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Matching the experiences of what culturally competent mental health support means to LGBTQI individuals and practitioners

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Master in Psychology of Intercultural Relations

Supervisor:
Dr. Carla Moleiro, Associate Professor, ISCTE-Instituto Universitário de Lisboa

October, 2023

CIÊNCIAS SOCIAIS
E HUMANAS

Department of Social and Organizational Psychology

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„*Nature also presents us with variations of lived experiences of our bodies, motivations, inclinations, and desires. Nature doesn't decide where the category of "male" ends, and where the category of "female" begins; or where the category of "normal" sexuality starts and ends. Nature also doesn't give any clues about what clothing and movements are "healthy" or "matching" expressions to our biological bodies. One of the basic characteristics of nature is diversity and humans decide these categories.*"
Common Point Project, Hungary, 2022

I think it's dangerous to assume you understand because even if they are similar, people give different meanings and have different experiences of that. So, I think it's about people being honest and open to relate to the other and try to understand where the other comes from, rather than having preconceived ideas what it is, what it means.

Cognitive-behavioral trauma psychotherapist, identifies as trans & genderqueer (P11)

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Resumo

Cuidados de saúde mental afirmativos ainda não são acessíveis para todos os indivíduos com diversidade sexual e de género. Este estudo qualitativo utilizou entrevistas semiestruturadas para explorar as experiências de clientes e profissionais sobre a competência em diversidade na saúde mental no contexto Europeu. As experiências de dez pessoas lésbicas, gays, bissexuais, transgénero, queer e/ou intersexuais (LGBTQI) (idades entre 24 e 36 anos) forneceram insights sobre as competências de profissionais na intervenção com clientes LGBTQI, e sobre melhorias para práticas mais afirmativas. Doze psicólogos/as clínicos/as ou psicoterapeutas (idades entre 26 e 65 anos) refletiram sobre a competência para a diversidade em termos de consciência, atitudes, conhecimentos e competências. Os seguintes temas surgiram numa análise temática separada de ambas as perspetivas. A perspetiva dos/as clientes identificou as áreas de (1) Experiência Terapêutica, (2) Competência de Profissionais e (3) Sistema de Cuidados de Saúde Mental. As experiências de profissionais foram categorizadas em (1) Consciência e Atitudes, (2) Conhecimento sobre Diversidade e (3) Competências Clínicas. Três temas prevaleceram em ambas as perspetivas: (1) Validação das Experiências e Emoções dos Clientes LGBTQI, (2) Qualidades Terapêuticas, e (3) Experiências Compartilhadas. A consciência de profissionais foi considerada mais importante, assim como a procura ativa de fontes válidas de conhecimento, incluindo experiências vividas relacionadas com a diversidade sexual e de género e redes LGBTQI. A coerência de ambas as perspetivas destaca a necessidade de ir além de um quadro clínico e desenvolver as competências para diversidade nos cuidados de saúde mental no contexto europeu.

Palavras-chave: competência cultural, diversidade sexual e de género, cuidados de saúde mental, indivíduos LGBTQI, terapia, aconselhamento, profissional, cuidados/serviços de saúde mental

Abstract

Affirmative mental health support is not yet equally accessible for sexual and gender diverse individuals. This qualitative study uses semi-structured interviews to explore what the experiences of both clients and professionals reveal about diversity competence in mental health care in the European context. The experiences of ten lesbian, gay, bisexual, transgender, queer, and/or intersex (LGBTQI) individuals (aged 24-36) offered insights into professionals' competencies in working with sexually and gender diverse clients and ideal improvements for affirmative support. In addition, twelve clinical psychologists, psychotherapists, and/or counselors (aged 26-65) reflected diversity on the continuum of cultural competence in terms of awareness, attitudes, knowledge, and skills. The following themes emerged in a separate thematic analysis of both perspectives. First, the client perspective reported their experiences in the areas of (1) Therapeutic Experience, (2) Practitioners Competence, and (3) Mental Health Care System. Second, practitioner experiences were categorized into (1) Awareness and Attitudes, (2) Diversity Knowledge, and (3) Clinical Skills. Third, three themes were prevalent in both perspectives: (1) Validation of LGBTQI Clients' Experiences and Emotions, (2) Therapeutic Qualities, (3) Shared Experiences. Practitioner awareness was considered most important, as was actively reaching out to valid sources of knowledge, including lived experiences related to sexual and gender diversity and LGBTQI+ networks. In summary, the coherence of both perspectives highlights the need to go beyond a clinical framework for recognizing diversity in mental health care and to create a more holistic picture of diversity competencies in mental health care in the European context.

Keywords: cultural competence, sexual and gender diversity, mental health care, LGBTQI individuals, therapy, counselling, practitioner, mental health care/services

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Chapter 1
Introduction

Many Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) people in the EU face ongoing risks to their safety and well-being, as they are unable to openly express their affection or be themselves without fear of discrimination, including a significant risk of poverty and social exclusion (EU LGBTQI+ Equality Strategy, 2020). Despite partially increasing in social acceptance (2015: 71% - 2019: 79%), and the legal recognition of same-gender marriages[1] and non-medical gender recognition procedures[2] in some EU member states (EU LGBTQI+ Equality Strategy, 2020), incidents of anti-LGBTIQ violence and hostility continue to occur in certain regions (Discrimination in the European Union, October 2019). In 2006, international human rights experts adopted a set of legal standards related to sexual orientation and gender identity, known as the Yogyakarta Principles. While the Yogyakarta Principles are not legally binding, they clearly reflect the position of international human rights law, as evidenced by the numerous calls for an official ban on conversion "therapies" some of which refer to them directly[3] (De Groot, 2022). While there is little data or statistics on these practices in the EU, it is estimated that 5% of people with sexual and gender diversity have been offered conversion "therapies" and 2% have received such "treatments," though these numbers are expected to be much higher. Nonetheless, the DSM III (1973) concluded that sexual orientation cannot be changed, and same-sex attraction is part of the existing spectrum of human sexuality, as it was finally removed in ICD 11 (2018). In comparison, gender identity was de-pathologized in DSM-5 (2013) and ICD 11 (2018) (American Psychological Association, 2013; World Health Organization, 2018). However, LGBTQI+ individuals continue to experience harmful practices aimed at "curing," "changing," or "repairing" their sexuality and gender (Bishop, 2019). So how does affirmative care for sexual and gender diverse (SGD) people look in the aftermath of conversion practice?

While negative explicit attitudes toward stigmatized groups decreased, implicit negative attitudes continue to influence behavior, from everyday encounters to clinical

[1] Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Luxembourg, Malta, the Netherlands, Portugal, Slovenia, Spain, Sweden
[2] Denmark, Ireland, Luxembourg, Malta
[3] Nationwide ban: Malta (2016), Germany (2020), France (2022), Greece (2022); regional ban: Spain (2021); partly ban, e.g., for minors and adults that are not able to consent, but 'treatment' itself is not prohibited: Irland (2021), Belgium (2021) (De Groot, 2022)

interactions (West & Schoenthaler, 2017). Normative ideas about how gender, sex, and sexuality are to be understood as expected expressions and characteristics, and are culturally and historically shaped (Sullivan, 2003), and therefore can only be interpretated taking these contexts into account. Hence, these dominant concepts of gender and sexuality are political choices (Foucault, 1980; Butler, 1990), benefitting those in power, on the costs of those who position themselves beyond dominant narratives. Since dominant narratives and power shape our institutional and structural organization, Eurocentric, heteronormative, and cisnormative structures have led to the pathologization of and discrimination against sexual and gender diversity among people in mental health care (Robinson, 2022; Moleiro, 2018).

Overall, sexual and gender diverse individuals are exposed to unique risk factors in society, compared to their heteronormative counterparts (Carastathis et al., 2017; Katz-Wise & Hyde, 2012; Puckett et al., 2019). Being exposed to prejudice, stigma, harassment, and discrimination can manifest in minority stress (Meyer, 2003), which often results in significantly higher risks of sexual and gender diverse individuals experiencing major depression, anxiety, suicidal ideation and suicide, substance misuse, and deliberate self-harm (e.g., Lim & Hewitt, 2018; Sutter et al., 2016; Cochran et al., 2003; Budge et al., 2013; Pucket et al., 2019; Testa et al., 2015, 2017). Nevertheless, sexual and gender diverse people report institutional barriers such as a lack of affirmative mental health care and counselling offer for their needs (EU Strategy, 2020; Bishop et al., 2021), as well as experiences implicit and subtle biases among mental health practitioners (Owen et al., 2011; 2018; Spengler et al., 2016; West & Schoenthaler, 2017; Nadal et al. 2011). These unconscious attitudes toward SGD clients likely manifest in the form of microaggressions among practitioners, which are associated with poorer therapeutic relationships, treatment outcomes, while impacting help-seeking behavior and treatment engagement (Owen et al., 2011; 2018; Spengler et al., 2016; Gary, 2005; Nadal, 2013; Israel et al., 2008). Consequently, this may indicate either a lack of practitioner awareness or knowledge of the consequences of imposing heteronormative, cisgender worldviews, or a lack of competence to integrate a practice beyond those dominant and harmful concepts in working with their clients.

The development of cultural competence is generally understood as the extent to which clinicians have appropriate self-awareness and openness, knowledge, and practical skills in working with people from diverse cultural backgrounds (Kirmayer, 2012; Sue & Sue, 2008; Sue, et al., 2009; Wu & Levitt, 2021). While overall practitioners perceived their own awareness as positive, they have mentioned concerns about the practical application of their knowledge (Cabral et al., 2016). However, SGD clients have reported already more positive

experience in therapy if the practitioner showed skills of empathy and active listening – even though the therapy was not perceived as useful overall (Arora, 2022; Israel et al., 2008).

Along with a focus on developing theoretical guidelines and training for professionals working with sexually and gender diverse people in mental health care (Arora et al., 2022), research has aimed to understand the needs of those meant by affirmative care (e.g., Israel et al., 2008; Shelton & Delgado-Romero, 2013; Bishop, Crisp, & Scholz, 2021). Queer theory in this matter supports the fundamental need to question the normative concepts of gender, sexuality, and identity, and introduces a more fluid, inclusive understanding of the complexity of human experiences (Sullivan, 2003; Semp, 2011).

> In affirmative approaches, sexual and gender diversity is seen as healthy and worthy of support. It is an approach that can be applied to a variety of counseling methods. The focus is on validating the client's identity, acknowledging the harm of discrimination, and addressing individual issues without preconceived judgments about LGBTQI+ identities. This approach recognizes all sexual orientations and gender identities as equal expressions of human diversity. (Common Point Project, 2022)

The present study combines sexual and gender diverse peoples' actual lived experiences within the mental health system with the affirmative experience they would need or desire to have. In addition, practitioner perspectives provide insights into key elements of diversity competencies. Therefore, this study aims to create a more holistic picture of cultural competence regarding sexual and gender diverse people within mental health care in the European context. In the following chapter, we therefore present a theoretical framework for normative narratives and intersectionality in relation to the experiences of sexual and gender diverse people in mental health care, outline general research findings on the development of cultural competence, and finally point to the importance of considering both the client and the practitioner perspectives. Next, we describe the methods used, including the samples, instruments, and procedures in a qualitative design. We then describe the results in chapter four, highlighting the perspectives of clients, practitioners, and its relation or match. Finally, we discuss the findings in light of the experiences reported in previous literature on cultural competent mental health care and point out the importance of incorporating socio-political contexts by providing professional psychological support to sexual and gender diverse clients.

Chapter 2
Theoretical Background

As evidence suggests, sexual and gender diverse[4] (SGD) people experience greater health disparities especially regarding their mental health needs and often face stigma and discrimination within mental health services (e.g., Rees et al., 2021; Bishop et al. 2021; Nadal et al., 2011). Forms of subtle discrimination, often described by perpetrators as unintentional, are more difficult to control and to identify as expressions of manifested prejudice and implicit attitudes (Dovidio et al., 2016; West & Schoenthaler, 2017). To understand where these inequities in mental health care are rooted, it is important to recognize that sexuality and gender are dependent on the cultural and historical context in which they developed. In order for professionals to develop competence in working with SGD people, they must expand their own awareness and attitudes to acquire new knowledge on an ongoing basis. As will be argued below, both client and professional perspectives are essential to recognize diversity in affirmative mental health care.

2.1. Normative Narratives and Intersectionality

Normative and dominant understandings of sexuality and gender have historically been shaped by Eurocentric Western societies that have used medical and psychiatric discourses to pathologize and classify non-normative sexualities, same-sex attraction, and gender non-conformity (Foucault, 1980; Sullivan, 2003). In *The History of Sexuality*, Foucault questions how sexuality became an important instrument of power, particularly in the context of historical efforts to ensure health and continuity. Foucault argues that the discourse on sexuality expanded as experts scientifically examined sexual behaviour beyond heteronormative marital practices (Foucault, 1980). The lens of Queer theory supports the idea of the effect of power in shaping and enforcing norms, that have been used to maintain control and power over non-conforming individuals, including gender and sex (e.g., Butler, 1990). Heteronormativity, cisnormativity, as well as homonormativity and transnormativity, shaped the clinical and psychological understanding of stigmatization and repression which persist in societal attitudes and policies (Johnson, 2018; Vipond, 2015; Duggan, 2002; Robinson, 2016). Heteronormativity as a social framework refers to a set of beliefs and practices at both the systemic and individual levels that

[4] This term is used as inclusive term for all individuals who state themselves as being lesbian, gay, bisexual, queer, intersex, trans, and/or non-binary, genderqueer, genderfluid, and much more that goes beyond a heteronormative and/or cisnormative understanding of sexuality, sex, and gender.

assume that a binary gender model of opposed gender and a heterosexual model of romantic and sexual relationships, based on the idea of attraction towards the "opposed" gender per default, are therefore publicly accepted (Kitzinger, 2005; Duncan et al., 2019). In this realm, cisnormativity is understood as the expectation of the exclusivity of cisgender, wherein all people should identify with their sex assigned at birth (Bauer et al. 2009; Catalpa and McGuire, 2018). As in the recent years homonormativity and transnormativity as hegemonic social frameworks are addressing the strive of LGBTQI people to conform to societal norms and expectations, either fitting into stereotypical heterosexual conformity or conforming to the medicalized binary framework of gender (Duggan, 2002; Robinson, 2016; Johnson, 2018; Bradford & Syed, 2019). Often these tendencies neglect SGD people that do not conform into these norms and social expectations. For instance, cisnormativity imposes challenges on transgender and gender diverse (TGD) individuals that do not identify with their assigned sex at birth and therefore challenging normative concepts of the binary understanding of cisgender identity (Bradford & Syed, 2019). These challenges include legal recognition, gender-affirming health care and its access, as well as affirming (mental) health care (e.g., Bauer et al., 2009; Pucket et al., 2017).

Unspoken heteronormative practices in society contribute to the persistent and pervasive anti-LGBTQI+ messages SGD individuals face on a daily basis (Boyer & Lorenz, 2020). These include internalized cognitive processes (Habarth, 2015), often expressed through the media, institutional practices, and religious or political ideologies (Duncan et al., 2019; Van der Toorn et al., 2020), which further contribute to greater risk for mental health problems among SGD individuals (Edwards & Watson, 2020; Puckett et al., 2018) or substance abuse (Fish, 2020). Heterosexist assumptions, endorsement of a heteronormative culture, assumption of universality of experiences, knowledge based on stereotypes, rejection, homophobia, pathologizing of sexual orientation, medicalization of gender, and denial of practitioner heterosexism all impact clients' experiences in mental health (care) (Nadal et al., 2011; Bishop et al., 2022; Szymanski & Henrichs-Beck, 2014). Individuals who have experienced heterosexism with professionals are less likely to participate in further therapy sessions or seek mental health services in the future (Utamsingh et al., 2016). Heterosexism can serve as an indicator of practitioners' lack of knowledge or understanding of LGBTQI+ individuals' experiences (Fell et al., 2008; Bishop et al., 2022), decrease the perceived quality of the therapist (Burckell & Goldfried, 2006), negatively impact the therapeutic alliance (Szymanski & Henrichs-Beck, 2014), and create mistrust (Foy et al., 2019).

In today's debates about diversity recognition, sexually and gender diverse clients are often mentioned in the same breath, yet clinical recognition has not followed the same historical path. The discussion of the pathologization of homosexuality occurred earlier and resulted in its removal from the DSM in 1973 (DSM-III) and its omission altogether in ICD 11 (2018). In comparison, gender dysphoria, recognized in the DSM-5 (American Psychological Association, 2013) and ICD-11 (World Health Organization, 2018), states that gender variance is not a pathology. Intersectionality emphasizes the experiences and challenges that arise from the intersection of multiple axes of oppression, as well as the uniqueness of experiences and the vulnerability of individuals (Adams et al., 2017). Culture in mental health contexts recognizes the intersection of multiple factors that together constitute a person's identity, such as migration status, race and/or ethnicity, language, religion and spirituality, age, gender identity, sexual orientation, socioeconomic and educational class, and abilisms (Moleiro, 2018). Therefore, normative cultural narratives related to sexuality and gender must be challenged when developing affirming approaches to people's mental health.

2.2. Cultural and Diversity Competence in Mental Health Care

As defined by Hofstede, culture refers to "*the collective programming of the mind which distinguishes the members of one human group from another*" (Hofstede, 2011, p. 3). Cultural competence is generally understood as the extent to which clinicians have appropriate self-awareness and openness, knowledge, and practical skills in working with people from diverse cultural backgrounds (Kirmayer, 2012; Sue & Sue, 2008; Sue, et al., 2009; Crisp, 2006; Wilkinson, 2014). In mental health research and practice, the concept of culture recognizes the combined effect of multiple collective factors that shape a person's identity. These factors include not only nationality, migration status, racial or ethnic background, language, religion, and spirituality, but also age, gender identity, sexual orientation, socioeconomic and educational status, and health conditions (Moleiro, 2018).

