Queer-Identified Clients' Preferences in Counseling Practice

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DEDICATION

To Lachlan, you are my whole heart, and being your aunt is the greatest joy. You have shown me the true meaning of openness and curiosity, allowed me to love deeply, and reminded me to be soft and vulnerable. This dissertation is for you and serves as a promise that I will always be by your side as you take on this world.

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it isn't blood that makes you my sister
it's how you understand my heart
as though you carry it
in your body

- rupi kaur

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ABSTRACT

This dissertation includes two manuscripts: a content analysis that sought to understand the state of the counseling literature related to counseling queer-identified clients and a Q Methodology study that identified preferences of queer-identified in counseling. In the first manuscript, all articles published from 2014 - 2020 in American Counseling Association journals and affiliates were examined. Articles were included in the final sample (N = 64) if they contained implications for working with LGBTQ+ clients in community settings. Using content analysis overlaid with Consensual Qualitative Research - Modified, the first manuscript provides a foundation for the second by exploring the current literature and distilling it into domains that describe counseling practices including, conceptual frameworks, counseling interventions, and person as counselor. These domains are the groundwork for the Q Sort in the second study. The second manuscript builds on the first by expanding the identified domains through a community survey and examination of current competencies for working with queer-identified clients. These three sources were used to create a concourse and Q Sort that participants sorted, identifying their counseling preferences. Participants (N = 50) in this study were queer-identified individuals who have attended counseling for at least seven sessions with the same Licensed Professional Counselor (LPC) within the last two years. From the Q Sort, three sets of preferences emerged: building relationship, enacting LGBTQ+ specific knowledge, and development through the lens of queer identity. Factor one centered on building trust, creating and maintaining safety, and doing no harm. Factor two centered on counselor knowledge, affirming queer identity, and broaching skills. Factor three was characterized by a more complex and complete understanding of queerness and the ability to enact higher-order interventions and skills. These sets of preferences are explored in the context of counseling practice, counselor education, and research.

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INTRODUCTION

Queer-identified individuals experience mental health concerns, including depression, anxiety, suicidality, substance use, and post-traumatic stress symptomology, at elevated rates when compared to their non-LGBTQ+ counterparts (Blosnich & Bossarte, 2012; Lehavot & Simoni, 2011; Marshal, 2011; Plöderl & Tremblay, 2015; Robinson & Rubin, 2016; SAMHSA, 2015; Streed et al., 2017). These mental health disparities are attributed to experiences of minority stress (Meyers 1995; 2003) and exposure to more violence and traumatic events, both connected and separate from their queer identities (Baams, 2018; Friedman, 2011; Operario et al., 2015; Roberts et al., 2010). Queer-identified individuals also report an increased need for mental health care and higher unmet mental health needs, despite receiving mental health care at higher rates than non-LGBTQ+ individuals (Macapagal et al., 2016; Spengler & Ægisdóttir, 2015; Williams & Chapman, 2011).

With the identified mental health disparities and unmet mental health needs of LGBTQ+ individuals, professional counselors have established frameworks for working effectively with queer-identified clients including, the American Counseling Association *Code of Ethics* (ACA; 2014), the Society for Sexual, Affectional, Intersex, and Gender Expansive Identities (SAIGE) *Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex and Ally Individuals* (LGBQQIA; 2013), and the *Multicultural and Social Justice Counseling Competencies* (MSJCCs; Ratts et al., 2015; 2016). The ACA *Code of Ethics* and the MSJCCs provide general frameworks for working generally with clients, focusing on ethical mandates (ACA, 2014) and working with diverse clients (Ratts et al., 2015; 2016); the SAIGE competencies (2013) focus specifically on work with LGBTQ+ clients. Although these

frameworks provide a starting point for working with queer-identified clients, they lack empirical evidence and practical applications for practicing counselors.

Therefore, manuscript one explores the current counseling literature related to working with LGBTQ+ clients to better understand the representation of best practices in the literature and use these findings as a groundwork for manuscript two. After reviewing the recent counseling literature (2014-2020), three domains emerged: conceptual frameworks, counseling interventions, and person as counselor. Through the lens of the MSJCCs, these domains focused largely on counselor knowledge, counselor self-awareness, and client worldview. Furthermore, the current literature as a whole had little focus on counseling skills and a lack of community voice, often providing general recommendations grounded in characteristics rather than counseling practice or outcomes. Therefore, manuscript two centers client voice by examining preferences of LGBTQ+ individuals in counseling. Using Q Methodology, participants completed a Q Sort, and three sets of preferences emerged: building relationship, enacting LGBTQ+ specific knowledge, and development through the lens of queer identity.

CHAPTER I: MOVING BEYOND NON-REFERRAL: A CONTENT ANALYSIS OF THE CURRENT LGBTQ+ COUNSELING LITERATURE

ABSTRACT

The present study sought to understand the current state of the literature related to counseling LGBTQ+ individuals, with a focus on identifying best practices or counseling implications. Researchers focused on American Counseling Association journals and affiliates and examined 64 articles containing implications for working with adult queer-identified individuals in community settings. Researchers used a qualitative approach, implementing content analysis overlaid with Consensual Qualitative Research - Modified. Findings indicate an overall lack of clear counseling implications grounded in empirical, outcome-based studies. Key domains describing counseling best practices included conceptual frameworks, counseling interventions, and person as counselor.

Keywords: LGBTQ+, Cross Cultural Counseling, LGBTQ+ Issues, Queer, Best Practice, Counseling Implications, Sexual Orientation, Gender Identity

LGBTQ+[1] individuals experience "strong and pervasive" health and mental health disparities (Marshal, 2011, p. 122), including higher rates of depression, anxiety, suicidality, substance use, and post-traumatic stress symptomatology compared to those who do not identify as LGBTQ+ (Blosnich & Bossarte, 2012; Lehavot & Simoni, 2011; Marshal, 2011; Plöderl & Tremblay, 2015; Robinson & Rubin, 2016; SAMHSA, 2015; Streed et al., 2017). Historically, these disparities were attributed to identity rather than factors unique to LGBTQ+ individuals (Burton et al., 2013; Meyer, 1995, 2003). However, researchers have now identified factors that explain the presence of disparities. Queer-identified individuals experience earlier and increased exposure to violence and traumatic events, including childhood adversity; physical, psychological, and sexual abuse from family members and peers; and victimization specific to their LGBTQ+ identity (Baams, 2018; Friedman, 2011; Operario et al., 2015; Roberts et al., 2010). Mental health disparities held true when controlling for explanatory variables such as substance use and severity of mental health concerns (Marshal, 2011).

Disparities in mental health concerns experienced by queer-identified individuals are further understood in terms of minority stress (Meyer 1995, 2003). Minority stress speaks to the experiences of often minoritized individuals who live in environments that do not support nor reflect their identities or associated norms, instead catering to those holding privileged identities (Meyer, 2003). Minority stress emerges as a means to explain the impact of day-to-day stigma, prejudice, and discrimination experienced by minoritized individuals through expected rejection, concealment, internalized homophobia, and explicit instances of discrimination. As a construct, minority stress explains the dire impact of accumulative, unique, and constant stress on mental health and well-being (Meyers 1995; 2003).

[1] LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, and Queer with the plus representing those identities in the community not encompassed in the abbreviation) and queer-identified will be used interchangeably.

Minority stress is associated with increased levels of overall distress for minoritized individuals and provides counselors with a framework to understand how victimization of LGBTQ+ people contributes to diminished coping resources and increased mental health concerns (Burton et al., 2013; Dürrbaum & Sattler, 2019; Htzanbuehler & Pachankis, 2016; Meyer, 1995, 2003). By understanding minority stress theory, counselors can shift conceptualization of queer-identified clients from one of deficits or pathology based on identity to a holistic, contextual understanding of the client (Burton et al., 2013; Meyer, 2003).

Across the lifespan, LGBTQ+ individuals consistently report increased need for mental health services compared to their heterosexual and cisgender counterparts (Macapagal et al., 2016; Spengler & Ægisdóttir, 2015; Williams & Chapman, 2011). Furthermore, LGBTQ+ individuals report higher levels of use of mental health services while also reporting higher percentages of unmet mental health needs compared to non-LGBTQ+ individuals (Macapagal et al., 2016; Williams & Chapman, 2011). This pattern of need is especially true among members of the LGBTQ+ community who experience further marginalization due to intersecting identities such as race or ethnicity (Macapagal et al., 2016; Williams & Chapman, 2011). Ultimately, queer-identified individuals not only have higher needs for mental health services due to mental health disparities, but they seek mental health care at higher rates while still experiencing higher levels of unmet mental health needs when compared to the general population.

Professional counselors have historically had focused dialogue concerning ethical responsibilities to work competently with queer-identified clients. Recent professional dialogue includes a focus on non-referral and avoiding value conflicts when working with LGBTQ+ clients, with an emphasis on the ethical imperative to develop skills to work competently with all clients, inclusive of identity (Kaplan, 2014; Kaplan et al., 2017). The ACA *Code of Ethics* (2014)

states that counselors are only to refer when there is an issue of competence (A.11.a.; A.11.b.), with the previous ACA *Code of Ethics* (2005) offering ambiguous guidance related to non-referral as highlighted in the Ward v. Wilbanks case (Kaplan, 2014; Kaplan et al., 2017). Additionally, counselors respect the diversity of their clients by not imposing their personal values or beliefs and seeking additional training rather than referring clients due to conflicts with personal beliefs or values, contrary to recent implementation of conscience clauses (Grzanka et al., 2020; A.4.b.; A.11.a.; A.11.b.) These codes help counselors understand that they should work with clients in a spirit of non-discrimination (Dugger & Francis, 2014; Herlihy et al., 2014; Smith & Okech, 2016; Minnix, 2018; Rose et al., 2019). At the same time, there are relatively few practical resources for helping counselors increase their competence and efficacy when working with LGBTQ+ clients.

Competency Resources

The Society for Sexual, Affectional, Intersex, and Gender Expansive Identities (SAIGE) *Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex and Ally Individuals* (LGBQQIA; 2013) and the *Multicultural and Social Justice Counseling Competencies* (MSJCCs; Ratts et al., 2015; 2016) are designed to enable professional counselors to work effectively and competently with members of the community. The SAIGE LGBQQIA Competencies Taskforce generated a competency set to specifically address the needs of queer-identified clients. These competencies were conceptually aligned with 2009 CACREP Standards, using the eight core curricular areas as a framework. Themes within the SAIGE competencies highlighted the need to attend to developmental considerations, intersectionality, knowledge and language, impact of discrimination, non-judgmental and affirming spaces, and ethical considerations.

Although SAIGE competencies include focal areas that may inform how counselors work with LGBTQ+ clients, they are grounded in educational standards, potentially leading professionals to see these as educational guidelines rather than guidelines that inform practice. Furthermore, they are detailed in ways that speak more to those identifying as experts in LGBTQ+ issues rather than designed to help all counselors foster competence in accessible ways. In addition, no empirical studies were found that provided systemic validation or empirical examination regarding the competencies.

The MSJCCs provide counselors with a framework for understanding the impact of diversity and oppression on mental health and counseling, providing multiculturally competent counseling services, and engaging in social justice advocacy (Ratts et al., 2015, 2016). The model highlights developmental domains as counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions. Each of these developmental domains includes four categories of competencies: attitudes and beliefs, knowledge, skills, and action. Counselor self-awareness focuses on counselors' responsibilities to connect with their own beliefs, biases, and power and privilege based on identities. Client worldview asks counselors to actively seek to understand and remain curious about their clients' perspectives and context, with particular attention to how clients' identities, beliefs, and perspectives impact their counseling work. Counseling relationships attends to the ability to understand how both client and counselor bring their own identities into the room and impact the counseling partnership. Finally, counseling and advocacy interventions details how counselors can advocate for and with clients on all levels (Ratts, 2015; 2016).

The MSJCCs serve as a middle ground between the ACA *Code of Ethics* (2014) and the SAIGE Competencies for Counseling LGBQQIA Individuals (2013), encompassing the call for

non-discrimination highlighted in the ACA *Code of Ethics* and providing broader guidelines for counseling that encompasses all identities rather than being specific to the needs of queer-identified clients. Ultimately, the MSJCCs offer a broad, general framework for practice. Still, they have not been operationalized in terms of skills, and the MSJCCs lack empirical support in terms of impact on counseling practice and outcomes (Hays, 2020).

Purpose and Research Questions

Despite need for quality mental health services for LGBTQ+ individuals due to mental health disparities and experiences of minority stress, much of the current literature focuses on - referral, self-awareness, and ethics specific to working with the LGBTQ+ community (Dugger & Francis, 2014; Herlihy et al., 2014; Minnix, 2018; Rose et al., 2019; Smith & Okech, 2016). Established competencies are conceptual and not always clearly aligned with complexities of counseling practice. The degree to which the counseling literature represents best practices for work with LGBTQ+ clients is unclear. The current study focused on understanding best practices or implications for counseling with LGBTQ+ adults in community settings, as expressed in articles published in journals of the American Counseling Association, its divisions, and its affiliates (i.e., CSI, NBCC) from January 2014 through December 2020, focusing on literature published after the update of the ACA *Code of Ethics*. Specific research questions were:

RQ1: What is the state of the current professional counseling literature related to counseling LGBTQ+ individuals?

RQ1a: What proportion of the literature about LGBTQ+ individuals contained counseling implications for working with LGBTQ+ adults in community settings?

RQ1b: What professional counseling journals published literature related to counseling implications for working with LGBTQ+ adults in community settings?

RQ1c: What age groups and specialty areas were examined in relation to counseling implications for working with LGBTQ+ adults in community settings?

RQ1d: What proportion of the literature offered counseling implications based on empirical findings versus conceptual suggestions?

RQ2: What best practices or implications for counseling LGBTQ+ adults in community settings emerged from the recent literature?

