6-6-2024

The Cultivation and Integration of Cultural Humility and Cultural Competence in LGBTIQ+ Client Work: A Constructivist Grounded Theory Approach

Gon Ratanashevorn
University of Missouri-St. Louis, r.rattanakorn@gmail.com

The Cultivation and Integration of Cultural Humility and Cultural Competence in LGBTIQ+ Client Work: A Constructivist Grounded Theory Approach

by

Rattanakorn (Gon) Ratanashevorn

M.A., Counseling Psychology, Chulalongkorn University, 2013
B.S., Psychology, Chulalongkorn University, 2009

A Dissertation

Submitted to The Graduate School of the

University of Missouri-St. Louis
in partial fulfillment of the requirements for the degree

Doctor of Philosophy

in

Education with an emphasis in Counseling

August 2024

Advisory Committee

Susan Kashubeck-West, Ph.D.
Chairperson

Phillip Waalkes, Ph.D.

Emily Brown, Ph.D.

Amney Harper, Ph.D.

Abstract

Previous researchers have highlighted the lack of consistency and standards in LGBTIQ+ cultural competence trainings which may cause negative therapy experiences for LGBTIQ+ clients. This research empirically explored counselors' (n = 12) process of the cultivation and integration of LGBTIQ+ cultural competence and cultural humility to inform training which leads to better services for LGBTIQ+ clients through constructivist grounded theory method. *The theory of the life-long cultivation and integration of LGBTIQ+CC and cultural humility* emerged with five categories: (1) motivation to do right by queer clients, (2) cultivating the right soil for queer folks, (3) walking the walk to integrate knowledge into practice, (4) the multifaceted application of LGBTIQ+CC and cultural humility, and (5) hardship, maintenance and self-care. The emerging theory offers a clear and organized blueprint for the process of cultivation, integration, and application of LGBTIQ+ cultural competence and cultural humility. The result of this study informs the training and practice towards betterment of counseling service for LGBTIQ+ clients and community.

Keywords: cultural humility, LGBTIQ+ cultural competence, cultivation, integration, LGBTIQ+ clients, counselor education, and constructivist grounded theory.

Acknowledgements

Even though this dissertation is my dearest creation, it would not have been possible without the guidance, advice and support of people who have surrounded me with care and love along the journey of my PhD and dissertation. First, I would like to express ineffably gratitude towards my advisor and chair, Dr. Susan Kashubeck-West, for her support and unwavering trust on me. She has been the pillar of my journey. Words cannot describe how much she has consistently and willfully helped me throughout the whole process. I could not have asked for a better guide and role model in my academic journey. I also would like to thank the rest of my dissertation committee; Dr. Phillip Waalkes for his prompt responses and support on my data collection, data analysis, and trustworthiness of the qualitative methodology; Dr. Emily Brown, and Dr. Amney Harper for their help in my dissertation design and writing refinement.

My journey has been blessed because of countless number of mentors along the way. Especially, I would like to dedicate my dissertation to the belated Dr. Mark Pope who had been an amazing mentor during the last bit in his life to make sure that I had been well supported in all possible aspects that he could, as well as a role model and inspiration for my research and advocacy journey for LGBTIQ+ population. I would like to thank Dr. Robert Conyne who has always been an unbelievably amazing mentor and guide in my academic journey since the day that we met in Thailand. Being considered as a top-notched student by him is an honor and a great motivation of mine to keep going and growing in my academic journey. I would like to also thank other professors at UMSL, especially Dr. So Rin Kim and Dr. Yuima Mizutani, who have been a great

mentor for my professional development as an international scholar in academia. I also want to thank Dr. Eunhui Yoon for all of the support.

I appreciate the help and support for all of the colleagues and collaborators both in Thailand and the U.S. (Dr. Timo Ojanen, UMSL, Relief Counseling Center, Ponce Health Science University, Webster University). I love my cohort and how all of them have helped me grow personally and professionally - especially, Sarah and Breon. I want to thank all of my friends (Pui, Tan, Parkorn, Natty, Johnny, Kirin, Corey, Harue, Tim, and Larry) and family in North America (Portland, Minneapolis, and Quebec City) as well as friends (Trinity, Nui, Song) and family (dad, mom, my nanny, my uncles and aunts, my siblings, my beautiful nephew and niece) in Thailand. Without all of you, I would not have made it to the end of this journey.

Last but not least, I would like to appreciate the help and participation of all the participants and nominators who made this dissertation possible. I am genuinely grateful that I was trusted and honored to be the one delivering the message and voices of all of my participants, in order to fill the knowledge gaps in practice and training of LGBTIQ+ cultural competence and cultural humility towards the betterment of mental health counseling services for LGBTIQ+ clients and community. All of the work and information shared by the participants in this study have inspired me to even more so advocate for LGBTIQ+ communities, both in the U.S. and Thailand.

Table of Contents

List of Figures

Chapter 1

Introduction

Society has perpetuated the ideology of heterosexual identities as desirable, central, and mainstream on societal and institutional levels (Herek, 2009). Such ideology does not only set up a standard that deems heterosexual and cisgender identities as desirable, acceptable, and normal, it also stigmatizes sexual and gender minority individuals in society. LGBTIQ+ people are faced with injustice in society (Gedro & Mizzi, 2014), such as stigma, prejudice, and stereotypes that create additional stress and hardship for them (Herek, 2009; Meyer, 2003).

The injustices linked to their identities impacts LGBTIQ+ people in the society in different forms and levels. For example, the concept of heteronormativity may lead to a belief and assumption that identities, and relationships of people in the society are heterosexual. The concept of heteronormativity also perpetuates a prejudice that a heterosexual way of living is the only right and normal way. Accordingly, these assumptions lead to silence and oppression of those who deviate from the sexual and gender norms and expectations (Gedro & Mizzi, 2014).

Another aspect of heteronormativity that harms LGBTIQ+ people is the use of fixed heteronormative binary labels and categories (e.g., male or female, masculine or feminine). The use of fixed labels is accompanied by the worldview that each label is associated with certain characteristics or expression; this creates stereotypes and images about these labels that are static and assumptions that might not fit all members under the same label or category. This kind of overgeneralization and stereotyping also happens with marginalized sexual and gender identities, such as gay, lesbian, bisexual,

transgender, as well, resulting in misunderstanding, inaccurate stereotypes, and assumptions about LGBTIQ+ people (Brooke, 2020; Thurber & DiAngelo, 2018).

Unfortunately, this societal dynamic has influenced the whole society, leading to negative mental health consequences among LGBTIQ+ individuals (Dworkin et al., 2018; Salim et al., 2020; Velez et al., 2019), including the mental health field. Similar to the broad societal impact of heteronormativity, injustice and discrimination in the field of mental health and counseling manifests in the form of professional pathologization, mistrust, misperception and rupture in therapeutic relationship (Brooke, 2020; Castro-Peraza et al., 2019; Logan & Barret, 2006).

Mental health professions have historically pathologized people with sexual and gender diversity (e.g., the pathologization in the Diagnostic and Statistical Manual in 1952; Castro-Peraza et al., 2019; Drescher, 2015), leading to stigmatization and pathological beliefs and views towards LGBTIQ+ individuals in society. Such pathologization was also accompanied by religious statements that being sexual or gender minority is wrong and sinful (Lomash et al., 2018), resulting in negativity towards LGBTIQ+ people and an attempt to fix or change these identities. In the present, even though therapist worldviews may be more accepting and inclusive, the negative and invalidating view of LGBTIQ+ people remains, along with mistrust from clients (Logan & Barret, 2006).

On top of that, the worldview of fixed labels and categories, preconceptions and stereotypes about LGBTIQ+ people can create ruptures and misunderstanding in the therapeutic relationship (Agner, 2020). Because LGBTIQ+ clients may not be accurately understood, or their voices may be silenced, they can experience misunderstanding,

microaggressions, insensitivity, or rejection from their mental health practitioners (Fattoracci et al., 2020), and consequently, poor quality of mental health services as well as their own poor mental health (Kidd et al., 2016).

In the past decades, there have been countless attempts in the mental health field to combat the negative and derogatory influences of societal stigma and demoralization of non-normative sexual and gender identities in therapy. Many of these attempts include research studies, practice guidelines, and codes of conduct (ACA, 2014; CACREP 2015; Ratts et al., 2016). They have served the field and led to critical movements in training to better mental health services for LGBTIQ+ clients.

However, the need for further advancement and progress remains because of the lack of consistency and standards in LGBTIQ+ cultural competence trainings in mental health graduate programs across the country and the reported negative therapy experiences of LGBTIQ+ clients in therapy (Berke et al., 2016; Kelly, 2015; McCullough et al., 2017; Vanmeter, 2019). Literature in the field suggested and proposed many of the potential approaches and factors that may be the answer to fill this gap. Out of many of the factors, two that are pertinent and key to better training are cultural competence and cultural humility (Ojanen et al., 2021).

LGBTIQ+ cultural competence (LGBTIQ+CC) helps therapists to gain knowledge, have awareness of one's potential negative attitudes, adopt positive attitudes and acquire relevant skills to work competently with LGBTQ+ clients (Carlson et al., 2012). LGBTIQ+CC results in a stronger therapeutic relationship and client's higher level of psychological well-being (Alessi et al., 2019), satisfaction, and perceived therapy outcomes (Davis et al., 2022).

By definition, cultural competence is not static or constant. For therapists to remain culturally competent, they must put an active ongoing endeavor to learn more about clients, and continuously becoming aware of one's own assumptions and biases, and actively attempting to understand the client worldviews (Sue et al., 2019). In other words, they need to stay open, learn from the clients, not act like an expert who has all the knowledge. Therefore, this ongoing aspect of cultural competence allows for the revision and updates of knowledge, and to know what knowledge and skills are applicable to which clients, especially among diverse LGBTIQ+ clients. This aspect of cultural competence is known as cultural humility.

Although both LGBTIQ+CC and cultural humility are important, in practice the simultaneous development of both qualities may seem counterintuitive. LGBTIQ+CC focus on specific aspects of knowledge, attitude, awareness, and skills, while cultural humility focuses on the revision of knowledge, the limitations of knowledge, and power sharing. Cultural humility is actually what keeps the acquired knowledge, attitude and skills relevant. As therapists learn about clients' culture and worldview, they can still maintain their openness and stay humble about client issues, which lead to an accurate understanding, and mutual bonding between therapists and LGBTIQ+ clients (Sprik & Gentile, 2020; Zhu et al., 2021). Therefore, both LGBTIQ+CC and cultural humility are additive and complementary, not contradictory.

Accordingly, the cultivation and training of both qualities within counseling field and for the counselors-in-training (CITs) will be vital in the preparation of skilled and quality therapists who can truly serve and benefit LGBTIQ+ population. Unfortunately, existing literature on LGBTIQ+CC and cultural humility relies mainly on guidelines and

recommendations (Hope et al., 2022; Killian et al., 2019; Singh et al., 2017) or focuses only on the components, not the development of these qualities (Moradi & Budge, 2018; Ojanen et al., 2021). Therefore, the main purpose of this study is to empirically explore counselor's process of the cultivation and integration of LGBTIQ+ cultural competence and cultural humility using a constructivist grounded theory method. The findings should inform training that leads to better services for LGBTIQ+ clients. The research question for this study is how do LGBTIQ+ competent counselors cultivate, integrate, and apply LGBTIQ+ cultural competence and cultural humility?

Chapter 2

Literature Review

Research and literature on topics that are important and relevant to this study will be reviewed and elaborated including the topics of: 1) Queer Theory, 2) Negativity towards LGBTIQ+ people, 3) Cultural competence and multicultural competence, 3) LGBTIQ+ cultural competence, and 4) Cultural humility. Queer theory will be the theoretical framework that this study uses to position itself, while the rest of the components will elaborate the importance of this study and specify the gap in the literature that this study aims to bridge.

Queer Theory

Queer Theory is a conceptual theory that emphasizes the speculation and deconstruction of constructs of and discourses about sexualities, genders, and identities. It was originated in de Lauretis' (1991) scholarly work on homosexuality. It is grounded in poststructuralism and postmodernism (Plummer, 2005). The meaning of queer theory varies greatly among scholars and can be hard to clearly define (Plummer, 2005). The first group of people who originated the movement around it, Teresa de Lauretis and Eve Kosofsky Sedgwick, termed queer theory as a critical analysis of the "modern Homo/heterosexual definition" (Sedgwick, 1990, p. 1), which meant to challenge notions of fixed labels and identities in the society (Goodrich et al., 2016).

Historically, the movement around queer theory was an attempt to resist and challenge the institutionalized systems that use the term queer and sexual minority identities to shame, devalue and eradicate homosexuality, and sexually diverse people (Butler, 1993; Gedro & Mizzi, 2014). Originally, studies of gay and lesbian people were

categorical and stereotypical based on limited experiences with and knowledge of queer people and their experiences, which reinforce categories and labels that are associated with derogatory connotations and values (Goodrich et al., 2016). The concept of heteronormativity is introduced in queer theory and represents a discourse that structures human relations and values according to heterosexuality (Gedro & Mizzi, 2014). The concept bestows a sense of normalcy and rightness to only heterosexuality (Warner, 2002). Accordingly, the term queer was associated with sickness, perversion, disdain, and being against social normal practices, values, and identities. This connotation pervades into many aspects, such as identities, ideas, and relationships (Gedro & Mizzi, 2014)

The reclamation of the term queer in queer theory from its original oppressive nature into a positive connotation came with a lot of political and transformative intentions. Some of the goals were: 1) to deconstruct and challenge the societal binary understanding and use of sex, gender, and identity, 2) to address and change the imbalance that come with these terms, labels, and identities, 3) to challenge established social norms, and 4) to broaden perspectives on these notions (Carroll & Gilroy, 2001; Goodrich et al., 2016; Hodges, 2008; Plummer, 2005).

According to queer theory, identity labels are mechanisms of a dominant heterosexual culture that regulate society and its people (Morris, 1998). Queer theory finds problem in the mechanisms and systems of fixed and stable identities. It posits that categories used in binary heterosexual gender (masculine/feminine), as well as those derived from them (lesbian/gay), are hetero-dominant and artificial. It also contends that gender and expression are formed as a social practice and rules to the extent that people in a society perform according to the gender role expectations based on societal rules.

This performance, termed “performativity”, takes away the sense of autonomy from an individual to be themselves and reinforces the illusion that gender is fixed and static (Butler, 1999).

Instead of fixed and stable identities, rethinking these labels and categories as plural, intersectional, and fluid is a foundation to enhance understanding about human sexual and gender diversity (Gedro & Mizzi, 2014). In doing so, queer theory encourages the contemplation on how gender and sexuality that are founded under the frame of binary influences understanding and perception that people hold about sexual and gender diversity, and LGBTIQ+ people. Also, queer theory aims to interrupt and invert societal status quo by normalizing abnormal connotation of the term queer and LGBTIQ+ people (Wozolek, 2019). Breaking down the continual use of these categories and labels are necessary to cease to stereotype and harm marginalized LGBTIQ+ people in the society (Gedro & Mizzi, 2014).

In summary, queer theory has introduced and offered a framework that addresses, challenges, and deconstructs the social systems and mechanisms based on heterosexuality and a binary that harms and create injustice for LGBTIQ+ people in the society. In order to elaborate and clarify the experiences of LGBTIQ+ people in the society, the next section will provide literature review on negativity towards LGBTIQ+.

Negativity towards LGBTIQ+ People

Stigma, prejudice, and stereotypes experienced by LGBTIQ+ people are common and different from those experienced by other minority groups (Herek, 2009). The ideology that heterosexuality is desirable, central, and mainstream has been perpetuated on societal and institutional levels (Herek, 2009). This ideology leads to a perception and

values that fheterosexual and cisgender people are desirable, acceptable, and normal, and sexual and gender minority individuals are undesirable, unacceptable and abnormal. This societal dynamic has influenced the whole society and led to negative mental consequences among LGBTIQ+ individuals (Dworkin et al., 2018; Salim et al., 2020; Velez et al., 2019). Many terms that were used to describe and explain how the stigma and prejudice towards sexual and gender minority people negatively impact LGBTIQ+ people will be explained in chronological order.

The term homophobia was popularized by Weinberg (1972). It means the prejudice towards homosexuals that stem out of irrational fear. Even though the term was originated from the term homosexual that refers only to sexual minority people, in a broad sense the term homophobia is used to refer to a broad sense of fear and loathing towards sexual and gender minority people. Later on, the term was transformed and specified to cover more specific identities, such as, lesbophobia, biphobia, transphobia, and acephobia, to include hatred towards lesbians, bisexuals, transgender, and asexual people as well (King, 2008; Davies, 1996).

However, the term homophobia did not accurately portray the underlying reasons and causes for the fear and hatred. The term homophobia emphasized the component of irrational fear, instead of the societal prejudice and stigma that are the root cause of the anti-homosexual sentiments (Herek, 2004; Szymanski et al., 2008). More recently, while the term homophobia is used to emphasize irrational fear and disgust towards trans individuals and homosexuals, other broader terms are used for anti-LGBTIQ+ sentiments (Herek, 2004).

Heterosexism, homonegativity, and heteronormativity, as introduced earlier from queer theory, are the alternative terms that were proposed to capture the anti-LGBTIQ+ prejudices instead of homophobia (Herek, 2004). These three terms have been used interchangeably with some nuances. Heterosexism refers to an ideological system on personal, institutional and cultural levels that works to the disadvantage of sexual minorities by stigmatizing, denigrating and denying their way of living (Herek, 2009; Szymanski et al., 2008). It was developed as a part of LGB rights movement. The term heterosexism includes the societal and external oppressive activity and the element of sexism that pervades and influences the sexual and gender minority individuals (Szymanski et al., 2008). Heteronormativity, in this sense, has similar meaning to heterosexism. However, the emphasis is on the belief that only heterosexual relationships are acceptable as a norm in the society (Lovaas & Jenkins, 2007) which convey a sense of normalcy and rightness (Warner, 2002). Homonegativity means "persons' negative affect and beliefs about LGB orientations" (Szymanski et al., 2008, p. 512). There are also other terms that convey similar idea and focus on prejudice, such as, homoprejudice, bi-prejudice, and transprejudice. Overall, the term homophobia was most used among the three and continue to be the main term that best describes the negative experiences of LGBTIQ+ people within society.

Even though homophobia usually refers to external societal phenomenon, it can be internalized as well. The internalization can lead to the negative affects towards oneself or self-stigma (Herek, 2009). These self-stigmas were termed internalized homophobia/homonegativity/ heterosexism (IH) which helps explain the internal struggle as a part of being in the societal context of heterosexism. Factors that impact IH are the

degree, degree, type, and heterosexism frequency in the environment, level of importance of perpetrators, a lack of exposure to counter messages, and heterosexist self-messages (Szymanski et al., 2008). Even though the concept of IH was criticized as being harmful when used as a guiding principle working with LGBTIQ+ clients because of its focus on the intrapsychic model (Szymanski et al., 2008), it helps to clarify and bridge the internal experiences and external heterosexism among sexual and gender minority individuals.

Cisgenderism or cissexism is the concept that advances the heterosexist framework to emphasize the gender aspects of societal and structural oppression. Cisgenderism incorporates the concept of gender normativity which deems binary gender as societal norm, and any deviation from this is considered abnormal or inappropriate (Blumer et al., 2013; Stryker & Aizura, 2013). The ideas that cisgender identities are natural and fixed are normalized along with heterosexual marriage and procreation between a cisgender woman and a cisgender man (Rogers, 2021).

A cisgenderist context encourages the belief that all individuals are expected to comply with the confinement of the gender binary. Consequently, gender minority individuals are judged and deemed abnormal, invalid or unnatural because of their incompliance to the cisgenderist norm (Ansara & Hegarty, 2014; Chevrette & Eguchi, 2020). Similarly, cisgenderism or cissexism can be internalized the same way as heterosexism is in the name of internalized transphobia (Bockting, 2015) which causes adverse experiences and detrimental mental health outcomes for gender minority individuals (Robinson, 2022; Scandurra et al., 2019).

The societal context of heterosexism, IH, and cisgenderism explains partly the reason why LGBTIQ+ individuals have been historically marginalized from the society.

Two theories that help to further filling in the picture of LGBTIQ+ individual negative experiences in the society are feminist theory and minority stress theory (Meyer, 2003). The feminist theory proposes that what is personal is political. It means that personal struggles are connected to one's cultural, political, economic, and social climate that one lives in. Therefore, the difficulties faced by people of limited power are the reactions to oppression in the society (Worell & Remer, 2003). To explain LGBTIQ+ individual's negative experiences according to feminist theory, LGBTIQ+ individuals have limited power as a result of heterosexism and heteronormativity. Therefore, the oppression that occurred in the heterosexist context are the main contributors to LGBTIQ+ individuals' struggle. Feminist theory is a powerful theory that can personally empower marginalized clients and mobilize societal change that can lower the impact of systemic oppression faced by marginalized populations.

The minority stress theory introduced by Ilan Meyer (2003) posits that the psychological difficulties that minority individuals report are the result of additional stigma, discrimination, and prejudice they experience because of their minority identities. Diverse LGBTIQ+ individuals who belong to the minority group are subjected to additional negative experiences from stigmatization, discrimination, heterosexist policies, as well as other social stressors (Drescher & Fadus, 2020). These additional negative experiences can cause expectations of rejection, identity concealment, and internalized oppression, which eventually leads to negative mental health outcomes (Drescher & Fadus, 2020). Minority stress theory clarifies the process in which minority identities and statuses lead to internal struggles that majority groups do not experience.

Both feminist theory and minority stress theory are counternarrative theories that voice the lived experiences of sexual and gender minority individuals. These narratives are usually silenced or muted in the heterosexist and cisgenderist society. The counternarrative nature of these theories enables the voice of sexual and gender minority people and raise a question "What does it mean to be an LGBTIQ+ individuals in our society and what kind of experiences do they face?" A plethora of research and studies has examined and explored this question in many different directions to illustrate and elaborate the topic.

Research found that exposure to heterosexism in daily life can lead to IH, and more serious consequences among LGBTIQ+ individuals. For example, Salim et al. (2020) found that IH mediated the relationship between anti-bisexual experiences and verbal sexual coercion among 350 bisexual-identified women. Among 348 sexual minority women with trauma exposure, daily exposure to heterosexism predicted trauma-related cognitions (e.g., self-blame) and maintained and exacerbated PTSD symptoms (Dworkin et al., 2018). In other words, the accumulation of exposure to seemingly insignificant heterosexism can seep into LGBTIQ+ individuals and lead to other issues.

Either as a primary or secondary issues, drug and substance abuse were reported among LGBTIQ+ people. Substance dependence is one of the coping strategies for their struggles with heterosexism (Collins & Levitt, 2021) or other primary issues that are caused by heterosexism. Heterosexist experiences and emotional dysregulation were found to mediate the relationship between lower levels of outness and harmful alcohol use among LGBTIQ+ individuals (Villarreal et al., 2020). In comparison to heterosexual youth, sexual minority youth reported greater rates of substance use (Villarreal et al.,

2020). Furthermore, a multilevel meta-analysis of 49 studies published between the years of 1996 and 2017 on IH and substance use showed that IH was also found to be linked to the increased use of heroin, cocaine, tobacco, and alcohol (Huynh et al., 2022).

Heterosexism can impact LGBTIQ+ individuals differently in different settings. In academic settings, sexual and gender minority students and staff may experience negative interactions with others that may affect their learning experiences and workplace (Asquith et al., 2019). Brady et al. (2020) found among 3,106 university staff and 412 university students that fear of heterosexism led to perceived lack of safety, greater fear in their neighborhood, fear to report heterosexism and unpreparedness to disclose their sexuality to the institution. Furthermore, the sense of disruption, misfit, and embarrassment because of their non-binary, trans and queer identities can also impact gender minority academics (Robinson, 2022). In the workplace, heterosexism may include harassment, discrimination, and victimization that results in heightened fear, anger, psychological distress, physical health complaints, turnover intentions, and lack of job satisfaction (Miner & Costa, 2018). These specific settings add complication to each kind of situation according to their minority statuses.

A recent direction of the research field includes studying racial diversity and looks at the heterosexism through the intersectional lens between racism and heterosexism. In 2019, Velez et al. (2019) tested the multiplicative associations among internalized heterosexism, heterosexist discrimination, racist discrimination, and internalized racism with well-being and psychological distress among 318 sexual minority People of Color (PoC). The results revealed the combinations of heterosexist discrimination and internalized racism, and racist discrimination and internalized racism

were associated with distress and well-being (Velez et al., 2019). Unsurprisingly, the results showed that the combination of heterosexism and racism has additive detrimental effects to mental health. These findings highlight the unique experiences of LGBTIQ+ PoC with additive risks, such as intersectional microaggression (Fattoracci et al., 2020), STI risks (Watson et al., 2019), and suicide (Trujillo et al., 2020).

Overall, being in a heterosexist, cisgenderist society can negatively impact the lived experiences and selfhood in ways that may not be obvious at times. However, the mental health consequences will eventually show up for many LGBTIQ+ individuals. A big part of that is due to the ideology that heterosexual and cisgender lifestyles are appropriate, right, and normal. This ideology is reflected in personal values, relationships with people, societal policies, and institutional structures. The mental health field is not immune to these ideologies. There were some historical events that negatively impacted the mental health of LGBTIQ+ people, even in the present (Capra et al., 2021). Unfortunately, the negative history in the field has damaged and created mistrust among LGBTIQ+ community impactfully.

Professional Pathologization and Mistrust

The cause of heterosexism and cisgenderism may lie in many long-standing theories and ideologies. One of the biggest influences in the Western world is probably religion. Before the power in society shifted to the hand of secular authorities, homosexuality was deemed sinful and categorized as the act of sodomy. This negative influence of religion did not simply just vanish after the era of religious influence, but transformed and permeated into the fields of law, medicine, psychiatry and sexology

(Drescher, 2015), which systematically stigmatized, ostracized and marginalized sexual and gender minority.

The widespread nature of homonegativity and trans-negativity also influenced the mental health field back in the day and led to the pathologization of homosexuality and transgenderism. In 1952, the Diagnostic and Statistical Manual Edition I (DSM-I) was published with the classification of homosexuality as a "sociopathic personality disturbance" and in DSM-II it was listed as a "sexual deviation." It was not until 1973 that the American Psychiatric Association decided to remove homosexuality from DSM-III (Drescher, 2015). On the other hand, gender identity disorder (GID) was added to DSM-III in 1980 and was revised in DSM-V as gender dysphoria (Castro-Peraza et al., 2019). As the DSM is used to diagnose patients and clients, the inclusion of the pathologization of homosexuality and gender nonconformity gives validity and confirmation to the stigmatization and pathological beliefs and views towards LGBTIQ+ individuals in the society.

Gender identity disorder (GID) was also included in the DSM to label and pathologize gender diverse individuals. The diagnosis mainly focused on profound disturbance about maleness or femaleness that gender diverse individuals may have (Lev, 2006). However, GID caused a lot of pushback and controversy from both the professional and trans community (Lev, 2006). In DSM-V, gender identity disorder was changed to gender dysphoria (Davy & Toze, 2018) including the following criteria: "1) a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/ expressed gender, 2) a strong desire for the primary and/or secondary sex characteristics of the other gender, 3) a strong desire to be

of the other gender, and 4) a strong conviction that one has the typical feelings and reactions of the other gender (American Psychiatric Association, 2013, pp. 452-453).” Even though gender dysphoria was meant to reduce pathologization from GID, both diagnoses are viewed as controversial from the trans community as they cause damage by using psychiatric labeling to pathologize gender diverse individuals (Davy & Toze, 2018; Lev, 2006).

Such pathologization also confirms and amplifies religious perspectives that indicate that being sexual and gender minority is wrong and sinful, and that therapy can fix or change it. This dynamic gave rise to the therapy that aims to change the sexual orientation and gender of LGBTIQ+ clients, reparative or conversion therapy (Capra et al., 2021; Israel et al., 2003). This kind of service is offered and advertised to LGBTIQ+ clients who are dissatisfied with their sexual or gender identities either because the therapist or the clients view the client’s identities as a disorder (Capra et al., 2021). However, there is research showing the danger and ineffectiveness of reparative therapy and that practitioners are practicing this kind of approach out of their own personal beliefs rather than evidence (American Psychological Association: APA, 2009).

In the present day, even though the negative influence of pathologization has subsided to certain extent, there are practitioners who reported that they were still willing to follow the reparative approach (also known as conversion therapy, and sexual or gender change therapy) if the client requested or desired it (Capra et al., 2021). Unfortunately, irregular practice based on beliefs that pathologize the LGBTIQ+ clients still exists, either with reparative approach, or with personal pathological attitudes (Shin et al., 2021). There was a report of incidents where LGBTQ+ clients experienced

rejection and judgmental responses from their counselors (Compton & Morgan, 2022; Kelly, 2015). Unsurprisingly, these incidents and aspects contribute to mistrust towards the mental health field among LGBTIQ+ clients.

When the mental health practitioner, who is supposed to understand and be a source of help and support, turns out to be a source of discomfort, danger, and misunderstanding, clearly the act of helping, healing, or saving LGBTIQ+ clients from the heavy societal and mental burden cannot take place. The current situation is a warning and a call for change in the mental health field. It is true that the depathologization of sexual and gender minority already occurred, but the depathologization alone could not change the widespread impact of the stigma and heterosexism in the field. Repairing the rupture and the lost trust are even more difficult, if not impossible. Therefore, additional steps and movements need to be implemented to ensure the safety, non-pathological and helpful services for LGBTIQ+ clients.

LGBTIQ+ Client Negative Therapy Experiences

Negative therapy experiences have been consistently reported among sexual and gender minority clients. LGBTIQ+ clients face with multiple types of negative experiences in therapy (Brooke, 2020; Champagne & McKinney, 2022; Compton & Morgan, 2022; McNamara & Wilson, 2020). LGBTIQ+ individuals use counseling services more often than heterosexual and cisgender individuals, and they also report higher levels of dissatisfaction with services received (Baams, 2018; Kidd et al., 2016). Moreover, LGBTIQ+ clients may prematurely terminate their counseling sessions because of perceived cultural misunderstanding, cultural invalidation, and a lack of cultural humility from therapists (Vanmeter, 2019) and not reattend the services that lack

LGBTIQ+ cultural awareness and competence (Utamsingh et al., 2017). Other factors contributing to their dissatisfaction and termination may include the fear of prejudice or discrimination upon their sexual and gender minority identities (Baams et al., 2018), and rupture in therapy (Brooke, 2020).

Baams et al., (2018) conducted an online survey to compare mental health service use among 25,844 college students by sexual orientation, with the majority of participants being graduate students (42.81%) and non-Hispanic White participants. The results showed that LGB participants used counseling and mental health services more often than their heterosexual counterparts. Bisexual male and LGBQ female participants, in comparison to their heterosexual counterparts, were less likely to seek help from a family member or parent. Additionally, gay and questioning males as well as LGBQ females reported that religion negatively impacted their ability to cope. The researchers in this study suggested that the perceived lack of acceptance of participants' sexual minority reduced the likeliness that LGBQ participants seek out for help and services from their family members and clergy services.

Brooke (2020) employed interpretative phenomenological analysis to explore rupture experiences and difficulties that in the relationship with therapists among seven gay men. The data were collected through face-to-face semi-structured interviews. Three themes emerged from data analysis: 1) The rupture's origins: therapist as a threat to invalidate gay identity, 2) Rupture from the strugge to defend one's sexual identity and the self, and 3) The negotiation of reparation or closure of the rupture. The findings also yielded that the main causes of rupture in therapy were therapist lack of understanding on gay issues and/or homophobia.

For sexual minority people, a scoping review (a review that determines the coverage of a body of literature on a certain topic) of 27 publications published between the years of 1999 and 2014 demonstrated that LGB people were twice as likely (17% versus 8%) to report dissatisfaction with a mental health service as heterosexual people (Kidd et al., 2016). About 25% of LG participants in Kelly's study (2015) reported that their therapists lacked lesbian and gay knowledge, and 21% reported therapists' dismissiveness of and/or view of sexual orientation as problematic.

McNamara and Wilson (2020) conducted a meta-narrative analysis from 13 empirical papers exploring experiences of LGB clients from 1999 to 2019. More negative experiences were reported than positive experiences, partly due to the nature of some studies that focused only on the barriers and negative experiences. Different degrees of negative experiences ranged from a sense of discomfort to an outright discrimination. Five themes of negative experiences in order of consistency of data were: 1) discomfort to discuss sexuality or poor cultural awareness of sexual minorities, 2) dismissing client's sexual identity, 3) lack of knowledge or understanding of sexual identity, 4) discrimination, and 5) pathologization.

Even though the first and the third themes may happen more often, they can be less damaging and discouraging. These themes included the therapist's discomfort discussing about same sex partners, the assumption that the client's partner is the opposite sex, and the reliance on client's educating a counselor on different topics, such as their sexual identity, in order for their needs to be met (McNamara & Wilson, 2020). While these incidents may appear mild and inconsequential, they can still disrupt the counseling process and undermine client's trust on the process and the therapist.

On the other hand, the other three themes were obviously much more damaging, not only to the therapeutic relationship, but also to the client's mental health itself. According to theme two, dismissing client's sexuality was not the only incident. Clients were told that their bisexual identity did not exist, and that their sexual minority identity can be converted. Furthermore, clients were asked not to bring a same sex partner to inpatient service, made a joke at, told that sexual minority is a phase that is unhealthy and needs to be worked on for the client to pass this phase, and that sexual minority identity is a result of past trauma or upbringing (McNamara & Wilson, 2020). Although there was a report of positive experiences in this study (e.g., affirmation, and good counseling skills), they were outweighed by the negative experiences.

Negative experiences among LGB clients were found not only in individual setting, but also in a couple counseling setting. Champagne and McKinney (2022) reported that gay couples had a "rollercoaster" experience even just to find the right fit for their need. Finding the right counselor was a trial-and-error process in that they had to go through a series of trials to see which therapist fit with them as a gay couple while facing invalidation and discrimination from many therapists in the searching process (Champagne & McKinney, 2022).

Gender minority or transgender and non-conforming (TGNC) clients also experienced dissatisfaction in their therapy. TGNC people reported that they struggled to find a therapist that was the right fit for them based on: 1) TGNC or ethnic minority identity that therapist shared with them, 2) their experiences of therapist invalidations in the form of misgendering, 3) therapist interpersonal bias, 4) therapist avoidance and refusal to take the client seriously, or 5) therapist lack of TGNC knowledge in terms of

political, cultural, political, and medical knowledge (McCullough et al., 2017). This knowledge may include the lack of protection for trans hate crimes in different states, the anxiety about bathroom use, and the fear of seeing a doctor who may dehumanize their treatment.

Compton and Morgan (2022) conducted a systematic review of therapy experiences of TGNC people from 10 studies. Two analytic themes in this study elaborate the negative experiences of how their gender was approached in therapy and how they viewed their therapists. A lot of participants felt that their therapists approached their gender in problematic ways, by either neglecting their gender and discussion about it altogether in their therapy or overemphasizing it to the point that they felt that they did not feel heard as an individual or that their gender identity was being problematized or objectified. These approaches caused problems for therapeutic relationships.

The second theme of the review revealed TGNC participant's negative view about their therapists (Compton & Morgan, 2022). These views ranged from therapists being uncomfortable, uninterested, dismissing, invalidating, or discriminatory, which may be caused by therapists misgendering, ignoring client's preferred pronouns, or expressing the view that gender variance is indicative of mental health issues. Another view that TGNC participants have of their therapists is being rigid and fixed, which is reflected in therapists' notion of gender that is cisnormative or "put into boxes." Some therapists also held pathologizing cisnormative views of gender variance and viewed the client's gender as an issue to be fixed. Some participants described their therapists as having a concept of what is "right" and "wrong" about gender expression, especially for nonbinary clients whose therapists assumed that being TGNC must involve body alterations. Additionally,

some participants noticed rigid view in therapists on what the transition process should look like. Thus, therapists held a view that the process that differs from their view is "wrong."

Some participants found working with LGBTIQ+ therapists helpful because these therapists can relate and empathize to their experiences of societal oppression. However, therapist sexual and/or gender minority identity did not guarantee helpfulness. Some LGBTIQ+ therapists also held rigid and fixed views themselves, which lead to participants feeling hurt and rejected from someone who is considered to be an insider of their community (Compton & Morgan, 2022). Unfortunately, these negative experiences may be worsened among TGNC clients, who might not even have knowledge or terms to describe themselves in therapy and particularly suffer from internalized cisgenderism (Stephens, 2018).

Accordingly, negative experiences of LGBTIQ+ clients (e.g., microaggressions and ruptures) may be a result of heterosexism, heteronormativity and cisgenderism, such as heterosexist assumptions, therapist's homophobia, inaccurate knowledge and attitudes based on stereotypes of LGBTIQ+ individuals, and lack of awareness of therapist's own prejudice about client sexual orientation, gender identity, or gender expression (Brooke, 2020; Shelton & Delgado-Romero, 2013; Thurber & DiAngelo, 2018).