Given the critique of the concept of cultural competence that implies an ideal end state (Mosher et al., 2017), the development of cultural competence may be better represented as a process aimed at the ability to acknowledge the importance of culture, the impact of cross-cultural relationships, as well as to continually increase vigilance to dynamics arising from cultural differences and to continue to adapt services to meet culturally driven needs (Cross, 1988, 2012). These factors can be summarized in practitioners' awareness, knowledge, and clinical skills, in which competence can develop on different continuums (incompetence, blindness, pre-competence, competence, and proficiency). The development of competency

usually stems from the philosophy of being completely biased, not acknowledging differences, and therefore viewing standardized approaches as effective for all, to the active acknowledgement of the importance of culture within clinical practice. Within a blindness stage, therapists ignore cultural strengths, promote assimilation, and may blame individuals for their problems (Cross, 2012). Often rooted in a deficit of knowledge and information resources, practitioners perceive their practice as responsive attitudes and practices. When practitioners acquire cultural knowledge but maintain extremely biased attitudes and perpetuate stereotypes, their behavior is characterized by ignorance or unrealistic threats toward a cultural group (Cross, 2012). Studies with sexual and gender diverse individuals have found that certain types of microaggressions occur in mental health care, such as minimizing, over- and underemphasizing, stereotyping sexual orientation or gender identities (Shelton & Delgado-Romero, 2013; Mizock & Lundquist, 2016). Within a low level of cultural competence, microaggressions can appear in forms of daily racism, heterosexism, and/or cisgenderism that are witnessed as stressors (Arora, 2022). Furthermore, the practitioners' non-verbal expression of fear and discomfort or exaggerated (inauthentic) positivity, uncomfortable and avoidant behaviour when addressing cultural realities goes hand in hand with the therapist's denial or ignorance of their own cultural biases (Knox et al., 2003; Hook et al., 2016).

As practitioners begin to acknowledge differences and respect diverse influences in society, they continue to self-assess culture, increase their cultural knowledge, pay attention to the dynamics between practitioners and clients, and become able to adapt interventions to better meet the needs of culturally diverse clients (Cross, 2012). As valid resources, they draw on lived experiences and can actively make decisions about their competence in working with a particular cultural group. Proficiency includes the expansion of knowledge and skills to engage in future research and providing training. Becoming more culturally responsive includes a higher level on self-reflexiveness, ability to address internal biases and attitudes (Bledsoe & Donaldson, 2015; Bishop, 2021). By doing so, professionals acknowledge diverse cultural characteristics and incorporate reflexivity, while broadens to socio-political aspects that can influence realities of minority clients as well (Hall, 2021).

Bishop et al. (2022) interviewed therapists on information resources that influenced their development of competence working with LGB clients. The overall reported aspects were affirmative attitudes, knowledge that underpins understanding, and cultural competence in practice creates inclusivity and a safer therapeutic space (Bishop et al., 2022). Clients perceived cultural modesty among their therapists, who seemed to be more transparent in disclosing practitioners' cultural missteps and more effective in attending to negative cultural events as

they occur within the therapeutic relationship (Hook et al., 2016). The therapists may to be more curious, open, and collaboratively explore cultural events in therapy as culture ruptures or microaggressions (Hook et al., 2013; Owen, 2013). Cultural Competence in forms of knowledge among the practitioners can help to build rapport between an LGB client and the practitioner (Croghan et al., 2015), increase the trustworthiness of the support and therefore make it more likely that a person discloses their LGB identity (McCann & Sharek, 2014b). For integrating unique vulnerabilities, such as understanding of additional stressors of prejudice of their sexual orientation and gender expressions, (identity) rejection, internalized phobia, the impact of coming out as a unique experience, along with the strain of pathologizing sexual orientation and gender, and the impact of intersectional characteristics (Foy et al., 2019; Meyer, 2003) - professionals need to gain confidence, when and how to navigate an appropriate conversation with clients about sexuality and the potential associated stressors (Bishop et al., 2021; Graham et al., 2012).

Thus, developing the ability to question one's professional knowledge and explore the self as a cultural being and one's cultural biases (Hall, 2021; Sue, 2008; Israel & Selvidge, 2003; Kirmayer, 2012), in combination with ongoing interaction with SGD people and spaces, is an important source of building affirmative clinical competence (Graham et al., 2012). However, interactive workshops and exposure to lived experiences increase significantly the counsellor's working confidence, these types of trainings are rare because they are more time- and resource-intensive than single lectures (Hall, 2021). Nonetheless, in the Anglo-American context, cultural competencies are already important aspects of several health educational programs (Mosher et al., 2017), but research has highlighted the lack of comprehensive training opportunities for professionals (Graham et al., 2012), as well as difficulties to access these (Rutherford et al., 2012). A lack of awareness, knowledge, and skills among professionals can hinder the therapeutic process, cause ruptures in the therapeutic alliance and further, either increase or maintain reasons for seeking support by maintaining societal stereotypes or function as a barrier for receiving affirmative and supportive mental health service.

2.3. Practitioners' and Clients' Perspectives

Both the clients' and practitioner[5]'s perspectives can give important insights about cultural competence for sexual and gender diverse (SGD) clients in therapeutic settings, as some research suggests (Bishop, Crisp & Scholz, 2021). Besides the overall positive effects of professional psychological care (e.g., Munder et al., 2018; Pucket et al., 2018; Campbell et al.,

[5] Includes psychotherapists, counsellors, & psychologists that practices in mental health care settings.

2013), the interaction in mental health care between practitioners and clients can cause distress on both sides. The overall reported SGD clients' experiences in mental health services ranged from subtle forms of prejudice in practitioner's behavior to open discriminative attitudes and practices (Bishop, Crisp & Scholz, 2021). Reasoning for that include the lack of knowledge and awareness on attitudes.

Non-affirmative approaches included practitioners lacking knowledge about LGBTQI specific issues or perceiving discomfort discussing one's sexual orientation or identity (Kidd et al., 2011; Eady et al., 2011; Bishop, Crisp & Scholz, 2021). Clients often reported feelings of frustration about the need to educate the professionals (Kidd et al., 2011). More active discriminative experiences pathologized sexual orientation or gender identity, e.g., linking sexual identity with negative mental health outcomes (Alexander & Clare, 2004), attributing it to either trauma or client's reasons for seeking mental health support (Hunt et al., 2006), or denying discussing same-sex relations (Ross et al., 2018). By dismissing their sexual and gender diverse realities, practitioners are not responsive to the needs of their clients (McCann & Shared, 2014; MacKay et al., 2017; Eady et al., 2011). In this realm, the fear of being dismissed or rejected by practitioners causes psychological distress among SGD individuals and increases fear of discriminatory experiences (Cyrus, 2017). Whether it is judging after clients disclosing their sexual identity (MacKay et al., 2017), practitioners using heteronormative, misgendering language (Knutson et al., 2019; Eady et al., 2011) or that they assume heterosexual partners when asking for different-sex partners (McCann & Sharek, 2014b), these have been taken as indications for a low level of awareness and knowledge about LGBTQI+ people (Eady et al., 2011). As soon as clients perceived their practitioners as uncomfortable talking about LGB+ issues, clients tend to be less open (McNamara & Wilson, 2020).

From a review of mental health services, 48% held biased attitudes towards LGB clients (Anderson & Holliday, 2006; Willging et al., 2006). Within this definition, biases included referral to „reparative" practices, invalidation of the legitimacy of an LGB identity and lack of provider willingness to refer to LGB+ friendly services (Anderson & Holliday, 2006). Overall, these biases had a negative impact on the perceived quality of the service among LGB individuals (Anderson & Holliday, 2006; Willging et al., 2006). On the other hand, practitioners expressed concerns about how and when to address a client's gender identity or sexual orientation without offending the person (Semp & Read, 2015; Semp, 2011), especially if the client did not identify themselves as LGBT before the session (Hughes et al., 2018) or the professional was not specialized working with SGD clients (Rutherford et al., 2012). McCann

and Sharek (2014b) extracted positive attitudes toward LGB people among professionals, which aligned with positive experiences of clients. As soon as the practitioner reacted positively or in a neutral way when the client came out, they felt affirmed in their identity (Eady et al., 2011). When clients perceive positive attitudes, acceptance, compassion, and respect in mental health services (Hunt et al., 2006; Holley et al., 2016), stereotyping and prejudice can be further reduced (e.g., Mohr, Israel & Sedlacek, 2001). These themes illustrate those experiences on both sides, i.e., practitioners and clients, vary widely depending on prevailing biases and are sensitive to already small changes.

2.4. Statement of the problem and definition of research questions

Overall, little research has been conducted the European context. Additionally, there is still an underrepresentation of intersectionality among SGD people. This study aims to collect common themes that emerge in culturally (in)competent mental health support settings. Therefore, people who identify as LGBTQI+ should have the opportunity to share and be encouraged in their experiences, as they are better able to communicate their priorities in relation to culturally diverse competent care, than a single theoretical driven approach. Both themes of clients and practitioners might provide important insights into discrepancies and commonalities in a sensitive mental health setting. That leads to the following research questions:

A) What do the ideal and real experiences of adults who self-identify as LGBTQI+ reveal about culturally competent counselling or psychotherapy services?
A.1 What common themes emerge among the sexual and gender diverse group?
A.2 Do intersectionality within the LGBTQI+ spectrum indicate specific challenges?

B) What do the ideal and real experiences of practising counsellors, psychotherapists, or psychologists reveal about culturally competent mental health support?
B.1 What common themes emerge among the practitioner?
B.2 Are there differences between experienced and less experienced practitioners?

C) How do the overall themes of both perspectives, i.e., LGBTQI-identifying adults and practitioners, align in terms of diversity competence in mental health care?

Chapter 3
Methods

This qualitative study conducted semi-structured interviews (*N* = 22) and thematic analysis was used to identify and describe experiences of LGBTQI adults and practitioners in a mental health setting and their perceptions of cultural and diversity competence in the European context.

3.1. Sample

Client perspective. Overall, all individuals (*n* = 10) lived in a country on the European continent, speaking and understanding English. Matching the ground conditions, individuals for the client sampling were self-identified as lesbian, gay, bisexual, transgender, queer, or/and intersex (LGBTQI) adults and have (had) previous experience with mental health services, such as psychotherapy, professional psychological support, or counselling. The experience included a minimum one interactional session with a counsellor/psychologist. The sample included individuals that described themselves as cis-gendered (*n* = 5), trans gendered[6] (*n* = 5), intersex (*n* = 1), their sexuality as lesbian (*n* = 1), gay (*n* = 2), bisexual (*n* = 2), straight (*n* = 1), shifting between asexual periods to pansexual and demisexual (*n* = 1), and polysexual (*n* =1). The age ranged between 24 – 36 years (*M* = 26.9, *SD* = 3.81). The participants' countries of origin were Portugal (*n* = 4), Germany (*n* = 2), United Kingdom (*n* = 2), Hungary (*n* = 1), and Brazil (*n* = 1). In addition, two of the participants described currently living in another country than their country of origin, Portugal (*n* = 1), Netherlands (*n* = 1). Table 1 shows the detailed self-descriptions the participants offered.

Table 3.1. *Sample of Client Self-descriptions*

Code	Age	Country of Origin/(Residence)	Gender	Sexual orientation
CL1	28	Portugal	*Cis women; she/her*	*Lesbian*
CL2	25	Portugal	*Trans* being gender queer and intersex*	-

[6] Including stated forms of genderqueer, genderfluid, CUIR descriptions.

Cl3	30	Germany	*Genderfluid & genderqueer; she/they*	*Currently more asexual; also pansexual, demisexual*
CL4	24	Portugal	*CUIR; they/them*	*Polysexual*
CL5	27	Brazil (Portugal)	*Cis male; he/him*	*Bi-sexual*
CL6	27	United Kingdom	*Cis male; he/him*	*Gay*
CL7	24	Portugal (Netherlands)	*Cis women*	*Bi-sexual*
CL8	24	United Kingdom	*Transgender man; assigned female at birth; he/they*	*Straight*
CL9	24	Germany	*Transman*	-
CL10	36	Hungary	*Cis male; he/him*	*Gay*

Note. These self-descriptions capture the moment of the interview and may have changed in the meantime.

Practitioners' perspective. The practitioner sample consisted of professionals trained in counselling or psychotherapy and practicing at least one year in any mental health care setting in Europe. Both high- and low-experience level of working with LGTQI+ clients were desired. All individuals (*n* = 12) lived in a country on the European continent, speaking and understanding English. Matching the ground conditions for practitioners in this study, the person needed to be trained and experienced as a clinical psychologist, psychotherapist, and/or counsellor and working as such in the European context. The countries practitioners practiced were Portugal (*n* = 3), United Kingdom (*n* = 1), the Netherlands (*n* = 2), Belgium (*n* = 1), Hungary (*n* = 2), Spain (*n* = 1) and Germany (*n* = 2). They received parts of their training in countries such as Portugal (*n* = 4), Germany (*n* = 2), the United States (*n* = 2), Hungary (*n* = 2), Spain (*n* = 1), New Zealand (*n* = 1), Belgium (*n* = 1), the Netherlands (*n* = 3), France and Israel (*n* = 1). The age ranged between 26 and 64 (*M* = 42.54, *SD* = 13.66); participants identified as cis-gender male and gay (*n* = 2), cis-gender female (*n* = 9), and trans und genderqueer (*n* =1). The experience level differed from mainly working with LGBTQ+ clients

(n = 4), frequently (n = 2), from time to time (n = 3), and never (n = 3). Table 2 shows the detailed self-descriptions the participants offered.

Table 2 *Sample of Practitioner Self-descriptions*

Code	Age	Country of Origin/ (Practice)	Education (Country of Training)	Experience LGBTQI+ clients
P1	30	Portugal	Clinical psychologist; psychodynamics; victim support (Portugal)	working with LGBTQ+ clients in daily practice
P2	32	Portugal	Clinical, criminal, & sexology psychology; victim support (Portugal)	working in LGBTI+ association as victim supporter and therapist
P3	26	Germany	Clinical psychology; coach (United States, Germany)	never
P4	-	Spain	Gestalt counsellor; somatic experience (Spain, Portugal)	frequently with transgender children/ adolescents
P5	65	Germany	Gestalt counselor; dance therapist (United states, Germany)	receives gay clients, clients in gender transition processes
P6	51	Hungary	Gestalt counsellor (Hungary)	never
P7	32	Portugal	Clinical psychologist; ethno-psychotherapist (Portugal, France, Israel)	receives LGBTQ+ refugees, asylum seeker
P8	52	Italy (Nether-lands)	Integrative Psychotherapist (Netherlands)	some clients
P9	46	Hungary	Gestalt Psychotherapist (Hungary)	never
P10	54	Hungary (Belgium)	Psychosynthesis; integrative psychotherapy (Netherlands, Belgium)	clients with different sexual orientation, gay couples

P11	26	New Zealand (Nether-lands)	Clinical Psychology; Cognitive-behavioral, dialectical-behavioral, trauma, EMDR psychotherapist (New Zealand, Netherlands)	receiving mainly clients through LGBTQ community
P12	54	Portugal (United Kingdom)	Clinical psychologist; psychoanalytic psychotherapist (Portugal, UK)	gay and lesbian clients

Note. These self-descriptions capture the moment of the interview and may have changed in the meantime.

3.2. Materials

This study utilized qualitative methodology to conduct an in-depth analysis of the experiences with diverse competencies of LGBTQ+ adults and practitioners in the European context. Qualitative methodology has been widely used to highlight social issues that are grounded in core counselling and psychology values (Abreu et al., 2022; Levitt et al., 2018; Yeh & Inman, 2007), as well as addressing social justice issues such as power relations, privileges, and systemic injustice (Beer et al., 2012; Cadaret et al., 2018; Levitt, 2016, 2018). Therefore, qualitative research can engage in better understanding and challenging oppressive and dehumanizing structures and actions to individuals and populations (Abreu et al., 2022). The research design engaged one-on-one interviews to focus on lived experiences and individual sense-making (Maldonado-Castellanos & Barrios, 2023; Flick, 2022; Roulston & Choi, 2018), considering both interactional perspectives within mental health services. Drawing on individual sense-making of mental health experiences can yield analyzed content that facilitates broader cultural discussions (Hammack & Toolis, 2014, 2015b). Therefore, this study aims to open a space to gather subjective experiences and unrepresented opinions in mental health care. The semi-structured interview protocol provides flexibility to capture individual experiences while focusing on specific content-oriented questions relevant to the study's objectives and research questions (Frost et al., 2020).

The semi-structured interview guidelines (Appendix A & B) provided topics that should be covered to generate meaningful data for the purpose of this study. To introduce the interview, participants were asked to provide some demographic information. Participants from the client perspective were asked about their age and current self-identification. The practitioner were

asked about their age and their educational path, such as the type and country of their professional training and the fields and institutions in which they have worked. To initiate the main part of the interview, participants were asked to define diversity personally and apply it to mental health care, as well as to explain the challenges for sexual and gender diverse people in accessing mental health services. Through specific questions, participants further described their experiences within mental health care and recalled specific situations. Depending on the perspective (practitioner or client perspective), the scope of interest slightly differed. Practitioners were asked about if and how they adjusted their approach to diverse clients and what they believed/perceived as needs and specificalities that a therapist should cover by working with SGD people. Participants within the client's perspective were asked about their experiences and what they wished from their practitioner, either in general or in their specific experiences. To ensure that both groups addressed similar topics, the focus overall was the recall on personal experiences, ideal improvements of mental health care, or drawing on necessary therapeutic qualities, such as characteristics, skills, and knowledge working with sexual and gender diverse clients. The closing part gave space for comments and questions. Each participant signed an informed consent form (Appendix C) prior to the interview and was provided with a debriefing form (Appendix D).