Method

We utilized integrative content analysis (Neuendorf, 2002) and overlaid the guiding framework of Consensual Qualitative Research - Modified (CQR-M) to provide structure and rigor in analyzing emergent codes (Spangler & Hill, 2012). Content analysis is "the systematic, objective, quantitative analysis of message characteristics" (Neuendorf, 2002, p. 19) and allows researchers to identify key themes present in a body of qualitative data. Analysis utilized etic unitization in which "scientifically generated knowledge and perspectives" (Nuendorf, 2002, p. 108) were examined, with the sampling unit being academic manuscripts.

Research Team

The research team was comprised of three members: the first author was a doctoral candidate in Counselor Education with a certificate in Evaluation, Statistics, and Methodology, the second author was a professor of Counselor Education who served as auditor and research mentor, and the third author was a doctoral student in Counselor Education who served as co-coder. Team members all hold identities as professional counselors and counselor educators and are committed to social justice and providing multicultural counseling services and training.

Prior to beginning coding, team members discussed assumptions and biases present related to the current study. These included the first author's close work with members of the

LGBTQ+ community in clinical settings and all authors' beliefs that all counselors should be prepared to work with clients who are queer-identified. The team affirmed a need for accessible, clear guidelines for working with members of the LGBTQ+ community that can be utilized by practicing counselors. This belief, along with the strong desire for members of the LGBTQ+ community to receive effective, affirmative, and competent care, drove the current inquiry. Before beginning the current study, we believed there would be an overall endorsement of competency sets with a lack of specific skills and focused research to inform work.

Screening and Resulting Sample

Criteria for inclusion in this content analysis included presence in an ACA or ACA affiliate journal, use of prespecified keywords, and inclusion of implications for counseling with adult LGBTQ+ individuals in clinical settings. ACA and ACA affiliate journals were examined to maintain focus on the work of professional counselors. To determine keywords for identifying potential articles for inclusion, the first author examined keywords in the *Journal of LGBT Issues of Counseling*, *Journal of Counseling and Development*, *Journal of Multicultural Counseling and Development*, and the *Journal of Mental Health Counseling*. The following keywords were used to identify potential articles: LGBTQ people, gender identity, sexual minority, sexual orientation identity, sexual orientation, psychology of LGBTQ people; each phrase was paired with counsel*, best practice, and competenc*.

The first author searched all 26 journals using these keywords, resulting in an initial sample of 131 empirical and conceptual articles to be considered for full analysis. Then, a team of two coders narrowed the sample to only include those that contained implications for counseling with adult clients who identified as members of the LGBTQ+ community. In all, 36 articles did not contain counseling implications, 12 articles were not specific to LGBTQ+ issues,

and 19 articles focused on implications for work with children or adolescents or in school settings, leaving 64 (48.85%) articles for full analysis. Agreement for inclusion was 88.23%.

Procedures

The first author trained a co-coder using a comprehensive training document including information about the specific study as well as foundational knowledge about content analysis, coding, and a priori code definitions. The co-coder also completed a training session in which they could ask questions and be trained on the coding procedure. Finally, the first author and co-coder completed a pilot coding of 15% of the initial sample ($N = 131$) to gain experience coding together, amend the coding procedure, clarify a priori codes, and develop a process for determining emergent themes and reconciling their codes.

The coding team then coded articles included in the full analysis ($n = 64$) as empirical or conceptual. The coding team identified the setting intended for implications with clinical, rehabilitation, career, college, not specified, and other as a priori codes. Researchers also coded articles for the age group of participants or target population: emerging adults (ages 18 - 25), adults (ages 25 - 64), older adults (ages 65 and above), not specific to a particular age group, or other. The coding tool included space to copy and paste implications and include notes regarding potential emergent themes related to implications for counseling with queer-identified clients.

Content analysis may include both a priori codes and emergent coding for qualitative data; however, Neuendorf (2002) did not provide an explicit framework for working with emergent codes. Therefore, the team utilized CQR-M (Spangler et al., 2012) to complete coding for emergent domains in a large sample with concise data through an inductive process. The researcher and co-coder independently coded eligible articles for domains (i.e., overarching

topics used to group data together) related to counseling implications and then met to reach consensus on the identified domains, including associated categories and definitions.

After coding one-half of the eligible sample and establishing clear, present domains with relevant categories, an auditor reviewed the emerging framework and offered two rounds of feedback regarding definitions and logical organization of domains (Hill, 1997; 2005). The audit process included independently coding a random sample of 10% of articles using established domains and categories. After the initial audit, the auditor and the researcher reconciled and amended the codebook to clarify emergent domains and categories and simplify coding structure. The coding team then conducted a cross-analysis to identify common themes present in the domains and categories (Hill 1997; 2005). The auditor and researcher re-coded the random sample of articles with the updated codebook and achieved a 70.59% agreement rate. Finally, the team coded remaining articles using those updated, prominent domains and categories while also coding for any additional emergent domains and categories. No new domains emerged following the audit. The coding team achieved an overall agreement of 85.31%.

Results

RQ1: State of Literature

As noted in the method, 64 articles were included in the analysis, of which 53.13% (n = 34) were from the *Journal of LGBT Issues in Counseling.* See Table 1 for a breakdown of the eligible and coded articles by journal. Articles focused on emerging adults (10.94%), adults (71.88%), or older adults (12.50%); articles were also included if the applicable age group appeared to be non-specific but could be reasonably applied to work with adults (3.13%). Additionally, the articles contained implications for clinical mental health counseling (33.33%),

rehabilitation (3.70%), career (5.56%), college (0%), and non-specified (62.96%) settings with implications that had the potential to be applied across clinical settings.

Two-thirds of articles (67.91%, *n* = 43) were empirical, and one-third (32.81%, *n* = 21) were conceptual. In the empirical articles, researchers offered counseling implications largely based on studies that examined a particular experience or characteristic such as friendship (Lee Hughes, 2019; Vásquez et al., 2014), life satisfaction and workplace climate (Allan et al., 2015), and family dynamics (Trahan & Goodrich, 2015). The counseling implications were typically overarching suggestions disconnected from specific clinical interventions. However, one Salpietro et al. (2019) examined clinician experiences counseling LGBTQ+ clients, and four studies focused on queer-identified clients' experiences in counseling (e.g., Anzani et al., 2019; Duffy et al., 2016). Not a single study examined counseling outcomes with LGBTQ+ individuals. In contrast to the empirical articles, implications within many of the conceptual articles were more specific and directly applicable to counseling practice (e.g., Boccone, 2016; Flores & Sheely-Moore, 2020; Singh & Moss, 2016; Wheat & Thacker, 2019).

RQ2: Emergent Domains and Categories

The coding team identified three key emergent domains related to implications for counseling with adult members of the LGBTQ+ community: Conceptual Counseling Framework, Counseling Interventions, and Person as Counselor.

Conceptual Counseling Framework

Conceptual Counseling Framework (*n* = 34, 53.13%) included frameworks for understanding clients or practice without explication of tangible interventions or skills. The domain was further divided into two categories: core counseling concepts and intersectionality.

Table 1. Overview of Articles Coded by Journal

Journal	Initially Identified	Eligible for Coding
Adultspan Journal	1	0
Career Development Quarterly	4	3
Counseling and Values	6	5
Counselor Education and Supervision	1	0
Journal for Social Action in Counseling	7	1
Journal of Addictions and Offender Counseling	2	1
Journal of College Counseling	8	3
Journal of Counseling and Development	20	7
Journal of Creativity in Mental Health	6	2
Journal of Humanistic Counseling	2	0
Journal of LGBT Issues in Counseling	51	34
Journal of Mental Health Counseling	5	0
Journal of Multicultural Counseling and Development	3	0
Measurement and Evaluation in Counseling	2	2
Professional School Counseling	6	0
Rehabilitation Counseling Bulletin	2	2
The Family Journal	2	3
The Professional Counselor	3	1
Total (n)	**131**	**64**
Total (%)		

Core Counseling Concepts (n = 29, 45.31%) consisted of core aspects of professional counselor identity and practice, including attending to developmental considerations, using a holistic approach, using a strengths-based approach, and fostering wellness. Overall, scholars recommended attending to core concepts that aligned with professional counselor identity and creating a sense of consistency in working with clients regardless of identity.

Scholars called for counselors to take into account developmental considerations experienced by members of the LGBTQ+ community. Literature included special considerations for queer-identified older adults (Greene et al., 2016) and understanding adult experiences through the lens of affirmation received during childhood (Greene & Britton, 2015). Additionally, scholars called for counselors to understand the developmental process of integrating identities after coming out (Beagan & Hattie, 2015; Ikizler & Szymanski, 2014) as well as attending to the process of coming into one's identity as a member of the LGBTQ+ community (Ali & Barden, 2015; Parmenter et al., 2019).

Other Core Counseling Concepts emerged in the analysis. Some scholars suggested using a holistic approach to consider the entirety of clients' context, in particular seeking to understand how they exist within systems (Bozard & Young, 2016; Prati & Pietrantoni, 2014). Several authors indicated a need to work with queer clients through an empowering and affirmative approach that highlighted coping skills and strengths clients already possess (Burnes & Singh, 2016; Moe, 2016). Several authors called for counselors to overtly foster wellness through counseling relationships (Lassiter et al., 2017; McGlasson & Rubel, 2015).

Finally, Intersectionality (n = 17, 25.56%) spoke to counselors' need to recognize that LGBTQ+ clients have complex, intersecting identities that impact their experiences and perspectives as they interact with their other identities, with attention to intersectionality most

closely aligning with the work of Crenshaw (1989; 1991). Researchers primarily focused on the impact of holding identities often viewed as non-affirming to LGBTQ+ people. Implications primarily focused on the intersection of religion and queer identities, though the results may have been impacted by a special issue of *Counseling and Values* focused on the intersection of religion and LGBTQ+ issues (Balkin et al., 2014; Kim & Epstein, 2018; Shurts et al., 2020). Additionally, researchers called for counselors to be intentional about considering intersections with ability status (Dispenza et al., 2016) and race and ethnicity (Singh & Moss, 2016).

Counseling Interventions

Counseling Interventions (n = 53, 82.81%) referred to tangible skills or interventions for working with LGBTQ+ clients. The domain was further divided into categories: counseling relationship, advocacy, skills/interventions, and assessment.

Counseling Relationship (n = 28, 43.75%) emphasized the need to build a strong foundation of trust and safety between counselors and clients. Researchers consistently highlighted trust and safety as a main change agent. Many authors provided general calls to build foundational aspects of the counseling process without offering clear recommendations regarding how skills may be customized to needs of queer-identified clients (Cavanaugh & Ladd, 2017; Flores & Sheely-Moore, 2020; Suprina et al., 2019).

Advocacy (n = 21, 32.81%) referred to professional counselors' roles supporting LGBTQ+ clients in individual and systemic context. Advocacy implications often included generic calls for counselors to act as advocates for the LGBTQ+ community (Cogan et al., 2020; Suprina et al., 2019) and assist their clients in becoming self-advocates (Allan et al., 2015; Prati & Pietrantoni, 2014). Furthermore, authors highlighted a need to advocate for appropriate

assessment and diagnosis (Effrig et al., 2014; Moe et al., 2015; Toscano & Maynard, 2014), with some focus on making services more accessible (Moe et al., 2018).

Skills/Interventions (n = 19, 29.69%) addressed specific skills or interventions to use with LGBTQ+ clients. Researchers recommended a variety of specific skills, interventions, or theoretical approaches for this population. Theoretically, there were calls for use of Relational Cultural Theory (Flores & Sheely-Moore, 2020; Singh & Moss, 2016) and the empty chair technique (Boccone, 2016). Authors also recommended using more basic counseling skills such as validations and reflecting emotions (D. C. Greene et al., 2016; J. H. Greene, 2018).

Assessment (n = 12, 18.75%) included calls to ensure assessments are selected and interpreted correctly given the lack of assessments normed on queer-identified participants (Duffy et al., 2016; Puckett & Levitt, 2015; Russett, 2016). Authors also focused on creating and validating new measures such as the Gender Identity Reflection and Rumination Scale (Bauerband & Galupo, 2014) and the Acceptance of Couple Violence Scale (McRae et al., 2018) to be used specifically with queer-identified individuals.

Person as Counselor

Person as counselor (n = 35, 54.69%) highlighted the impact of counselors as individuals, including how their development influences the counseling relationship and conceptualization of LGBTQ+ clients. This domain was further divided into three categories: education/knowledge, ethical considerations, and self-awareness.

Education/knowledge (n = 28, 43.75%) indicated a need for counselors to learn about the LGBTQ+ community and experiences beyond their counselor education programs. Researchers primarily focused on ensuring that counselors were up to date on the language they used, followed the lead of their clients and allowed clients to define what specific terms mean to them

(Anzani et al., 2019; Burnes & Singh, 2016). Furthermore, scholars highlighted that counselors need to have knowledge or continuing education related to the LGBTQ+ community. Researchers focused on a variety of knowledge areas, such as a working understanding of experiences of discrimination and microaggressions (Anzani et al., 2019), loss (Wheat & Thacker, 2019), and the coming out process (Shurts et al., 2020).

Ethical Considerations (n = 11, 17.19%) included calls to follow the ACA *Code of Ethics* and apply established competencies when working with members of the LGBTQ+ community (Farmer & Byrd, 2015; Puckett & Levitt, 2015; Suprina et al., 2019). Scholars focused on ensuring that counselors attended to biases and values that may impact the counseling relationship and work to minimize impact through self-reflection, supervision, and using established competencies to inform practice (Farmer & Byrd, 2015; Puckett & Levitt, 2015).

Finally, Self-awareness (n = 8, 12.50%) highlighted the need for counselors to understand and acknowledge their own values and beliefs related to identities, experiences, and perspectives of members of the LGBTQ+ community. Self-awareness spoke to the specific need to understand beliefs and values related to intersections of religion and the queer-identified community (Balkin et al., 2014; Bayne, 2016; Bidell, 2014). Several authors also spoke to the need to be aware of biases related to the LGBTQ+ community, such as beliefs or assumptions related to gender identity (Knutson & Koch, 2019; Singh & Moss, 2016).

