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Development and Evaluation of a Brief LGBT Competence Training
for Counselors and Clinical Psychologists: A pilot applied study

Abstract

The present study aimed to develop and test a brief training program on LGB competencies for counselors and clinical psychologists (N=20). Pre- and post-training assessment of LGBT competencies were conducted through a written case vignette, and in addition a focus group at 2-months follow up of training was conducted. Results revealed that (1) quantitative and qualitative changes occurred in the ability of participants in responding to a case between pre- and post-training and that (2) reported changes included impacts on personal and social lives of the clinicians at follow-up, beyond clinical practice. However, subtle pathologization was also found and increased needs for supervision on LGB-related issues.

Keywords: LGB; diversity; competence training; professional development

Development and Evaluation of a Brief LGBT Competence Training for Counselors and Clinical Psychologists: A pilot applied study

Introduction

In recent years, there have been a number of positive changes regarding equality and formal rights of lesbians, gays, bisexual and transgender (LGBT) people in several countries around the world (e.g. USA, UK, Spain, Portugal, Argentina). However, despite the progression, homophobia and heterosexism are still prevalent in society. For instance, even in countries considered to be socially affirming, there are still many issues with regard to the LGBT population. According to the *European Union Agency for Fundamental Rights* (FRA, 2009), LGBT persons across Europe experience discrimination in various institutional settings - including health and education.

Several studies (e.g. Cochran & Mays, 2000; Cochran, Sullivan & Mays, 2003; Dean, *et al.*, 2000; Meyer, 2003) strongly suggest that experiences of discrimination and stigmatization place LGBT people at higher risk for problems related to psychological well-being. Furthermore, there is evidence that LGBT persons resort to psychotherapy at higher rates than the non-LGBT population (Bieschke, McCanahan, Tozer *et al.*, 2000; King, Semleyn, Killasy *et al.*, 2007). Therefore, LGBT clients may be exposed to higher risk for harmful or ineffective therapies, not only as a vulnerable group, but also as frequent users. At the same time, they have an enhanced need to have psychotherapists that are efficient and competent in terms of individual and cultural diversity (Brown, 2006).

Counseling and psychotherapy with LGBT clients

In 1973, the American Psychiatric Association removed homosexual behavior from its third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. In addition, until 1990, lesbians and gays were considered mentally ill by the World Health

Organization. This recent past of pathologization contrasts with the mental health field's current concerns, oriented to the promotion of the well-being among non-heterosexual and transgender people. This is established, for instance, by the amount of literature on gay and lesbian affirmative psychotherapy which has been developed in recent decades (e.g. Davis, 1997) and, also, by the fact that major accrediting bodies in counseling and psychotherapy have identified the need for clinicians to be able to work effectively with minority clients, namely LGBT people. The American Psychological Association's guidelines for psychotherapy with lesbian, gay, and bisexual client (APA, 2000, 2012) are a main reference. These ethical guidelines highlight, among several issues, the need for clinicians to recognize that their own attitudes and knowledge about the experiences of LGB people are relevant to the therapeutic process with these clients and that, therefore, care providers must look for appropriate literature, training and supervision.

There is evidence that the number of clinicians using an affirmative approach is increasing (Bieschke *et al*, 2000; Hayes & Erkis, 2000; Kilgore, Sideman, Bohanske *et al*, 2005), and some studies support the idea that more and more mental health practitioners do not reveal homophobic positions (Phillips & Fischer, 1998). Furthermore, for example, they are increasingly supportive of bisexuality (Bowers & Bieschke, 2005) and lesbian and gay parenting (Crawford, McLeod, Zamboni *et al*, 1999). However, empirical research also reveals that some therapists pursue less appropriate clinical practices with LGBT clients. In a review of empirical research on the provision of counseling and psychotherapy to LGB clients, Bieschke, Paul and Blasko (2006) encountered an unexpected recent explosion of literature focused on "conversion therapy". There are, in fact, some mental health professionals that still attempt to help lesbian, gay and bisexual clients to *become* heterosexual (Bartlett, Smith & King, 2009), despite the fact that a recent systematic review of the peer-reviewed journal literature on sexual orientation change efforts concluded that