In summary, the negative experiences that LGBTIQ+ faced in therapy included invalidation, discrimination, dismissal, avoidance, ignorance, and pathologization (Brooke, 2020; Champagne & McKinney, 2022; Compton & Morgan, 2022; McNamara & Wilson, 2020). These negative therapy experiences presented additional mental burden and obstacle to LGBTIQ+ clients.

Intersectionality

Another layer that may add to client's negative experiences in therapy is intersectionality. Intersectionality refers to the multiple aspects and identities (e.g., sexual identity, gender, race, and ableness) of an individual that shapes their experiences (Astramovich & Scott; 2020; Collins & Bilge, 2020). According to intersectionality theory, individuals who identify with multiple minority identities face greater oppression (Astramovich & Scott; 2020). Clearly being LGBTIQ+ alone comes with negative mental health consequences, but other aspects of identities increase this negativity in general, as well as in therapy sessions. Especially in the US, race plays a major part in LGBTIQ+ PoC's intersectional experiences due to discrimination and microaggressions based on race (Meyer, 2010; Sutter & Perrin, 2016; Wynn & West-Olatunji, 2009).

Negative therapy experiences and difficulties faced by LGBTIQ+ PoC have been documented by both sexual and gender minority PoC clients. Moore et al. (2020) conducted semi-structured interviews among 38 African American and Hispanic American LGB young adults to explore their experiences with mental health services. Almost half of the participants (45%) reported disengagement in therapy despite their need for services. They experienced barriers to engage in therapy in a form of therapist's stigma, negative cultural attitude about sexual orientation, hesitation about treatment effectiveness, and difficulty finding suitable and affordable care that fits their intersectional identity as an LGB PoC.

Similar to LGB PoC who did not feel properly served because of their intersectional experiences (Moore et al., 2020), TGNC PoC in other studies also reported negative experiences due to their intersectional identities between race and gender as

well. TGNC PoC experienced their therapists' intersectional insensitivities because of the failure to recognize the importance of client's multiple marginalized identities (McCullough et al., 2017). Some clients did not feel they were able to use therapy because they could not comfortably share and discuss their experiences of a TGNC person that experiences racism in therapy. Unfortunately, this led to a feeling that they need to keep different parts of their identity separate in order to maintain the therapeutic relationship (Compton & Morgan, 2022). These experiences of LGBTIQ+ PoC highlights their marginalization and ostracism from available mental health services in society, as well as an extra layer of obstacles that they have to face.

Intersectionality can explain why other marginalized identities among LGBTIQ+ clients (e.g., ableness, nationality, ethnicity, age) act as an additional layer to their identities which can further complicate their therapy experiences and increase negative therapy experiences among LGBTIQ+ clients. The review of literature in this section depicts the issues that LGBTIQ+ clients may experience in their therapy while acts as a call for change in mental health service and training of mental health practitioners. Changes in policy and professional guidelines have been implemented up until now, which will be elaborated in the next section.

The Movement Away From Negativity

A lot of efforts and actions have been exerted from professional organizations attempting to rectify the damage and mistrust caused by the pathologization (Singh et al., 2017) and lack of appropriate training among practitioners (Killian et al., 2019). The revision and refinement of professional codes of ethics, standards of practice and guidelines, such as the American Counseling Association Code of Ethics (ACA, 2014),

the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (APA, 2017), the Association of American Medical Colleges (AAMC, 2014), British Psychological Society (BPS, 2012), and Royal College of General Practitioners (RCGP, 2015a, 2015b), guidelines and competencies for working with sexual minority (APA, 2021; Harper et al., 2013) and transgender individuals (ACA, 2010; APA, 2015), reflects an endeavor to mend the rupture and move away from the negative professional position in the past.

In 2022, Williams et al. (2022) conducted a template analysis among code of ethics and training accreditation guidelines for working with LGBTIQ+ clients of nine mental and behavioral health fields. The analysis also revealed that the inconsistencies among these guidelines. The ten codes in this analysis were: 1) nondiscrimination, 2) service delivery protections, 3) supervision, 4) referrals, 5) LGBTQ students, 6) LGBTQ faculty, 7) coursework and curriculum, 8) client-centered advocacy, 9) culturally-competent professional development, and 10) mission and values. Interestingly, while all code of ethics that govern mental health practice had at least one instance of all of the ten codes, no accreditation guidelines covered all of them. In other words, the standard that professional organizations hold may be higher than the training programs, and that the training programs may not be able to train accordingly.

Some other critiques from the authors were that many of the codes of ethics and guidelines can be easily outdated and inapplicable considering the fast-evolving policies, vocabularies and best practices related to LGBTIQ+ individuals. Also, even though the codes and guidelines are in place, the gap between professional organization standards and the training programs still exists. Therefore, the codes and guidelines themselves are

not a panacea for LGBTIQ+ clients. Nevertheless, these documents are a firm foundation that call for the improvement of cultural competence among practitioners and better quality of service for LGBTIQ+ people (Williams et al., 2022).

Two of the major approaches arose from the movement away from negativity towards LGBTIQ+ people were the gay/LGBQ+ affirmative therapy (Moradi & Budge, 2018; Singh et al., 2017) and LGBTIQ+ cultural competencies (Israel et al., 2003; Ojanen et al., 2021). The two approaches extended and offered knowledge beyond the components mentioned in the guidelines (Harper et al., 2013) as well as give additional layers to conceptualize and work effectively and non-pathologically with LGBTIQ+ clients. The next section will first review the concept and history of cultural competence to lay groundwork for discussion of affirmative therapy and LGBTIQ+ cultural competencies.

Cultural Competence

Cultural competence is a concept under the umbrella of counseling competence (Sue et al., 2019). It was introduced to the mental health field in 1970s because the US population at that time became more racially diverse, which brought about the need for counselor's understanding of client's different culture (Boroughs et al., 2015; Sue et al., 1992). It was believed that cultural competence is an important component that makes counseling sessions culturally relevant and effective for clients (Sue, 1998; Sue et al., 2019).

Cultural competence has multiple definitions with different aspects. Some of the definitions are (a) "having a necessary understanding of cultural influences to provide appropriate care for patients from a diverse cultural group, which may or may not differ

from the background of the clinician" (Boroughs et al., 2015, p. 2), (b) "the ability to work and communicate effectively and appropriately with people from culturally different backgrounds" (Alizadeh & Chavan, 2016, p. e120), and (c) "a lifelong process in which one works to develop the ability to engage in actions or create conditions that maximize the optimal development of client and client systems" (Sue et al., 2019, p. 38). These definitions reflected the three emphases that the models focused on: (a) skills or intervention tactics that one uses, (b) characteristics the culturally competent one has, and (c) processes involved (Sue et al., 2009). Among the three model types, the process-oriented model was least studied and researched, probably because of the difficulties in defining and operationalizing (Sue et al., 2009). Therefore, the main focus of this section will be on the first two model types.

Among the three types of models, the skill-focused model received the most attention because it is the most readily definable and fit for the research and professional guidelines (Sue et al., 2009). The most popular skill-emphasized model of cultural competence is the three-domain model of cultural competence proposing three key components of cultural competence (Boroughs et al., 2015). The three domains are: (a) attitudes/beliefs - one's understanding of one's cultural conditioning, and its impact on attitudes and personal beliefs towards culturally diverse clients, (b) knowledge - knowledge and understanding about culturally diverse client's worldviews and cultural contexts, and (c) skill – an ability to decide and utilize intervention strategies that are culturally appropriate with culturally diverse clients (Sue et al., 2019). Later on, the action domain – one's engagement in action by advocating for the culturally diverse

clients, was added as the fourth domain to highlight the advocacy aspect of cultural competence (Ojanen et al., 2021; Ratts et al., 2016).

On a different account, Sue (1998) proposed three components of cultural competence based on the characteristic-emphasized model of cultural competence. The first characteristic of the culturally competent counselor is the *culture-specific elements* which is the expertise that is specific to a particular cultural group and may not apply to other groups, such as an ethnic or sexual minority group. The other two characteristics are the generic elements that are applicable across the board. *Scientific mindedness* is the ability to form and test hypotheses about clients, rather than making a premature assumption or conclusions about clients. *Dynamic sizing* is the ability to choose when to generalize the culture-specific knowledge to the client and when to individualize client's experience as unique and avoid stereotyping the client. Recently, Sue et al. (2019) emphasized cultural humility as an additional generic characteristic of cultural competence. The concept, components and history of cultural humility will be explained in the cultural humility section.

In general, the focus of cultural competence seemed to base heavily on the components proposed in the skill-focused model instead of the characteristic-focused model, overlooking the generic components or common factors that are applicable across the board. Seemingly, these generic components are deemed unimportant compared to the rest of the specific components of cultural competence. However, the fact that the importance of both specific and generic components was emphasized in the beginning suggests the generic components may be worth exploring and developing to improve the cultural competence of therapists serving culturally diverse clients.

Apart from the concept of the original cultural competence, there have been many variations and types of cultural competencies that were proposed to fit more specific need and contexts. Even though the core concepts of these variations are similar to the original concept of skill-focused model, they still have something to offer for the advancement of cultural competence and to show the history and development of the concept over time. These variations include cross-cultural competence, multicultural and social justice cultural competence and LGBTIQ+ cultural competence.

Cross-Cultural Counseling Competence

In 1960s, the traditional counseling model and training were criticized for its irrelevance and oppression towards racial minority clients (Sue et al., 1982). The situation called for a more relevant and effective counseling approach and training. Therefore, many of the pioneering leaders in the mental health field proposed and suggested cross-cultural counseling competence as a necessary addition to the field (Sue et al., 1982). Cross-cultural counseling competence is the skills, socio-political awareness and cultural sensitivity that leads to counseling effectiveness with culturally diverse clients (LaFromboise et al., 1991).

Along the line with the characteristic model, Sue et al. (1992) proposed three characteristics of the cross-culturally competent counselor as actively in the process of: (a) becoming aware of one's assumptions, values and biases, (b) attempting to understand the worldview of culturally different clients without stereotyping or negative judgment, and (c) developing and practicing appropriate intervention strategies and techniques. These characteristics added more depth to cross-cultural counseling competence and made it more applicable for practitioners. Even though they may seem to be aspirational,

these characteristics are pivotal to the development of the development of multicultural and social justice cultural competence that builds on cross-cultural competence.

Multicultural and Social Justice Cultural Competence (MSJCC)

Because of the multimodal nature of cultural competence (Sue et al., 2009), the merge of different models helped to expand the existing models. Sue et al. (1992) developed a multicultural competence model by crossing between the three domains of the three-domain model and the three characteristics of cross-cultural counseling competence. A 3-dimension x 3-charateristic framework was introduced and proposed to the Association for Multicultural Counseling and Development (AMCD). The organization endorsed and implemented the extended version of multicultural competence framework refined by Arredondo et al. (1996).

The adoption of multicultural competence by AMCD was followed by similar movements from other associations and code of ethics (Ratts et al., 2016, Sue et al., 2009), which marked a more serious consideration and importance of multicultural competence in the mental health professional. The framework that first focused on the cultural differences based on race and ethnicity (Bathje et al., 2022) was expanded to cover other cultural factors, like gender and sexual orientation (Drinane et al., 2016), and related topics, such as homophobia and sexism (Sue et al., 2019).

Later in 2015, the American Counseling Association (ACA) developed the Multicultural and Social Justice Cultural Competencies (MSJCC; Ratts et al., 2016) which further highlighted the need for sensitivity, reflectivity and understanding when working with culturally diverse clients. Instead of the 3-dimension x 3-charateristic framework, MSJCC added the action dimension to the framework and offered a 4-

dimension x 3-charateristic framework. The social justice domain was added separately to address the need for social justice initiatives and actions on multiple levels (Ratts et al., 2016; Sue et al., 2019). The framework also proposed quadrants that explained the working dynamic between the counselor and the client where one is either a member of a privileged or an oppressed group (privileged counselor & privileged client, privileged counselor & oppressed client, oppressed counselor & privileged client, and oppressed counselor and oppressed client). However, the quadrants framework was not as impactful as the social justice components integrated in the guideline (Sue et al., 2019).

The MSJCC is the latest version of the multicultural competencies that has been widely used as a framework for multicultural training (Sue et al., 2019). Within each domain, four aspirational competencies (knowledge, attitudes and beliefs, skills, and action) constitute core elements and framework towards MSJCC. To briefly explain the framework, the mindset of working with diverse clients requires awareness and acknowledgment of one's culture and identity, including attitudes and beliefs. Such awareness is also required for the client's worldview, leading to better grasp of how the therapist's and client's package would impact the counseling relationship and, eventually, the advocacy and intervention needed.

Multiple flaws and criticism of cultural competence, multicultural competence and MSJCC have been pointed out in many different aspects. As mentioned earlier, the different definitions, models and ingredients of cultural competence makes it difficult to find consensus on definitions and components of each framework (APA, 2015). This issue did not only create inconsistency and a lack of standards in training and research, it also obstructed the development of theories for cultural competence and the evaluation of

the treatment (Sue et al., 2009). Another issue arose around whether the culture-specific component of the cultural competence encouraged practitioners to inaccurately stereotype their clients based on culture-specific knowledge (Sue et al., 2009). This can be the case when practitioners focus solely on the culture-specific component of cultural competence without necessary generic components, such as scientific mindset, dynamic sizing, and cultural humility.

With its flawed and scattered nature, the need for cultural competence grows even more relevant and fundamental to the counseling and mental health field because of the fast-growing cultural diversity in the US and globally (Jensen et al., 2021). The development and advancement of the concept and models of cultural competence has served the need of the culturally diverse population and answered the need of the society with countless social justice and advocacy movements and initiatives in the past half century. The development and advancement of the models also act as a foundation to form and create more specific guidelines and ethical standards for specific populations, such as affirmative approaches and LGBTIQ+ cultural competence.

Affirmative Approaches

The onset of gay affirmative approaches was in the 1970s when the depathologization of homosexuality occurred (Johnson, 2012). Since then, they have been one of the most common approaches in counseling and psychotherapy with sexual minorities clients (Davies, 1996; Johnson, 2012). Affirmative therapy refers to “therapy that is culturally relevant and responsive to LGBQ clients and their multiple social identities and communities, addresses the influence of social inequities on the lives of LGBQ clients, fosters autonomy, enhances resilience, coping, and community building,

advocates to reduce systemic barriers to mental, physical, and sexual flourishing, and leverages LGBQ client strengths" (O'Shaughnessy & Speir, 2018, p. 4). In affirmative therapy, therapists view LGBTIQ+ people and identities positively, with knowledge and lack of prejudice about LGBTIQ+ issues. The therapy provided does not pathologize LGBTIQ+ identities (King et al., 2007).

The application of affirmative therapy was to take the opposite view of the societal view at that time which was pathological and non-affirming. The term affirmative itself emphasizes the importance of the affirmation of the client's sexual orientation as a positive identity. This emphasis helps to ameliorate the damage of homophobia and heterosexism in the society (Davies, 1996). The approach offered a range of psychological knowledge that challenges the traditional perspective that views fixed homosexual orientations and homosexual desire as pathological.

Along the same line with cultural competence, affirmative therapy also consists of both generic components and specific components (Johnson, 2012; O'Shaughnessy & Speir, 2018). The generic components are the elements that form a good and trusting therapeutic alliance between the therapist and LGBTIQ+ client (Johnson, 2012, Wampold, 2015). The specific components include the affirmative stance from the practitioner that conveys acceptance and understanding when directly addressing topics like coming out, internalized homophobia and identity development (Goldblum et al., 2017).

Moradi and Budge (2018, p. 2030) reviewed previous literature on LGBQ+ affirmative psychotherapies and proposed four key themes: (a) counteracting anti-LGBQ+ therapist attitudes and enacting LGBQ+ affirmative attitudes, (b) acquiring

accurate knowledge about LGBQ+ people's experiences and their heterogeneity, (c) calibrating integration of accurate knowledge about LGBQ+ people's experiences and their heterogeneity into therapeutic actions, and (d) engaging in and affirming challenges to power inequities. Importantly, it is noteworthy that the absence of non-affirming therapy is not equivalent to the presence of affirmative therapy (Moradi & Budge, 2018). Therefore, both the absence of a pathological approach and the presence of an affirmative approach need to be maintained simultaneously. Accordingly, sexual minority clients also reported that they valued mental health services which display cultural affirming practices, whether their presenting issues are related to their sexuality or not (Bishop et al., 2021; Burckell & Goldfried, 2006).

Interestingly, the overlap between proposed components of affirmative therapy and cultural competence are noticeable. For example, the components of attitudes, knowledge, skills, and actions were all included in Moradi and Budge's (2018) affirmative therapy components. This was captured as well in the social work definition of affirmative practice which concluded that affirmative psychotherapy is "the integration of knowledge and awareness by the therapist of the unique developmental and cultural aspects of LGBT 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 (Perez, 2007, p. 408)."

In conclusion, the components of affirmative therapy have a large overlap with LGBTIQ+CC. Therefore, while affirmative therapy can be perceived as the precursor to LGBTIQ+CC, LGBTIQ+CC can also be perceived as an expansion and refinement of affirmative approaches as well. Afterall, both the approaches share the same goal, which

is to help LGBTIQ+ individuals combat the toxicity of homophobia, heterosexism and cisgenderism. Thus, I view them as complementary and building on each other. The next section will elaborate on the importance of LGBTIQ+CC, its definition, components as well as research.

LGBTIQ+ cultural competence

The concept of LGBTIQ+ cultural competence (LGBTIQ+CC) started to receive attention in the mental health field in 1990s. But it was not until the 2000s that research studies explored and investigated the concept more empirically (Israel et al., 2003), which, sadly, was much later after the need for LGBTIQ+CC training was addressed in the field through the codes of ethics and guidelines and other calls for actions. However, this delay did not convey that LGBTIQ+ was not important, but rather was a reflection of societal pushbacks and unreadiness (Pope, 1995). The need to mend distrust and rupture in the mental health field is critical to remove potential obstacles from the mental health practitioner's side.

Along the same line with affirmative approach's goal to assist and equip mental health practitioners with the ability to address and help LGBTIQ+ clients, LGBTIQ+CC are instrumental in the same way (Bidell & Stepleman, 2017). LGBITQ+CC is the component that can help improve therapist competencies that allows for better therapeutic alliance both in terms of affirming and validating client's experiences and identities as well as avoiding negative incidents, such as microaggressions, invalidation, and pathologization. For example, therapists who are unaware of LGBTIQ+ client's cultural context may apply more heteronormative stereotypes and assumptions and fail to

provide culturally inclusive services that are appropriate for LGBTIQ+ clients (Bishop et al., 2022b).

Therefore, in the therapy context, LGBTIQ+CC is meant to be a quality in the counselor that counteracts societal and professional negativity that manifests itself in therapy as well as in therapists. A clear understanding of the definition and components of LGBTIQ+CC is first needed in order to have an accurate idea of what knowledge, skills and attitudes are necessary and helpful to LGBTIQ+ clients.

Definition of LGBTIQ+CC

LGBTIQ+ cultural competence (LGBTIQ+CC) has a variety of definitions and meanings, the same way that cultural competence does. One of the clear definitions of LGBTIQ+CC is "a framework for creating safe, supportive, and caring relationships with LGBQIQA individuals, groups, and communities that foster self-acceptance and personal, social, emotional, and relational development (Harper et al., 2013, p. 2)." However, many of the definitions did not clarify the components that are relevant or important to the concept of LGBTIQ+CC. Therefore, building on the model of MSJCC (Ratts et al., 2016), the definition of LGBTIQ+CC is the LGBTIQ+-specific attitudes, knowledge, skills, and action competencies required for counselors to work competently with sexual and gender minority clients.

The knowledge components of LGBTIQ+CC consist of knowledge relevant to sexual and gender minority people, such as discrimination, oppression, prejudice, and homophobia. The attitude component of LGBTIQ+CC consists of appropriate attitudes working with LGBTIQ+ clients, such as openness, not having the attitude that homosexuality should be changed, is evil, or wrong, and not assuming that client's

problems are relevant to their gender identity and/or sexual orientation. The skill component of LGBTIQ+CC consists of skills relevant to LGBTIQ+ client's need and issues, such as talking about and listening to all aspects of LGBTIQ+ client lives and assisting clients with the coming out process. The action components consist of a broad range of actions that help to maintain good relationship, avoid harm, and advocate for LGBTIQ+ clients, such as communicating acceptance and respect for clients, and expressing humility with recognition of one's limits of knowledge (Israel et al., 2003; Harper et al., 2013; Ojanen et al., 2021).

In a way, the guidelines for LGBTIQ+CC are meant to be aspirational, so it might be difficult to have exactly the same standards for every practitioner. On top of that, there are multiple variations of LGBTIQ+CC and guidelines from different organizations; at a minimum, practitioners need to be able to: (1) gain awareness of personal and societal prejudices and biases towards LGBTIQ+ people, (2) develop clinical experience and skills to work effectively with LGBTIQ+ clients, and (3) gain a knowledge of LGBTIQ+ psychosocial and health issues (Bidell, 2017).

Components of LGBTIQ+CC

Following the foundation of cultural competence, many of the researchers tried to identify the scope and components of LGBTIQ+CC through the framework of cultural competence or MSJCC. However, because the cultural competence originally focused on ethnic and racial minority, the concept of cultural competence might not be readily applicable to sexual gender minority (SGM) clients. Although ethnic minority and SGM people shared some similar oppressed experiences (Israel & Selvidge, 2003), the difference between ethnic minority, such as PoC and especially Black people, and sexual

and gender minority in terms of negative experiences and oppressions are nonnegligible, such as the pathologization of LGBTIQ+ individuals and the history of reparative and conversion therapy. Therefore, the exploration of LGBTIQ+CC as a separate set of competence may be needed (Israel et al., 2003).

Initially, several researchers studied the components of LGBTIQ+CC in scattered and partial manner. For example, most of the studies focused only on attitude components (Rudolph, 1990; Gilliland & Crisp, 1995), while some studies added the knowledge components (Graham et al., 1984), and skill components (Hayes & Gelso, 1993). In the beginning, there was still a lack of big picture that include all the proposed components of LGBTIQ+CC in a study.

Israel et al. (2008) surveyed 42 individuals who identified as LGBT to explore what they considered to be helpful and unhelpful in therapy. The data revealed that alliance, basic counseling skills, and confidentiality were the most helpful aspects which are applicable trans-theoretically regardless of practitioner training backgrounds and approaches. Additionally, therapist's knowledge on and affirmative attitudes toward sexual and gender diversity was a desirable characteristic (Burckell & Goldfried, 2006; Israel et al., 2008).

Compiled data from a panel of LGB mental health expert across disciplines (e.g., marital and family therapy) showed that the qualities most needed among partitioners were open-mindedness about diversity as well as self-awareness of one's comfort level, prejudice and biases. (Godfrey et al., 2006). The knowledge that panelists agreed that practitioners should be familiar with were literature on sexual orientation formation, coming out, homophobia and transphobia (Eubanks-Carter et al., 2005).

A measurement of LGBTIQ+CC was also developed to advance the empirical study of LGBTIQ+CC and to examine its components. Bidell (2017) created and developed *The Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale* (LGBTDOCSS) to measure practitioner knowledge about health and mental health disparities of LGBT individuals, awareness of explicit bias and prejudice towards LGBT, and LGBT training and clinical experience.

The exploratory and confirmatory factor analyses reported in Bidell (2017) revealed three subscales for the LGBT-DOCSS: (1) Clinical Preparedness, the LGBT-related training and clinical experiences; (2) Attitudinal Awareness, the awareness of explicit bias and prejudice towards LGBT; and (3) Basic Knowledge, the health and mental health disparities. The three-subscale structure aligns with the three-domain model of multicultural competence that emphasizes attitudes, skills, and knowledge (Sue et al., 1982). The results also confirmed the main three components of LGBTIQ+CC as was proposed initially.

Even though these studies were helpful in partially shedding the light on the components of LGBTIQ+CC, there were only two studies that focused holistically on what constitutes LGBTIQ+CC and helped shed the light on the concept more empirically. In 2003, Israel et al. (2003) conducted a study to comprehensively identify the LGB cultural competence in the USA among two groups of experts, 14 professionals with expertise in the area of LGBTIQ+ psychotherapy (i.e., mental health practitioner, teacher, and researcher) and 8 LGB individuals who had experienced therapy who were considered community experts. The survey aimed to: (a) determine the components of LGB cultural competence; (b) rank the level of importance of each component for each

type of expert; and (c) compare and contrast the importance rankings between two types of experts. A two-step Delphi technique was used to identify the components of LGB cultural competence. The study used the framework of the 3-domained model multicultural competence to guide the data.

In the first phase of the Delphi technique process, the panelists generated 274, 120 and 146 items for knowledge, attitudes, and skills respectively (Israel et al., 2003). These initial items were combined with additional items from the existing LGBTIQ+ guidelines. These items were grouped and eliminated to the final 31, 23, and 31 categories for knowledge, attitudes, and skills respectively. These categories were returned to the experts in the second round to rate each category on a 5-point Likert-type scale (5 = absolutely essential to counselor competence with LGB clients to 1 = harmful, would be detrimental to counselor competence with LGB clients).

The results yielded that all the categories except for one attitude category were rated higher than 3.0, which was considered helpful (Israel et al., 2003). Overall, both the LGB-identified and professional experts attached similar importance to the same categories in each domain (See Israel et al., 2003). Three of the most highly rated knowledge categories were: 1) knowledge about discrimination, oppression, and prejudice; 2) knowledge about homophobia/biphobia and heterosexism; and 3) knowledge about mental health issues affecting LGB individuals. Three of the most highly rated attitude categories were: 1) do not feel homosexuality is wrong, evil, or should be changed; 2) non-homophobic attitudes; and 3) acceptance of same-sex intimacy as a healthy. Three of the most highly rated skill categories were: 1) be sensitive

to ethical issues, like confidentiality: 2) talk about and listen to all aspects of LGB clients' lives; and 3) help clients with the coming-out process.

Interestingly, comparing the results from the two group of experts, LGB-identified experts rated many of the knowledge categories less important than professional (Israel et al., 2003). For example, while professional experts rated 27 categories in the knowledge domain as very helpful (4.0 or higher), 12 categories were identified as helpful by LGB-identified experts. The gap was not as big in the attitude and skill domains. The results may indicate that LGB-identified experts thought that counselors require fewer knowledge, attitudes, and skill categories than the professional expert for effective practice. This was probably because the LGB-identified community experts were unfamiliar with professional language and terminologies (e.g., heterosexist bias in psychology, countertransference). Additionally, lower-rated knowledge categories from LGB-identified experts may reflect that clients care less about their therapist's level of knowledge, but more about seeing that knowledge expressed in attitudes and skills. Even though these possible gaps may exist, including non-professional or self-identified experts in the data analysis avoided a chance that the data would be one-sided and professional-dominant. As Israel et al. (2003, p. 13) put it, "professionals may know best about clinical issues, and LGB individuals may know more about what they find credible in a counselor."

In 2021, Ojanen et al., (2021, p. 162) conducted similar study using the Delphi technique in Thailand with the research question of "What competencies are considered crucial for mental health practitioners' appropriate practice with LGBTIQ clients in Thailand?" The participants were 11 partitioners and 12 former clients who identified as

LGBTIQ. Cultural factors and influences of Buddhism, as all participants identified as Buddhist, were taken into consideration. The study followed the 4-domain model of MSJCC and added the action domain to the data analysis. The first round of data collection was a mix of survey and interviews to generate items for the second round of data collection. The results revealed 41, 37, 14, 35 items on knowledge, attitude, skill, and action domain respectively.

The second round of data collection asked participants to rate each of the proposed competence items from the first round in Google Form survey on a 7-point Likert-type scale (7 = most beneficial to 1 = most harmful). Interquartile ranges (IQRs), a measure of disagreement, was used to determine the level of consensus for each competence. Four levels of agreements were as follow: (1) *consensus of benefit* (IQRs not higher than 1.5; no individual scores below 5); (2) *majority agreement of benefit* (overall mean no lower than 5, overall IQR no more than 1.5); (3) *contested* (overall IQR 1.6–2.9); and (4) *highly controversial* (overall IQR 3 or higher).

Only one item in the knowledge domain reached the consensus of benefit level of agreement: mental health treatment for LGBTIQ groups is for addressing clients' problems, not for changing their identity or sexuality. Four items in the attitude domain reached the level: 1) accepting gender/sexual diversity, 2) believing that each gender is equal, not seeing any gender as superior, 3) willingness to learn new things about gender/sexual diversity from clients, not holding onto one's previous knowledge, and 4) openness to gender/sexual fluidity.

Six items in the skill domain reached the level, such as: 1) verbally communicating artfully and sensitively about gender/sexual diversity and related

sensitive issues (e.g., sex, family, bullying), 2) communicating an accepting stance to allow clients to feel safe enough to come out to the service provider, and 3) behaving neutrally with clients of all sexes/genders/sexualities. Ten items in the action domain reached the level, e.g., 1) showing respect to the identities and genders that their clients exhibit, 2) striving to understand sensitivity toward gender/sexual diversity in particular, and 3) explaining to clients that gender and sexuality are diverse and there are no right or wrong types.

Even with researcher consideration of potential cultural influences, the results turned out to be quite similar to the findings from the west and covered most of the aspects presented in major articles and research (Bidell, 2017; Borough et al., 2015; Israel et al., 2003; King et al., 2007). While the item about collectivistic culture was agreed on and regarded as majority agreement of benefit, the belief in karma item was regarded as contested. Apart from the collective culture aspect, the client and practitioner participants seemed to agree on the ratings of importance in each domain, which is similar to the results of Israel et al.'s (2003) study (See Ojanen et al., 2021).

In 2022, Bishop et al. (2022a) conducted an inductive structured tabular thematic analysis from an online open-question data to examine the most important components that service providers can do to demonstrate culturally competent services among sexual minority people in Australia. Three major themes that emerged from the data were: 1) positive attitudes, 2) affirming practice, and 3) knowledge. These three themes resonated with previous literature and covered most of the aspects that were introduced in the past. Positive attitudes consisted of both positive attributes (e.g., open-mindedness, respect, and inclusivity) and the lack of negative attributes (e.g., lack of heteronormative biases,

judgments and fetishization). Affirmative practices included both the skill components and actions components, such as using pronouns appropriately and conveying support for sexual minority clients. Knowledge on various topics were mentioned as being important, for example, experiences of LGBTIQ+ people, shame, minority stress, and intersectionality. A number of participants in this study also emphasized an importance of service providers' cultural competence to improve their ability to work with LGBTIQ+ clients.

Research on LGBTIQ+CC

Research has supported that LGBTIQ+CC, under different names and alterations, is associated with many positive factors and outcomes. LGBTIQ+CC were related to the perception of the ability to work competently with LGBTIQ+ clients (Carlson et al., 2012), stronger therapeutic relationship and higher level of psychological well-being (Alessi et al., 2019), greater client satisfaction, and better perceived outcomes (Davis et al., 2022). Furthermore, counselor's high interest and comfort with LGBTIQ+ client's diversity was associated with client-reported therapeutic alliance, in-session smoothness, and depth (Stracuzzi et al., 2011).

Moreover, Bishop et al. (2022a) conducted a frequency analysis in an online survey to measure the importance of cultural competence practices among sexual minority people. The result showed that majority of participants (80-98.5%) agreed that all of the items on the Gay Affirming Practices Scales are important in therapy. Five of the items from GAD with the highest frequencies of agreement were: 1) knowledgeable about support resources (98.5%), 2) self-education (97.8%), 3) assist clients in reducing shame (97.1%), 4) affirming attitudes (96.7%), and 5) address discrimination in treatment

(96.4%). These five items spread across the board for the 4 aspects of LGBTIQ+CC (knowledge, skills, attitude, and actions). Even though the item that asked participants if "they were more likely to attend a service that was culturally competent" did not top the list in terms of percentages, 91.9% of participants either agreed or strongly agreed to the statement. These high percentages confirmed the importance of all the aspects of LGBTIQ+CC, and LGBTIQ+CC as a whole from the client's perspective.

LGBTIQ+CC was also perceived from the lack of negativity as well. Compton and Morgan (2022) found from their meta narrative analysis of therapy experiences that TGNC participants perceived positive experiences from the lack of negativity of therapists. These included therapist's lack of microaggression, no sense of disgust or threat, no judgment nor discouragement about their transitioning (Anzani et al., 2019; Hunt, 2014). All of these was viewed as conducive to helpful therapy experiences (Compton & Morgan, 2022) and LGBTIQ+CC.

In summary, over the past few decades, studies in the mental health field have examined and summarized that the components of LGBTIQ+CC covered four aspects, which are knowledge, attitude, skills, and actions. These components overlap, and all play a part in practitioner's ability to build a meaningful therapeutic relationship and work effectively with LGBTIQ+ clients. Although there has been a lack of consensus and a lack of theoretical foundation in the same manner as the construct of cultural competence, the importance of LGBTIQ+CC remains in the mental health field and grows even more so in the recent years. Even though research studies have indicated that LGBTIQ+CC are correlated with many positive outcomes and therapeutic relationship

with LGBTIQ+ clients, much about LGBTIQ+CC remains to be explored and investigated.

Shortcomings in Training and Development of LGBTIQ+CC

Trainings for LGBTIQ+CC have been well documented in different mental health fields, e.g., psychiatry (Corral et al., 2017), and psychology (de los Reyes & Collict, 2022; Moleiro et al., 2014). Mental health professionals tried to emphasize the components or courses in LGBTIQ+ which reflects the need for LGBTIQ+CC. Moreover, many factors are related to the development of LGBTIQ+CC and the training process. Research indicated that client's perception of their therapist's LGBTIQ+CC are increased by increasing training level (from master's to doctoral), numbers of LGBTQ+ clients met (Nowaskie & Patel, 2021), and LGBTQ+ workshop and conference attendance (Graham et al., 2012).

Regardless of the endeavor and attempts to implement and incorporate the LGBTIQ+CC components in the professional training programs (Boroughs et al., 2015), the barriers and shortcomings of the effective and successful implementation of LGBTIQ+CC training have been documented as well (Ginicola et al., 2017; Goodrich & Luke, 2015; Killian et al., 2019; Logie et al., 2007). According to the research results, a big part of the barriers is due to shortcoming from the academic training program, such as lack of access to training (Boroughs et al., 2015).

The lack of access to LGBTIQ+CC training and quality training may be caused by different factors, such as uninformed and negative faculty, inadequate course work, insufficient clinical training, poor quality of materials, insufficient general training, lack of preparation and lack of opportunities to work with LGBTIQ+ populations (Fitterman-

Harris et al., 2022). When these factors combined, it is likely that CITs would not benefit or be able to learn and acquire necessary knowledge and skills to work with LGBTIQ+CC clients.

On top of that, even when LGBTIQ+CC related components and affirmative stances were included, it focused more on LGBQ populations in comparison to TGNB populations (Fitterman-Harris et al., 2022; Soulliard et al., 2023). This is not surprising as gender minority population tends to be overlooked and received less attention in the mental health field compared to sexual minority population in general (Soulliard et al., 2023). Accordingly, the perceived level of cultural competence and affirmative training towards TGNB population among graduate students and faculties from nationally accredited programs (APA, CACREP, COAMFTE, and CSWE) were reportedly limited and inadequate (Boe, 2021).

O'Hara et al. (2013) found that neither duration in a counseling program (beginning vs. advanced students) nor completion of a supervised practicum experience correlated with transgender competence scores. They further critiqued that if no difference is found in level of competence between CITs and trained counselors, then the counselor education programs accreditation bodies, and professional organizations did not succeed in preparing counselors for diverse gender minority clients. Accordingly, the results reflected that CITs did not receive adequate supervised and experiential training to work with transgender individuals. The only factor that made a difference with the participants' perceived competence was knowing a trans person in their life to add some exposure, which unfortunately was not offered by the program.

Kirkland (2018) used hermeneutic phenomenological study to explore the lived experiences of 7 licensed professional counselors' therapeutic work with gender diverse clients. The semi-structured interview highlighted 10 major themes. The results showed a theme of self-sought education and lack of formal gender education which reflected the lack of training, knowledge and exposure to the necessary learning opportunities in the academic program. Furthermore, the formal education program left participants in this study feeling ill-equipped of necessary skills and knowledge, which drove participants to education on the knowledge about gender on their own. Participants' self-awareness and introspection regarding the thoughts and potential hidden biases were instrumental in helping them being an open and accepting counselor with affirmative stance towards diverse LGBTIQ+ clients.

According to the results of these studies, the situation regarding the training of LGBTIQ+CC among current students in the mental health fields are quite concerning and alarming, considering the quality of services for LGBTIQ+ clients, and their reports of negative therapy experiences. Furthermore, there are also criticisms in the mental health field on LGBTIQ+CC.