3.3. Procedure

This study was reviewed and approved by the ethical committee of the ISCTE-IUL University of Lisbon (13/2023). Within the European context, clinical psychologists, therapists, and counsellors were recruited for the practitioner perspective and LGBTQI identifying individuals with previous mental health experience were recruited for the client perspective. Convenience sampling was used for both perspectives, via social media posts, organizations, and direct contacting practitioners via email through European psychotherapy association platforms (European Association for Psychotherapy; European Psychiatric Association). Members of public and private mental health services and collaborating LGBTQI organizations and student supports were further contacted and asked to distribute information about this study to their colleagues and members.

Considering the European context, some interviews were conducted online (n = 16) via video call as face-to-face interviews were not feasible. Some interviews were conducted in person (n = 6) at a location preferred by participants (e.g., home, park, or private room at the university). Nevertheless, every participant was offered to do the interview online as they prefer. This enabled the researcher to engage with participants in real time, despite being in

distant locations (Maldonado-Castellanos & Barrios, 2023). Each participant was asked to sign the informed consent form pursuant to Article 13 of the General Data Protection Regulation (GDPR) which was handed or sent via email prior the interview. Before starting the recording, each participant received verbal mention of the consent form, informing about the confidentiality, that they could stop or pause the interview at any time without reasoning, how their personal data will be treated and any doubts or questions from the participants were clarified. A debriefing from was provided to clarify the purposes of the study and mentioned ILGA Europe as example institution where participants can reach out for support and training. Each interview lasted approximately between 25 and 80 minutes ($M = 45.05$, $SD = 0.57$) and all interviews ($N = 22$) were held in English. The length and structure of the interview depended on the willingness of the participants, what and how much the person shared, whereas the semi-structured interview guideline was leading through the conversation. The audio recordings were completely deleted after verbatim transcription and the anonymized transcripts were used for further data analysis. Recording, transcript, and analysis were stored in an external separated storage disks.

3.4. Data Analysis

This study used a reflexive, thematic analysis approach with initial coding to identify, analyze, and report patterns within a dataset (Braun & Clarke, 2006, 2012, 2022; Clarke & Braun, 2013). Through this approach, data can summarize key features and offer a broad description of a rich dataset, highlight similarities and differences, for instance between both perspectives, generate unanticipated insights and further benefit from social and psychological interpretations of the data (Braun & Clarke, 2012).

Data processing and conducting a thematic analysis was done manually by the researcher, supported by Excel and Word software. Using an inductive approach, both perspectives were analyzed separately. First, the clients' perspective provided insight into the experiences, challenges, and needs of sexual and gender diverse people in mental health care. After visualizing the pre-final client themes in a virtual mind-map, the same procedure followed for the practitioners' perspective. While the initial themes emerged among practitioners, a more deductive approach was taken, organizing themes and statements using the cultural competence framework (Sue & Sue, 2008; Sue et al., 2009; Cross, 2012, 2020). In this way, the single statements could be structured from incompetence to competence without making assumptions about the practitioner's overall competence. These individual examples

could be further used to highlight the client experiences. The third and final step of extracting the results from the data was to look at common themes that emerged in both perspectives.

The single perspectives were analyzed in orientation on the six-phase model of Clarke and Braun (2022). Firstly, the analysis process started with the familiarization of the data. Therefore, the recordings were listened to a second time while the transcripts were read through to mark statements and construct broad codes and themes. This was followed by generating initial codes and searching for themes. This process was repeated until a final cluster of themes and subthemes was developed. After finishing both perspectives, adjustments were made in regard to reviewing, defining and naming themes. Finally, the experiences of the client and practitioner perspectives could be organized in the following results.

3.5. Reflexive Statement

Qualitative reflexive analysis aims to value the researcher's subjectivity as a resource by reflecting theory, data, and interpretation (Braun & Clarke, 2021). Nevertheless, interviews in research are influenced by the researchers' characteristics and remains not neutral (Punch, 2014). The researcher present characteristics – cis-female, white – may have caused potential biased, blind sports, and interpersonal factors during data collection and interpretation (Adams et al., 2017). Especially working with certain populations it is even more important to engage self-reflection and accountability, as well as maintain an awareness of potential power differences and relationship dynamics between participant and themselves, regardless of shared experiences (Pearce, 2016; Galupo, 2017). Therefore, guidelines and ethical considerations working with sexually and gender diverse clients were used as resource constructing and implementing this study project (e.g., Adams et. al., 2017; Henrickson et. al., 2020). Initially, considering social and political impacts on the experiences of sexually and gender diverse people in European countries, the scope slowly narrowed to the mental health situation of SGD people. The researcher became familiar with yet unfamiliar concepts of gender, relationship dynamics, and inclusive language, which developed continuously throughout the project. Therefore, the researcher included various sources of information, such as scientific research, activism approaches, general literature, and lived experiences. After preparing, conducting the interviews, and further analyzing the results, the researcher was careful to amplify the participants' voices and not speak for them. The researcher intended to keep personal presence to a minimum during the interview in order to give participants as much space as they wanted to take. Given the own personal affirmative positioning and relationship to sexual and gender diversity, it was sometimes challenging to remain neutral in the accounts of practitioners,

especially if there was less emphasis for sexual and gender diverse people. Overall, these factors were monitored, discussed, and revised by the university supervisor, who has experience in research on cultural competence and LGBTQI+-related issues, as well as in psychotherapeutic practice with sexually and gender diverse clients.

Chapter 4
Results

In the following, the themes of the client and practitioner perspectives are described separately and in detail, including illustrative depersonalized quotes. The next section highlights the thematic commonalities between the two perspectives. The participants' descriptions were selected according to their own definition during the interview. The countries of origin are not included in the results due to the mobility of people in the European context and therapeutic experiences; a detailed description can be found in the description of the participants (Table 1 & 2).

4.1. Client Perspective

Throughout the interviews, participants representing the client perspective (*n* = 10) reported on their experiences of accessing mental health services, their therapeutic processes, especially regarding the practitioner's qualities and knowledge, and how they perceived the recognition of sexual and gender diversity in mental health care. In addition, participants identified important aspects that currently hinder either accessibility or adaptation to the needs of people with sexual and gender diversity within the mental health care system. The following three themes, (1) Therapeutic Experience, (2) Practitioners Competence, and (3) Mental Health Care System, emerged from these subjective and context-dependent experiences and opinions. Therapeutic Experience contains *Sub-themes 1.1.: Continuous Factors, 1.2.: Discontinuous Factors;* Practitioners Competence: *2.1. Awareness, 2.2. Knowledge & Skills, 2.3. Shared Experiences;* Mental Health Care System: *3.1. Accessibility, 3.2. Structural Conformity.*

4.1.1. Theme One: Therapeutic experience

The first theme, the therapeutic experience, reflects the general themes that emerged from the participants' accounts of the therapeutic interactions and the process itself. This theme is organized in reasons for staying (continuous factors) or leaving (discontinuous factors) in the mental health context.

Sub-theme 1.1. Continuous Factors

This sub-theme contains reported factors that made the participants stay in therapy. One major factor was the validation of their emotions and feelings. As this genderqueer and intersex trans person (CL2) reported:

> I kept for two or three years. But he was not aware of that many things regarding the queer identity. He was just nice because he validated my feelings and that was basically

> the bare minimum and I thought, OK, I can keep you, you're nice. Even if I have to explain everything to you, I feel like at least you're validating enough that I can […] use it somehow.

Similarly, this genderfluid and genderqueer person (CL3) ignored *"the sexist comment or whatever is seeming sexist"* of the therapist because he was "*validating all of*" their experiences. Other reasons for staying in therapy given by some participants were their personal investment in the therapist, as described by this genderqueer and intersex trans person (CL2): "*I was actually with for a couple of years but even the ones that I was with for a couple of years they were people that I invested a lot in personally to explain to them a lot of basics on my identity and then I felt like I didn't want to switch because then I would have to teach the others so so much."*

The practitioner's expertise in a particular area of mental health was another important factor. This CUIR person (CL4) reported on their therapist specializing in non-monogamous and polyamorous relationships, that the therapist often "*doesn't keep up with the pronouns."* Nevertheless, they "*only have two sessions per month. […] there's no space for communication after the therapy. Which I respect."* Additionally, this genderfluid and genderqueer person (CL3) acknowledged, that the therapist has *„done so much for* [their] *trauma and also like ADHD. She's also very like willing to learn."* In this sense, participants partly described not being able to address LGBTQI related issues as "*so much of a problem*" or emphasized on "*just focus on the really important stuff that I need to tackle."* This gay participant (CL10) indicated that "*For the very first time that there are professionals or there is a professional way that somebody is listening who understands, and they don't need to explain everything"*, is a crucial factor for a trustworthy and empowering mental health experience. As this trans man (CL9) reports, reasons for ending therapy can also be that "*there was nothing trans related anymore to talk about"*.

Sub-theme 1.2. Discontinuous Factors

Most participants reported reasons for dropping out of therapy or not entering a therapeutic process as part of their overall experience with mental health services. Mainly, characteristics of the therapist that were perceived by the participants as interfering with the therapeutic process or relationship dynamics were described.

A common feeling of educating the professionals pervaded throughout the mental health experiences, as this genderqueer and intersex trans person (CL2) pointed out:

> I went from psychologist to psychologist, and I always felt like I had to be very patient. Educate them on really basic things related to me. […] I had to often lead into such fields of education that I often felt like they didn't have that much space for just having emotions.

This CUIR participant (CL4), who lives polyamorous, also quit therapy *"because I was like, I'm not going to pay more to educate this person."* Closely related to the feeling of having to explain one's reality, LGBTQI clients frequently mentioned the feeling of not being understood or seen. A transgender man from the UK remembered that the psychologist *"didn't understood what it was to be trans. [...], I was just answering questions that I was thinking you should have some record, but you should already know these questions and it was hard for me to have to relive things and bring things up again. And that caused part of the frustration.*" This aligns with the experience of that this transgender man (CL9) reported:

> I once went to another therapist in my small hometown. […] it was right after main school before I went to the trans therapist. This therapist, I went there because of depression and I briefly mentioned that I think I am in the wrong body but I don't know if this could be a cause of depression. And he just said straight away "First, we can cure your depression, and then you can go your way to find out if you are male or female"

The discontinuous factor carried over into the reports of how practitioners receive explanations from an LGBTQI client. Such as these two participants reported:

> This idea that if even for example when I felt like I had to educate them on something - for the big vast majority of them - I didn't feel like I could do that openly because they also would not openly tell me: 'oh I would like you to explain this'. They would mostly express it in a way that is like just not really understanding and then making comments that are reversed and lead me to basically refute those. (CL2)

> And I had another appointment with her. And it just seemed like the most stupid kind of help. Like it wasn't like actual advice that was gonna help me improve. It was just sort of: 'Have you thought about doing this? You tried that? Oooh.' (CL8)

Most participants reported that practitioners supported this feeling of not being understood with misgendering and the use of non-affirmative language. This CUIR participant (CL4) highlighted that their therapist who does not adhere to pronouns: "*Pronouns are not a big deal for me in this sense of I have to terminate the relationship because people are not using the pronouns I want. [...]. If the therapist learned and practiced how to contemplate them in this*

realm of pronouns. I would feel a lot more understood." This continuous slipping on pronouns also reported this genderqueer and intersex trans person (CL2) "*Then I informed him as he went on that I started using a different name and this was the name I felt better with. He still would slip up quite a bit especially when we started getting sporadic. Not so much maybe on the name but then on misgendering for example which was very complicated.*" In realm, this lesbian woman (CL4) emphasized "*I think if I was in a session and the person would misgender me, I would search for someone else.* […]."

The vast majority of participants clearly stated that if they would "*need to kind of dive deeper into gender*" or other LGBTQI+ related topics, this genderqueer and genderfluid person (CL3) from Germany "*would be looking for a therapist who specializes in that.*" Such as this bisexual, non-monogamous participant (CL5) changed his therapist:

> At some point, the non-monogamic dynamics can be really specific. And when I started and I needed help at something like to manage because it's really too much sometimes. I searched [for a] different approach or someone that's more can be more sensitive with it or flexible. […] this therapist that I'm seeing now. I think she's not like specific for like non-monogamic people, but her specialization is in relationships in general, family relationships.

Which quite aligns with the experiences of a gay man (CL6) that "*if I wanted some more LGBTQ specific, I would go to someone else*". A therapist who is not familiar with LGBTQI related themes can miss out on development opportunities, as this CUIR participant (CL4) experienced:

> I had a therapist before, which I went to because I was going through some stuff that was not related to LGBT+ issues. But then once I was there, I understood that maybe... I mean, I didn't understand because the therapist didn't help me accept that but that maybe I'm non monogamous and maybe I'm not hetero. But the therapist was always like 'actually, uh, you can just kiss someone and not tell the other person. You know there's not a big deal. I mean you just move on'. That was not really helping me and when I understood that she was not helping at all, it was just making it worse. I started reading a lot about these topics that I was interested in. Our last therapy sessions were just us discussing, but like really debating.

In addition, a participant that is working in LGBTQI+ peer support (CL10), that many LGBTQI+ people "*already started sessions with a therapist before, but it was a very*

uncomfortable situation because somehow, they felt that they could not speak openly about [LGBTQI+ related] *issues."* As he reported, his own therapy experiences in therapy, "*I never had to explain anything or I didn't see that I cannot open up to her with these issues to talking about man or I don't know. So I fortunately, I don't have this experience with mental health professionals. I mean I had only one."* Getting professional psychological support from LGBTQI+ experienced therapists can avoid the tendency of therapists to rush on LGBTQI+ related issues, as this genderqueer and genderfluid person (CL3) reported,

> I had to explain like when there was someone who was trans and like I was involved, and I was like having to explain. Like I couldn't just explicitly tell her like that I was feeling like she was coming on too strong because I know in like for lot of like trans women like this can come off as you perceive them as you would a cis man you know things like this.

This bi-sexual women living in the Netherlands reported that "*with my therapist I haven't told her that I'm bisexual"*, because "*I don't want to feel that to be her focus. But that's for me because you know, like I didn't go there for it"*. In fact, this bi-sexual man (CL5) reported:

> And I went to the therapy session not to deal with sexuality or anything like that. […] It was really good to have this help at that moment. I got depression like after like acknowledging everything because I couldn't deal with the idea of [being bisexual]. And after that, I didn't feel that we are progressing like in a way of dealing with it […] and I changed. At some point I feel that she's pushing.

Additional discontinuous factors were categorized by participants as biased assumptions, avoidance behavior or lack of knowledge on the part of practitioners. For example, a trans man (CL9) illustrated:

> What kind of put me off my therapist is that he commented my clothing. Sometimes he would say like 'a girl would also wear that'. [Now, as advice] I would tell them, that what they see doesn't really relate to what they are going to work with. For example, if someone wears a dress or a hoody, a suit or baggy pants, it has no relation to what the person has inside and doesn't define that person. That we like don't reference to their appearance.

Another example from this genderqueer and intersex trans person (CL2) was that a psychiatrist commented on their *"issues with anxiety episodes,* […] *as soon as I said that I*

have two girlfriends at that time, she said: oh, that's why you are anxious. Exactly, that is so hard to deal with, isn't it?". Experiences of practitioner commenting on sexuality, this genderfluid and genderqueer trans person (CL3) remembered:

> The sexist things, […] like if I was talking about like sexual partners and things like this, he was quite understanding and he was like against anything like slut shaming. But then he would have these like comments, or he would share sort of these stories. Kind of like worn-out things for me. I thought that like maybe like I took this as kind of sexist because it was like… maybe not sexist. I think it was just this very hetero man and then he would just have these comments every now and then like 'if I wanted to and I wasn't your therapist I could have you wrapped around my finger.'

These behaviors of practitioners were reasoned by a participant, that works with LGBTQI+ people in peer support in Hungary (CL10), "*the attitudes* [LGBTQI+ people] *experienced was kind of... I wouldn't say hostile. Somehow, I believe that somebody who is a psychologist, so they are not hostile doing that job. But rather the lack of understanding or kind of neutral attitude. So somehow* [LGBTQI+ peers] *expressed that they did not feel understood."* In realm, a genderqueer and intersex trans person (CL2) experienced "*all these other things which ended up maybe falling into this microaggression type of issue which of course is not the intention to be aggressive",* which made the person *„flinch at every single point"* and *"one of the reasons why I didn't keep going".*

4.1.2. Theme Two: Practitioners Competencies

This theme summarizes the experiences of sexual and gender diverse clients in professional psychological support regarding the practitioners' competencies. All participants stressed the importance of diversity competencies among professionals. The participants experiences were organized in the sub-themes 2.1. Awareness, 2.2. Knowledge and Skills, and 2.3. Shared-Experiences.

