significant impact on GSTs's perceived skills, attitudes, and knowledge of LGBTQ+ psychology. The results revealed significant increases in self-reported skills and knowledge between pre-test and post-test as a result of the cultural competency training that includes information about minority stress, unique barriers, and mental health needs of the LGBTQ+ population. The finding is consistent with previous studies (Alvarez and Rodríguez, 2020; Benuto et al., 2019; Lie et al., 2011) indicating that additional training in affirmative LGBTQ+ psychotherapy results in increased counselors' competency. More specifically, GSTs's self-reported skills and knowledge have improved after receiving a specialized training that included didactic and experiential components about how to provide psychological services to the LGBTQ+ population. There were no significant changes in GSTs perceived pre-and post-training attitudes. GSTs started the PHC training with favorable self-reported attitudes towards LGBTQ+ individuals ranking themselves high on the attitude scale and that positive appraisal stayed consistent throughout the year.

The findings also did not reveal significant changes in gender essentialism or gender immutability. GSTs started the training year with high acceptance of all gender expressions and low acceptance of binary constructs. This trend remained the same throughout the year.

It was hypothesized that self-reported clinicians' skills, attitudes, and knowledge will be enhanced with more therapeutic contact with LGBTQ+ clients as well as supervision hours devoted to those clients. The finding did not reveal any significant changes in counselor's perceived competency when assessing their clinical hours. In other words, GSTs self-reported

skills and knowledge had improved regardless of their clinical exposure with LGBTQ+ clients. It is important to note that due to organizational limitations there was an uneven flow of patient referrals to GSTs, which created an unequal distribution of clinical hours amongst student therapists. Despite the existing limitations, clinical exposure did not impact GSTs self-reported competency. The review of the PHC experience questionnaires shed some light on the reason why the hypothesis that competency is improved with clinical exposure was not supported. Most GSTs commented that they found peer supervision that covered case discussions and conceptualization to be the most helpful training component. In other words, all student therapists despite their clinical hours were exposed to the same vicarious learning that could have potentially improved their skills and knowledge.

The present dissertation echoes past studies that have advocated for the use of affirmative training as a way to increase counselors' competency when working with LGBTQ+ individuals. There is mounting evidence that LGBTQ+ folks are in a dire need of high-quality psychological services and are at loss with the dearth of available resources. As mentioned above, queer individuals are more likely to trust providers who are confident in their skill set and competent in the affirmative care provision, whose language is free of heteronormative bias and who take an active anti-oppressive stance in their work. The collaboration between client and therapist starts with this trust and results in improved mental health outcomes, which is ultimately the goal of providing affirmative care training to counselors.

Limitations

The present study contains several limitations that need to be considered when interpreting the results. First, although the PHC has grown in the past five years with its continued emphasis on high quality care and strong affirmative training for graduate student

therapists, it is still a relatively new program that is in the process of figuring out the best way to not only increase clinician's competency but also how best to assess this. In the first two years of training only one measure was administered (SOCCS) before and after the summer training. The following year, GSTs were asked to complete measures at the end of the year and only during the fourth- and fifth-year students were asked to complete measures before and after the training as well as additional measures such as DOCCS and GEATS. The fluctuations in administered assessments were a result of the PHC team working on finding the best way to measure the training effectiveness. As a result, this study's limitation is that the data collected from all the cohorts was somewhat sparse and inconsistent.

Another limitation that stems from the aforementioned challenges is the small sample size. It would be useful to assess the impact of changing curriculum in-between cohorts but unfortunately due to a small group size it was not feasible.