Criticisms of LGBTIQ+CC

Some of the criticisms of LGBTIQ+CC training are about the potential assumptions and power dynamic in therapeutic relationship. Relying on one's LGBTQ+ knowledge may lead to counselors developing inaccurate preconceptions of clients in the form of stereotyping and assumption, such as assuming the sexual orientation or gender of client's partner based on the client's sexual or gender identity (Hussen et al., 2020; Ruud, 2018). A therapist may develop their own version of understanding of client's

culture based on their own preconception or previous knowledge (Agner, 2020), which may not be accurate or fit with the client's experiences. This kind of assumption or preconception may conflict with the notion that nobody can actually be truly competent in another's culture (Murray-García & Tervalon, 2014) and may not best benefit LGBTIQ+ clients with potentially unique experiences according to the intent of LGBTIQ+CC.

In addition, when a therapist put themselves in a position of competence, it can convey a message that I know your culture and I am the expert (Ruud, 2018). The focus of the therapy then is on the therapists' own competence and held knowledge and attitude, rather than on the clients. Suddenly, the power to direct a session falls on the therapist with less power sharing to the clients and a greater power imbalance. In this case, regardless of what the therapist has to say about the client or their own competence, they might never know if the client truly benefits from therapy, or if the client holds the same view as what they hold.

Reviewing the concepts and definitions of MSJCC and multicultural competence that LGBTIQ+CC builds on, both competencies emphasized that therapists need to maintain an active and ongoing endeavor to learn more about clients. By definition, cultural competence is not static or constant. For therapists to remain culturally competent, they must: (a) engage in an active ongoing endeavor to learn more about clients, (b) continuously be aware of one's own assumptions and biases, (c) actively attempt to understand client worldviews, and (d) actively develop and practice skills and actions relevant to working with diverse clients (Sue et al., 2019). Therapists with true cultural competence need to stay open, learn from the clients, do not act like an expert or

stick to their own knowledge. Therefore, cultural competence allows for the revision and updates of knowledge, and to know what knowledge and skills are applicable to which clients, especially among diverse LGBTIQ+ clients.

In summary, these criticisms pointed out an aspect of LGBTIQ+CC that was missing. This missing aspect of cultural competence that helps to maintain its active and ongoing openness and freshness to make sure that therapist's cultural competencies and knowledge align and are relevant with client's lived experiences is cultural humility. Therefore, the inclusion of cultural humility as a part of LGBTIQ+CC and its training is necessary and needed.

Cultural Humility

Cultural humility was first coined and introduced in medical field to address an open attitude towards diverse patients (Tervalon & Murray-Garcia, 1998). The concept was also welcomed in the mental health field as it can also refers to an open attitude towards culturally diverse clients in mental health services (Hook et al., 2013; Owen et al., 2014). Cultural humility enhances and complements overall cultural competence by allowing and welcoming atypical narrative and individual stories of clients that do not fit with group narrative and stereotypes (Fisher-Borne et al., 2015) with an openness and nuances to diverse cultures and differences (Hook et al., 2013). Accordingly, cultural humility helps avoid a group of people with a static and stereotypical knowledge that limit recognition of within-group diversity (Edwards, 2016). Cultures and groups are non-monolithic, despite the fact that they are most conveniently perceived that way.

Because both the knowledge about the culture and openness to client lived experiences are imperative and important to counseling work and complement each other

(Compton & Morgan, 2022; Ojanen et al., 2021), LGBTIQ+CC without cultural humility is considered poorly executed LGBTIQ+CC which can be damaging and dangerous to LGBTIQ+ clients (Agner, 2020; Greene-Moton & Minkler, 2020; Hussen et al., 2020; Ruud, 2018). Sue et al. (2019) suggested that cultural humility may be as important as the rest of the components of CC (knowledge, awareness, skills, and actions); it may be the case that cultural humility is an overlooked and neglected aspect of LGBTIQ+CC that can help enhance LGBTIQ+CC of practitioners in mental health services to better serve diverse LGBTIQ+ clients.

Component/Definition of Cultural Humility

Cultural humility was first defined as "a lifelong commitment to self-evaluation and critique, to redressing power imbalances . . . and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García, 1998; p. 123). As the concept was popularized in the mental health field, its definition and components became clearer and more contextualized towards counseling and therapy setting.

Cultural humility is "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client" (Hook et al., 2013, p. 354) which comprised of 1) practitioner's motivation to learn from other people, 2) critical examination of practitioner's cultural awareness, 3) interpersonal respect, 4) mutual partnership investment with the address of relational power imbalances, and 5) an open stance to novel cultural information from client with the sense of other orientation (Mosher et al., 2017). A recent sociolinguistic discourse analysis study found 3 dimensions of cultural humility that corroborate with

previous literature. The 3 dimensions were: 1) cultural teachability, 2) lack of cultural arrogance, and 3) relational orientation (Zhu et al., 2022).

The recognition of cultural diversity, social injustice and power imbalance are the potential preceding conditions that lead to cultural humility among practitioners. Once cultural humility is present in practitioners, the personal attributes of cultural humility, such as openness, and egolessness, then lead to positive and helpful consequences, which are mutual empowerment, respect, and partnerships (Foronda et al., 2016). Cultural humility is compatible to apply to multiple aspects of diversity, including ethnicity, sexual orientation and gender (Foronda et al., 2016). The quality and characteristic of culturally humble therapists and the process in which cultural humility enhances the therapeutic relationship and therapy are profound and impactful, which will be elaborated in the next section.

Qualities and Processes of Cultural Humility

Cultural humility is a quality in a practitioner that requires an ongoing process of in-depth and critical self-reflection. Therefore, culturally humble counselors strive to reflect on themselves and reduce their biases, to learn from clients about their cultural experiences and backgrounds, and maintain a lifelong motivation to learn more about different cultural beliefs (Mosher et al., 2017). Thus, the quality that cultural humility adds to therapists working with LGBTQ+ clients are an awareness of their inevitably limited knowledge, understanding of client's cultural background and experiences, and striving to understand client's lived experiences with openness and other centeredness (Sprik & Gentile, 2020). With cultural humility, the pressure and expectations that therapists need to know all the details about client's culture are taken away (Agner,

2020), which allows more focus and energy for therapists to learn more from their clients. In this sense, they can meet the clients where they are with little or less preconception of clients, mitigate the power as a therapist in the session with less pressure to know everything as well as respect the client's experiences.

The framework of cultural humility enables the dialogue and actions that practitioners can initiate beneficially in counseling. Therapists can acknowledge their own limitations and imperfections with the client, which reflects a quality of modesty and authenticity in the therapist (Zhu et al., 2021). Then the dialogues that allow therapists to notice, recognize, and respond to client's diverse culture and experiences will ensue (Agner, 2020). The notion that culture is pervasive and changeable also allows for therapists to be culturally teachable as well as identify the impact of cultural dynamic in therapeutic relationship (Zhu et al., 2022). Open-ended questions can also be a powerful skill to open space for the clients and to learn from them and understand them more accurately. The willingness of counselors to learn, self examine and change their own perspectives conveys a lack of cultural arrogance (Zhu et al., 2022).

The aspect of power sharing and egalitarianism is also a core aspect of cultural humility. When therapists enact egalitarianism in therapy, they balance the power in the relationship between themselves and the client. By doing so, the therapists invest the session time to establish an egalitarian and fair therapeutic relationship and avoid imposing their power or worldview upon the clients. The mutual relational space based on a balanced relational position between a therapist and client is a key towards mutual learning in a culturally humble relationship (Zhu et al., 2021; 2022). The reason that the balanced relational position is important, instead of an exclusive client-orientation, is that

in the latter case, the therapist could be perceived as suppressing, pleasing or inauthentic, instead of culturally humble (Zhu et al., 2021).

Cultural humility benefits both the therapist and the client. While the culturally humble therapist's self-awareness about their own assumptions, privileges, and limitations is heightened, the client may perceive respect, acceptance, and a willingness to engage in a more meaningful and authentic conversation in the session. In turn, this state of cultural humility in the relationship helps to solidify and deepen authentic and meaningful relationships leading to more cultural learning and growth consequently (Zhu et al., 2021). These qualities and processes that cultural humility brings to counseling sessions lead to a more collaborative work and therapeutic alliance with LGBTQ+ clients. Extant research supports the importance of cultural humility in relation to other important factors and variables with culturally diverse clients as well as SGM clients.

Research on Cultural Humility in Counseling

Most of the existing cultural humility studies focused on racial and ethnic minority clients (Govere & Govere, 2016; Hook et al., 2013; Morales, 2019), not on LGBTIQ+ clients. Although there were mentions of cultural humility in LGBTQ+ literature in different fields, especially in nursing and medical fields (Kuzma et al., 2019; Ruud, 2018; Thomas et al., 2020) with different kind of specific setting, such as LGBTQ+ individuals with breast cancer or in palliative care (Sarkin, 2019; Sprik & Gentile, 2020), they were only a call for action or attention.

Cultural humility was found to have relationships with therapeutic alliance and improvement in therapy in multiple studies. Predominantly White adult clients who viewed their therapist as culturally humble reported stronger therapeutic alliance, even

after controlling for race, gender, and other multicultural competence (Hook et al., 2013). Therapeutic alliance also mediated the relationship between cultural humility and improvement in therapy with a large effect size among Black adult clients (Hook et al., 2013). Furthermore, cultural humility can buffer negative events in therapy, such as microaggression (Mosher et al., 2017), solve the relational conflicts, and deepen the relationship (Zhu et al., 2021).

Cultural humility is also essential for LGBTQ+ clients because of the heterogeneity and diversity among the diverse LGBTIQ+ population with potential intersectional identities. Intersectional cultural humility combines the need for ongoing learning and openness with the inclusion of multiple social contexts, e.g., race, gender, and sexual orientation (Buchanan et al., 2020). For example, cultural humility was a vital lens in the guidelines working with diverse intersectional LGBTQ+ clients, such as those who are in conflict with disconfirming religion (Aijian & Wang, 2020) and Aboriginal LGBTQ+ individuals (Bennett & Gates, 2019).

Vanmeter (2019) investigated the experiences of lesbian and gay clients who prematurely terminated their counseling using hermeneutic phenomenology under the theoretical framework of relational cultural theory. Data was gathered through semi-structured interviews among six gay and lesbian adult participants. Four major themes found in this study were: 1) Therapeutic alliance, 2) Interpersonal interference, 3) Ethical boundaries, and 4) Cultural humility/cultural misunderstanding, and cultural invalidation. The clients in this study perceived a lack of cultural humility from their therapists to be one of the reasons that they decided to prematurely terminate the service with their therapists.

Kangos and Pieterse (2021) examined 136 LGB clients' perceptions of cultural humility of their therapists and religious commitment in relation to the working alliance and therapeutic outcomes. Participants in this study were currently or had been in psychotherapy within one year before the participation. The results showed that the perception of cultural humility in their therapists positively predicted therapy outcomes. A partial mediating effect of therapeutic alliance was found on the relationship between cultural humility and therapy outcome. Contrary to researchers' prediction, participants' religious commitment did mot moderate the relationship between perceived cultural humility and therapy outcome.

Ratanashevorn et al. (2024) examined the relationships between the perception of therapists' cultural humility, therapeutic alliance, and therapy outcome in 584 LGBTQ+ counseling clients who were currently or had been in therapy within six months before the study. The results showed that perceived cultural humility, perceived therapeutic alliance, and therapy outcome were positively related to one another. Therapeutic alliance was found to mediate the relationship between cultural humility and therapy outcome with both direct and indirect effects. Greater cultural humility predicted stronger therapeutic alliances, which in turn, predicted better therapy outcome The mediation model in this study accounted for 58% of the variance in therapy outcome after controlling for gender, sexual orientation, and level of education.

Additionally, Compton and Morgan's (2022) meta-analysis also confirmed the importance of cultural humility. TGNC clients had more positive experiences when their therapists were more open-minded, willing to educate themselves, did not make

assumptions about their gender identity or try to fit clients into boxes on therapist's idea about how clients "should" identify.

These studies described above, whether with ethnic minority or LGBTIQ+ participants, all pointed to the same direction that cultural humility is critical and indispensable in working with LGBTIQ+ clients. Considering the fact that the U.S. population is rapidly becoming more diverse (Agner, 2020; Jensen et al., 2021), it is likely that cultural humility will be more necessary for mental health services to LGBTIQ+ clients. The more diverse the clients, the more important cultural humility is, especially in regards to building rapport, strong and positive therapeutic relationship, and therapy outcome.

In summary, both LGBTIQ+CC and cultural humility are essential for effective and appropriate work with LGBTIQ+ clients. Many research studies also examined and explored their roles for the work with LGBTIQ+ clients which further confirmed their importance. Results from Ojanen et al. (2021) indicated that both the practitioners and clients agreed that practitioners need to acquire knowledge about LGBITQ+ culture in advance so that they do not have to exclusively rely on clients educating them. At the same time, being upfront about one's knowledge and limitation, staying culturally humble and avoiding stereotyping are all emphasized as majorly important.

Furthermore, although specific knowledge about LGBITQ+ culture is crucial, this knowledge needs to be updated and tested to see if it fits with each individual client and to avoid stereotyping or assuming. The concept of scientific mindedness that forms and tests hypotheses about clients and dynamic sizing that choose when to generalize the preowned knowledge to an individual client can help bridge the specific and generic

components. Along the same line, cultural humility is also what keeps the acquired knowledge, attitude and skills relevant. As therapists learn about client culture and worldview, they can still maintain their openness and stay humble about client issues, which lead to an accurate understanding, and mutual bonding between therapists and LGBTIQ+ clients (Sprik & Gentile, 2020; Zhu et al., 2021). Therefore, both specific and generic qualities are additive, not contradictory. In conclusion, the findings suggested that both LGBTIQ+CC and cultural humility are important and need to be implemented in practitioner's work with LGBTIQ+ clients (Ojanen et al., 2021)

Accordingly, the coexistence of LGBTIQ+CC and cultural humility is complementary in practice. While LGBTIQ+CC focuses on the specific aspects (knowledge, attitude, awareness, and skills), cultural humility focuses on the broad characteristics and worldviews that accept and embrace limitations of knowledge and to learn more from the clients (Sawyer & Brady, 2021). Therefore, cultural humility helps to keep LGBTIQ+CC up-to-date and relevant with diverse LGBTIQ+ clients.

Summary

Overall, a lack of practitioner cultural competence was reflected from both sexual and gender minority clients who reported negative experiences and views on their therapists. The combination of the lack of LGBTIQ+CC, the lack of cultural humility, and clients' negative therapy experiences paints the picture of how dire the need to advance and better the counseling training and services for LGBTIQ+ is. Countless recommendations and calls for actions highlight the need for further advancement in the training and investigation of the key components underlying LGBTQ+CC. As many studies and scholars indicated, LGBTIQ+CC and cultural humility are both strongly

needed in order for therapists to be culturally competent working with LGBTIQ+ clients (Alessi et al., 2021; Danso, 2019; Greene-Moton & Minkler, 2020; Ojanen et al., 2021).

However, research on the process of integrating both components of LGBTIQ+CC and cultural humility for CITs and continuing education is still missing. Even though both LGBTIQ+CC and cultural humility were identified as important working with LGBTIQ+ clients, little empirical work has filled this knowledge gap. The knowledge and information of how LGBTIQ+CC and cultural humility can be integrated and cultivated will help to clarify, sequence and plan what education, materials and teaching components are needed in each step to prepare CITs and practitioners to be better equipped and ready to work with LGBTIQ+ clients effectively. Even though such knowledge can be obtained from different perspectives (e.g., educators and practitioners), this study aims to gain this knowledge from a practitioner's perspective which might reflect more of what actually works with LGBTIQ+ clients in real life from practitioner direct clinical experiences.

Chapter 3

Method

This study explored how therapists who have experiences working successfully and effectively with LGBTIQ+ clients experienced the process of the integration of LGBTIQ+CC and cultural humility. Grounded theory was employed to explore themes and theory underlying how the participants cultivate and integrate their competence in working with LGBTIQ+ clients. Considering the importance of both the LGBTIQ+CC and cultural humility as the foundation to effectively build therapeutic relationships that affirm and support LGBTIQ+ clients, their identities and experiences, the results of this study contributed to the LGBTIQ+ competence literacy and inform the process of incorporating both components for trainings and continuing education. The research question for this study was how do LGBTIQ+ competently perceived counselors successfully cultivate, integrate, and apply LGBTIQ+ cultural competence and cultural humility?

Based on the research questions and goals of this study, the definition of LGBTIQ+ culturally competent counselors are counselors who create a safe, supportive, and trusting relationship with the client while offering ethical, affirmative, and competent services to the clients within a framework that aims to foster personal, social, emotional, and relational development as well as self-acceptance for LGBTIQ+ clients (Bidell, 2005; Harper et al., 2013). LGBTIQ+ culturally competent counselors also successfully integrate the central components such as LGBTIQ+ cultural competence and cultural humility in their framework and practice.

Queer theory was used as a guiding framework for initial criteria to find participants who have worked extensively to deconstruct and challenge the societal binary understanding and use of sex, gender, and identity and help clients to fight the misuse of queer terms, labels, and identities in the society. The integration of the concept of LGBTIQ+CC and cultural humility into practice with LGBTIQ+ clients was also grounded in a queer theory framework, as both concepts involve how therapists can break free from and help clients deal with social systems and mechanisms based on heterosexuality and a binary that harms and creates injustice for LGBTIQ+ people in the society.

Queer theory was also a guide to design and construct questions in the interview protocol that elicited a systemic viewpoint in how participants think about client issues as well as how they cultivate, integrate and apply LGBTIQ+CC and cultural humility. Eventually, the focus and significance of this study to promote better services for LGBTIQ+ community fit within the framework of queer theory.

Research Method and Justification

Grounded theory (Charmaz, 2014) fits with the research question of this study because it offers an open and flexible approach to analyzing and creating a theory that is grounded in the data. Because the process of the integration of LGBTIQ+CC and cultural humility may look different and consist of different components for each participant, grounded theory can create a flexible and tentative theoretical process model that encompasses all the variations of data, applies broadly and practically (Metelski et al., 2021), and helps to explain the patterns in development of LGBTIQ+CC and cultural humility.

Specifically, this study employed constructivist grounded theory (CGT; Charmaz, 2014) which emphasized the fact that, instead of the assumption of an external objective reality of a traditional grounded theory, there are multiple, and constructed realities, including the researcher's position, identities, perspective, and interaction in the research study, data collection and data analysis (Charmaz, 2014). Therefore, both researcher and participants play a part in the data collection and analysis and construct the data together. With this awareness, CGT fosters researcher reflexivity about the actions and decisions in research process (Charmaz, 2014). In this case, not only is the researcher more aware and transparent about their potential impact and influence on the grounded theory results, but the research consumer can also take the researcher's reflexivity and impact into consideration along with the results.

Because it is common that emerging themes keep evolving and need refinement over the data collection and analysis, a strategy called theoretical sampling is being employed in CGT. Theoretical sampling means "seeking and collecting pertinent data to elaborate and refine categories in the emerging theory (Charmaz, 2014, p. 379)". In this sense, theoretical sampling allows for simultaneous data collection and data analysis which is a two-way checking between the data collected and emerging themes and patterns simultaneously. This process helps to ensure that the theory is multifaceted, accurate to the voices of participants, and grounded in the data (Charmaz, 2002).

Recruitment Procedures

Because the researcher's judgment and criteria may not be the most valid criteria to identify the participants, the researcher used a purposeful sampling procedure called snowball sampling peer-nomination in this study to identify the participants. This method

relies on peer or colleague's judgment or perception of the therapists who possess mastery or expertise (Jennings & Skovholt, 1999). The process involves asking peers to nominate therapists based on criteria until the saturation point is reached (Patton, 1990). The process of peer nomination in this study used social media platform (Queer Therapist Facebook Group and LinkedIn) to ask peers who are practitioners or educators in the mental health field to nominate counselors who they perceived as working competently with LGBTIQ+ clients, one for LGBQ+ and another for TCNG clients, according to the following criteria:

(a) this person is considered an "expert therapist" working with LGBTIQ+ clients.

(b) this person is most frequently thought of when referring a close family member or a dear friend who identifies as LGBTIQ+ because the person is considered exceptional.

(c) one would have full confidence in seeing this therapist for one's own personal therapy (in case of LGBTIQ+ therapist) or if one were an LGBTIQ+ person (in case of non-LGBTIQ+ therapist).

(d) this person is still an active practitioner.

These criteria served to narrow the participants down to only those who are perceived as possessing expertise in working with LGBTIQ+ people. Sixty-four entries were submitted with the nomination process through Qualtrics. Twenty therapists were nominated as a therapist who work competently with LGBQ+ clients, and twenty-two for TGNC clients.

To ensure that the nominated participants have integrated LGBTIQ+ cultural competence and cultural humility in their own practice, the researcher created a second

set of criteria. Because this set of criteria is of a personal and internal nature, the researcher checked with the nominated therapists directly when reached out to them through email, instead of asking the nominators. The criteria were as follows:

(a) have an active practice license and/or certificate in one's mental health profession

(b) have training in LGBTIQ+ competence training

(c) is an active practitioner (currently meeting at least 2 LGBTIQ+ clients)

(d) have successfully integrated LGBTIQ+ cultural competence and cultural humility in their own framework and practice with a brief set of questions about their work with LGBTIQ+ clients.

The screening questions for the participants included their definition of LGBTIQ+ cultural competence, cultural humility, the population that they predominantly work with over the past 5 years (LGBQ+/sexual minority or TGNB/gender minority), and their demographic information (e.g., age, sexual orientation, gender, ethnicity, race, religion, years of practice, professional affiliation, professional credentials, theoretical approach, area of practice). The information on the population that they work with helped to balance the information between the data with sexual and gender minority clients. The answers the nominees gave would determine if they were a good fit with this study.

The researcher reached out to twenty-six nominees via email with the second set of criteria, informed consent and screening questions to invite them to join this research study. Nineteen nominees who completed the consent form and screening questions in Qualtrics fit with this study criteria and agenda. The researcher chose the participants that reflect and represent diversity in terms of: participant identities (such as sexual

orientation, gender, ethnicity, and race), population that they work with (LGBQ+/sexual minority or TGNB/gender minority), and their local and national engagement with the LGBTIQ+ mental health field and practice. As the data collection and analysis proceeded, the researcher continued to choose participants intentionally to ensure that the participants represent diversity and allow for the data to represent diversity and inclusivity and for theoretical sampling. Because the saturation of data and theoretical sampling are the key aspect of grounded theory data collection, of the number of participants will finalize based on the saturation of data (Hennink et al., 2017). The researcher sent out an email to arrange a time and date to interview participants.

Twelve participants were interviewed between October, 2023 – March, 2024. Participants' mean age was 34.5 years (range: 27–45 years, SD = 5.58). Identified genders were as follows: nonbinary (50%), transgender man (16.7), cisgender woman (16.7%), cisgender man (8.3%), and genderqueer (8.3%). Participant-reported sexual and affectional orientations were as follows: queer (50%), bisexual (33.3%), and pansexual (16.7%). Identified race and ethnicity were as follows: White (50%), Asian (16.7%), multiracial (16.7%), Black/African American (8.3%), and Latiné (8.3%). Reported religions were as follows: Agnostic (33.3%), Spiritual (25%), atheist (16.7%), Christian (8.3%), Buddhist (8.3%) and non (8.3%). Participants practiced in following areas of the country: Midwest (50%), Northeast (16.7%), South (16.7%), and West (16.7%). Participants' mean years of practice was 8.7 years (range: 1–22 years, SD = 7.39). Percentages of participants serving each LGBTIQ+ population were as follows: nonbinary x (91.7%), transgender man (83.3%), bisexual (83.3%), gay (75%), pansexual (75%), transgender women (75%), cisgender woman (66.7%), lesbian (66.7%), asexual

(58.3%), genderfluid (50%), genderqueer (50%), questioning (50%), cisgender man (41.7%), intersex (16.7%). Three fourths of the participants were professionally affiliated with mental health counseling field (75%). A quarter of participants were professionally affiliated with social work (25%). One participant was professionally affiliated with art therapy, and one participant was professionally affiliated with psychology. Two thirds of participants had a master's degree (66.7%), and a third of participants had a doctoral degree (33%).

Data Collection Procedures

According to Charmaz (2014), an intensive interview is used as the main data collection tool in constructivist grounded theory. The intensive interview encourages and allow for the relationship to elicit participant's interpretation of their experiences. The intensive interview is semi-structured and will be guided by an interview protocol. The probes and follow-up questions were used to deepen participant's answers and get enough depth during the interviews. Types of probes use may include silent probe, echo probe, uh-huh probe, tell-me-more probe, long question probe, etc. (Holland, 2013). The questions in the protocol were as follows.

1. What components are most important in your work with LGBTIQ+ clients?
    a. Ask about LGBTIQ+ cultural competence and cultural humility, if not mentioned
2. What are the signs, indicator, or feedback from the clients that tell you that you're doing the right kind of work for your LGBTIQ+ clients?
3. How did you cultivate those components to best benefit your work with LGBTIQ+ clients?

   a. Ask about examples, or moments that reflect the cultivation of LGBTIQ+ cultural competence and cultural humility, if not mentioned

4. How did you integrate those components to best benefit your work with LGBTIQ+ clients?
   a. Ask about examples, or moments that reflect the integration of and between LGBTIQ+ cultural competence and cultural humility, if not mentioned
5. How do you apply those components to best benefit your work with LGBTIQ+ clients?
   a. Ask about examples, or moments that reflect the application of LGBTIQ+ cultural competence and cultural humility, if not mentioned
6. If there were a recipe for making an LGBTIQ+ expert therapists, what ingredients would you include?
   a. How did these ingredients come about in you and your life?
   b. What roles or importance do these ingredients play or contribute?

To ensure the theoretical sampling which seek to find the samples that can fill the gaps of the data, the interview protocol was adjusted and informed in the later stage of data collection by the data analysis and the concepts of LGBTIQ+CC and cultural humility in order for the protocol to successfully enrich and deepen the interview to capture the missing data. The following prompts and questions were included along the process.

1. Were there links between your personal and professional cultivation?
2. How was it like when you started cultivating?

3. What change have you seen or observed over time?

4. What components are still lacking/missing in our field or training regarding the work with LGBTIQ+ clients?

5. Clarification on intersectionality (when mentioned)

The researcher conducted 12 semi-structured interviews through zoom with the mean interview length of 66 minutes and 3 seconds (range: 48 minutes and 22 seconds – 95 minutes and 43 seconds). The researcher contacted participants twice after the interview and sent the transcript, and emerging themes from the interview for the first member checking and the final theory from data analysis for the second member checking. The data from member checking were included in the analysis. The $50 gift cards were provided to compensate for participant's time and effort. The interview was audio and video recorded. Analytical memos were written right after each interview ended to accurately capture the researcher's thoughts and observations. Documents related to service provision for LGBTIQ+ clients (i.e., online biographies, publications, etc.) were used for triangulation and as additional data to analyze along with the data from the interview.

Data Analysis

Following Charmaz's (2014) data analysis process, the data analysis consisted mainly of the coding process that lays foundation and structure for the emerging theory. Two main types of coding in constructivist grounded theory are *initial coding* and *focused coding*. Initial coding focuses on actions happening in the data and stick to the data closely, rather than applying the pre-existing theory or categories to the data, as initial coding should be free of researcher's preconception. The coding is open for further

exploration of possible theory from the data in later stages of data analysis (Charmaz, 2014). The codes in this stage are provisional, flexible, comparative as well as grounded in the data. The process of initial coding lays a groundwork for the ongoing involvement in the data, and lets the data guide the process and analysis into a more concrete codes and themes in the following steps. The researcher also employed a line-by-line coding (Charmaz, 2014) with the first two transcipts.

The next step of data analysis is focused coding. Focused coding narrows down on the codes that frequently appear in the data or codes that appear to be more significant than others. The decision of what codes make the most analytical sense to categorize the whole data is made in this step. These codes then are used to sift, synthesize, and analyze the data in the process. The focused codes move the analysis from initial codes to a more conceptual code, including similarity and patterns in the initial codes, and gaps. The focused codes still maintain flexibility and tentativeness, to allow for change and adjustment for codes with better fit as the data unfolds (Charmaz, 2014).

Focused coding permits the researcher to sort, separate, and synthesize the large amount of data collected from the interviews as well as accelerating the data analysis process (Charmaz, 2014). Instead of using axial coding, as is typical of other kinds of grounded theory coding, constructivist grounded theory prefers to keep the codes simple, direct, and emergent to keep the analysis fresh and creative (Charmaz, 2014). Along this process, the grounded theory evolves and transforms, leading to a theory that is grounded in the data.

The central idea, variation and saturation of the data emerged along the coding process, leading to the construction of a visual portrayal of the theory (see Hays & Wood,

2011). After multiple rounds of abductive data analysis and collection (a recursive process of making preliminary guesses from the interplay between data and existing theories when unexpected findings occur), saturation was reached when the categories in the analysis were robust. No new categories were found outside of the established categories derived from the analysis after 10th interview, and the established categories richly accounted for the patterns found in the data by the 12th interview (Charmaz, 2014). The development of a graphical model demonstrating the emerging theory (see Hays & Wood, 2011) was developed to answer the research question and portray the process of the cultivation, integration, and application of LGBTIQ+CC and cultural humility as a result of this study (see Figure 1).

Trustworthiness

There were multiple strategies and measures used to enhance and maintain the trustworthiness and rigor of this study. The first strategy was the triangulation of data sources, which is the use of multiple sources of data to validate the findings from multiple different points (Flick et al, 2004), and check if the participants' expertise and attributes are consistent and congruent across the board. The main and primary source of data in this study was the verbal data collected through the individual semi-structured interviews. Additional data from documents related to their involvement in LGBTIQ+ community and clinical work was used to triangulate the trustworthiness of data. These artifacts captured participants' elements and process of their growth process than just answering interview questions alone. Additionally, triangulation increases the generalizability of the CGT results and elicits more data from the participants (Flick et al., 2004).

The researcher did member-checking (Birt et al., 2016) following the first interview. The interview transcript and emerging themes from the interview were sent to participants to review, so that they could confirm, modify, verify, and add more information. The additional information served to fill the gaps from the first interview and data analysis towards theoretical sampling and saturation (Charmaz, 2014).

The researcher wrote fresh and immediate memos after the interviews to enhance the richness of the data collected as well support the emerging themes and categories as they arose. Also, memo writing helped the researcher to recognize one's bias and positionality in the research process through reflexivity and avoiding preconceptions (Charmaz, 2014). Therefore, the researcher could approach the data with fresh mindset with mitigated biases and subjectivity (Corbin & Strauss, 1990). Additionally, the interviews were audio and video recorded. These recordings were used in combination with memos and transcripts in the analytical process and member checking to ensure the accuracy of data and analysis.

Thick description was attained through the process of theoretical sampling where the data collection will be gathered with persistent observation. The emphasis of analysis was grounded on the data from the interview with the openness for modification and adjustment from the later interview and data analysis until saturation was reached (Charmaz, 2014).

Reflexivity Statement

I, as a researcher in this study, am a Thai cisgender gay male Buddhist counselor who is enrolled in a counselor education PhD program in the Midwest area of USA as an international student. I am the youngest child of an upper middle class Thai family. I

have lived a collectivistic life with a lot of extended family almost throughout my whole life. English is not my native language, but I possess fluent and natural English communication. I first came to the USA when I started my PhD program in 2019 and thus have limited exposure to and experiences with the culture and history of the USA and its LGBTIQ+ community compared to lifelong residents.

I have worked as a counselor in a university setting for longer than 6 years and have advocated for counseling competence for LGBTIQ+ clients and other underrepresented and underserved population both in Thailand and the USA. I have a humanistic existential approach to life and therapy and view human beings as growth oriented. My humanistic stance and the Buddhist philosophical views, that believe in constructivism and multiple realities, aligns with the concept of cultural humility.

My personal beliefs that might be relevant to this study are: (a) therapists need more specific training and skills to work competently with LGBTIQ+ clients; (b) all clients need to be accepted, respected and valued; (c) counselor humility and awareness of one's assumptions and presumptions are pivotal to a good counseling relationship; (d) client voices are more important than the counselor's voice in therapy sessions; (e) the ability and skills required for LGBTIQ+CC and cultural humility are cultivable; and (f) the integration of LGBTIQ+CC and cultural humility is a long and arduous process that lasts a lifetime.

Even though some of these beliefs may be perceived as a widely accepted agreement and common-sense knowledge in our community, their potential influences on how I view and analyze the data need to be addressed. Because I am a firm believer in cultural humility, the likeliness to highlight cultural humility and overlook or downplay

other emerging themes and categories may exist. Also, my humanistic view of human beings as capable of self-growth and development leads to the belief that all counselors are capable of cultivating LGBTIQ+CC and cultural humility. Accordingly, my focus might be on the components of data that coincide with this view which may limit my capacity to explore other components and aspects of the data.

On another account, my journey of making sense of and integrating LGBTIQ+CC and cultural humility can be impactful to my approach the data in this study. My beliefs and experiences about cultural humility and how I cultivated it can be unique to my experiences. To begin with, the Buddhist perspective that aligns with constructivism and multiple reality opened the way for my deep connection with the concept of cultural humility. In a way, cultural humility and putting aside my own frame of reference come more naturally to me. While I was studying the concept of LGBTIQ+CC in my master's program, I was presented with opportunities for me to reflect my biases as well as addressing some of the missing link that cultural humility can fill. From that point, I have consistently exposed myself to diverse community and clients, e.g., Thai LGBTIQ+ community, Thai trans community, Midwest American community. Accordingly, I highly value the role that exposure to culturally diverse experiences and environments plays in cultivating and integrating LGBTIQ+CC and cultural humility. My recent experiences in the US further emphasize the importance of the exposure as well as cultural humility in working with LGBTIQ+ population. Therefore, these experiences might lead to my overvaluing exposure, while it might not necessarily be the only important factor. Ideally, there might be times in data collection and data analysis process that I need to step outside of this view and be open to potential pivotal aspects that leads

to the cultivation of LGBTIQ+CC and cultural humility that might differ from my own experiences.

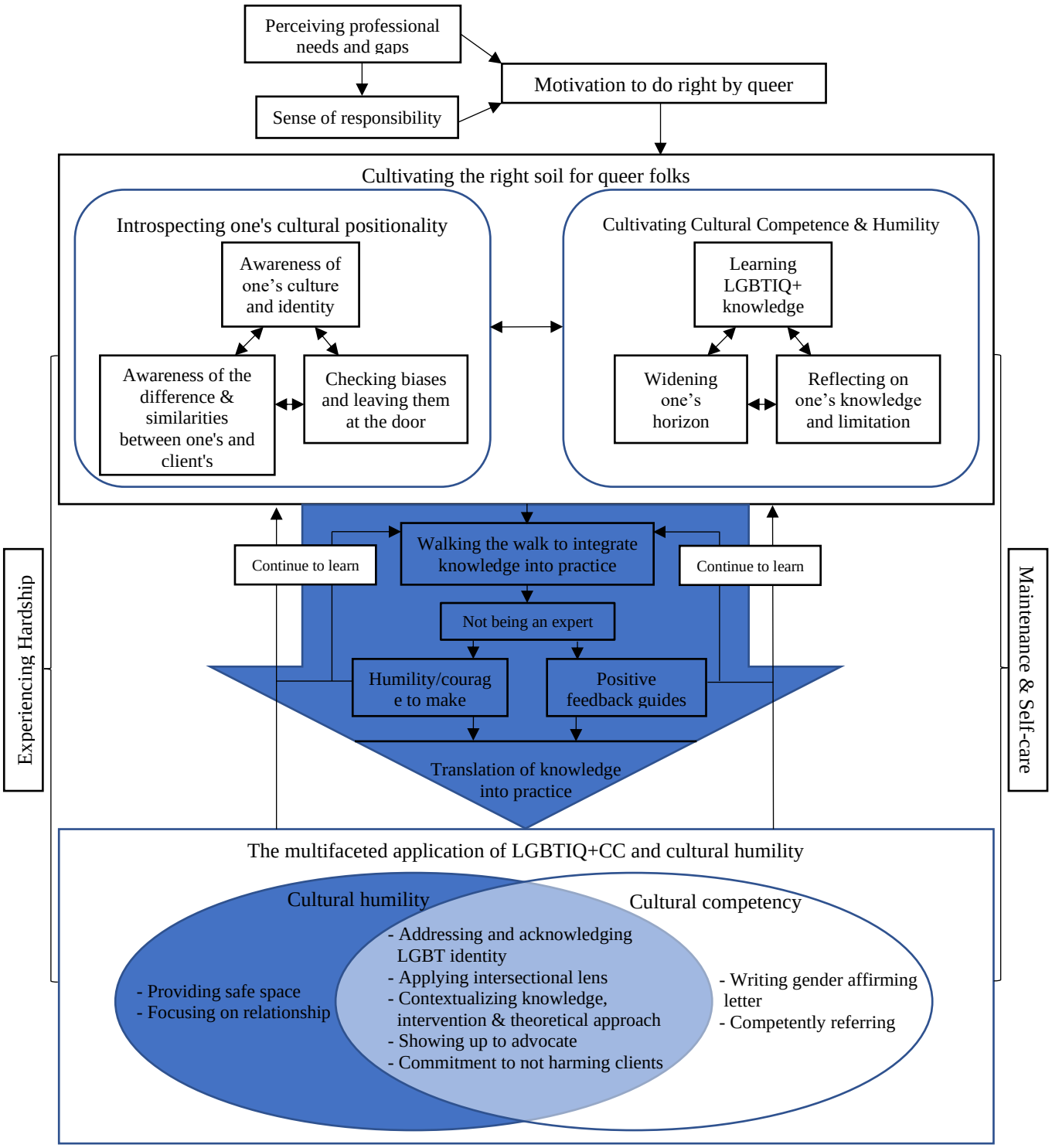
Chapter 4

Findings

In this chapter, I present the findings of this study through the constructivist grounded theory data analysis. The purpose of this study was to explore the process of the cultivation, integration, and application of LGBTIQ+ cultural competence and cultural humility among counselors who are perceived to be culturally competent in working with LGBTIQ+ clients. This study explored the following research question: how do LGBTIQ+ competent counselors cultivate, integrate, and apply LGBTIQ+CC and cultural humility? With this research question, I initially explored the process with six interview questions and six prompts. Through the approach that is consistent with constructivist grounded theory approach, I employed the process of simultaneous data collection and data analysis, constant comparison, and theoretical sampling. Two original prompts were dropped, and one question and four prompts were added to further explore the emerging theory. The additional question and prompts clarified and solidified the theory according to the research question.