Discussion

Results highlighted the continued focus on providing overall ethical, culturally sensitive care to LGBTQ+ clients. The majority of the articles were empirical; however, they largely examined characteristics or life experiences of queer-identified individuals to draw general implications. These counseling implications most often focused on aspects of counseling that

work with all clients: having a strong relationship (Wampold & Budge, 2012) and cultivating multicultural counseling competence by attending to biases and seeking additional education (Ratts, 2015; 2016). In this way, there was limited focus on specific skills or interventions.

The current state of the literature suggests some movement beyond calls for non-referral (Kaplan, 2014; Kaplan et al., 2017); however, it stops short of providing ways to adapt foundational common factors or evidence of specific interventions and skills for working with queer-identified clients. Scholars appear to be balancing between a need for guidelines specific to working with queer-identified clients and general calls for equitable practice. This may suggest that, when professional counselors enact core tenets of our profession, good practice is effective regardless of identity or specialty area.

This study highlights connections between the current LGBTQ+ literature and the MSJCCs in that the emergent domains and categories aligned with constructs highlighted in the model (Ratts 2015; 2016). In the current sample, scholars attended mostly to competencies related to client worldview and counselor self-awareness. Primary attention was on attitudes and beliefs alongside knowledge; scholars indicated the importance of avoiding values conflicts, reducing the impact of biases, using appropriate language, and understanding client experiences. Through holistic conceptualizations, scholars implied that counselors are able to work ethically and effectively with queer clients. At the same time, the literature is largely silent on actionable items within the MSJCCs: immersing in the community, engaging in collaborative community-based advocacy, and implementing nontraditional helping models (Ratts et al., 2016).

The aspirational competencies related to action in the MSJCCs moves the framework from one of conceptualization to one of intentional intervention and advocacy (Ratts 2015; 2016). The current LGBTQ+ literature highlights conceptualization with little attention to

intentional intervention and advocacy. Hays (2020) argued that even the MSJCCs are not enough to work ethically and effectively with diverse clients. Rather, there is a need to pair the MSJCCs with a better understanding of how counselors' multicultural and social justice competency impacts effectiveness of counseling relationships within a context of intersectionality.

Considering the need for clear guidelines for working with queer-identified clients, the SAIGE *Competencies for Counseling LGBQQIA Individuals* (2013) provided a framework for work with the LGBTQ+ community, and study findings aligned in many ways with these guidelines. Specifically, emergent domains and categories aligned with SAIGE competencies focused on advocacy, bias, and furthering knowledge of the queer community. Again, this highlights a lack of action-oriented suggestions, with both SAIGE competencies and current literature stopping short of specific, applicable skills for work with queer-identified clients.

Limitations

The current study focused only on journals associated with ACA and affiliate organizations. We did not include interdisciplinary journals to LGBTQ+ or other scholarly venues such as books. Additionally, the coding protocol did not attend to depth or novelty of counseling implications, rather focusing on presence or absence of types of implications in journals. Finally, the current study did not differentiate between the source of implications (e.g., client or community voice) or degree to which implications were clearly grounded in research.

Counseling Implications

Given the clear alignment of results with the MSJCCs (Ratts et al., 2016) and the SAIGE (2013) competencies, counselors may turn to these guidelines as a way to foster a foundation of competence through self-awareness, knowledge, and general recommendations that can be beneficial to LGBTQ+ clients. With this foundation, counselors will be better able to enact

practices endorsed by the current literature. Furthermore, counselors can lean on their professional identity, attending to aspects such as wellness, using a strengths-based approach, and taking developmental considerations into account. These foundational aspects are well established as components of effective counseling relationships that provide space for growth, and these aspects should be effective a broad range of individuals, including queer clients.

After building foundations, counselors should consider steps they can take to begin to incorporate the aspirational action competencies related to the MSJCCs, adapting their practices and interventions for use with queer-identified clients when necessary. These steps may include seeking consultation and supervision from those who are more experienced in working with LGBTQ+ clients, using appropriate assessments to build treatment plans, and fostering self-advocacy so clients can provide feedback throughout the counseling process.

Research Implications

Future research should focus on increasing examination of the efficacy of counseling skills and interventions with LGBTQ+ clients. For example, multiple scholars highlighted the potential for Relational Cultural Therapy (RCT) to be used effectively with queer-identified clients. Future studies may examine adaptations and outcomes of RCT with queer-identified clients. Given the lack of consumer voice, researchers should include attention to the perspectives of LGBTQ+ people in identifying experiences and disparities in counseling relationships, effectiveness of interventions in meeting their needs, and practices they see as effective in fostering growth. Perspectives of clinical samples of LGBTQ+ people and increased focus on understanding the efficacy of counseling interventions would increase the depth and applicability of the literature. Such studies would also help practicing counselors utilize research to include interventions specific to queer-identified clients. Research designs such as Q

Methodology may enable researchers to first understand what LGBTQ+ community members see as important in counseling relationships and then what actual clients value in counseling, using that as a foundation for what practices and interventions to examine first.

Finally, scholars may attend to understanding queer clients' experiences of counseling relationships. Across populations, the counseling relationship contributes to counseling outcomes above and beyond many other factors (Wampold & Budge, 2012). Researchers may consider what about the counseling relationship may be different when working with queer-identified clients, examining aspects specific to the population and understanding the unique contribution of the counseling relationship to client outcomes with queer-identified samples.

Conclusion

It is not enough to merely understand queer-identified clients; professional counselors must be able to use skills and interventions that can be readily applied by practitioners and empirically validated by researchers. These skills and interventions should be understood through the lens of the experiences and voice of members of the LGBTQ+ community.

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CHAPTER II: QUEER-IDENTIFIED CLIENTS' PREFERENCES IN COUNSELING PRACTICE: A Q METHODOLOGY STUDY

ABSTRACT

This study sought to better understand queer-identified clients' preferences in counseling, centering on client voice by using Q Methodology. Participants ($N = 50$) were recruited through MTurk and were members of the LGBTQ+ community who had attended counseling for at least seven sessions with a licensed professional counselor. Following the Q Sort, three factors emerged, indicating three sets of preferences for counseling: building relationship, enacting LGBTQ+ specific knowledge, and development through the lens of queer identity. Implications for counseling, counselor education, and research are explored.

Keywords: LGBTQ+, queer, counseling implications, gender identity, sexual orientation, best practice

Mental health disparities are prevalent in the LGBTQ+[2] community, with queer-identified individuals experiencing mental health concerns such as depression, anxiety, suicidality, and post-traumatic stress symptomology at higher rates than their non-LGBTQ+ counterparts (Blosnich & Bossarte, 2012; Lehavot & Simoni, 2011; Marshal, 2011; Plöderl & Tremblay, 2015; Robinson & Rubin, 2016; SAMHSA, 2015; Streed et al., 2017). These mental health disparities can be explained in part through minority stress (Meyer 1995, 2003) which accounts for the accumulative impact of discrimination on mental health. Relatedly, when compared to their non-queer counterparts, queer-identified individuals report higher needs for mental health services, more use of mental health services, and greater unmet mental health needs (Macapagal et al., 2016; Spengler & Ægisdóttir, 2015; Williams & Chapman, 2011).

Given the presence of these disparities and the ethical mandate to provide non-discriminatory services (ACA, 2014), all professional counselors must be prepared to work effectively with members of the LGBTQ+ community. The counseling profession grounds its work with queer-identified clients in the Society for Sexual, Affectional, Intersex, and Gender Expansive Identities (SAIGE) *Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex and Ally Individuals* (LGBQQIA; 2013) and the *Multicultural and Social Justice Counseling Competencies* (MSJCCs; Ratts et al., 2015; 2016). Both documents offer broad, conceptual recommendations for working with queer-identified individuals in counseling. The MSJCCs highlight key developmental domains, including counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions (Ratts et al., 2015, 2016). These are further divided into aspirational competencies focused on attitudes and beliefs, knowledge, skills, and action (Ratts et al., 2015, 2016).

[2] LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, and Queer with the plus representing those identities in the community not encompassed in the abbreviation) and queer-identified will be used interchangeably.

Although the MSJCCs (Ratts et al. 2015, 2016) provide important insight into working with members of the LGBTQ+ community, there is little empirical evidence regarding how counselors implement the MSJCCs in practice and how implementation impacts client outcomes (Hays, 2020). Although counselor behaviors appear to most influence clients' perceptions of their counselors' overall multicultural orientation (Davis et al., 2018; Owen et al., 2011), the current literature primarily focuses on conceptualization and counselor development. The majority of counseling implications for working with queer-identified clients emanate from researchers rather than client voice (Hightower et al., 2020), and it is pertinent to highlight the mismatch between counselors' and clients' perceptions of counselors' multicultural responsiveness (Owen et al., 2016). This mismatch may be addressed with the use of broaching skills that build strong therapeutic alliances grounded in cultural sensitivity (Day-Vines, 2020), though attention to these skills is missing in the literature related to working with LGBTQ+ clients.

Counseling Implications for LGBTQ+ Clients

When conceptualized through the MSJCCs, current literature highlights the prevailing focus on counselor knowledge and self-awareness and client worldview with neglected attention to counseling skills and client voice (Hightower et al., 2020). A comprehensive review of the 2014-2020 literature containing implications for counseling with LGBTQ+ adult clients in clinical settings revealed that scholarship in this area was primarily empirical (67.91%, $n = 43$) with a large focus on experiences or characteristics of members of the LGBTQ+ community in general (Hightower et al., 2020). Despite the importance of centering client voice and experience in the MSJCCs, these empirical studies offered implications for working with queer-identified clients that were tied to reported characteristics rather than grounded in counseling practice. Few

studies highlighted client experiences in counseling such as the use of microaffirmations related to gender when working with transgender clients (Anzani et al., 2019), treatment strategies for working with men who have sex with men and use methamphetamine (Jerome & Halkitis, 2014), and transgender clients' experiences of counselors' competence related to eating disorder treatment (Duffy et al., 2016). No studies examined counseling outcomes with LGBTQ+ clients. Overall, the current literature leaves implications for working with LGBTQ+ individuals lacking input from the community itself. This literature review includes attention to recommendations for counseling LGBTQ+ clients from the perspective of the MSJCCs developmental domains.

In line with the counselor self-awareness developmental domain, counselors are responsible for recognizing deficits in knowledge or understanding when working with queer-identified clients and continuing to acquire knowledge related to the LGBTQ+ community. Certainly, counselors should keep up to date on language related to the LGBTQ+ community and allow clients to determine what language they use (Anzani et al., 2019; Burnes & Singh, 2016). Additionally, counselors should seek continuing education related to the LGBTQ+ community, attending to areas such as discrimination and microaggressions (Anzani et al., 2019), loss (Wheat & Thacker, 2019), and the coming out process (Shurts et al., 2020). Although the intentional building of a functional knowledge base related to the LGBTQ+ community is central to working competently, having knowledge does not ensure counselors use knowledge effectively in session.

When considering the developmental domain of client worldview, current literature recommends utilizing core aspects of the counseling profession such as considering the impact of development, using holistic and strengths-based approaches, and attending to wellness (Hightower et al., 2020). Counselors should attend to how development may be impacted by one's identity as LGBTQ+. In particular, it is important to understand the process of integrating

identities after coming out (Beagan & Hattie, 2015; Ikizler & Szymanski, 2014) and understanding one's identity as a member of the LGBTQ+ community (Ali & Barden, 2015; Parmenter et al., 2019). Holistic approaches may include considering how queer-identified clients may be impacted by their systems (Bozard & Young, 2016; Prati & Pietrantoni, 2014). Strengths-based approaches may highlight queer-identified clients' coping skills and strengths (Burnes & Singh, 2016; Moe, 2016), while wellness should be central to the counseling relationships (Lassiter et al., 2017; McGlasson & Rubel, 2015). Although these recommendations align with core aspects of counselor identity, they largely include calls to work with queer-identified clients as one would with clients who do not identify as LGBTQ+.

Current literature highlights the importance of the counseling relationship when working with queer-identified clients. It is imperative that counselors establish and maintain trust and safety between themselves and their LGBTQ+ clients (Cavanaugh & Ladd, 2017; Flores & Sheely-Moore, 2020; Suprina et al., 2019). Flores and Sheely-Moore (2020) suggested RCT as a framework to establish a "collaborative and egalitarian therapeutic relationship… model a growth fostering relationship in which both parties share their authentic selves" (p. 80). As a whole, the literature lacked attention to nuanced skills, attention to client voice, or accounts of experiences within counseling relationships.

Overall, recommendations for individual and systems-level counseling and advocacy were paired with some theoretical approaches. In context of broader recommendations for integrating spirituality, Suprina et al. advised counselors to "advocate for LGBTQ+ clients as appropriate" (2019, p. 314) and Cogan et al. (2020) advised counselors to "enact public policy reform particularly in the area of legal protection" for transgender clients (p. 13). Additionally, counselors should help their queer-identified clients learn to be effective self-advocates (Allan et

al., 2015; Prati & Pietrantoni, 2014). Again, existing literature remained general and did not include examination of counseling outcomes or the impact of advocacy skills on clients.

Purpose of the Study

Although the literature base for counseling queer-identified clients offers insight into some practices that may improve counselors' work with LGBTQ+ clients, there is an overall lack of voice of members of the LGBTQ+ community who have attended counseling. This lack of voice is compounded by a lack of outcome-based research that informs practice, with counseling implications emanating from researchers rather than clients. Instead, the current research focuses on experiences such as coming out and friendship, without clear ties to counseling practice. This study sought to understand aspects of counseling most important to members of the LGBTQ+ community who have attended or are currently attending counseling. In this, the current study may provide insight into research and clinical recommendations based on client values and experiences. The research question guiding the inquiry was: Which counseling competencies, counseling implications, or community generated aspects of counseling do adult LGBTQ+ clients in clinical settings prefer in their counseling relationships?