Sub-theme 2.1. Awareness

"*Aware. Yes, being aware of the diversity."* (Lesbian Woman from Portugal, CL1) Awareness was the most frequently mentioned characteristic of practitioners by the LBGTQI+ clients interviewed. The participants focused on why this is important when working with diverse clients. In this sense, practitioners need to be mindful of "*their own privileges"*, as this CUIR person (CL4) stated. Mindfulness in this sense was also described as understanding that "*especially if you were trans, that would be keep them different and like coming at things from different perspectives"* or "*And if you can kind of be a bit more understanding and knowledge*

of how different people experience different things then" as this gay participant (CL6) highlighted. The same applies to awareness of persisting stereotypes among practitioners, as this trans man (CL9) noted "*Well, what I've experienced is that often the services would think people – queer people kinda are crazy. Like obviously we are mentally not in a good place that is why we are asking for help."* Especially, when working with SGD clients, *"there is a lot of complexities to it that need to be explored and considered. Upon, discussing things with someone who is from that group. There is a lot in it what often gets overshadowed or looked over."* expressed by this straight trans man (CL8). All participants reported that it is important to be aware of the diversity of experiences within the LGBTQI+ spectrum. For example, these two bi-sexual participants stated:

> Like just don't let it blind whatever, whoever this person is, and whatever problems this person might have, because being LGBTQI plus is not a problem. It might be, you know, might cause a lot of traumas. But in essence, it's not a problem and it's not who you are. (CL7)

> I think [the therapist] helped me about the thing what we call identity. I had no references of a Bi man. She was really important to help me to trying to build like my own identity or that idea of myself. In a way that it's not I couldn't get from other references. (CL5)

Awareness of structural and societal norms that affect the lives and experiences of SGD people was another important quality mentioned by participants. "*OK everyone probably will have like some specificities like to process or to manage. But I mean LGBT Plus people will probably need more because I think it's more common for the society to not help them to process this in the in other spaces",* as a bisexual man (CL5) described social challenges for sexual and gender diversity in mental health care. This trans man (CL9) illustrated his "*whole journey was about having shaking knees and being afraid of being let down, pushed away."* As he described that experiences of rejection because "*'no, you are not trans, you don't look trans. You don't look like hurting yourself. You don't look like XY.' People always look at you one time and then assume"*. These experiences left the participants with the "fear of being accepted by others", as one trans man (CL8) reported. What created a double stress of "not only how to except yourself, but then how others are kind of view you and is the help you're gonna get the help that you want slash need." In fact, this CUIR person (CL4) expressed concern about being "*scared that my therapist*" who specializes in non-monogamous relationships even "*has her own bias in what is the right way to do non monogamy or to be trans or to whatever*." When

approaching specialized LGBTQ+ services, this genderqueer and intersex trans person (CL2) experienced an imposing of a norm:

> When I went to this queer association, that had also psychologists. In there, there were aware of what means to be queer in the sense mostly being gay or bi or just sexuality related things. But if I am then there are in the vibe of let's normalize it. Like this is just as you were straight. And for me it was like, no that is not avenue that I want people to consider my queerness as being straight. There is a whole completely different cultural and social structure of being queer. This is not the same as being straight.

Being mindful of different challenges faced within LGBTQI+ spectrums is another key factor in providing affirmative psychological support. As this bi-sexual woman pointed out, "*being bisexual is different from being lesbian or being gay. Or being transgender, it's complete different topic. So even for me sometimes to put it all in the same bucket* […] *it's not fair because we're not all fighting for the same rights. There's a lot in between".* Whether sexual diversity is more social accepted or not, impacts how accessible affirmative mental health care is "*for trans people and non-binary" people.* This bi-sexual man (CL5) shared: "*at my experience it took really long to talk about sexuality in my therapy.* […] *I think, for example, for gay men to search for a therapist that can acknowledge* [who] *he is, I think would be more easier."* In realm, depending on country contexts, some characteristics are more socially integrated and can impact the experiences of SGD clients in mental health care. These two participants illustrated:

> I am quite lucky with that because I am just gay. […] Because I am a kind of majority in the in the community. It's kind of easy. It's, you know, a lot of people have the kind of understanding anyway. So, but if you were part of the minority, so if you were a black trans woman or a black trans man. Even if you were trans and straight like it would be, I think, adding those extra complexities to. (CL6, UK)
>
> This very, very specifiques, which is the difference between someone who is indeed a transgender person or just a gay man who is ashamed of being feminine, not confident with being a feminine man. So, so they rather say, okay, maybe I'm transgender. (CL10, Hungary)

Coming out in therapy was considered from the most clients as important source for the practitioner to understand better the client's reality and experiences. As it gives the practitioner the space to "*put everything into context and it helps them understand everything"*

(CL6). Some participants reported to disclose themselves in the first session of the therapy, whereas they "*didn't pass through this process in the therapy. I don't know how it would have went if I passed through this process with her [therapist].* […] *So, when I went to therapy, I already knew this, so it was easier for me"* (CL1). Participants differed in seeing the importance of disclosing themselves towards the practitioner, whether in the "*first or second session, or further down the line"* (CL6). For instance, this bi-sexual man (Cl5) shared his experience of being followed by his coming out process:

> I was not aware of my sexuality. So it was during that process the therapy sessions. At that point I Identify as a hetero and straight man. At some point when I was aware in my desire to other men or to other people that were not women, I was just in a crisis first. And then in the process I was understanding what can be bisexuality or anything other than to be straight. […] Now I can see that she brought the topic. She was like trying to put this topic like visible for us to deal with. So, it was it was really good.

Later, the same participant (CL5) benefited of that experience within his next therapy, as he "*entered in the first session, like talking about my sexuality and myself. Yes, I was kind of OK with that."* In realm, this participant (CL10) reported about his coming out to the therapist by *"approached her that these are my problems as a gay man*". One reason for his confident to enter this therapy like that *"was because* […] *on her website, it was stated that she's dealing with people with sexual orientation or gender identity questions."* Yet another bisexual participant (CL7) actively chose not to share their sexuality with their therapist due to the fear that *"it's all that he or she can see".*

Sub-theme 2.2: Knowledge & Skills

The knowledge that the participants considered essential for a therapeutic process was mainly related to concepts and specificities that might affect SGD clients, as well as resources for accessing knowledge.

Being able "*to raise awareness to this minority stress or microaggression that people can face as an LGBTQ person"* (CL10), was frequently stressed by participants from the client perspective. A practitioner should "*understand what these minority stress means",* including "*how stigma, how minority distress is working and what effects these have on people's life"* and "*to understand that many of the issues that* [LGBTQI+] *people face are coming from a long way".* Additionally, risk factors and mental health challenges faced by SGD people were considered as important practitioners' knowledge, as this trans man (CL9) expressed about his old therapist: "*he was primarily a therapist and specialized in transitioning of female to male,*

male to female and also depression. More on the trans side than on depression, but because depression is extremly common and heavy side effect of trans. It just belongs there.“ In the same manner, this genderqueer and genderfluid trans person (CL3) wished for “*little bit about you know kinds of cultural and generational trauma that happens in the queer community“.* Further participants stressed on the knowledge about *“historical backgrounds, historical context, […] to understand the cultural differences between the countries where these people grow, because it's very different to grow LGBTQI Plus in the Netherlands as it is opposed to Portugal. And certainly, different from India. [...] The social context of this person versus this persons inherent“,* as this participant (CL7) stated. This also includes reflecting on societal developments, such as this participant from Hungary (CL10) shared, *“removing [LGBTQI+ topic] books from stores that are close to schools or churches. And the media is proving that“* and how that affects SGD *“people's everyday life and how they how they perceive themselves. So am I doing something wrong? Am I a bad person just because I am who I am?“*

The practitioner’s responsibility to active reach out to knowledge was something that most clients reported as mandatory. For instance, this CUIR client (CL4) reported:

> APA [American Psychological Association]. They released the document on ethical non-monogamy stuff, so it's not that difficult for psychologists to start getting into these new things. Or just ask their clients. Where could I find some information that you think could contemplate?

In addition, most participants described forms of diversity training as a way to be better equipped to provide affirmative support and the ability to “*how they navigate between these very sensitive topics*“ (CL10). In realm of the importance of training, a genderqueer and intersex trans person (CL2) emphasized that “*it all goes down to how people are trained to become mental healthcare professionals.”* As shifting the focus on diversity within the education and training of professionals, enhance the feeling of being seen.

> Specially, because I felt isolated and not having support systems, it was really complicated. Yes, I definitely think of the lack of training on a lot of issues and complex issues. I think the expectation that people cannot have that many complex issues. (CL2)

All participants wished for practitioners that are skilled to give them the space to explore themselves and work with what matters to the person. This bisexual man (CL5) experienced that the therapist “*didn't gave much inputs like to find references but made more space for me to do it”*, so he *“could build this own identity that can be unique“.* This space,

offered to this transgender man (CL8) by a psychologist, he reported, gave him room to "*just completely, like, get everything out*" and *"do it with somebody that could converse things with me. And make you feel like I was understood."*

Sub-theme 2.3: Shared experiences

Throughout the sample, participants discussed how sharing life experiences with the therapist can influence the therapeutic relationship, either in terms of how the therapist themselves relate to the LGBTQI+ spectrum and other commonalities between clients and practitioners.

> I think there are many times that I think if I did have someone who is at least queer in some of these aspects there would be a lot less explaining I would have to do maybe in the therapy. […] I mean my therapist now I don't think we have the same trauma experiences or something similar to mine. So, I think there's definitely a way and humans are good at empathizing and learning but I think just the state of the world now. Genderqueer and Genderfluid person (CL3)

In terms of the future qualities of a therapist, this trans man (CL8) pictured: *„if anything, I want them to be LGBT somehow".* The same participant (CL3) further expressed that "*it can be difficult explaining like the current day-to-day things like the difference between a queer space or a queer relationship* […] *if they're hetero, they're probably monogamous, they probably have a nuclear idea of a family and things.*" Participants stated that practitioners often had difficulties to understand what it means "*to be trans*" or "*conceptualizing someone who's non-binary."* Being followed by an LGBTQI+ therapist was mostly indicated when looking for a new therapist. LGB participants were more likely to report that an LGBTQI+ therapist "*would help"*, but "*doesn't necessarily need to be that way"* (CL6). Another participant (CL7) agreed that "it *could be very interesting"*, because *"then the path to understanding would even be shorter."* In realm, this bisexual person (CL5) considered that his current therapist identifies "*as a lesbian woman. I don't think that it's something that it's enough maybe. […] the same identity […] can be helpful to be open or something, but I don't know if it's enough".* Later, this trans man (Cl8) acknowledged that *„they don't have to be trans. But they have to have that specialist knowledge of the trauma that can come along with being trans, like childhood trauma with being trans."* In this sense, a genderqueer and genderfluid person (CL3) steered in "*I don't think that it's impossible for someone to specialize in therapy with gender and not be genderqueer themselves but at this day and age I would just it's easier to prefer that".*

Sharing lived experiences were also reported in domains such as cultural background, daily contexts, or where one grew up. For example, this woman (CL1) reported such a situation about something they shared the same threat in therapy,

> Then in the next session in the beginning told her 'oh so we were talking about this and you said this and I didn't feel very safe in that moment'. She was very sorry and then she starts to be in therapy like she was therapising herself like 'oh I think it was because of this and I'm so sorry because we are both woman and the girl that was unfortunately raped was in the same area that we both lived'. So, I think she was feeling very personal about subject, but it was so nice to feel like feel that connection.

In fact, this Portuguese woman (CL7) recognized the advantages of having a Portuguese therapist due to shared socialization processes,

> Not necessarily for the language, […] if I tell someone from abroad from this place in Portugal, the way that it's perceived and contextualized is very different from somebody that is from Portugal and knows this place. […] If I talk about my parents' generation. The parents, our parents' generation in Portugal comes from just outside dictatorship and from a very like big transitional period in Portugal. And historically speaking it had a huge impact on the generations. So obviously our parents' generation have a lot of importance and it's really important to know this inherently. I don't need to explain it.

4.1.3. Theme Three: Mental Health Care System

Theme three reports the experiences of SGD people regarding common factors related to the use of psychological professional care. Aspects of accessibility such as legal frames and financial barriers, as well as the offer of LGBTQI+ affirmative support opportunities were reported.

Sub-theme 3.1. Accessibility

In the experience of the client perspective participants, the accessibility of mental health services played an important role in their help-seeking behavior. A lack of public services that impacted this trans man from the UK (CL8):

> Before socially transitioning, I went [to a gender clinic]. But when I went to see it [again], they offered me the opportunity to go speak with like groups […] or have counseling […]. But all those years ago, I don't think they offered that, and they did only recently. […] I could go and look for a therapist who would have knowledge in

> transgender people and LGBT issues and that sort of thing. But in terms of actual help provided to me by the government has not really been a lot.

In the context of visibility, participants reported that they found their former therapist by chance, for example, through "*just a Google search*", as this gay man (CL10) shared: "*And then I checked the web pages and then I saw her site. And saw what she's dealing with and then that was it.*" Another example, "*was a list that I don't know who created*" about which a CUIR participant (CL4) said that they "only have *been able to find the therapist that at least understands and knows some things that I'm going through*". In realm, this participant (CL10) referred to the lack of visibility, due to the politicized, and difficult public atmosphere in Hungary.

> And kind of gender and the LGBTQ people became escape gods in the country at the moment. There are professionals who rather just ignore the topic or who don't want to deal with questions or publicly state anything. So, I can imagine that this information [offer of LGBTQ+ affirmative services] is not flowing transparently.

Another important factor is the lack of capacity of LGBTQI+ welcoming or specialized services, as this CUIR participant (CL4) mentioned *"the therapists in non-monogamy are full. […] There are three and there are full."* Additionally, this trans man (CL8) stated "*At least in the UK there's not enough. The NHS is massively understaffed. And from this like more minor departments which would include LGBT people, there's not gonna be enough specialist help which is needed.*" Suffering from the lack of capacity, the participants often reported their difficulties to get affirmative mental health care while facing financial barriers, as this experience from this bi-sexual person (CL5) illustrated "*that she helped me with the process of being non-monogamic.* […] *I think at that point, I stopped really* [because of] *financial reasons.*" Another example stated this non-monogamous living person (CL4) "*My psychologist made a discount, but it's like the general price now that every psychologist, private psychologist asks for.*" In realm, a lesbian women (CL1) quoted:

> I didn't have the option of selecting the therapies because I was paying so little. She's not like specialized in LGBT community. I don't know what her focus is but she it has been really helping. Sometimes it is strange because I talk about some questions about some issues about my relationships because I started going because relationship issues and some things she doesn't know. […] She doesn't know these little details but, in this time, I feel it's not a problem for me. It isn't being a problem because most of my issues are with myself.

Sub-theme 3.2. Structural conformity

Apart from accessibility, client perspective participants highlighted structural factors that influenced their mental health experience, such as targets of mental health and societal norms, such as trans people that have to go for transitioning to two or three different therapists "just to be considered". Participants often perceived the "*structural sense [...] the focus tends to be on standards but perhaps in mental well-being psychological healthcare there is more awareness of the individual but perhaps there's still a lot of standardization.*" This CUIR participant (CL4) stated „ *my opinion, clinical psychology and psychotherapy is still within the norm, which is binary.*" In realm, participants perceived that "professionals would treat the social norms. "*I think to look beyond that, would be good* [for] *the people that are inside diversity.* [...] *mental health services would be like, really maybe necessary because in general I think the society will not be nice to* [LGBTQI+ people*]. Like we're not meet* [SGD individuals] *needs.*"

4.2. Practitioners' Perspective

According to the model of cultural competence (Cross, 1989), the development of cultural competence can be described with different competence stages (Cross, 2012; Kirmayer, 2012). These stages, incompetence, blindness, pre-competence, competence, (proficiency), were applied to categorize the experiences of mental health professionals (*n* = 12). Following a three-dimensional model (Sue, 2008; Israel and Selvidge, 2003; Kirmayer, 2012) the practitioners' statements were organized according to the extent to which clinicians have adequate awareness, relevant knowledge and practical skills in working with people from different cultural backgrounds. Three themes emerged through this thematic data analysis, (1) Awareness and Attitudes, (2) Diversity Knowledge, and (3) Clinical Skills. Awareness and Attitudes contained three sub-themes: *1.1 Central Belief, 1.2 Practitioners' Bias, 1.3 Awareness Common Factor*. Diversity Knowledge is as well organized in three sub-themes *2.1 Lack of Knowledge, 2.2 Self-education and Resources, and 2.3 LGBTQI Related Topics*. Clinical Skills in *3.1 Adaptation, 3.2 Acknowledging Boundaries, 3.3 Exposure & Shared Experiences, 3.4 Diversity Training.*

4.2.1 Theme One: Attitudes and Awareness

According to the literature, cultural awareness refers to the ways in which the clinician's attitudes, beliefs, values, assumptions, and self-perceptions affect their interactions with patients who are culturally different from them. It involves exploring the self as a cultural being and one's own cultural biases (Sue, 2008; Israel and Selvidge, 2003; Kirmayer, 2012). In the purpose of this study, the theme Attitudes and Awareness include the beforementioned attitudes

and awareness factor in regard to SGD clients. Three subthemes emerged within the theme of Attitudes and Awareness, the practitioners' 1.1 Central Belief, 1.2 Practitioners' Bias, 1.3 Awareness Common Factor.

Subtheme 1.1. Central Belief

The central belief relates to general acceptance and respect for differences. Practitioners' statements assigned to the continuum of incompetence expressed mixed attitudes toward sexual and gender diversity in society. "*Not so long ago, no one would say anything against it*", as one clinical psychologist (P3) stated, referring to "*just because this is his belief* [boys are boys, girls are girls] *and people are no longer accepting it".* In addition, a Gestalt counselor (P9) reported "*So, this is one part when I'm projecting something that I'm the diverse and different. That with me something is wrong."* Along with the tendencies of diversity as difficulty, the public diversity discussion was stated as "*that some people are taking it a little bit too far"*, what this clinical psychologist (P3) illustrated:

> There's this children's [explaining transgender topics]. And I think that's fundamentally wrong because you should not confuse kids like that. I think if a kid identifies with a different gender, they will let you know. They will let you know, and you don't have set something into their head before it's even happened yet.