Lastly, all the participants self-selected to be a part of the PHC clinic to learn how to provide affirmative services to LGBTQ+ individuals. It is assumed that clinicians who generally hold more positive attitudes towards LGBTQ+ people are more likely to be interested and engaged in this type of training. From the data it is evident that positive attitudes towards queer individuals were ranked initially high and remained high throughout the entire year. It is possible that social desirability bias was a contributing factor for some GSTs and it would be helpful to discern a change in actual and perceived attitudes as well as to assess change in clinicians who held more negative attitudes to begin with. In this study GSTs who received the PHC training were not compared to a control group, which leaves a question about other compounding variables that might have impacted the change in skills and knowledge such as being in a graduate program, exposure to diverse clients and rigorous academic workload.

Recommendations

The present dissertation highlights the importance of affirmative psychological training for clinicians who work with LGBTQ+ individuals. It is evident that therapists felt more knowledgeable and confident in their work with sexual and gender diverse individuals after receiving a formal training.

G power analyses revealed that the study was underpowered. It was challenging to obtain a larger sample due to several reasons such as novelty of the PHC program (only fifty GSTs have been trained in the past five years) and logistical issues (thirty-two GSTs consented to participate in the study but some of the collected data was incomplete). The future studies need to focus on increasing the sample in order to obtain significant and meaningful results.

The future research could benefit from focusing on measuring attitudes amongst clinicians by adding a comparison group of folks who chose not to participate in the affirmative training. This will help address discrepancies in potential changes in the attitudes and find ways to improve them.

The results of this study add to the body of existing research by stating that didactic and experiential parts of affirmative training, in-person workshops that cover self-reflections, peer supervision, and case conceptualizations are the most helpful conduits of effective training. However, there is a need to continue to explore the format and mechanisms of positive changes in counselors' competencies. A majority of the studies are void of client voices which means we are missing the most invaluable viewpoints. Future research would benefit from adding a clients' perspective on their therapist's competency. In addition, it seems that incorporating LGBTQ+ affirmative training into a graduate school curriculum would be able to address some of the

concerns raised by clinicians of wanting to receive more formal ongoing training and supervision as well as allow for a more objective measure of cultural competence.

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Appendix A

LONG ISLAND UNIVERSITY/ POST Campus
Informed Consent Form for Human Research Subjects

You are being asked to volunteer in a research study called "Psychologists in Training: Developing LGBTQ+ Cultural Competence in Trainees" conducted by Anna (Anya) Shumilina, Doctoral candidate in Clinical Psychology. This project will be supervised by Dr. Eva Feindler, Clinical Supervisor and Professor at LIU Post. The purpose of the research is to evaluate the effectiveness of LGBTQ+ training at the subclinic Pride Healing Center dedicated to providing affirmative psychological services to children, adolescents, adults and their families.

As a participant, you will be asked to sign an informed consent allowing access to the preexisting data that you have submitted during your training year at the PHC. The data includes answers and scores on measures such Sexual Orientation Counselor Competency Scale (SOCCS), Measures of Attitudes Towards Lesbian, Gay, Bisexual, and Transgender Clients, LGBTQ+ knowledge assessment based on the assigned training modules, GST freeform self-reflections, LGBT DOCSS, The Gender Expression Attitudes Scale and Clinical Exposure. The time commitment will include only sending a signed consent and short demographic form back to principle investigator and this amounts to ten minutes. None of these procedures are experimental. While there is no direct benefit for your participation in the study, it is reasonable to expect that the results may provide information of value for the field of affirmative care and multicultural competency.

Your identity as a participant will remain confidential. Your name will not be included in any forms, questionnaires, etc. This consent form is the only document identifying you as a participant in this study. This will be stored securely in Google Drive, G Suite the platform is protected by TLS (Transport Layer Security) encryption and available only to the investigator. Data collected will be destroyed at the end of five years. Results will be reported only in the aggregate. If you are interested in seeing these results, you may contact the principal investigator.

If you have questions about the research you may contact the student investigator, Anya Shumilina, anna.shumilina@my.liu.edu, the faculty advisor Dr. Eva Feindler, eva.feindler@liu.edu. If you have questions concerning your rights as a subject, you may contact the Institutional Review Board Administrator Dr. Lacey Sischo at (516) 299-3591.

