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MEASURING MULTICULTURAL COMPETENCIES WITH SEXUAL AND GENDER
MINORITIES: A STUDY OF THERAPY DYADS

by

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Measuring multicultural competencies with sexual and gender minorities: A study of therapy dyads

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Although there have been targeted efforts to improve mental health care provision to SGM individuals in the last several decades, SGM mental health consumers report ongoing barriers to therapy, including providers' poor SGM-specific multicultural competencies. The current project examines (1) differences in perceptions of SGM-specific multicultural competence between providers and their clients, and (2) how perceptions of SGM multicultural competence are predictive of variation in treatment outcomes. To this end, 73 SGM mental health consumers and 53 of their therapists were recruited to independently evaluate the mental health provider's SGM-specific multicultural competence at two time points, with respective retention rates of 93.2% and 94.3%. In addition, data on demographics, general satisfaction with treatment, therapeutic process outcomes, and mental health outcomes were collected. In the current sample, therapy clients ($M = 5.60$, $SD = 0.53$) and their providers ($M = 6.19$, $SD = 0.29$) varied significantly on their perceptions of provider's SGM-specific multicultural competence, $t(53) = -7.093$, $p < 0.001$, $r = 0.70$. In a series of regression analyses, therapy clients' perceptions of SGM multicultural competence were predictive of 5.9% of the variation in the therapeutic process outcomes above and beyond general satisfaction with care, $F(3,49) = 11.92$, $p = 0.03$.; therapists' perceptions were not significantly predictive. Neither clients' nor providers' perceptions of SGM multicultural competence were significantly predictive of changes in the client's psychological distress at the three-month follow up. These results suggest that disparate perceptions of multicultural competence could have important considerations for the therapeutic process. Implications for research and practice are discussed.

Keywords: sexual minority, gender minority, LGBT, mental health, therapy, multicultural competence, affirmative therapy

Eighty-nine years after its inception, the American Psychological Association (APA) formally recognized the provision of equitable care across its culturally diverse consumer base as an ethical obligation. Specifically, the 1981 APA ethical code addresses diverse demographics under three premises: that researchers should be careful to couch their results in language and context as to not detriment any given age group, sex, ethnicity, or socioeconomic status; that psychologists should not discriminate based on race, age, gender, or “sexual preference” (p. 634); and that psychologists should provide competent services for diverse groups. The revised ethical code dictates:

Psychologists recognize difference among people, such as those that may be associated with age, sex, socioeconomic, and ethnic backgrounds. When necessary, they obtain training, experience, or counsel to assure competent service or research relating to such persons. (p. 634)

While this cannot be counted as the first utterance of “cultural competence” in the field of psychology, it represented a forthcoming shift in the field of psychology away from viewing the ‘default’ human as a White, middle-class, Judeo-Christian, heterosexual man. This push ran concurrent with burgeoning feminist discourse that aimed to disrupt the “mythical norm”—a term coined by writer/activist Audre Lorde in 1984 that referred to the assumption of Whiteness/maleness/heterosexuality as the social norm—and sought to center the experiences of marginalized groups of people in public discourse. Indeed, the fine tuning of the APA ethical principles on cultural competence over the next two and a half decades would correspond with developing intersectional feminist themes that would define the Third Wave of feminist thought; while the Second Wave of feminism focused on sexual liberation and workplace equality for women, the Third Wave fully arrived in the 1990s to emphasize the ways in which multiple,

intersecting social identities impact one's experiences of privilege and oppression. These intersectional considerations continue to be increasingly reflected in psychological research and methods (Else-Quest & Shibley Hyde, 2016).

Subsequent revisions to the APA ethical codes demonstrated a more nuanced recognition of minority experiences, adding such categories as disability and national origin to the cultural competency principle. Moving away from the pejorative language of "sexual preference" in the 1981 ethical code, the 1992 ethical code debuted the term "sexual orientation." Moreover, a new principle found its way into the mix: "Principle D, Respect for People's Rights and Dignity" (p. 1599). A closer examination of this "Principle D" reveals that specific mention of minority identities entirely moved from the principle of "competence" to that of "respect." This shift can be understood as a new way of viewing cultural competence entirely—that is, that competence in psychological practice is inherently *culturally competent*, and that 'competence' and 'cultural competence' are not separate constructs. Thus, a competent clinician must be able to work effectively with diverse consumer populations. With the 1992 revisions to the ethical code, psychologists were expected to be more than technically adept; they had to be *respectful* of individuals' experiences and rights to "self-determination."

While the 1992 version of the APA's ethical code may have been the most sweeping in terms of inclusive language, important changes continued to come out of the organizing entity in the following decades. "Gender identity" was specifically recognized in the 2002 ethical code, and the APA attempted to operationalize its expectations for cultural competence through enumerated "guidelines" for education, practice, and research via stand-alone publications (see, for example, APA, 1994; APA, 2003; APA, 2015). Such emphases on applied cultural

competence were concurrently reflected in other organizing bodies of mental health practitioners (Tseng & Streltzer, 2004).

Nonetheless, the current enthusiastic adoption of the principles of respect and cultural competence belies the ambiguity of their execution. While the majority of psychologists would indicate that cultural competence is a vital part of their profession (Govere & Govere, 2016), there is little consensus on what cultural competence *is*, and how it can be practiced and measured (e.g., Chu, Leino, Pflum, & Sue, 2016; Smith & Trimble, 2016; Worthington, Soth-McNett, & Moreno, 2007). Moreover, while literature on the theoretical bases of cultural competence continues to abound—particularly among counseling psychologist—empirical studies of cultural competence in practice have waned since the early 2000s (Worthington, Soth-McNett, & Moreno, 2007). Overall, there has been a dearth of progress on a unifying, empirically-based, theoretical framework for cultural competence.

Adding to these complications, the majority of literature on cultural competence focuses on ethnic background. Ethnicity is undoubtedly a vital consideration in cultural competence and deserves unique and careful consideration; nonetheless, other axes of identity, and the ways in which they intersect, merit further consideration in regard to the theoretical foundation, empirical basis, and application of cultural competence.

Notably, there exists a gap between the proliferation of mental health disparity research on sexual and gender minorities (SGM) in the last twenty years and research on culturally competent clinical practice intended to address those documented health disparities. Thus, the current project aims to augment the empirical literature on multicultural competencies with SGMs. In this process, I will outline the need for multiculturally competent research on SGMs specifically, how fractured understandings of multicultural competence obscure its practice with

SGMs, as well as general issues in multicultural competence measurement. I will then propose a study that will explore the ways in which mental health consumers and providers understand SGM-specific multicultural competencies and describe the impact of SGM multicultural competence on mental health treatment outcomes.

Considerations for Working with SGMs

Mental health burden. Elevations in psychological distress and clinically significant mental health symptoms are well-documented among SGM populations (IOM, 2011). Despite sweeping sociopolitical changes over the past two decades that have resulted in wider acceptance of sexual minorities in the United States, studies on sexual minority mental health continue to demonstrate higher rates of depression, anxiety, and substance abuse than those found among the general population (Ploderl & Tremblay, 2015). On average, SGM individuals are two to three times more likely than straight, cisgender individuals to be diagnosed with a classifiable mental illness (Meyer, 2003; Smalley, Warren, & Barefoot, 2016; Warren, Smalley, & Barefoot, 2016).

While effect sizes for these preceding symptom clusters tend to be small to medium in size, literature on suicide attempts among sexual and gender minorities repeatedly reveal a large elevated risk (Bockting et al., 2013; Ploderl & Tremblay, 2015). Meta-analysis indicate that lesbian, gay, and bisexual people endorse a two-fold risk, in general, of suicide attempts as compared to heterosexual samples (King et al., 2008). Moreover, around one-third of gender minority individuals have endorsed attempting suicide in their lifetimes (e.g., Bockting et al., 2013; Risser et al., 2005; Smalley, Warren, & Barefoot, 2016). Both of these statistics are vastly higher than the general U.S. population, in which the rate of lifetime suicide attempts approaches 2.7% (Kessler et al., 2001).

As more research has begun to break down differences between sexual minority subgroups, it has become apparent that bisexual individuals, in particular, tend to face higher rates of psychological distress and mental health symptoms (Ploderl & Tremblay, 2015; Smalley, Warren, & Barefoot, 2016). Gender minorities, too, face a significantly increased risk of depression, anxiety, substance abuse, and suicide attempts compared to cisgender sexual minority individuals (Bockting et al., 2013; Smalley, Warren, & Barefoot, 2016).

Higher rates of psychiatric symptoms and diagnoses among SGMs have repeatedly been taken to indicate the pathological nature of non-heterosexual orientations and non-cisgender identities. These discriminatory models reflect a “social selection” hypothesis, in which members of a minority group are viewed as inherently more prone to negative outcomes such as mental illness, physical illness, and poverty. It wasn’t until the mid-1990s that “social causation” models began to permeate the literature on SGM health, suggesting that inequitable social structures were contributing to negative health and wellness outcomes. The minority stress model, coined by psychologist Ilan Meyer (2003), is indisputably the most distinguished of these models, suggesting a three-tier paradigm for identifying sexual minority-specific factors that could predispose gay men to higher rates of psychological distress (the model was later expanded to include other sexual minorities and gender minorities; Meyer, 2008; Meyer, 2013). In short, the minority stress model proposes that SGM individuals face “distal” stressors related to their minority status (such as acts of real/vicarious victimization and discrimination), which in turn bring about “proximal” stressors that are experienced internally—including internalized stigma and anticipation of rejection. In the minority stress model, mental health outcomes depend on how these two types of stressors interact with other personal factors, such as identity salience, resiliency, and support.

Recent theorists have had some success at fine-tuning Meyer's minority stress model. For example, Riggs and Treharne (2016) took issue with Meyer's concept of "proximal stressors," noting that the minority stress model seemed to infer individual failure if a person was not resilient enough to cope with marginalization. Riggs and Treharne suggested a model of "decompensation," in which individuals have a certain reservoir of compensatory factors (such as wealth, majority identities, support, education, and so on) to combat minority-related stressors. To "decompensate," then, means to experience more stressors than one has compensatory factors.

Riggs and Treharne employ the "myth of the meritocracy" to clarify their theory of decompensation (2017). In the myth of the meritocracy, it is stated that individuals can achieve any level of success with enough hard work and good luck. Research indicates the contrary, however: although Americans have the highest rates of belief in a meritocracy (69%), America has one of the lowest rates of social mobility among developed countries (Urahn et al., 2012). Riggs and Treharne's theory implies that a similar phenomenon can better explain the minority stress model. The authors point out that research into resilience among SGMs relies on a similar assumption that good health is accessible based on one's personal work towards resilience, often ignoring the privileges and supports that might aid in one's resiliency. Altogether, then, Riggs and Treharne's model of decompensation urges researchers to develop more inclusive models that include a wider array of distal compensatory factors. Notably, Meyer's minority stress model does mention general strengths and external supports that might impact individual outcomes, and could be considered to already include the principles that Riggs and Treharne demand to be considered.

Another important model of mental health to consider is the “dual continuum” model of mental health (Keyes, 2002). Although the dual continuum model is not specific to minority groups, it offers better precision to describe the mental health outcomes that both the minority stress and decompensation models discuss. The dual continuum model separates the concepts of psychiatric mental illness and “positive mental health” into two concepts; specifically, Keyes states that “mental disorders” refer to symptoms associated with classifiable mental illness, and “positive mental health” refers to one’s overall mental health and flourishing. Keyes suggests that one can have a significant mental illness, but still be flourishing—for example, someone with major depression can be well-equipped with positive supports, coping skills, and life meaning. Given that the majority of research into SGMs focuses on mental illness symptomology, the dual-continuum model offers a more holistic understanding of the mental health of SGM individuals. Indeed, when Bariola and colleagues applied the dual continuum model to a sample of lesbians and gay men, 47.1% of their sample was found to have “flourishing mental health,” even though 23.3% met criteria for generalized anxiety and 29.4% met criteria for depression among the “flourishing” sample (2017). This finding has important implications for the way mental health is measured among SGMs, as well as the interventions targeting these communities.