“efforts to change sexual orientation are unlikely to be successful and involve some risk of harm” (p.1; APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Moreover, there is evidence of other forms of inappropriate (while less blatant) clinical practices with LGBT clients (e.g. Garnets, Hancock, Cochran *et al*, 1991; Hayes & Erkis, 2000; Jordan & Deluty, 1995; Liddle, 1996). Even those clinicians who intend to be affirmative and supportive of LGBT individuals can reveal subtle heterosexist bias in the work with these clients (Pachankis & Goldfried, 2004). Examples of such micro-aggressions might be automatically assuming that a client is heterosexual, trying to explain the aetiology of the client’s homosexuality, or focusing on the sexual orientation of a LGB client despite the fact that this is not an issue at hand. Heterosexual bias in counselling and psychotherapy may manifest itself also in what Brown (2006) calls “sexual orientation blindness” (p. 350); the therapist struggles for a supposed neutrality and dismisses the specificities related to the minority condition of non-heterosexual clients. This conceptualization of the human experience mostly in heterosexual terms, found in the therapeutic setting, does not seem to be independent of psychotherapist’s basic training and the historical heterosexist in the teaching of psychology (Alderson, 2004; Simoni, 1996).

Competence to work effectively with LGBT clients

Several studies had been researching which variables may improve counseling and psychotherapy practices with LGBT clients. Variables such as the clinician’s gender (e.g. Bowers & Bieschke, 2005; Kilgore *et al*, 2005), sexual orientation (e.g. Liddle, 1996; Jones & Gabriel, 1999), religious beliefs (e.g. Liszcz & Yarhouse, 2005), or level of homophobia (e.g. Jordan & Deluty, 1995; Barrett & McWhirter, 2002; Twist, Murphy, Green *et al*, 2006) have been identified as important factors that affect diverse aspects of the therapy with non-heterosexual and transgender clients. Despite the importance of these studies, others (e.g. Israel & Selvidge, 2003; Hunt, Matthews, Milsom, *et al*, 2006; Israel, Gorcheva, Walther *et*

al, 2008) have identified and analysed a broader and changeable variable: the competence to work effectively with LGBT clients. Moreover, there is evidence that therapist competence is more important than other factors, such as his or her sexual orientation, according the preferences of non-heterosexual clients (Saulnier, 2002).

Israel and Selvidge (2003) took advantage of the foundations and expertise of multicultural counselling (e.g. Sue, Arredondo & McDavis, 1992) in order to conceptualize therapist competence with LGB clients, building a broader vision of counselor individual and cultural diversity competences. Similarly to multicultural competence, this model defends that a therapist competent in working with LGB clients should have appropriate knowledge, attitudes and skills. Firstly, the knowledge component of multicultural competence is intended to bring the therapists up to date on unfamiliar cultures or groups. In the case of LGB competence, these researchers suggest that mental health practitioners should be knowledgeable on issues like socio-political history, biases in assessment and mental health services, diversity within groups, identity development, coming out process, parenting and family structures, family of origin concerns, among others. Secondly, multicultural counseling literature emphasizes the importance of therapists exploring their own stereotypes and prejudices about minority populations. Similarly, Israel and Selvidge (2003) propose that clinicians can develop an awareness of their reactions to LGB clients (attitudes and values, homophobia, stereotypes). Thirdly, these authors exemplify some of the skills that a LGB competent psychotherapist can demonstrate: to recognize when sexual orientation should be, or not, the focus of clinical attention; to tailor his or her interventions to the client's sexual identity development; to educate his or her clients about internalized homophobia; being familiar with sources of social support within the LGB community; to advocate for LGB clients by disseminating accurate information through research and outreach; among others. In order to improve LGB clinical competence in its various dimensions, Israel and Selvidge

(2003) recommend adequate training for mental health practitioners, as did several other authors (e.g. Garnets *et al*, 1991; Liddle, 1996; Crawford *et al*, 1999; Barret & McWhirter, 2002; Bowers & Bieschke, 2005; Kilgore *et al*, 2005; Twist *et al*, 2006; Bieschke *et al*, 2007; Israel *et al*, 2008). Further, it has been recognized that there are a number of specific questions regarding the competence to work effectively with transgender clients in particular (Carrol, Gilroy & Ryan, 2002; Israel, 2005; Bess & Stabb, 2009; Israel *et al*, 2008).