Compared statements that were placed on the blind continuum of competence development tended to deny the existence of differences, as this dance therapist (P5) quoted "*It doesn't matter whether you're purple, pink, or yellow or whatever [...] Or let me say with gay people, for example that the relationships are the same.*" This central belief that "*relational issues are also universal. It's not based on the issue that they are gay"* (P10) was often expressed by practitioners working with gay couples in therapy. Central beliefs within the blind continuum rejected the notion of ongoing discrimination, for instance, that participation in psychotherapy to change a client's sexuality could only be sustained by "*a few old*" practitioners (P5). These statements about full equality in professional practice are at odds with this report from an LGBTQ organizational psychotherapist (P2) on the competency continuum:

> [It] is quite a broad generalization but having this awareness that for example that you could have a monogamous gay couple where one of the partners has sex with other men. And this is fairly normal in this relationship. Were as I would hope that the relationship therapist could see as this is the norm, this is not problematic.

As the individual are accepting and respecting differences, the competence in the central belief is reaching the pre-competence continuum (Cross, 2012). As Gestalt counselor (P6) illustrated:

> So, gestalt is a pretty much a general attitude, and therefore, in my opinion, sexual orientation would not be anything more special than any other way of living. So, I would not consider it different from a straight person's attitude. Though, I can imagine that some issues which are mainly LGBTQ issues would pop up obviously.

Within the acceptance and respect of differences, a psychotherapist working in an LGBTQ organisation (P2) reported that the clients *"need to be validated in their own experience".* According to this practitioner, "*what makes the difference in these particular cases is that they want to be a part of something, some group, some little box and sometimes they don't.*" A cognitive-behavioural trauma psychotherapist who identifies themselves as trans and genderqueer (P11) highlighted the importance of *"being really aware that my perception of things is not the same for all the people".* In addition, a clinical ethno-psychotherapist (P7) emphasized that it is important *"to understand what they're saying not creating my own ideas"*. As equivalent, this practitioner from Portugal (P2) shared:

> The most empowering thing that you can do for someone that the literature said that has so many specific things about them […] Kind of have to be open to invest in the person that's in front of you and to put your own experience a little bit aside.

Sub-theme 1.2. Practitioners' Bias

The expressed attitudes and awareness were organized within the practitioners' bias towards SGD clients. As this psychoanalytic psychotherapist (P12), practitioners "*can do quite harm*" if "*they don't know what belongs to them and what belongs to the patient".* A clinical psychologist (P3) quoted *"to be open minded and non-judgmental, but it's obviously much more difficult to relate to that person without having anything to relate to".* Statements such as these may indicate biased attitudes (Cross et al., 1989; Cross, 2012) toward SGD people and thus have been classified on the continuum of incompetence, as illustrated later:

> But in that bad way, I find it very difficult for young kids and for teenagers to on top of all their issues that they have, […], and now have to think about all the new rules surrounding LGBTQ. They have to understand that they now need to call their classmate Leo instead of Leah, right? They now have to understand that there's no separate bathrooms. They now have to understand that there's very different rules, and

a lot of problems come with that also. That are scared to hurt anyone, right? Because people actually get very offensive if you don't say the right pronoun or if you don't treat them with respect right away. (P3)

Claiming to be completely unbiased, practitioners expressed attitudes of not noticing differences, such as "*whatever is purple*" (P5) or not seeing a need for any type of diversity training because they see themselves as "*sensitive enough to the world to work with different age groups, with different regions*" (P9), seemed to fit into the continuum of blindness in developing awareness and attitudes toward sexually and gender diverse clients. In comparison, this Gestalt practitioner (P6) emphasized self-motivation through the acquisition of knowledge, especially if it is "not the *system who supports the individual or provides the courses or regulates".* Whereas the pre-competence and competence stage include continuing self-assessment regarding culture, as an integrative psychotherapist (P8) stated "*that has to do with working on yourself, because what you judge is what is in your shadow."* This implied, the practitioners responsibility of self-assessment, to "*notice that there is a bit of judgment in one direction, you know what it is and you take care of* it*",* as this psychoanalytical psychotherapist (P12) further expressed:

> If you get it wrong yet, […] be honest with yourself. […] Supervision, for example, would be important [to] explore […] more unconscious biased or moralistic, judgmental attitudes that can come in very discreet ways, but that the patient may get without it may not be verbal, you see, maybe be the positions, face expressions, stuff like that.

In addition, the competent stage statements validated practitioners' awareness of projection, triggers, and unconscious bias. Accordingly, psychotherapy remains "*a profession, like others, but in a way, one has to be very honest with oneself and know what things we are good at, what are the things we may struggle with"* (P12). Acknowledging practitioners responsibility, these to statements illustrate incidents in therapy:

> A client, […] she identified with the woman in all sense. But when she was talking about her life, […] once she was talking about having dated a man and she was talking about dating a woman. And it was, I mean she was not coming for dating problems. So, that were just information flying by and that was really normal. […] But the problem is that now when you hear something that doesn't really […] resonates, you get distracted, you get triggered often. And then you need to know more. You need to understand. Integrative Psychotherapist (P8)

So, when [the first and only trans person] talked about her concerns. I said I don't have these kinds of tools. […] Of course, I respect, but I will not understand a lot. We can do it together but I'm recognizing some flaws I have. We can do it, or we can transmit your case because it […] was not for example, depression, anxiety. [The person] was in the [transition] process. Ethno-Psychotherapist (P7)

Both (pre-competence) statements include awareness of one's own abilities working with SGD clients. The competence stage further includes, from the practitioner's perspective, awareness of harm from ignorance and unawareness, as illustrated by this LGBTQ organizational psychotherapist and victim supporter (P2):

All those specific issues or problems or ways of being, those are so specific that if you don't learn about it, […] you will never know. If you find someone in front of you that brings that history and those stories to you, if you don't know how to receive them - well, what kind of work will you be doing with them? Are you contributing to the transphobia that they've suffered being non-binary?

Sub-theme 1.3. Awareness Common Factors

The importance of considering common factors that might impact on SGD clients was often mentioned by practitioners within the competency continuum of awareness. For instance, this psychotherapist (P1) stated:

People that aren't gay or homosexual or whatever didn't suffer homophobia, internalized homophobia, external homophobia, what kind of impact does that have on the person being trans for instance? What kind of impact does it have on someone that grows, is growing, is developing in a certain way, but the world around them is telling them you must behave, you must be calm?

In order to understand the client's experience, the legal framework and the implications for SGD people remained important. Either practitioners "*would ask some questions to find out* [if legal marriage, gender] *has* […] *been recognized or not,* [and] *ask if* [the client] *felt it was relevant" (*P12) or informing themselves in sense of *"juridical counseling in sorts of the law* […]*, this is the law, and* [professionals] *need to keep up with it"* having "*these resources available for* [LGBTQI] *people"(P1).* Additionally, most practitioners in the competence stage stressed on the importance of practitioners being aware of historical and societal changes. Giving the example that "*there are upcoming transgender psychologists that is fantastic […].*", but "*it was also really hypocritical for queer people treating queer people*", as this cognitive-

behavioral trauma therapist (P11) highlighted. These statements on awareness and attitudes in working with people with sexual and gender diversity emphasized the second theme – Cultural Knowledge.

4.2.2. Theme Two: Cultural Knowledge

Cultural knowledge includes understanding cultures that are different from one's own (Cross, 2012). Within this theme three subthemes emerged among the practitioners' perspective: 2.1. Lack of Knowledge, 2.2. Self-education and Resources, and 2.3. LGBTQI Related Topics.

Sub-theme 2.1. Lack of knowledge

Most statements that addressed persistent stereotypes towards LGBTQI people were placed on the continuum of incompetence. This lack of knowledge can be illustrated through a comment that implies LGBTQI clients in therapy to a certain age group:

> [Colleagues working LGBTQ clients] share in supervision situations some stories that he or she was shocked, what she heard because we couldn't imagine with our age. […] But in my profession, I haven't met yet […]. My clients are mostly above 30 so. Maybe that's why. Gestalt Counselor (P9)

A lack of knowledge was also expressed by placing LGBTQI topics within psychopathologies, such as treating a patient who was seeking gender affirmation, *"someone ones asked me if I would work with a* [refers to another psychopathology] *person. Even though, I feel like I could have empathy with that person, I sensed that is outside of my boundaries"* (P10). In a similar manner, a Gestalt therapist (P9) stated *"From physical violence, I heard a lot of different stories from alcohol, from any other addictions. […] So, I don't think so I became shocked or anything. Just I think, I haven't met* [LGBTQI clients] *yet, that's all."* Statements as such continued the lack of knowledge in the blind stage of cultural development.

> I never get approached by [LGBTQI] people. It's interesting, because I believe that we attract people with who's problematic we already dealt with or partly. So, I never had gender issues with myself, so they don't come to me. It's the law of attraction. I can imagine if I had those issues, like if I wanted to be a man, probably I would attract this kind of client. Integrative Psychotherapist (P10)

This blindness to the importance knowledge is also illustrated by an understanding of current diversity discourses as "*little bit too narrow*", because only thinking of "*people of color*", "*only thinking of sexual orientation*", "*gender issues*", as a dance and Gestalt therapist (P5) stressed on *"the diversity of discussion".* The role of knowledge in the development of

cultural competence was recognized by practitioners in the pre-competence phase as basic cultural knowledge. In this sense, this participant quoted:

> I think the only advice I can say is that always keep your mind open. Never think that you know everything. Because every time you can surprise about something, about a person, about a reality, about is impossible to be a psychotherapist and know everything. Gestalt and Somatic Experience Counsellor (P4)

Additionally, the practitioners in the pre-competence stage indicated resources for basic cultural knowledge. In realm, a Gestalt counselor in Hungary (P6) mentioned the role of self-education:

> If the individual [therapist] is interested in, let's say, LGBTQ issues, she or he can turn via Internet or the library or courses to the most modern informative websites. But if an individual [therapist] is just sitting back home – […] if [it is] a therapist without language knowledge and with an active propaganda. [...] All the news, all the radio station, all the billboards on the streets are owned by the state.

This is consistent with the testimony of a trans and genderqueer cognitive behavioral therapist (P11) who indicated that research is a good source of knowledge about LGBTQI+ topics, like "*how does that work or not asking inappropriate questions, […] what sort of questions are okay to ask.*" Most of the participants stressed the importance of asking the client to "*put yourself in and explain it to me like I'm a child. And they explain everything, or they give references. Normally this is the thing they write or they say 'check out in the Internet',* as this ethno-psychotherapist (P7) emphasized the combination of self-awareness and client experience as a valid source of information. However, competent practitioner statements emphasized the importance of asking appropriate questions related to the therapist's ability to allow "*the patient to explain to you what that experience are like*" and "*dealing also honest to be in a position of unknowing*" while *"always communicate back without making assumptions"* (P12).

Sub-theme 2.2: Self-education & Resources

According to the most practitioner participants the expansion of cultural knowledge is a continuously and active process. As discussed above, the practitioner needs to engage actively and critically in training and knowledge, because often are provided resources lacking, as participants reported from "*so-called cultural training"* which covered some topics around *"the gay communities"* but addressed *"mainly violence against females"* (P6). For example,

this practitioner (P4) shared the process of reaching out to knowledge when got the first trans kid as client, "*There is not so much by the biography about this. I first of all I search in associations […] that have groups and a lot of material. And then I buy also a lot of books.*" However most participants claimed the need for continuous learning, accessible and valid resources around sexual and gender diversity topics were illustrated by statements of practitioners within the competence continuum. Another example of the need for critical reflection on available resources was cited as an experience by this trans and genderqueer psychotherapist (P11):

> Further education, one of the biggest post-master educational programs in Utrecht and Amsterdam, they offer now a course on sexual orientation and gender. So, I was curious what they are teaching. It was not good. Hearing another psychologist saying 'Well, I shouldn't have to know these things, if my client brings them in, they will teach me.' And I was like nooo, this is incredibly worrying to hear a perspective colleague talking like that.

Sub-themes 2.3. LGBTQI related topics

Practitioners reported that knowledge includes concepts and processes, as this psychotherapist working in a LGBTQ organization (P1) stressed "*people that belong to the LGBTI+ population […] might react in a similar fashion that most people do, but they still have certain peculiarities.*" For example, this cognitive-behavioral psychotherapist (P11) stressed the importance of practitioners being able to support the client in informed decision-making. They stated that before a person makes decisions about their body, they should explore "*that gender is developed. That gender is something that is influenced by societal expectations. That is influenced by the way you grow up. By so many different things. By life experiences.*" The coming out process was further considered as possible "*very anxious process*", sometimes "*very dangerous process*", that practitioners need *"to be mindful of those dangerous situations"* (P1) working with SGD clients. According to the practitioners' statements, knowledge further involves the cultural impacts on psychological development, social minority stress and identity development. These two practitioners working in an LGBTQI+ association in Portugal explained:

> Regardless of what minority is - we have to be extra careful or extra mindful of what does it mean to be part of that minority? Does that minority will give that person an extra load of stress? Will that anxiety or is that anxiety symptom of being part of that minority, or is it some something else? (P1)

> LGBTI+ people because sometimes they don't want to disclose their sexual orientation, for instance. When they become entangled in the abuse in a toxic, toxic relationship, they are much less likely to disclose their issues and their toxic relationship to other people. So, they are much more likely to become stuck in an abusive relationship in domestic violence et cetera. (P2)

The importance of a holistic picture to acknowledge diversity illustrated an ethno-psychotherapist (P7) as "*that's going to differ from what the people are saying to us. [...] I don't have to put that person in the transsexuality when the person is not talking to me about it*".

> Different presentations and the different narratives that people bring. The different life stories, the different upbringings, the different interpretations they give. So again, it's quite rich because no depression is the same, so to speak, or anxiety or, you know, this symptom one can relate as a general sort of applicable generally as symptoms. But in a way, when you go to the specificity of the causes and the narrative, and that's always that's a special reason to do with that individual. So again, it brings more richness. Psychoanalytical Psychotherapist (P12)

All practitioners within the continuum of pre-competence and competence indicated that LGBTQ+ relatedness should have its place in therapy but need not be the focus. In the same sense as this practitioner (P11) highlighted *"chances are that [LGBT clients] are not coming because of their identity. It's something around that. And maybe their gender identity or sexual orientation plays a role, but it is not the main thing."* Therefore, the statements within the competence stage clearly reported that SGD clients bring a variety of topics, experiences, and features into therapy, such as this ethno-psychotherapist working with asylum seeker and refugees (P7) acknowledged "*LGBT is not only LGBT. Migrant, it is not always migrant.*"

4.2.3. Theme Three: Clinical Diversity Skills

In the present study, practitioners highlighted skills that are important to provide affirmative mental health care for SGD clients (SGD). The subthemes emerged throughout the practitioners' interviews regarding skills: 3.1 Adaptation, 3.2 Acknowledging Boundaries, 3.3 Exposure & Shared Experiences, 3.4 Diversity Training.

Sub-theme 3.1: Adaptation

In fact, all practitioners felt that a mixed box with all skill levels provided a better quality of care for the individual because "*if my client comes with something, I look at my toolbox and decide what can be most helpful*" (P11). Starting from the stage of incompetence, most

practitioners expressed their critical opinions about general developments in diversity and tended to see responsibility toward SGD clients. According to a clinical psychologist (P3):

> I think it's very important that they feel comfortable with me and maybe my approach doesn't relate to them. Because of their belief system, because of their background. That also happened. So, for me it's I guess it's more their challenge than my challenge and I just have to accept that I might not be the right fit for that person at that time.

Another practitioner (P9) reported a situation where the client felt that the assumptions of his work colleagues were based on his sexual orientation:

> It came out that this is his projection to the others. And not a reality what was in the other one's mind. The other one was really angry about what he did wrong. In the workplace, but not because he likes boys. […] I also tell them about his projection and why it is not useful in many situations.

Within the blind stage of cultural competence, practitioners expressed overall that they perceive themselves as fully unbiased and responsive to the needs of SGD clients. None of the statements considered the practitioner actively involved in the reflection process. For example, this practitioner stated (P5):

> When I am with an intersexual person, and they do a gender change. Of course, we talk about these issues you know because it's very complex and it's that's what they deal with and but not in the way of, I hope under the way of like right or wrong or whatever.

Statements that were categorized within the pre-competence continuum, practitioners validated the own impact on the client. An ethno-psychotherapist (P7) illustrated "*I have to understand what they're saying not creating my own ideas. […] So, the person can say a lot of things to me if I start thinking in my own head 'maybe this is X' that's all wrong*".

Sub-theme 3.2: Acknowledging Boundaries

The ability to self-reflect their own cultural biases led most practitioners in the pre-competence phase to a conscious recognition of the limits of their expertise. For instance, an integrative psychotherapist (P8) shared that "*teenager struggling with gender identity, I really felt this is out of my expertise* [and] *I could just make it worse. But it's a boundary that you need to keep an eye on.*" Practitioners that stated the awareness on knowing their own boundaries with SGD clients within the pre-competence, also reported the importance of networking. For instance, connecting with LGBTQI organizations, as this practitioner (P6) quoted "*There are support groups for LGBTQ people.* […] *I actually I wanted to connect them already to talk about*

possible contribution" or valuing the lived experiences of LGBTQ+ people as valid points of reference, as this practitioner (P8) stated in that school she studied psychotherapy *"one of the head teacher is also part of the LGBT +, I know that he has been giving this short training. I think he calls it queer coaching."* In the same sense, a practitioner that is often working with trans children (P4) highlighted:

> I'm not a trans person, so to really, really understand that I have to read a lot and hear a lot of trans people to try to understand more. […] So, for me it's so important that part of respectful hear what the experience of that people and I can empathize a lot, but always will be a part that I don't know.