Given the high rates of mental illness symptomology among SGM individuals, it might be unsurprising to find out that SGMs tend to seek out mental health services at higher rates than the general population (Macapagal, Bhatia, & Greene, 2016). However, this statistic does warrant some puzzlement when one considers the current and historical barriers to care for SGMs that continue to impact the ways in which they interact with mental health systems.

Careful consideration of these barriers to care is vital to understanding how to provide culturally competent services to SGM individuals.

Historical treatment. In 1975, the APA adopted a resolution stating that “homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities” (p. 109). Mental health providers were then tasked with removing the mental illness stigma associated with non-heterosexual orientations. Over thirty years later, the APA affirmed that “...same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity” (APA, 2009, p. 121).

Today, the APA features dozens of statements and publications on SGM health, many produced by the APA’s Office on Sexual Orientation and Gender Diversity. Nine of the APA’s 54 divisions count SGM-related interests among their topic priorities. Moreover, the APA goes beyond practice considerations to promote the advocacy of SGM equality in wider sociopolitical systems. The APA had released specific guidelines for working with sexual minorities (2000; 2011) and gender minorities (2015). These guidelines provide ample supplemental material (specifically, 21 guidelines for working with sexual minorities and 16 for working with gender minorities) for approaching work with SGM mental health consumers, covering such topics as religion, family, gender affirmation procedures, and stigma.

The APA’s current celebration of SGM communities makes it easy to ignore the mental health community’s past grievances. Although homosexuality was removed from the Diagnostic and Statistical Manual (DSM) in 1973—the widely accepted standard for diagnosing mental illness in the United States, written by the American *Psychiatric* Association—a new classification of “sexual orientation disturbance” arose to allow individuals who struggled with

their sexual orientations to receive gay conversion therapy (Hegarty, 2018), remaining in the DSM until 1987. Moreover, the APA did not deem gay conversion therapies as “treatments that harm” until a statement released in 1997. As a whole, then, anti-gay policies were only wiped out of the mainstream mental health community in the last couple decades.

Notably, specific reference to transgender identities was left out of much of the APA’s evolution toward equality for SGM individuals. Indeed, many gender minority advocates continue to criticize mental health systems for their ongoing pathologization of transgender identities. Gender Identity Disorder was first introduced to the DSM-III in 1980, prior to which transgender identities were often confused with transvestic fetishism or homosexuality. In an attempt to destigmatize gender minorities, the DSM-5 reclassified Gender Identity Disorder to “Gender Dysphoria,” with important changes made to the diagnostic criteria. While the shift to Gender Dysphoria was meant to take a step away from pathologization and instead focus on the distress associated with a mismatch between gender identity and anatomy/socialization, its ongoing existence is highly controversial. While some argue that the Gender Dysphoria diagnosis helps individuals to obtain reimbursable mental and physical health services, others contend that it continues to pathologize gender minorities and sets up a gatekeeping model for receiving gender affirming services (Hegarty, 2018).

Barriers to care. The mental health establishment’s history of pathologizing SGMs continues to impact the attitudes of SGM mental health consumers in the present day. This is further complicated by the general anticipation of stigma that many SGM individuals experience as they navigate society as a whole (Meyer, 2003). Indeed, some SGM consumers delay care-seeking for fear of potential discrimination (Berke, Maples-Keller, & Richards, 2016; Macapagal, Bhatia, & Greene, 2016; St. Pierre & Senn, 2010), and some avoid disclosing their

SGM identity altogether (Daley, 2010). Additionally, past negative experiences in mental health care can have a significant impact on future care-seeking (Romanelli & Hudson, 2017), and thus it is important to consider that recent improvements in mental health providers' competencies might be a moot point for SGM consumers who suffered grievances in the past.

SGM individuals face both system- and individual-level barriers when seeking mental health services. In regard to systems, SGM-tailored services may be difficult to identify or altogether unavailable in a certain area. Providers' knowledge of transgender-related issues, in particular, is often sparse or even misinformed (Powell & Cochran, submitted). In a recent systematic review of transgender individuals' experiences in mental health care, all seven articles included instances of enacted stigma (White & Fontenot, 2019). Moreover, high rates of unemployment among SGMs (MAP, 2013) can make it difficult to afford insurance, further complicating service access.

At the micro-level, SGM mental health consumers may be unaware of their rights to non-discriminatory care; even those who are aware of their rights might feel ineffective in filing appropriate grievances (Romanelli, 2017; White & Fontenot, 2019). SGM individuals might be wary of seeking mental health services for fear of conflating their identities with pathological processes. Moreover, long commutes to dispersed SGM-affirmative services might dissuade SGM consumers from regularly accessing care (Romanelli, 2017).

In addition, there is research to suggest that health care providers may harbor biases that can impact treatment delivery to SGM consumers. SGM mental health consumers have reported receiving treatment from providers who have microaggressed against them, shown visible discomfort, and refused to provide services to them based on their sexual and/or gender identities (Bauer, 2009; Kenagy, 2005; Romanelli & Hudson, 2017; White & Fontenot, 2019). Other SGM

consumers have remarked on the ways in which providers seem to overlook the variety of experiences and stigmas that different SGM identities face—a phenomenon that has been referred to as “queer blindfolding” (Smith & Shin, 2014).

Treatment outcomes. When SGM consumers do access mental health services, there is conflicting evidence regarding whether those services result in the same mental health outcomes as experienced by heterosexual, cisgender mental health consumers. In a study of lesbian, gay, bisexual, and heterosexual men and women accessing psychological services in a primary care setting, sexual minority women—but not men—demonstrated fewer reductions in symptomology and psychological distress (Rimes et al., 2017). Similarly, a study of sexual minority and heterosexual substance abuse treatment consumers found that sexual minority men had lower abstinence levels at the end of treatment (Senreich, 2009). Conversely, several studies suggested that there were no differences between sexual minorities and heterosexual mental health consumers (e.g., Beard et al., 2017). On the other end of the spectrum, a study of sexual minority and heterosexual individuals receiving services in a public psychiatric hospital suggested that sexual minorities evidenced slightly better treatment outcomes than heterosexual consumers (Ploderl et al., 2017). These inconsistent results suggest that more research is needed to better understand the interactions between SGM status, providers’ SGM competence, presenting concerns, and treatment outcomes. Research into gender minorities warrants additional consideration here, given the limited sample sizes of transgender participants in existing outcome studies.

Multicultural Competence

In the landmark *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (2003), the APA attempted to operationalize the

concept of multicultural competence. Six enumerated guidelines were provided, along with case examples and working definitions to contextualize them:

Guideline 1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves. (p.382)

Guideline 2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals. (p.385)

Guideline 3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education. (p.386)

Guideline 4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethnical psychological research among persons from ethnic, linguistic, and racial minority backgrounds. (p.388)

Guideline 5: Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices. (p.390)

Guideline 6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices. (p.392)

Although the document defines multiculturalism as “[recognizing] the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions,” the guidelines then go on to state, “. . .in these guidelines, we use the term multicultural rather narrowly to connote interactions between racial/ethnic groups in the United States” (p. 380) The authors explain that

this focus on racial and ethnic minorities is rooted in the historical connotation of the work ‘multicultural,’ as well as the need to address the specific issues faced by racial and ethnic individuals that may not be experienced by other minority groups. While the decision to focus on racial and ethnic minorities is well-justified, the couching of these guidelines under the general label of ‘multicultural competence’—which they themselves define as pertaining to a broader series of populations—can be misleading. The APA’s focus on racial and ethnic diversity in this document foretells a trend in multicultural competence research focusing on racial and ethnic minority experiences without comparable attention paid to other minority identities. Indeed, the vast majority of publications on multicultural competence overlook intersecting and other minority experiences (Tao, Owen, Pace, & Imel, 2015; Worthington, Soth-McNett, & Moreno, 2007).

Certainly, this is not to suggest that there should be less of a focus on racial and ethnic minority cultural competencies. Rather, this finding calls for more studies into multicultural competence that look at racial and ethnic minority experiences *as well as* other underrepresented minority groups and the intersecting nature of social identities. It would be misguided to suggest that any form of multicultural competence research should happen at a lesser rate; after all, the field of psychology continues to be hard-pressed to deliver any sort of unifying, empirically based, content valid frameworks for enacting multicultural competencies.

A review of the research suggests that multicultural competence is generally correlated with improved process outcomes (e.g., rapport, attendance, trust), but research into treatment outcomes reveals a mix of conclusions (Govere & Govere, 2016; Lie et al., 2011; Tao, Owen, Pace, & Imel, 2015). These results have been taken by some to indicate that multicultural competence is not worth the investment of psychologists’ time and resources. However, I

contend that these results should be viewed as significant given that so many noteworthy findings have come out of a field with such vague and disparate operationalizations of what it means to be multiculturally competent. It follows that more research is needed into the theoretical and evidence bases of multicultural competence in order to optimize treatment delivery to an increasingly diverse population of consumers.

Frameworks of multicultural competence. Despite the APA's attempts at offering guidelines for multicultural competence, their proclamations on the subject have lacked an overarching theoretical structure. On the other hand, the majority of publications on multicultural competence rely solely on theory and do not offer tangible actions for operationalizing multicultural competence. Thus, we must attempt to reconcile the research on multicultural competence theory, action steps, and data to answer the question: *What does multiculturally competent care entail?*

Undoubtedly, the most prolific of the multicultural competence models is Derald Sue's tripartite framework (Sue et al., 1982). This model consists of three major competency areas: knowledge, awareness, and skills. Sue's multicultural framework is widely considered to be the "initial blueprinting for multicultural education in psychology and counseling," and was used to inform the APA's multicultural guidelines (Smith & Trimble, 2016, p. 22). Later in 1996, Arredondo and colleagues operationalized the tripartite model by providing measurable objectives in each of the three areas. Since Arredondo's study, several measures of multicultural competence have been developed to reflect Sue's tripartite model and Arredondo's objectives; these measures tend to be the most common indicators of multicultural competence used in psychological research over the last two decades (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006).

Despite the popularity of this model, most multicultural education based on Sue's framework has emphasized knowledge and self-awareness, overlooking the development of concrete skills. A survey of multicultural competence instructors in the social sciences found that while awareness and knowledge and were frequently taught (93% and 82%, respectively), multicultural skills were only addressed by around half of the instructors (49%; Reynolds, 2011). This is likely due to the difficulty of operationalizing concrete multiculturally competent practices, which is further complicated by the grading of these practices. Another common criticism of this model's applications is how minority individuals can easily be left behind in the classroom; improving White trainees' competence with consumers of color and nurturing awareness of their privileges frequently seems to be the focus of such curricula. A study by Chao and colleagues (2011) suggests that instruction based on the tripartite model had a significant positive effect on White students' multicultural awareness, but not on that of racial and ethnic minority students. Chao and colleagues explain that this disparity is likely because what is being taught is perspective on privilege and oppression—something that minority individuals might already be experientially versed in.