Development of LGBT competence

Despite the amount of literature on multicultural counseling, there is a lack of consensus regarding the types of training considered to be most effective. This is even truer in the case of LGBT competence. Nevertheless, the “debate in the counseling literature is no longer *whether* to include training on LGB[T] issues but *how*” (Pearson, 2003, p.293). It is generally accepted that the most effective way of attending multicultural and LGBT training is to infuse it into the training curriculum (Ponterotto, 1997; Israel & Selvidge, 2003), and some authors (e.g. Buhrke & Douce, 1991) are providing information and resources for doing so. However, a separate course has been the model of choice for most training programs on LGBT competence, even though it has been conceived solely as a first step in a developmental stage-like rout to obtaining cultural sensitivity. Phillips (2000) suggested that a separate course is an ideal context for providing training on LGB competence, as an addition to, not a substitution for, integrating these issues throughout the training curriculum. This seems to be a particularly ideal approach in the case of professionals already in practice.

While recognizing the importance of training on LGBT issues, the specific mechanisms of competence development remain unclear (Israel & Selvidge, 2003). Multicultural training programs generally focus on one of two approaches (Rogers-Sirin, 2008). On the one hand, some programs emphasize experiential learning. These have an underlying assumption that participants learn best when they experience culture and diversity

through either real or simulated experiences. Some examples of experiential learning are role-plays, simulations, self-reflection exercises and process-oriented group discussions. On the other hand, training programs that emphasize didactic learning are based on the assumption that participants cannot effectively engage in cultural experiential learning until they have a cognitive understanding of cultural facts. Examples of didactic/cognitive learning include readings, lectures, guest speakers and videos. In choosing a didactic, experiential, or mixed approach, the specific needs of the professionals should be considered (Rogers-Sirin, 2008). Like multicultural training, LGB(T) training may usually include awareness/attitude change, knowledge acquisition, and skill development (Israel & Selvidge, 2003), thus approaching a mixed application: didactic and experimental. In addition to providing accurate information, it is crucial for training programs to increase trainees' consciousness of LGBT issues in personal and experiential ways, so that clinicians become aware of the impact of heterosexism and homophobia on themselves and their clients (Phillips, 2000).

There is evidence of positive outcomes regarding LGB training (Pearson, 2003; Grove, 2009) and of changes in mental health practitioners' attitudes toward lesbian and gay clients after a workshop (Rudolph, 1989). Even if these issues are addressed for only one session, trainees can have a significant impact on their knowledge levels (Israel & Hackett, 2004). Interesting results have been found regarding the outcomes on the attitude component. For example, comparing information and attitude impact of LGB training, Israel and Hackett (2004) found that participants who experienced the attitude training reported more negative cognitive attitudes afterwards. Grove's study (2009) pointed in the same direction. This may reflect an increased level of awareness in trainees, and a consequent discomfort that challenged the initial positive self-assessment of the attitudes (Israel & Hackett, 2004; Grove, 2009). Therefore, a brief workshop (e.g. 2.5-hour) may be sufficient to acknowledge initial attitudes, but more extensive training may be necessary to encourage positive attitude change

(Israel & Hackett, 2004). The present study aimed to: (1) develop a brief training program to promote LGBT competences among a group of clinical psychologists and (2) evaluate the effectiveness of that brief training. In other words, does a brief training have an impact on self-perceived LGBT competence among clinical psychologists with little to no exposure to LGBT clients or training in this domain?

Method

Sample. Participants were all clinical psychologists with at least a 5-year training degree, focused on clinical psychology, some at a postgraduate level (e.g. additional training on psychotherapy). Of the 20 participants, 19 were female and 1 male, with ages between 24 and 42 years. The group of participants was heterogeneous concerning clinical experience, ranging between 1 and 15 years of clinical practice in different theoretical models of psychotherapeutic intervention (mostly brief psychodynamic, CBT, or humanistic). None of the participants had worked in a LGBT specific context, nor had any previous training in LGBT competences. A few (less than 1/3) had had LGBT clients previously. Therefore, their main motivation was to seek specific training in LGBT competences, to understand LGBT specificities, to learn different approaches and to develop specific working skills.