Method

The author utilized Q Methodology to assess the subjective preferences of queer-identified individuals when attending counseling. Q Methodology enables researchers to analyze subjective content by having participants sort statements that are analyzed into factors that represent perspectives or preferences. Q Methodology includes open ended opportunities for participants to provide rationale for their preferences and enrich the data (McKeown & Thomas, 2013; Newman & Ramlo, 2010).

Recruitment and Participants

In Q Methodology, the person sample (P sample) is selected based on the characteristics needed to accomplish the goals of the study (McKeown & Thomas, 2013). The P sample is central to Q Methodology as participants rather than Q sample items are used to establish common factors that represent similar perspectives and preferences (McKeown & Thomas, 2013). Given the analysis associated with Q Methodology, sample size cannot be determined a priori; rather, it depends on the number of factors that emerge during analysis (Brown, 2008; McKeown & Thomas, 2013). Scholars recommend oversampling when it is unknown how many factors will emerge and consider 30 - 60 participants adequate (Brown, 2008; McKeown & Thomas, 2013).

The current study was approved through the Institutional Review Board (IRB) prior to recruitment via Amazon Mechanical Turk (MTurk). MTurk enabled recruitment of a diverse sample that meets inclusion criteria and has been shown to be effective in conducting survey research in behavioral sciences (Chan & Holosko, 2016). Participants were compensated through MTurk via a $12 Amazon credit; on average, participants completed the study in one hour.

In order to be included in the current study, MTurk workers completed a screening questionnaire that determined if they were at least 18 years of age, identified as a member of the LGBTQ+ community, and had attended counseling for at least seven sessions with the same licensed professional counselor (LPC) within the last two years. Seven sessions was selected because that is the point at which 50% of clients begin to experience change (Lambert, 2013). The screening survey was attempted a total of 1,195 times by 367 unique participants, with 939 attempts (78.58%) not meeting inclusion criteria. Of the remaining 256 attempts, 190 (74.22%) responses were disqualified due to participants taking the screening survey multiple times. Of the

remaining 66 responses, 16 (24.24%) were disqualified due to submitting incomplete sorts or not completing the open-ended items, leaving a final sample of 50 unique participants who met inclusion criteria and submitted complete sorts and open-ended responses. Table 2 for participant characteristics.

Instrumentation and Data Collection

Data collection in Q methodology focuses on the Q sort and a reflective qualitative data collection (McKeown & Thomas, 2013). Data were collected online due to COVID-19, and participants completed the Q Sort, demographics questionnaire, barriers questionnaire, and reflective open-ended items in an online format which was used in place of qualitative interviews (McKeown & Thomas, 2013). Participants completed the screening and demographic questionnaires via QuestionPro and the Q Sort and open-ended items via QAssessor (The Epimetrics Group, 2014). Participants were asked to first complete a brief screening survey that terminated the survey if inclusion criteria were not met. See Appendix C for the screening items.

If inclusion criteria were met, participants first completed the demographic questionnaire and barriers assessment. Demographic items included sexual orientation, gender identity, race/ethnicity, religious/spiritual identity, perceived social class, and age. Barriers were assessed using a portion of the National Comorbidity Scale - Revised (National Comorbidity Survey, 2005) which assessed for potential barriers to accessing mental health care such as cost, time commitment, and satisfaction with available services (See Appendix J for the full scale). Participants rated each potential barrier on a four-point Likert scale from not a barrier to extreme barrier. Additional questions attended to experiences in counseling and collected data related to how long ago participants were in counseling, how many sessions they attended, what type of helping professional they saw, and their reason for seeking counseling.

Table 2. P Sample Demographic Characteristics

Characteristics		*n*	%
Gender			
	Cisgender Male	17	34
	Cisgender Female	20	40
	Transgender Male	6	12
	Transgender Female	4	8
	Genderqueer	2	4
	Prefer not to Answer	1	2
Sexual Orientation			
	Gay	15	30
	Lesbian	13	26
	Bisexual	17	34
	Pansexual	1	2
	Queer	1	2
	Heterosexual	3	6
Race/Ethnicity			
	White	38	76
	Hispanic/Latine	1	2
	Black/African-American	11	22
Religion			
	Agnostic	7	14
	Atheist	5	10
	Christian	36	72
	Prefer not to Answer	2	4

Table 2. Continued

Characteristics		*n*	%
Education			
	High School Graduate (or equivalent)	2	4
	Some College (1 – 4 years, no degree)	5	10
	Associate's Degree	1	2
	Bachelor's Degree	29	58
	Master's Degree	13	26
Counseling Characteristics			
Time Since Counseling	Currently Attending	26	52
	> 6 months	12	24
	6 months – 1 year	10	20
	1 year – 2 years	2	4
Presenting Problems			
	Anxiety	31	62
	Depression	36	72
	Suicidality	5	10
	Relationship Issues	13	26
	Eating Disorder	3	6
	Trauma	7	14
	Life Transitions/Stressors	6	12
	Loss/Grief	2	4
	Identity Issues	7	14
	Career/Work	14	28
	Substance Use	3	6
	Discrimination/Prejudice	3	6
	Non-suicidal Self Injury	4	8

Table 2. Continued

Characteristic	M	SD
Age	31.24	7.12
Perceived SES	6.02	1.84
Perceived Barriers	2.53	.57

*N = 50

Participants then completed the initial step of the Q Sort by reading all items and rating each item as Important, Neutral, or Not Important. Next, participants completed the full Q Sort with a forced-choice condition by first identifying items that were most important to them in a counseling relationship (+6) and then identifying those items that are least important to them (-6). Participants filled in the rest of the sort depending on what items were more and less important to them. Finally, participants were asked to review their entire sort and make any final edits. After confirming the final sort, participants completed a series of four open-ended items to capture their experience of completing the sort and reasons for rating certain aspects of counseling as most or least important. See Table 3 for example items. This captured data to aid in interpretation of findings (McKeown & Thomas, 2013). Data collection ended with a page of LGBTQ+ affirmative mental health resources.

Concourse and Q Sample Development

In Q Methodology, the concourse represents all possible items that could be included as a part of the Q sample, with nearly unlimited possibilities in order to represent the whole of the experience being examined (McKeown & Thomas, 2013). For the current study, the researcher created a concourse representative of competencies and counseling implications for working with members of the LGBTQ+ community. The concourse consisted of 147 total items. To arrive at the concourse, the researcher edited 96 items from the SAIGE (2013) competencies to remove jargon and increase clarity. Likewise, the lead author created 24 items derived from a content analysis (Hightower et al., 2020) which distilled implications from 64 counseling articles regarding implications for counseling with LGBTQ+ clients into domains and categories. Additionally, the researcher surveyed members of the LGBTQ+ community, analyzed data using CQR-M, and created 27 concourse items not yet captured in items generated from the SAIGE

competencies and content analysis. Thus, the survey generated concourse items to maintain community voice and language (McKeown & Thomas, 2013; Spangler et al., 2012). See Table 3 for a breakdown of the dispersion of items in the concourse derived from these three sources.

In an IRB-approved survey of queer-identified individuals, participants (N = 111) completed screening questions to ensure that they identified as members of the LGBTQ+ community and were at least 18 years of age. Participants were then asked to provide open-ended responses to, "What would you consider to be the top five most important things for your counselor to do when working with you?" and completed demographic questions related to their counseling experiences, sexual orientation, gender identity, and race/ethnicity. Participants' average age was 33.26 (SD = 9.13), and the sample was primarily white (n = 96, 86.5%). For additional demographic data, see Table 4.

Participants provided 471 brief qualitative responses detailing their counseling preferences, and the researcher and co-coder analyzed the data using CQR-M, a modified version of CQR appropriate for brief qualitative data (Spangler et al., 2012). The coders started with the established domains and categories based on analysis of the current LGBTQ+ literature (Hightower et al., 2020) and noted potential additional domains and categories emerging in the data. After establishing several new areas, researchers coded independently and reconciled to consensus, with an agreement rate of 83.51%. Results from the community survey contributed new categories under the domains from the content analysis including: comfort and acceptance, appropriate broaching of queer identity, counselor dispositions, and counselor experiences and identities. A new domain, foundations, also emerged and included access/logistics, presenting issues, foundational expectations, and outward displays of support. See Appendix K for a

Table 4. Concourse Item Dispersion

Source	**Number of Items**	**Example Item**
SAIGE Competencies	96	My counselor is aware of misconceptions and myths related to my queer identity.
Current Literature	24	My counselor is empowering and affirmative by highlighting the strengths and coping skills that I already use.
Community Survey	27	My counselor is visibly comfortable sitting with, hearing, and responding to me in session.
Total	**147**	

*Total items included in the concourse

Table 5. LGBTQ+ Community Survey Demographics

Demographic		***n***	**%**
Gender			
	Cisgender Male	23	20.7
	Cisgender Female	63	56.8
	Transgender Male	7	6.3
	Transgender Female	2	1.8
	Non-binary/Third Gender	10	9.0
	Genderqueer/Gender Non-conforming	7	6.3
	Prefer Not to Answer	1	.9
Sexual Orientation			
	Straight/Heterosexual	2	1.8
	Gay	24	21.6
	Lesbian	32	28.8
	Bisexual	24	21.6
	Pansexual	19	17.1
	Asexual	3	2.7
	Queer	21	18.9
	Prefer to Self-Describe	5	4.5
Attended Counseling			
	Current Attending Counseling	40	36.0
	Previously Attended Counseling	58	52.3
	Never Attended Counseling	12	10.8
Longest Counseling Relationship			
	1-3 Sessions	7	6.3
	4-6 Sessions	15	13.5
	More than 6 Sessions	75	67.6
	Prefer Not to Answer	1	0.9

breakdown of the domains, categories, and subcategories used in the concourse derived from the content analysis of counseling literature and additions from the community survey.

The Q sample consisted of 85 items drawn from the concourse. Items were selected to highlight ideas most representative of community members' own language and experiences while still providing a comprehensive list of items to describe the phenomena (McKeown & Thomas, 2013). Within Q Methodology, participants sort Q sample items based on what they consider to be most important (McKeown & Thomas, 2013). Thus, the structured Q sample involved a systematically created, theoretically grounded, and representative sampling of items (McKeown & Thomas, 2013), with the themes and levels based on the emergent domains and categories of the content analysis which also align with the competencies offered by SAIGE. The themes and levels inform the minimum number of Q sample items needed (N = 72) and consisted of conceptual framework made up of intersectionality and core counseling concepts, counseling interventions made up of advocacy, assessment, counseling relationship, and skills/interventions, and person as counselor made up of education/knowledge, ethical considerations, and self-awareness. See Table 5 for a breakdown of the themes and levels used for the Q sample and the formula used to calculate the number of Q sample items needed (N = 72). See Table 6 for a breakdown of the development of the Q sample from the concourse, including the inclusion of major themes and levels.

Data Analysis

Q methodology analysis includes sorting participants into factors and subsequent analysis of demographic items and open-ended responses to provide context regarding why participants sorted items into particular categories (McKeown & Thomas, 2013). Composite factors that emerge during analysis represent participants who have similar perspectives on what is important

Table 6. Q Sample Design

Theme	**Levels**	***n***
A. Conceptual Framework	(a) Intersectionality (b) Core Counseling Concepts	2
B. Counseling Interventions	(c) Advocacy (d) Assessment (e) Counseling relationship (f) Skills/Interventions	4
C. Person as Counselor	(h) Education/Knowledge (i) Ethical considerations (j) Self-awareness	3
Total Items		**72**

* Q Sample (N) = (Main Effects)(Replications) = ([A][B](*m*)

Table 7. Concourse and Q Sample Narrowing and Dispersion

	SAIGE		**Content Analysis**		**Community Survey**	
	Concourse	Q Sample	Concourse	Q Sample	Concourse	Q Sample
Conceptual Framework	39	18	10	2	3	3
Counseling Interventions	24	7	7	6	14	14
Person as Counselor	34	18	7	7	6	6
Foundations	-	-	-	-	4	4
Overall Totals	97	**43**	24	**15**	27	**27**

*Final Q Sample = 72

in a counseling relationship. Data were analyzed using thematic analysis, correlations, and principal components analysis (PCA; Newman & Ramlo, 2010) using KADE, a Q methodology analysis software.

Data were cleaned, assessed for missingness, and examined for normality prior to analysis (Tabachnik & Fidell, 2019). The researcher then conducted a Pearson correlation in which each participant's scores were correlated with scores of the other participants, indicating who sorted items in a similar order. The researcher looked for correlations that were ≥ .30 (McKeown & Thomas, 2013). Next, PCA was used to sort the P sample into factors, retaining factor loadings ≥ .32 (McKeown & Thomas, 2013; Newman & Ramlo, 2010; Tabachnik & Fidell, 2019).

After determining what to retain for each composite factor, the researcher examined z-scores of items to gain insight into the most and least important counselor behaviors or characteristics for participants who loaded onto each factor. Finally, the researcher examined demographic characteristics of participants loading on each factor and then used thematic analysis to analyze open-ended data associated with each factor. The researcher followed the protocol for thematic analysis, including familiarizing oneself with the data, thematic coding, review emergent themes, and defining and naming emergent themes (Braun & Clarke, 2006).