Sue's tripartite model is sometimes referred to as a *person-oriented model* (e.g., Chu, Leino, Pflum, & Sue, 2016). Indeed, each of its major elements describes measurable qualities of a clinician; therefore, some researchers contend that the tripartite model has the potential to overlook the interpersonal, dynamic processes that make up a therapeutic relationship. Conversely, *process models* focus on the dynamic nature of provider-consumer interactions

(Lopez 1997; Sue, 1998¹; Whaley & Davis, 2007). One such model (Sue, 1998¹) proposed the following multicultural framework:

“...multicultural competence [is viewed as] a multidimensional process that includes three essential ingredients: (a) scientific mindedness by the therapist, which involves testing hypotheses rather than making premature conclusions about diverse clients; (b) dynamic sizing, which involves therapists’ flexibility in knowing when to generalize versus individualize therapeutic approaches; and (c) culture-specific expertise in skills and knowledge of one’s worldviews and the sociopolitical influences on clients’ lives.”

(Chu, Leino, Pflum, & Sue, 2016, p. 19)

This model is seen as process-oriented due to the active role of the consumer in competent care delivery; clinicians’ multicultural competence can only be described in relation to the consumers they serve. This is an important consideration; just as there are many ways to be an ally to a minority individual—e.g., someone who is one sexual minority’s best ally might not be the type of ally another sexual minority finds support in—there are as many ways to deliver culturally competent care as there are mental health consumers. In this way, multicultural competence is similar to therapeutic interventions; no single theoretical orientation can promise beneficial results to every consumer. Thus, process models of care focus on how to be culturally competent for any given consumer receiving mental health treatment; there is no ‘one size fits all.’ Nonetheless, many researchers criticize process models for being difficult to operationalize, thereby impeding both training and research into its effectiveness.

¹ This refers to Stanley Sue, not Derald Wing Sue who is known for the development of the tripartite model.

Altogether, the tension between person-oriented and process-oriented models of multicultural competence can be summed up well by the concept of “design-time/run-time balance,” a principle from a separate line of research altogether (Chorpita & Daleiden, 2014, p. 325). This terminology is borrowed from information science, in which ‘design-time’ refers to features that are established prior to program execution, and ‘run-time’ refers to the way in which “an object or entity is further configured or affected by interacting with its environment” (p. 325). In this way, the authors urge mental health providers and researchers to consider both person-oriented and process-oriented variables in conjunction with each other. While this seems like a tall order, Chorpita and Daleiden assure us that it is achievable:

Handling both issues is not a new concept in other areas of our lives. Navigation in automobiles using GPS technology works on a platform of design-time controls (i.e., satellites, stored maps, compact displays, etc.) but also depends on run-time controls to develop the initial route based on a driver’s current position (i.e., accommodating differences in current status) as well as unlimited updates to the route to handle detours, surprises, or driving errors. (p. 328)

Finally, Chorpita and Daleiden suggest that to achieve design-time/run-time balance, mental health researchers and academics must deal with run-time issues (ironically) in design time. Although the authors are referring to child and family service delivery, their advice is equally timely in the realm of multicultural competence. The term “modular” is used to describe treatment that combines evidence-based approaches with real-world applications. In doing so, he focuses on the need to deftly respond to the unique needs of our consumers in an evidence-informed way, so as to not obstinately stick to practices that are not working for our consumers (with the reasoning that even the most supported structured interventions fall short of 100%

efficacy). Thus, our initial question for understanding frameworks of multicultural competence can be transformed to inquire: *What does modular multiculturally competent care entail?*

Applying intersectionality to multicultural competence. Applying the concept of design-time/run-time to multicultural competence demands that we understand both overarching theoretical frameworks of multiculturalism (similar to design-time) as well as developing multiculturally competent skills that are responsive to the unique experiences of precise groups of people (similar to run-time). This can be accomplished by approaching the issue of multicultural competence through an intersectional feminist lens. The term ‘intersectionality’ was first coined by Kimberlé Crenshaw, a legal and feminist scholar, in 1989. Discussing Black women’s employment in the US, Crenshaw noted the ways that academic and political discussions dismissed within-group differences, instead concentrating on broad categories such as “the Black experience.” Crenshaw argued that erasure of the multiply marginalized can be avoided by uplifting their narratives and applying them outward, rather than generalizing the approximate needs of a group to its more vulnerable members:

If their efforts instead began with addressing the needs and problems of those who are most disadvantaged and with restructuring and remaking the world where necessary, then others who are singularly disadvantaged would also benefit. In addition, it seems that placing those who currently are marginalized in the center is the most effective way to resist efforts to compartmentalize experiences and undermine potential collective action.
(p. 167)

Intersectionality theory has since gained traction as an inclusive critical feminist and race theory with multidisciplinary impacts. Indeed, the entire Third Wave feminist movement has been repeatedly characterized by its intersectional underpinnings (Archer Mann, 2013). Similar

to First and Second Wave feminist theorists, the social sciences have lagged behind in promoting intersectionality as a theoretical lens, instead operationalizing social identities as unidimensional, independent constructs (Bowleg, 2008). This pitfall is frequently witnessed in multicultural competence research that generally focuses on mental health care provision to a singly defined group of people, without adequate consideration of intersectional experiences. When multiple identities are considered, they are often treated—both conceptually and statistically—as additive experiences, rather than intersectional ones (e.g., Black + lesbian, instead of Black lesbian; Bowleg, 2008).

By leaning on the theoretical subdivisions of intersectionality, we can shed light on the different ways in which multicultural competence can be conceptualized. Specifically, intersectionality can be classified into two approaches: “relational intersectionality” and “locational intersectionality” (Ferree, 2010). Relational intersectionality is concerned with the experiences of individuals as they navigate cultural conflicts and inequalities that result from sources of oppression. Herein, individuals are seen as negotiating institutional practices and cultural discourses; they are dynamic actors that shape and are shaped by a multitude of interpersonal and structural forces. Whereas relational intersectionality takes a top-down approach, locational intersectionality targets the individual narrative and how it shapes one’s subjective understanding of the world. While both approaches to intersectionality have their flaws, both contribute important information to the ways in which we understand experiences of privilege and oppression.

If the language of relational intersectionality and locational intersectionality seem similar to the language of ‘process-oriented’ and ‘person-oriented’ models of multicultural competence, that is because each set of ideas reference similar distinctions in ways of conceptualizing the

experiences of minority group members. Given the inconsistent theoretical foundations that make up the field of multicultural competence, scholars on the subject have much to learn from the proliferation of intersectional theories.

Issues in measurement. Just as there are many ways to understand multicultural competence, there are many ways to measure it. The majority of existing measures are based on the components of Sue's tripartite model, with a greater emphasis being placed on the knowledge and awareness components. The Cross-Cultural Counseling Inventory (CCCI; Hernandez & LaFromboise, 1985) and the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman & Hernandez, 1991) are such measures, and they have had the greatest usage in the peer-reviewed literature (Worthington, Soth-McNett, & Moreno, 2007). The CCCI-R consists of 20 items that were originally meant to be rated by an external evaluator observing a mental health provider working with a racial or ethnic minority consumer. In this regard, these measures are similar to adherence measures for different models of psychotherapy, in which an external expert rates the therapist's adherence to the treatment manual.

Herein lies a major point of contention in the field of multicultural competence research; the evaluator seems to matter just as much as—and perhaps, more than—the content of the measure itself. Although self-report by clinicians is likely the most accessible data on a clinician's performance, it is generally subject to social desirability biases (Ponterotto, 2000). Neutral observer ratings have been considered the gold standard, given that observers can be trained in what multicultural competence entails but are not subject to the same biases as self-reporting mental health providers. Nonetheless, both of these approaches are criticized as ignoring the perspectives of the consumers themselves, who each have the most knowledge about their own cultural experiences. The issue remains, however, that consumers might not be

knowledgeable about ‘multicultural competence’ as a professional skill for diverse experiences beyond their own, or they may be subject to their own biases about their provider.

It is worth noting that the popular CCCI-R focuses on racial and ethnic identities. Indeed, the majority of measures on multicultural competence are exclusively designed to measure competence when working with a variety of racial and ethnic groups. Although this focus makes sense in terms of historical influences in the field of multicultural competence as well as the urgency of persisting racism, more measures are needed to describe cultural competencies with various and intersecting marginalized identities.

Language. The study of multicultural competence is further obfuscated by a lack of consensus around its terminology. One can find any combination of cross-cultural/multicultural/cultural and competence/competency/competencies in the literature. Indeed, many textbooks, journal articles, and presenters seem to use the terms interchangeably (Tao, Owen, Pace, & Imel, 2015). However, the process of imprecisely defining these terms risks varying adaptations of ideas and conclusions. A unifying theoretical framework for multicultural competence also demands a common etymological foundation.

The APA recognizes ‘cultural competence’ and ‘multicultural competence’ as synonymous terms, but prefers the language of ‘multicultural’ to reflect the diversity of social groupings (APA, 2003). While I argue that ‘cultural competence’ denotes competence in a single area (e.g., with sexual minorities, or with Arab Americans) and ‘multicultural competence’ refers to dynamic competence that can be applied to a range of intersecting identities, I will ultimately defer to authorities on the topic to draw the distinction between these terms for fear of further complicating this linguistic tangle. However, I do propose that the term ‘cross-cultural’ implies either a collaborative meaning-making process wherein each ‘side’ crosses into the perspective

of the other to achieve a goal, or simply a demarcation of in-groups and out-groups coming to a head.

As for the specific group that serves as the focus of this manuscript, I have chosen the term ‘sexual and gender minorities’ over such terms as ‘queer’ and ‘lesbian/gay/bisexual/transgender/queer (LGBTQ)’ to encompass individuals who are marginalized for their sexual orientations, affective orientations, gender expressions, and gender identities, regardless of self-identification with LGBTQ terms. I have chosen to lump together sexual and gender minorities because of the historical interconnection of the two communities, as well as their shared oppression based on deviation from gender norms and expectations. Notably, however, individuals who are lesbian, gay, bisexual, transmen, transwomen, and nonbinary experience both overlapping and unique stigma based on their perceptions of deviation from cultural norms; for example, while sexual and gender minorities might all be stigmatized for being a threat to ‘traditional families,’ transwomen in particular have to contend with cultural forces that label them as hyper-sexual “deceivers,” and bisexual individuals are subject to a stereotype of being unfaithful and fickle-minded in relationships (Serano, 2009). The choice to lump together sexual and gender minorities in this project is made in relation to those shared experiences of marginalization—at the risk of undermining the important differences between individual identities—in addition for the practical need of achieving a certain sample size for interpreting statistical analyses. As such, results from the current study should be interpreted in the context of this lumping together of experiences.

To better understand the use of the term ‘multicultural’ as well as the lumping of sexual and gender minorities, it is useful to yet again consider the work of intersectional theorists. Namely, McCall (2005) identifies three approaches to the categorization of social groups:

anticategorical complexity, intracategorical complexity, and intercategorical complexity. Anticategorical advocates take a postmodernist stance on socially constructed categories, questioning their legitimacy as concrete social boundaries and pointing out the arbitrary nature with which they have been constructed. The intracategorical approach “interrogates the boundary-making and boundary-defining process itself” (p. 1773), and attempts to understand how a given marginalized group negotiates its structural and discursive context in regards to group identity and experiences. Finally, the intercategorical approach seeks to determine the relationships among multiple social groups, and aims to reveal the structural processes organizing power across them. As such, it can be said that I generally take an intercategorical approach to social identities in the current project in order to shed light on trends in experiences of power and oppression experienced by SGM communities.

Affirmative Therapy or Multicultural Competence?

The concept of ‘affirmative therapy’ provides a unique etymological and conceptual issue in the consideration of multicultural competence. SGM affirmative therapy and SGM multicultural competence are rarely used in a way that makes them seem synonymous. Indeed, a cursory PsychInfo search at the time of this manuscript’s preparation revealed 91 articles fitting the search terms “LGBT/LGBTQ” and “multicultural/cultural competence,” and 86 articles that used the terms “LGBT/LGBTQ” and “affirmative therapy/counseling.” However, when the two searches were combined—“LGBT/LGBTQ” and “multicultural/cultural competence” and “affirmative therapy”—there were *zero* results. The concepts are written about as if they are mutually exclusive.