In response to the research question, five categories emerged from the data (Figure 1). These categories include: motivation to do right by queer clients, cultivating the right soil for queer folks, walking the walk to integrate knowledge into practice, the multifaceted application of LGBTIQ+CC and cultural humility, and hardship, maintenance and self-care. The first category, motivation to do right by queer clients, outlines a prerequisite or condition prior to the cultivation and integration as described by the study's participants. The second category, cultivating the right soil for queer folks, entails the process of preparation and cultivation of the personal and professional

Figure 1: The Theory of Cultivation and Integration of LGBTIQ+CC and Cultural Humility



qualities that are a foundation for the integration and application. The third category, walking the walk to integrate knowledge into practice, explains the process of the integration of the cultivated quality into participants' professional selves and application. Additionally, this category links other categories together and explains the process and interaction among them. The fourth category, the multifaceted application of LGBTIQ+CC and cultural humility, outlines different components and approaches of how participants apply the cultivated and integrated LGBTIQ+CC and cultural humility. The fifth category, hardship, maintenance and self-care, summarizes the hardship that participants have gone through and how they handled it and took care of themselves to sustain the overall process.

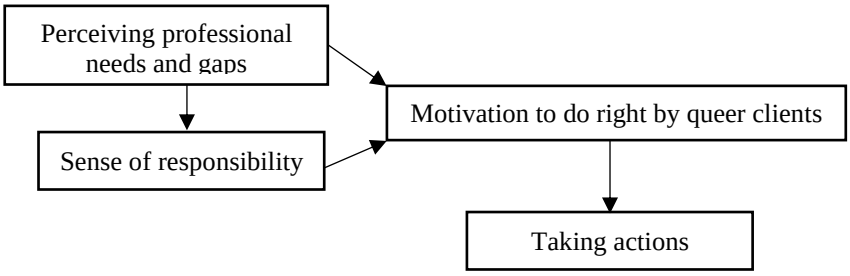
Category 1: Motivation to Do Right by Queer Clients

This category addresses the prerequisite or condition of the research question of this study: how do LGBTIQ+ competent counselors cultivate, integrate, and apply LGBTIQ+CC and cultural humility? The data under this category came directly and indirectly from the following questions during the semi-structured interview: What components are most important in your work with LGBTIQ+ clients? How did you cultivate those components to best benefit your work with LGBTIQ+ clients? What components are still lacking or missing in training in our field regarding work with LGBTIQ+ clients? If there were a recipe for making an LGBTIQ+ expert therapists, what ingredients would you include?

This category comprises of three subcategories (Figure 2): perceiving professional needs and gaps for queer clients, feeling the sense of responsibility, and taking actions. These subcategories explain the process of how the participants felt motivated to take

action by cultivating, integrating and applying LGBTIQ+CC and cultural humility in the rest of the categories. As illustrated in figure 2, the perception of needs and gaps for queer clients in different areas and directions leads to motivation to do right by queer clients. The sense of responsibility and accountability in relation to the perceived needs and gaps also increases the motivation to do right by queer clients, which eventually leads to taking actions in different capacities towards the areas of needs and gaps that participants perceived (e.g. being a change agent, growing competence).

Figure 2: The Motivation to Do Right by Queer Clients Category



Perceiving Professional Needs and Gaps for Queer Clients.

This subcategory captures many areas of professional needs and gaps in the mental health field (counseling, social work, and psychology). These areas of gaps include professional organizations and training programs, incompetent, harmful and unethical practice of other practitioners, and systemic injustice. The category also captures the needs of LGBTIQ+ clients based on the oppression, discrimination and hardship that queer community faces.

Professional gaps in the mental health field as a whole were reported by many participants. PT8 shared that it's important to be able to "adapt the field as a whole to members of the (LGBTIQ+) community. The counseling or psychology field as a whole was created by and for White men. A lot of things are still through that lens." The lack of

gender and trans-related content was reported across the board. A specific aspect that PT11 suggested as important which also tied to the need for a decolonizing lens is:

> "A reframe of how we understand gender and gender dysphoria specifically… gender dysphoria as a medical condition that affirming care is like the cure for versus seeing gender variation as a natural part of humanity and personhood that is not pathological and does not need to be cured. But it is rather just another way that we present in the world. Some people wear glasses, some don't. Like there's just differences and people, I think being able to detach from that very rigid sense of gender would be incredibly beneficial."

Some participants shared their negative experiences and discrimination they received in their training program as well. PT5 shared that "I did not have a positive grad school experience at all. There was lots of discrimination, religious trauma."

Most participants reported existing incompetent, harmful, and unethical practice which they directly observed or heard from their LGBTIQ+ clients. PT2 learned about the harm that their client shared about previous counselors:

> "but I have definitely seen counselors behave in not very counselory ways. And I've seen the impact that the clients receive. I had one client who was a teenager and they had been to 7 therapists before coming to me, before finally being affirmed in their gender. Every single therapist had misgendered them consistently (and) said 'Well, I'm just going to call you so and so'."

Some participants were concerned about other counselors' competence. PT6 shared about "clinicians that might even identify as a member of the community who, when it comes to trans clients, don't want to write surgery letters." PT7 expressed their concern over

"the danger that they (some LGBTIQ+ counselors) use their own experience and journey as a way to understand… their clients and the danger around that is because people are so different and unique."

Most of the participants also reported how the queer community and clients are facing oppression, discrimination and hardship, especially for trans and non-binary people. For example, layered and complex traumas manifested in the queer community as PT9 shared their view that:

> "Traumas present almost everywhere. It's one of those things that, at this point, has become as good as breathing. Traumatic experiences for marginalized population or LGBTQIA+ population. Someone not having a traumatic experience is unheard of for me in my work with my clients. And it's so layered and complex, especially with this population… the traumatic experiences for queer populations are so intricate, and nuanced, and scary, and heartbreaking."

Feeling the Sense of Responsibility

This subcategory captures the process of how the perception of professional needs and gaps for queer clients leads to the sense of responsibility and accountability among participants. It covers the concern of the harm being done to LGBTIQ+ clients, care and love for their queer clients and community, and the need to do hard work. PT3 shared their concern that:

> "I wish every counseling space would be like this (affirming) and in my ideal perfect world, you know. We wouldn't have these concerns of our clients not feeling like they can open up about parts of their identity. I just had a client in my office who told me that he had been looking at other counselors and just (said) 'I

> wouldn't have talked about the gay part.' I wouldn't have talked about my gay identity. And you know, I would have just hidden that for my counselor and talked about the other things"

Some participants also mentioned about the love and care that they have for their clients. PT4 suggested the importance of "heartful love, like that's something I don't think we really talk about that as much in the counseling field, but like a deep care for our clients as people… That goes beyond just like them, being our clients."

Taking Actions

This subcategory captures actions to better serve and do right by queer clients that take place as a result of the perception of professional needs and gaps for queer clients and the sense of responsibility and accountability among participants which covers a decision to become therapist and choosing therapy career path and bettering oneself to be more competent for clients. Many participants reported that they decided to become a therapist because of their own negative therapy experiences and the lack of affirming practice in the field. PT6, reported harmful therapy experiences firsthand:

> "As far as transitioning, female to male, that was approximately 7 years ago for me. Prior to that, I would say that that was the experience that played a bigger role in my youth, going to a therapist as a female who identified as a lesbian. I had a therapist - that I was seeing - tell me that she couldn't help me until I was no longer gay. So, you know, as a young person, that's not something that you wanna hear. You never wanna hear that at any time. But between that experience and also throughout my transition and realizing that I personally hadn't encountered

> any trans therapists, that made me really want to just, I mean, as cheesy as it sounds, become a therapist that I would want."

Furthermore, most participants shared the need to better oneself to be more competent in serving and doing right by queer clients. PT6 wanted to make sure that "I'm doing the best for my clients and bringing in that new knowledge to serve them… and keep wanting to provide the best for their clients." When PT9 ran into the areas that they did not have knowledge of:

> "I wanna take some time to do my own research, to do my own homework and then come back, and make sure that I'm able to hold that space for you and support you, be it like in sound boarding or brainstorming, however you needing support with."

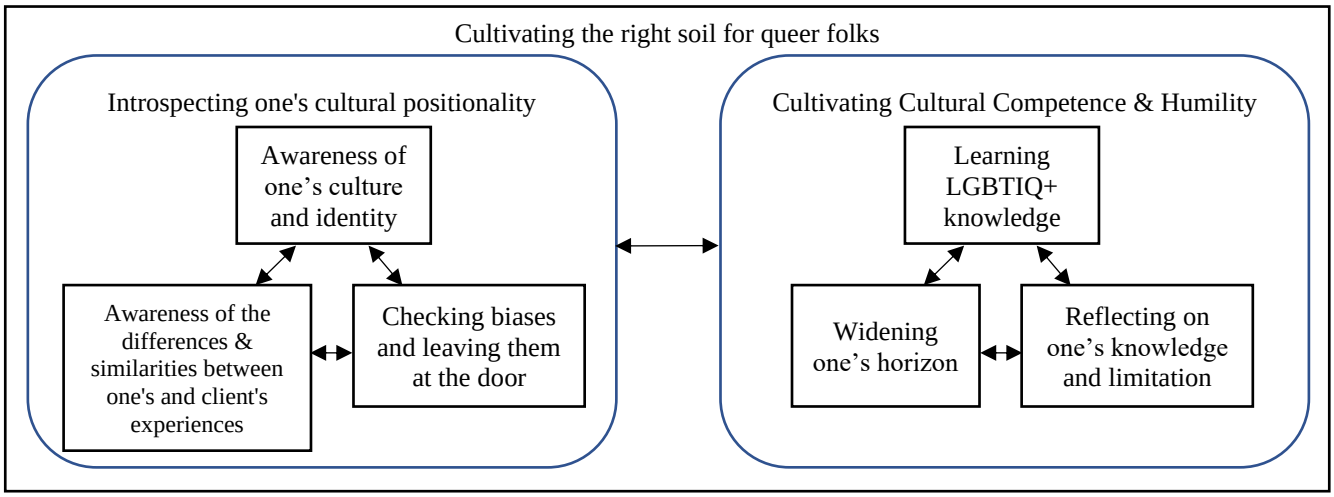
The data presented above illustrated how the motivation to do right by queer clients leads to more actions in the following categories: the cultivating the right soil for queer folks category (Category #2), the walking the walk to integrate knowledge into practice (Category #3), and the multifaceted application of cultural competence and cultural humility category (Category #4).

Category 2: Cultivating the Right Soil for Queer Folks

This category addresses the cultivation of LGBTIQ+CC and cultural humility aspect in the research question. The data under this category came directly from the following question and prompts during the semi-structured interview: How did you cultivate those components to best benefit your work with LGBTIQ+ clients? Were there examples, or moments that reflect the cultivation of LGBTIQ+CC and cultural humility?

Was there a link between personal and professional aspects in the cultivation? How was it like when you started? What change have you seen/observed over time?

Figure 3: The Cultivating the Right Soil for Queer Folks Category



Participants in this study shared how they cultivated their LGBTIQ+CC and cultural humility in two major aspects, which are personal and professional aspects that are intertwined. Hence, the cultivating the right soil for queer folks category comprises of two subcategories (Figure 3): introspecting on one's cultural positionality, and cultivating cultural competence and cultural humility. Each of these subcategory captures the components that are personal and professional aspects accordingly. These subcategories also interact with each other as the two aspects are inseparable and build on each other to cultivate the right soil and plant a seed for the integration of LGBTIQ+CC and cultural humility in the walking the walk to integrate knowledge into practice category (Category #3).

Introspecting One's Cultural Positionality

This subcategory captures the internal and personal aspects of the cultivation of cultural competence and cultural humility which covers three interactive components:

awareness of one's culture and identities, awareness of differences and similarities between one's and clients' experiences and checking biases and leaving them at the door. Most participants indicated that the cultivation started personally from their personal life experiences and qualities. Therefore, this category explains the interaction and iterative process among the three components that build on one another. The awareness of differences and similarities between one's and clients' experiences and recognition of one's biases also improve capacity to be aware of one's culture and identities. The recognition of one's biases also increases the awareness of differences and similarities between one's and clients' experiences.

Awareness of One's Culture and Identities. The introspection starts with cultivating the awareness of one's culture and identities. All participants emphasized the importance of cultivating and increasing awareness of one's culture and identities. PT11 suggested the importance of "doing my own work of better understanding myself and my values, my beliefs… how those can impact and show up in the therapeutic space…To be able to show up authentically, you have to know who you are." In order to cultivate such awareness, participants self-reflected and explored who they were and unpacked whatever was going on. PT2 found it necessary to explore their own gender in order to effectively work with gender diverse clients that "it got to the point where I need to really consider my own gender because I'm working with gender. And I cannot explore that if I'm going to be working with people who are gender diverse."

Participants pointed out connections between their personal and professional experiences in regard to the cultivation of LGBTIQ+CC and cultural humility. PT12 emphasized the importance of personal lived experience that "lived experience is

essential and it is more quality than any training or that you can have." Different aspects of participants' lived experiences cover a broad range of experiences and identities. Participants of color also shared their intersectional experiences and identities as a part of their experiences and exploration of their identities. For PT9, they "wonder a lot on how I show up as a POC queer-individual therapist in spaces with my clients. And that's something that I still continue reflecting on and I feel it's made me … a more intentional therapist." Some participants mentioned that not being a part of the community can be an obstacle or disadvantage. PT5 made a point that for them "it does give me a little bit of an advantage that I'm (a) part of the community rather than not being… whereas not all clinicians are going to have that."

Many participants also shared about their valuable personal qualities and attributes that help with the cultivation. For example, some participants mentioned intentional curiosity as a quality which they have that helps them to cultivate competence. PT10 said that their:

> "curiosity, just like. 'Oh, I'm gonna study this. I'm gonna look into this. I'm gonna read that. I'm gonna involve myself here. How can I be of most support? What are my strengths and how can I be helpful here?' and that's how I cultivated over time."

In PT12 opinions "if you can stay curious and remember your core values and how they align with the reason in which you are pursuing the practice, then that is what will feed your role as a mental health provider." Additionally, PT8 shared their value in equity that:

> "it is just my personality of making sure that people have equal opportunity or equity. Really, it's equity. I didn't know it then, but making sure people have access to be able to do things that bring them joy... even when it's hard."

Being Aware of the Similarities and Differences Between One's and Client's Experiences. With the awareness of one's culture and identity as a foundation, participants emphasized the importance of the awareness of the similarities and differences between their and their clients' experiences as well as power dynamic. PT6 shared that their intersectional identities as Black male trans benefit their work with Black and LGBTIQ+ clients:

> "Being a Black trans male, I think I tend to understand more probably the Black clients that I have, simply because you're going to have issues that a Black person deals with and then you also have the issues that a person within the LGBTQ community deals with. So those are things that I can personally identify with. I've also had clients where I have the intersectionality of sexuality with religion or culture maybe."

Most participants expressed the importance of their awareness of difference between their own and clients' experiences. Just because the participants are a part of the LGBTIQ+ community, does not mean they have the same experience with their clients. People who share the same identities and background can be different. PT5 shared that "let's say, I have a couple clients who are people of color. But even within those, the cultures are completely different…I've learned that the therapist has a much different view than the client on how things are going."

Another aspect that most participants highlighted was the recognition of their privilege and power dynamic between therapists and clients. PT3 shared that "while I do have a level of understanding of their experiences that a lot of other counselors (who are not queer) don't have, I do hold a lot of privilege and actively acknowledge that in sessions with my clients."

Checking Biases and Leaving Them at the Door. Going in the same direction of having awareness about one's privilege and power dynamics, participants pointed to checking their own biases and leaving them at the door as an important part of introspecting about one's cultural positionality, as biases and stereotypes can be harmful and implicit. This enhanced their attitude, awareness, delivery of service, and quality of the rapport, trust and counseling alliance with their LGBTIQ+ clients. PT1 shared their way of recognizing their own biases and leaving them at the door as:

> "I notice it and I'm gonna rewind to before that came up and continue from that point. So, it's how I work with it. I've tried to rewire my brain the best that I can with it to try to remove it in the future; probably won't but it's a goal. So, definitely when I have those little judgements that popped up, I check them and leave them at the door…all of the biases, that internalized homophobia and transphobia I had my whole life. By having to do the work myself, I can understand or relate to people who are transitioning, allies."

A systemic approach to decolonize their mindset and practice was also addressed by some participants. PT8 shared that "you have to have an understanding of how white supremacy and colonization have negatively impacted everything for LGBTQ folks as

well. It's all very connected with oppression, and who gets to succeed, or who systems are built for."

Cultivating Cultural Competence and Cultural Humility

This subcategory captures the external and professional aspects of the cultivation of cultural competence and cultural humility which covers three interactive components: learning LGBTIQ+ knowledge, widening one's horizon and reflecting on one's knowledge and limitations. Therefore, this subcategory explains the interaction and iterative process among 3 components that build on one another. While the content of knowledge and approaches that participant took to widen their horizons go hand in hand, the reflection of one's knowledge and limitation helps them to have a critical eye and see limitation in their own knowledge and practice. Accordingly, they will continue to learn more relevant, accurate and up-to-date knowledge and widen their horizon even more.

Learning LGBTIQ+ Knowledge. Participants shared the experiences of how they learned this knowledge along with the importance of learning. PT3 mentioned:

> "having enough base knowledge about LGBTQI+ identities broadly… (and) knowing enough terminology to be able to understand what is a sexual orientation, gender identity, (and) gender expression. What is being trans or non-binary? You know, being able to differentiate between sex and gender. Being able to understand that gender identity and sexual orientation aren't inherently linked…"

Areas of knowledge that participants mentioned were knowledge about gender and trans issues,

coming out, intersectionality, ethical and boundary competencies, STDs, and societal and systemic oppression around LGBTIQ+ community. PT12 elaborated that "as healthcare providers, having an awareness of our role within that and attempting to provide treatment that is sensitive to those issues, to this oppression that affects all of us" because "policies are impacting individual care for queer and trans clients in particular and how that might be re-traumatizing for them especially if (clients) are trying to engage in the medical field (PT10)."

Widening One's Horizon. To gain LGBTIQ+ knowledge, cultural competence, exposure, experiences, and cultivate cultural humility, participants employed many approaches in widening their horizons. Two of the approaches that were most frequently mentioned by participants were consulting the literature and attending trainings. PT11 considered trainings to be an avenue that they get to diversify voices that they heard from the community by "trying to have as many perspectives as I can, taking various trainings from different people with different lived experience… panel discussions and hearing… a group of 12 queer people and they all have a different response to this." Participants also included consulting with colleagues and other professionals, supervision and mentorship, and community engagement as helpful to their cultivation of LGBTIQ+CC and cultural humility. PT9 shared learn about LGBTIQ+ people's lived experiences and culture through community events that:

> "Communicating or even asking questions, 'what made you start this business?' and there are so many small BIPOC queer-owned businesses in the community that I am a part of. And there's so much to learn about where they all come from,

what made them start their journey, their experiences, learning more about queer culture."

Reflecting on One's Knowledge and Limitations. With knowledge, competencies, and insights gained, the reflection on one's knowledge and limitations helped participants to have a critical eye and stay in check while further cultivating cultural humility. They first had to accept that they do not have to know all the answers, and that it is impossible to know all the answers. Additionally, they reflected on their own knowledge to see the limitation in their own knowledge and practice, and stay culturally humble.

Almost all participants agreed and admitted that they did not have to know all the answers. PT11 shared that it is important for "recognizing that we don't know everything and there's no way we could know everything." Once you are aware of your own knowledge and competence, it becomes clearer where the limitation of your knowledge is. PT9 shared that a good practice that comes after accepting one's limitation is:

> "owning up to areas that I lack knowledge…So for instance, with one of my clients, we were talking about bottom surgery and the types of procedures that one can opt for. My client mentioned some(thing) that I did not have an awareness of and I felt comfortable letting them know, 'Hey, I've heard about X. I don't know about Y and Z'."

However, it requires vulnerability and authenticity in order to do so.

Another aspect of reflection of their knowledge that some participants addressed was the contemplation of their theoretical approaches and how the theories impact queer community and their service. PT11 realized that "more mainstream interventions can be a

bit invalidating … maybe trying to distract our focus from things like that…There is a healthy and unhealthy. We're obsessing over it, then that's probably not going to be beneficial for us." PT5 also shared that with a person-centered approach:

> "You really have to meet them where they're at. Why I think person-centered works so well for this population, because how can you know where they're at if you don't take the time to figure that out?... Unintentionally it also brings in kind of like the social justice component because they for once are being able to use their voice."

Category 3: Walking the Walk to Integrate Knowledge into Practice

The walking the walk to integrate knowledge into practice category is the category that addresses the integration of LGBTIQ+CC and cultural humility aspect in the research question. The data under this category came directly from the following questions and prompts during the semi-structured interview: How did you integrate those components to best benefit your work with LGBTIQ+ clients? Were there examples, or moments that reflect the integration of and between LGBTIQ+CC and cultural humility? What are the signs, indicator, or feedback from the clients that tell you that you're doing the right kind of work for your LGBTIQ+ clients?

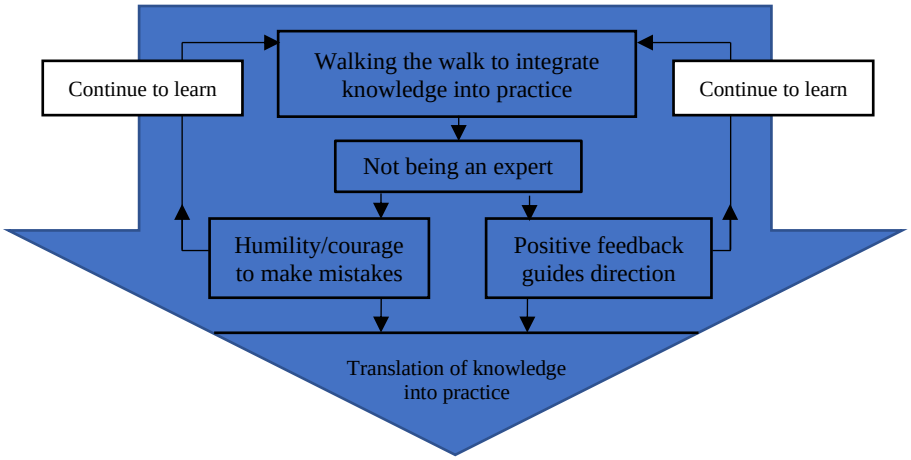
The emerging data reflects participants' ongoing process of integration of and between LGBTIQ+CC and cultural humility into their practice and themselves. The walking the walk to integrate knowledge into practice category captures the importance of the integration and bringing in the cultivated competence and knowledge into real practice, not just learning or talking about them. PT2 highlighted that "if I say that I am

competent in gender-affirming care or something like that, I need to behave in a way that is congruent with that… learning to walk the walk and not just talk the talk."

This category comprises of six subcategories (Figure 4): taking knowledge into practice, not being an expert, humility/courage to make mistakes, positive feedback guides direction, being a lifelong learner, and the translation of knowledge into practice. Each of these subcategory captures the step of how participants engage and interact with themselves, their knowledge, and clients. These subcategories also show the reiterative process of the integration of LGBTIQ+CC and cultural humility.

As illustrated in figure 4, the integration process starts from taking the cultivated knowledge and qualities from cultivating the right soil for queer folks (Category #2) into practice through the perspective that participants are not the expert and humility/courage. There are potential mistakes or the positive feedback from clients that guides participants to go back to cultivating the right soil for queer folks (Category #2), taking knowledge into practice, or improve their translation of knowledge into practice that leads to the multifaceted application of LGBTIQ+CC and cultural humility category (Category #4) to provide LGBTIQ+ culturally competent and culturally humble counseling service for LGBTIQ+ clients. It's noteworthy that even if participants received the positive feedback that guides their direction that they are in the right track or have the right mindset, it does not mean that they no longer have to cultivate or learn more. The cultivation and integration process itself is a core on-going component, that participants are in the right cycle and process to continue to be more competent and humbler for their LGBTIQ+ clients.

Figure 4: The Walking the Walk to Integrate Knowledge into Practice Category



Taking Knowledge into Practice

This subcategory captures ways in which participants bring in the cultivated LGBTIQ+CC and cultural humility into their practice. For example, PT1 explained that:

> "Taking it into a practical application is how I took these ideas and these words, and I was actually able to cultivate that in my work. Literally what it is, right? You take these ideas and then you cultivate it into your soil, your work, your client, your practice, because it's a practice, you know."

PT4 mentioned many aspects of cultivated components they brought into their session, which is "the knowledge that I've gained from growing my competence to our work together…it's this backpack that I've accrued of continuing education, trainings, (and) the activist and advocacy work I've done, all of these things that I'm bringing into session." Participants were also very intentional about the integration. For example, PT10 prioritized quality over quality and said that "I'm gonna focus on a couple of key things that are really gonna benefit, but I think that sometimes it's important to focus on a couple of key things and really do those to the best of my ability."

Participants connected and compared their own knowledge and competence to client's lived experiences. PT3 shared the conversation they approached this with their clients by:

> "Being open to talking to my clients and saying 'This is something that I have seen as far as what these experiences could look like. What do your experiences look like? Are they similar to this? Do they differ from this? If they differ from this, how do they differ from this?' to help provide context and some language in terms of understanding…and so being able to say 'This is what I know. This is what I've done. This is how I've worked within this aspect before'."

Not Being an Expert

This subcategory captures aspects of mindset that participants cultivated cultural humility by not acting or being an expert in counseling sessions and relationships. This reflects their absence of arrogance and therapist's centeredness. These aspects included being open with beginner's mind**,** client is the expert on themselves, and therapists are not always right. Such a mindset is crucial to participants in the process of taking knowledge into practice and integration overall. Many participants reported that they admitted that they were not an expert. PT1 reported that "I don't see myself as an expert and an authoritative/authoritarian position." Along the same line, participants highlighted the importance of being open with a beginner's mind with their clients. PT7 shared that:

> "the humility is around the curiosity about what that competency looks like when you're sitting in front of another human being… So it's about how do you use those as themes for which you can be curious about whether they apply with

> clients or not… and then if they do, just like you're doing right now, ask me or asking clients to talk about them or do certain things, etc."

As participants did not act like an expert, they let clients be an expert in their life and lived experiences, as PT12 explained "the story comes from the person (client) that is entering your space (therapy). It is not your job to tell their story…(it's the clients) who are really the ones that are the expert of themselves." In order to do so, many participants reported that they learn from and believe in their LGBTIQ+ clients. PT12 shared that:

> "Whatever this person is bringing to the table, you have just as much to learn from them as they from you…components that I feel are crucial to being a provider for this (LGBTIQ+) community, I believe in when you're entering into any community, whether you're familiar or not familiar, is how having that humility and being open to learning from others."

Humility (Courage) to Make Mistakes

This subcategory explains the mindset and the consequence of how participants integrate their knowledge into practice with the mindset of not being an expert in terms of how they handled potential mistakes from the integration. Inevitable limitations to fully understand all LGBTIQ+ client's lived experiences and gaps in participant's LGBTIQ+CC unavoidably led to mistakes. PT2 said that "I've taught myself through practice, and trial, and error, and trainings and all of those things to pause and reflect." Therefore, many participants described how it takes a lot of humility and courage to make mistakes. The mindset that's growth-conducive for the integration process is to admit and own one's wrongs to learn what is right. PT1 explained such process through their experiences and perspective that:

> "I think working with any culture apart of your own, (cultural) humility is like understanding any knowledge that you had before you speak with somebody in that community can be totally wrong, the humility to just let go of any preconceived notion, hinder, bias, whatever it might be, and really be open to hearing and experiencing with the person…and fail (to go) forward."

Apart from admitting their mistakes, some participants mentioned the importance of being open to correction, and critique as well as being able to forgive oneself. PT6 shared how they were accountable for their mistakes in the demographic questionnaire that "we must acknowledge and be accountable for our faults or having the wrong information and continue to be curious… learning (the) ways (which) you have caused harm, owning it, apologizing, and making meaningful changes, ongoing." Because such conversation to accept and apologize for one's mistake might not be the most comfortable conversation, PT3 mentioned that "it is going to need to have confidence in navigating some potentially really uncomfortable conversation and being able to acknowledge that some of those conversations might be uncomfortable."

Positive Feedback Guides Direction

This subcategory captures the positive signs and responses that participants received and observed in different aspects, implicitly and explicitly, that showed that they are doing the right kind of work for their LGBTIQ+ clients. Positive feedback that the participants reported are positive responses from their clients, the observation of positive signs in their clients, growth within oneself, and other professional milestones that reflected LGBTIQ+CC and cultural humility. Such positive signs and feedback help to guide and inform their practice, the direction of being a life-long learner, the translation

of knowledge into practice, and that they are doing the right kind of work for their LGBTIQ+ clients. PT11 recalled their work with one of their teen clients:

> "I am (the) eighth, ninth, tenth therapist this kid has had. I don't even know how many at this point, (the client) just bounced around a lot of different agencies, and unfortunately in community mental health turnover tends to be quite high for clinicians. And this kid had made the remark about not anticipating how much of a benefit it would be to have a queer therapist, but that they felt so much more seen, so much more supported simply just by virtue of me sharing that component of my identity with them."

PT8 also shared a meaningful moment with their client that:

> "They gave me this button 'you are safe with me' and they said, 'I wanted to give you this because I'm giving a few people in my life these buttons to let you know specifically that you are always a safe person to talk to. And you're a part of my safety plan and that you can be reminded that you're my person, you're one of my people, but also like that you're this person for other people too'."

Participants also considered their client's engagement and vulnerability as a positive sign. Participants also perceived growth within themselves in different directions. PT9 shared that:

> "I think when I talk about being shaped as a therapist, specifically meant as, in my training and in my journey of becoming an affirming provider or an affirming care therapist, in addition to all the trainings and consultation, I think my work with the queer clients has been very…what's the word I'm looking for? Yeah. It

> has contributed to a lot of self-confidence…and validation in the sense that the work I'm doing is effective, it's important, and it's helpful."

Being a Life-Long Learner. This subcategory captures the positioning and perspective of how participants keep on learning from the previous subcategories, e.g., taking knowledge into practice, humility/courage to make mistake, positive feedback guides direction. Being a life-long learner category is also critical as it links and connects different components in the walking the walk to integrate knowledge into practice category (Category #3) in Figure 4 and also with the cultivating the right soil category (Category #2) in Figure 1 in the form of ongoing and cyclical process of continuing to learn.

Most participants emphasized the benefit of being a life-long learner and shared their perspectives or mindset of how they maintained their growth-oriented mindset. PT8 explained in detail that:

> "cultural humility says like. 'I'm gonna learn more about this topic, but my journey is not done'…I think also I am a lifelong learner so I geek out about books and research…but I think having a drive to learn or having an interest in always learning or taking a new information… I think the humility and knowing that there's always more to learn (are important components)"

Many participants mentioned the importance of being a life-long learner, because "(LGBTIQ+ related) stuff is always changing (PT8)." Accordingly, many participants also emphasized the importance of keep growing humility regardless of one's competence.

The Translation of Knowledge into Practice. This subcategory reflects understanding of translation of knowledge into practice as a part of walking the walk to integrate knowledge into practice. Such understanding of the translation of knowledge into practice is a foundation to the multifaceted application of LGBTIQ+CC and cultural humility category (Category #4) along with the cultivated LGBTIQ+CC and cultural humility. Aspects that participants covered include not relying on clients to educate counselors, having critical eyes of competence, filtering knowledge before application, and the understanding of the connection between LGBTIQ+CC and cultural humility.

A lot of participants mentioned that it is not LGBTIQ+ clients' responsibility to educate counselors about LGBTIQ+ knowledge. PT11 shared that "we're not asking them to educate us on things that we should already know. I'm not having them define gender to us. We should know what gender is…already having the base-level understanding ourselves." Many participants also highlighted having a critical eye about knowledge and competence. PT11 elaborated how they approached information with a critical eye:

> "critically look at things. So, if I'm reading an article and it's saying it's beneficial for this population or this is associated with this thing, what else could be going into this? Like what are maybe some of the other variables that weren't picked up on… I noticed that probably the sample population was only this certain group, and could that have impacted the results of the study?"

PT1 shared about filtering knowledge before application that "I go to specific trainings for different clients. I make sure to inquire about how does this specifically impacts LGBTIQ+ population…having that lens and that mental filter to what's gonna be helpful."

Several participants thought of knowledge that focuses only on LGBTIQ+CC as reductionistic or misleading. PT11 observed that "a lot of coursework around cultural competence is stereotyping in a way…if you work with a client from XYZ population, they're gonna think these things and it can be really flattening of the experience of a group of people." However, when cultural competence and cultural humility are both present, such flaws and gaps are taken care of. Many participants found them to be overlapped, interdependent and intertwined. PT8 summarized the connection between LGBTIQ+CC and cultural humility that:

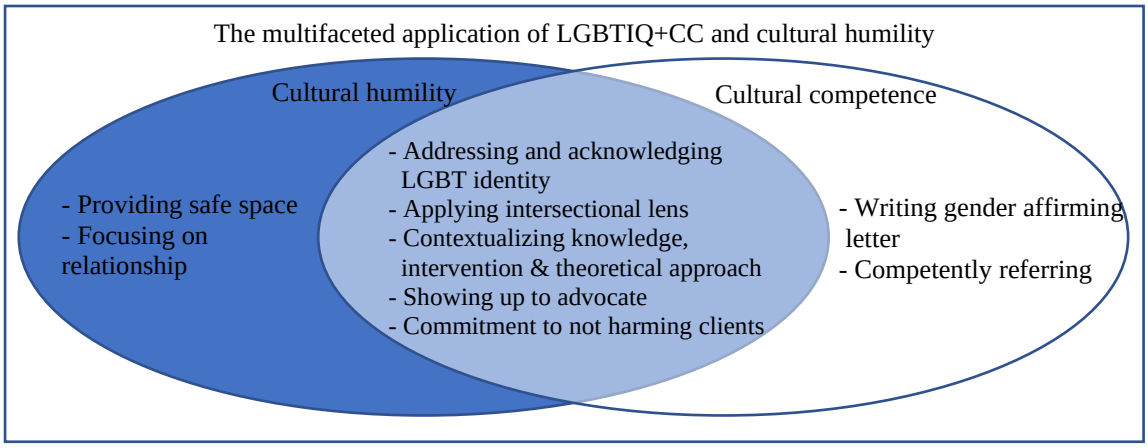
> "So, I think as far as competency with LGBTQ+ clients, it's an ongoing journey of humility and learning… when you start in those spaces of 'I want to give you some basic info' or like 'I'm gonna like fact check you' or like 'tell you that why what you believe is a myth.' That, to me, is more like cultural competence where it's likr, 'this is the low basic, everyone should know this.' And then once we can get you there, then we can start on this journey of cultural humility."