Results

A PCA with varimax rotation was performed on the P sample using KADE (Banasick, 2019). Eight composite factors were identified with eigenvalues > 1, and analysis of the scree plot (See Figure 1) was used to retain (Tabachnik & Fidell, 2019) three principal components explaining 32% of the variance. In all, 43 members of the P sample (86.0%) loaded onto one of the three components with a factor loading ≥ .32, indicating data quality then triangulated with

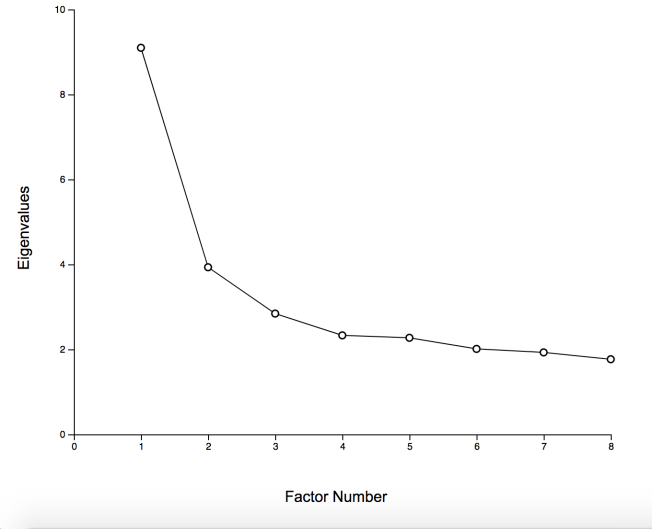

Figure 1. Scree Plot for PCA of P Sample

qualitative data analysis (Tabachnik & Fidell, 2019). Three members cross loaded onto two factors at ≥ .32 level and were retained on the factor with the higher factor loading. See Table 7 for factor loadings.

Each composite factor represented the subjective views of the members of the P sample that loaded onto that component, with those who sorted items similarly loading onto factors together (McKeown & Thomas, 2013). No demographic differences emerged across the factors, and participants across factors endorsed anxiety and depression and their primary presenting concerns (See Table 8). The three factors are centered on relationship (Factor 1), enacting knowledge (Factor 2), and queer development (Factor 3).

Consensus Statements

Consensus statements represent statements that did not differentiate between the identified factors (McKeown & Thomas, 2013). Three consensus statements emerged, with one representing a statement rated neutral, one rated slightly unimportant, and one rated as most important across all factors. All factors highlighted the importance of counselors using basic counseling skills, with it falling in the top three statements for each factor. Understanding myths and misconceptions related to queer identity and historical discrimination within the profession emerged as largely neutral across factors. Finally, an understanding that clients may be slow to trust counselors due to the often unsupportive history of the profession was rated as slightly unimportant across factors.

Factor One: Relationship

Factor one represented members of the P sample (n = 19) who most valued relationship in counseling, highlighting a desire for a strong foundation in relationship across their top

Table 8. PCA with Varimax Rotation Factor Loadings

P Sample	Factor Loading		
	1	2	3
Factor 1			
15019	**0.74**	0.15	-0.23
14990	**0.71**	0.00	0.20
14962	**0.67**	0.07	0.02
14996	**0.67**	0.16	-0.18
15081	**0.66**	0.12	-0.18
15157	**0.63**	-0.02	-0.06
14981	**0.61**	0.08	0.11
15117	**0.59**	-0.08	0.09
15086	**0.59**	0.18	0.04
15010	**0.55**	0.25	0.02
15032	**0.50**	0.25	-0.06
15172	**0.49**	-0.19	0.04
15012	**0.48**	0.39	0.16
15146	**0.47**	0.17	-0.23
15164	**0.47**	0.03	-0.10
15179	**0.43**	0.40	0.16
14976	**-0.42**	-0.12	0.03
14974	**0.37**	0.02	-0.36
15007	**-0.34**	-0.12	-0.21
14999	-0.27	0.15	0.16
Factor 2			
15044	0.31	**0.77**	0.03

Table 8. Continued

P Sample	Factor Loading		
	1	2	3
15048	-0.08	**0.70**	0.15
15051	-0.02	**0.61**	-0.07
15060	0.29	**0.60**	-0.29
15107	0.07	**0.57**	-0.16
15119	0.43	**0.57**	-0.08
15129	-0.16	**-0.54**	0.09
14941	-0.07	**0.54**	0.05
14991	0.12	**0.53**	0.15
15056	0.14	**0.49**	-0.12
15065	0.27	**0.45**	-0.04
15040	0.02	**0.39**	-0.39
14970	-0.07	**0.32**	-0.08
14987	-0.13	-0.29	0.14
15043	0.01	0.28	-0.12
14952	-0.16	0.19	-0.17
14984	0.13	0.18	-0.17
Factor 3			
14971	-0.32	-0.38	**0.61**
15139	-0.12	0.08	**0.56**
14972	0.02	-0.08	**0.56**
15124	0.10	-0.03	**0.51**
15042	0.13	0.00	**0.50**
15059	-0.39	-0.23	**0.48**
15003	-0.12	-0.12	**0.41**

Table 8. Continued

P Sample	Factor Loading		
	1	2	3
15062	0.17	0.34	**-0.35**
15171	0.28	0.12	**0.34**
15105	0.19	0.31	**-0.34**
15165	-0.02	-0.08	**0.32**
15092	0.14	0.15	-0.23
15087	0.12	0.00	0.20
Eigenvalue	9.09	3.93	2.84
% of Total Variance	14%	11%	7%
Total Variance			32%

Note. N = 50. Factor loadings ≥ .32 were retained.

Table 9. Demographic Characteristics and Barriers by Factor

		Factor 1 (n = 19)		Factor 2 (n = 13)		Factor 3 (n = 11)	
Characteristics		*n*	%	*n*	%	*n*	%
Gender							
	Cisgender Male	8	42	5	39	2	18
	Cisgender Female	6	32	6	46	4	36
	Transgender Male	2	11	1	8	3	27
	Transgender Female	3	16	0	0	1	9
	Genderqueer	0	0	1	8	0	0
	Prefer not to Answer	0	0	0	0	1	9
Sexual Orientation							
	Gay	6	32	3	23	5	46
	Lesbian	6	32	3	23	3	27
	Bisexual	4	21	6	46	3	27
	Pansexual	0	0	0	0	0	0
	Queer	1	5	0	0	0	0
	Heterosexual	2	11	1	8	0	0
Race/Ethnicity							
	White	15	79	10	77	8	73
	Hispanic/Latine	1	5	3	23	0	0
	Black	3	16	0	0	3	27
Religion							
	Agnostic	1	5	3	23	2	18
	Atheist	3	16	0	0	1	9
	Christian	14	74	10	77	8	73
	Prefer not to Answer	1	5	0	0	0	0

Table 9. Continued

Characteristics		*n*	%	*n*	%	*n*	%
Education							
	High School Graduate	0	0	1	8	1	9
	Some College	2	11	1	8	1	9
	Associate's Degree	0	0	1	8	0	0
	Bachelor's Degree	12	63	7	54	6	55
	Master's Degree	5	26	3	23	3	27
		M	**SD**	**M**	**SD**	**M**	**SD**
Age		28.47	2.76	30.85	6.68	33.36	9.04
Perceived SES		6.26	1.70	6.08	1.89	5.36	1.50
Counseling Characteristics							
Time Since Counseling							
	Currently Attending	10	53	5	39	6	55
	Less than 6 months	4	21	3	23	4	36
	6 months – 1 year	4	21	4	31	1	9
	1 year – 2 years	1	5	1	8	0	0
Presenting Problems							
	Anxiety	9	53	10	77	8	73
	Depression	12	63	8	62	10	91
	Suicidality	0	0	2	15	1	9
	Relationship Issues	4	21	4	31	4	36
	Eating Disorder	1	5	1	8	0	0
	Trauma	0	0	3	23	2	18
	Transitions/Stressors	2	11	2	15	1	9

Table 9. Continued

		M	SD	M	SD	M	SD
	Loss/Grief	1	5	1	8	0	0
	Identity Issues	3	16	1	8	2	18
	Career/Work	6	32	3	23	4	36
	Substance Use	1	5	1	8	0	0
	Discrimination	1	5	1	8	1	9
	Non-suicidal Self Injury	1	5	1	8	1	9
Perceived Barriers to Access		**M**	**SD**	**M**	**SD**	**M**	**SD**
Barriers							
	Health Insurance	2.53	.84	2.31	.86	2.18	.98
	Better by Itself	2.89	.94	2.85	.99	2.45	1.04
	Not Bothered	2.68	1.00	2.62	.87	2.45	1.04
	Handle on Own	2.89	.94	2.69	1.03	2.64	1.03
	Would Not Work	2.84	.83	2.00	.82	3.00	.63
	Previous Tx Not Effective	2.42	.96	2.15	.80	2.45	.93
	Cost	3.00	.88	2.92	1.04	2.36	1.12
	Other's Perceptions	2.74	1.05	2.38	1.12	2.36	1.12
	Logistics	2.32	.89	2.31	1.25	2.45	1.04
	Unsure Where/Who	2.79	.78	2.15	.90	2.27	.79
	Time/Inconvenient	2.63	.90	2.23	1.12	2.64	.81
	Availability	2.53	1.07	2.23	1.09	2.27	1.19
	Hospitalization	2.53	.91	2.15	1.28	2.00	.78
	Not Satisfied	2.74	.81	2.31	1.18	2.09	1.14
	Confidentiality	2.47	.91	2.54	1.13	2.36	1.21
Total Barriers		2.67	.45	2.39	.73	2.40	.62

statements, distinguishing statements, and open-ended responses. See Table 9 for the top and bottom ranked statements for this factor.

Additionally, members of the P sample who loaded onto this factor reported more barriers ($M = 2.67$) to accessing services when compared to the other two factors and to the overall P sample ($M = 2.53$). The following barriers were rated higher than the overall average: believing the problem would resolve on its own ($M = 2.89$), the problem not bothering them very much ($M = 2.68$), wanting to handle the problem on their own ($M = 2.89$), not thinking treatment would work ($M = 2.84$), cost ($M = 3.00$), concern about others' perceptions of their being in treatment ($M = 2.74$), being unsure about where to go or who to see for services ($M = 2.79$), time commitment ($M = 2.63$), and not being satisfied with available services ($M = 2.74$).

Distinguishing Statements

Factor one contained 42 distinguishing statements, those that differentiate it from the other two factors. These statements highlighted key themes that make this factor unique, the distinguishing statements indicating an importance of relationship and seeing one's queer identity as normal and the unimportance of performative or less personal aspects of advocacy and intersectionality. Distinguishing statements highlighting the importance of relationship focused on building safety/trust, feeling comfortable, and the counselor checking-in with the client about the status of the relationship between them. Those highlighting the importance of seeing queer identity as normal centered on not seeing queer identity as problematic, seeing queer relationships as valid, and not supporting conversion therapy. Distinguishing statements highlighting less important aspects of counseling focused on performative or less personal aspects of advocacy such as learning history or events in queer history and showing outward displays of support for the LGBTQ+ community. Both attention to relationship and less personal

Table 10. Consensus Statements

	Factor 1		Factor 2		Factor 3	
Statement	Rank	Z-Score	Rank	Z-Score	Rank	Z-Score
I want my counselor to be aware of misconceptions and myths related to my queer identity.	1	0.15	0	-0.10	0	0.03
I want my counselor to know that I may not readily trust them because mental health professionals have not always been supportive of the LGBTQ+ community	-2	-0.53	-1	-0.41	-2	-0.35
I want my counselor to use basic counseling skills such as listening, validating, using a theory, and helping me create and reach goals.	6	2.12	6	2.08	6	2.36

Table 11. Factor One Top and Bottom Statements

Statement	Rank	Z-Score	Focus
I want my counselor to be open minded.	6	2.14	Relationship
I want my counselor to be non-judgmental.	6	2.13	Relationship
I want my counselor to use basic counseling skills such as listening, validating, using a theory, and helping me create and reach goals.	6	2.12	Skills
I want my counselor to understand that assessment results can negatively impact me, especially if it labels my reactions to oppression and discrimination as symptoms.	-6	-1.49	Technical Aspects
I want my counselor to explore the intersection of my religious/spiritual identity and my queer identity.	-6	-1.61	Intersectionality
I want my counselor to understand that the LGBTQ+ community is close-knit which means that I may have connections to my counselor outside of our counseling relationship.	-6	-1.67	Technical Aspects

aspects of counseling such as assessments were also reflected in the overall highest and lowest ranked statements.

Open Ended Response Themes

Finally, open ended responses connected to factor one echoed the themes highlighted above and offered insight into the lack of desire for discussions of intersectionality. A thematic analysis revealed themes related to having a foundation for a relationship, wanting to be viewed and treated positively in relation to queer identity, and personal connections and identity.

When discussing the importance of having a foundation for a relationship with their counselor, one participant stated, "These [top ranked] items will form the basis of my relationship with my counselor, if they are not met I cannot see that the counseling will be helpful, rather it is likely to be damaging to me." Others noted that the items ranked as most important to them were central to counseling because "they are the key to any good working relationship" and "allow my therapist and myself to have an open level of communication based on trust and openness." Additionally, participants spoke to the desire to be viewed and treated positively in relation to their queer identity, with one participant noting, "I want to be treated just like anyone else would be I don't want to be singled out. I want the counselor to be aware of my background, but not treat me like there's something wrong with me."

When reflecting on items they rated as least important, participants spoke to not feeling personally connected to items or feeling that their identities were captured in discussions of intersectionality. One participant said, "These are least important to me because I haven't lagged behind in my development… I also don't feel like the impact of microaggressions has anything to do with my want and need for counseling." Others noted, "these items just don't impact me very much" and "visual signifiers of LGBTQ support are unnecessary for me for to feel

comfortable in a mental health setting," rather highlighting the importance of being treated positively in relation to their queer identity, saying "the biggest (and most important) indicator that the therapist is not a bigot is their words and actions, not whether they have little rainbow flags around their office." Finally, some participants noted that discussion of intersectionality was not a priority because they did not see intersectionality as personally relevant, stating "There is no intersection between my queer identity and my religion because I have not religion" and "my race and gender do not affect me much due to being a white male."

Factor Two: Enactment of Knowledge

Members of the P sample (n = 13) making up factor two highlighted a desire for counselors have a working knowledge of the queer experience and the ability to use that knowledge through tangible skills, highlighted by their attention to skills and understanding queer experience in the top-rated statements. See Table 11 for the highest and lowest ranked statements for factor 2.