Your participation in this research is voluntary. Refusal to participate (or discontinue participation) will involve no penalty or loss of benefits to which you are otherwise entitled.

Please sign below of you have fully read the above text and have had the opportunity to ask questions about the purposes and procedures of this study. Your signature acknowledges receipt of a copy of the consent form as well as your willingness to participate.

_____

Typed/Printed Name of Participant

_____   _____
Signature of Participant   Date

_____
Typed/Printed Name of Investigator

_____   _____
Signature of Investigator   Date

Appendix B

Demographic Information for Graduate Student Therapists at Pride Healing Center:

Age:
Gender:
Sexual Orientation:
Race/Ethnicity:
Any other information about your identity that you'd like to share:

Appendix C

Dear former and current Graduate Student Therapists,

My name is Anya Shumilina and I am a fourth-year doctoral candidate in Clinical Psychology at LIU Post. I am reaching out to you because during your doctoral training at LIU Post you have dedicated yourself to learning and providing multicultural competent care to LGBTQ+ community and their families at Pride Healing Center. Similarly, to you I participated in a yearlong PHC training in my second year and served as a PHC Co-Director in my third year. My commitment and love for PHC and the community has inspired me to conduct research that aims to investigate the effectiveness of our training with the ultimate goal of improving the quality of care for clients receiving services at the PHC. I am turning to you with hopes to achieve this goal. You completed pre and post measures during your training year at the PHC and I am asking for your permission to use these data to examine how the PHC training impacts clinician's knowledge, skills and attitudes.

The participation in my research study is voluntary and includes signing an informed consent and completing a short demographic form. This won't take more than 10 minutes. I have attached an informed consent and the demographic form to this email.

Please do not hesitate to reach out to me if you have any questions.
Thank you for your time and consideration.

Anya Shumilina, LCSW, BCN, MA
Doctoral Candidate in Clinical Psychology
Anna.shumilina@my.liu.edu
(917) 690 3071

Appendix D

LGBT-DOCSS

Instructions: Items on this scale are intended to examine clinical preparedness, attitudes, and basic knowledge regarding lesbian, gay, bisexual, and transgender (LGBT) clients/patients. Please use the provided scale to rate your level of agreement or disagreement for each item. Please note, items on this scale primarily inquire about either sexual orientation (LGB = lesbian, gay, and bisexual) or gender identity (transgender). Two questions are inclusive and refer collectively to lesbian, gay, bisexual, and transgender (LGBT) clients/ patients. Circle the number that corresponds to your level of agreement or disagreement.

1. I am aware of institutional barriers that may inhibit transgender people from using health care services.

Strongly Disagree	Somewhat Agree/Disagree	Strongly Agree
1 2	3 4 5	6 7

2. I am aware of institutional barriers that may inhibit LGB people from using health services.

Strongly Disagree	Somewhat Agree/Disagree	Strongly Agree
1 2	3 4 5	6 7

3. I think being transgender is a mental disorder.

Strongly Disagree	Somewhat Agree/Disagree	Strongly Agree
1 2	3 4 5	6 7

4. I would feel unprepared talking with a LGBT client/patient about issues related to their sexual orientation or gender identity.

Strongly Disagree	Somewhat Agree/Disagree	Strongly Agree
1 2	3 4 5	6 7

5. A same sex relationship between two men or two women is not as strong and committed as one between a man and a woman.

Strongly Disagree	Somewhat Agree/Disagree	Strongly Agree
1 2	3 4 5	6 7

6. I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals.

Strongly Disagree	Somewhat Agree/Disagree	Strongly Agree
1 2	3 4 5	6 7

7. LGB individuals must be discreet about their sexual orientation around children.

        Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
        1   2   3   4   5   6   7

8. I am aware of research indicating that transgender individuals experience disproportionate levels of health and mental health problems compared to cisgender individuals.

        Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
        1   2   3   4   5   6   7

9. When it comes to transgender individuals, I believe they are morally deviant.

        Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
        1   2   3   4   5   6   7

10. I have received adequate clinical training and supervision to work with transgender clients/ patients.

        Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
        1   2   3   4   5   6   7

11. I have received adequate clinical training and supervision to work with lesbian, gay, and bisexual (LGB) clients/patients

        Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
        1   2   3   4   5   6   7

12. The lifestyle of a LGB individual is unnatural or immoral.

        Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
        1   2   3   4   5   6   7

13. I have experience working with LGB clients/patients.

        Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
        1   2   3   4   5   6   7

14. I feel competent to assess a person who is LGB in a therapeutic setting.

        Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
        1   2   3   4   5   6   7

15. I feel competent to assess a person who is transgender in a therapeutic setting.

Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
1   2   3   4   5   6   7

16. I have experience working with transgender clients/patients.

Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
1   2   3   4   5   6   7

17. People who dress opposite to their biological sex have a perversion.

Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
1   2   3   4   5   6   7

18. I would be morally uncomfortable working with a LGBT client/patient.

Strongly Disagree   Somewhat Agree/Disagree   Strongly Agree
1   2   3   4   5   6   7

BELOW FOR SCORING ONLY – DO NOT MARK

Subscale scores:
   Clinical Preparedness: _____
   Attitudes Scale: _____
   Knowledge: _____
   Total Score: _____

Scoring Instruction for the LGBT-DOCSS
1) Reverse score all 8 questions in parentheses: (3), (4), (5), (7), (9), (12), (17), and (18). Use the reverse scoring Likert scale (1 = 7, 2 = 6, 3 = 5, 4 = 4, 5 = 3, 6 = 2, 7 = 1).
2) Calculate total LGBT-DOCSS mean score: Add all test items (using the reverse score for items in parentheses) and divide by 18.
The total LGBT-DOCSS mean score is equal to: 1 + 2 + (3) + (4) + (5) + 6 + (7) + 8 + (9) + 10 + 11 + (12) + 13 + 14 + 15 + 16 + (17) + (18) = LGBT-DOCSS Total Raw Score. Divide by 18 to obtain mean score.
3) Calculate Subscale scores: For each subscale, add up the scores of the questions listed (using the reverse score for items in parentheses) and divide by the number of questions in each subscale.
Clinical Preparedness subscale: (4) + 10 + 11 + 13 + 14 + 15 + 16 = LGBT-DOCSS Clinical Preparedness subscale Total Raw Score. Divide by 7 to obtain mean score. **Attitudes subscale**:

(3) + (5) + (7) + (9) + (12) + (17) + (18) = LGBT-DOCSS Attitudes subscale Total Raw Score. Divide by 7 to obtain mean score. **Knowledge**: 1 + 2 + 6 + 8 = LGBT-DOCSS Knowledge subscale Total Raw Score. Divide by 4 to obtain mean score.

4) Higher scores are indicative of higher levels of clinical preparedness and rudimentary knowledge and less prejudicial attitudinal awareness regarding LGBT clients/patients. Scoring instructions are not initially provided to potential respondents and typically not provided to research participants.

Appendix E

Gender Expression Attitudes Towards Transgender Clients Scale (GEATCs)

This survey contains questions regarding your thoughts about counseling transgender clients. Transgender describes a person whose gender identity does not fully align with their sex assigned at birth. It may also describe a person whose gender expression or gender role differs from gender norms related to their assigned birth sex, regardless of gender identity. Gender identity refers to a person's deeply-felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, boygirl, ladyboi), which may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics (APA, 2015). **Please rate the following statements. Items are rated on a five-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree).**

Factor I – Emphasis on Assigned Sex Expression

1. Transgender clients should practice sitting the proper way for their assigned sex._____

2. I think it is critical for all transgender clients to participate in activities that are traditional for their assigned sex. _____