Category 4: The Multifaceted Application of Cultural Competence and Cultural Humility

This category addresses components of the application of LGBTIQ+CC and cultural humility aspect in the research question. The data under this category came directly from the following questions and prompts during the semi-structured interview: How do you apply those components to best benefit your work with LGBTIQ+ clients? Were there examples, or moments that reflect the application of and between LGBTIQ+CC and cultural humility? If there were a recipe for making an LGBTIQ+ expert therapists, what ingredients would you include?

This category comprises of nine subcategories (Figure 5): providing safe space, focusing on relationship, addressing and acknowledging LGBTIQ+ identity, applying intersectional lens, contextualizing knowledge, intervention & theoretical approach, writing gender affirming letter, competently referring, showing up to advocate, and being committed to not harming clients. Each of these subcategory captures the step of how participants engage and interact with themselves, their knowledge, and LGBTIQ+ clients. As illustrated in Figure 5, the cultural-humility cluster of subcategories to the left are based more on cultural humility. The LGBTIQ+CC-and-cultural-humility cluster of subcategories in the middle are based on both LGBTIQ+CC and cultural humility. The LGBTIQ+CC cluster of subcategories to the right are based more on LGBTIQ+CC.

Figure 5: The Multifaceted Application of Cultural Competence and Humility Category



Providing Safe Space

This subcategory captures the different aspects and components that participants described as pivotal to creating and providing a sense of safety and safe space for LGBTIQ+ clients. It is noteworthy that a sense of safety is not static or perfunctory. Even

though tangible and visual materials that represent diversity and inclusivity are a good device to start with, the sense of safety is continually co-created through relationship and interactions between therapists and LGBTIQ+ clients. As PT12 put it, “safety is subjective and it's also contingent upon someone's experience with their environment.” PT5 added that, in order to provide safe space, they needed to be “able to show them (clients) over time. ‘Yes, I'm safe. Yes, I (the counselor) can be trusted’.”

The first things that LGBTIQ+ clients observe are the biographies that participants had online. All participants emphasized their intention and approach to create a safe space and environment for LGBTIQ+ clients and community, such as empowerment, safety, authenticity, and affirmation. The next thing many participants mentioned was therapy spaces and how they were intentional about setting their therapy room and office and presenting visible LGBTIQ+ welcoming material. Some participants reported providing safe intake and paperwork as well.

Being authentic and genuine were highlighted as very important. PT11 shared that “(with) my theoretical orientation and just the way that I practice therapy, I really put a lot of high value on being very authentic with my clients… practicing authenticity through the whole session, showing a genuine interest in them.” Some participants also mentioned that they modeled authenticity and honesty, which they considered as a two-way process. PT12 shared that “if you are going to encourage honesty from the client, there needs to be an environment in which they can feel like they want to be vulnerable with you. So, honesty works both ways.” Once this happened then the clients can open up and do the deep work together

The second aspect is being straightforward and transparent. PT2 shared that “the biggest piece of it for me has been transparency…I think that transparency is a really significant component in that (cultural humility).” Participants reported many areas that they were transparent to their LGBTIQ+ clients, such as their approach and practice, limitation of their knowledge, boundaries, and their sexual, affectionate, and gender identity, and pronouns. For example, PT3 shared that “I'm very transparent with my clients in terms of where I'm hearing there are differences between how we are coming into the counseling, and how to potentially navigate those differences.” One caution that most participants kept in mind about transparency of their identities and experiences, is to share minimally or self-disclose very intentionally. Participants also shared in their demographic information and online biographies openly of their affirmative and safe approaches to LGBTIQ+ community, such as, person-centered, queer theory, feminist, social justice approach, decolonizing, strength-based, and trauma-informed approach.

Some participants also reassured their clients by sharing their open stance. PT10 told their clients that “I think you should ask all kinds of questions, like you should feel free to ask whatever questions you have.” PT7 added that:

> “And I think it's also about the fact that I'm really open with clients that they can talk about whatever they want. They can talk about their homophobia. They can talk about other people's homophobia. They can talk about sex. Like, it's just I'm just pretty open about it.”

The participants also mentioned about validating client's story and lived experiences as critical in making clients feel safe, seen, and heard. This validation aspect of this subcategory captured the ongoing process of co-creating safe space with clients,

which is also a foundation for the next subcategory, focusing on relationship. PT12 mentioned a way to cultivate safety with clients by "affirming and letting that client know that they are valued… understanding where they are coming from and be able to offer that soft landing space, where they can come and not feel like they have to be on guard."

Focusing on Relationship

This subcategory outlines the important aspects that participants invested in the therapeutic relationship with their LGBTIQ+ clients. As the sense of safety was in place, it allows for the relationship to take place as a part of the continuing work along the line with providing safety space. Trust and rapport were the first thing that participants highlighted. PT6 shared that "being able to build a rapport that I am able to make them comfortable so we can do the best work together." PT11 revealed their queer identity as a way to build rapport: "So, I myself am queer and I have had so many experiences with clients where I'll disclose that to them and it makes a very significant impact on the working relationship in a very positive way." Not being an expert, humility to make mistake (Subcategories of Category #3) and providing safe space (Subcategory of Category #3) can also lead to better trust and rapport. PT8 shared that "that's been a really pivotal part of gaining that trust, rapport, (and) safety… (that) is they'll know that 'oh she's gonna make mistakes but she's okay with saying that she makes mistakes,' right? I (client) am not gonna be harmed."

As illustrated in Category #1, LGBTIQ+ clients tend to experience harm and aggression in their previous counseling services and from the professional field and system; therefore, participants in this study reported professional mistrust with their LGBTIQ+ clients which got in the way of building trust and rapport. PT2 shared about

their client who had religious trauma and mistrust that by the time that they met this client:

> "they (client) assumed that I was going to be yet another therapist that was going to tell them that they were going to hell… But the experiences that this client had had really affected the ability to connect with me because they were terrified."

Accordingly, many participants addressed mending professional mistrust and rupture as important to building trust and rapport. First of all, the beginning of mending the mistrust is about having the right mindset to understand the source of mistrust and not taking the mistrust personally. PT2 shared that "I don't ever expect them to immediately trust me because I understand that, you know, historically our profession has not helped queer people." These understanding helped participants to be patient and respectful of their clients' mistrust and guardedness.

To create a meaningful and therapeutic relationship based on cultural humility, many participants talked about being on equal plain field, collaboration and alliance with their clients. PT1 shared that:

> "I definitely think it's important that my clients feel that they are in control, that we are on equal plain field. I don't see myself as an expert and an authoritative/authoritarian position… When the clients are new to me, I tell them right away like this is us working together. This is a collaboration"

Participants were also intentional with letting clients have and hold the therapy space. PT9 mentioned that "so making space and being aware about how does (counselor) support this client with these identities in the best possible manner. So, meeting them where they're at - LGBTQ+ edition."

Another thing that participants mentioned is to set a clear boundary with clients. PT6 shared the conversation they had with their client that:

> "I think that starts with knowing the client that you're working with, knowing what backgrounds they're coming from…that way, you can have that conversation with them upfront. If you see me out in public or somewhere, this is what I would do, I will let you be, I won't acknowledge you if you don't want me to, you can come up and acknowledge me if you want to, having that understanding in the very beginning."

Addressing and Acknowledging LGBTIQ+ Identity

This subcategory emphasizes the importance of the address and acknowledgment of client's LGBTIQ+ identities and the topics and approaches that are beneficial for LGBTIQ+ clients. Such conversation required the sense of safety and a good relationship with LGBTIQ+ clients, which will further enhance both the sense of safety and relationship with the clients. PT3 mentioned that:

> "For a lot of my trans clients, how to navigate consent, and language and barriers and all of those things, and sexuality, and so having an openness to even talk about sexuality is something that a lot of counselors, especially here, are given… we acknowledge their identity in a session."

PT7 shared their opinion on talking about sex in therapy that "I do feel like in some ways if therapists are more…if they're more comfortable talking about it and clients will talk more about it." Furthermore, some participants suggested ways to address and acknowledge their clients' identities. For example, balancing between the LGBTIQ+

related issues and non-LGBTIQ+ related issues in the work with LGBTIQ+ clients is important as PT2 suggested:

> "I understand that you do have to pay attention to those things, right? That's very relevant. And we have to make sure that we're addressing the reason the client came in… so I get the image of a pendulum swinging too far to either end and it needs to kind of fall somewhere in the middle, right?"

Applying Intersectional Lens to Clients.

This subcategory outlines the application and perspective of intersectional lens that further deepen the conversation from the acknowledgement of clients' LGBTIQ+ identities and therapy work with LGBTIQ+ clients. PT11 emphasized that:

> "intersectionality piece as well, I found is very important, you know… and so really paying attention to, if a client comes in and maybe they're in a religious family, and that can impact positively, negatively, or kind of neutrally their relationship with their gender or their sexuality, and being able to recognize that that creates a complexity."

The intersectional lens is one of the key subcategories that helps to enhance the work of the application of the LGBTIQ+CC and cultural humility of Category #4. Participants addressed ways that they applied an intersectional lens to best work with LGBTIQ+ clients, such as broaching. PT3 explained how they broached and brought intersectional lens into the conversation with their client that:

> "Are these conversations that I'm comfortable broaching with my clients to say…as I'm talking to my clients saying, 'I understand that this information is coming from a white person so I don't have the same experiences as my queer and

> trans Latina clients,' for example. This is information that is coming from a person you don't have to fear…because of my career and trans identities."

An intersectional lens allowed participants to go deeper about how their client's LGBTIQ+ identities impact other areas of their life, recognize and understand their experiences. PT7 shared that their reference of clients also based on cultural background and understanding of intersectionality with LGBTIQ+ clients: "I may refer one client to a certain support group, but I have another client that I may not … because I'm concerned about their experiences as a person of color in a predominantly White space." Curiosity and treating every client differently and uniquely were emphasized as important in the navigation of client's intersectionality. PT1 shared that "it's very important for me to take every single person and what they say and how they present as a very individual as an experience."

The last aspect that some participants highlighted as a part of intersectional lens was treating clients as a human being holistically. Sexual, affectionate, and gender identities are not the only aspects of LGBTIQ+ clients. PT12 mentioned that:

> "the person that you are providing services to… it's good to remember that they're a human being with feelings and thoughts… in the end we're all just people… Acknowledging that who you love is just one aspect of your personhood. And things that can affect our level of stress…what kind of traumas are imposed, your ability to be able to love oneself… others, to love the world, (all of the above) is going to be subject to all of these other layers of human identity."

Contextualizing Knowledge, Intervention, and Theoretical Approach

This subcategory outlines ways in which participants adjusted and contextualized the knowledge, intervention, and theoretical approach that they learned to fit with LGBTIQ+ clients' intersectional contexts and lived experiences. In order to do so, it is extremely important to know enough about client's culture and what to bring up, which is linked to Focusing on Relationship and Applying Intersectional Lens to Clients subcategories. PT3 gave an example about their "cisgender gay man (client), for example. Do I know enough to ask about protection around STIs? What is my client's HIV status? Do I have enough knowledge around that to be able to navigate that conversation?" Participants then adjusted and queered their approaches accordingly. PT3 also shared how they reflected on their thoughts and languages to contextualize:

> "So, I had to very intentionally reflect inward on what was I actually meaning when I was talking about codependence. Why was that the language that I chose? How was I contextualizing that? So, you know, what lens of my identity was I looking at that from? And how might I read that? Then, reframe that within my client's cultural context."

A lot of participants reframed their LGBTIQ+ clients' narrative. PT11 reframed and used strength-based approach with their client:

> "especially if a client is saying that maybe if they're doing something that isn't the most functional or healthy for them. Okay, well, let's be curious as to why we're doing this because I'm coming at it from…well, there has to be some benefit here. Doing like a strength-based approach, so why are we doing this? Let's explore this more."

PT5 shared that the reframing helped their clients: “Rather than saying, ‘let's shift your perspective because it is wrong’…try and reframe, but not in the sense of invalidating what they're experiencing, more reframing it to make it more livable and less painful for them.” PT4 also reframed by connecting it back to “this system of violence… it was really powerful to be able to conceptualize out loud to them, that the things that they were doing that were getting them into the detention center were actually survival strategies,” and “connecting it also to potential for action…potential for activism. Using engaging in activism as a mode of healing, if clients are interested in that.”

Showing up to advocate

This subcategory outlines different aspects and areas in which participants branched out beyond their scope of responsibility, either to fill the professional gaps for LGBTIQ+ clients and in the mental health profession or to create change and impact as a change agent. PT2 shared that “being an advocate is the biggest thing for me anyway. Not the only thing, but the biggest thing (for their application).”

Participants included many advocacy roles and areas that they advocated for their clients. PT11 shared that “I know for me personally that's huge. I see my role as a therapist as being an advocate for my clients.” The first area that many participants mentioned was being visible as an LGBTIQ+ affirming therapist so that LGBTIQ+ clients could find them. In their online biographies, a quarter of participants stated openly that they identified as a part of the LGBTIQ+ community. Whether they revealed their identities as a part of the community or not, all participants indicated and included their specialty areas of working on LGBTIQ+ topics and with population (e.g., trans and gender nonconforming, rural LGBTQIA+, intersectionality, kink, polyamory, traumas,

social justice and empowerment). Another important aspect that most participants agreed on as very important to advocate for their clients is “the ability to locate and access community support (PT7).” Some participants advocated financially, such as, offering sliding scale or collaborating with clients to come up with a fund for surgery expenses.

Areas and roles that participants engaged in to advocate professionally went in many different directions. Advocacy in their workplace involved educating and confronting different people. PT4 shared when their supervisor kept misgendering a client in the videotape that “I stopped the tape and I said so: ‘I'm actually…I've asked you twice now to not do this (misgendering). You're not honoring (them), so I'm gonna stop watching this tape with you and we can go ahead and end supervision’.” Participants also educated in the role of educator, mentor, workshop facilitator, researcher and authors.

Many participants also addressed advocating professionally on the systemic level. PT4 mentioned that “I think making our voices louder than the misinformation and disinformation campaigns that are out there… and getting people to vote in a way that protects us, damn it, that's one thing.” Donation, community outreach and serving in professional organizations were also ways that participants advocated systematically. Some participants also shared how they advocated in their personal life. PT11 felt the sense of responsibility “as being an advocate for my clients, I don't feel that my responsibility ends when they leave my office. I think that we definitely need to be making these changes both within the agency and society at large.”

The last aspect that participants emphasized was that advocacy looks different for everybody. PT4 talked about advocacy that “if that means we're taking to the streets, awesome. If that means we're engaging with legislators, awesome. If that means we're

funneling money into organizations that are supporting folks, awesome." PT10 added that "so there's…it's really easy to be involved (in) a community. I think you just gotta find, perhaps, what really drives you or what's passionate for you."

Commitment to Not Harming Clients

This subcategory captures many aspects of potential harm and mistakes that can undermine the sense of safety, relationship and work with LGBTIQ+ clients. Throughout the application process, commitment to not harm LGBTIQ+ clients based on participants' knowledge of harm (e.g., safety, danger, microaggression, aggression, interpersonal and systemic issues) is also a key condition for an ongoing sense of safety. While the other components and process of application are important, the harm caused to LGBTIQ+ clients can sabotage the sense of safety and therapeutic relationship which would undermine the benefit and effectiveness of those components. In a way, this subcategory is almost a reminder for participants to keep committing to not harming clients as much as possible as a way to maintain their best work with LGBTIQ+ clients. PT1 emphasized that "If you are not harming your clients in any way, then you are already doing better than many people." PT2 chose the term "don't be a dick to your clients" to reflect this. The participants included many aspects of not harming LGBTIQ+ clients.

The aspect that participants talked about the most are not judging and avoiding assumptions and stereotypes. PT6 shared about their learning experiences on kink and BDSM community that "there's a phrase that they use within the sex therapist world 'Don't yuck my yuck'. So, I've had to take that in. It's one of those… it means something that someone else enjoys. I can't necessarily throw that away and say ew to it."

Participants also highlighted about how important it was for them to not misgender, deadname, nor cause microaggressions to their clients. PT2 mentioned that "I was the eighth therapist that this kid went to and was the only one who gendered them correctly…one of the most healing things for a counselor to the client was to not engage in microaggressions…the absence of microaggressions." Participants also included different ways that they stayed firm in their affirming theoretical approach. PT11 shared firmly that:

> "And so, for me personally, I feel that it's very important to still provide the care that a client needs. Even if legislators are like 'hey, no, being trans is bad' or saying no this, this is something that's very important. The evidence is very clear that gender-affirming care is the treatment we need to be providing. And being willing to take a risk in order to make sure that our clients are supported, I feel it is very important."

According to their opinion, PT12 added that "It is not our job to diagnose what is sanity." The last thing that PT4 added to not harming the clients is confidentiality. They shared that:

> "making sure that I'm never outing a client ever, ever, ever in any way, shape or form… And that might mean having really like painstakingly detailed conversations of…let's say even like if I'm…if I was working with a student in a school of with teachers, 'Do you want me to use this name and from these pronouns in front of?', 'Which family members do you want me to use the same in pronoun?' like every class period, right?', like, 'how do you want me to refer to you in my office?', 'How do you want to be referred to?'…"

Writing Gender Affirming Letters

This subcategory explains how participants approached and collaborated on gender affirming letter writing for their trans and gender diverse clients. A number of participants brought up their work on gender affirming letter writing. PT10 mentioned that "letter writing comes up with some frequency for people." Participants were very clear and straightforward about the requirements for the letter to their clients. PT3 told their clients straight that:

> "I need time to be able to talk to them and see those things so that I can accurately attest to that… Do they meet the criteria for a diagnosis of gender dysphoria? Is there other mental health care?…so symptoms of depression, anxiety, etc…(are) those things well-controlled (and) well-managed? I need time to be able to talk to them and see those things, so that I can accurately attest to."

Clients' reaction about the requirement and process of letter writing reported by participants was mixed. PT7 reported seeing a client who "don't want to participate in this system. (The client said) 'I think this is horrible. I don't want to talk about this. This is ridiculous. I just want a letter'." However, other participants reported more positive reaction from their clients. PT8 added that their clients "really appreciate that (participant's explanation). And most (of) the time are willing to sit and go through all of the things anyway, because they know what they have to go through to get the care they need."

Competently Referring

This subcategory explains how participants approached the referral process, either for additional resources or services, or to another therapist that seemed to fit better with

clients. Referral can be an important process because “it's my responsibility to make sure that harm's not happening (PT4),” because of existing harmful practice in the field. PT6 shared that if they were to refer “someone out, it has to be someone who has a similar framework and value set… for instance, someone who's a lesbian…from a Christian background, but were hurt by religion. I wouldn't refer them out to a Christian counselor.” Some participants also shared how they realized that they were not a good fit with their clients. PT6 shared that:

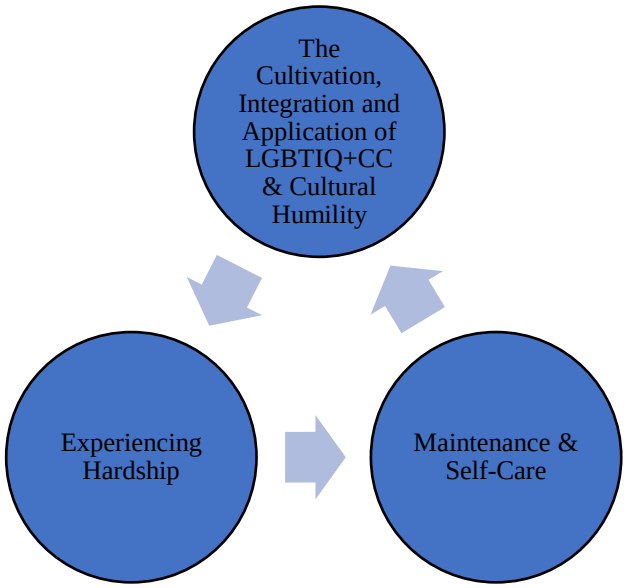
> “I did have an individual who was an Asian student, was male-to-female identified, and this kind of goes into more of a competence type thing… I took the client’s individual intersectionality and I saw that it probably would have been best suited for them to work with someone who had a similar intersectionality.”

Category 5: Hardship, Maintenance, and Self-Care

This category concludes hardship and maintenance during the cultivation, integration, and application of LGBTIQ+CC and cultural humility aspects in the research question. The data under this category came indirectly from all of the questions and prompts during the semi-structured interview.

The emerging data reflects personal and professional hardship that participants experienced during the cultivation, integration, and application process of LGBTIQ+CC and cultural humility as well as how they handled and took care of themselves in order for them to stay in the cycle of cultivation, integration, and application LGBTIQ+CC and cultural humility to continue to work competently with LGBTIQ+ clients. This category comprises of two subcategories (Figure 6): experiencing hardship, and maintenance and self-care.

Figure 6: The Hardship, Maintenance, and Self-Care Category



Experiencing Hardship

This subcategory captures personal and professional hardship that participants experienced in different areas which directly and indirectly complicated or burdened their process and journey of cultivation, integration and application of LGBTIQ+CC & cultural humility. The first thing that many participants mentioned was the process of cultivation and integration itself can be hard and require a lot of time and effort in different aspects. PT2 viewed humility as difficult because “humility part is, in my opinion, a way of being. You have to actively check yourself and address whatever ego stuff might be going on or, whatever. And that is a hard gap to bridge for some people.”

Another big part that burdened participants was a lack of access in different ways. Because PT3 worked in a rural area, lack of access became very obvious in comparison to more urban areas: “there are more queer-resource centers, and hospitals, and university

systems that have LGBTQI+ centers where clients are aware that they can go to get that information. Where out here in the middle of nowhere, we don't have that."

Some participants also experienced difficulties with their perceived sense of competence. PT1 explained how their own insecurity came up in their first job serving prestigious university students: "I was about to, for a lack of better phrase, shit a brick… 'oh my gosh, what am I gonna do? They're gonna see right through me that I'm not an expert. I don't know what I'm talking about'." PT5 added that they took the fact that they did not fit with some clients personally: "I'm just not a fit and that's okay. It sucks at first. You take it personally… reframing was really helpful…knowing that if it doesn't go well for some reasons, (and it) backfires on me, it doesn't make me a bad clinician."

As some participants practiced more professionally, they experienced the toll of professional demand. For example, PT1 shared the mental toll they observed as:

> "it's a field where…when you have a really tough session and I have to get a crisis unit, so that my client gets safely to the hospital because they're about to attempt to end their life, that's a hard, heavy session. It impacts my mental health and personal life later on."

Some hardship was also exacerbated by the fact that participants in this study identified as LGBTIQ+. For example, PT10 shared their burden of witnessing double discrimination on both their client and themselves that "it does hit you differently when you've had a lot of those lived experiences of your own. And then, you have your client who's actively struggling or has struggled in the past or has had those experiences."

Systemic and institutional issues could be barriers to participants too. For example, PT3 reported that some agencies they interviewed with in a rural area did not

support their publicly out profile as a queer therapist: “other agencies that I interviewed for would not allow me to do that. And so even that, like that's the culture here… A lot of places keep us so shut down and so quiet out of fear of retaliation.”

Legislation barriers toward LGBTIQ+ community also impacted participants in this study in different ways. PT4 shared that “just being totally transparent with you… It's hard because…if you're not within these communities, you can be upset by legislation, but you don't feel it in your core… It's always eating you up from the inside. Yeah, it's hard.” Practicing in a state where gender-affirming care is illegal can be a threat to practitioners. PT9 observed that “a lot of states have banned the use of pronouns at workplaces. A lot of states are banning HRT and puberty blockers.” PT1 shared boldly that, even with a potential legal issue: “if I ever went to jail for providing gender-affirming care, I feel like that will be the best reason for me to be in jail.”

Professional boundaries are another struggle that many participants reported as clinicians who work for the community that they are a part of. PT6 reported that as a clinician who’s a part of kink community: “personal boundaries with that ethical piece too, because it can be difficult working within your own community, because you're going to end up running across people probably.” PT6 also experienced awkwardness on dating apps as:

> “what do you do on a dating app if you see a client or should you stay off of the dating app? I think in this day and age, you know, a lot of people are finding partners on apps. But our clients are going to be on there too.”

Some participants also mentioned that they experienced personal hardship as well. PT1 expressed the hardship when they had to grieve their womanhood as a part of their

transition: “I had to grieve my womanhood self, right? …that I was told by the society I needed to be. Umm, I grieved the loss of my marriage because my ex wasn’t ok with my sexuality and gender.” PT11 shared their background of being raised in a religious household as challenging: “it was pretty overwhelming…growing up in a very fundamentally religious household. There's a lot of very black or white thinking, lots of distortions going on in those fundamental households. And I had a lot of very, very rigid thinking.” PT3 was extensively harmed and invalidated by their biological mother which also impacted them professionally:

> “My biological mom, who was an incredibly toxic person, she sent me a message that pretty much, ‘you are never going to be an effective counselor, you are in effect too broken, too damaged, too mentally ill to be an effective counselor. This is a horrible career choice. You're only going to do harm. You're only going to hurt people. You're only going to hurt yourself. There's no way, no possible way that you will ever be good in your career and succeed in your career choice’…The impact of that conversation is a very large part of what led to me being so guarded professionally.”

Maintenance and Self-Care

This subcategory captures different aspects of how participants coped with hardship, and difficulties that came with the process and journey of cultivation, integration, and application of LGBTIQ+CC and cultural humility. Some parts were more about their selves and stress management, some parts were more about their self-care or perspective that they had towards themselves or their work with LGBTIQ+ community.

PT12 beautifully made a point about the important role of holistic maintenance and self-care for mental healthcare provider that:

> "And when you are stepping into the role of someone providing healthcare, you're more apt to be able to fulfill that role when your own cup is full, when you have resource... when you feel resourced and you feel supported. So, whatever it is that you have to do, in order to maintain that (self-care) and to acknowledge when you're needing rest or add more aid, whether it's mentally, emotionally, spiritually, physically or all of the above…and the more awareness of these (all the above), this personal ecosystem that a practitioner can be, that is the sign I think of a good practitioner."

One important that participants emphasized was to make sure that they are in a good shape to provide quality service for the LGBTIQ+ clients. PT1 emphasized how ensuring time and energy for clients is pivotal: "I do not overwork myself. I make sure to have the time and energy to give to my clients. And it's just important that as much as you bring to the session in a positive way." Balancing between professional and personal life as a counselor is important. For example, PT8 gave an example of how they did that as:

> "It's okay to rest. I know what it's like to feel like you want to make change, and to feel helpless, and to stretch myself really thin, because I am a helper and a fixer. And it's also okay to set that aside, and binge-watch TV or hang out with a friend or lose yourself in a book."

PT1 mentioned the importance of personal therapy when their own traumas arose along the process of cultural humility and cultural experiences: "I was put in situations where I wasn't safe, or rejected, or more traumas came up, as a process of humility and cultural

experience. I go to therapy every other week." PT9 also addressed supervision as a place that helped them when they were vulnerable from sessions: "and of course, then, sort of going back and unpacking this in supervision." Advocacy work was how some participants dealt with stress. PT2 shared that they advocated for their LGBTIQ+ participants: "how I kind of deal with the stress that comes along with knowing that my clients have been hurt and harmed in the past." Therefore, these maintenance and self-care allow for energy and time to continue the work.

Some participants also included constructive perspectives toward themselves as a part of self-care. Humanizing oneself as a therapist in the counseling room is important as PT9 shared that "I think, at the end of the day, it's important to acknowledge my humanness also in that space that things will and things do impact me. And sometimes the humanness will be more prominent than the therapist's self." PT4 added the importance of self-compassion that "I'm gonna add this to the recipe if that's okay. Some, some self-compassion, love and care… and we need to make sure that we are taking care of ourselves, so that we are accessing resiliency."

Last but not least, even though there are a lot of hardships and complications along the process of cultivation, integration, and application of LGBTIQ+CC and cultural humility, most participants felt rewarded from the work with LGBTIQ+ clients. PT7 shared their perspective about queer community and healing that:

> "I think one of the amazing things about queer community is the ways that we transcend traditional understandings of mental health… And so the way that queer people talk about their growth, their pain, their experiences, especially in a world that has silenced them, because queer people have been taught for so long, but

> they're not allowed to talk about their queerness, right? And so, I think the way that people use metaphors, especially my queer clients use metaphors as a way to talk about who they are, it's kind of inspiring."

Furthermore, some participants found their advocacy work and service rewarding and meaningful. PT4 shared how they found their role as an instructor meaningful regardless of struggles as "there's always been a part of the struggle in that, but the struggle feels meaningful because I can see the impact it makes on students, or clients, or the community."

The Emergence of Theory

In the current study, the walking the walk to integrate knowledge into practice category (Category #3) is central to the rest of the categories and their properties. Throughout the data analysis, the *theory of the life-long cultivation and integration of LGBTIQ+CC and cultural humility* emerged. Within this dissertation context, this theory elaborates the connection between different components and steps involved in the process of the cultivation, integration, and application of LGBTIQ+CC and cultural humility for counselors to benefit LGBTIQ+ clients in counseling work. The use of constructivist grounded theory approach and techniques (e.g., constant comparison, theoretical sampling) allowed for a meaningful and systemic engagement with data (Charmaz, 2014).

As I explored the data through theoretical sampling (Charmaz, 2014), the first connection that emerged was between the motivation to do right by queer clients (Category #1) and cultivating the right soil for queer folks (Category #2). However, in the beginning of the data analysis, the distinction between the cultivation, integration, and

application of LGBTIQ+CC and cultural humility was not so clear. As I pondered on this unclarity, I pondered through these seemingly conflated data and sorted the data between the preliminary categories of cultivating LGBTIQ+CC and cultivating cultural humility. Later in the process of data analysis and constant comparison (Charmaz, 2014), I continuously engaged in and theoretically sorted the data among the preliminary categories again and merged the two preliminary categories (cultivating LGBTIQ+CC and cultivating cultural humility) and differentiated among the components of the cultivation, integration, and application process that allowed for new and refined categories to emerge (Charmaz, 2014). Accordingly, the three categories emerged: cultivating the right soil for queer folks (Category #2), walking the walk to integrate knowledge into practice (Category #3), and the multifaceted application of LGBTIQ+CC and cultural humility (Category #4).

Throughout data analysis, subcategories of the walking the walk to integrate knowledge category (Category #3) have always emerged (i.e., not being an expert, humility/courage to make mistake, positive feedback guides direction, and being a lifelong learner). However, this category was not as strongly solid and saturated in comparison to the other categories. Therefore, I intentionally focused on the questions and the prompts about the integration process to saturate the properties of the category (Charmaz, 2014).

Participants reported many aspects that they found pivotal to the multifaceted application of LGBTIQ+CC and cultural humility (Category #4). Even though these aspects seemed scattered, when sorted through the preliminary categories that separate

between the LGBTIQ+CC and cultural humility, I could explain the relationship and function among the nine subcategories.

As I explored the data, the scattered and seemingly random sharings about participants' difficulty, both personal and professional appeared. However, as I continued to interview more participants and engaged with the data, these difficulties kept coming up in different areas, leading to the emerging preliminary category of experiencing hardship. Along the same line, most participants shared how they how they kept themselves in check and were able to keep going even when things were hard for them as a counselor working with LGBTIQ+ clients. The maintenance and self-care preliminary category emerged accordingly. However, as I reflected in the memo-writing and constant conparison (Charmaz, 2014), the two categories were two sides of the same coin. Therefore, the two preliminary themes were merged together and formed the Hardship, Maintenance and Self-care category (Category #5), which captured the indirect yet important aspects of the cultivation, integration, and application of LGBTIQ+CC and cultural humility.

Conclusion

The current study was designed to explore the process of the cultivation, integration, and application of LGBTIQ+ cultural competence and cultural humility among counselors who are perceived to be culturally competent in working with LGBTIQ+ clients through the constructivist grounded theory data analysis. Findings of this study represent five categories (i.e., motivation to do right by queer clients, cultivating the right soil for queer folks, walking the walk to integrate knowledge into practice, the multifaceted application of LGBTIQ+CC and cultural humility, and

hardship, maintenance and self-care) emerged from the data. The findings suggest that participants' motivation to do right by queer clients (Category #1) is a prerequisite quality to cultivate and integrate LGBTIQ+CC and cultural humility. The ongoing and cyclical process of cultivating the right soil for queer folks (Category #2) goes in personal and professional directions to prepare for the personal awareness and quality combined with knowledge and cultural humility. Afterward, the process of walking the walk occurs to integrate the cultivated quality and knowledge into practice (Category #3) which may lead back to cultivating more (Category #2) for better quality, knowledge and service and/or the multifaceted application of LGBTIQ+CC and cultural humility (Category #4) to competently serve LGBTIQ+ clients. Such process is an ongoing life-long learning process (Subcategory of Category #3). The feedback received from the integration informs the integration process which participants either learn from the mistakes or positive feedback (Subcategories of Category#3) from their LGBTIQ+ clients. The multifaceted application of LGBTIQ+CC and cultural humility (Category #4) represents the competent and humble work that the LGBTIQ+CC and cultural humility were applied and adjusted to best benefit LGBTIQ+ clients. Reportedly, participants experienced hardship along the process, which required maintenance and self-care (Category #5) for them to continue in the process and competently serve LGBTIQ+ clients and community.

Chapter 5

Discussion

The purpose of this study was to explore the process of the cultivation, integration, and application of LGBTIQ+CC and cultural humility among LGBTIQ+-competent counselors who are perceived to be culturally competent in working with LGBTIQ+ clients. Twelve semi-structured interviews were conducted between October 2023 – March 2024 with twelve counselors who were perceived and nominated as working competently with LGBTIQ+ clients.

In this chapter, I revisit the research question: how do LGBTIQ+ competent counselors cultivate, integrate, and apply LGBTIQ+CC and cultural humility? From data collection and data analysis, five categories and multiple subcategories emerged. The categories included: motivation to do right by queer clients, cultivating the right soil for queer folks, walking the walk to integrate knowledge into practice, the multifaceted application of LGBTIQ+CC and cultural humility, and hardship, maintenance and self-care. The discussion and comparison with previous literature, research, and guidelines for each of the categories will be elaborated. I will also evaluate the limitations and add suggestions for future research.

Findings

Literature related to the categories in this dissertation are scarce, with the majority of the existing research studies related to the perceiving professional needs and gaps for queer clients subcategory (Category #1), cultivating cultural competence and cultural humility subcategory (Category #2), focusing on relationship subcategory and applying intersectional lens subcategory (Category #4). Outside of these areas, even though there

is plenty of relevant literature on LGBTIQ+CC and cultural humility, most of it relies mainly on guidelines and recommendations (Hope et al., 2022; Killian et al., 2019; Singh et al., 2017) or focuses only on the components, not the development of these qualities (Moradi & Budge, 2018; Ojanen et al., 2021). Accordingly, the dearth of literature present gaps in the field.

This dissertation study adds to the field by clarifying the process of cultivation, integration, and application of LGBTIQ+CC and cultural humility among counselors who were perceived and nominated as working competently with LGBTIQ+ clients. Based on the results of this study, perceiving professional needs and gaps for queer clients seem to increase the motivation to do right by queer clients, which is a prerequisite or condition prior to cultivation and integration. Furthermore, the ongoing and cyclical process of cultivating the right soil for queer folks, personally and professionally, prepares personal awareness and knowledge, with on-going reflection and introspection of self and knowledge. The process of walking the walk occurs to integrate the cultivated quality and knowledge into practice as an ongoing life-long learning process. Furthermore, the application of LGBTIQ+CC and cultural humility represents the competent and humble work from previous cultivation and integration to best benefit LGBTIQ+ clients in different aspects. Additionally, hardship, maintenance and self-care were reported as a part of the process. As a result, *the theory of the life-long cultivation and integration of LGBTIQ+CC and cultural humility* emerged from the grounded theory methodology in this study which informs LGBTIQ+ training for future and current counselors on LGBTIQ+CC and cultural humility trainings and policies.

Motivation to Do Right by Queer Clients

This category explains the internal process of how the awareness and recognition of the needs and gaps of queer clients in the mental health field lead to the sense of responsibility and motivation for them to do right by queer clients in different capacities. A plethora of previous literature has shown these needs and gaps that resonate with the result of this study (Bettergarcia, et al., 2021; Coleman et al., 2022; Compton & Morgan, 2022; Fitterman-Harris et al., 2022). However, the link or role of how the awareness plays towards change or development of LGBTIQ+CC and cultural humility have not been solidly captured in the counseling field. Only one study by Kirkland (2018) highlighted the sense of ownership and responsibility for the continuing education and training about TGNC in response to the lack of training in their academic program.

Similar aspects of the motivation and desire to change the situation and improve one's competence were mentioned in the social justice training (Beer et al., 2012) and overall health professional desire to learn about LGBTQ + health (Yu et al., 2023). Beer et al. (2012) found among counseling trainees that the firsthand experiences of injustice or those faced by their people of the same cultural heritage was a motivation to engage in social justice movement and change for the community. Accordingly, participants in this study probably felt the same way as a part of the LGBTIQ+ community who want to create change by becoming more culturally competent and/or culturally humble for LGBTIQ+ clients and community. Therefore, this category corroborates previous literature on how the perception of needs and gaps can direct therapists towards self-improvement and growth.