Additionally, participants who loaded onto factor two reported fewer barriers (M = 2.39) to accessing services than those indicated in factor one, with 66.67% of the rated barriers falling below the overall average (M = 2.53). Barriers rated above the overall average for members of the P sample who loaded onto factor 2 included: believing that the problem would get better by itself (M = 2.85), the problem not bothering them very much (M = 2.62), wanting to handle the problem on their own (M = 2.69), cost (M = 2.92), and concerns about confidentiality (M = 2.54).

Factor two contained 40 distinguishing statements, with themes centered on the importance of counselors being affirmative of queer identity, continuing to seek out knowledge related to the LGBTQ+ community, and using skills informed by that knowledge. When considering the importance of affirming queer identity, participants highlighted a desire for

Table 12. Factor Two Top and Bottom Statements

Statement	Rank	Z-Score	Focus
I want my counselor to be easily recognized as being supportive of the LGBTQ+ community via the way they advertise, their reputation, and items displayed in their office.	6	2.64	Support
I want my counselor to treat me the same as my heterosexual/gender-conforming peers.	6	2.16	Queer Experience
I want my counselor to use basic counseling skills such as listening, validating, using a theory, and helping me create and reach goals.	6	2.08	Skills
I want my counselor to be non-judgmental.	-6	-1.44	Relationship
I want my counselor to understand that my chosen family and friends may be an important part of my family structure.	-6	-1.55	Queer Experience
I want my counselor to advocate for the LGBTQ+ community.	-6	-1.57	Advocacy

counselors to create an affirming environment where it felt safe to come out, calling for counselors to move beyond tolerance into more celebratory practices. Participants also spoke to the need for counselors to work to continue to educate themselves, rather than relying on the client for education and use resources available to them to do so. Finally, they noted the importance of using skills such as appropriate broaching and self-disclosure. Members of the P sample who loaded onto factor two also spoke to the unimportance of intersectionality to their counseling experience, indicating that it was not important to them that their counselor attend to the intersectionality of oppression, complexity of identities, nor social/cultural influences.

Open Ended Response Themes

Participants highlighted reasons for identifying the enactment of knowledge and use of affirmative practices related to queer identity as important saying that these would help to "increase comfort between us" and that these were the aspects of counseling that "were central to what I consider important for a counselor to know and implement." They also characterized less important items such as understanding self-advocacy and attending to intersectionality as being "extra benefits," stating that they did not see them as essential to the counseling process.

Factor Three: Queer Development

Factor three was made up of P sample members (n = 11) who considered understanding queer development and discrimination as most important in counseling. See Table 12 for the top and bottom ranked statements in factor three.

Additionally, participants making up this factor experienced fewer barriers (M = 2.40) to accessing services than both those making factor one and factor two, with 80% of the rated barriers falling below the overall average. Participants in factor three rated the following barriers higher than the overall average (M = 2.53): wanting to handle the problem on their own (M =

Table 13. Factor Three Top and Bottom Statements

Statement	Rank	Z-Score	Focus
I want my counselor to be easily recognized as being supportive of the LGBTQ+ community via the way they advertise, their reputation, and items displayed in their office.	6	2.53	Support
I want my counselor to use basic counseling skills such as listening, validating, using a theory, and helping me create and reach goals.	6	2.36	Skills
I want my counselor to know that their beliefs and values impact their attitudes about queer people.	6	1.91	Counselor Beliefs/Values
I want my counselor to have an understanding of "queer time" and knows that queer folks can lag behind their straight peers in "adulting" milestones.	-6	-1.78	Queer Development
I want my counselor to not be afraid to use resources such as Google to look up general information related to the LGBTQ+ community.	-6	-1.91	Knowledge
I want my counselor to be visibly comfortable sitting with, hearing, and responding to me in session.	-6	-2.12	Relationship

2.64), not thinking that treatment would work (M = 3.00), and thinking that treatment would take too much time or be inconvenient (M = 2.64). They also rated three barriers, insurance not covering treatment (M = 2.18), fear of being involuntarily hospitalized (M = 2.00), and not being satisfied with available services (M = 2.09), well below the overall average.

Distinguishing Statements

Factor three was defined by 49 distinguishing factors, with themes centering on the importance of both understanding development through the lens of queer identity and discrimination based on identity and enacting this understanding through interventions. Factor three was also characterized by the unimportance of acceptance, relationship, and knowledge. Participants considered items related to understanding development through the lens of queer identity as important and focused on wanting their counselor to understand that coming out is not a linear process, queer identity can be expressed in different ways, the importance of chosen family, the overall impact that holding a queer identity can have on development, and the integration of multiple identities. Participants in factor three also highlighted the need for their counselor to understand the discrimination that they may experience based on their queer identities, wanting counselors to understand the impact of sexism and heterosexism, know that oppression can inform why someone comes to counseling, recognize the negative self-beliefs that can stem from discrimination, and recognize the impact a counselor's beliefs and values can have on the client. Participants also wanted counselors to be able to engage in interventions such as providing affirming resources in the community, using assessments in the context of their queer identity and knowing the potential for the negative impact of assessments when it pathologizes queer-specific experiences, and advocating for the LGBTQ+ community.

The distinguishing statements for factor three also highlighted the unimportance of acceptance, general relationship building, and knowledge to members of the P sample loading onto this factor. Participants noted the lack of need for acceptance in the counseling relationship, indicating that aspects such as not dismissing queer identity, using specific affirming interventions, taking queer relationships seriously, and understanding that queer relationships may not fit into the counselor's understanding of heteronormative relationships as less important. Participants in this factor expressed an importance for an overall accepting environment related to their individual identity development but rated that acceptance related to queer relationships as less important. They also noted that general relationship building such as checking in on the counseling relationship, creating an affirmative space to come out, and seeing the counselor's comfort in the room were not important. Finally, although participants who loaded onto this factor noted the importance of understanding development through a queer lens, it was not important to them that their counselor have a strong understanding of LGBTQ+ history or language nor use resources at their disposal to understand the queer experience rather than relying on the client.

Open Ended Response Themes

Following a thematic analysis of open-ended responses connected to factor three, two major themes emerged: basic skills and counseling relationship. Participants in this factor highlighted the need for the counselor to effectively use basic counseling skills, saying that it is a "very important thing that the counselor have basic skills" and is the "most important thing for me in counseling." Participants also indicated that they rated their top items highly because they saw these as the foundation for building a strong counseling relationship, saying "these items are

core to understanding and communicating effectively" and "I want my counselor to truly accept me and not just tolerate me."

Discussion

Results of the current study offer insight into the counseling preferences of LGBTQ+ clients, with three factors indicating different counseling preferences. Moving from factor one to factor three, participants requested increasingly complex, integrated, and identity-specific care which also requires higher levels of LGBTQ+ specific expertise and experience from the counselor. Factors were grounded in a desire for basic counseling skills and a strong therapeutic relationship. All factors also alluded to the expectation that a minimum standard of care be met in line with the *ACA Code of Ethics* (2014) and ethical expectations outlined in the SAIGE competencies (2013), demonstrating the crucial movement beyond a focus on non-referral (Dugger & Francis, 2014; Herlihy et al., 2014; Minnix, 2018; Rose et al., 2019; Smith & Okech, 2016). Across the factors, the task of meeting consumer preferences for counseling becomes increasingly more complex, with the first factor highlighting the importance of relationship and basic skills, the second factor highlighting acceptance and knowledge, and the final factor an understanding of complexity of clients' identity development and experiences with discrimination.

Overall, the relationship factor (factor one) aligns closely with the minimum expected standards of care presented in the ACA *Code of Ethics* (2014) and parallels the general focus on relationship highlighted in the current literature (Cavanaugh & Ladd, 2017; Flores & Sheely-Moore, 2020; Suprina et al., 2019). Preferences expressed in this factor do not move into aspirational calls for more complex application of skills and knowledge presented in the MSJCCs (Ratts 2015; 2016) nor expertise specific to the LGBTQ+ community as noted in the

SAIGE competencies (2013). The preferences expressed by this subset of the P sample align most closely with the attitudes and beliefs competencies in the MSJCCs (Ratts 2015; 2016), with little to no attention to the call for action that integrates these key competencies.

The enactment of knowledge factor (factor two) built on expectations for relationship skills alongside a desire for some specialty knowledge related to the LGBTQ+ community that is able to be actively applied in session. Counselor knowledge as highlighted by this factor does not extend to more complex integration of developmental concerns, systems level implications, nor experiences of discrimination. Finally, participants in this factor expected that counselors would be accepting and affirming, create spaces that echoed that stance, and take actions that signal they are safe for members of the community.

In factor two, the desire for active application departed from that highlighted in the current literature. Current literature focuses on specific aspects of knowledge such as language (Anzani et al., 2019; Burnes & Singh, 2016) and not on in-session applicability, indicating that factor two is more aligned with the SAIGE (2013) competencies than participants in the relationship factor. Expectations from this subset of participants aligned most closely with the aspirational competencies of knowledge and skills in the MSJCCs (Ratts 2015; 2016). This signals the importance of active affirmation. Although the idea of providing affirmative counseling is noted in the literature (Burnes & Singh, 2016; Moe, 2016), concrete examples of providing affirmative care as requested by members of this factor are not explored.

In contrast to those in the first two factors, participants in the queer development factor (factor 3) considered nuanced knowledge and application of advanced skills as necessary within counseling relationships and expected that their counselors would have expertise related to their LGBTQ+ identity and have addressed their own values and beliefs in ways that allowed them to

be present and accepting to individual identity development in sessions. Participants making up factor three wanted counselors who were able to help them explore complex experiences related to their identities such as coming out (Shurts et al., 2020), integrating identities (Beagan & Hattie, 2015; Ikizler & Szymanski, 2014), and discrimination (Anzani et al., 2019). In addition, they wanted counselors who used higher order skills such as applying theory (SAIGE, 2013), broaching (Day-Vines, 2020) and self-disclosure (SAIGE, 2013), displaying signs of support, and integrating into the community. Neither displaying signs of support and integration into the community are accounted for in the current literature (Hightower, 2020).

Overall, participants in factor three highlighted a desire for counselors who were grounded in a holistic approach that honored and affirmed queer identity with an integration of attitudes and beliefs, knowledge, and skills into actionable interventions. These expectations align most closely with the action aspirational competency in the MSJCCs (Ratts 2015; 2016). Participants making up this factor also expected that counselors would attend to all four of the developmental domains (Ratts 2015; 2016): counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions, resulting in a holistic approach that honors and affirms queer identity. This factor also began to address more specific aspects of counseling reflected in the SAIGE competencies (2013). Though both the SAIGE competencies and factor three speak to the importance of identity specific topics and providing affirming care, the current literature lacks practical applications related to these topics (Hightower et al., 2020).

Overall, factors increasingly aligned with more specific aspects of the SAIGE competencies (2013). The relationship factor primarily showed preference for counselors who present as non-judgmental and build a trusting, safe therapeutic alliance (Cavanaugh & Ladd,

2017; Flores & Sheely-Moore, 2020; Suprina et al., 2019). The enacting knowledge factors included attention to knowledge (SAIGE, 2013) and affirmation (SAIGE, 2013). The queer development factor attended to integrated, queer-specific developmental considerations (SAIGE, 2013). Although these factors incorporated aspects of the SAIGE competencies (2013), they aligned less with the CACREP standards that these competencies are based on and more with MSJCCs (Ratts, 2015; 2016).

Based on the current factors, it is not technical skills nor attention to professional issues highlighted in the SAIGE competencies (2013), ACA *Code of Ethics* (2014) and CACREP (2016) standards that communicate competency to queer-identified clients. These aspects of counseling are best represented through the action aspirational competencies described in the MSJCCs (Ratts, 2015; 2016), with clients asking for counselors who possess attitudes and beliefs, knowledge, and skills and are able to apply them in a comprehensive manner. This is in line with current literature that highlights the importance of skills in communicating competence (Davis et al., 2018; Owen et al., 2011), particularly broaching skills (Day-Vines, 2020), and the frequent mismatch between counselors' self-identified multicultural competence and clients' perceptions of multicultural competence (Owen et al., 2016). Furthermore, this action focused less on the outward displays of advocacy often highlighted in the competencies (ACA, 2014; SAIGE, 2013), rather highlighting how counselors communicate through clear application of the foundational knowledge and self-awareness expected of counselors.

Factor Characteristics

Participants in each factor consisted of similar demographic characteristics, meaning that factors contained other differentiating factors, potentially including barriers to mental health care access, severity of distress, and queer identity development. Barriers experienced by participants

decreased across the factors. This movement followed complexity of preferences which increased as barriers decreased.

Participants in factor one reported diminished access to mental health care which may lead to decreased choice in who they see for counseling. This diminished choice may explain this factor's preference for foundational aspects of counseling, recognizing that there may be perceived diminished access to queer-specific care. Participants loading onto factor two reported fewer barriers to care than those in the relationship factor. Members of this factor had minimal barriers to treatment, were confident they would be satisfied with the treatment they received, and had resources to seek treatment. It could be that these contextual considerations allowed them to be more specific in their preferences. With this increased access, participants rated foundational aspects of counseling such as therapeutic alliance as less important; though, this may speak less to the unimportance of these aspects and more to expectations that these would be readily available or that other aspects of counseling build relationship. These findings may align with previous findings that queer-identified individuals seek services more often and still report higher unmet mental health needs (Macapagal et al., 2016; Spengler & Ægisdóttir, 2015; Williams & Chapman, 2011). Those who have increased barriers care requested services more aligned with basic expectations of professional counselors. It is possible that these individuals have less choice in who they see and therefore request only those foundational aspects, creating the potential for identity-specific concerns or growth to remain stagnant while other concerns are addressed, thus resulting in continued unmet mental health needs despite having received care.