Instruments. (a) *Case Vignette Pre- and Post-training Assessment:* The participants were given a written case vignette, followed by six questions related to the clinical case (as in Neufeldt, Pinterits, Moleiro, *et al*, 2006) concerning: 1) intervention objectives and strategies; 2) client facilitative characteristics; 3) expected client difficulties; 4) facilitative characteristics of self/clinician; 5) expected difficulties of self/clinician in the therapeutic relationship with that particular client and 6) supervision needs. The case presented a young male client who had just come out to his family and very close friends, and was struggling with the process of adjustment (his own and to his family and friends' reactions). Each open ended question had a space for one to up to three replies, in a bullet-like fashion.

A case vignette was chosen as the primary measure since self-report questionnaires have been demonstrated to have several limitations (D'Andrea, Daniels & Noon, 2003; Ponterotto & Potere, 2003; Hays, 2008), such as the influence of the social desirability in the participants' behavior and the fact that self-report might reflect anticipated rather than actual behaviors and attitudes (Worthington, *et al*, 2000; Constantine & Ladany, 2001; Neufeldt *et al*, 2006). In addition, when awareness is low, self-report may not be at all adequate as a means of evaluation (Moleiro, Marques & Pacheco, 2010), since it implies that the clinician has to be aware of his or her own competencies, strengths and difficulties. Even though self-report methodologies have become the primary method in assessing multicultural competence (Constantine & Ladany, 2001; Neufeldt *et al*, 2006; Hays, 2008), portfolios, case vignettes (written or video-presented) and direct observation have also been used (Pope-Davis, Coleman, Liu *et al*, 2003) and may better capture actual competencies.

(b) Post-training focus group: Using a qualitative methodology, a focus group was conducted with participants of the training, after 2 months of the end of training. While all the participants were invited, only 8 of the initial 20 volunteered to take part in the group. Participants were asked about the impact of training in their clinical practice. The semi-structured protocol for the focus group included the following questions: (1) How did the participation in the training affect your clinical practice, (a) with clients overall, (b) and specifically with LGBT clients? (2) How would they comment or interpret the results from the case vignette provided at the beginning and end of training? Examples of most significant collective responses to the case vignette, both pre- and post-training, were presented and discussed by the group, in order to validate the content analyses of the data and control for researcher bias. The focus group was conducted by the junior trainer and an independent researcher (hence, the senior trainer was not involved in the follow-up assessment to avoid influencing participant's reports).

Training Program. The training program was designed with 2 day-long sessions (each totaling 6 hours), with a two-week interval (for reading and homework reflections). The sessions were subdivided into sections intended to generally address a component of the development of multicultural competencies model of Sue and colleagues (1992): awareness, knowledge and skills.

The first session (mostly referring to awareness and basic knowledge) was based on experiential exercises for self-knowledge and group dynamics. It explored the individuals' awareness of self and others, prejudice and stereotypes associated to cultural and sexual minorities, and how they influence interpersonal relationships. Related with the knowledge component, this session was also composed by the presentation of important concepts in the development of cultural and sexual diversity competencies. A brief overview about psychopathology and well-being of LGBT people was provided, including data about children, adolescents, couples and families. At the end, ethical issues were discussed in a large group format, specifically focusing on a video and “conversion psychotherapies”.

Literature was provided to participants to read during the two-week interval. References mostly followed AFFIRM's (Psychologists Affirming Their Gay, Lesbian, and Bisexual Family (see Goldfried, 2001) recommended bibliography. Participants chose a topic and were asked to read the articles pertaining to that topic to present and discuss in the following session.

The second session, focusing on advanced knowledge and skills, sought to integrate the application of techniques/skills to the clinical practice with LGBT clients. Small groups made summaries of the readings and presented to each other. A video of a psychotherapy session with a lesbian client was viewed and discussed at length. Finally, a practice session took place in small working groups, presenting cases of LGBT clients, where issues of sexual

diversity were addressed and discussed. Participants had the opportunity to reflect on the program and ask questions that arose during the training.

Two trainers were recruited in order to apply the training program - one senior trainer with over 10 years of experience in training in the area of diversity, and a junior trainer who was a PhD student, with a specialty in cultural and sexual diversity.