However, close consideration of the affirmative therapy literature reveals significant overlap between the two terms. Perez (2007) defines affirmative therapy as “the integration of

knowledge and *awareness* by the therapist of the unique developmental and cultural aspects of LGBTQ individuals, the therapist's own self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy *skills* at all stages of the therapeutic process" (emphasis mine; p. 408). This is not a far cry from the first peer-reviewed article on affirmative therapy that called therapists to action; Lenihan (1985) urges therapists to be knowledgeable of sexual orientation identity development models and queer family structures, and urges her readers to embody "self-awareness and well-established comfort with one's own sexuality and personal life-style... this requires that the therapist must not only accept but also value his or her own homosexual thoughts, feelings, fantasies, and behaviors" (p. 736). Although Lenihan's work does not explicitly focus on therapists' affirmative skills, later models of affirmative therapy are sure to discuss the importance of applied knowledge, and many add on the need for strengths-based approaches and advocacy (O'Shaughnessy & Speir, 2018). Altogether, the working definitions of affirmative therapy almost seamlessly reflect the major tenants of Sue's tripartite model of multicultural competence, with several important additions. The current project uses 'SGM-specific multicultural competence' as an umbrella term that includes 'affirmative therapy' in attempt to work towards a more unified literature base.

This is an issue because there have been no investigations into the impact of this linguistic distinction on research and application (to this author's knowledge). Such a divide in the literature can lead to redundancy, delayed innovation, and incomplete dissemination of relevant information. After all, without collaboration between affirmative therapy researchers and multicultural competence researchers, the two areas are left to divine their own theoretical models and disseminate information to their own respective audiences.

When investigating both the affirmative therapy and multicultural competence literatures, systematic review suggests that models of competence for working with SGMs yield mixed results on psychotherapy processes and psychological outcomes; however, the field is limited by its primary focus on gay, cisgender men (O'Shaughnessy & Speir, 2018). Similar to the field of multicultural competence as a whole, the majority of works on affirmative therapy/multicultural competence with SGMs are theoretical in nature (rather than evidence-based), and have been criticized for being too idealistic and difficult to operationalize.

Despite its shortcomings, the SGM affirmative therapy/multicultural competence literature does a good job of intentionally eliciting the perspectives of consumers (O'Shaughnessy & Speir, 2018). This is rare in the field of multicultural competence as a whole (Tao, Owen, Pace, & Imel, 2015; Worthington, Soth-McNett, & Moreno, 2007), and might be reflective of the advocacy and empowerment paradigms that inform much of SGM-focused psychology. However, this focus on the consumer could overlook important considerations for practice that would be better identified by trained professionals. Moreover, providers tend to over-evaluate their competence with SGM consumers (Powell & Cochran, Under Review) and are subject to social desirability biases in self report (Ponterotto, 2000). I aim to address these biases in the current study by comparing and contrasting perspectives of SGM multicultural competence in consumer/provider dyads.

Summary

In the mental health community and beyond, the last several decades represent unparalleled progress in the promotion of SGM rights and dignity. In the mental health care system, these improvements can be demonstrated in several ways, including fewer homophobic attitudes among providers and better training on mental health issues relevant to SGM

communities (O'Shaughnessy & Speir, 2018). Despite a general push towards multicultural competence for working with individuals with complex, intersecting identities, divisions in the conceptualization and operationalization of such competencies trouble the field. These divisions persist in the area of SGM care provision, wherein theory and guidelines on concrete applications have yet to be reconciled, and complex identities are often minimized.

Nonetheless, substantial mental health disparities persist among SGM individuals, including significantly heightened risk for depression, anxiety, substance abuse, and suicide (Ploderl & Tremblay, 2015; Smalley, Warren, Barefoot, 2016). Yet, SGM mental health consumers report ongoing barriers to mental health treatment, including poor SGM multicultural competencies and fear of discrimination (Romanelli & Hudson, 2017). These conflicting findings warrant further investigation into the state of SGM-specific multicultural competencies among mental health providers, from both the perspectives of providers themselves as well as the SGM individuals they treat. A better understanding of the state of SGM multicultural competencies, as well as explicit successes and pitfalls in both design-time (theory) and design-time (practice), are crucial to promoting effective, evidence-based practice with SGM consumers.

The Current Study

At present, there are no quantitative studies of SGM multicultural competencies that: (a) compare and contrast perspectives of competence in therapy dyads, (b) provide accounts of current (i.e., not prospective or retrospective) perspectives on SGM multicultural competence in treatment-as-usual (i.e., not controlled trials), or (c) provide longitudinal analysis on the correlation between SGM multicultural competencies and outcomes in current treatment-as-usual settings. These are significant gaps that obscure the significance of SGM multicultural

competencies in mental health care, particularly when SGM mental health consumers are reporting multiple barriers to affirmative care (Romanelli & Hudson, 2017). Moreover, the lack of research in this area puts providers in the position of relying on theoretical frameworks of multicultural competence that are not backed by empirical data. Individually as providers and systemically via the APA, the field of psychology values evidence-based practice and rejects theoretically-based interventions that lack an empirical foundation. The same must be true for the way we approach multicultural competence.

Thus, in the current study I answer two primary questions: (a) how do SGM consumers and their providers diverge or converge on their perspectives of the provider's SGM-specific multicultural competence, and (b) how do the perspectives of SGM-specific multicultural competence in therapy dyads correlate with treatment outcomes?

A two-phase quantitative study was used to answer these questions. Members of therapy dyads separately answered questions about their perceptions of the provider's SGM-specific multicultural competence and the therapeutic relationship at Time 1 (T1) and then 3 to 4 months after at Time 2 (T2). Consumers answered questions about their levels of psychological distress at both time points, as well as their general satisfaction with therapy.

Specifically, for this study, quantitative analyses tested three hypotheses:

- Hypothesis 1: Providers and consumers in therapy dyads significantly differ in their perceptions of the provider's *SGM multicultural competence*.
- Hypothesis 2: Perceptions of the provider's *SGM multicultural competence* are predictive of the *therapeutic process*, above and beyond what can be explained by *general satisfaction* with treatment.

- Hypothesis 3: Perceptions of the provider's *SGM multicultural competence* are predictive of changes in *psychological distress*, above and beyond what can be explained by *general satisfaction* with treatment.

Methods

Participants

Fifty-five therapy dyads from the United States were sought for this study (total N = 110). This number was selected based on a power analysis for a matched pairs *t*-test with a moderate effect size (0.5) and where $p < 0.05$. To fit within the purview of this study, the consumer in each dyad must have identified as an adult SGM, and the mental health provider must have been licensed. Participants were recruited via various LGBTQ-oriented social media groups, including on Facebook, Instagram, and Tinder. To avoid a homogenous sample with poor generalizability, I attempted to over-represent gender minorities and SGMs of color by recruiting among social media groups that focused on these communities.

A total of 128 participants consented to participate in the study. Specifically, 89 mental health consumers began the first survey. Of these, 75 individuals completed at least one half of the T1 survey; two of these participants were excluded from analysis based on not meeting inclusion criteria. Fifty-three corresponding mental health providers completed the T1 survey, totaling 53 complete therapy dyads for T1. Several participants reported that they were not comfortable contacting their mental health providers to engage in the study, and it is possible that some among the remaining 20 therapists who did not complete the study were never contacted.

For T2, 68 consumers completed the survey. Fifty corresponding mental health providers completed the T2 survey, totaling 50 complete therapy dyads for T2. See Figure 1 for a visualization of participant recruitment and retention.

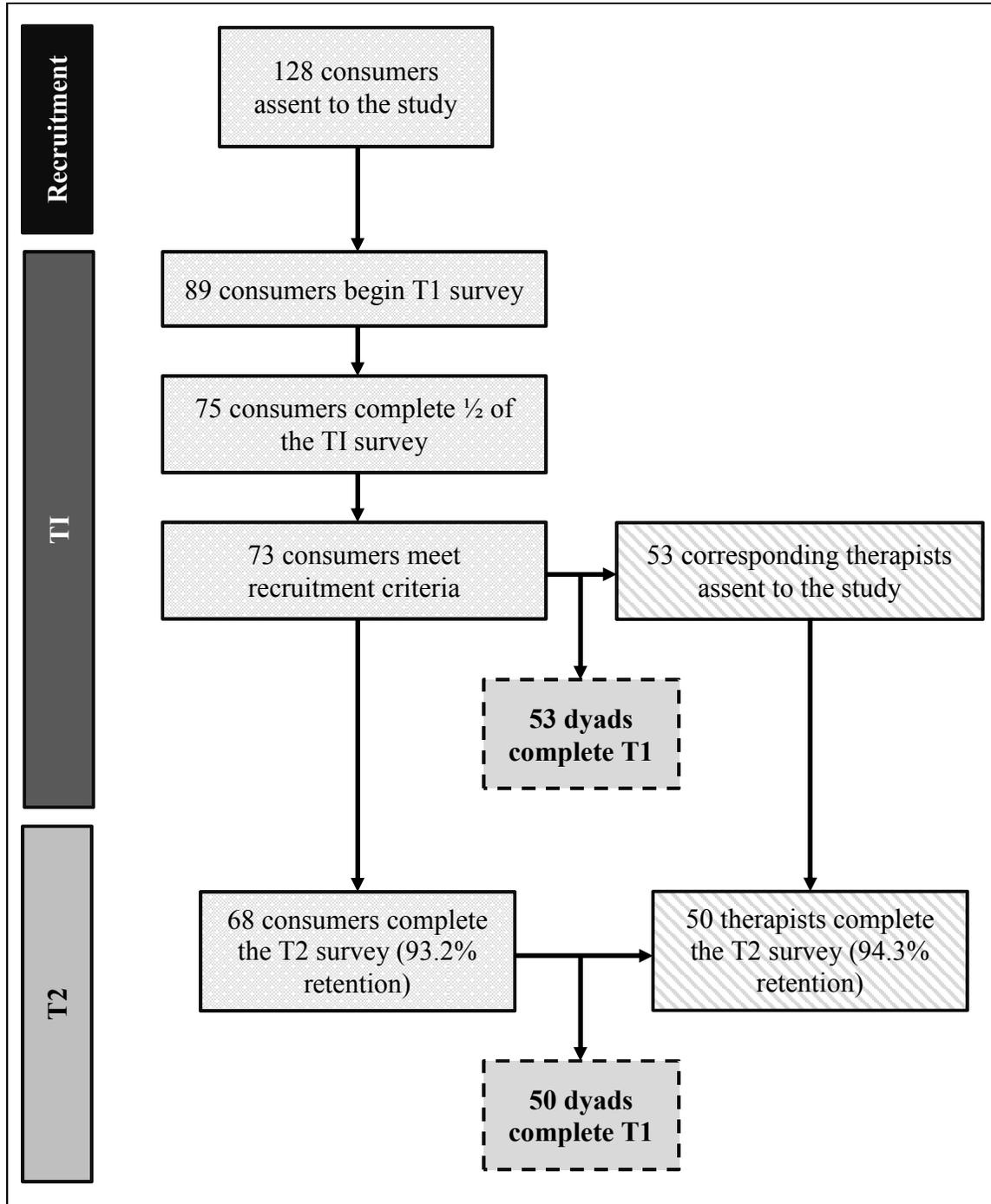


Figure 1. Flow chart of participant recruitment and retention.