3. Transgender clients should practice walking the proper way for their assigned sex. ____

4. Transgender clients should always use pronouns associated with their assigned sex. _____

5. I should make sure that transgender clients emphasize an appearance that's consistent with their assigned sex. _____

6. Transgender clients should always speak in a way that's consistent with their assigned sex. ____

7. If a transgender client is undecided about transitioning to a different gender, I should encourage the client to remain in their assigned sex. _____

8. Transgender clients should talk to religious/spiritual leaders in order to identify with their assigned sex_____.

9. Transgender clients should avoid identifying with members of an opposite sex._____

Factor II – Affirmation of Gender Expression in All Forms

1. Some transgender clients benefit from choosing gender neutral pronouns._____

2. Some transgender clients benefit from not conforming to a male or female gender identity. _____

3. I think transgender clients should appear according to their own preferences (masculine, feminine, etc.), regardless of assigned sex or affirmed gender. _____

4. I should ensure that transgender clients speak according to their own preferences (masculine, feminine, etc.), regardless of their assigned sex or affirmed gender. _____

5. I should ensure that transgender clients walk according to their own preferences (masculine, feminine, etc.), regardless of their assigned sex or affirmed gender. _____

6. If a transgender client is undecided about transitioning to a different gender, I should encourage the client to take some more time to consider the options. _____

Factor III – Generalized Emphasis on Gender Binary Expression

1. All transgender clients should choose a male or female pronoun that is consistent with their affirmed gender. _____

2. All transgender clients should participate in activities that are traditional for their affirmed gender. _____

3. I think it is critical for all transgender clients to sit like members of their affirmed gender. _____

4. I think it is critical for all transgender clients to walk like members of their affirmed gender. _____

5. I think it is critical for all transgender clients to emphasize an appearance consistent with their affirmed gender. _____

6. I think it is critical for all transgender clients to speak in a way that's consistent with their affirmed gender. _____

7. All transgender clients were born in the wrong body. _____

8. If a transgender client is undecided about transitioning to a different gender, I should encourage the client to transition to his/her affirmed gender. _____

9. All transgender clients should come out to their friends and family quickly. _____

Appendix F

Thank you for taking the time to complete this questionnaire. Your responses will be used to inform the training and clinic experience for the next cohort. We greatly appreciate your constructive feedback, as it helps us to better create the training and continuing education experiences for the years ahead.

Initial Training
1. What were your initial thoughts about completing the 20-hour self-directed training prior to your start in PHC? Overwhelmed with so much info
2. Did your thoughts change throughout the course of the 20-hour training? Yes, it was super helpful and I enjoyed the content
3. What aspects of the 20-hour training did you most enjoy? Least enjoy? Videos, hearing from people from the lgbtq community first hand.
4. What aspects of the 20-hour training did you find most helpful? Least helpful? Sometimes was too much reading, was impacted more by hearing first hand
5. What did you think of the format of the training (i.e. webinars, articles, etc.)? good balance overall
6. Did you wish the training could have been delivered differently (i.e. in person, combo in person/self-directed, etc.)? I enjoyed it
7. Did you wish that other topics had been covered in the training? Hearing from a religious individual as part of the LGBTQ community

At the Clinic
1. Did you find your training useful? In what ways? Yes, helped me understand different issues that come up, different feelings and thoughts that people have, and some terminology that I was unaware of
2. Which modules from your training were most useful in your work with clients? Least useful? Learning about specific difficulties that people in the bisexual community face
3. Did you ever go back to your training for extra information/insight during your time with clients? Yes
4. When you had a question/concern about a PHC client where did you go for information/insight (i.e. training materials, Google, peer, PHC leader, etc.)? phc leader, training materials

Continuing Education
1. What was your experience with the team meeting? Did you find it useful? At times
2. What aspects of the team meeting were most helpful? Least helpful? Consulting about my clients ; at times hearing about others clients and brainstorming together
3. Do you wish you had more continuing education? If so, in what format? Yes, more content in PHC meetings rather than hearing from one person for a long time