Procedure. An advertisement of the training was placed on the LGBT community center webpage. The same advertisement was sent out to several mailing lists of clinical psychologists and psychotherapists. A total of 25 applications was received. Five candidates were eliminated because they did not fulfill the legal requirements for clinical practice. All remaining candidates were accepted and received brief information about the training program via email. Before training began, all participants also received information regarding confidentiality and voluntary participation in the research study associated with the training. Informed consent was also guaranteed two-months later, when the focus group was conducted (see APA, 2002).

Data Analysis. Answers to the objective measure were analyzed using qualitative data analysis. The approach utilized a blended model, incorporating features of Grounded Theory Analysis (such as open coding; Glaser & Strauss, 1967) and also Consensual Qualitative Research (Hill, Thompson & Williams, 1997), since it most adequately fit the goals and methodology of the study.

Initial content domains were established based on the open-ended questions of the vignette (objectives, client facilitators, client difficulties, therapist facilitators and therapist difficulties, supervision needs). Another domain was initially agreed upon: unit/category related to LGBT issues vs non-related to LGBT issues. Sub-categories were then created using open coding (Glaser & Strauss, 1967). To remain close to the data, category names used participants' words as much as possible, while similarities and comparisons between

participants' answers allowed for succeeding modifications of categories after each vignette was coded as well as new emergent categories.

A team of three researchers made decisions on the data by consensus, following Hill and colleagues (1997). First, each judge independently coded all the participants' answers in the domains agreed upon before the analysis. A meeting was conducted to initially allow for the computation of reliability. Pairwise agreement among judges resulted in a 89.9% agreement rate. No unit of analysis resulted in a disagreement of all three judges. Consensus on all units of analysis and categorization was achieved through discussion. The senior researcher also served as auditor, who facilitated the discussion when discrepancies arose. Final units of analysis and categories were checked against the raw data (Hill *et al*, 1997).

Finally, the results were later discussed with the participants themselves, during the focus group, which occurred 2 months later, in order to provide further reliability to the analysis conducted by the researchers and control for researcher bias.

Results

Pre- and Post-training Case vignette. A total of 443 content units were analysed as answers to the seven questions to the vignette, in total (pre- and post-training). Of those, 290 (65.5%) content units were specifically related to LGBT issues (e.g. coming out issues), while 153 (34.5%) pertained to general clinical aspects of the case (e.g. symptom reduction).

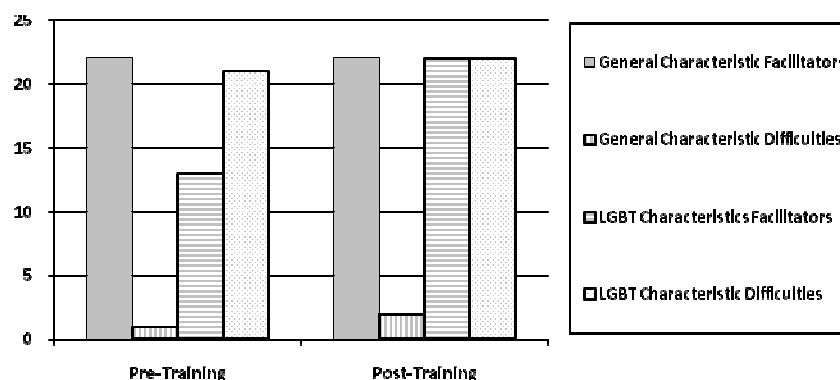
In terms of objectives of the counselling work, at pre-training, 16 (36%) general clinical goals were presented, and 28 (64%) objectives related to LGBT issues were presented. Examples of the former were "*improve self-esteem*" and "*reduce symptoms like anxiety and insomnia*", while the latter were represented by answers such as "*explore the meaning of coming out at this moment*" or "*explore internalized homophobia and guilt*". At post-training, 16 (33%) general clinical therapeutic goals were described (e.g. "*establish a*

trusting therapeutic relationship”) and 33 (67%) LGBT-related goals were identified (e.g. *“support coming out in multiple settings”*).

The categorization of the clinicians’ identified needs for supervision revealed that more units of analysis were reported for LGBT-related themes (36) than for general clinical (6) questions. Before training, 21 aspects were mentioned as questions or needs for supervision. Of these, 4 (19%) were general clinical issues and 17 (81%) were LGBT related. After the training, participants reported 2 (10%) general clinical supervision issue and 19 (90%) LGBT-related questions for his/her supervisor.