Participants’ demographics are summarized in Table 1. Participating clients were mostly male (57%), gay/lesbian (58%), and cisgender (82%). Forty-nine percent of clients were White,

and the average age of clients was 31 ($SD = 6.7$). The vast majority had been in therapy at least once before (90%), and the median number of therapy sessions attended with their current therapist at T1 of this study was 3 ($M = 12.0$, $SD = 27.9$).

Participating therapists were largely female (64%), straight (64%), cisgender (94%), and White (70%). The majority of clinicians were either counseling psychologists (36%), clinical social workers (30%), or clinical psychologists (23%). The average age of providers was 42 years ($SD = 8.9$). The median number of sexual minorities seen by clinicians was 40 ($M = 41.5$, $SD = 28.4$), and the median number of gender minorities seen was 7.5 ($M = 14.9$, $SD = 34.7$).

Table 1

Demographics and Background Data of the Sample

	Clients (<i>n</i> , %)	Therapists (<i>n</i> , %)
Gender		
Ciswoman	22, 30.6	33, 63.5
Cisman	37, 51.4	15, 28.8
Transwoman	6, 8.3	1, 1.9
Transman	4, 5.6	1, 1.9
Nonbinary	3, 4.2	2, 3.8
Sexual Orientation		
Lesbian/Gay	42, 58.3	7, 13.5
Bisexual	24, 33.3	8, 15.4
Heterosexual	0, 0.0	34, 65.4
Other sexual orientation	6, 8.3	3, 5.8

Race

Multiracial	5, 6.9	6, 11.5
Asian	1, 1.4	3, 5.8
Black/African American	15, 20.8	2, 3.8
Latinx/Hispanic	12, 16.7	3, 5.8
Native American or Alaska Native	4, 5.6	1, 1.9
White/Caucasian	35, 48.6	37, 71.2

Provider type

Clinical psychologist		12, 23.1
Counseling psychologist		19, 36.5
Clinical social worker		16, 30.8
Marriage/Family Therapist		5, 9.6

Educational attainment

High School or GED	3, 4.2
Trade school certificate	21, 29.2
Some college	28, 38.9
Associate's degree	1, 1.4
Bachelor's degree	14, 19.4
Master's degree	5, 6.9

Measures

SGM multicultural competence. The Cross-Cultural Counseling Inventory—Revised (CCCI-R; LaFramboise et al., 1991) is a 20-item measure that assesses mental health providers' multicultural competencies as they were initially defined by the APA's 1983 guidelines. Although the CCCI-R was originally designed to be completed by an impartial observer, it has since been adapted to be completed by both providers and consumers (Owen, Leach, Wampold, & Rodolfa, 2011). Participants rate items on a 6-point scale in which higher scores indicate more perceived multicultural competencies. The CCCI-R is considered to have good content validity due to its consistency with the APA's guidelines (APA, 1994). The measure has demonstrated strong interrater reliability, as well as excellent internal consistency ($\alpha = .95$; LaFromboise, Coleman, & Hernandez, 2001). In the current study, the CCCI-R yielded excellent internal consistency, $\alpha = .93$.

The CCCI-R targets the assessment of racial and ethnic minority multicultural competencies. Thus, in the current study we adapted the CCCI-R to apply to SGM multicultural competencies (Appendix 1). Previous adaptations of the measure in which minor changes were made to the original wording have demonstrated good to excellent psychometric properties (e.g., Fuertes et al., 2006; Li & Kim, 2004; Owen, Leach, Wampold, & Rodolfa, 2011). However, the CCCI-R has been criticized for being prone to social desirability biases (Constantine & Ladany, 2000). The current study attempts to address this limitation through additional measurement of social desirability, described later.

Satisfaction with treatment. To help differentiate consumers' general satisfaction with their therapist from their perceptions of providers' multicultural competence, the Revised Helping Alliance Questionnaire (HAQ-II; Luborsky et al., 1996) was used (Appendix 2). The

HAq-II uses the client's perception of the therapeutic alliance to represent clients' overall satisfaction with their therapists. The HAq-II patient version was chosen based on its good convergent validity with other measures of satisfaction, as well as for its good test-retest reliability and good internal consistency ($\alpha = .85$; Luborsky et al., 1996). In the current study, the HAq-II demonstrated excellent consistency, $\alpha = .93$.

Therapeutic process. The quality of therapeutic processes was measured by the Individual Therapy Process Questionnaire (ITPQ; Mander et al., 2014), a 36-item measure of therapeutic process factors that are rated on a 5-point scale, where a higher score indicates higher quality therapeutic processes (Appendix 3). The ITPQ's factor structure is composed of eight factors: resource activation, problem actuation, mastery, clarification of meaning, emotional bond, goals and tasks, therapist interference, and patient fear. The ITPQ is meant to be rated by the therapist and the consumer, and can be used in both research and clinical settings. The ITPQ has demonstrated high predictive validity in individual therapy settings, as well as adequate to good internal consistency ($.71 \leq \alpha \leq .90$; Mander et al., 2015). In the current study, the ITPQ demonstrated excellent internal consistency, $\alpha = .94$.

Psychological distress. The Kessler 10 (K10; Appendix 4) is a brief screening measure for psychological distress developed for the US National Health Interview Survey (Kessler et al., 2002). The K10 is valued for both its brevity (10 items rated on a 5-point scale) as well as its ability to discriminate between clinically significant and sub-clinical mental health symptomology. The K10 has demonstrated noteworthy precision and consistent psychometric properties, with good internal consistency ($\alpha = .88$; Kessler et al., 2002). In the current study, the CCCI-R yielded acceptable internal consistency, $\alpha = .78$.

Social Desirability. To help contextualize clinicians' self-ratings, the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) short form version C (Reynolds, 1982) was used (Appendix 5). Items on the Marlowe-Crowne Social Desirability scale were designed to correlate with MMPI validity scales (Crowne & Marlowe, 1960). The short form version C of the Marlowe-Crowne Social Desirability Scale demonstrates a reliability coefficient of .76 and closely correlates with the reliability of the full, standard scale (Reynolds, 1982). In the current study, the Marlowe-Crowne short form yielded lower internal consistency, $\alpha = .65$.

Procedure

Mental health consumer participants were initially directed to a secure online form that explained the study, requested participants' email and physical addresses, and provided a consent form for the participant to complete. After participants completed the form, they received both an email and a physical message in the mail directing them to the online Qualtrics survey for T1. These messages included a unique identifier in order to match the client with their therapist and track the participant over time, as well as a link to retrieve a \$5 Amazon.com gift card incentive. The physical mailing also contained a recruitment packet for the participant to deliver to their therapist. The therapist's packet contained an explanation of the study, a unique identifier, a link to retrieve a \$5 Amazon.com gift card, and a link to the Qualtrics survey.

After three months, all participants received a targeted email and a physical mailing with reminders about the study's purpose, reminders of their unique identifiers, links to retrieve a \$5 Amazon.com gift card, as well as the link for the T2 Qualtrics survey. At both timepoints, participants received two additional email reminders to engage in the study.

Both client participants as well as therapists were informed that therapists had the right to choose whether or not to engage in the study, and that it was up to the therapist whether or not to

divulge their participation to their client. Participants were also debriefed on the possible impacts of study involvement on the therapeutic relationship. Moreover, both client and therapist participants could choose whether or not to retrieve their \$5 Amazon.com gift card. To promote the timely completion of measures and to standardize the length of time between the two time points, participants were asked to complete the online survey within three weeks of receiving their links to the study.

T1. Participants were asked to complete the T1 measures along with demographic data (Appendix 6) within three weeks of receiving their link to the survey. At T1, consumers completed the adapted CCCI-R, the ITPQ, the K10, the HAq-II, and demographic questions. Mental health providers completed the adapted CCCI-R, the ITPQ, the Marlow-Crowne Social Desirability Scale, and demographic questions. Providers were given the option to complete a unique, anonymous username so that they could bypass redundant survey questions if they had more than one client participating in this study; however, no participant used this option.

Participants were also asked to respond to the question “How competent [are you/is your mental health provider] in working with sexual and gender minorities (e.g., people who are lesbian, gay, bisexual, transgender, and queer)?” on a 10-point Likert scale, where higher scores represent higher evaluations of multicultural competence. Participants were asked to explain their rating. In addition, participants answered several open-ended questions about the ways in which they conceptualize SGM multicultural competencies (Appendix 7).

T2. Three months after completing the initial measures, consumers and providers were independently contacted to complete T2 measures. Participants were asked to complete the T2 measures within three weeks of receiving their T2 survey links. The average length of time from T1 to T2 for consumers was 96 days (ranging from 92 to 111 days); for providers, the average

length of time was 99 days (ranging from 92 to 113 days). Consumers completed the adapted CCCI-R, the ITPQ, the HAq-II, and the K10. Mental health providers completed the adapted CCCI-R and the ITPQ. As with T1, participants were asked to rate the provider's SGM-specific competence on a 10-point Likert scale.

Results

Generally speaking, both clients and therapists endorsed relatively high estimates of providers' SGM-specific cultural competence. Specifically, clients and providers were asked to rate a general estimate of the therapists' SGM-specific cultural competence on a scale from zero to ten, where zero represented "not at all competent," five represented "somewhat competent," and ten represented "completely competent." Clients' average rating on this measure was $M = 7.31$, $SD = 1.17$ (responses ranged from 5 to 10), whereas therapists' average rating was $M = 7.72$, $SD = 0.84$ (responses ranged from 6 to 9). Given that the vast majority of clients in this sample selected their therapists due to the therapists' reputation or self-promotion as being LGBTQ-affirmative (89%), these high ratings of competence are not surprising. Additionally, client participants whose therapists did complete the survey ($M = 5.58$, $SD = .61$), and those whose providers did *not* complete the survey ($M = 5.42$, $SD = .48$), did not significantly vary on their perceptions of multicultural competence $t(72) = -1.06$, $p = .30$.

To help contextualize results in this study, therapists were asked to respond to a shortened measure of social desirability. In this sample, therapists answered in a socially desirable way, on average, to 3.75 items on a 13-item scale ($SD = 2.31$, ranging from 0 to 9 items). This falls within the typical range of socially desirable responding compared to other non-forensic samples, and is considered relatively low (Reynolds, 1982). Given these results,

providers' ratings on the CCCI-R should be a relatively accurate representation of their beliefs about their SGM-specific cultural competence.

Differences in Perceptions of Cultural Competence

To answer the first hypothesis, providers' and consumers' CCCI-R scores, respectively, were averaged across the two time points. This decision was made in order to provide a more reliable perspective on multicultural competence, rather than leaving open the possibility that CCCI-R scores reflected one particularly good or bad session.

CCCI-R scores in this sample were not distributed normally and were somewhat positively skewed for clients (see Figure 2), but other assumptions for means comparison were met. Matched pairs *t*-tests are known to be robust to violations of these assumptions (Field, 2013); as such, this test can be interpreted, but must be done so cautiously and within the context of increased chance for Type I errors. A two-tailed, matched pairs *t*-test determined that CCCI-R scores were significantly different between clients ($M = 5.60, SD = 0.53$) and therapists ($M = 6.19, SD = 0.29$), $t(53) = -7.093, p < 0.001, r = 0.70$. To corroborate these results in light of the non-normal sample, the nonparametric Wilcoxon signed ranks test was also run, which reified a significant difference between the two groups, $T = 134.50, p < 0.001, r = -0.44$. Notably, both tests yielded a medium-to-large effect size. Specifically, therapists tended to rate their SGM-specific multicultural competence higher when compared to their clients' ratings.