Sub-theme 3.3: Exposure

The practitioner statements attributed to cultural competence referred to the need for contact with LGBTQI people for practitioners to gain more experience. For example, is this psychoanalyst (P12) recommended "*resources in terms of support networks* for practitioners], *support networks for the parents too. That sometimes can feel very left out."* Practitioners who themselves belong in some way to the LGBTQI spectrum emphasized the still existing lack of LGBTQI practitioners in general, especially in relation to trans or non-binary practitioners. As this practitioner, identifies themselves a trans and genderqueer, noted *"there are almost no trans psychologists and there are also not a lot of queer psychologists either."* As the same therapist (P11) points out, practitioners should be aware of an approach "without objectifying" or SGD peoples experiences: "*Just because you have talked to a trans person does not mean you know the whole trans experience. Or the whole queer experience*". This also comes with an understanding of that "*there is so much to touch on. Every culture whether that's like I said with all these different intersections, all different cultures I don't think it's possible to have an entire knowledge about them."* (P11).

Sub-theme 3.4: Diversity Training

All the practitioners who pointed out the importance of trainings for working with SGD clients have themselves conducted trainings, which address clinical skills within the proficiency continuum. This psychotherapist working in a LGBTQ+ organization (P1) illustrated "*We first try to refer* [Practitioners] *to us, so we can provide training to whatever association or school is reaching out"*. In this realm, this practitioner (P11) stated "*I give lectures at the university, I was asked twice. So, for upcoming psychologists and it is quite nice. […] So, that there are upcoming psychologists that have knowledge of this. But most of them have absolutely no clue"*. Most of the competency continuum statements also highlighted important LGBTQI

related topics that should be addressed in diversity training. Key factors that were mentioned included deconstructive work on the practitioners themselves, "*Associations and professionals are also afraid of* [LGBTQ+] *people because they don't know how to handle it.* […] *there's still […] a lot of deconstructive work to do amongst entities that work with people*" (P2). In addition, basic knowledge around sexual and gender diversity needs to be transferred, like *"how do I approach this issue, or I have a trans patient or client. What should I know? What kind of issues should I be aware of?"* (P1). In realm, these training providing psychotherapists explained:

> They've asked me to give workshops for other psychologists. That I've gone really to the grid of it like what is a binder, what is a packer and actually showing it to them. So, bringing my own personal stuff. So when a client is telling them that they are planning to buy a binder or where can I buy some tucking swimwear that they know what that means. (P11)

> Being a part of the LGBTI+ community is a risk factor as it. Because we know that these people are more prone to behaviors like bullying or hate crimes. Some behaviors like outing as well and that being used as a threat too. So, they would behave a certain way or they be a certain way. So, these are like the main things that are mentioned in this training programs. Psychotherapist and victim supporter, Portugal (P1)

However, most practitioners further mentioned challenges in providing diversity training or support for mental health professionals, such as frequency and the space given to training, or practitioners' time resources. "*I mean with my training, they had like half a page in a book. That's it. And now they get me to come for one session. And then that's it.*" (P11)

4.3. Client-Practitioner Match

Overall, the way in which both experiences were aligned regarding diverse competencies was dependent on the level of the practitioners' experience level. These three themes were dominant throughout both perspectives: (1) Validation of LGBTQI+ Clients' Experiences and Emotions, (2) Therapeutic Qualities, (3) Shared Experiences.

4.3.1 Validation of LGBTQI+ Clients' Experiences and Emotions

> People feel that they don't have the room to be or to just exist. So that's the first step, […] in helping any person who belongs to the LGBTI+ population/ community, whatever you want to call it. Just create the room, create a space for them to exist and then work from there. And let them explore.

LGBTQI+ organizational psychotherapist (P1)

Most of the pre-competence to competence statements reflected the bare minimum of the clients' therapeutic conditions in order to receive appropriate treatment. The validation of the client was reported to start with very basic things, such as asking the client for the names or pronouns they would like to be addressed by. As illustrated by this LGBTQI+ experienced psychotherapist (P1) in his practice "*The first thing that I ask is what name should I call you? […] I can also guess the pronounce, but I still ask about the pronouns.*" Aligning with "*If the therapist learned and practiced how to contemplate them in this realm of pronouns*", this CUIR participant (CL5) reported from a client point of view, "*would feel more understood*". In this context, a psychotherapist (P1) from an LGBTQI+ organization reported on the reaction of his clients that not being asked what the person wanted to be called often resulted in them "*able to share the things that* [they] *wanted to share*" or lacking of "*the space to be who* [they] *wanted to be*". This clinical psychotherapist and victim counsellor (P2) expressed this sort of experiences with LGBTQI+ "*person*[s] [that] *needs to be validated in their own experience. I believe what makes the difference in these particular cases is that they want to be a part of something, some group, some little box and sometimes they don't.*" In this realm, a genderqueer and intersex trans person (CL2) reported that they "*couldn't just go [to a psychological support] and share everything because as soon as I shared everything very openly, I would get thrown into this category to simplify my experience* […]. *I always felt very unsafe with these situations*." In fact, this is consistent with the experience of one trans man (CL9) who witnessed "*that often the services would think people – queer people kind of are crazy. Like obviously we are mentally not in a good place that is why we are asking for help*". Supportively, this clinical psychotherapist and victim counselor (P2) noted "*that people from LGBTI+ community are still very afraid to ask for help because they think that they won't be understood. They won't be validated in their experiences.*"

The issue of understanding was one of the most common themes that ran through all the interviews from both perspectives. Whether it was the feeling of not being understood by clients, as this participant (CL10) who himself works in a peer support facility reported, "*Somehow, I believe that somebody who is a psychologist, so they are not hostile doing that job. But rather the lack of understanding or kind of neutral attitude. So somehow they expressed that they did not feel understood*", or, depending on the skill level of the therapist, whether they felt able to relate to LGBTQI+ experiences. For instance, this ethno-psychotherapist (P7) emphasized "*I don't have these kinds of tools. I think I of course I respect,*

but I will not understand a lot“. Another important validation point reported from both the clients' and more experienced practitioners' perspectives was the separation of reasons for seeking psychosocial support from LGBTQI+-related topics. This bisexual woman (CL7) illustrated:

> Like just don't let it blind whatever, whoever this person is, and whatever problems this person might have, because being LGBTQI plus is not a problem. It might be, you know, might cause a lot of traumas. But in essence, it's not a problem and it's not who you are.

Validating the variety of one's experiences were mostly expressed within the pre-competence to competence continuum. For instance, this cognitive-behavioral trauma therapist, trans and genderqueer themselves (P11), reported from many clients "*that happened to be LGBT and we never talked about it because that is not why they are seing me".* For example, this bisexual man (CL5) ended a therapy because the therapist was pushing too much on his sexuality "*and to continue like in the same pace would be not good for me. At that point it was not really fine".*

4.3.2. Therapeutic Qualities

Not being judgmental, open, and interested towards LGBTQI+ clients was reported throughout all interviews as important therapeutic quality. Being mindful of having "*an open curiosity that is not fetishizing or objectifying or voyeuristic“*, as this cognitive-behavioral trauma therapist (P11) framed. The frequency of questions was described as "*caused part of the frustration*“ when this trans man (CL8) "*was just answering questions [...]. It was hard for me to have to relive things and bring things up again*". Referring to asking as valid resource, this dance therapist (P5) illustrated "*curiosity helps us to ask questions in order to find answers. [...] It's more important that we ask more questions than having good answers. The clients have the answers we just need to ask good questions."* In realm, this cognitive-behavioral trauma therapist (P11) stated the importance of *"real curiosity. How does that work or not asking inappropriate questions“.* Whereas this psychoanalyst (P12) reflected a case where he helped a male gay client of him overcoming is shame towards some dreams and kinkiness, with "*kind of showed some interest and wanting to go deeper. I was in a position of understand being rather than being, judgy or moralistic."* This CUIR client (CL4) also felt validated by "*exploring what is to be non-monogamous or what different ways could there exist being non monogamous and that is also legitimate to be non-monogamous as legitimate as being monogamous*" in therapy. Clients clearly distinguished between the therapist's interest and

curiosity and slipping into standardization. From the client's perspective, as reported, it depends on how the practitioner asks and receives the answers. For example, this genderqueer and intersex trans person (CL2) quoted:

> When [practitioners] say they are wrong, they are not saying they are wrong as simple thing. They are justifying what they don't know something. Like you don't need to explain to me why you don't know - you could just tell me 'I don't know'. Then we can go from there.

(Pre-) Competence statements referred to practitioners that act responsive and should be "*someone that is open to their own mistakes because even if it wasn't like a mistake on purpose, it made me feel unsafe in a space where I should be always safe humble towards the client"*, as this lesbian woman (CL1) stressed. Acknowledging boundaries in a pre-competent stage is about by acknowledging one's own biases. Quite clearly, this CUIR participant (CL4) shared "*like the psychologist must know their limits, no? So, maybe someone who is more conservative would not see this topic that is legitimate to be working on, gender, sexuality, whatever*". In realm, this ethno-psychotherapist (P7) expressed:

> I don't really understand that kind of dramatics, so I tend to transmit […] the case. Because I can be biased, and […] I don't want to be pushed to fall in my own biases, so I don't permit myself in even to go to reach that point.

On the contrary, this dance therapist (P5) reported "*I do it with awareness then to learn and hear. I hope that they would also say, I was always open, and they didn't feel discriminated because I have this attitude you are a person*." When clients pointed out biases and prejudices of practitioners, such as issues that may fall into the realm of microaggressions, it was often "*with the intention of being aggressive"*. Yet this prejudiced experiences mostly resulted not staying in mental health care at all. Statements of practitioners that were attached to the incompetence or blind continuum seemed to not reflect own biases and prejudice neither how to maintain or build this competence.

> But I also think that we need to have a little bit of space for people to adjust, and I think it's hard for both. Like, obviously the people who are identifying as a different gender or non-binary, they have a lot to carry. They might have carried this weight for a long time, but the other people be able to adjust as well. Clinical Psychologist (P3)

In validating the client's experiences, the effort and motivation to reach out to knowledge clearly made the difference in dealing with LGBTQI+ related topics. As this ethno-

psychotherapist (P7) notice "*So, I'm not going to put me in the situation that if I don't know, I don't care.*".

> Also, by becoming more informed you find out there is so much more to know. There are also people that are asexual, people that flow, people that are polyamorous. There is so much to know. And my personal opinion is that when let's say the heterosexual traditional folks become more aware, I think that's also where the fear is that you get ideas, you realize there are more options. Integrative Psychotherapist (P8)

While incompetent and blind practitioners statements were mostly that they are "pretty much aware [their] capabilities", what they „like to be working with", as this practitioner (P3) shared „If I already noticed that there's a person who, let's say, has issues surrounding LGBTQ, I would definitely refer them to another medical professional." Another common attitudes was that practitioners just never had an LGBTQI+ client, but if they would, they „would have to research". Nevertheless, clients differed in their expectations about the knowledge level of the practitioners. For example, this trans man (CL8) stressed "when it comes to a therapist, I'd want them to be like know a lot a lot. Hence why I don't want to have to sit down with someone and explain everything. […] I mean, they're professional". This integrative psychotherapist (P8) stated:

> Being curious, being open, being honestly interested in finding out more. Not dispensing your knowledge, but really like a meeting where the client is the expert of himself, herself or themselves and you are the expert in your own techniques, but you are growing and there is this really healthy therapeutic interaction.

Having "a bit of an understanding", this cognitive-behavioral trauma therapist (P11) highlighted when more psychologist would "*know a little bit", "have a little bit of understanding of what's going on", or "specific terms",* or *"what it means to be non-binary, as opposed to be a transman or transwomen",* would cover already not having "*specific expertise"* in working with LGBTQI+ clients. This is consistent with this trans man's (CL8) experience with a therapist who "*didn't understand what it meant to be trans*". Clients often stated that practitioners should have basic diversity "*module in their educational program"* with the possibility to "*always choose to have a bigger understanding of the community*" (CL4).

Valid resources of basic knowledge were mentioned throughout both sample, for example, (APA) Guidelines for professionals in the mental health area, addressing specifics they need pay attention when they are dealing with LGBTQ clients (CL10, CL4) or the internet for "*the*

most modern informative websites" (CL6), or information as *"not asking inappropriate questions*" (P11). Participants reported knowledge on the competence continuum further contained being aware of potential risk factors and intercorrelated mental health outcomes to LGBTQI belonginess, basic understanding and acknowledgement of concepts, processes, and the language. By acknowledging that *„being a part of the LGBTQI+ community is a risk factor as it,* [SGD] *people are more prone to behaviors like bullying or hate crimes"* (P2), or "minority stress or microaggression that people can face as a LGBTQ person" (CL10). Therefore, the client perspective and the higher experienced practitioners stated that mental health support needs to consider „kinds of cultural and generational trauma that happens in the queer community" (CL3), or *„what is it the reality here, in this society but also in home, also in school or with their friends,* […] *hearing, what the person needs or hear what is happening to him or her. Or them."* (P4)

4.3.3. Shared Experiences

Throughout both perspectives, all participants stated on the importance to be able to relate to the clients' experiences. Whereas, the client perspective often stated an LGBTQI practitioner as beneficial for having to do „*a lot less explaining*" (CL3) and the „*path of understanding would be even shorter*" (CL7), this psychotherapist (P11) highlighted:

> Being really aware that my perception of things is not the same for all the people. Just because I am gender queer or masculine, doesn't mean that my clients that are also trans-masculine or gender queer have had the experiences that I have had. It means that I think I have a much better understanding what they could go through, and I was sitting there along and say like 'hey this is my experience, do you recognize that, if no what is you experience. How does it look for you'.

From the client perspective, commonalities with the practitioner were also reported about cultural aspects or historical influences, which are not necessary for their explanation (CL7). Sometimes it is also about other similarities, like „*being both a woman* […] *and living in the same area*" (CL1). Most of the practitioner statements that were organized within the incapacity or blind continuum tend detached their reality from the reality of an LGBTQI client, as "*without having anything to relate to*" (P3).

> For example, an African person, just telling you an example, like Kenya or Core Africa, would come to therapy – I don't know if I would accept that person. I have my boundaries. I have my knowledge and that is mostly Europe and the

> Western culture. […] Because research wouldn't be enough in that case. The knowledge in that sense comes from experiencing that culture. For me that is not something you can learn from a book. Integrative Psychotherapist (P10)

However, all pre-competent, competent practitioners and all client perspectives agreed on the need to consider the diversity of experiences of sexually and gender diverse people:

> But there's still a very long way to go because like LGBT's, this group of letters, and they're all the same. Like they're all experiencing the same thing. And it's not like that as it is for "normal" people. And I'm putting this between quotes because again, we're all our own persons and we all have our own experiences, and these people are not different. They're also need to be validated in their own existence and in their own experience. They just want to belong. (P11)

Chapter 5
Discussion

The goal of this qualitative study project was to illustrate what the experiences of both the client and professional perspectives reveal about diversity competency in mental health care in the European context. By presenting both perspectives, initially, the experiences of LGBTQI clients interviewed offered insights into professionals' competencies in working with sexual and gender diverse (SGD) clients, as well as ideal improvements for affirmative support. Further, the practitioners' perspectives, covered by clinical psychologists, psychotherapists, and/or counsellors, reflected a diversity on the cultural competence stages regarding awareness, attitudes, knowledge, and skills. In summary, the consistency of both perspectives underscores the need to move beyond clinical frameworks for recognizing diversity in mental health care. In addition, these perspectives offer potential starting points for implementing ideas for diversity training, workshops, and education for professionals.

5.1. Embedding Results in Existing Research

5.1.1. Clients' perspective

LGBTQI individuals shared their experiences of accessing mental health support, particularly in relation to the qualities and knowledge of practitioners, and how they perceived the recognition of SGD people in mental health care. Therapeutic experiences were distinguished between continuous and discontinuous factors, i.e., whether a circumstance led them to stay in therapy or leave the specific psychiatric context.

Continuous factors. The practitioner's expertise in specific areas such as trauma therapy and/or ADHD treatment and the validation of the client's experiences and emotions were reported as the main reasons for continuing with a practitioner and will be further discussed in the *Recognition of Diversity* (5.1.3.). The reason for seeking therapy remained an important aspect for continuing or leaving the therapy. Acknowledge when LGBTQI-related issues such as gender or sexuality are important to a client's experience and assess when and how it is not important to address them. Both over- and under-focusing on it are presented in literature as forms of microaggressions in therapy (Anzani et al., 2019; Hunt, 2014; Mizock & Lundquist, 2016). However, the results show that not being able to address LGBTQI-related issues was not a clear disruption if therapy could cover other current issues in the clients' life. For example, a study by Hunt (2014) reported that 52% of transgender people sought therapy for depression and for 50%, exploring their gender was a reason for seeking therapy among many other reasons (Benson, 2013; Aggarwal & Gerrrets, 2014). Most of the participants from

the client perspective in this study clearly indicated that they discuss gender issues or other LGBTQI+ related topics with a practitioner who specializes in this area. This is supported by Puckett et al. (2023), who found that TGD participants reported higher satisfaction with their mental health support when their practitioners were more knowledgeable and had a higher focus on gender. One reason for this finding might be due to the mental health service being part of their gender-affirmation process or it created a safe environment to talk about their gender experiences.