Cultivating the Right Soil for Queer Folks

The findings in this category mainly reflected two components of LGBTIQ+CC, attitude and knowledge (Harper et al., 2013), and cultural humility (Hook et al., 2013). According to the theory in this study, the relationship between attitude and knowledge were mutual and cyclical, as one's knowledge increases, the attitude and awareness improves, and vice versa. Previous literature has not covered much about the relationship between the two components (Harper et al., 2013). While the knowledge and attitude aspects captured in this study (learning LGBTIQ+ knowledge subcategory and checking biases and leaving them at the door subcategory, respectively) resonated with previous literature (Bishop et al., 2022a; Coleman et al., 2022; Compton and Morgan, 2022; Israel et al., 2003), the theory in this study further explains in depth other components and aspects that are important.

On the knowledge side, the theory identifies effective ways in which LGBTIQ+ knowledge can be expanded along with cultural humility, such as education and supervision, and contact with LGBTIQ+ people (Carrington & Sims, 2024). On the attitude side, the theory combines multiple components that were introduced as important in cultural competence literature together, such as awareness of one's culture and identity, potential biases (Carlson et al., 2012), awareness of similarities and differences between one's and client's experiences (Boroughs et al., 2015), and power dynamic in the counseling relationship (Ratts et al., 2016).

The highlight of the findings in this category is the cultivation of cultural humility into the process, which is the ongoing process of reflecting on one's knowledge and limitations. With knowledge, competencies, and insights gained, the reflection on one's

knowledge and limitations helped participants to have a critical eye and stay in check while further cultivating cultural humility. There is a dearth of research that directly study this aspect of self-reflection on one's knowledge and practice. Only the literature on cultural humility captured this aspect. Zhu et al. (2021) found in their study that a cultural humility lens provides an understanding that every culture and cultural beings have limitations. Similarly, the lifelong self-examination aspect of cultural humility means "a commitment to develop cultural self-understanding, awareness of one's strengths and limitations, acknowledging blind spots (Zhu et al., 2022, p. 104)." Along the same line, the findings in this category shows that participants accepted that they do not have to know all the answer, and that it is impossible to know all of the answers. Instead, they continued to reflect on their own knowledge, biases, limitations in their own knowledge and practice and to stay culturally humble. In other words, this category adds to the literature on how all these components come together and cultivate the right soil to work with LGBTIQ+ clients.

Walking the Walk to Integrate Knowledge into Practice

This category is the core category of the whole theory and contains the components that connect everything together. It adds to the literature by depicting the process of the integration of LGBTIQ+CC and cultural humility into practice. Even though the idea of integration of bringing what was learned into practice may seem straightforward, it may be more complicated with cultural competence. The theory identifies not being an expert and the humility/courage to make mistakes as components that make the integrating process successful. While some previous literature mentioned the integration process of LGBTIQ+CC (Moradi & Budge, 2018) and cultural humility,

there was only one study that captured and illustrated a similar process of novice counselors working with LGBTIQ+ clients (Owen-Pugh & Baines, 2014). Owen-Pugh and Baines (2014) found among novice counselors who work with LGBTIQ+ clients that while they transferred LGBTIQ+ knowledge and skills which they learned from LGBTIQ+ coursework into their work, they still were challenged in their knowledge and skills, and eventually needed to learn from their LGBTIQ+ clients.

Along the process of integration, participants in this study did not act as an expert in counseling sessions and relationships, by not being arrogant or centering on themselves or their knowledge. Previous research did not cover much about the importance of not being an expert, except for literature on cultural humility. Zhu et al. (2021) addressed the absence of superiority and arrogance in counselor's cultural positioning as a key component of cultural humility. Instead, a number of studies supported the importance of open-mindedness (Godfrey et al., 2006) and willingness to learn from LGBTIQ+ clients (Ojanen et al., 2021; Reeves et al., 2023). The open-minded stance shared by participants echoed the components of cultural humility (i.e., motivation to learn from other people, and an open stance to novel cultural information from client with the sense of other orientation; Mosher et al., 2017) and cultural competence (e.g., an active ongoing endeavor to learn more about clients, and actively attempting to understand the client worldviews; Sue et al., 2019).

Participants reported that it is inevitable to make mistakes as a part of the integration; therefore, admitting their mistakes and being open to correction and critique are the humble ways to approach LGBTIQ+ clients. A similar process was illustrated as an enactment of cultural humility in counseling process when a discrepancy occurred

between a therapist and a client, the therapist could admit their mistakes, stay in discomfort, explore and learn from clients (Zhu et al., 2021). This aspect of the integration is in line with the literature's definition of cultural humility as being egoless, being culturally teachable, and showing a lack of cultural arrogance (Foronda et al., 2016; Zhu et al., 2022). Participants also mentioned the importance of a genuine apology, which goes in line with the rupture resolution model (Chang et al., 2021) which focuses on exploration of ruptures and collaborative repair.

While growth happens naturally along the process of making mistakes, positive feedback, and learning from clients, this category further emphasizes the broader scope of life-long learning which encompasses the whole model and explains the connection of major categories in the emerging theory. Being a life-long learner subcategory is a critical link that connects walking the walk to integrate knowledge into practice category (Category #3) and the multifaceted application of LGBTIQ+CC and cultural humility (Category #4) with the cultivating the right soil category (Category #2) in the form of ongoing and cyclical process of continuing to learn.

The translation of knowledge into practice which participants noted corroborated previous literature. Not relying on clients to educate counselors was mentioned as important by LGBTIQ+ clients (Compton & Morgan, 2022; Reeves et al., 2023). Additionally, participants saw LGBTIQ+CC and cultural humility as intertwined and when they are together, cultural humility helps to bridge the potential flaws and knowledge gaps of LGBTIQ+CC. This finding corroborated the relationship between cultural competence and cultural humility that were found to be overlapped and complementary (Zhu et al., 2023). This study also echoed the results of previous studies

that cultural competence focuses more on knowledge and skills, while cultural humility focuses on learning (Zhu et al., 2023), which was summarized as balancing and seeking harmony in knowing (cultural competence) and not knowing (cultural humility; Alessi et al., 2023). The translation of knowledge into practice is the result of the cultivation and integration in the previous steps that serve as a foundation for the multifaceted application of LGBTIQ+CC and cultural humility (Category #4) into practice for LGBTIQ+ clients.

The Multifaceted Application of LGBTIQ+CC and Cultural Humility

This category conceptualizes the application process of LGBTIQ+CC and cultural humility and groups all the relevant subcategories into three clusters in an orderly sequence (i.e., cultural-humility cluster, LGBTIQ+CC-and-cultural-humility cluster, and LGBTIQ+CC cluster, respectively). This conceptualization not only identifies important components in the application process, but also explains the role that each of these components play, as well as the connections among these components. This category adds to the literature by mapping out important components (Coleman et a., 2022; Harper et al., 2013) in an organized order. This category also links these components back to and explains how they build on the cultivation and integration components in the previous categories and process.

The cultural-humility cluster acts as a base foundation which focuses more on the cultural humility aspect, including providing safe space and focusing on relationship. While there is a plethora of research and literature that has emphasized the importance of providing safe space, in this study therapist attributes and ongoing communication that allowed for the co-creation of safe space with LGBTIQ+ clients (i.e., authenticity,

genuineness, straightforwardness, transparency, and validation) were highlighted. Ojanen and colleagues (2021) found communicating an accepting stance to allow clients to feel safe to be pivotal in the work with LGBTIQ+ clients. Cultural humility enactment (Zhu et al., 2021) and safe communication (Israel et al., 2008, McCullough et al., 2017) contribute to the sense of safety in LGBTIQ+ clients which potentially leads to client disclosure and vulnerability. Similarly, validation was found to be important for LGBTIQ+ people's sense of safety and their sense of existence (Mendenhall, 2021; Rubinsky & Cooke-Jackson, 2021). These components help to set up a foundation for rapport, trust, and a positive counseling relationship.

Under the same cluster, the emphasis on the relationship with LGBTIQ+ clients was highlighted, which coincide with previous studies that have shown the therapeutic alliance/relationship to be one of the most important factors in therapy outcome in LGBTIQ+ clients (Jennings & Sprankle, 2023; Kangos & Pieterse, 2021; Ratanashevorn et al., 2024). One aspect of focusing on relationship that participants highlighted was mending mistrust caused by previous professional harm, which was also extensively reported in literature (Alessi et al., 2023; Brooke, 2020, Jones et al., 2022; Pepping et al., 2018). With the same culturally humble attitude that participants approached mistakes, they approached mistrust with an understanding of the source of mistrust, not taking it personally, and were patient and respectful to clients' guardedness, which helps to build rapport and trust (Zhu et al., 2021).

Once both safety and relationship components are in place, they become a foundation that is built on previously cultivated and integrated LGBTIQ+CC and cultural humility (e.g., LGBTIQ+ knowledge, awareness of the power dynamic, not being an

expert, humility/courage to make mistakes, and learning from clients). Such a foundation allows for a deeper and more meaningful conversation and work with LGBTIQ+ clients in the application of the rest of the components in this category.

The LGBTIQ+CC-and-cultural-humility cluster of the application process requires more knowledge and technical components of LGBTIQ+CC, in combination with the culturally humble approach to make the application effective and collaborative. Important components, especially to the work with diverse LGBTIQ+ clients with multiple marginalized identities, are applying an intersectional lens and contextualizing knowledge intervention and one's theoretical approach. These aspects are also good examples that reflect how LGBTIQ+CC and cultural humility are applied together.

Participants in this study used an intersectional lens to deepen the conversation with LGBTIQ+ clients by broaching and explore clients' intersectional experiences. Such conversation based on participants' awareness of power dynamic between them and clients or how multiple identities of clients impact one another. While a number of research studies captured LGBTIQ+ PoC's negative therapy experiences due to their intersectional identities and needs (Fattoracci et al., 2020; Moore et al., 2020; Velez et al., 2019), no research was found that clearly explored the application of an intersectional lens in therapy. Literature addressed the use of broaching and intersectionality in addressing and exploring power differentials in clients' multiple marginalized identities (Erby & White, 2022), focusing on the overlooked or erased identities of clients (Freeman-Coppadge & Langroudi, 2021). The aspect of intersectionality that participants explore and learn from LGBTIQ+ clients' intersectional experiences coincides with the

concept of intersectional cultural humility which combines the need for ongoing learning and openness with the inclusion of multiple social identities (Buchanan et al., 2020).

Additionally, participants emphasized treating clients holistically. Sexual, affectionate, and gender identities are not the only aspects of LGBTIQ+ clients; counselors need to view and look at them with humanity. A dearth of research and literature covered this topic. Only some studies found that humanizing transgender people helped to reduce stigma and prejudice towards TGNC people (Sawaya & McCarty, 2023; Tomptkins et al., 2015). It is noteworthy that some participants shared their opinion that the concept of humanity for LGBTIQ+ clients goes beyond the concept of intersectionality.

The contextualization of approach can be powerful for LGBTIQ+ clients, such as reframing the narrative of clients from negative to affirming and empowering, which resonate with narrative therapy (Jordan, 2020; Nylund & Temple, 2018) and relational cultural therapy (Flores & Sheely-Moore, 2020) for LGBTIQ+ clients. Furthermore, participants' contextualization and choices of theories was also based on their reflection and information in the cultivation and integration (Category #2 & Category #3) process as well as from focusing on relationship and applying intersectional lens subcategories.

An aspect of this category that should not be overlooked is the commitment to not harm LGBTIQ+ clients, which is noted in previous literature (Compton & Morgan, 2022). Apart from a plethora of research that captured harm that has been done to LGBTIQ+ clients (McNamara & Wilson, 2020), studies have addressed the importance of not harming clients that echoed with the findings in this dissertation, such as being non-judgmental and having a non-pathological stance (McNamara & Wilson, 2020),

firmness with affirming approach (Ojanen et al., 2021), and not misgendering (Bishop et al., 2022a). The professional guidelines also emphasized “do-no-harm” approaches across the board (APA 2021; Coleman et al., 2022; Harper et al., 2013). This subcategory links back to the motivation to do right by queer clients as well as the perception of harm done to LGBTIQ+ clients. It builds on the LGBTIQ+ knowledge (e.g., microaggression and misgendering), and culturally humble stance (lack of arrogance and being client oriented; Mosher et al., 2017).

The LGBTIQ+CC cluster of the application process mainly requires knowledge and technical components of LGBTIQ+CC, including writing gender affirming letters and competently referring. Even though this cluster may seem less central compared to the rest of the application, when needed, these activities can be extremely helpful for LGBTIQ+ clients (Attara, 2022; Coburn & McGeorge, 2019; Coleman et al., 2022).

Hardship, maintenance and self-care

Most of the hardship experienced by participants in this study has been reported in the literature on LGBTIQ+ mental health professionals or therapists who work with LGBTIQ+ clients, such as lack of access, support and resources (Edwards et al., 2018; Lykins, 2021), professional demand (Maru, 2018), systemic and institutional issues (Eliason et al., 2018; Matsuno et al., 2023; Wolfe, 2023), and professional boundaries (Lykins, 2021). As all participants in this study identified as LGBTIQ+ as well, there are additional involvement and proximity to LGBTIQ+ clients that they work with (Lykins, 2021), which can cause double discrimination or vicarious trauma.

In response to this hardship, participants mentioned many ways that they cope with this hardship and allocate time for self-care, such as personal therapy (Eliason et al.,

2018), self-compassion (Nelson et al., 2018), gaining meaning from the work with LGBTIQ+ clients (Lykins, 2021) and social justice work (Beer et al., 2012), and activism and advocacy (Eliason et al., 2018; Gonzalez et al., 2022). While some parts of participants' coping were more about their self-management and stress management, some parts were more about their self-care or perspective that they had towards themselves or their work with LGBTIQ+ community. It is important to be reminded that counselors are all human being, therefore, we need to be able to humanize and maintain the sense of well-being so that the whole process of cultivation, integration, and application of LGBTIQ+CC and cultural humility can still happen effectively and sustainably.

The theory of the life-long cultivation and integration of LGBTIQ+CC and cultural humility

The emerging theory in this dissertation as a whole contributes to the literature by offering a step-by-step blueprint that maps all of the components that are relevant to the integration of LGBTIQ+CC and cultural humility together (Moradi & Budge, 2018; Ojanen et al., 2021; Zhu et al., 2021) in an orderly and organized manner. The theory also connects, organizes, and explains how these all come together through the lens of the cultivation, integration, and application. Such a blueprint also offers an easy visual and understanding that trainees or counselors who are on their path to cultivate and/or integrate LGBTIQ+CC and cultural humility can apply conveniently in their journey, whichever level of competence and professionally developmental stage they are in.

The theory also has an open-ended, broad, and flexible nature which is ready for future revision and adjustment, which can potentially embrace more relevant components

that will be found as important in the future to better fit with the context and change that will be commensurate with the needs and gaps of future LGBTIQ+ clients. With the flexibility of this theory, it can be flexibly applied to a wide range of mental health professionals (psychiatry, psychology, counseling, and social work) and a broad variety of diverse LGBTIQ+ clients (LGBQ+ and TGNC clients). Particularly, the focus on or expansion of the applying intersectional lens subcategory and contextualizing knowledge intervention and theoretical approach subcategory (subcategories of Category #4) can increase applicability of this theory towards intersectional LGBTIQ+ clients with multiple marginalized identities.

Even though the main categories of the theory in this study did not capture the topic of power that is also a core element of cultural humility (Zhu et al., 2021), many of the subcategories (e.g., not being an expert, providing safe space, and focusing on relationship) directly and indirectly emphasize the power-related elements of cultural humility in a practical way. Therefore, even though not overtly, the model emphasizes the importance of the absence of superiority and arrogance as a part of the cultivation and integration of LGBTIQ+CC and cultural humility as a whole.

Because there is no representation of non-LGBTIQ+ participants in this dissertation, some adjustment might be needed for counselors who are not members of the LGBTIQ+ community. For example, under the cultivating the right soil for queer folks category (Category #2), non-LGBTIQ+ participants may not have the same level of experiences of being marginalized by sexual, affectionate, or gender identity, with different dynamic between them and LGBTIQ+ clients and potentially wider difference gaps with the clients. Likely, the work on checking biases and leave them at the door will

be harder than for LGBTIQ+ counselors. These differences under Category #2 will likely have ripples effect on Category #3, #4, and #5 as well. Therefore, the consideration of the aspects that may differ from LGBTIQ+ participants in this study (e.g., culture and nationality; Aijian & Wang, 2020; Bennett & Gates, 2019; Ojanen et al., 2021) need to be taken into consideration.

The model also helps to validate the hardship and the nature of the process (the ongoing and cyclical nature) of bettering one's LGBTIQ+CC and cultural humility as a counselor. The findings may help counselors to normalize the hardship, guide them in utilizing internal resources (e.g., patience, end self-compassion) and external resources (e.g., personal therapy, mentorship, supervision, and advocacy) to cope with the hardship.

Limitations and Future Directions

The data collected in this study relied mainly on semi-structured interviews. Even though the researcher used triangulation methods (Flick et al, 2004) to increase rigor from participants' screening questions and online data (i.e., online biographies and publications), the additional data can only triangulate with certain categories and areas of the theory (e.g., showing up to advocate, providing safe space). Therefore, different sources of data might be used in the future to more directly triangulate the theory, such as focus groups or journaling (Carter et al., 2014). While member-checking was employed with a good response rate (33%) and positive feedback, the researcher decided to not ask for a follow up interview and relied on the first interview (mean interview length = 66 minutes and 3 seconds) mainly to avoid difficulty in reconnecting with participants and potential low response rate. A follow up interview may have enhanced the rigor of the data (Birt et al., 2016).

The nomination in the recruitment process may emphasize the peer therapist's view that might not always be the most accurate one, especially with covert qualities (Cillessen & Marks, 2017). On top of that, among many possible recruitment strategies, it is difficult to find the best fit that can guarantee that the known group for this study does actually possess the integration process. At the end of the day, the gap between what a therapist or their peer perceived as LGBTIQ+CC and cultural humility might be different from how the client perceives it (Fuertes et al., 2006). Therefore, a more innovative and inclusive procedures that includes client views may help justify the participant's quality of LGBTIQ+CC and cultural humility.

Even though not advertised specifically to look for LGBTIQ+ therapists who work with LGBTIQ+ clients, all of the participants nominated in this study identified as LGBTIQ+. Therefore, it is noteworthy that the theory in this dissertation study may explain mainly the experiences of the cultivation, integration, and application of LGBTIQ+CC and cultural humility among LGBTIQ+ therapists. Some previous studies have captured the experiences of non-LGBTIQ+ therapists who worked with LGBTIQ+ clients (Owen-Pugh & Baines, 2014), but not specifically the cultivation and integration process directly. Future research may expand on this theory by recruiting non-LGBTIQ+ participants to explore and compare the process between LGBTIQ+ and non-LGBTIQ+ participants and make the data and theory more generalizable with non-LGBTIQ+ therapists.

Many parts of the data shared by participants may be generic and not only applicable to LGBTIQ+ clients. The conflation between common factors and LGBTIQ+ specific factors echoed previous literature on LGBTIQ+CC (Ojanen et al., 2021). Future

studies may seek to separate between the two components and identify their relationship so that the common factors that are potentially applicable to other minority groups can be identified.

Different aspects of my positionality and identities as a gay POC counselor may influence the analysis and result of the study. The framework for this study, as well as my belief that cultural humility is important and critical, might limit or downplay other important factors that are equally or more important in the data collection and analysis process. My identity as gay man might also influence the data; for example, I might not be as inclusive or attentive to female or non-binary clients' stories. My cultural background and my theoretical approach may also impact my engagement with the data. Being raised and born in Thailand with Buddhist and collectivistic influences may impact my view of cultural humility and participants' stories. My humanistic existential approach to life and therapy may also heavily influence my certain values and interpretation of data and analytical process. Future studies may employ a methodology that include a researcher team with multiple and diverse identities to mitigate this (e.g., consensual qualitative research; Hill et al., 2005).

Even though the interview protocol broadly asked about components that were important in working competently with LGBTIQ+ clients, the main focus and analysis in this study were on LGBTIQ+CC and cultural humility. Therefore, future study may focus on other components that are critical for LGBTIQ+ work, such as intersectionality, and a sense of humanity (viewing client holistically) towards LGBTIQ+ clients. Further studies on these or other relevant topics will help to fill knowledge gaps and inform the training program and continuing education sessions more holistically. These future studies and

trainings will better equip and prepare therapists to work more competently with LGBTIQ+ clients.

Implications for Training

First and foremost, most existing training programs and continuing education focus mainly on the LGBTIQ+CC and knowledge (Bettergarcia et al., 2021; 2024; Gerloff, 2021); more focus on the cultural humility side will help to complement the LGBTIQ+CC as well as instill a culture of continuing education and desire to learn more in trainees. The theory explains and exemplifies many potential areas to enhance cultural humility in training (see Don-Medeiros & Christensen, 2019; Viggiani et al., 2023), such as focusing on biases, reflecting on knowledge and one's limitations, not being an expert or arrogant, enhancing curiosity, focusing on collaboration, and being aware of power dynamic. Some strategies include self-reflection and deep conversation on the following topics; worldviews, stereotypes, biases, harms and microaggressions in an open and accepting environment, the power differential and roles of a counselor, ways to lower one's power and give voices and power to LGBTIQ+ clients to foster collaborative work, how to foster a sense of safety in the therapeutic relationship, normalizing not knowing something and not having to know everything, encouraging having a beginner's mind and cultural respect, normalizing ruptures and mistrust in working with LGBTIQ+ and how to repair them effectively. In designing activities and interventions for CITs, educators can include cultural humility when introducing LGBTIQ+ knowledge or content. For example, apart from simply teaching about the concept of intersectionality in LGBTIQ+ clients, educators can facilitate an exploration of students' intersectional identities, differences and similarities between the students and intersectional LGBTIQ+ clients,

limitations of their knowledge regarding clients' intersectional identities, ways to learn from clients and stay humble, mistakes management and rupture mending, as well as balancing between learning from the clients and educating oneself further.

Educators can also encourage and assign trainees to learn more about the gaps in professional fields and the mental health needs of LGBTIQ+ people as these perceptions can lead to motivation to improve themselves to better serve LGBTIQ+ clients. A discussion on the perception of the needs, gaps, and social injustice faced by LGBTIQ+ people may help students to understand why the extra work is needed. This may include an assignment to join LGBTIQ+ activities and local communities, an interview with LGBTIQ+ people on their mental health needs and disparity, and the impact of LGBTIQ+-related laws on their lives and the sense of safety. Such conversation does not have to be forced, as most of the counseling and mental health students usually already have passion or desire to help and better people lives, especially for minority people. However, such a conversation can be an opportunity for educators to educate and advocate, or even gatekeep students who might do potential harm to LGBTIQ+ clients to safeguard the LGBTIQ+ community, if the education and the remediation prove to be fruitless. Activities such as *privilege walks* (Magana, 2017) or *privilege for sale* (Safe Zone Project, n.d.) can help foster awareness of one's privileges and the importance of cultural humility among more privileged CITs with potential barriers and/or pushbacks to the concept of cultural humility.

Similar to participants' suggestion that authenticity in their work is two-way, counselor educators also need to model authenticity and cultural humility as well. Educators need to be the ones who first walk the walk of cultivating and integrating

LGBTIQ+CC and cultural humility by educating themselves, especially with intersectionality and TGNC topics, reflecting, and making mistakes themselves. One of the things that may be harder to do is to admit one's limitation of knowledge. Educators need to balance and prepare what they know, and leave room for where they do not know or where their knowledge stops as well as be honest and authentic with students and learn together with them. Inviting experts and/or people in the community to educate and share might help to fill this gap. Previous research has shown that knowing and learning from people in the community help to humanize and lower prejudice against LGBTIQ+ people (Sawaya & McCarty, 2023; Tomptkins et al., 2015). Some other suggested alternative learning approaches include mindfulness-based and experiential learning (see Hilert & Tirado, 2018; Lynch, 2013).

Furthermore, educators can use the theory presented in this study as a blueprint to investigate what is still missing in their curricula and/or in their trainees for both non-LGBTIQ+ and LGBTIQ+ trainees. For non-LGBTIQ+ trainees, educators can emphasize viewing people of all diversity as a human being, starting from the exploration of trainees' own experiences of being a minority, what that means to them, and link that to LGBTIQ+ client's experiences. For LGBTIQ+ trainees, educators can validate and support their struggles as an LGBTIQ+ person in the mental health field and professionals and potential past traumas, and facilitate a conversation on how their experiences may resemble or differ from their diverse LGBTIQ+ clients. Educating students on the topic of systemic, legislative and social justice issues and how they impact lives of LGBTIQ+ clients with examples and potential for advocacy work and taking actions is important (see Gerloff, 2021). Finally, educators can provide helpful and

relevant resources, and teach trainees on how to find additional resources and filter them for the benefit of LGBTIQ+ clients. Some of the resources include the standards of care for the health of transgender and gender diverse people, version 8 (WPATH; Coleman et al., 2022), professional guidelines and competencies from American Counseling Association and American Psychological Association (ACA, 2010; APA, 2015; 2021; Harper et al., 2013), and the resources suggested by the Society for Sexual, Affectional, Intersex, and Gender Expansive Identities (SAIGE, n.d.).

Even though all the suggestions are applicable to supervisors in the context of supervision, supervisors may need to pay attention to certain areas particularly. As the recruitment in this dissertation reflected, many of the counselors who work with LGBTIQ+ clients also identify as LGBTIQ+ themselves. Therefore, supervisors need to cultivate LGBTIQ+CC and cultural humility themselves to establish trust and meaningful relationships with their LGBTIQ+ supervisees, and for the benefit of their supervisees' LGBTIQ+ clients. Supervisors may need to address and validate challenges and hardships that LGBTIQ+ CITs have to go through (Lykins, 2021), as suggested in the hardship, maintenance and self-care category. They can assist their LGBTIQ+ supervisees to explore similarities and differences that their LGBTIQ+ supervisees have in comparison to LGBTIQ+ clients. Such comparison will help CITs to learn what similarities that they can use to build rapport with their clients. On the other hand, the differences can serve as a caution for CITs not to make assumptions about their LGBTIQ+ clients based on their own experiences (Lykins, 2021). Supervisors can help LGBTIQ+ CITs to navigate this while normalize the nuance and diversity of LGBTIQ+ umbrella and experiences. For a non-LGBTIQ+ CIT, supervisors may focus more on

building awareness of privilege, and the mental health needs and gaps for LGBTIQ+ clients as suggested in the above paragraphs.

Previous literature pointed out barriers in training, such as, lack of LGBTIQ+ coursework, insufficient clinical training, and poor quality of materials, (Fitterman-Harris et al., 2022). LGBTIQ+-related topics often are only covered briefly as one of the topics in other classes (e.g., multicultural counseling class; Fitterman-Harris et al., 2022); such limited focus and time is not enough to deliberately cover aspects of LGBTIQ+CC and cultural humility. Therefore, on a programmatic level, training programs need to develop a coursework that specifically focuses on LGBTIQ+-related topics, especially trans-related topics, which allows more time to cover both LGBTIQ+CC and cultural humility effectively and elaborately. Furthermore, because each program may differ regarding resources and readiness to provide such a course, those programs with no competent faculty can hire an adjunct or invite local LGBTIQ+ communities to be a part of the coursework to train CITs. Such a change can start from a policy level that creates a top-down change. Even though the change may be demanding and difficult, it will better prepare CITs in working with LGBTIQ+ clients to do right by queer clients.

Implications for Practice

The original intent of this dissertation was to develop a theory that could serve as a guideline on how counselors can do right by queer clients. Accordingly, the emerging theory provides many suggestions toward that goal. The first suggestion is for counselors to recheck themselves along the theory of what is still missing in their practice or what might further help to increase effectiveness in working with LGBTIQ+ clients, either on an LGBTIQ+CC side, cultural humility side, or both. This may include journaling, and

discussion with supervisors and/or colleagues. The theory suggested different approaches on how to do so, such as self-educating to fill knowledge gaps (e.g., HRT, letter writing, and legislations that impact LGBTIQ+ clients' lives and community; Attara, 2022; Graham et al, 2012), immersing in the community and pride events (Beer et al., 2012), committing to not harming clients - big or small (McNamara & Wilson, 2020; Ojanen et al., 2021), and advocating for LGBTIQ+ clients (Harper et al., 2013).

One particular aspect about cultural humility that may be difficult for counselors to apply is the humility to make mistakes. Mistakes may have societal negative connotation and be hard to embrace; counselors may need more intention and time to be able to process and embrace mistakes (Zhu et al., 2021). Counselors may benefit from reflecting on their view of mistakes, not getting things right, and checking their egos which might get in the way of their learning and integrating LGBTIQ+CC and cultural humility. For example, they can review past ruptures or misunderstanding with queer clients, reflect on their feelings and reactions pertaining those events, unpack these feelings with their supervisors and/or personal counselors, and adopt a narrative that mistakes are an opportunity for growth and improvement. With the openness to make mistakes and learn from clients, they can learn to develop an embracing stance to learn from clients (Foronda et al., 2016).

The importance of relationship, rapport, and trust was highlighted as a pivotal component in working with LGBTIQ+ clients (Ratanashevorn et al., 2024). Therefore, the aspects of the application of cultural humility in the counseling relationship as well as providing a safe space is very important (Compton & Morgan, 2022; McCullough et al., 2017). Reflecting on oneself and the sense of safety that is cocreated in the relationship is

a lens that allows for counselors to be more reflective and go back to themselves concerning what is still lacking on their end (Zhu et al., 2022). For example, counselors can let their queer clients have and hold the space, believe what the clients say, learn from their clients, validate clients' experiences, pay attention to clients' body languages or sense of comfort in therapy room, check in with clients regularly on how safe and heard they feel in the session, and mend potential ruptures and mistrust. Through the relationship and safety lens, counselors can use the theory suggested in this study to check in with themselves and LGBTIQ+ clients on what is missing and work on those components either with the current clients or as an on-going journey for their professional development.

As a counselor, the old sayings of "know thyself" and "using self as instrument" hold truth (Ahonen, 2019; Wilson, 2009). Accordingly, the cultivation and integration of LGBTIQ+CC and cultural humility starts personally and from one's own experiences. Therefore, the internal work is of priority, including reflecting on one's personal experiences, worldviews, biases, theories, theoretical approaches, limitations, and how all of them come together (Moradi & Budge, 2018; Mosher et al., 2017). Such reflection can inform how counselors can expand and grow further their selfhood, current knowledge, and scope of practice. For example, counselors can create a routine of checking their own gaps in knowledge, reframe having knowledge gaps as normative, and figure out how to fill the knowledge gaps. Additionally, being upfront and honest about one's scope of practice and limitation of knowledge (Zhu et al., 2022), even though potentially difficult, will be beneficial for both oneself and LGBTIQ+ clients. They can discuss their scope of

practice and limitation of knowledge from the beginning with their queer clients in session and express how they will expand their knowledge to benefit the clients.

Last but not least, the theory proposed in this dissertation suggests that the cultivation and integration process is an on-going cyclical learning journey; there is no end to it (Harper et al., 2013; Zhu et al., 2021). Being on this life-long growth journey is an indicator that counselors are in the process towards the right kind of work for LGBTIQ+ clients. The process may be hard and vulnerable, with potentially unpacking and uncovering parts and areas which might be emotional or hard to accept. Accordingly, guidance from mentors and supervisors (Sánchez et al., 2018), support from personal counselors (Eliason et al., 2018), as well as patience and compassion for oneself can be helpful (Nelson et al., 2018). Another phrase that a participant mentioned was "have your shit together," which is a good reminder that self-care and maintenance along the process is extremely important, no matter what it looks like (e.g., personal therapy, time off, or processing and unpacking with colleagues; Eliason et al., 2018). Therefore, when counselors feel burdened or disheartened by the hardship of the process, they can turn to these sources of support, create a habit of checking with themselves, and have these self-care strategies with resources ready when in need.

Conclusion

Overall, the theory of the life-long cultivation and integration of LGBTIQ+CC and cultural humility proposed in this study offers a clear and organized outline for the process of cultivation, integration, and application of LGBTIQ+CC and cultural humility. It helps to bridge knowledge gaps empirically in these areas through the lens of cultivation, integration, and application among scattered important components in the

literature. It adds value by informing educators in their training, and practitioners in their professional development. Regardless of the limitations described above, the theory offered in this dissertation is an addition to the field in terms of clarifying this process. It is a steppingstone towards further betterment of LGBTIQ+CC and cultural humility training for more consistent and informed training programs, and hopefully, less harm done to LGBTIQ+ clients, and better quality of counseling work for LGBTIQ+ clients, and the LGBTIQ+ community as a whole.

References

Agner, J. (2020). Moving from cultural competence to cultural humility in occupational therapy: A paradigm shift. *American Journal of Occupational Therapy, 74*(4), 7404347010p1-7404347010p7. https://doi.org/10.5014/ajot.2020.038067

Ahonen, H. (2019). 'Self as instrument' – Safe and effective use of self in music psychotherapy: Canadian music therapists' perceptions. *Approaches: An Interdisciplinary Journal of Music Therapy, 11*(2), 208-235. https://doi.org/10.56883/aijmt.2019.211

Aijian, R., & Wang, D. C. (2020). Cultural humility: A framework when religious and sexual identities conflict. *Reflections, 26*(2), 114-122.

Alessi, E. J., Dillon, F. R., & Kim, H. M-S. (2015). Determinants of lesbian and gay affirmative practice among heterosexual therapists. *Psychotherapy, 52*(3), 298-307. http://dx.doi.org/10.1037/a0038580

Alessi, E. J., Dillon, F. R., & Van Der Horn, R. (2019). The therapeutic relationship mediates the association between affirmative practice and psychological well-being among lesbian, gay, bisexual, and queer clients. *Psychotherapy, 56*(2), 229-240. https://doi.org/10.1037/pst0000210

Alessi, E. J., Greenfield, B., Kahn, S., & Woolner, L. (2021). (Ir)reconcilable identities: Stories of religion and faith for sexual and gender minority refugees who fled from the Middle East, North Africa, and Asia to the European Union. *Psychology of Religion and Spirituality, 13*(2), 175-183. https://doi.org/10.1037/rel0000281

Alessi, E. J., Kahn, S., Ast, R. S., Cheung, S. P., Lee, E. O. J., & Kim, H. (2023). Learning from practitioners serving LGBTQ+ forced migrants and other diverse

groups: Implications for culturally informed affirmative practice. *Journal of the Society for Social Work and Research, 14*(3), 609-631. https://doi.org/10.1086/716722

Alizadeh, S., & Chavan, M. (2016). Cultural competence dimensions and outcomes: a systematic review of the literature. *Health & Social Care in the Community, 24*(6), e117-e130. https://doi.org/10.1111/hsc.12293

American Counseling Association (ACA). (2014). *ACA code of ethics*. Alexandria, VA: Author. Retrieved from https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Counseling Association Competencies for Counseling with Transgender Clients. (2010). *Journal of LGBT Issues in Counseling, 4*(3–4), 135–159. https://doi.org/10.1080/15538605.2010.524839

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*. American Psychiatric Pub.

American Psychological Association (APA). (2009). *Report of the task force on appropriate therapeutic responses to sexual orientation*. Washington, D.C.: Author. Retrieved from https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf

American Psychological Association (APA). (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*(9), 832–864. https://doi.org/10.1037/a0039906

American Psychological Association (APA). (2017). *Ethical principles of psychologists and code of conduct*. Retrieved from https://www.apa.org/ethics/code/ethics-code-2017.pdf

American Psychological Association (APA). (2021). *Guidelines for psychological practice with sexual minority persons.* Retrieved from www.apa.org/about/policy/psychological-practice-sexual-minority-persons.pdf.