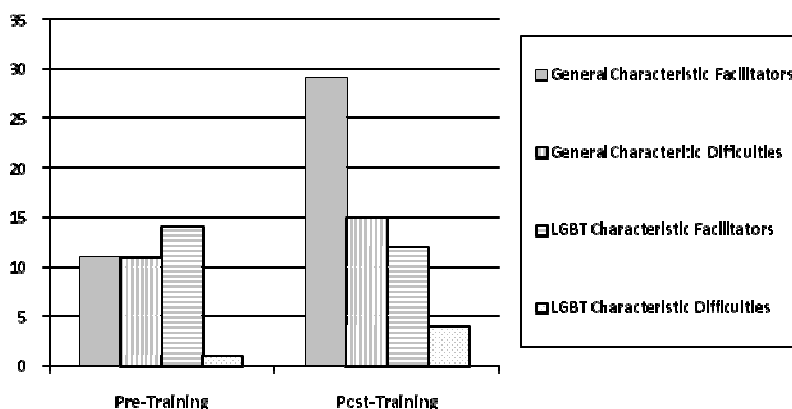
When analysing the facilitative and hindering difficulties that the clinicians identified in the case, three types of comparisons were made: (a) positive vs. negative attributes reported; (b) LGBT vs. non-LGBT related attributes; and (c) pre- and post-training results. Figure 3 captures these results. As the figure demonstrates, before training, 22 (63%) general facilitative characteristics of the client were reported, in comparison to only 13 (37%) LGBT-related facilitative attributes. In contrast, 1 (5%) general difficulty was mentioned and 21 (95%) LGBT-related difficulties. After training, the following results were obtained: 22 (50%) general and 22 (50%) LGBT-related positive attributes were referred; 2 (8%) general and 22 (92%) LGBT-related hindering attributes were reported. An example of a positive general attribute of the client was *“seems to have insight”*, whereas a positive LGBT-related characteristic referred was *“has accepted his sexual orientation”*; in contrast, a negative general feature mentioned was *“lacks social support”* and a LGBT-specific negative attribute was *“appears to have some guilt/internalized homophobia”*.

Figure 1. Number of units of analysis for Characteristics of Miguel (case vignette)



Results of the analysis of the facilitative and hindering difficulties of the clinicians themselves in working with this case led to a lower number of units of analysis (97) than of client characteristics (125). The pattern of results, however, appeared similar. Before training, therapists identified 14 (56%) general facilitative attributes such as “*having clinical experience with young adult clients*”, and 11 (44%) LGBT-related facilitative features such as “*being in LGBT training*”. Expected therapist difficulties were only 1 (8%) in general (e.g. “*having little clinical experience*”) and 11 (92%) LGBT-specific (e.g. “*having little experience with LGBT community*”). After the training, 12 (29%) general facilitators and 29 (71%) LGBT-specific positive attributes (e.g. “*completing training on LGBT issues*”) were reported. In turn, 4 (21%) general clinical difficulties and 15 (79%) LGBT-related therapist difficulties (e.g. “*recognize a lot to learn still on LGBT issues*”) were referred (see Figure 2).

Figure 2. Number of units of analysis for Characteristics of Therapist (in relation to case in vignette)



Focus Group. The focus group aimed to explore the impact of the training after a length of time, as well as validate and discuss the analysis of the results from the case vignette. Impacts of training were found in more ways than the ones expected. On the one hand, impacts were found at the level of awareness, knowledge and skills, which were specifically addressed in training. Examples of the discourse of group participants included: (1) Awareness - “*I asked myself for the first time what my beliefs and my values were regarding homosexuality*”; (2) Knowledge - “*to know specific needs and social issues*”; (3) Skills – “*new approaches like Affirmative psychotherapy*”, “*the importance of not pathologizing in a subtle way*” and “*using adequate language*”.

The clinicians were also able to exemplify concrete impacts of training in the sessions with their clients. An example provided by a participant regarding a non-LGBT client was “*it is as if I was able to bring sexuality into the room and that it was not there until I realized it*”. Another example provided by a counselor of a lesbian client was the following: “*this person had been my client 4 years ago. She returned now, a few years after leaving college, and*

seeks my help to talk about her hidden homosexuality. It had always been there. All these years. At that time, I completely missed it. Now it just jumped into the room”.