Discontinuous factors. Most of the reasons reported for leaving therapy were related to frustrating or disruptive experiences which is in line with previous literature (e.g, McNamara and Wilson, 2020). For example, a commonly stated discontinuous factor was the need to explain or teach practitioners basic things about their gender expression, sexual orientation, or LGBTQI experiences. They reported that this experience led to the feeling of not having enough space for their emotions or not feeling seen by their therapists. Findings by Kidd et al. (2011) or Mair (2003) support the experience of frustration reported be SGD clients, especially when clients were having to pay by themselves for the support (Eady et al., 2011). In fact, due to this issue, two participants in this study discontinued therapy. Another important factor cited by clients was a sense of not being understood or seen in their LGBTQI reality, which was also triggered by practitioners not adhering to pronouns or asking for people's chosen names. In Line, McNamara and Wilson (2020) found that low cultural awareness among professionals was perceived when they tend to use heteronormative language (McNamara & Wilson, 2020; Kidd et al., 2011; Ross et al., 2018).

Other discontinuous factors were identified by client perspective participants as biased assumptions, avoidance behaviors, or lack of practitioners' knowledge. These forms of prejudiced behaviors are frequently described in the literature in relation to discrimination and microaggressions against SGD clients, as well as other underrepresented groups in mental health care (Shelton & Delgado-Romero, 2009; Nadal et al., 2011; Own et al., 2014; Rees et al. 2021). Nadal et al. (2011) indicate that individuals' experiences and coping mechanism dependent highly on several factors such as the individual's LGBT identity, personality, context of the situation, and history and past experiences. Most participants from the client perspective reported that prejudicial behavior by practitioners was less likely to affect someone who was already further along in their process than someone who might still be questioning their gender or sexuality. However, transgender and gender non-conforming people reported different experiences in the current study. This may be reflected in the fact that TGD individuals reported significant difficulties accessing and finding mental health professionals who are skilled in

working with TGD individuals (Holt, King, et al., 2021; Matsuno & Budge, 2017; Whitman & Han, 2017). In addition, TGD clients experience more stress symptoms than cisgender clients and may be slower to respond to therapy overall (Puckett et al., 2023).

Self-disclosure. The LGB individuals in our study indicated different moments disclosing themselves in therapy. Including right at the beginning, after a few sessions, or as the therapeutic process continued. Previous research has found that LGBTQI individuals feel more comfortable disclosing or discussing their sexual orientation when mental health services feel like a safer space, and that this also has positive effects on the therapeutic relationship (McCann & Sharek, 2014; Foy et al., 2019; Magee & Spangaro, 2017). Nonetheless, 90% of the LGB participants reported a positive or mixed reaction from their practitioners when they disclosed their LGB identity (McCann & Sharek, 2014b). This is also consistent with the experiences of LGB clients in the current study, who reported that their therapists' reactions ranged from overall positive to neutral. Consequently, this finding implies that whether the response is perceived as non-judgmental and open to LGBTQI-related issues does not necessarily depend on the therapist's level of diversity competence, but sometimes on the person's process state and contextual circumstances.

5.1.2. Practitioners’ perspective

In contrast to the above-mentioned importance of cultural competence for mental health practitioners as stated by the LGBTQI client perspective, the practitioners were asked for their perspective on the possession of affirmative mental health care for SGD clients. Within the practitioners’ group, statements were ranked according to the extent to which clinicians have appropriate awareness, relevant knowledge, and practical skills in working with diverse client populations, as cultural competence is defined in literature (American Psychological Association, 2012, 2021).

Awareness. LGBTQI clients interviewed cited awareness as the most common characteristic of professionals who provide positive mental health support. This is also consistent with the important practitioners’ qualities required by participants in both samples: being nonjudgmental, empathetic, aware of own biases, and informed. According to the literature, cultural awareness refers to how the practitioners’ attitudes, beliefs, values, assumptions, and perceptions of self-influence interactions with patients who are culturally different from them, which requires exploration of the self as a cultural being and one's own cultural biases (Sue, 2008; Israel & Selvidge, 2003; Kirmayer, 2012). Several studies were able to highlight LGBT clients' expectations of practitioners' characteristics in terms of knowledge,

skills, and confident handling of LGBTI concerns (e.g., McCann & Sharek, 2016; McCann & Sharek, 2014a; Moleiro & Pinto, 2014; Puckett et al., 2023). For instance, in another study of Hunt et al. (2006), LGBT clients identified good counseling skills as the professional being accepting, compassionate, and embodying positive attitudes towards LGBT people. This was also shown by practitioners' statements. Those were able to identify their own flaws toward SGD clients, further stated to incorporated them into the therapeutic dynamics and demonstrated greater knowledge and skills in dealing with LGBTQI+ related topics. Further, findings that reported disruptive experiences of LGBTQI people were reported in the present study. It was found that these experiences may be experienced due to facing common social beliefs around SGD people in mental health support (Ross et al. 2010; Dobinson et al. 2003). For example, given the history of pathologizing gender and sexual minority identities (Mizock, 2017; Schuster, 2021), it is not surprising that the therapist's political ideology (Bidell, 2014) or sexual values (Ford & Hendrick, 2003) may create discomfort for therapists when discussing sexual topics or imposing ethical behavior on the client (Bidell, 2014).

Knowledge. Overall, LGBTQI people reported a higher level of satisfaction with their mental health professionals, if they perceived at least a moderately knowledge about LGBTQI people, which is supporting previous literature (Pucket et al., 2023; Bishop et al., 2022; Vermeir et al., 2018). This was found particularly for knowledge that was presented within the pre-competence and competence continuums, such as knowledge about LGBTQI related topics, concepts, processes, risk factors, and correlated mental health concerns. Literature suggests that individuals who had to educate the practitioners on transgender issues tend to further avoid mental health services (McCann & Sharek, 2016). This might also incorporate knowledge about societal impacts LGBTQI individuals face as well as the legal framework surrounding them. Discrimination, violence, and stigma can act as social stressor for these populations (Lombardi, Wilchins, Priesing, & Malouf, 2002; Carastathis et al., 2017). These later stressors are also known as Minority stress and can result to a poorer mental health compared to the dominant population (Mongelli et al., 2018; Meyer, 2003).

On the contrary, the present findings indicate that clients would desire the practitioners reach out for knowledge themselves and only ask the client for valid sources if needed, such as when unknown topic emerged during therapy. According to the developmental on the stages of cultural competence (Cross, 2012), practitioners must be informed and not rely on their clients to educate them (Vermeir et al., 2018). As supported by pre to competence practitioner statements in the present study and previous literature, practitioners should build knowledge about SGD people as cultural groups. This includes professionals participating in in-depth

cultural competency training, receiving clinical supervision from professionals who have experience working with LGBTQI individuals, and gathering information about the experiences that affect SGD individuals from internet research and lived experiences (Bishop et al., 2022; American Psychological Association, 2012, 2015). Therefore, it is important to be mindful of exploitative power dynamics (Bishop et al., 2022). Especially, practitioner statements within the incompetence to blind stage stated the importance of themselves being completely unbiased. A study by Whitman and Han (2017) showed a significant discrepancy between self-perceived competence and the provision of an affirmative approach: those who described themselves as competent in working with TGD clients were more likely to agree with stereotypical statements about TGD people. All professionals who noted the importance of training for working with SGD clients emphasized that training should address clinical skills that deconstruct the work of the professionals themselves.

Skills. Practitioners that are equipped with skills and tools to provide cultural sensitive assessment (Crisp, 2006; Sue et al., 1982), were found to be able to tailor and adapt interventions according to clients individual developments and simultaneously assess current and lifetime stressors (Alessi, 2014). Given by practitioner statements that were organized in the incompetence to blind stage tend to express a critical opinion on general diversity developments and further leaving the responsibility with SGD clients. For example, practitioners were unable to connect clients' concerns about societal messages to internalized homophobia. Stigma persisted because SGD individuals often personalized negative messages conveyed by heteronormative (and cisnormative) society (Boyer & Lorenz, 2020; Camp et al., 2020; Lin, Israel & Ryan, 2019). For example, people in a non-normative binary system often do not have harmful intentions toward SGD individuals, whereas subtle assumptions and behaviors in a heteronormative system lead to stigma, discrimination, and harassment (Habarth, 2015; Boyer & Lorenz, 2020).

Boundaries of Expertise. In the present study, practitioners demanded to acknowledge their own boundaries of expertise. Significant differences emerged within the developmental stages of cultural competence. Incompetent or blind stages either avoided working with LGBTQI clients entirely or tended to "normalize" LGBTQI experiences and therefore did not consider SGD related topics or possible impactful historical and political developments. Research highlighted that normalizing the clients LGBTQI reality in the conversation can lead to the client's perception of rejection (Magee & Spangaro, 2017; Mair, 2003). The statements within the pre-competence and competence stages expressed more active and informed decision making about their boundaries. Whether they pointed to knowledge resources or ways

to support the client by networking with peer groups or LGBTQI+ organizations to get valuable referrals. Literature supports the resilience strengthening benefits of support networks and group therapies for SGD people (Matsuno & Israel, 2018). As suggested by Beckstead and Israel (2007), collaborative approaches are valuable for examining negative effects of prejudicial beliefs among practitioners. This aligns with general findings of Bishop et al. (2022) that practitioners benefit from being honest with their clients about their limits of knowledge, while demonstrating interest to understand their clients' realities. The acknowledgement of one's own boundaries requires one to be humble, which was often stated within the competence stages. Especially, in situations where practitioners slipped on gender, pronoun, or name, clients preferred openness to apologize and correction of the mistake (Vermeir et al., 2018), instead of presenting excuses reported in the client sample.

All participants from the client perspective as well as higher experienced practitioners stressed the importance of practitioners to provide space to explore themselves and adopt to the individual needs of the person they are working with. Research suggests that overt visual cues such as rainbow flags, or TGD affirmative resources in waiting areas or avoidance of item that reflect anti-LGBTQI attitudes, already influence clients' perceptions that they are validated and provide a safer space (Bishop et al., 2022; Croghan et al., 2015; Lev, 2009). This also helps clients assess whether LGBTQI-related issues are relevant and should be discussed (Burckell & Goldfried, 2006; Croghan et al., 2015).

5.1.3. Recognition of Diversity

Overall, the answers of the current study indicated that both experiences are aligned regarding diverse competencies is dependent on the level of the practitioners' experience level. Despite the clear focus on practitioners' diversity competency, both perspectives met in the general recognition of diversity in mental health care, which can be captured in the three areas of validating the client, therapeutic qualities, and attitudes toward shared experiences.

Validation of LGBTQI clients' experiences and emotions. Most statements from pre-competence to competence reflected the bare minimum of the client's therapeutic conditions in order to receive appropriate treatment. It was reported that validation of the client begins at the grassroots level, such as asking what names or pronouns they would like to be addressed by. Using inclusive language and practices helps clients feel more confident in disclosing their sexuality, as it reinforces the perception of meeting their needs (Croghan et al., 2015; Pennay et al., 2018; American Psychological Association, 2012, 2015). Another important validation point reported from both the clients' and more experienced practitioners' perspectives was the

separation of reasons for seeking psychosocial support from LGBTQI+-related topics. Validating the variety of one's experiences were mostly expressed within the pre-competence to competence continuum. In addition, practitioners who demonstrate basic knowledge and an effort to seek knowledge were more likely to appear trustworthy and reliable to SGD clients. It was either that they emphasized the potential impact of LGBTQI realities in society and life, or know how and when to address related issues. A more nuanced understanding of concerns that may impact SGD diversity has been shown to be an indicator of effective therapeutic interventions (Alessi, 2014). The emphasis on the relevance of knowledge about LGBTQI issues (Bishop et al., 2021a) was echoed in the current study through the perspectives of clients and practitioners, who emphasized topics such as non-monogamous or polyamorous relationship dynamics, the impact of gender transitioning on sexuality, relationship dynamics, gender expression, and more.

Therapeutic Qualities. Being non-judgmental, open, and curious about LGBTQI experiences without objectifying was mentioned in all interviews as an important therapeutic quality. Statements of practitioners within the incompetence or blind continuum were not reflecting own biases and prejudices, neither how to engage in diversity competence. When clients pointed out practitioners' biases and prejudices that fell within the realm of microaggressions, it was often perceived as unintentional. Nonetheless, these experiences resulted often in not remaining in mental health care at all. This may illustrate why validating, inclusive, and empowering approaches are important in working with SGD people (Burckell and Goldfried, 2006; Chavez-Korell & Johnson, 2010). Some SGD characteristics are more visible than others, so it is even more important that practitioners recognize their prejudices and attitudes towards SGD people.

Overall, the client perspective reported limited awareness on gender and relational concepts or social impact on SGD people. Aligning with findings from previous studies, participants perceived therapists as less competent and unaware when they made heteronormative assumptions, such as that two girlfriends might be the cause of anxiety and were less willing to open up or continue the therapeutic process (Fell et al., 2008; Bishop et al., 2022; Utamsingh et al., 2016), which creates mistrust (Foy et al., 2019), and reduced the perceived quality of the professional (Burckell & Goldfried, 2006). Practitioners who are unaware of their heteronormative attitudes and practices, for example, tend to unintentionally do more harm when it comes to minimizing the damage done by not working from an affirming and reflective perspective (Kuhlmeier et al., 2021). Heteronormativity, as a social framework in which heterosexuality is assumed to be the norm, refers to a set of beliefs and practices at

both systemic and individual levels that assume that a binary gender model of two sexes and a heterosexual model of romantic and sexual relationships and are therefore publicly accepted (Kitzinger, 2005; Duncan et al., 2019). Homonormativity, on the other hand, replicates heteronormative ideals within the LGBTQI+ spectrum as individuals seek acceptance and assimilation within the social norm without challenging or disrupting basic social norms (Tislen and Nylund, 2010), which tend to divide into individuals who may or may not conform to current gender roles (Robinson, 2016). For example, same-sex couples are often pressured to conform to relationships that tend to be hostile to or invalidate their relationships (American Psychological Association, 2012). Most statements from practitioners within the blind or incompetent continuum related that working with gay couples is the same framework as working with heteronormative couples. Competent statements and the client perspectives clearly reported a variety of possible dynamics and relationship constructs that may influence work with non-heteronormative couples. For instance, heterosexism leads to psychological distress and internalized oppression for SGD individuals by invalidating their experiences (Nadal et al., 2011; Szymanski & Henrichs-Beck, 2014). Practitioners who become aware of their own attitudes and biases must also recognize the impact of heterosexist assumptions, such as advocacy for a heteronormative culture, assumption of universal SGD experiences, stereotype-based knowledge, rejection of SGD people and their experiences, e.g., through pathologizing, and denial of one's heterosexism on clients' experiences in mental health services (Nadal et al., 2011).

Many of the practitioners interviewed who regularly work with LGBTQI people drew a clear line at which all available knowledge and skills were no longer sufficient to fully relate to the experiences of TGD clients. Regardless of whether clients felt it was relevant to work with a practitioner who is LGBTQI themselves or not, all agreed that it was important for the practitioner to have a deep understanding of LGBTQI experiences, including sociopolitical implications such as legal recognition, societal barriers, or concepts of gender or pronouns, when relevant to the clients’ experiences. Both distal stressors, such as social rejection or lack of legal protections, and proximal stressors, such as expectations of facing rejection or internalized homophobia, biphobia, or transphobia, are rooted in a complex sociopolitical system that consistently causes psychological distress for SGD people (Herek, 2007; Meyer et al., 2021; Collins & Levitt, 2021). The impact nevertheless is highly context and individual depended, as reported by the client perspective.

Overall, practitioners should be encouraged to address their SGD clients’ experiences with mental health services and provide feedback to promote an SGD affirming environment.

As a result, SGD individuals are less likely to experience harm, disempowerment, or pathologization when accessing various treatment settings and public spaces and are therefore more likely to access resources and support (American Psychological Association, 2015)

Shared experiences. The question of whether clients felt misunderstood by practitioners, or whether or not practitioners felt able to relate to the SGD experience, was one of the most common themes that ran through all interviews from both perspectives. Statements from practitioners placed on the continuum of incompetent or blind tended to disconnect their reality from that of an LGBTQI person in the sense that they generally have nothing to relate to. In contrast, participants from the client perspective reported other characteristics that can create a sense of shared life experiences, such as cultural background or living in the same neighborhood as the woman. Since the term "cultural competence" suggests the idea that one can become competent in relation to an experience that one has not had oneself, existing critiques of the concept of "cultural competence" claim that it is not possible, for example, to fully understand what it means to be trans (Baker & Beagan 2014; Gregg & Saha 2006). To challenge the limits of shared lived experience, queer theory as an umbrella term offers a variety of competing and complementary ideas for destabilizing discourses that uphold privileged norms (Rowland and Cornell, 2021). It challenges practitioners that are working with SGD clients to question and deconstruct assumptions about what is perceived as "normal" (Goodrich et al., 2016). In clinical practice it means to not just work on the clients' individual psychological meaning, it further recognizes a level of box-thinking and identity production in order to tackle underlying oppressive ideologies, as the sociopolitical background (Rowland & Cornell, 2021). Through active inclusion and willingness to affirm the realities of SGD people, mental health services must create a space where the person can feel safe from discrimination and prejudice (Gacita et al., 2017).

5.2. Implications

This study extends previous literature on what affirmative mental health support to SGD clients need to acknowledge. In recent years, more and more competent practitioners and researchers have been advocating for more inclusive mental health care regarding sexual and gender diversity (e.g., Bishop, Crisp & Scholz; Puckett et al.; Moleiro; Israel et al.; n.d.). Thus, across European countries, it appears that there are different experiences and training opportunities, ranging from incompetence and complete disengagement from mental health care to competence and meaningful clinical encounters. Therefore, the following three implementation emerged from the main findings: training, intersectionality, and future directions.