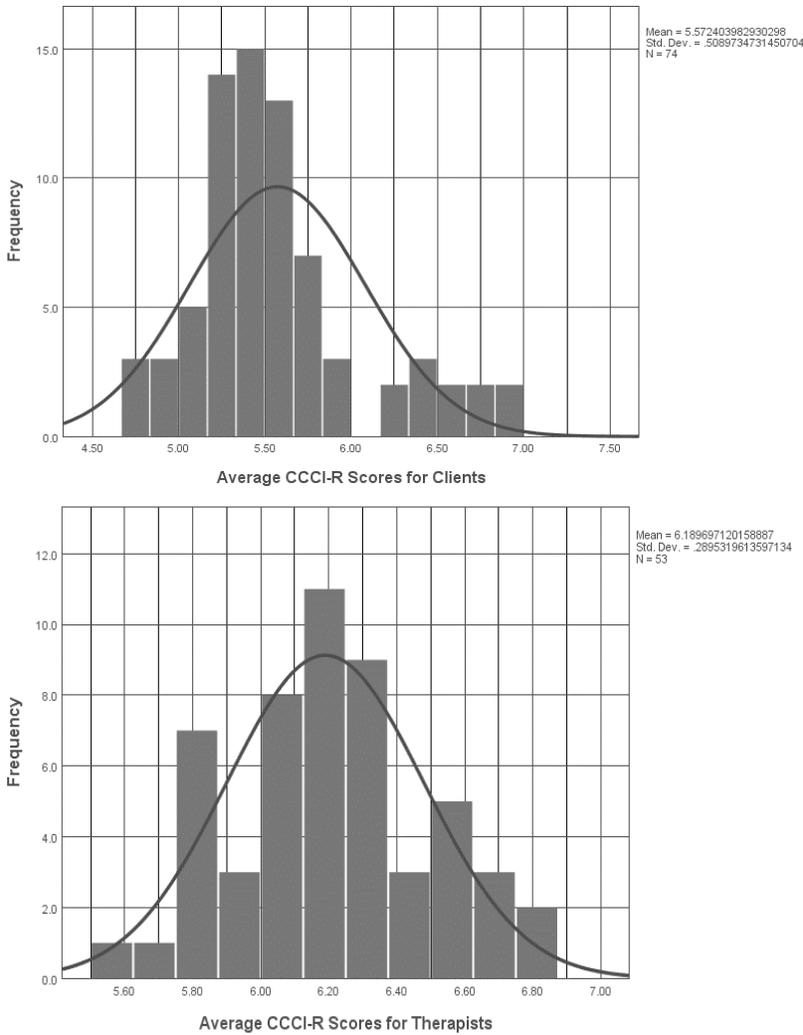


Figure 2. Histograms of CCCI-R scores. This figure illustrates the distribution of clients’ CCCI-R scores (top) and therapist’s CCCI-R scores (bottom).

Therapeutic Process and Perceptions of Cultural Competence

For the second hypothesis, two hierarchical regressions were run. For each regression, block one contained anticipated confounding predictors of the therapeutic process; namely, number of sessions and general satisfaction with treatment (as measured by the HAQ-II) were included. Block two contained the independent variable of either clients’ or therapists’ averaged CCCI-R scores. The dependent variable was the therapeutic process, measured by ITPQ scores

averaged for each dyad and across times. This was decided based on the construction of the ITPQ itself, which suggests that both clients' and clinicians' scores are necessary for describing the therapeutic process, due to the interpersonal nature of this construct (Mander et al., 2014). The ITPQ scores were measured across both timepoints to help glean a more reliable picture of the therapeutic relationship, rather than being indicative of one particularly bad or good session.

Both hierarchical regressions revealed that block one variables contributed significantly to the regression model, where $F(2,50) = 14.223, p < 0.001$ for both. Specifically, this block accounted for 36.3% of the variation in therapeutic process scores. Within block one, only general satisfaction was significantly correlated with the therapeutic process (see Table 2).

In the first hierarchical regression, clients' perspectives of cultural competence, as measured by their averaged CCCI-R scores, accounted for an additional 5.9% of the variation in therapeutic process, $F(3,49) = 11.92, p = 0.03$. In the second hierarchical regression, therapists' perspectives of cultural competence were not significantly predictive, accounting for almost no additional variation beyond block one, $F(3,49) = 9.32, p = 0.83$. See Table 2 for tabulated results from the second hypothesis.

While multicollinearity generally did not present as a statistical problem in these analyses, it is possible that consumers' general satisfaction with treatment was intertwined with their perceptions of cultural competence (see Table 3 for variable correlations). Thus, it is possible that including general satisfaction in the model may have absorbed much of the variance, obscuring the broader impact of multicultural competence on the model. When these analyses were run without the HAQ-II scores included, clients' CCCI-R scores accounted for an additional 19.9% of the variance after controlling for total number of sessions, $F(2,50) = 13.81, p < .001$. When HAQ-II scores were excluded from the model using therapists' CCCI-R scores and

controlling for number of sessions, the model gained statistical significance $F(2,50) = 4.68, p = .01$. However, therapists' CCCI-R scores did not significantly contribute to the model and only accounted for 1% of the variance.

Table 2

Summary of Hierarchical Regression Analysis for Variables Predicting ITPQ (Therapeutic Process)

Variable	β	t	sr^2	R	R^2	ΔR^2
Step 1				.60	.36	.36
HAq-II (client satisfaction)	.61	4.01**	.06			
Number of sessions	-.01	-.08	.00			
Step 2				.65	.42	.06
HAq-II (client satisfaction)	.41	2.37*	.07			
Number of sessions	-.11	-.75	.00			
Client CCCI-R (cultural competence)	.37	2.24*	.09			
Step 1				.60	.36	.36
HAq-II (client satisfaction)	.61	4.01**	.06			
Number of sessions	-.01	-.08	.00			
Step 2				.60	.36	.00
HAq-II (client satisfaction)	.61	3.98**	.06			
Number of sessions	-.01	-.09	.00			
Therapist CCCI-R (cultural competence)	-.03	-.21	.11			

Note. ** $p < .01$, * $p < .05$

Table 3

Correlation Table of Model Variables

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6
1. HAq-II (client satisfaction)	5.03	.72	--	.63**	.54**	-.01	.37**	-.13
2. Number of sessions	11.99	27.92	.63**	--	.42**	-.14	.25	-.34**
3. Client CCCI-R (cultural competence)	.5.59	.41	.54**	.42**	--	-.01	.47**	-.06
4. Therapist CCCI-R (cultural competence)	6.21	.24	-.01	-.14	-.01	--	-.03	-.02
5. ITPQ scores (therapeutic process)	3.58	.23	.37**	.25	.47**	-.03	--	-.13
6. K10 change scores (distress)	-.41	.53	-.13	-.34**	-.06	-.02	-.13	--

Note. ** $p < .01$, * $p < .05$

Predicting Changes in Psychological Distress

For the third hypothesis, two hierarchical regressions were again conducted. For each regression, block one contained anticipated confounding predictors for psychological distress at T2; namely, number of sessions, general satisfaction with treatment (as measured by the HAq-II), and psychological distress at T1 (as measured by the K10) were included. Block two contained the independent variable of either clients' or therapists' averaged CCCI-R scores. The dependent variable was clients' K10 scores at T2.

Both hierarchical regressions revealed that block one variables contributed significantly to the regression model. For the model with clients' perceptions of cultural competence, block

one accounted for 25.0% of the variation in psychological distress at T2, $F(3,60) = 8.01, p < 0.001$. For the model with therapists' perceptions of cultural competence, block one accounted for 26.5% of the variation in psychological distress, $F(3,49) = 5.884, p = 0.002$. Within block one for each regression, only psychological distress at T1 was significantly correlated with the psychological distress at T2 (see Table 4).

In these models, neither clients' nor therapists' averaged CCCI-R scores were significantly predictive of K10 scores at T2. Clients' CCCI-R scores accounted for 2.3% of the variance beyond block one, $F(4,59) = 6.59, p = 0.17$. Therapists' CCCI-R scores accounted for almost no additional variance beyond block one, $F(4,48) = 4.32, p = 0.99$. See Table 3 for tabulated results regarding the third hypothesis.

To test if the lack of a significant result might be due to a lack of power, I re-ran the analyses using a change score for psychological distress and removing HAq-II scores from the model, thereby reducing two variables in the regression and increasing the models' degrees of freedom. Similarly, this test was not significant for clients' CCCI-R scores, $F(2,61) = 1.38, p = 0.26$, nor for therapists' CCCI-R scores, $F(32,50) = .17, p = 0.84$.

Table 4

Summary of Hierarchical Regression Analysis for Variables Predicting CCCI-R (Cultural Competence)

Variable	β	t	sr^2	R	R^2	ΔR^2
Step 1				.54	.29	.29
HAq-II (client satisfaction)	-.11	-.80	.09			
Number of sessions	.21	1.39	.00			
K10 (psychological distress)	.44	3.66**	.18			

Step 2				.56	.31	.02
HAq-II (client satisfaction)	.03	.19	.11			
Number of sessions	.25	1.62	.00			
K10 (psychological distress)	.46	3.84**	.18			
Client CCCI-R (cultural competence)	-.23	-1.40	.14			
Step 1				.52	.27	.27
HAq-II (client satisfaction)	-.01	-.06	.09			
Number of sessions	.25	1.43	.00			
K10 (psychological distress)	.36	2.67*	.18			
Step 2				.52	.27	.00
HAq-II (client satisfaction)	-.01	-.06	.09			
Number of sessions	.25	1.41	.00			
K10 (psychological distress)	.36	2.63*	.18			
Therapist CCCI-R (cultural competence)	.00	.01	.18			

Note. ** $p < .01$, * $p < .05$

Discussion

Summary

The current study sought to shed light on the nature of SGM-specific multicultural competence in therapy dyads, and to describe the ways in which perceptions of SGM-specific multicultural competence were related to treatment outcomes. Results from this study

demonstrated that therapists had significantly higher evaluations of their SGM-specific multicultural competence when compared to their SGM clients. When perceptions of SGM-specific cultural competence were used to predict treatment outcomes, it was found that clients' perceptions of their providers' SGM-specific multicultural competence, and not therapists' perceptions, were significantly predictive of therapeutic process outcomes. In particular, clients' perceptions of their providers' SGM-specific multicultural competence accounted for therapeutic process outcomes above and beyond their general satisfaction with treatment. However, perceptions of SGM-specific cultural competence were not significantly predictive of improvements in clients' psychological distress, regardless of whether the report of cultural competence came from the client or the therapist.

Implications

The potential implications for this study span the areas of research and practice. Because there is a general dearth of empirical literature on mental health providers' SGM competencies, there exists no consensus on how to measure or operationalize multicultural competencies with SGM mental health consumers. Moreover, few studies consider the ways in which perspectives on multicultural competence diverge across therapy dyads, and none explore these topics in relation to SGM consumers. Altogether, this study gleans insight into how mental health providers and SGM consumers experience multicultural competence in the therapy room, and offers reasons for why those disparate perspectives are important.

Given that therapists may gauge their SGM-specific cultural competence more positively than their clients suggests that more intentional evaluation of SGM clients' experiences in therapy is warranted. While both clients and therapists tended to rate therapists' SGM-specific cultural competence relatively highly, the fact that such a subtle discrepancy could still produce

significantly different results raises questions about how this discrepancy functions in the therapeutic relationship. There are multiple theories that could explain such a discrepancy, not the least of which is that people generally think about themselves more highly than evidence might suggest (e.g., Kruger & Dunning, 1999). Moreover, research suggests that mental health providers do not consistently report on therapeutic practices in a way that can be easily or clearly validated, suggesting that providers' ideas about the content of therapy might not reflect observable practice (Borntrager, Chorpita, Orimoto, Love, & Mueller, 2015). In the case of multicultural competence, it is possible that therapists' intentions do not equate to the reception of competent practice by sexual and gender minority mental health consumers. For SGM-specific multicultural competencies in particular, rapid sociopolitical shifts outside and within SGM communities might further complicate the maintenance of relevant cultural knowledge, and providers who were once up-to-date might find their pertinent competencies to be lacking.