In addition, clinicians reported impacts of training on themselves personally and also in their social lives, such as *“I believe the training changed me in a structural way (...). It is a question of personal attitude, more encompassing and more open”*; and *“I feel I realized I need to learn more, to be more aware and present with people, even in my personal life and family, where there are also gay/lesbian people...”*.

Discussion

The present paper aimed to contribute to design a training program to promote LGBT competences among a group of clinical psychologists and evaluate its effectiveness. Our findings suggest that relatively brief training programs may be effective in changing both awareness and actual ability to work with LGBT clients. In fact, a program with 12 hours was implemented and resulted in gains not only in terms of knowledge and skills, but also (and primarily) in attitudes and awareness. These gains resulted in differences in clinical practice with LGBT and heterosexuals, as in the personal lives of the clinicians. This increased awareness may have been responsible for a decrease in self-perceived diversity competence, including reported increased need for supervision on LGBT issues and further training.

The relative efficacy of brief training programs directed toward professionals in practice had already been defended by Ridley and Kleiner (2003). These and other authors (e.g. Tomlinson-Clarke, 2000) have argued for the importance of continuous education and training of practitioners in individual and cultural diversity competences, across professional development. This is in line with the developing ethical guidelines (APA, 2000). These ethical concerns, however, have not been translated into training programs in a systematic manner in most European countries.

These findings also suggest that clinicians consider LGBT – related issues important aspects of therapeutic work and goals. This seems to be particularly important since, even with a very interested and motivated sample of clinicians, difficulties related to LGBT issues far outnumbered positive attributes. This trend was found at pre-training, but also at post-training, which reveal that most clinicians without training may subtly pathologize their LGBT clients. This result is consistent with data provided by previous authors (e.g. Pachankis & Goldfried, 2004) and reinforces the relevance of specific training and supervision.

Another result worth-mentioning was that clinical psychologists have greater difficulty thinking of themselves as participants in the counselling process and relationship, than of their clients. Decades of clinical psychology literature dedicated to the clients and their problems, and only recent attention to the contributions of the therapists (e.g. Garfield, 2006; Safran & Muran, 2000) to the interpersonal process of psychotherapy may relate to this finding. Other authors (Neufeldt *et al*, 2006) found a similar pattern of results when exploring case conceptualizations of clients from different ethnic backgrounds, in which clinicians in training were less able to think about their own difficulties in relation to minority clients. In our study, in fact, most expected clinician self-reported difficulties pertained to LGBT issues.

The use of both case vignette and focus group approaches in the investigation of the impact of training seemed particularly relevant. In fact, much has been discussed with regards to the available methods to assess multicultural competencies (Suzuki, Ponterotto & Meller, 2001). While self-report measures have been mostly utilized (Constantine & Ladany, 2001; Neufeldt *et al*, 2006; Hays, 2008), their limitations have been widely reported (D'Andrea, Daniels & Noon, 2003, Ponterotto & Potere, 2003; Hays, 2008). The use of case vignettes have been supported in the evaluation among clinicians with no or little awareness of issues of individual and cultural diversity competencies (Moleiro, Marques & Pacheco, 2010), and

the combination with interviews or focus groups with trainees was shown to be much richer in the understanding of the gains due to the training.

While we recognize the contributions of this study, we also acknowledge some limitations. First, it is important to note that the sample was small. While group size was adequate to develop the training, statistically it does not enable comparative analyses of pre- and post-training changes. Furthermore, the sample was composed by volunteer clinicians, who initially appeared motivated and interested in issues related to LGBT clients. This warrants caution in both reading the present results, but also in the ability to generalize them. In fact, if subtle discrimination and pathologization was present among these clinicians, much more would be expected from a general sample of clinicians. Finally, and most importantly, a control group was not possible in our study design. Hence, pre- and post-training differences could be partially attributed to time and other variables associated with clinician development.

Notwithstanding, this paper contributes to the discussion on sexual diversity competencies among practitioners, by proposing new assessment methodologies and brief training programs for professionals.

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