Ansara, Y. G., & Hegarty, P. (2014). Methodologies of misgendering: Recommendations for reducing cisgenderism in psychological research. *Feminism & Psychology*, *24*(2), 259-270. https://doi.org/10.1177/0959353514526217

Anzani, A., Morris, E. R., & Galupo, M. P. (2019). From absence of microaggressions to seeing authentic gender: Transgender clients' experiences with microaffirmations in therapy. *Journal of LGBT Issues in Counseling*, *13*(4), 258-275. https://doi.org/10.1080/15538605.2019.1662359

Arredondo, P., Toporek., R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the Multicultural Counseling Competencies. *Journal of Multicultural Counseling and Development*, *24*(1), 42-78. https://doi.org/10.1002/j.2161-1912.1996.tb00288.x

Asquith, N. L., Ferfolja, T., Brady, B., & Hanckel, B. (2019). Diversity and safety on campus@ Western: Heterosexism and cissexism in higher education. *International Review of Victimology*, *25*(3), 320-340. https://doi.org/10.1177/0269758018799032

Association of American Medical Colleges, Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development. (2014). *Implementing curricular and*

institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD: A resource for medical educators. Retrieved from http://members.aamc.org/eweb/upload/LGBTDSD%20Publication.pdf

Astramovich, R. L., & Scott, B. E. (2020). Intersectional advocacy with LGBTQ+ clients in counseling. *Journal of LGBTQ Issues in Counseling, 14*(4), 307-320. https://doi.org/10.1080/15538605.2020.1827473

Atkins, K., & Lorelle, S. (2022). Cultural humility: Lessons learned through a counseling cultural immersion. *Journal of Counselor Preparation and Supervision, 15*(1). Retrieved from https://digitalcommons.sacredheart.edu/jcps/vol15/iss1/9

Attara, C. M. (2022). *Licensed professional counselors and licensed mental health counselors' experiences evaluating TGNB clients prior to hormone replacement therapy* (Publication No. 29393045) [Doctoral dissertation, Capella University]. ProQuest Dissertations & Theses Global.

Baams, L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. *Pediatrics, 141*(5). https://doi.org/10.1542/peds.2017-3004

Baams, L., Dubas, J. S., Russell, S. T., Buikema, R. L., & van Aken, M. A. G. (2018). Minority stress, perceived burdensomeness, and depressive symptoms among sexual minority youth. *Journal of Adolescence, 66*(1), 9-18. https://doi.org/10.1016/j.adolescence.2018.03.015

Bathje, G. J., Pillersdorf, D. & Eddir, H. (2022). Multicultural competence as a common factor in the process and outcome of counseling. *Journal of Humanistic Psychology*, 002216782210996. https://doi.org/10.1177/00221678221099679

Bauer, G. R., Churchill, S. M., Mahendran, M., Walwyn, C., Lizotte, D., Villa-Rueda, A. A. (2021). Intersectionality in quantitative research: A systematic review of its emergence and applications of theory and methods. *SSM - Population Health, 14*, 100798. https://doi.org/10.1016/j.ssmph.2021.100798

Beer, A. M., Spanierman, L. B., Greene, J. C., & Todd, N. R. (2012). Counseling psychology trainees' perceptions of training and commitments to social justice. *Journal of Counseling Psychology, 59*(1), 120–133. https://doi.org/10.1037/a0026325

Bennett, B., & Gates, T. G. (2019). Teaching cultural humility for social workers serving LGBTQI Aboriginal communities in Australia. *Social Work Education, 38*(5), 604-617. https://doi.org/10.1080/02615479.2019.1588872

Berke, D. S., Maples-Keller, J. L., & Richards, P. (2016). LGBTQ perceptions of psychotherapy: A consensual qualitative analysis. *Professional Psychology: Research and Practice, 47*(6), 373-382. https://doi.org/10.1037/pro0000099

Bettergarcia, J., Matsuno, E., Conner. K. J., Geilhufe, B., & Burnes, T. R. (2024). Effectiveness of a 9-month queer- and trans-affirming training for mental health providers: A waitlist control group design. *Professional Psychology: Research and Practice Professional Psychology: Research and Practice, 55*(1), 18-27. https://doi.org/10.1037/pro0000526

Bettergarcia, J., Matsuno, E., & Conover. K. J. (2021). Training mental health providers in queer-affirming care: A systematic review. *Psychology of Sexual Orientation and Gender Diversity, 8*(3), 365-377. https://doi.org/10.1037/sgd0000514

Bidell, M. P. (2005). The sexual orientation counselor competency scale: Assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education & Supervision, 44*(4), 267-279. https://doi.org/10.1002/j.1556-6978.2005.tb01755.x

Bidell, M. P. (2017). The lesbian, gay, bisexual, and transgender development of clinical skills scale (LGBT-DOCSS): Establishing a new interdisciplinary self-assessment for health providers. *Journal of Homosexuality, 64*(10), 1432-1460. https://doi.org/10.1080/00918369.2017.1321389

Bidell, M. P., & Stepelman, L. M. (2017). An interdisciplinary approach to lesbian, gay, bisexual, and transgender clinical competence, professional training, and ethical care: Introduction to the special issue. *Journal of Homosexuality, 64*(10), 1305-1329. https://doi.org/10.1080/00918369.2017.1321360

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Bishop, J., Crisp, D., & Scholz, B. (2021). A systematic review to determine how service provider practises impact effective service provision to lesbian, gay and bisexual consumers in a mental health setting. *Clinical Psychology & Psychotherapy, 29*(3), 874-894. https://doi.org/10.1002/cpp.2699

Bishop, J., Crisp, D., Grant, J. B., & Scholz, B. (2022a). “You say you're inclusive, but can you show us?” The importance of cultural competence when working with sexual minorities in a mental health setting. *Journal of Clinical Psychology, 78*(11), 2145-2163. https://doi.org/10.1002/jclp.23434

Bishop, J., Crisp, D., & Scholz, B. (2022b). The real and ideal experiences of what culturally competent counselling or psychotherapy service provision means to lesbian, gay and bisexual people. *Counselling and Psychotherapy Research, 22*(2), 429-438. https://doi.org/10.1002/capr.12469

Bitterman, A., & Hess, D. B. (2021). Understanding generation gaps in LGBTQ+ communities: Perspectives about gay neighborhoods among heteronormative and homonormative generational cohorts. In A. Bitterman, & D. B. Hess (Eds.), *The life and afterlife of gay neighborhoods: Renaissance and resurgence* (pp. 309–340). Springer.

Blumer, M. L. C., Ansara, Y. G., & Watson, C. M. (2013). Cisgenderism in family therapy: How everyday clinical practices can delegitimize people's gender self-designations. *Journal of Family Psychotherapy, 24*(4), 267-285. https://doi.org/10.1080/08975353.2013.849551

Bockting, W. (2015). Internalized transphobia. *The International Encyclopedia of Human Sexuality*, 583-625. https://doi.org/10.1002/9781118896877.wbiehs236

Boe, J. L. (2021). *The state of transgender and non-binary affirmative training in mental health graduate education: Explorations and implications for clinical practice* (Publication No. 28411512) [Doctoral dissertation, University of Georgia]. ProQuest Dissertations & Theses Global.

Boroughs, M. S., Andres Bedoya, C., O'Cleirigh, C., & Safren, S. A. (2015). Toward defining, measuring, and evaluating LGBT cultural competence for psychologists. *Clinical Psychology: Science and Practice, 22*(2), 151–171. https://doi.org/10.1111/cpsp.12098

British Psychological Society, Professional Practice Board. (2012). Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients. Retrieved from http://www.bps.org.uk/publications/policy-and-guidelines/practice-guidelines-policy-documents/practice-guidelines-poli

Brady, B., Asquith, N. L., Ferfolja, T., & Hanckel, B. (2020). Fear of heterosexism among sexuality and gender diverse staff and students. *Journal of Interpersonal Violence, 37*(3-4), NP1908-NP1938. https://doi.org/10.1177/0886260520928648

Brooke, P. (2020). *How do gay men experience ruptures in the relationship with their therapist? An interpretative phenomenological study* [Doctoral dissertation, London Metropolitan University]. London Met Repository. https://repository.londonmet.ac.uk/5630/

Buchanan, N. T., Rios, D., & Case, K. A. (2020). Intersectional cultural humility: Aligning critical inquiry with critical praxis in psychology. *Women & Therapy, 43*(3-4), 235-243. https://doi.org/10.1080/02703149.2020.1729469

Burckell, L. A., & Goldfried, M. R. (2006). Therapist qualities preferred by sexual-minority individuals. *Psychotherapy: Theory, Research, Practice, Training ,43*(1), 32-49. https://doi.org/10.1037/0033-3204.43.1.32

Butler, J. (1993). *Bodies that matter: On the discursive limits of "sex"*. New York, NY: Routledge.

Butler, J. (1999). *Gender trouble: Feminism and the subversion of identity* (Rev ed.). New York, NY: Routledge.

Council for Accreditation of Counseling and Related Educational Programs (CACREP). (2015). *2016 CACREP standards*. Retrieved from http://www.cacrep.org/wp-content/uploads/2012/10/2016-CACREP-Standards.pdf

Capra, A. C., Ferracini, I. M. V., & Irigaray, T. Q. (2021). Reparative therapy and beliefs in the practice of clinical psychology: A systematic review. *Psicologia: Teoria e Prática, 23*(3), 1–22. https://doi.org/10.5935/1980-6906/eptpcp12860

Carrington, M., & Sims, M. (2024). How can counselling training courses better prepare their trainee therapists to work with LGBTQ+ clients? *Counselling and Psychotherapy Research, 24*(2), 513-523. https://doi.org/10.1002/capr.12684

Carlson, T. S., McGeorge, C. R., & Toomey, R. B. (2012). Establishing the validity of the affirmative training inventory: Assessing the relationship between lesbian, gay, and bisexual affirmative training and students' clinical competence. *Journal of Marital and Family Therapy, 39*(2), 209-222. https://doi-org.ezproxy.umsl.edu/10.1111/j.1752-0606.2012.00286.x

Carroll, L., & Gilroy, P. J. (2001). Teaching "outside the box": Incorporating queer theory in counselor education. *Journal of Humanistic Counseling, Education and Development, 40*(1), 49-58. https://doi.org/10.1002/j.2164-490x.2001.tb00101.x

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*(5),545-547. https://doi.org/10.1188/14.onf.545-547

Castro-Peraza, M. E., García-Acosta, J. M., Delgado, N., Perdomo-Hernández, A. M., Sosa-Alvarez, M. I., Llabrés-Solé, R., & Lorenzo-Rocha, N. D. (2019). Gender identity: The human right of depathologization. *International Journal of*

Environmental Research and Public Health, 16(6), 978. https://doi.org/10.3390/ijerph16060978

Champagne, B., & McKinney, R. (2022). A rollercoaster experience: Gay males pursuing couples counseling. *Journal of LGBTQ Issues in Counseling, 16*(2), 130-147. https://doi.org/10.1080/26924951.2021.1983500

Chang, D. F., Dunn, J. J., & Omidi, M. (2021). A critical-cultural-relational approach to rupture resolution: A case illustration with a cross-racial dyad. *Journal of Clinical Psychology, 77*(2), 369-383. https://doi.org/10.1002/jclp.23080

Charmaz, K. (2002). Grounded theory: Methodology and theory construction. In N. J. Smelser and P. B. Baltes (Eds): *International Encyclopedia of the Social and Behavioral Sciences* (pp. 6396-6399). Amsterdam: Pergamon.

Charmaz, K. (2008). Grounded theory as an emergent method. In S. N. Hesse-Biber, & P. Leavy, *Handbook of emergent methods* (pp. 155-170). New York, NY: Guilford Press.

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd Ed.). Thousand Oaks, CA: Sage.

Chevrette, R., & Eguchi, S. (2020). "We don't see LGBTQ differences": Cisheteronormativity and concealing phobias and irrational fears behind rhetorics of acceptance. *QED: A Journal in GLBTQ Worldmaking, 7*(1), 55-59. https://doi.org/10.14321/qed.7.1.0055

Cillessen, A. H. N., & Marks, P. E. L. (2017). Methodological choices in peer nomination research. *New Directions for Child and Adolescent Development, 157*, 21–44. https://doi.org/10.1002/cad.20206

Clayton, M. J. (1997). Delphi: A technique to harness expert opinion for critical decision-making tasks in education. *Educational Psychology, 17*(4), 373-386. https://doi.org/10.1080/0144341970170401

Coburn, K. O., & McGeorge, C. R. (2019). Christian pastors' perspectives and insights on the practice of family therapists referring LGB Clients: Exploring the role of religion. *American Journal of Family Therapy, 47*(5), 328-343. https://doi.org/10.1080/01926187.2019.1673260

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B. T., Johnson, W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health, 23*(sup1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

Collins, P. H., & Bilge, S. (2020). *Intersectionality* (2nd ed.). Polity Press.

Collins, K. M., & Levitt, H. M. (2021). Heterosexism and the self: A systematic review informing LGBQ-affirmative research and psychotherapy. *Journal of Gay & Lesbian Social Services, 33*(3), 376-405. https://doi.org/10.1080/10538720.2021.1919275

Compton, E., & Morgan, G. (2022). The experiences of psychological therapy amongst people who identify as transgender or gender non-conforming: A systematic review of qualitative research. *Journal of Feminist Family Therapy, 34*(3-4), 225-248. https://doi.org/10.1080/08952833.2022.2068843

Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology, 13*(1), 3-21. https://doi.org/10.1007/bf00988593

Corral, I., Johnson, T. L., Shelton, P. G., & Glass, O. (2017). Psychiatry resident training in cultural competence: An educator's toolkit. *Psychiatric Quarterly, 88*(2), 295-306. https://doi.org/10.1007/s11126-016-9472-9

Corturillo, E. M., & McGeorge, C. R., & Carlson, T. S. (2016). How prepared are they? Exploring couple and family therapy faculty members' training experiences in lesbian, gay, and bisexual affirmative therapy. *Journal of Feminist Family Therapy, 28*(2-3), 55-75. https://doi.org/10.1080/08952833.2016.1179549

Davies, D. (1996). Towards a model of gay affirmative therapy. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counselors and therapists working with lesbian, gay, and bisexual clients* (pp. 24–40). Buckingham, England: Open University Press.

Davis, A. W., Lyons, A., & Pepping, C. A. (2022). Inclusive psychotherapy for sexual minority adults: The role of the therapeutic alliance. *Sexuality Research and Social Policy, 19*, 1842-1854. https://doi.org/10.1007/s13178-021-00654-y

Davy, Z., & Toze, M. (2018). What is gender dysphoria? A critical systematic narrative review. *Transgender Health, 3*(1), 159-169. https://doi.org/10.1089/trgh.2018.0014

de los Reyes, G. O. R., & Collict, D. (2022). "It's not only about clinical tools but also our role as agents of social change": Implementing a LGBT competency training

for future mental health practitioners in Mexico. *Journal of Homosexuality*, *69*(2), 230-253. https://doi.org/10.1080/00918369.2020.1815433

Dorn-Medeiros, C. M., & Christensen, J. K. (2019). Developing a rubric for supervision of students counseling LGBTQ clients. *Journal of LGBT Issues in Counseling*, *13*(1), 28–44. https://doi.org/10.1080/15538605.2019.1565798

Drescher, J. (2015). Out of DSM: Depathologizing Homosexuality. *Behavioral Sciences, 5*(4), 565-575. https://doi.org/10.3390/bs5040565

Drescher, J., & Fadus, M. (2020). Issues arising in psychotherapy with lesbian, gay, bisexual, and transgender patients. *FOCUS, 18*(3), 262-267. https://doi.org/10.1176/appi.focus.20200001

Drinane, J. M., Owen, J., Adelson, J. L., & Rodolfa, E. (2016). Multicultural competencies: What are we measuring? *Psychotherapy Research*, *26*(3), 342-351. https://doi.org/10.1080/10503307.2014.983581

Dworkin, E. R., Gilmore, A. K., Bedard-Gilligan, M., Lehavot, K., Guttmannova, K., & Kaysen, D. (2018). Predicting PTSD severity from experiences of trauma and heterosexism in lesbian and bisexual women: A longitudinal study of cognitive mediators. *Journal of Counseling Psychology, 65*(3), 324-333. https://doi.org/10.1037/cou0000287

Edwards, L., Goodwin, A., & Neumann, M. (2019). An ecological framework for transgender inclusive family therapy. *Contemporary Family Therapy, 41*, 258 – 274. http://dx.doi.org/10.1007/s10591-018-9480-z

Edwards, L. L., Robertson, J. A., Smith, P. M., & O'Brien, N. B. (2014). Marriage and family training programs and their integration of lesbian, gay, and bisexual

identities. *Journal of Feminist Family Therapy, 26*(10), 3-27. https://doi.org/10.1080/08952833.2014.872955

Edwards, W. J. (2016). Measuring relationship satisfaction: Is it possible for Black gay male couples to be satisfied in a relationship? *Deviant Behavior, 37*(8), 931-951. https://doi.org/10.1080/01639625.2016.1156983

Eliason, M. J., Streed, C. Jr., & Henne, M. (2018). Coping with stress as an LGBTQ+ health care professional. *Journal of Homosexuality, 65*(5), 561–578. https://doi.org/10.1080/00918369.2017.1328224

Erby, A. N., & White, M. E. (2022). Broaching partially-shared identities: Critically interrogating power and intragroup dynamics in counseling practice with trans people of Color. *International Journal of Transgender Health, 23*(1-2), 122–132. https://doi.org/10.1080/26895269.2020.1838389

Eubanks-Carter, C., Burckell, L. A., & Goldfried, M. R. (2005). Enhancing therapeutic effectiveness with lesbian, gay, and bisexual clients. *Clinical Psychology: Science and Practice, 12*(1), 1–18. https://doi.org/10.1093/clipsy.bpi001

Fattoracci, E. S. M., Revels-Macalinao, M., & Huynh, Q-L. (2020). Greater than the sum of racism and heterosexism: Intersectional microaggressions toward racial/ethnic and sexual minority group members. *Cultural Diversity and Ethnic Minority Psychology, 27*(2), 176-188. https://doi.org/10.1037/cdp0000329

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 480–490. https://doi.org/10.1037/0033-3204.43.4.480

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Journal of Social Work Education, 34*(2), 165–181. https://doi.org/10.1080/02615479.2014.977244

Fitterman-Harris, H. F., Hughes, H. M., Soulliard, Z. A., & Zane, K. L. (2022). Barriers to LGBQ- and TGNB-affirmative clinical training in psychology doctoral programs. *Psychology of Sexual Orientation and Gender Diversity*. Advance online publication. https://doi.org/10.1037/sgd0000565

Flick, U., Kardoff, E., & Steinske, I. (Eds.). (2004). *A companion to qualitative research*. Los Angeles: Sage Publications.

Flores, C. A., & Sheely-Moore, A. I. (2020). Relational-cultural theory-based interventions with LGBTQ college students. *Journal of College Counseling, 23*(1), 71–84. https://doi.org/10.1002/jocc.12150

Foronda, B., Baptiste, D-L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*(3), 210–217. https://doi.org/10.1177/1043659615592677

Freeman-Coppadge, D. J., & Langroudi, K. F. (2021). Beyond LGBTQ affirmative therapy: Fostering growth and healing through intersectionality. In K. L. Nadal & M. R. Sharrón-del R´ıo (Eds.), *Queer Psychology*. Springer.

Gardner, A., McCutcheon, H., & Fedoruk, M. (2012). Discovering constructivist grounded theory's fit and relevance to researching contemporary mental health nursing practice. *Australian Journal of Advanced Nursing, 30*(2), 66-74.

Gedro, J., & Mizzi, R. C. (2014). Feminist theory and queer theory: Implications for HRD research and practice. *Advances in Developing Human Resources, 16*(4), 445-456. https://doi.org/10.1177/1523422314543820

Gerloff, S. (2022). *Counselor educators' experiences teaching counseling students LGBTQ+ affirmative counseling* (Publication No. 28968817) [Doctoral dissertation, Capella University]. ProQuest Dissertations & Theses Global.

Gilliland, B. & Crisp, D. (1995). *Homophobia: Assessing and changing attitudes of counselors in training*. Paper presented at the 103rd annual meeting of the American Psychological Association, New York, NY, August 14.

Ginicola, M. M., Filmore, J. M., & Smith, C. (2017). Developing competence in working with LGBTQI+ communities: awareness, knowledge, skills, and action. In M. M. Ginigola, C. Smith, & J. M. Filmore, *Affirmative Counseling with LGBTQI+ People* (pp. 1-20). Alexandria, VA: American Counseling Association. https://doi.org/10.1002/9781119375517.ch1

Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay, and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy, 32*(4), 491–504. https://doi.org/10.1111/j.1752-0606.2006.tb01623.x

Goldblum, P., Pflum, S., Skinta, M., Evans, R. W., & Balsam, K. (2017). Psychotherapy with lesbian, gay, and bisexual clients: Theory and practice. In A. J. Consoli, L. E. Beutler, & B. Bongar (Eds.), *Comprehensive textbook of psychotherapy: Theory and Practice* (pp. 330–345). New York, NY: Oxford University Press.

Gonzalez, K. A., Pulice-Farrow, L., & Abreu, R. L. (2022). “In the voices of people like me”: LGBTQ coping during Trump’s administration. *The Counseling Psychologist, 50*(2), 212-240. https://doi.org/10.1177/00110000211057199

Goodrich, K. M., & Luke, M. (2015). *Group counseling with LGBTQI persons.* American Counseling Association.

Goodrich, K. M., Luke, M., & Smith, A. J. (2016). Queer humanism: Toward an epistemology of socially just, culturally responsive change. *Journal of Humanistic Psychology, 56*(6), 612-623. https://doi.org/10.1177/0022167816652534

Govere, L., & Govere, E. M. (2016). How effective is cultural competence training of healthcare providers on improving patient satisfaction of minority groups? A systematic review of literature. *Worldviews on Evidence-Based Nursing, 13*(6), 402-410. https://doi.org/10.1111/wvn.12176

Graham, D. L., Rawlings, E. I., Halpern, H. S., & Hermes, J. (1984). Therapists' needs for training in counseling lesbians and gay men. *Professional Psychology: Research and Practice, 15*(4), 482-496. https://doi.org/10.1037/0735-7028.15.4.482

Graham, S. R., Carney, J. S., & Kluck, A. S. (2012). Perceived competency in working with LGB clients: Where are we now? *Counselor Education & Supervision, 51*(1), 2-16. https://doi.org/10.1002/j.1556-6978.2012.00001.x

Greene-Moton, E. & Minkler, M. (2020). Cultural competence or cultural humility? Moving beyond the debate. *Health Promotion Practice, 21*(1), 142-145. https://doi.org/10.1177/1524839919884912

Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H. C., Loos, B., Harper, B., Graham, S., Singh, A., Kocet, M., Travis, L., Lambert, S., Burnes, T., Dickey, L. M., Hammer, T. R., & ALGBTIC LGBQQIA Competencies Taskforce. (2013). Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals. *Journal of LGBT Issues in Counseling, 7*(1), 2–43. https://doi.org/10.1080/15538605.2013.755444

Hayes, J. A., & Gelso, C. J. (1993). Male counselors' discomfort with gay and HIV-infected clients. *Journal of Counseling Psychology, 40*(1), 86-93. https://doi.org/10.1037/0022-0167.40.1.86

Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs. *Journal of Counseling & Development, 89*(3), 288–295. https://doi.org/10.1002/j.1556-6678.2011.tb00091.x

Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation. *Qualitative Health Research, 27*(4), 591-608. https://doi.org/10.1177/1049732316665344

Herek, G. M. (2004). Beyond “Homophobia”: Thinking about sexual prejudice and stigma in the twenty-first century. *Sexuality Research and Social Policy, 1*(2), 6-24. https://doi.org/10.1525/srsp.2004.1.2.6

Herek, G. M. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States. *Journal of Interpersonal Violence, 24*(1), 54-74. https://doi.org/10.1177/0886260508316477

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*(2), 196–205. https://doi.org/10.1037/0022-0167.52.2.196

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353-366. https://doi.org/10.1037/a0032595

Hope, D. A., Holt, N. R., Woodruff, N., Mocarski, R., Meyer, H. M., Puckett, J. A., Eyer, J., Craig, S., Feldman, J., Irwin, J., Pachankis, J., Rawson, K. J., Sevelius, J., & Butler, S. (2022). Bridging the gap between practice guidelines and the therapy room: Community-derived practice adaptations for psychological services with transgender and gender diverse adults in the central United States. *Professional Psychology: Research and Practice*, *53*(4), 351-361. https://doi.org/10.1037/pro0000448

Hunt, J. (2014). An initial study of transgender people's experiences of seeking and receiving counselling or psychotherapy in the UK. *Counselling and Psychotherapy Research*, *14*(4), 288-296. https://doi.org/10.1080/14733145.2013.838597

Hussen, S. A., Kuppalli, K., Castillo-Mancilla, J., Bedimo, R., Fadul, N., & Ofotokun, I. (2020). Cultural competence and humility in infectious diseases clinical practice and research. *Journal of Infectious Disease*, *222*(Supplement 6), 535–542. https://doi.org/10.1093/infdis/jiaa227

Huynh, K. D., Murgo, M. J., & Lee, D. L. (2022). Internalized heterosexism and substance use: A meta-analysis. *The Counseling Psychologist, 50*(5), 674-707. https://doi.org/10.1177/00110000221086910

Israel, T., & Selvidge, M. M. D. (2003). Contributions of multicultural counseling to counselor competence with lesbian, gay, and bisexual clients. *Journal of Multicultural Counseling and Development, 31*(2), 84-98. https://doi.org/10.1002/j.2161-1912.2003.tb00535.x

Israel, T., Ketz, K., Detrie, P., Burke, M., & Shulman, J. (2003). Identifying counselor competencies for working with lesbian, gay, and bisexual clients. *Journal of Gay & Lesbian Mental Health, 7*(4), 3-21. https://doi.org/10.1080/19359705.2003.9962353

Israel, T., Gorcheva, R., Burnes, T. R., & Walther W. A. (2008). Helpful and unhelpful therapy experiences of LGBT clients. *Psychotherapy Research, 18*(3), 294-305. https://doi.org/10.1080/10503300701506920

Jennings, L., & Skovholt, T. M. (1999). The cognitive emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology, 46*(1), 3-11. https://doi.org/10.1037/0022-0167.46.1.3

Jennings, T. L., & Sprankle, E. (2023). Therapist multicultural orientation: Client perceptions of cultural humility, LGB identity, and the working alliance. *Journal of Homosexuality, 70*, 1–17. https://doi.org/10.1080/00918369.2023.2229473

Jensen, E., Jones, N., Rabe, M., Pratt, B., Medina, L., Orozco, K., & Spell, L. (2021). *The chance that two people chosen at random are of different race or ethnicity groups has increased since 2010*. Retrieved from

https://www.census.gov/library/stories/2021/08/2020-united-states-population-more-racially-ethnically-diverse-than-2010.html

Johnson, S. D. (2012). Gay affirmative psychotherapy with lesbian, gay, and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry, 82*(4), 516–522. https://doi.org/10.1111/j.1939-0025.2012.01180.x

Jones, T., Power, J., Jones, T. W., Pallotta-Chiarolli, M., & Despott, N. (2022) Supporting LGBTQA+ peoples' recovery from sexual orientation and gender identity and expression change efforts. *Australian Psychologist, 57*(6), 359-372. https://doi.org/10.1080/00050067.2022.2093623

Jordan, F. (2020). Changing the narrative for LGBTQ Adolescents: A literature review and call for research into narrative therapy to improve family acceptance of LGBTQ teens. *Counseling and Family Therapy Scholarship Review, 3*(1), 1-8. https://epublications.regis.edu/cftsr/vol3/iss1/6

Kangos, K. A., & Pieterse, A. L. (2021). Examining how lesbian, gay, and bisexual Christian clients' perceptions of therapists' cultural humility contribute to psychotherapy outcomes. *Psychotherapy*, *58*(2). 254-262. https://doi.org/10.1037/pst0000375

Kelly, F. A. (2015). The therapy relationship with lesbian and gay clients. *Psychotherapy, 52*(1), 113-118. https://doi.org/10.1037/a0037958

Kidd, S. A., Howison, M., Pilling, M., Ross, L. E., & McKenzie, K. (2016). Severe mental illness in LGBT populations: A scoping review. *Psychiatric Services, 67*(7), 779-783. https://doi.org/10.1176/appi.ps.201500209

Killian, T., Farago, R., & Peters, H. C. (2019). Promoting queer competency through an experiential framework. *The Journal of Counselor Preparation and Supervision, 12*(4). Retrieved from https://repository.wcsu.edu/jcps/vol12/iss4/10

King, S. (2008). Exploring the role of counselor support: Gay, lesbian, bisexual, and questioning adolescents struggling with acceptance and disclosure. *Journal of GLBT Family Studies, 4*(3), 361-384. https://doi.org/10.1080/15504280802177599

King, M., Semlyen, J., Killaspy, H., Nazareth, I., & Osborn, D. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people.* British Association for Counselling and Psychotherapy, BACP House.

Kirkland, V. M. (2018). *Professional counselors' lived experiences of counseling gender diverse clients* [Doctoral dissertation, Walden University]. Scholar Works. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=7332&context=dissertations

Kuzma, E. K., Pardee, M., & Darling-Fisher, C. S. (2019). Lesbian, gay, bisexual, and transgender health*: Creating safe spaces and caring for patients with cultural humility. Journal of the American Association of Nurse Practitioners, 31*(3), 167-174. https://doi.org/10.1097/jxx.0000000000000131

LaFromboise, T. D., Coleman, H. L. K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory—Revised. *Professional Psychology: Research and Practice, 22*(5), 380-388. https://doi.org/10.1037/0735-7028.22.5.380

De Lauretis, T. (1991). Queer theory: Lesbian and gay sexualities an introduction. *Differences, 3*(2), iii-xviii. https://doi.org/10.1215/10407391-3-2-iii

Lekas, H-M., Pahl, K., & Lewis, C. F. (2020). Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights, 13*, 117863292097058. https://doi.org/10.1177/1178632920970580

Lev, A. I. (2006). Disordering gender identity: gender identity disorder in the DSM-IV-TR. *Journal of Psychology & Human Sexuality, 17*(3–4), 35–69. https://doi.org/10.1300/j056v17n03_03

Linstone, H. A., & Turoff, M. (2002). *The Delphi Method: Techniques and applications*. (Digital Edition). http://web.njit.edu/~turoff/pubs/delphibook/delphibook.pdf

Logan, C. R., & Barret, R. (2006). Counseling competencies for sexual minority clients. *Journal of LGBT Issues in Counseling, 1*(1), 3-22. https://doi.org/10.1300/J462v01n01_02

Logie, C., Bridge, T. J., & Bridge P. D. (2007). Evaluating the phobias, attitudes, and cultural competence of master of social work students toward the LGBT populations. *Journal of Homosexuality*, *53*(4), 201-221. https://doi.org/10.1080/00918360802103472

Lomash, E. F., Brown, T. D., & Galupo, M. P. (2018). "A whole bunch of love the sinner hate the sin": LGBTQ microaggressions experienced in religious and spiritual context. *Journal of Homosexuality*, *66*(10), 1495-1511. https://doi.org/10.1080/00918369.2018.1542204

Lovaas, K. E., & Jenkins, M. M. (2007). *Sexualities and communication in everyday life: A reader*. Thousand Oaks, CA: Sage.

Lykins, C. C. (2021). *Training while queer: An interpretative phenomenological analysis of the experiences of queer therapists-in-training* (Publication No. 28720755) [Doctoral dissertation, Rutgers, The State University of New Jersey]. ProQuest Dissertations & Theses Global.

Madrak, E., Volberding, J. L., Harris, A. M., & Richardson, L. (2020). Patient perceptions in receiving LGBTQIA culturally competent healthcare. *Oklahoma State Medical Proceedings, 4*(1). Retrieved from https://www.okstatemedicalproceedings.com/index.php/OSMP/article/view/133/392

Magana, G. J. (2017). *Reactions to the privilege walk: An exploratory study*. [Master thesis, California State University, San Bernardino] Electronic Theses, Projects, and Dissertations. https://scholarworks.lib.csusb.edu/etd/581

Maru, G. (2017). Advocacy for and with LGBT students: An examination of high school counselor experiences. *Professional School Counseling, 20*(1a), 38–46. https://doi.org/10.5330/1096-2409-20.1a.38

Matsuno, E., Hashtpari, H., Domínguez, S., Jr., Maroney, M. R., Gonzalez, K. A., & Knutson, D. (2023). “There’s no real roadmap that I know of”: Experiences of transgender and nonbinary graduate students in counseling psychology programs. *Journal of Counseling Psychology, 70*(1), 16–29. https://doi.org/10.1037/cou0000647

McCullough, R., Dispenza, F., Parker, L. K., Viehl, C. J., Chang, C. Y., & Murphy, T. M. (2017). The counseling experiences of transgender and gender nonconforming

clients. *Journal of Counseling & Development, 95*(4), 423-434. https://doi.org/10.1002/jcad.12157

McErlean, A. (2021). *Development of competency with gender-expansive clients: A multiple-case study analysis* (Publication No. 28318816) [Doctoral dissertation, Capella University]. ProQuest Dissertations & Theses Global.

McGeorge, C. R., Coburn, K. O., & Walsdorf, A. A. (2018). Factors predicting the inclusion of lesbian, gay, and bisexual affirmative content taught in couple and family therapy courses. *The American Journal of Family Therapy, 46*(3), 306-317. https://doi.org/10.1080/01926187.2018.1526656

McNamara, G., & Wilson, C. (2020). Lesbian, gay and bisexual individuals experience of mental health services — A systematic review. *The Journal of Mental Health Training, Education and Practice, 15*(2), 59–70. https://doi.org/10.1108/JMHTEP-09-2019-0047

Mendenhall, S. G. (2021). *Narratives of (in)validation: Experiences of gay/queer cisgender men in college* (Publication No. 28320519) [Doctoral dissertation, University of Georgia]. ProQuest Dissertations & Theses Global.

Metelski, F.K., Santos, J. L. G., Cechine-Peiter, C., Fabrizzio, G. C., Schmitt, M. D., & Heilemann, M. (2021). Constructivist Grounded Theory: characteristics and operational aspects for nursing research. *Revista da Escola de Enfermagem da USP*. 55:e03776. https://doi.org/10.1590/S1980-220X2020051103776

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674 – 697. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H. (2010). Identity, stress, and resilience in lesbians, gay men, and bisexuals of color. *The Counseling Psychologist, 38*(3), 442–454. https://doi.org/10.1177/0011000009351601

Miner, K. N., & Costa, P. L. (2018). Ambient workplace heterosexism: Implications for sexual minority and heterosexual employees. *International Social Science Journal, 34*(4), 563–572. https://doi.org/10.1002/smi.2817

Moe, J., Pope, A., Dominguez, V. & Kemer, G. (2021). Factors predicting instruction of LGBTQ counseling competence. *Journal of LGBTQ Issues in Counseling, 15*(4), 389-405. https://doi.org/10.1080/15538605.2021.1967252

Moleiro, C., Pinto, N., & Chhaganlal, A. (2014). Development of a brief LGBT competence training for counselors and clinical psychologists: A pilot applied study. *Revista Transcultural, 6*(1), 87–100. Retrieved from http://hdl.handle.net/10071/16730

Moore, K. L., Lopez, L., Camacho, D., & Munson, M. R. (2020). A qualitative investigation of engagement in mental health services among Black and Hispanic LGB young adults. *Psychiatric Services, 71*(6), 555-561. https://doi.org/10.1176/appi.ps.201900399

Moradi, B., & Budge, S. L. (2018). Engaging in LGBQ+ affirmative psychotherapies with all clients: Defining themes and practices. *Journal of Clinical Psychology, 74*(11), 2028-2042. https://doi.org/10.1002/jclp.22687

Morales, K. C. (2019). *Cultural humility, therapeutic relationship, and outcome: Between- therapist, within-therapist, and within-client effects* [Master's thesis, University of Maryland, College Park]. Digital Repository at the University of

Maryland. https://api.drum.lib.umd.edu/server/api/core/bitstreams/05d18cf0-3073-4ae3-aba1-5624e7e5cbd2/content

Morris, M. (1998). Unresting the curriculum: Queer projects, queer imaginings. In W. F. Pinar (Ed.), *Queer theory in education* (pp. 275-286). Mahwah, NJ: Lawrence Erlbaum. https://doi.org/10.4324/9781410603760-16

Mosher, D. K., Hook, J. N., Captari, L. E., Davis, D. E., Deblaere, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging diverse clients. *Practice Innovations*, *2*(4), 221–233. https://doi.org/10.1037/pri0000055

Murray-García, J., & Tervalon, M. (2014). The concept of cultural humility. *Health Affairs*, *33*(7), 1303-1303. https://doi.org/10.1377/hlthaff.2014.0564

Nelson, J. R., Hall, B. S., Anderson, J. L., Birtles, C., & Hemming, L. (2018). Self–compassion as self-care: A simple and effective tool for counselor educators and counseling students. *Journal of Creativity in Mental Health*, *13*(1), 121–133. http://dx.doi.org/10.1080/15401383.2017.1328292

Nowaskie, D. Z., & Patel, A. U. (2021). How much is needed? Patient exposure and curricular education on medical students' LGBT cultural competency. *BMC Medical Education*, *20*(1), 1-8. https://doi.org/10.1186/s12909-020-02381-1

Nylund, D., & Temple, A. (2018). Queer informed narrative therapy: Radical approaches to counseling with transgender persons. In C. Audet & D. Paré (Eds.), *Social justice and counseling: Discourse in practice* (pp. 159–170). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9781315753751-16

Ojanen, T. T., Phukao, D., Boonmongkon, P., & Rungreangkulkij, S. (2021). Defining mental health practitioners' LGBTIQ cultural competence in Thailand. *Journal of*

Population and Social Studies, 29, 158-176. https://doi.org/10.25133/jpssv292021.010

O'Hara, C., Dispenza, F., Brack, G., & Blood, R. A. C. (2013). The preparedness of counselors in training to work with transgender clients: A mixed methods investigation. *Journal of LGBT Issues in Counseling, 7*(3), 236-256. https://doi.org/10.1080/15538605.2013.812929

O'Shaughnessy, T., & Speir, Z. (2018). The state of LGBQ affirmative therapy clinical research: A mixed-methods systematic synthesis. *Psychology of Sexual Orientation and Gender Diversity, 5*(1), 82–98. http://dx.doi.org/10.1037/sgd0000259

Owen, J., Jordan, T. A., Turner, D., Davis, D. E., Hook, J. N., & Leach, M. M. (2014). Therapists' multicultural orientation: Client perceptions of cultural humility, spiritual/religious commitment, and therapy outcomes. *Journal of Psychology and Theology, 42*(1), 91-98. https://doi.org/10.1177/009164711404200110

Owen-Pugh, V., & Baines, L. (2014). Exploring the clinical experiences of novice counsellors working with LGBT clients: Implications for training. *Counselling and Psychotherapy Research, 14*(1), 19-28. https://doi.org/10.1080/14733145.2013.782055

Pachankis, J. E., Soulliard, Z. A., Seager van Dyk, I., Layland, E. K., Clark, K. A., Levine, D. S., & Jackson, S. D. (2022). Training in LGBTQ-affirmative cognitive behavioral therapy: A randomized controlled trial across LGBTQ community centers. *Journal of Consulting and Clinical Psychology*, *90*(7), 582–599. https://doi.org/10.1037/ccp0000745

Pepping, C. A., Lyons, A., & Morris, E. M. J. (2018). Affirmative LGBT psychotherapy: Outcomes of a therapist training protocol. *Psychotherapy, 55*(1), 52–62. https://doi.org/10.1037/pst0000149

Perez, R. M. (2007). The "boring" state of research and psychotherapy with lesbian, gay, bisexual, and transgender clients: Revisiting Baron (1991). In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (2nd ed., pp. 399-418). Washington, DC: American Psychological Association. https://doi.org/10.1037/11482-017

Plummer, K. (2005). Critical humanism and queer theory: Living with the tensions. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., pp. 357-373). Thousand Oaks, CA: Sage.