Notably, the current sample significantly differs in demographic backgrounds between clinicians and mental health consumers. It is possible that differences in perception of multicultural competence in the current study could be rooted in these intersecting identities as they exist within individuals and across therapy dyads. It is possible that a sample matched on demographic factors such as race may have more similar perceptions of multicultural competence. Future research on multicultural competence would benefit from more careful consideration of intersecting identities.

The very concept of cultural "blind spots" infers that certain biases and informational gaps are difficult to recognize until they are intentionally pointed out. As such, providers would do well to invite feedback about their SGM-specific multicultural competence from their clients. Notably, SGM mental health consumers have reported about needing to educate their mental

health providers about SGM-specific concerns and experiences (Blondeel et al., 2016); therefore, such feedback from SGM clients should be welcomed—but not necessarily expected. The importance of continuing education is particularly salient here, as with other multicultural competencies; “culture” itself is dynamic and shifts with the chronosystem. Thus, ongoing training—both formal and informal—are crucial for maintaining multicultural competence over time. To improve and maintain their SGM-specific multicultural competence, therapists could consider attending SGM community events, subscribe to SGM-focused newsletters and blogs, stay abreast of sociopolitical issues impacting SGM individuals, and attend “refresher” trainings on evolving SGM terminology. As others have pointed out, multicultural competence should be understood as a process, and not a point of arrival or a thing to be achieved (e.g., Sue, 1998).

The incongruence between providers’ and clients’ perceptions differentially predicted the therapeutic process. Therapeutic process outcomes have been linked to engagement in therapy, both in terms of early termination and treatment adherence (Holdsworth, Bowen, Brown, & Howat, 2014). In particular, this literature emphasizes the significance of clients’ perception of the therapy process, rather than providers’, for predicting treatment engagement. This is particularly important given that there is research to suggest that some minority group clients drop out of treatments at higher rates than non-minority individuals (Olfson, Mojtabai, Sampson, Hwang, & Kessler, 2009); however, no research to date looks at treatment retention among SGM mental health consumers in outpatient mental health care. Future research should explore the relationship between providers’ SGM-specific multicultural competence and SGM individuals’ early termination of therapy.

The difference between SGM consumers’ and their therapists’ perceptions of multicultural competence raises additional questions that fall outside the scope of this project. It

is possible that this mismatch in perceptions could result in therapy ruptures that are misperceived by the therapist, who might be unaware of their own misstep. Given that ample research suggests that past bad experiences in therapy predict future utilization of mental health services (Romanelli & Hudson, 2017), it is possible that one microaggression—missed by the therapist—could impact the client’s engagement and eventual re-engagement in therapy. Indeed, the way this incongruence could play out is numerous; for example, a cognitive therapist might try to challenge a client’s fear of discrimination or violence, seeing it is unlikely, when the likelihood of such an event might be high and very real. Or a therapist might repeatedly use the label of “gay” as synonymous with “queer” for their client when the client explicitly identifies as “queer,” which could cause the client to feel exasperated or simply not seen in the therapy relationship. Moreover, these sorts of events leave the onus of rectifying the therapist’s behavior on the client; a trend which, as previously mentioned, is frequently endorsed by SGM consumers of mental health care as a barrier to services (Blondeel et al., 2016).

Furthermore, the discrepancy between clients’ and therapists’ perceptions of SGM-specific multicultural competencies is noteworthy from a research standpoint. Existing studies that rely on providers’ self-reports of multicultural competence might not be capturing the whole picture of competency. Indeed, such a reliance on providers’ self-report could overlook significant relationships between multicultural competence and other variables of interest, as highlighted in this study’s second hypothesis. Moreover, if such a relatively small discrepancy produced significantly different results, as it did in the present study, this might have even more significant impacts in therapy dyads wherein a provider objectively and acutely lacks multicultural competence.

This has far-reaching implications for measures of multicultural competence more broadly; most existing measures rely on clinicians' report, and there are very few validated measures that rely on clients' perspectives (Ponterotto, 2000). It becomes complicated, then, to measure the implementation of multicultural competence directives from large professional organizations and accrediting/licensing bodies. Without proper measurement, such directives risk becoming hollow aspirations that lack the power to be gauged and enforced.

In the current study, perceptions of SGM-specific multicultural competence did not significantly explain changes in clients' psychological distress. These results suggest that other factors not accounted for in the current models are better predictors of symptom outcomes. Future studies should explore the relationship between SGM-specific multicultural competence and the dual continuum model of mental health, which accounts for both general symptomology as well as quality of life (Bariola, Lyons, & Lucke, 2017). It is possible that certain mental health outcomes that are better captured by quality of life indices could be linked the perceptions of SGM multicultural competence.

Lastly, it is worth returning to the point that mental health consumers endorsed consistently high perceptions of their providers' SGM-specific multicultural competence. On the single-item estimation of providers' competence, all consumers indicated that their therapist was "somewhat competent" to "completely competent," with an average that fell halfway between these two constructs. Indeed, therapists on average indicated that they had received multiple forms of training and had worked with an arguably substantial number of SGM clients. This finding highlights an important strength of the mental health field, and serves as a positive indication of the field's evolving capabilities to adequately address the concerns of SGM individuals. Researchers should consider looking at conditions of high and low LGBTQ-

affirmation by therapists in the future, given that markedly low SGM-specific cultural competence is not represented in the current sample.

Limitations

This study includes several methodological and theoretical limitations. First, SGM individuals might be more motivated to partake in this study if they have strong opinions of their providers' SGM multicultural competence (either negative or positive). Indeed, perceptions of SGM-specific multicultural competence trended high in this study. Deliberately studying high and low affirmation conditions that naturally occur across treatment settings would likely provide a more complete understanding of the impact of SGM-specific multicultural competencies on treatment outcomes.

Given the diverging theoretical backgrounds regarding multicultural competence, future research should apply different measures of the construct to approach a clearer picture of affirmative practice. The current study utilizes the CCCI-R (LaFromboise et al., 1991), which has been criticized for its content validity despite its abundant use in the literature. Nonetheless, there are no validated measures that capture SGM-specific multicultural competence, which warrants the construction and validation of such a measure in the future.

Additionally, it is possible that other confounding factors not accounted for in the current models might be better predictors of treatment outcomes. For example, clients who come from a particularly stigmatizing background might rate an "average" provider as higher on SGM-specific multicultural competence, whereas clients who are regularly surrounded by progressive and affirming groups of people might see the same provider as comparatively lacking in competence. Future studies should explore how minority stress and resiliency are related to perceptions of others' SGM-specific multicultural competence.

As previously noted, the current sample lumps together SGM individuals with a variety of queer and transgender identities. It is possible that the effects of relationships noted in this study are stronger or weaker across individual identity groups. Moreover, the current models do not account for the ways in which intersecting identities might interact with experiences of providers' SGM-specific multicultural competence.

Notably, this study does not consider the ways in which mental health systems more broadly might be influenced by sociopolitical factors that in turn impact the therapy experiences of individual SGM consumers. Future research should explore these broader influences, such as models for SGM-specific multicultural competence (e.g., practitioner-advocate models, cultural humility frameworks, etc.) and chronosystem factors (e.g., how mental health systems change over time in response to those sociopolitical factors, such as presidential legacies and mass hate crimes), and how they impact the experiences of SGM mental health consumers.

Conclusion

Although SGM-affirmative practice is recognized as the standard of care for working with SGM individuals, there is little empirical research into the construct of SGM-specific multicultural competence and how it exists in the therapy room. The current study serves as an important contribution to the literature, in that it describes therapist's cultural blind spots and underscores the relationship between affirmative practice and therapeutic process outcomes. By gaining insight into our limitations as providers, we can glean strategies for bolstering our affirmative care practices.

Altogether, this study stresses the importance of eliciting SGM individuals' perspectives on their experiences in mental health treatment. Historically and in the present, SGM individuals have been at the mercy of mental health professionals, who have served as both 'objective'

authorities for modeling sociopolitical attitudes toward SGM people, as well as gatekeepers to needed services for SGM health consumers. By highlighting relationships between clients' perceptions of multicultural competencies and treatment outcomes, this study aims to uplift the experiences of SGM mental health consumers to help steer the mental health community toward more affirmative research and practice.

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Appendix 1: ADAPTED Cross-Cultural Counseling Inventory Revised (CCCI-R)

The purpose of this inventory is to measure your perceptions about the Cross Cultural Counseling Competence of you (your therapist/counselor). We are interested in your opinion so please make a judgment on the basis of what the statements in this inventory mean to you. In recording your response, please keep the following points in mind:

- a. Please circle the appropriate rating under each statement.
- b. Please circle only one response for each statement.
- c. Be sure you check every scale even though you may feel that you have insufficient data on which to make a judgment—please do not omit any.

Rating Scale:	1 = strongly disagree	4 = slightly agree
	2 = disagree	5 = agree
	3 = slightly disagree	6 = strongly agree

- | | | | | | | | |
|----|---|---|---|---|---|---|---|
| 1. | Counselor is aware of his or her own cultural heritage and social background. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. | Counselor values and respects cultural differences. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. | Counselor is aware of how own values might affect this client. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. | Counselor is comfortable with differences between counselor and client. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. | Counselor is willing to suggest referral when cultural differences are extensive. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. | Counselor understands the current socio-political system and its impact on the client. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. | Counselor demonstrates knowledge about client's culture and social background. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. | Counselor has a clear understanding of counseling and therapy process. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. | Counselor is aware of institutional barriers which might affect client's circumstances. | 1 | 2 | 3 | 4 | 5 | 6 |

Rating Scale: 1 = strongly disagree 4 = slightly agree
 2 = disagree 5 = agree
 3 = slightly disagree 6 = strongly agree

10.	Counselor elicits a variety of verbal and non-verbal responses from the client.	1	2	3	4	5	6
11.	Counselor accurately sends and receives a variety of verbal and non-verbal messages.	1	2	3	4	5	6
12.	Counselor is able to suggest institutional intervention skills that favor the client.	1	2	3	4	5	6
13.	Counselor uses language that respects the client's identity.	1	2	3	4	5	6
14.	Counselor attempts to perceive the presenting problem within the context of the client's cultural experience, values, and/or lifestyle.	1	2	3	4	5	6
15.	Counselor presents his or her own values to the client.	1	2	3	4	5	6
16.	Counselor is at ease talking with this client.	1	2	3	4	5	6
17.	Counselor recognizes those limits determined by the cultural and social differences between client and counselor.	1	2	3	4	5	6
18.	Counselor appreciates the client's social status as a sexual and/or gender minority.	1	2	3	4	5	6
19.	Counselor is aware of the professional and ethical responsibilities of a counselor.	1	2	3	4	5	6
20.	Counselor acknowledges and is comfortable with cultural differences.	1	2	3	4	5	6

Appendix 2: The Revised Helping Alliance Questionnaire Patient version

Instruction: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

Rating scale: 1 = strongly disagree; 2 = disagree; 3 = slightly disagree; 4 = slightly agree; 5 = agree; 6 = strongly agree

1. I feel I can depend upon the therapist.
2. I feel the therapist understands me.
3. I feel the therapist wants me to achieve my goals.
4. At times I distrust the therapist's judgment.
5. I feel I am working together with the therapist in a joint effort.
6. I believe we have similar ideas about the nature of my problems.
7. I generally respect the therapist's views about me.
8. The procedures used in my therapy are not well suited to my needs.
9. I like the therapist as a person.
10. In most sessions, the therapist and I find a way to work on my problems together.
11. The therapist relates to me in ways that slow up the progress of the therapy.
12. A good relationship has formed with my therapist.
13. The therapist appears to be experienced in helping people.
14. I want very much to work out my problems.
15. The therapist and I have meaningful exchanges.
16. The therapist and I sometimes have unprofitable exchanges.
17. From time to time, we both talk about the same important events in my past.
18. I believe the therapist likes me as a person.
19. At times the therapist seems distant.