Another potential differentiating factor is the severity of presenting concerns. Among all factors, anxiety and depression emerged as the primary presenting concerns, though severity was not measured in this study. Across factors, participants may experience less severe presenting

concerns, moving from factor one to factors three. With factor one, participants may be experiencing increased levels of anxiety and depression, leading to a diminished focus on identity-specific care and an increased focus on relationship to first lower distress and address presenting concerns. This may also connect to the diminished access reported by participants in factor one, as barriers to treatment may lead to increased severity of presenting mental health concerns when they do receive care. This also aligns with the increased mental health concerns experienced by members of the LGBTQ+ community (Blosnich & Bossarte, 2012; Lehavot & Simoni, 2011; Marshal, 2011; Plöderl & Tremblay, 2015; Robinson & Rubin, 2016; SAMHSA, 2015; Streed et al., 2017). If severity of presenting issues decreases across the factors, it matches the tendency to move towards more holistic and identity-specific care. This may be explained by the ability for those experiencing less distress being able to spend time exploring identity as they are not focused on managing crises.

Finally, the movement across factors to more complex and identity-specific may align with clients' queer identity development, with those who are younger and/or earlier in their identity development requesting less queer-specific care (Factor 1) and those who are older and/or at a critical point in their identity development requesting more queer-specific care (Factor 3). For example, in the context of Cass's (1996) Homosexual Identity Development Model, those in the Identity Confusion and Identity Comparison stages may prefer counselors more aligned with factor one as this may present a way to ease into explorations of queer identity without becoming overwhelmed as well as alleviating potential anxiety and naming of queer identity that would be required in seeking out a counselor with more identity-specific expertise. Additionally, factor one would enable clients earlier in their identity development to be in a non-judgmental space with a focus on relationship skills that would allow space for open exploration

and potential for working to alleviate anxiety or distress. Clients who fall into Identity Tolerance or Identity Acceptance may prefer the increased identity-specific knowledge paired with a more open, affirming therapeutic alliance offered in factor two as a means to support continued identity development and increase access to affirming individuals. Clients in these stages may benefit from counselors enacting factor two as they would be exploring what is means to experience discrimination or marginalization related to their queer identity and seeking connections within community. They may benefit from feeling that they are treated the same as their heterosexual counterparts and that their counselor is visible as supportive to the community. Finally, those in Identity Pride and Identity Synthesis may prefer counselors operating out of factor three. Those in these final two stages would benefit from factor three as there is an increased focus on integration of identity and queer development as well as increased advocacy, in line with the work that clients are doing to integrate queer identity and increase their activism.

Limitations

The current study has several limitations. Typically, Q methodology accounts for face validity by leaving Q sample items in participants' words. However, the current study contains a mixture of items generated from LGBTQ+ community members, the current literature, and professional competencies. The use of a Q sample requires that items be simple and easily comprehended by participants while also maintaining the representativeness of the included statements. This representativeness may be less apparent in some statements due to the need to remove jargon or edit items so that they may be easily accessible to participants. Second, reliability for a Q methodology study may be established but requires a test-rest which was not be feasible due to the anonymous nature of the online administration. Additionally, participants were likely unfamiliar with this type of survey thus limiting the number of items that could be

included and potentially limiting responses for members of the community with lower levels of education (Valenta & Wigger, 1997). Q methodology typically uses interviews immediately after the sort in order to increase depth data collected. Although it is appropriate to use online alternatives (McKeown & Thomas, 2013), depth of participant open-ended responses varied, with more depth of responses for factor one and less for factor two and three, and the researcher was not able to probe or request follow-up clarification to clarify their perspectives. Collecting data through MTurk resulted in numerous participants who did not meet inclusion criteria attempting the screening survey multiple times in order to be able to complete the survey for the compensation. Although this was tracked, there may be some question as to the authenticity of some responses.

Implications

The current study presents factors that detail the preferences of LGBTQ+ clients in counseling. These findings have implications for counseling, counselor education and supervision, and future research.

Counseling

In understanding the three factors identified by this study, professional counselors may be better equipped to understand queer-identified clients' needs and preferences while assessing their own competence and expertise in working with LGBTQ+ clients. Given the differing levels of complexity and expertise needed to successfully operate from each factor, counselors may use these factors as a way to conceptualize their own competence. Through supervision or consultation, counselors can work to determine which of the factors they are able to enact, with the first factor representing a minimum standard of care expected from all professional counselors as outlined by the *ACA Code of Ethics* (2014) and the third factor representing an

approach in line with the aspirational action MSJCC competency that requires higher levels of expertise and integration. This understanding may help counselors more accurately advertise their level of expertise and approach to working with members of the LGBTQ+ community. This may help LGBTQ+ clients identify practitioners who would be a better fit for their specific needs. For example, if a client is requesting a counselor who is operating out of the third factor, counselors working out of the first factor may consider referring out based on the client needing a level of expertise they do not have yet, while continuing to work to be able to enact this factor. Using these factors as a guideline to conceptualize competence can also help counselors to understand their growth edges and seek supervision, consultation, experience, or continuing education specific to their gaps in knowledge and practice.

Counselors may also use these factors as a framework for understanding client preferences. Clients may express different needs based on presenting concerns, identity development, involvement within community, and previous counseling experiences. Counselors can conceptualize client needs within the framework of these factors, meeting clients where they are and utilizing specific skills, expertise, and conceptualizations based on which factor they are operating from. Counselors can then adjust their approach based on client feedback and needs over time. For clients who openly identity as LGBTQ+, this assessment begins at the intake or consultation, where counselors can ask clients what they value in a counselor and use broaching skills to open up conversations related to client preferences for attending to their queer identity in their work together. This can become a regular part of checking in with clients regarding the progress they are making and any changes the client may need as the progress. For example, clients who initially present requesting care most closely aligned with factor two may, in their work with the counselor, come to prefer increased attention to their development consistent with

factor three as they move towards integrating their queer identities in a more holistic way. Additionally, those who initially prefer care most closely aligned with factor one may shift preferences as they work with the counselor and experience relief from distressing symptoms related to anxiety or depression, allowing them space to work in other areas such as identity.

Counselors may identify clients who are earlier in their identity development process, have experienced increased barriers to accessing services, or who are in distress from mental health concerns such as anxiety or depression as those who may prefer the first factor. Clients requesting care based on factor one may prefer a focus on relationship building, general sense of safety and trust, and demonstrated openness from the counselor. Counselors may identify clients who are engaged in their identity development process, who have increased access to services, or who have less severe presenting concerns as those who prefer care based on the second factor. Clients requesting care based on the second factor may prefer the counselor to demonstrate LGBTQ+ specific knowledge, show acceptance and affirmation beyond a level of tolerance, using skills such as broaching and self-disclosure. Finally, clients seeking care based on the third factor may at a critical point in their identity development, have greater access to services, or are experiencing less distress due to mental health concerns. These clients may prefer a demonstration of an integrated understanding of the queer experience, with expertise that is evident and nuanced, higher order counseling skills, and affirmation beyond tolerance.

Counselor Education and Supervision

Counselor educators may use these factors to assess student development specific to their competence in working with queer-identified clients. Master's students may be expected to enter into their practicum experience with the goal of enacting factor one, focusing on using basic counseling skills, expressing openness, and building relationship. It would be developmentally

appropriate to expect students to move into their first semester of internship continuing to hone skills within factor one and seeking to move into the use of factor two as they approach their second semester of internship. During their second semester of internship and as they complete their programs, master's level students could be expected to operate from factor two, with the goal of continuing to develop skills through post-graduation supervision to move towards the use of factor three in their practice. Additionally, master's students may also better understand the MSJCCs through the application of factors, seeing in a concrete way the necessity of holding the MSJCCs as a framework while also taking into account the complexity of client preference and experience when enacting the MSJCCs.

In conceptualizing these factors through the lens of professional identity development, faculty and doctoral supervisors will be better able to assess student competence and have a more structured, objective means to help students conceptualize their strengths and growth edges when working with queer-identified clients. This framework may also be used in gatekeeping to provide students with clear goals for a successful remediation. Additionally, students may be able to more effectively use supervision to hone specific skills and conceptualizations for working with LGBTQ+ clients, working alongside supervisors to move beyond internal reflection and knowledge acquisition toward integrated, complex conceptualizations that include attention to identity development and systems level considerations that may speak to barriers experienced by clients and build on basic skills to enhance use of broaching skills.

Research

The current study highlights the mismatch between clients' preferences for skills and action and the current literature base heavily focusing on counselor knowledge and self-awareness (Hightower et al., 2020). Researchers should consider continuing to highlight client

voice, diversifying the voices present in the literature base and exploring the reliability of these factors across more diverse samples in terms of identities, barriers, and demographics. Additionally, researchers may explore of the impact of identity development and barriers to accessing mental health care on queer-identified clients' counseling preferences. Researchers may explore the alignment of identity development models and the factors to better understand how preferences shift or remain stable over the course of identity development. Similarly, researchers should examine the impact of severity of mental health concerns on client preferences, expanding samples to investigate whether these factors remain stable for those who have presenting concerns other than anxiety and depression.

Researchers may consider the impact of diminished access to care on client preferences. This could include identifying effective advocacy efforts that may help clients understand and advocate for the care they need within their context. Further research is also needed to explore the application of these factors in clinical settings and use of these factors as a means to evaluate competence. Researchers may examine how these factors are experienced in session by clients as well as outcomes of clients whose counselors use these factors to inform their work. Further examination is also needed to understand how these factors may be used in the context of counselor education to provide specific supervision and feedback to students working to increase their competence in working with queer-identified clients.

Conclusion

Across factors, clients consistently rated relationship and basic skills over other counseling implications, with little attention given to aspects related to the counselor personally. Ultimately queer-identified clients asked for action in line with the aspirational competencies of the MSJCCs. Clients highlighted the need for counselors to be able to operationalize and apply

their self-awareness, knowledge, and skills into a well-integrated approach that centered clients' experience and worldview. These action-oriented competencies are not aspirational; rather, they are critical to providing quality care to members of the LGBTQ+ community.

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Appendix

Appendix A

MTurk Recruitment Statement

Thank you for your interest in this study! The purpose of this study is to better understand what is important to members of the LGBTQ+ community when receiving counseling. In order to be eligible to participate, you must identify as a member of the LGBTQ+ community, have attended counseling or be currently attending counseling, and be 18 years of age or older. Please follow the link below to complete the screening survey to see if you are eligible. If you are eligible, you will be provided with the link to the main survey. This survey should take you approximately 45 minutes to complete.

Appendix B

Consent for Research Participation

Research Study Title: LGBTQ+ Counseling Competencies

Researcher(s): Jennifer Hightower, University of Tennessee, Knoxville
Casey Barrio Minton, University of Tennessee, Knoxville

Why am I being asked to be in this research study?

We are asking you to be in this research study because you identify as a member of the LGBTQ+ community and have received or are currently receiving counseling services.

What is this research study about?

The purpose of the research study is to better understand what is important to members of the LGBTQ+ community when receiving counseling.

How long will I be in the research study?

If you agree to be in the study, your participation will last for approximately 45 minutes and will involve completing one only survey.

What will happen if I say "Yes, I want to be in this research study"?

If you agree to be in this study, we will ask you to complete one online survey.

What happens if I say "No, I do not want to be in this research study"?

Being in this study is up to you. You can say no now or leave the study later. Either way, your decision won't affect your relationship with the researchers or the University of Tennessee.

What happens if I say "Yes" but change my mind later?

Even if you decide to be in the study now, you can change your mind and stop at any time.

If you decide to stop before the study is completed, you may exit the survey, and any incomplete survey data will be deleted. If you complete the anonymous survey and submit it, your data will not be able to be removed.

Are there any possible risks to me?

It is possible that someone could find out you were in this study or see your study information, but we believe this risk is small because of the procedures we use to protect your information. These procedures are described later in this form. Though we believe the risks to be low, it is possible that you may experience some discomfort when reflecting on previous counseling experiences.

Are there any benefits to being in this research study?

We do not expect you to benefit from being in this study. Your participation may help us to learn more about providing counseling to members of the LGBTQ+ community. We hope the knowledge gained from this study will benefit others in the future.

Who can see or use the information collected for this research study?

We will protect the confidentiality of your information by collecting anonymous survey data through a secure online platform that is password protected. Data will be stored on a secure computer that is password protected and will only be able to be accessed by the primary investigator and the faculty advisor who will ensure that the research is conducted properly.

What will happen to my information after this study is over?

We will keep your information to use for future research. Your name and other information that can directly identify you will not be collected as part of the study.

Who can answer my questions about this research study?

If you have questions or concerns about this study, or have experienced a research related problem or injury, contact the researchers, Jennifer Hightower, **jhighto3@vols.utk.edu** or Casey Barrio Minton, **cbarrio@utk.edu**.

For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board
The University of Tennessee, Knoxville
1534 White Avenue
Blount Hall, Room 408
Knoxville, TN 37996-1529
Phone: 865-974-7697
Email: utkirb@utk.edu

STATEMENT OF CONSENT

I have read this form and the research study has been explained to me. I have been given the chance to ask questions and my questions have been answered. If I have more questions, I have been told who to contact. By selecting agree below, I am agreeing to be in this study.

Appendix C

Table C 1. Condition of Instruction

Survey Part	Condition of Instruction
Part 1: Rating All Items	
	Each of the following items describes something that a counselor may do in sessions when working with members of the LGBTQ+ community. Please read each item carefully and rate according to **how important that item is to you** when you attend counseling. Rating from: Not Important, Neutral, Important as instructed by McKeown & Thomas (2013)
Part 2a: Sorting Important Items	Each of the following items are the items that you rated as important to you in the previous section. Click and drag those items that are most important to you in a counseling relationship to the box.
Part 2b: Sorting Least Important Items	Each of the following items are the items that you rated as not important to you in the first section. Click and drag those items that are least important to you in a counseling relationship to the box.
Part 2c: Sorting the Remaining Items	Continue to rank order the items from most to least important by dragging them to the box in the order of importance.
Part 3: Review Sort	Review your final rank order of items and make any last edits.
Part 4: Open Ended Items	Please answer the following questions as you reflect on your experience of sorting the counseling relationship items.