Pope, M. (1995). The "Salad Bowl" is big enough for us all: An argument for the inclusion of lesbians and gay men in any definition of multiculturalism. *Journal of Counseling & Development, 73*(3), 301-304. https://doi.org/10.1002/j.1556-6676.1995.tb01752.x

Pott, T. (2018). *How Highly Effective Psychotherapy Supervisors Supervise: A Longitudinal Study of Supervisees' Experiences.* [Doctoral dissertation, University of Alberta]. Education & Research Archive. https://era.library.ualberta.ca/items/b6ba95cd-e245-4f23-b644-d24134c36edd

Ratanashevorn, R., Kim, S. R., Kashubeck-West, S., & Ojanen, T. T. (2024). Cultural humility, counseling alliance, and counseling outcome among LGBTQ+ clients. *Journal of Counseling & Development, 102*(3), 253-263. https://doi.org/10.1002/jcad.12510

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*(1), 28-48. https://doi.org/10.1002/jmcd.12035

Reeves, K., Sarah, J., Christopher, B., Kyle, S., Shannon, C., & Lindsay, T. (2023). Provider cultural competence and humility in healthcare interactions with transgender and nonbinary young adults. *Journal of Nursing Scholarship, 56*, 18–30. https://doi.org/10.1111/jnu.12903

Robinson, B. A. (2022). Non-binary embodiment, queer knowledge production, and disrupting the cisnormative field: Notes from a trans ethnographer. *Journal of Men's Studies, 30*(3), 425-445. https://doi.org/10.1177/10608265221108204

Rogers, M. M. (2021). Exploring the domestic abuse narratives of trans and nonbinary people and the role of cisgenderism in identity abuse, misgendering, and pathologizing. *Violence Against Women, 27*(12-13), 2187–2207. https://doi.org/10.1177/1077801220971368

Royal College of General Practitioners, Northern Ireland. (2015a). *Guidelines for the care of lesbian, gay and bisexual patients in primary care.* Belfast, Ireland, UK: Author.

Royal College of General Practitioners, Northern Ireland. (2015b). *Guidelines for the care of trans* patients in primary care*. Belfast, Ireland, UK: Author.

Rubinsky, V., & Cooke-Jackson, A. (2021). "It'd be nice to know I'm allowed to exist": Designing ideal familial adolescent messages for LGBTQ women's sexual health.

American Journal of Sexuality Education, 16(2), 221–237. https://doi.org/10.1080/15546128.2021.1880346%20

Rudolph, J. (1990). Counselors‟ attitudes toward homosexuality: Some tentative findings. *Psychological Reports, 66*(3): 1352-1354. https://doi.org/10.2466/pr0.66.4.1352-1354

Ruud, M. (2018). Cultural humility in the care of individuals who are lesbian, gay, bisexual, transgender, or queer. *Nursing for Women's Health*, *22*(3), 255-263. https://doi.org/10.1016/j.nwh.2018.03.009

Safe Zone Project, (n.d.). *Privilege for Sale.* https://thesafezoneproject.com/activities/privilege-for-sale/

Salim, S. R., McCornell, A. A., & Messman-Moore, T. L. (2020). Bisexual women's experiences of stigma and verbal sexual coercion: The roles of internalized heterosexism and outness. *Psychology of Women Quarterly*, *44*(3), 362–376. https://doi.org/10.1177/0361684320917391

Sánchez, N.F., Callahan, E., Brewster, C., Poll-Hunter, N., & Sanchez, J.P. (2019). The future LGBT health professional: perspectives on career and personal mentorship. *LGBT Health*, *5*(3), 212-220. https://doi.org/10.1089/lgbt.2017.0134

Sarkin, C. A. (2019). Queering healthcare: Why integrating cultural humility into medical education matters for LGBTQ+ patients. *Journal of Critical Thought and Praxis, 8*(2), 1-14. https://doi.org/10.31274/jctp.8207

Sawaya, A. T., & McCarty, M. (2023). The impact of a brief humanizing intervention on prejudice towards transgender individuals. *Graduate Student Journal of Psychology*, *20*, 127-152. https://doi.org/10.52214/gsjp.v20i1.10781

Sawyer, J. M., & Brady, S. R. (2021). Beyond cultural competence: A methodology for teaching effective practice across difference. *Journal of Teaching in Social Work, 41*(4), 342-359. https://doi.org/10.1080/08841233.2021.1959491

Scandurra, C., Mezza, F., Maldonato, N. M., Bottone, M., Bochicchio, V., Valerio, P., & Vitelli, R. (2019). Health of nonbinary and genderqueer people: A systematic review. *Frontiers in Psychology*, *10*, 1453. http://dx.doi.org/10.3389/fpsyg.2019.01453

Sedgwick, E. K. (1990). *Epistemology of the closet*. Berkeley: University of California Press.

Shelton, K., & Delgado-Romero, E. A. (2013). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Psychology of Sexual Orientation and Gender Diversity, 1*(S), 59-70. https://doi.org/10.1037/2329-0382.1.s.59

Shin, R. Q., Smith, L. C., Vernay, C. N., Welch, J. C., Sharma, R., & Eberhardt, M. (2021). Accessing counseling services where the rainbow doesn't shine: A heterosexism audit study. *Journal of Homosexuality*, *68*(13), 2246-2265. https://doi.org/10.1080/00918369.2020.1734377

Sikolia, D., Biros, D., Mason, M., & Weiser, M. (2013). *Trustworthiness of grounded theory methodology research in information systems.* MWAIS 2013 Proceedings, 16. Retrieved from http://aisel.aisnet.org/mwais2013/16

Singh, A. A., Hwahng, S. J., Chang, S. C., & White, B. (2017). Affirmative counseling with trans/gender-variant people of color. In A. Singh & L. M. Dickey (Eds.), *Affirmative counseling and psychological practice with transgender and gender*

nonconforming clients (Perspectives on sexual orientation and diversity) (p. 41–68). American Psychological Association. https://doi.org/10.1037/14957-003

Singh, A. A., Nassar, S. C., Arredondo, P., & Toporek, R. (2020). The past guides the future: Implementing the Multicultural and Social Justice Counseling Competencies. *Journal of Counseling & Development*, *98*(3), 238-252. https://doi-org.ezproxy.umsl.edu/10.1002/jcad.12319

Skovholt, T., & Jennings, L. (2004). *Master therapists exploring expertise in therapy and counseling.* New York, NY: Pearson Education.

Society for Sexual, Affectional, Intersex, and Gender Expansive Identities (SIAGE). (n.d.). *Resources*. https://saigecounseling.org/resources/

Soulliard, Z. A., Zane, K. L., & Hughes, H. M. (2023). Affirmative stances in training programs toward sexual and gender minority clients: Views from clinical and counseling psychology graduate students. *Journal of Homosexuality*, *70*(2), 542-564. https://doi.org/10.1080/00918369.2021.1993663

Sprik, P., & Gentile, D. (2020). Cultural humility: A way to reduce LGBTQ health disparities at the end of life. *American Journal of Hospice and Palliative Medicine*, *37*(6), 404-408. https://doi.org/10.1177/1049909119880548

Stephens, M. H. (2018). *Re-queering the trans binary: Gender nonconforming individuals' experiences in counseling and therapeutic settings* (Publication No. 10838241) [Doctoral dissertation, Duquesne University]. ProQuest Dissertations & Theses Global.

Stracuzzi, T. I., Mohr, J. J., & Fuertes, J. N. (2011). Gay and bisexual male clients' perceptions of counseling: The role of perceived sexual orientation similarity and

counselor universal-diverse orientation. *Journal of Counseling Psychology*, *58*(3), 299-309. https://doi.org/10.1037/a0023603

Stryker, S., & Aizura, A. (2013). *The transgender studies reader 2*. Routledge.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, *53*(4), 440-448. https://doi.org/10.1037/0003-066x.53.4.440

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, *20*(2), 64-88. https://doi.org/10.1002/j.2161-1912.1992.tb00563.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *Counseling Psychologist*, *10*(2), 45–52. https://doi.org/10.1177/0011000082102008

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Hoboken, NJ: Wiley.

Sue, S., Zane, N., Nagayama Hall, G. C., Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*, *60*, 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of Counseling Psychology*, *63*(1), 98–105. https://doi.org/10.1037/cou0000126

Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: A historical and theoretical overview. *The Counseling Psychologist, 36*(4), 510-524. https://doi.org/10.1177/0011000007309488

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125. https://doi.org/10.1353/hpu.2010.0233

Thomas, M., Balbo, J., Nottingham, K., Forster, L., & Chavan, B. (2020). Student journal club to improve cultural humility with LGBTQ patients. *Journal of Primary Care & Community Health, 11*, 215013272096368. https://doi.org/10.1177/2150132720963686

Thurber, A., & DiAngelo, R. (2018). Microaggressions: Intervening in three acts. *Journal of Ethnic & Cultural Diversity in Social Work, 27*(1), 17–27. https://doi.org/10.1080/15313204.2017.1417941

Tompkins, T. L., Shields, C. N., Hillman, K. M., & White, K. (2015). Reducing stigma toward the transgender community: An evaluation of a humanizing and perspective taking intervention. *Psychology of Sexual Orientation and Gender Diversity*, *2*(1), 34–42. https://doi.org/10.1037/sgd0000088

Trujillo, M. A., Perrin, P. B., Henry, R. S., & Rabinovitch, A. E. (2020). Heterosexism and suicidal ideation: Racial differences in the impact of social support among sexual minority adults. *Crisis, 41*(6), 429-436. https://doi.org/10.1027/0227-5910/a000657

Utamsingh, P. D., Kenya, S., Lebron, C. N., & Carrasquillo, O. (2017). Beyond sensitivity. LGBT healthcare training in U.S. medical schools: A review of the literature. *American Journal of Sexuality Education, 12*(2), 148–169. https://doi.org/10.1080/15546128.2017.1298070

Vanmeter, J. (2019). *The lived experiences of lesbian and gay clients who terminated counseling prematurely* (Publication No. 13901069) [Unpublished Dissertation, Walden University]. PQDT Open. https://www.proquest.com/docview/2287051444?pqorigsite=gscholar&fromopenview=true&sourcetype=Dissertations%20&%20Theses

Velez, B. L., Polihronakis, C. J., Watson, L. B., & Cox, R. Jr. (2019). Heterosexism, racism, and the mental health of sexual minority people of color. *The Counseling Psychologist, 47*(1) 129–159. https://doi.org/10.1177/0011000019828309

Viggiani, P. A., Russell, E., & Kozub, M. (2023). A course sequence as a model to teach cultural humility to MSW students. *Journal of Teaching in Social Work, 43*(3), 353-373. https://doi.org/10.1080/08841233.2023.2221172

Villarreal, L., Charak, R., Schmitz, R. M., Hsieh, C., & Ford, J. D. (2020). The relationship between sexual orientation outness, heterosexism, emotion dysregulation, and alcohol use among lesbian, gay, and bisexual emerging adults. *Journal of Gay and Lesbian Mental Health*, 25(1), 94-115. https://doi.org/10.1080/19359705.2020.1809588

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270-277. https://doi.org/10.1002/wps.20238

Warner, M. (2002). *Publics and counter-publics.* New York, NY: Zone.

Watson, R. J., Allen, A., Pollitt, A. M., & Eaton, L. A. (2019). Risk and protective factors for sexual health outcomes among Black bisexual men in the U.S.: Internalized heterosexism, sexual orientation disclosure, and religiosity. *Archives of Sexual Behavior*, *48*(1), 243–253. https://doi.org/10.1007/s10508-018-1216-5

Watson, D. M., & Super, J. (2020). Selecting a theoretical orientation: A constructivist grounded theory study with counselors-in-training. *The Journal of Counselor Preparation and Supervision, 13*(2). http://dx.doi.org/10.7729/132.1339

Weinberg, G. (1972). *Society and the healthy homosexual*. New York: St. Martin's.

Williams, N. D., Winer, B., Aparicio, E. M., Smith-Bynum, M. A., Boekeloo, B. O., & Fish, J. N. (2022). Professional expectations of provider LGBTQ competence: Where we are and where we need to go. *Journal of Gay & Lesbian Mental Health, 28*(2), 1-26. https://doi.org/10.1080/19359705.2022.2146825

Wilson, T. D. (2009). Know thyself. *Perspectives on Psychological Science*, *4*(4), 384-389. https://doi.org/10.1111/j.1745-6924.2009.01143.x

Wolfe, A. (2023). Incongruous identities: Mental distress and burnout disparities in LGBTQ+ health care professional populations. *Heliyon, 9*(4), e14835. https://doi.org/10.1016/j.heliyon.2023.e14835

Worell, J., & Remer, P. (2003). *Feminist perspectives in therapy: Empowering diverse women* (second ed.). New York: Wiley.

Wozolek, B. (2019). Implications of queer theory for qualitative. In G. Noblit (Ed.), *The Oxford Research Encyclopedia of Education.* New York: Oxford University Press. https://doi.org/10.1093/acrefore/9780190264093.013.735

Wynn, R., & West-Olatunji, C. (2009). Use of culture-centered counseling theory with ethnically diverse LGBT clients. *Journal of LGBT Issues in Counseling, 3*(3–4), 198–214. https://doi.org/10.1080/15538600903317218

Yu, H., Flores, D. D., Bonett, S., & Bauermeister, J. A. (2023). LGBTQ + cultural competency training for health professionals: a systematic review. *BMC Medical Education*, *23,* 558. https://doi.org/10.1186/s12909-023-04373-3

Zhu, P., Isawi, D. T., & Luke, M. (2022). A discourse analysis of cultural humility within counseling dyads. *Journal of Counseling & Development*, 1-13. https://doi.org/10.1002/jcad.12457

Zhu, P., Luke, M., & Bellini, J. (2021). A grounded theory analysis of cultural humility in counseling and counselor education. *Counselor Education & Supervision*, *60*(1), 73-89. https://doi.org/10.1002/ceas.12197

Zhu, P., Luke, M. M., Liu, Y., & Wang, Q. (2023). Cultural humility and cultural competence in counseling: An exploratory mixed methods investigation. *Journal of Counseling & Development, 101*(3), 1–13. https://doi.org/10.1002/jcad.12469

Appendix A

Peer Nomination Criteria

(a) this person is considered an “expert therapist” working with LGBTIQ+ clients.

(b) this person is most frequently thought of when referring a close family member or a dear friend who identifies as LGBTIQ+ because the person is considered exceptional.

(c) one would have full confidence in seeing this therapist for one's own personal therapy (in case you’re an LGBTIQ+ person) or if one were an LGBTIQ+ person (in case you’re not an LGBTIQ+ person).

(d) this person is still an active practitioner.

Appendix B

Participant Eligibility Criteria

(a) have an active practice license and/or certificate in one's mental health profession

(b) have training in LGBTIQ+ competence training

(c) is an active practitioner (currently see 2 or more LGBTIQ+ clients)

(d) have successfully integrated the LGBTIQ+ cultural competence and cultural humility in their own framework and practice.

Appendix C

Nomination Form

You are invited to participate in a research study titled "The integration of cultural humility and cultural competence in LGBTIQ+ client work" conducted by Gon Ratanashevorn, with IRB approval from University of Missouri, St. Louis (#2097697).

The purpose of this research is to explore the process of the cultivation, integration and application of LGBTIQ+ cultural competence and cultural humility in working with LGBTIQ+ clients. The researcher will reach out to the nominees of this nomination and invite them to join an in-depth interview about their professional experiences in working with LGBTIQ+ clients.

Please READ carefully!

Please nominate counselors/therapists whom you perceive as or know to work with LGBTIQ+ clients competently according to these criteria:

(a) this person is considered an “expert therapist” in working with LGBTIQ+ clients.

(b) this person is most frequently thought of when referring a close family member or a dear friend who identifies oneself/themselves as LGBTIQ+ because the person is considered exceptional.

(c) one would have full confidence in seeing this therapist for one's own personal therapy (in case of LGBTIQ+ therapist) or if one were an LGBTIQ+ person (in case of non-LGBTIQ+ therapist).

(d) this person is still an active practitioner.

The diversity of nominations in terms of location and area (local, national, urban, suburb, or rural area) is appreciated as the goal is to represent diversity and inclusivity. Also, your nomination does not have to be someone you know personally.

Please fill in the following information and leave the blank(s) empty for the information that you do not know.

Nomination for a competent counselor/therapist with **LGBQIA+ or sexually/affectional** diverse clients

Name _____

Region/State/City _____

Contact (optional) _____

You nominated this counselor/therapist as a... (choose all that applies)

o Peer

o Client/patient

o Supervisor

o Supervisee

o Educator

o Student

o Other (Please specify) _____

Nomination for a competent counselor/therapist with **trans and gender-expansive** diverse clients

Name _____

Region/State/City _____

Contact (optional) _____

You nominated this counselor/therapist as a... (choose all that applies)

o Peer

o Client/patient

o Supervisor

o Supervisee

o Educator

o Student

o Other (Please specify) _____

Appendix D

Demographic/Screening Questionnaire

Age _____

Sexual orientation

- o Gay
- o Lesbian
- o Bisexual
- o Pansexual
- o Intersex
- o Asexual
- o Queer
- o Questioning
- o Prefer not to answer
- o Other (Please specify) _____

Gender

- o Cisgender man
- o Cisgender woman
- o Transgender man
- o Transgender woman
- o Nonbinary
- o Genderfluid
- o Genderqueer

o Prefer not to answer

o Other (Please specify) _____

Ethnicity/Race

o American Indian or Alaskan Native

o Asian / Pacific Islander

o Black or African American

o Hispanic

o White / Caucasian

o Prefer not to answer

o Other (Please specify) _____

Religion _____

Years of Practice _____

Who are the population that you predominantly work with over the past 5 years? (Please select all the applies)

o Cisgender man

o Cisgender woman

o Transgender man

o Transgender woman

o Nonbinary

o Genderfluid

o Genderqueer

o Gay

o Lesbian

o Bisexual

o Pansexual

o Intersex

o Asexual

o Queer

o Questioning

o Other (Please specify) _____

Professional affiliation _____

Degree _____

Professional credentials _____

Theoretical approach _____

Area of practice _____

The approximate number of trainings related to LGBTIQ+ population_____

What kind of content were covered in these trainings that you attended (list as many as possible)? _____

What is your definition of LGBTIQ+ cultural competence?

_____

What is your definition of cultural humility?

_____

The email that you're comfortable and convenient to be reached out to schedule an interview.

_____

Appendix E

Interview Protocol

1. What components are most important in your work with LGBTIQ+ clients?
    a. Ask about LGBTIQ+ cultural competence and cultural humility, if not mentioned
    b. Ask about their opinion on terminologies between LGBTIQ+ cultural competence and cultural humility (drop)
2. How did you cultivate those components to best benefit your work with LGBTIQ+ clients?
    a. Ask about examples, or moments that reflect the cultivation of LGBTIQ+ cultural competence and cultural humility, if not mentioned
    b. Link from personal to professional?
    c. How was it like when you started?
    d. What change have you seen/observed over time?
3. How did you integrate those components to best benefit your work with LGBTIQ+ clients?
    a. Ask about examples, or moments that reflect the integration of and between LGBTIQ+ cultural competence and cultural humility, if not mentioned
4. How do you apply those components to best benefit your work with LGBTIQ+ clients?
    a. Ask about examples, or moments that reflect the application of LGBTIQ+ cultural competence and cultural humility, if not mentioned

5. What are the signs, indicator, or feedback from the clients that tell you that you're doing the right kind of work for your LGBTIQ+ clients?
6. If there were a recipe for making an LGBTIQ+ expert therapists, what ingredients would you include?
    a. What components are still lacking/missing in our field / training regarding work with LGBTIQ+ clients?
7. Are there any other things that you think are relevant to the topic or this conversation that we have not covered?
8. What opinion, feedback, or comments that you have for the researcher of this study, the study itself, or the consumers of this study?

Appendix F

Informed Consent

Informed Consent for Participation in Research Activities

The integration of cultural humility and cultural competence in LGBTIQ+ client work

Participant _____ Approval Number _____

Principal Investigator _____ PI's Phone Number _____

1. You are invited to participate in a research study conducted by Gon Ratanashevorn under supervision of Dr. Susan Kashubeck-West. The purpose of this research is to explore the process of the cultivation, integration and application of LGBTIQ+ cultural competence and cultural humility in working with LGBTIQ+ clients.

2. a) Your participation will involve:

- Completion of a brief screening questionnaire that asks your demographic information and about your experience in working with LGBTIQ+ clients
- At least one video-recorded interview lasting 45-90 minutes
- You'll be given the opportunity to review your interview transcript and the themes identified by the researcher
- Optional additional video-recorded interviews

The maximum of 12 participants will be involved in this research.

b) The amount of time required for your participation will be about 45-90 minutes. This will include participation in an initial interview and review of your initial interview transcription to assess its accuracy. If you participate in this project, you will receive a $50 gift card that will be emailed to you.

3. There are no known risks associated with this research other than the potential for mild boredom or fatigue. Once your interview is transcribed, the recording will be deleted.

4. There are no direct benefits for you participating in this study. However, your participation may contribute to knowledge about the process of the cultivation, integration, and application of LGBTIQ+ cultural competence and cultural humility working with LGBTIQ+ clients.

5. Your participation is voluntary, and you may choose not to participate in this research study or to withdraw your consent at any time. If you want to withdraw from the study, you can contact me at: 314-665-6935. You may choose not to answer any questions that you do not want to answer. You will NOT be penalized in any way should you choose not to participate or to withdraw from this study.

6. By agreeing to participate, you understand and agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, your identity will not be revealed. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for

Human Research Protection) that would lead to disclosure of your data as well as any other information collected by the researcher. That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored in a password-protected folder in a password-protected computer and/or in a locked office.

7. If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Gon Ratanashevorn 314-665-6935 or the Faculty Advisor, Dr. Susan Kashubeck-West, at 314-330-0666. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research Administration, at 314-516-5897 or irb@umsl.edu.

I consent my participation by clicking the Continue button below.

Appendix G

Social Media Nomination Invite and Poster

Hi everyone,

I'm conducting research for my dissertation (University of Missouri, St. Louis) under the topic of LGBTIQ+ cultural competence and cultural humility in the counseling field. And I would like to ask for your help in nominating counselors/therapists that you consider as competent, skillful or effective. Please follow the link below to nominate them. Feel free to share the link/poster. Thank you so much!

Link: XXXXXXX

Appendix H

Participant Invite Email

Hi XXXX,

You are invited to participate in a research study titled "The integration of cultural humility and cultural competence in LGBTIQ+ client work" conducted by Gon Ratanashevorn, with IRB approval from University of Missouri, St. Louis (#2097697).

You are reached out to because you were nominated by Ashley Stack as a counselor/therapist who works competently with LGBTIQ+ people, as a part of peer-nomination process in this study.

The purpose of this research is to explore the process of the cultivation, integration, and application of LGBTIQ+ cultural competence and cultural humility in working with LGBTIQ+ clients.

The eligibility criteria for this study includes:

(a) have an active practice license and/or certificate (for example, LPC, and LMHC) in one's mental health profession

(b) have training in LGBTIQ+ competency training

(c) is an active practitioner (currently meeting at least 2 LGBTIQ+ clients)

(d) have successfully integrated the LGBTIQ+ cultural competency and cultural humility in their own framework and practice

Your participation involves:

(a) Completion of a brief screening questionnaire that asks your demographic information and about your experiences in working with LGBTIQ+ clients

(b) At least one video-recorded interview lasting 45-90 minutes

(c) You'll be given the opportunity to review your interview transcript and the themes identified by the researcher

(d) Optional additional video-recorded interviews

For your time and effort, the compensation in the amount of $50 gift card will be provided after the interview.

If you fit with the criteria and are interested in participating in this study, please follow the link (xxxxxxxxxxxx) for the consent form, and demographic survey. I will reach out to you with a link to set up for an interview appointment after you complete the forms. Your time and interest are highly appreciated!

Best regards,

Gon Ratanashevorn

Principal Investigator

Appendix I

Participant's Demographic and Screening Information

Theoretical Approach	- I used a relational, culturally & trauma informed way of providing gender affirming care. I have also been trained in Seeking Safety, TFCBT, ART, DBT, and some IFS theory that I like to incorporate eclectically based on client need at an individual basis. - I primarily work from a person-centered theoretical lens with integration of resilience-centered counseling, narrative therapy, queer theory, and relational-cultural theory. - Person-centered, feminist, and queer theories make up the foundation of my approach. - Person-centered I tailor treatment to meet my client's needs. I use a lot of strength-based practices and integrate various approaches as needed. - My theoretical orientation incorporates person-centered, relational cultural theory, narrative, feminist, gestalt, and body-focused techniques within a framework of social constructivism, intersectional liberation, family systems, and attachment theory. I find it impossible to work with families and individuals without examining the effects of social constructs as well as the pervasiveness of multi-level discrimination, oppression, and privilege within our society.

	Through this socially conscious, standpoint, liberation lens, I hope to collaborate with clients in identifying and targeting socially-influenced maladaptive beliefs, enhancing unique client strengths and holistic wellness, and facilitating client empowerment and actualization. - Systems, harm reduction, strengths-based, social justice, trauma informed, CPT, CBT, MI, feminist, de-colonizing - Existential feminist - Person centered, EFT , MI - Eclectic, person centered, strengths based, culturally inclusive, social justice minded, systemic lens, and LGBTQ+ Affirming - Multicutural and anti-oppressive - Person-centered, decarceral, strengths-based. I focus on how systems of oppression impact clients and seek to empower them to make the changes they want to make in their lives to improve their wellbeing. - Person-centered, Adler, Relational-cultural, trauma-informed
Area of Practice	- Relationships, LGBTQIA+, transgender, neurodiverse, polyamorous, kink allied, sex worker allied, PTSD - I specialize in serving queer+ and transgender clients in rural communities.

	- LGBTQ+ clients with clinical mental health concerns and issues related to being in the LGBTQ+ community. Work in a group practice. - Mental Health - LGBTGEQ+ client populations - Specialize in LGBTQ issues, LGBTQ Educator - sexuality (sex work, sexual functioning); gender transition; poly and CNM couples - Individual & Relationship Counseling - Seeing clients with Mood disorders, Attachment trauma, Gender Expansive Care, Neurodivergence, Low self esteem concerns, Borderline Personality Disorder, Anxiety Disorders, and Trauma Related Disorders - CPTSD, Transitioning and Mood D/O - community outpatient clinic - anxiety, depression, transition, ptsd, immigrants, lgbtqia
The approximate number of trainings related to LGBTIQ+ population	- 8 - Over 50 (50 is the number of CE credit certificates just from SAIGE that I can track down at the moment, but I know I've done more at other conferences as well), - Unsure; I have given and attended a multitude of trainings each year - 10

	- particpated in hundreds, have offered approximately 80 presentations/trainings at national, regional, state, and local level - A lot (45+ hours) - 45-50 over the last ten years - 10+ - N/A - over 20 - 5 - 2
Content of Trainings	- Adolescent suicide warning signs, statistics, and method of intervention. Parental interventions to promote queer adolescent health. Queer informed interventions related to trauma and intimate partner violence. Policy and social justice related training. - Content of these CEs included utilizing the WPATH standards of care, letter writing for trans clients, legislative advocacy, intersectionality and multicultural LGBTQIA+ idenities, navigating LGBTQIA+ identities in school settings, queer and trans liberation, LGBTQIA+ competencies in supervision, IPV considerations for LGBTQIA+ people, access to care, integration of LGBTQIA+ competencies across master's curricula, working

	with family members of LGBTQIA+ people, group counseling with LGBTQIA+ people, suicide assessment and considerations for LGBTQIA+ people, social class and queer identities, body image and sexual orientation, addiction in the LGBTQIA+ community, and the "Rainbow Counselors" and "Beyond the Binary" competence primer CEs offered by SAIGE. I know there are a lot more that I'm missing, these are just the most recent trainings. I have also taught several trainings on competence working with LGBTQIA+ clients in rural counseling settings and LGBTQIA+ advocacy for counselors. - Gender affirming care, sexuality, supervision with LGBTQ+ supervisees, LGBTQ+ 101, LGBTQ+ adolescents and adults, current legislation affecting LGBTQ+ individuals, consensual non-monogamy. - Suicide prevention, coping, not accepting family, dysphoria, dx, letter writing - LGBTQ+ affirming care intersectionally diverse LGBTGEQ+ populatons Liberatory research practices LGBTGEQ+ supervision Liberatory pedagogical approaches LGBTGEQ+ experiences in family systems Advocacy trauma-focused approach to work with youth and adults Queer relationship structures Kink-aware and affirming

	practices Disability justice framework and sexuality and gender Broaching - Transitioning (general) Gender expression LGBTQ Aging LGBTQ Health Disparities Trauma Neurodivergence Medical transitions and impact BIPOC intersectionality Queer Indigenous care addiction intuitive eating and eating disorders consensual non-monogomy Ace spectrum veterans supervising queer counselors gender affirming care letter writing codependency in the queer community trans bodies and sex lgbtq trauma HIV and PrEP Coming out health disparities in lesbian and bisexual women - trauma in LGBGTQ+ communities intersectionality LGBGTQ+ in sex work working with gender diverse youth - How to write letters, proper use of pronouns, how relationships of gender diverse may differ - General 101 trainings, letter writing for gender affirming care, unintentional harm, SUD amongst LGBTQ+ population, How to work with Queer youth, working with LGBTQ+ Adults. - Sensitivity, letter writing, modality modifications - gender affirming care, appropriate terminology, barriers to care

	- Queering Your Practice: Exploring & Expanding Queerness Philosophy & Principles of Peer Counseling Queering Sex & Relationships Expanding Power Awareness Abolition & Transformative Justice in Practice Queering Ethics
Definition of LGBTIQ+CC	- I don't believe in competency as much anymore. I think we are always striving to be competent with one another, but it is not an achievable outcome because it takes far too much knowledge and experience to be competent in any one person's experience; as soon as we gain that the finish line moves and we are left continuing to learn and therefore never truly become competent in what is present. - The integration of knowledge and skills to work with LGBTQIA+ clients, reflection of personal beliefs and values regarding LGBTQIA+ identities, and awareness of ways that each of these parts can impact the counseling relationship when working with LGBTQIA+ clients. - I don't believe cultural competency in any area is possible; I believe in cultural humility. In the case of LGBTQ+ people, being culturally humble includes understanding best practices of care and the challenges associated with current legislation, understanding terminology and stats regarding LGBTQ+ people, and being able to connect with clients in a way that allows the client to feel safe to be who they are.

	- Understanding clients in the queer community are a minority and what comes along with it. This can include oppression, discrimination, abandonment and so much more. Working with our community also means taking additional trainings to understand it, whether you are a part of it or an ally. - A commitment to an ever-growing awareness and process of learning to holistically support intersectionally-diverse LGBTGEQ+ clients, populations, and communities. Understanding that the community and terminology within will shift and change with time, and we must remain engaged with relevant materials. A commitment to intersectional liberation and advocacy. Never believing we are the experts on our clients, but instead trusting client expertise on themselves. Focus on needs and concerns, but also deep resiliency. - Cultural competency implies you can become "competent" or "arrive" at mastering a culture/topic. I think there is very basic knowledge that everyone should know about the LGBTQ+ communities, but many do not. Some might define that basic knowledge as at least a little competency. It's a complicated question. I think the intent behind cultural competency is generally good, but it falls short of the big picture.

	- i don't like the term "cultural competency," as I don't believe that people can be competent in someone else's cultural, even if we use the same labels to identify each other. - Understanding the history, values, risks, & beliefs of the group while understanding that my beliefs & values may differ. - Acknowledging and fully understanding (even experiencing) the day to day experiences that population could be faced with; being able to both affirm their individuality while also understanding group identity and provisioning care in a way that balances these 2 areas while realizing that societal implications are often not in the favor of those who identify as QT. - LGBTIQ+ cultural competency involves an acknowledgement and understanding of the nuanced elements of queer culture that can impact a client's presentation and functioning in a variety of spheres including interpersonal, intrapersonal, academic, occupational, social, etc. - can answer this more in depth at time of interview
Definition of Cultural Humility	- Humility is a better term to describe the journey to becoming more aware of the adversity and oppression a community faces within a specific culture. I think it can also include

	positive cultural events and ideas, but is usually focused around the social justice issues and struggles that lie within the community and is a way to respect those pieces. In respecting the culture, you are less likely to cause harm and more likely to provide more inclusive and acceptable care to help promote growth and healing. - Cultural humility is an ongoing process of self-reflection and assessment of personal experiences, values, beliefs, and biases and how these impact ongoing relationships with others (clients, supervisees, students, etc.). This process acknowledges that each person comes into the relationship with their own experiences and worldviews that may differ from each other, and that neither is inherently "right" or "better." - Cultural humility is the concept that counselors must be culturally sensitive and aware when interacting with every client they see. It is the idea that we are humble enough to avoid making assumptions and stereotyping. However, it is also the understanding that we can never truly be "competent" with multiculturalism of any type, because there is an infinite combination of intersections that occur within our clients.

	- For me, cultural humility involves acknowledging other cultures are just as important as yours while also being open to learn about other cultures from a client's perspective. - An approach of openness, genuine care and curiosity to learn with and from clients of marginalized communities. Dedication to continuing learning across career and to engage from collaborative power-sharing position (never power-over). - Cultural humility is an ongoing journey of learning, not a place to arrive. It is remembering that we are not the expert on someone else's experience. We must acknowledge and be accountable for our faults or having the wrong information, and continue to be curious. White supremacy is engrained in us, to be perfect and to have the right to comfort always. It's important to get uncomfortable, to stay in it and actual feel the discomfort. It's learning ways you have caused harm, owning it, apologizing, and making meaningful changes. Ongoing. Forever. - The ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to the aspects of cultural identity that are most important [to the person] (McElroy-Heltzel, Davis, DeBlaere, Worthington & Hook, 2019). The help giver as “expert” shifts to “learner” with the

	important emphasis of the help seekers' active participation and expertise in their own healing (Dunley-Matos, 2014). - Being able & willing to acknowledge & admit when you don't know something about a particular culture. - Having a reflexive approach to engaging in continual learnings about a background of any kind to better serve the person and their needs- minimally being able to provide support in authentic form. - Cultural humility is the position whereby one is open to growth and does not assume they know what a person's experience looks like as everyone's cultural and social location impacts their life experience differently. - Can answer this more in depth at time of interview