Appendix 3: Individual Therapy Process Questionnaire (ITPQ)

Instruction: How did you experience today's therapy session? Using the rating scale below, please indicate how strongly the following 36 items apply to you. Though the content of some items might not seem suitable to you, please respond to all 36 items.

Rating scale: 0 = does not apply; 1 = somewhat applies; 2 = half□ applies;
3 = predominantly applies; 4 = fully applies

20. Today, I felt comfortable in the relationship with the patient (therapist).
21. In today's session, the patient (I) was highly emotionally involved.
22. In today's session, the patient (I) felt where his/her (my) strengths lie.
23. Today, I (the therapist) enabled the patient (me) to view his/her (my) problems in new contexts.
24. Today, the patient (therapist) and I worked toward mutually agreed upon goals
25. Today, the patient (therapist) and I agreed about the steps to be made in therapy.
26. After today's session, I assume that the patient (I) can cope better with situations which are difficult for him/her (me).
27. The patient (therapist) and I understood each other today.
28. Today, I (the therapist) touched the patient's (my) sore spots.
29. By means of today's session, the patient (I) felt enhanced in his/her (my) self□ concept.
30. The patient(I) has (have) a better understanding of himself/herself (myself) and his/her (my) difficulties after today's session.
31. Today, the patient (therapist) and I had a good understanding of what changes are good for him/her (me).
32. The patient (therapist) and I agreed on the usefulness of the activities in today's session.
33. Today, we really made progress in therapy in overcoming the patient's (my) problems.
34. Today, I felt that the patient (therapist) appreciates me.
35. What we did today affected the patient (me) very deeply.
36. Today, I (the therapist) intentionally used the patient's (my) abilities for therapy.
37. Today, the patient (I) became more aware of the motives for his/her (my) behavior.

38. Today, the patient (therapist) and I had a shared view on what his/her (my) real problems are.
39. Today, the patient (therapist) agreed with me on how therapy was conducted.
40. I have the impression that the patient's (my) capacity to act improved by today's session.
41. I feel that the things the patient (I) did today in therapy will help him/her (me) to accomplish the changes that he wants (I want).
42. What the patient is (I am) doing in therapy gives him/her (me) new ways of looking at his (my) problem.
43. Today, I (the therapist) pushed my patient (me) too much on certain issues.
44. The patient (I) didn't talk about certain feelings today because he/she (I) was afraid about what I (the therapist) might think about him/her (me).
45. Today, I had the feeling that my patient (therapist) likes me.
46. I (My therapist) care (cares) about the patient (me) even when he/she does (I do) things that I do (he/she does) not approve of.
47. There were aspects of my (my therapist's) personality that seemed to interfere with (my) therapy today.
48. It was too embarrassing for the patient (me) today to tell me (the therapist) about certain thoughts and feelings.
49. As a result of today's session I am confident that, through my own efforts and those of my patient (therapist) my patient (I) will gain relief from his/her (my) problems.
50. As today's session started, I (the therapist) had no desire to get involved.
51. Today, I (the therapist) insufficiently acknowledged the patient's (my) efforts and progress.
52. Today, it was difficult for the patient (me) to talk openly with me (the therapist) about his/her (my) thoughts and feelings.
53. During today's session the patient (I) held back his/her (my) emotions.
54. I (the therapist) was too emotionally withholding or absent today.
55. As a result of today's session the patient is (I am) clearer as to how he/she (I) might be able to change.

Appendix 4: Kessler Psychological Distress Scale 10 (K10)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. In the last four weeks, about how often did you feel tired out for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. In the last four weeks, about how often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. In the last four weeks, about how often did you feel hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In the last four weeks, about how often did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. In the last four weeks, about how often did you feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. In the last four weeks, about how often did you feel restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. In the last four weeks, about how often did you feel so restless you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. In the last four weeks, about how often did you feel that everything was an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. In the last four weeks, about how often did you feel so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix 5: Marlowe-Crowne Social Desirability Scale Short Form Version C

Instruction: Please respond true or false to each statement.

1. It is sometimes hard for me to go on with my work if I am not encouraged.
2. I sometimes feel resentful when I don't get my way.
3. On a few occasions, I have given up doing something because I thought too little of my ability.
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.
5. No matter who I'm talking to, I'm always a good listener.
6. There have been occasions when I took advantage of someone.
7. I'm always willing to admit it when I make a mistake.
8. I sometimes try to get even rather than forgive and forget.
9. I am always courteous, even to people who are disagreeable.
10. I have never been irked when people expressed ideas very different from my own.
11. There have times when I was quite jealous of the good fortune of others.
12. I am sometimes irritated by people who ask favors of me.
13. I have never deliberately said something that hurt someone's feelings.

Appendix 6: Demographic Questions**Time 1: Therapist**

1. What is your age?
2. Which gender do you identify with?
 - a. Male
 - b. Female
 - c. Genderqueer
 - d. Another gender not listed: _____
3. What is your sex assigned at birth?
 - a. Male
 - b. Female
4. What is your sexual orientation
 - a. Heterosexual
 - b. Bisexual/Pansexual
 - c. Lesbian/Gay
 - d. Another orientation not listed: _____
5. What is your race?
 - a. Black/African American
 - b. Native American/Alaska Native
 - c. Latinx/Hispanic
 - d. Asian
 - e. White/Caucasian
 - f. Native Hawaiian or Other Pacific Islander
 - g. Another race not listed: _____
6. Are you a
 - a. Clinical Psychologist
 - b. Counselor
 - c. School Psychologist
 - d. Clinical Social Worker
 - e. Other: _____
7. What types of training have you received in working with lesbian, gay, bisexual, transgender, and queer clients?
 - a. Dedicated graduate school courses focusing solely on sexual and/or gender minorities
 - b. A section of a general multicultural competence course in graduate school
 - c. Dedicated continuing education training focusing solely on sexual and/or gender minorities
 - d. A section of continuing education course on general multicultural competence
 - e. A community presentation focusing solely on sexual and/or gender minorities
 - f. A community presentation focusing on issues generally related to diversity
 - g. A primary supervisor with a general focus on multicultural competence
 - h. A primary supervisor with a specific focus on working with sexual and/or gender minorities

- i. Other: _____
8. About how many clients have you worked with who identify as lesbian/gay/bisexual/queer?
9. About how many clients have you worked with who identify as transgender?

Time 1: Consumer

1. What is your age?
2. Which gender do you identify with?
 - a. Male
 - b. Female
 - c. Genderqueer
 - d. Anther gender not listed: _____
3. What is your sex assigned at birth?
 - a. Male
 - b. Female
4. What is your sexual orientation
 - a. Heterosexual
 - b. Bisexual/Pansexual
 - c. Lesbian/Gay
 - d. Another orientation not listed: _____
5. What is your race?
 - a. Black/African American
 - b. Native American/Alaska Native
 - c. Latinx/Hispanic
 - d. Asian
 - e. White/Caucasian
 - f. Native Hawaiian or Other Pacific Islander
 - g. Another race not listed: _____
6. What is your highest level of education
 - a. Did not complete high school
 - b. High school or GED
 - c. Trade school/Certificate program
 - d. Some college
 - e. Associate's degree
 - f. Bachelor's degree
 - g. Master's degree
 - h. Doctoral-level degree
7. Approximately what is your combined household income?
 - a. Less than \$20,000
 - b. \$20,000 - \$40,000
 - c. \$40,000 - \$75,000
 - d. \$75,000 – \$100,000
 - e. \$100,000 or above
8. What is the main reason that you sought out therapy? (select all that apply)
 - a. Depression

- b. Anxiety
 - c. Substance use/abuse
 - d. Suicidal thoughts
 - e. Obsessions and compulsions
 - f. Disordered eating/body image concerns
 - g. Trauma
 - h. Sleep concerns
 - i. Family concerns
 - j. Relationship concerns
 - k. General life stress
 - l. Another reason: _____
9. Have you been in mental health treatment before?
- a. Yes, once
 - b. Yes, multiple times
 - c. No
10. Did you seek out your current mental health provider based on their competence working with lesbian, gay, bisexual, transgender, and/or queer individuals?
- a. Yes
 - b. No

Time 2: Therapist

1. Which gender do you identify with?
 - a. Male
 - b. Female
 - c. Genderqueer
 - d. Another gender not listed: _____
2. What is your sexual orientation
 - a. Heterosexual
 - b. Bisexual/Pansexual
 - c. Lesbian/Gay
 - d. Another orientation not listed: _____
3. What types of training have you received in working with lesbian, gay, bisexual, transgender, and queer clients?
 - a. Dedicated graduate school courses focusing solely on sexual and/or gender minorities
 - b. A section of a general multicultural competence course in graduate school
 - c. Dedicated continuing education training focusing solely on sexual and/or gender minorities
 - d. A section of continuing education course on general multicultural competence
 - e. A community presentation focusing solely on sexual and/or gender minorities
 - f. A community presentation focusing on issues generally related to diversity
 - g. A primary supervisor with a general focus on multicultural competence
 - h. A primary supervisor with a specific focus on working with sexual and/or gender minorities

- i. Other: _____
- 4. About how many clients have you worked with who identify as lesbian/gay/bisexual/queer?
- 5. About how many clients have you worked with who identify as transgender?

Time 2: Consumer

- 11. Which gender do you identify with?
 - a. Male
 - b. Female
 - c. Genderqueer
 - d. Another gender not listed: _____
- 12. What is your sexual orientation
 - a. Heterosexual
 - b. Bisexual/Pansexual
 - c. Lesbian/Gay
 - d. Another orientation not listed: _____
- 13. What is your highest level of education
 - a. Did not complete high school
 - b. High school or GED
 - c. Trade school/Certificate program
 - d. Some college
 - e. Associate's degree
 - f. Bachelor's degree
 - g. Master's degree
 - h. Doctoral-level degree
- 14. Approximately what is your combined household income?
 - a. Less than \$20,000
 - b. \$20,000 - \$40,000
 - c. \$40,000 - \$75,000
 - d. \$75,000 - \$100,000
 - e. \$100,000 or above

Appendix 7: Open-ended Questions

Therapist questions

1. How competent are you in working with sexual and gender minorities (e.g., people who are lesbian, gay, bisexual, transgender, and queer)?

Not at all					Somewhat					Completely
1	2	3	4	5	6	7	8	9	10	
2. Give an (anonymous) example of the best thing you have ever done in your clinical practice that demonstrated multicultural competence with sexual and/or gender minorities.
3. Give an (anonymous) example of the worst thing you have ever done in your clinical practice that demonstrated multicultural *in*competence with sexual and/or gender minorities.

Consumer questions

1. How competent is your therapist/counselor in working with sexual and gender minorities (e.g., people who are lesbian, gay, bisexual, transgender, and queer)?

Not at all					Somewhat					Completely
1	2	3	4	5	6	7	8	9	10	
2. In your opinion, what are the main factors that make up cultural competence for therapists and counselors working with sexual and gender minority individuals?
3. In your opinion, what kind of training would be important for improving therapists' and counselors' cultural competence for working with sexual and gender minority individuals?