Training. As the overall findings of this study supports, is important that practitioners do not contribute to the suffering of their SGD clients by responding in an uninformed manner (e.g., McCann & Sharek, 2016; Moses & Cole, 2023). Participants stressed the importance of practitioners being empathetic, nonjudgmental, and sensitive to unique experiences. However, the implementation of these therapeutic qualities varies across within the competence continuums. Subtle biases, often hidden behind indirect attitudes, can perpetuate traditional values and exaggerate cultural differences (Pettigrew & Merton, 1995). Negative attitudes of practitioners are often linked to their lack of awareness and knowledge of social constructs of heteronormativity and cisnormativity that affect SGD people (Willing et al., 2006). In line with the present study, practitioners generally perceive their awareness positively, there are shared concerns about the practical application (Cabral et al., 2016). Previous research highlighted that interactive workshops and contact with SGD clients significantly increase counselors' confidence, when and how to navigate an appropriate conversation with clients about sexuality and the potential associated stressors (Hall, 2021; Graham et al., 2012; Bidell, 2014). Although cultural diversity training has shown to help reduce prejudice, for instance, towards TGD people (Pepping et al., 2018), practitioners must become actively aware of their own responsibility for perpetuating oppressive structures that SGD people face. Power and marginalization do not exist in a vacuum as they are (re)produced and maintained in the therapeutic interaction (Rowland & Cornell, 2021). Understanding SGD related issues and experiences, from coming out processes to the effects of minority stress, is critical, in addition to specific knowledge about same-sex relationships, queer sex, and intersectional stressors (Bishop et al., 2021a). Historical context and understanding of stereotypes, prejudice, and discrimination should be integrated into training, while emphasizing self-reflection and consideration of internal biases and perceived professional knowledge (Pettigrew & Merton, 1995; Bledsoe & Donaldson, 2015; Hall, 2021; Goodrich et al., 2016). Furthermore, practitioners who understand their part in the social structures from which SGD are excluded and who continue to find personal connections in queer discourses to counter avoidance strategies will continue to provide more responsive support (Rowland & Cornell, 2021).

More experienced practitioners who have worked with SGD individuals reflect on their impact, access knowledge and professional support, and network with LGBTQI individuals and organizations. However, they often do not publicly label their services as LGBTQI-friendly because they do not feel specialized or share common experiences. The literature shows that already visible signs of validation, such as pronoun options on intake forms and rainbow flags in therapy rooms, influence clients' perceptions of validation and safety (Bishop et al., 2022;

Croghan et al., 2015; Hinrichs & Donaldson, 2017; Holley et al., 2016). Mental health service websites that mention connections to the LGBTQI spectrum result in higher client satisfaction than experienced practitioners who do not highlight this on their websites, especially for gender diverse and TGD clients (Pucket et al., 2023; American Psychological Association, 2015). For professionals with prior knowledge, diversity trainings may be more effective for learning LGBTQI+-friendly practices and applying basic skills in practice. Furthermore, diversity training that specifically explores sexual orientation and gender diversity in the context of intersecting social and multicultural identities can raise awareness, skills, and knowledge about multiple minority groups (Bidell, 2014). In addition, the benefits of supervision or intervision were frequently mentioned, while a focus should be more on cultural sensitive explorations of practitioner awareness and further promotion of knowledge and resources for providing positive support to people with SGD.

Intersectionality. As the experiences of the LGBTQI people in the current study support, considerations of intersectionality become even more important as practitioners and researchers seek to understand individuals and groups in their own terms and in all their complexity (Henrickson et al., 2020). TGD participants reported to struggle with not conforming to traditional norms regarding their sexuality and gender identity and difficulties of the practitioner to relate to their experiences. In realm, affirmative practices may differ when therapists seek to provide support to trans and gender diverse individuals (Bishop et al., 2022; Israel, 2008). Affirmative practices may differ when therapists seek to support transgender and gender diverse individuals (Bishop et al., 2022; Israel, 2008). In line with the experience reported in the findings, intersex people are mostly overshadowed in society, as they are pushed into a binary understanding of gender and sex. Intersexuality is a biological condition, not a gender identity, leading to unique challenges that often result from societal stigma and medical interventions without consent (Common Point Project, 2022). Most guidelines for working with SGD individuals are traditionally cisgender and heteronormative and often exclude and underestimate the needs of TGD individuals (Ashley & Domínguez, 2021). Additionally, studies suggest that that bisexual individuals may experiences higher rates of depression, anxiety, suicidality, and substance abuse than lesbian, gay, or heterosexual populations do (e.g., Dodge & Standfort, 2007). These are just a few examples of the need for greater education and awareness of normative structures that overlook the unique experiences of sexual and gender diversity.

In realm, practitioners should expand their implicit biases beyond a heteronormative, cisnormative, transnormative, and homonormative perspective to ensure that their spaces and

language allow for diverse representation and validation of SGD clients' experiences (Burckell & Goldfried, 2006; American Psychological Association, 2012, 2015; Smith, Shin & Officer, 2012). Intersectional theory advises practitioners to consider the unique experiences (and vulnerabilities) of individuals that intersect with multiple dimensions of oppression (Adams et al., 2017). An affirmative approach encourages mental health professionals to avoid categorizations and assumptions about these experiences by flexibly interpreting what issues are important to clients, being aware of the various expressions of (cisgender) privilege and prejudice, and acknowledging the psychological impact of exclusion and oppression (Rowland & Cornell, 2021; Bishop et al., 2022; American Psychological Association, 2015). Clinical approaches that incorporate queer sensitivity can support, for example, deconstructing the clients' fear of rejection through normative ideologies, as the therapist has a responsibility to support psychological exploration and deeper understanding of themselves (Rowland & Cornell, 2021). While some studies, such as those by Holt et al. (2019, 2021), report higher rates of confirmatory components, there remains an inconsistency in these services that requires attention.

Future directions. In the European context, LGBTQI individuals face issues in mental health care and a lack of affirmative structures (Anzani et al., 2019, Cavanaugh & Luke, 2021; Puckett et al., 2018). Future research is needed to examine how SGD experiences of mental health services differ and what improvements will help to meet the unique needs of SGD individuals. In addition, the impact of contact interventions with practitioners and LGBTQI topics should be explored through lived experiences. However, intersectionality may also suggest that SGD individuals from diverse racial, ethnic, and cultural backgrounds may exhibit resilience to mental health problems because of the skills they have developed in coping with stigma (Cochran et al., 2007; Meyer et al., 2008). Practitioners should aim to help these individuals identify effective coping strategies and protective factors (American Psychological Association, 2012; Selvidge et al., 2008). Therefore, future research should focus on protective factors, to provide practical strategies for individuals and practitioners. In addition, the current data should be validated by cross-checking the statements from both perspectives, in a dyadic design. The client perspective would be given the opportunity to evaluate the practitioners' statements and voice their implications. Conversely, practitioners would get confronted with harmful impact of their biases and attitudes. By integrating a multicultural lens, psychotherapeutic theories, and considering the impact of power dynamics, privilege, and oppression on personhood development, practitioners can be encouraged to advocate for social change as part of their professional role (Collins & Levitt, 2021). This is especially important

in theoretical approaches that have historically pathologized and medicalized SGD people (American Psychological Association, 2021; Lingiardi & Nardelli, 2019).

5.3. Limitations

The qualitative methodology allowed for a robust, in-depth, participant-centered exploration (Braun & Clarke, 2006) of the mental health care experiences described by the participants in this study. They provided valuable insights that highlighted the need for cultural competence and affirmative supports for SGD people. However, the following limitations of this study must be considered when interpreting the findings.

First, the limited generalizability of the findings is due to several factors. A relatively small survey sample inherently limits the generalizability of the study to a broader population and underscores the contextual nature of the findings. The study relied on a convenience sample of LGBTQI+ individuals and practitioners that were required to be clinical psychologists, psychotherapists, or counsellors. This selection method may have attracted participants who were already interested in the topic, resulting in a sample that may not be representative of the broader mental health care experiences. The selection criteria for both perspectives, therefore, were very broad by limiting it to English speakers. Further, a diverse sample resulted, due to the mobility within the European context. On the one hand, this acknowledges a richness of socialization perspectives. On the other hand, it includes different educational paths and political situations regarding the openness to talk about LGBTQI+ related topics. In addition, the study sample lacks ethnic diversity, as all but two participants were white (exceptions were one Brazilian person living in Portugal and one person from New Zealand living in the Netherlands). It is important to note that the political atmosphere and access to resources around SGD individuals play an important role as they influence practitioners' attitudes as well as their ability to openly inform and qualify themselves. The client sample additionally was limited to a certain age group and individuals that are currently in mental health hospitals or residential care were not included. Second, the presence of subjectivity and bias is a major concern in qualitative research (Braun & Clarke, 2006). The researcher’s visible persona – white and female, might have influenced the data collection and interpretation which can lead to bias in the results. In addition, biases can occur when answering questions. As the client perspective and high experienced practitioners were more likely to share particularly negative experiences, whereas lower experienced practitioners tended to report more positive experiences. In addition, the statements tended to assume subtle attitudes and biases among practitioners working with a diverse client population. To avoid subjective presumptions, future

research should consider assessing socialization and attitudes toward diversity prior to data collection to increase the usefulness of the information collected.

Despite these limitations, this qualitative study provided valuable insights into what diversity competence means in mental health care and offers a deeper understanding of the experiences of practitioners and SGD clients. Therefore, the results should be interpreted through the lens of these limitations and offer new entry points for further research in this complex and multifaceted field.

Conclusion

This qualitative study project adds to the existing literature on what cultural competence must contribute in terms of affirmative mental health care for sexual and gender diverse clients. Overall, the experiences from both perspectives demonstrate the importance of practitioners deconstructing their attitudes and biases toward sexual and gender diversity, while further engage in knowledge, and become more skilled to meet the needs of sexual and gender diverse clients. By providing a sociopolitical perspective, the findings can contribute to an understanding of cultural competence by acknowledging the implications of living in a heteronormative and cisnormative society rather than pathologizing the individual. Hopefully, the present study will encourage practitioners to engage in more practical discussions about what is considered "normal" in mental health support and how to be aware of one's responsibility to promote change.

> I think every mental health professional should be prepared that one day someone from the LGBT[QI+] community will apply and […] would like to go into therapy.
> Cis-male, gay participants, working in peer support in Hungary (CL10)

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Appendix

Appendix A: Interview Guideline – Practitioners' Perspective

Framing work experience

First, maybe you can start to introduce yourself a bit (How old are you, what kind of working experience you have, how you are trained and what are you currently doing)

Diversity (in Mental Health Care)

*How would you define **diversity** for yourself? When you hear diversity, what comes into your mind?*

*Taking this definition of diversity, how would you **transfer it into mental health care**?*

Experience level/ Cultural Competence

*Can you think about **specific challenges and chances** in professional psychological support especially for sexual and gender diverse people? If yes, could you name some. If no, can you explain why not*.

*Are you aware of the legal situation for LGBTQ+ people in the country you are practicing? **Offer of LGBTQ+ welcoming mental health services** in the country you are working?*

Forms of cultural and diversity competence training? Are you working or have you ever worked with LGBTQ+ people?

Recall on specific situation(s):

*Can you give some **examples?** From your daily work.*

Therapeutic relationship, helpful and/or unhelpful behavior(s), stabilizing or rapture in the therapeutic process.

Wrap-up: Beneficiaries of cultural competence

*What **ideal qualities** should a therapist have, that you think are necessary to work with sexually and gender diverse clients? such as characteristics, skills, or specific knowledge.*

*Do you think specific **training always necessary?** What about **training** opportunities - are they visible, accessible, demanded and used?*

→ *If you think about your definition of diversity from the beginning of this conversation and your experiences in mental health care, we talked about. How can diversity competencies be translated into **training for professionals**?*

Ideal improvements of mental health care?

Appendix B: Interview Guideline – Client Perspective

Please, could you give a short introduction of yourself. Age? Define yourself in the moment?

Introduction – Define diversity in mental health setting.

How do you define diversity for yourself? What does it mean to you?

How could you transfer this [reframing definition] into mental health care?

Could you think about specific challenges in professional psychological support for sexual and gender diverse people? Gaps between needs and offer?

Framing treatment history.

Are you currently accessing any form of mental health support, such as seeing a therapist or a counsellor? If not, when was the last time you were receiving support?

What type of services did you access? Where? How did you choose this specific mental health care?

Personal experiences – recall on specific experiences.

Can you tell me a story about how it is/was like to seek professional psychological support for you as someone who identifies as …. (LGBTQI+)?

Do you have the feeling, that your LGBTQI+ Identification affected the interaction with the practitioner in any form?

What about the other way around, did the practitioners background, affect your relationship somehow?

Were/are you able to talk with your psychologist about your LGBTQI+ identity and possible related issues/could you disclose yourself? If yes, reaction; If not, why not?

Is there any specific situation(s) that sticked into your mind? Rather good or bad. Key points either stabilizing or rapture the therapeutic process? It can be a whole interaction, conversation, a single reaction, or overall perceived attitudes among the professional(s) or repeating patterns.

Can you name helpful and/or unhelpful behavior(s), that you remember within this experience? Unhelpful situations: what would you have needed/wished from the practitioner?

If more than one mental health experience: Can you compare – what made you stay/ leave one service, what was different?

Reflecting – ideal improvements.

If you had a chance to give advice on working with LGBTQI+ people to practitioner, what advice would you give. Is diversity training helpful? What to address?

Ideal improvements of mental health care?

Appendix C: Informed Consent

This study is part of a research project taking place at **Iscte – Instituto Universitário de Lisboa**. The study aims to the implementation of diverse counseling competence in therapeutic settings in Portugal. It focuses specifically on the experiences in therapy or counseling of LGBTQI individuals, and practicing counsellors and psychologists. Your participation in the study, which is highly valued as it will contribute to the advancement of knowledge in this field of science, consists of one interview that will last for approximately 45 – 90 minutes.

Iscte is responsible for the processing of your personal data that are collected and processed exclusively for the purposes of the study, legally based on Article 9(2)(a)[7].

The study is conducted by Inga Schmidt, istan@iscte-iul.pt, who you may contact to clear up any doubts, share comments or exercise your rights in relation to the processing of your personal data. You may use the contact indicated above to request access, rectification, erasure or limitation of the processing of your personal data. Further, this contact is open if you want to ask questions or make comments about the study.

Your participation in this study is **confidential**. Your personal data will always be processed by authorised personnel bound to the duty of secrecy and confidentiality. Iscte assures the use of appropriate techniques, organisational and security measures to protect personal information. All investigators are required to keep all personal data confidential.

In addition to being confidential, participation in the study is strictly **voluntary**: you may choose freely whether to participate or not. If you have decided to participate, you may stop your participation and withdraw your consent to the processing of your personal data at any time, without having to provide any justification. The withdrawal of consent shall not affect the lawfulness of processing based on consent before its withdrawal.

The conversation will be audio recorded. This recording will be kept for two months after the interview have been conducted and stored in an external memory disk to which only the investigator of this study has access. They will be destroyed after a transcript is made, ensuring the participants' anonymity in the results of the study, and only excerpts will be published only for the purposes of the master dissertation and scientific meetings or articles. The transcripts will be kept for maximum of five years.

There are no expected significant risks associated with participation in the study. Even though, interview might touch topics related to sensitive experiences in a vulnerable setting. To ensure that no participant will overstep their personal boundaries, the sharing of experiences in the situation is fully voluntary, same as participants are free to leave at any time. Also, contact lists of appropriate psychological support will be provided and the above-mentioned contact will be available for any doubts, issues, and comments. Iscte does not disclose, or share with third parties, information related to its personal data.

I declare that I have understood the aims of what was proposed to me, as explained by the investigator, that I was given the opportunity to ask any questions about this study and received

[7] Article 9(2)(a) is applicable to personal data that reveal racial or ethnic origin, political opinions, religious or philosophical beliefs, or union membership, and to the processing of genetic data, biometric data that unambiguously identify a person, data related to the health, sexual life, or sexual orientation of a person.

a clarifying reply to all such questions. **I accept** participating in the study and consent to my personal data being used in accordance with the information that was given to me.

Appendix D: Debriefing

DEBRIEFING/EXPLANATION OF THE RESEARCH

Thank you for having participated in this study. As indicated at the onset of your participation, the study is about the implementation of diverse counseling competence in therapeutic settings in Portugal. It focuses specifically on the experiences in therapy of LGBTQI+ individuals and practicing counsellors and psychologists, while also exploring real and ideal experiences of both counterparts in the interaction.

An important goal is to open the space for real life experiences in therapy. When both participants can share their experiences, helpful and unhelpful components are revealed and a deeper understanding of what diverse competence means can occur. Therapists can gain confidence through increased awareness, skills, and knowledge to provide inclusive and appropriate mental health support to all people. The experiences of LGBTQI+ individuals can be unique, but also represent some common issues that many minoritized groups face when seeking help.

Related to the goal of this study, a contact lists containing **local LGBTQI+ services** that also provide psychological support. In case an issue within the process triggers difficulties in participants, or for practitioners who refer LGBTQI clients. In addition, resources are also provided for practitioners to learn about their diverse competent care:

ASSOCIAÇÃO ILGA Portugal
https://www.ilga-europe.org
Telephone: + 32 2 609 54 10

We remind that the following **contact details** can be used for any questions that you may have, comments that you wish to share, or to indicate your interest in receiving information about the main outcomes and conclusions of the study: Inga Schmidt, istan@iscte-iul.pt.

Once again, thank you for your participation!