Overall Experience
1. Why was it important for you to join the PHC? To learn about the community, be competent in treating LGBTQ community, and help give care to individuals who at times have a hard time getting culturally competent care

2. What were your experiences with PHC leadership? Do you have suggestions for how to change GST interactions with PHC leadership? They're the best! My PHC supervisor was not so helpful
3. What do you think you will take away from your time working with PHC clients? More aware of specific issues that go on in the community, feelings about the heterosexual community, how to give competent care
4. Do you feel your understanding of working with this community changed over time? If so, in what way? Yes!! I did not have much exposure to LGBTQ individuals before this.
5. How would you rate your overall experience working in the PHC? 10/10!
6. What suggestions would you make on how to change the PHC (i.e. training, continuing education, etc.) to be more useful to students/clients? PHC meetings having more content, some groups for this community
7. Is there something you wish PHC leadership could have done differently to make your experience more meaningful? No! Thank you!

Appendix G

S.O.C.C.S.

Instruction: Using the scale following each question, rate the truth of each item as it applies to you by circling the appropriate number. It is important to answer all questions and provide the most candid response, often your first one. LGB = Lesbian, Gay, and Bisexual.

1. I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

2. The lifestyle of a LGB client is unnatural or immoral.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

3. I check up on my LGB counseling skills by monitoring my functioning/competency – via consultation, supervision, and continuing education.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

4. I have experience counseling gay male clients.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

5. LGB clients receive less preferred forms of counseling treatment than heterosexual clients.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

6. At this point in my professional development, I feel competent, skilled, and qualified to counsel LGB clients.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

7. I have experience counseling lesbian or gay couples.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

8. I have experience counseling lesbian clients.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

9. I am aware some research indicates that LGB clients are more likely to be diagnosed with mental illnesses than are heterosexual clients.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

10. It's obvious that a same sex relationship between two men or two women is not as strong or as committed as one between a man and a woman.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

11. I believe that being highly discreet about their sexual orientation is a trait that LGB clients should work towards.

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

12. I have been to in-services, conference sessions, or workshops, which focused on LGB issues (in Counseling, Psychology, Mental Health).

Not at all True			*Somewhat True*			*Totally True*
1	*2*	*3*	*4*	*5*	*6*	*7*

S.O.C.C.S.

13. Heterosexist and prejudicial concepts have permeated the mental health professions.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

14. I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

15. I believe that LGB couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine normal and traditional family values.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

16. There are different psychological/social issues impacting gay men versus lesbian women.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

17. It would be best if my clients viewed a heterosexual lifestyle as ideal.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

18. I have experience counseling bisexual (male or female) clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

19. I am aware of institutional barriers that may inhibit LGB people from using mental health services.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

20. I am aware that counselors frequently impose their values concerning sexuality upon LGB clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

21. I think that my clients should accept some degree of conformity to traditional sexual values.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

22. Currently, I do not have the skills or training to do a case presentation or consultation if my client were LGB.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

23. I believe that LGB clients will benefit most from counseling with a heterosexual counselor who endorses conventional values and norms.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

24. Being born a heterosexual person in this society carries with it certain advantages.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

25. I feel that sexual orientation differences between counselor and client may serve as an initial barrier to effective counseling of LGB individuals.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

S.O.C.C.S.

26. I have done a counseling role-play as either the client or counselor involving a LGB issue.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

27. Personally, I think homosexuality is a mental disorder or a sin and can be treated through counseling or spiritual help.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

28. I believe that all LGB clients must be discreet about their sexual orientation around children.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

29. When it comes to homosexuality, I agree with the statement: 'You should love the sinner but hate or condemn the sin'.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

Thank you for completing he S.O.C.C.S©
Markus P. Bidell, Ph.D.