*Condition of instruction as recommended by McKeown & Thomas (2013).

Appendix D

Table D 1. Screening Items

Question	Responses	Notes
What is your sexual orientation?	A. Straight/Heterosexual B. Gay C. Lesbian D. Bisexual E. Pansexual F. Asexual G. Queer H. Demisexual I. Prefer not to answer J. Prefer to self-describe	Choosing option I will terminate the survey
What is your gender identity?	A. Cisgender Male B. Cisgender Female C. Non-Binary/Third Gender D. Transgender Male E. Transgender Female F. Prefer Not to Answer G. Prefer to self-describe	Choosing A or B and A on the previous question will terminate
How long ago was the last time that you were actively in counseling?	A. I am currently attending counseling. B. Less than 6 months ago C. 6 months – 1 year ago D. 1 year – 2 years ago E. More than 2 years ago F. I have never attended counseling	Choosing options E or F will terminate the survey
The last time you attended counseling, approximately how many sessions did you attend with the same counselor?	A. 1 - 2 sessions B. 3 - 4 sessions C. 5 - 6 sessions D. 7 or more sessions E. I don't know	Choosing any option other than D will terminate the survey

Table D 1. Continued

Question	Responses	Notes
The last time you attended counseling, did you see a	A. Professional counselor (LPC, LPC – MHSP, LPC-A, APC, LMHC, LCPC) B. Social worker (LMSW, LCSW) C. Psychologist (PhD, PsyD, Licensed Psychologist) D. Marriage and Family Therapist (LMFT, MFT) E. Other _____ F. I don't know	Anything but option A will terminate the survey

Appendix E

Table E 1. Demographic Items

Questions	Responses	Notes
What is your race/ethnicity?	A. White B. Hispanic/Latinx C. Black/African-American D. Asian E. American Indian or Alaska Native F. Middle Eastern or North African G. Native Hawaiian or Pacific Islander H. Prefer not to answer I. Prefer to self-describe	Can select multiple
What is your religious/spiritual identity?	A. Agnostic B. Atheist C. Buddhist D. Christian E. Hindu F. Jewish G. Muslim H. Prefer to self-describe I. Prefer not to answer	
What is your age?	Sliding scale	
The last time you attended counseling, what were the primary reasons you chose to do so?	A. Anxiety B. Depression C. Suicidality D. Relationship Issues E. Eating Disorder F. Trauma G. Life transitions/stressors H. Loss/Grief I. Identity Issues J. Career/Work K. Substance Use L. Discrimination/Prejudice M. Non-suicidal self-injury N. Other_____ O. Prefer not to answer	Can select multiple

Table E 1. Continued

Questions	Responses	Notes
Think of this ladder as representing where people stand in the United States. At the **top** of the ladder are the people who are the best off -- those who have the most money, the most education, and the most respected jobs. At the **bottom** are the people who are the worst off -- who have the least money, least education, and the least respected jobs or no job. The higher up you are on this ladder, the closer you are to the people at the very top; the lower you are, the closer you are to the people at the very bottom. **Where would you place yourself on this ladder?** Please select the number that corresponds with the rung where you think you stand at this time in your life, relative to the other people in the United States.	Drop down box with numbers 1 - 10 Prefer not to answer	

Table E 1. Continued

Questions	Responses	Notes
What is the highest degree or level of school you have completed?	A. No schooling completed B. Schooling up to grade 8 C. Some high school (grades 9 - 12, no degree) D. High school graduate (or equivalent) E. Some college (1 - 4 years, no degree) F. Associate's degree (including occupational or academic degree) G. Bachelor's degree H. Master's degree I. Professional school degree J. Doctorate degree K. Prefer not to answer L. Prefer to self-describe	

Appendix F

Final Q Sample

I want my counselor to

1. know that their beliefs and values impact their attitudes about queer people.
2. is aware that I may have come to believe negative things about myself due to messages I have received about my queer identity.
3. helps me explore the intersection of my other identities, such as ability, race, ethnicity, with my queer identity.
4. recognizes that I hold complex and intersecting identities.
5. understands that my chosen family and friends may be an important part of my family structure.
6. understands that my relationship with my family of origin may shift over time.
7. understands my process of working to integrate all of my identities after coming out.
8. knows that I may identify as queer even if I am not out to them.
9. understands how intersections of oppressions such as racism, homophobia, classism, etc. impact my life.
10. advocates for the LGBTQ+ community.
11. helps me learn to better advocate for myself.
12. considers my assessment results in the context of my queer identity.
13. understands that assessment results can negatively impact me, especially if it labels my reactions to oppression and discrimination as symptoms.
14. acknowledges that coming out may not be linear and is an on-going process.
15. understands that coming out may not be the goal for everyone.
16. is aware of the social and cultural influences on my mental health.
17. understands that there are many aspects of my life that inform the ways that I express my queer identity.
18. takes into account how my development may be impacted by my identity as LGBTQ+.
19. acknowledges that heterosexism and sexism can negatively impact me.
20. acknowledges that my experiences of oppression may impact why I come to counseling.
21. helps me overcome experiences of prejudice and discrimination that I have internalized.
22. understands how diagnoses can perpetuate discrimination and oppression.
23. understands that I can live a full, healthy life despite experiencing prejudice, discrimination, and oppression.
24. understands the impact of microaggressions on me.
25. affirms that I can maintain healthy, functional relationships.
26. attends to my process of coming into and owning my identity as a member of the LGBTQ+ community.
27. understands that my queer identities are unique to me and may vary from other members of the community.
28. understands that my queer identities can be fluid and may change over the course of my life.
29. explores the intersection of my religious/spiritual identity and my queer identity.

30. recognizes the impact of me holding identities that may be non-affirming to the LGBTQ+ community.
31. continues to learn about the LGBTQ+ community.
32. is aware of misconceptions and myths related to my queer identity.
33. is familiar with cultural traditions, rituals, and rites of practice in the LGBTQ+ community.
34. knows that I may not readily trust them because mental health professionals have not always been supportive of the LGBTQ+ community
35. speaks to me about their experience, training, and expertise in working with LGBTQ+ clients during the informed consent process.
36. understands history and current events related to the LGBTQ+ community.
37. understands that the LGBTQ+ community is close-knit which means that I may have connections to my counselor outside of our counseling relationship
38. follows my lead in using appropriate language related to my identity and the LGBTQ+ community.
39. understanding the history and context of language in the LGBTQ+ community.
40. builds a strong foundation of trust and safety in our relationship.
41. understands and acknowledges their own values and beliefs related to the LGBTQ+ community.
42. checks in with me about our counseling relationship and makes adjustments as needed.
43. seeks consultation or supervision when they need help understanding something related to the LGBTQ+ community.
44. uses inclusive language in their initial paperwork and intake forms
45. uses interventions that affirm, accept, and support my wellbeing as a queer person.
46. creates an affirmative environment where I feel safe to disclose my queer identities if I want to.
47. uses specific interventions that are affirming to my queer identity.
48. Highlights the strengths and coping skills that I already use.
49. recognizes my resiliency and my ability to overcome obstacles even in the face of oppression.
50. helps me foster wellness through the counseling relationship.
51. is non-judgmental.
52. affirms LGBTQ+ identities as valid and worthy, moving beyond tolerance
53. does not dismiss my sexual orientation or gender identity.
54. does not rely on me to educate them about basic LGBTQ+ information.
55. Does not try to make my relationship fit into that of a “typical” straight relationship.
56. has an understanding of "queer time" and knows that queer folks can lag behind their straight peers in "adulting" milestones.
57. is "religion-neutral," basing their approach to religion on what I want in session.
58. is empathetic.
59. is not afraid to use resources such as Google to look up general information related to the LGBTQ+ community.
60. is open minded.
61. does not unnecessarily ask me about my sex life or other intrusive topics not related to what we are discussing.
62. is transparent and uses self-disclosure when appropriate.

63. is visibly comfortable sitting with, hearing, and responding to me in session.
64. only focuses on my sexuality or gender identity if it is relevant to the problem at hand.
65. recognizes my queerness as central to who I am without assuming it is the root of my problems.
66. sees me as a whole person and understands that my sexuality does not define all of who I am.
67. takes my relationships seriously, just as they would with heterosexual relationships.
68. treats me the same as my heterosexual/gender conforming peers.
69. can direct me to resources that are supportive of LGBTQ+ people.
70. does not support conversion therapy.
71. Is easily recognized as being supportive of the LGBTQ+ community via the way they advertise, their reputation, and items displayed in their office.
72. uses basic counseling skills such as listening, validating, using a theory, and helping me create and reach goals.

Appendix G

Table G 1. Open-Ended Items

Review the items you marked as **most important**. Why were these items most important to you?
Review the items you marked as **least important**. Why were these items least important to you?
Were there any items missing that you would have liked to see that have been important to you in counseling relationships?
Is there anything else that you would like to share with us about your experiences in counseling relationships?

Appendix H

Post Survey Resources

Thank you for taking the time to complete this survey. I recognize that reflecting on your counseling experiences may cause some discomfort. Please reach out to any of the following resources if you should want additional support.

Name	Type of Support	Contact Info
National Suicide Prevention Lifeline	24/7 support for suicidal crisis or emotional distress	1-800-273-8255
Crisis Text Line	24/7 support for those in crisis	Text CONNECT to 741741
SAMHSA's National Helpline	24/7 provides referrals and community resources and information about addiction	1-800-662-HELP (4357)
LGBT National Hotline	Crisis support and resources	1-888-843-4564
Trevor Lifeline	24/7 crisis line, specifically tailored for members of the LGBTQ+ community	1-866-488-7386
Trans Lifeline	24/7 crisis line, specifically tailored for those who identify as transgender	877-565-8860

Appendix I

Table I 1. Analysis Plan

Research Question	Which counseling competencies, counseling implications, or community generated aspects of counseling do adult LGBTQ+ current or past clients in clinical settings prefer in their counseling relationships?		
Data Cleaning	Steps	Notes	Initial *n* =
	Initial Frequencies		
	Coding Mistakes	Search for coding and spelling errors; Label categories; Specify missing data	
	Modify and Create Variables	Scores based on sorting	
	Frequencies and Descriptives		
	Outliers		
	Assess for Normality	Assess with skewness and kurtosis for single variables; multivariate normality is assumed and can be addressed with transformation; linearity assessed through scatterplots (pairs); delete variables with multicollinearity or singularity	Not necessary to have normality but may weaken conclusions if not
	Missing Data		

Table I 1. Continued

	Frequencies and Descriptives	Final to be used in paper	
	Assumption Testing		
Data Analysis	Steps	Notes	Final *n* =
	Pearson Correlation		See what is correlated together/who scored similarly of the P sample; looking for correlations > .30
	Factor Analysis	Exploratory with theoretical (hand) rotation and centroid extraction Run both PCA and centroid - see how they differ based on best mathematical (PCA) and allowance for theory/context (centroid)	Underlying factors exist that can be understood by the characteristics of the P sample that cluster together with similar counseling preferences; summary of patterns that emerge in correlations Focus on practicality and ability to study subjectivity
	Thematic Analysis	Familiarize, thematic coding, review emergent themes, define and name emergent themes	

*Data cleaning steps based on Morrow (2017)

Appendix J

Barriers to Mental Health Care Measure

National Comorbidity Survey - Revised

From NCS-R Section 13: Services

https://www.hcp.med.harvard.edu/ncs/replication.php

[Instructions from NCS-R: I'm going to read a list of reasons for delaying help-seeking and ask you to say yes or no for whether each one was a reason for why you didn't get professional help more quickly than you did.]

[Rated: Yes, No, Don't Know, Refused]

Instructions:

We understand people may experience barriers when it comes to seeking mental health care which may make it harder to get services or cause a delay in getting services. To what degree have the following barriers been a concern for you when seeking mental health care?

Likert Scale:

Not a barrier

Somewhat of a barrier

Moderate barrier

Extreme barrier

Items:

My health insurance would not cover treatment.

I thought the problem would get better by itself

The problem didn't bother me very much at first

I wanted to handle the problem on my own

I didn’t think treatment would work

I received treatment before and it didn't work

I was concerned about how much money it would cost

I was concerned about what people would think if they found out i was in treatment

I had problems with things like transportation or scheduling that made it hard to get to treatment

I was unsure about where to go or who to see

I thought it would take too much time or be inconvenient

I could not get an appointment

I was scared about being put in a hospital against my will

I was not satisfied with the available services

I was concerned that my sessions would not be kept confidential.

Appendix K

Table K 1. LGBTQ+ Community Survey Domains, Categories, and Subcategories

Domain	Category	Subcategory	Definition	*n*	*%*
Conceptual Framework				28	5.9
	Intersectionality			25	5.3
	Core Counseling Concepts			3	0.6
Counseling Interventions				108	22.9
	Advocacy			3	0.6
	Assessment			0	0
	Counseling Relationship			49	10.4
		Comfort and Acceptance	Counselors are overtly supportive and accepting of members of queer identified clients' identity and appear comfortable in session.	40	8.5
	Skills/Interventions			3	0.6

Table K1 Continued

Domain	Category	Subcategory	Definition	*n*	%
	Appropriate Broaching of Queer Identity		Counselors broach queer identities and related experiences in session. Counselors balance broaching queer identity with ensuring that they are not insensitive or intrusive and do not assume that holding a queer identity is the reason for presenting to counseling.	53	11.3
Person as Counselor				99	21.0
	Education/Knowledge			17	3.6
	Ethical Concerns			24	5.1
	Self-Awareness			0	0
	Dispositions		Counselors have qualities that inform the way that they practice, including characteristics such as open-mindedness, being non-judgmental, and patience.	49	10.4
	Counselor Identity/Experiences		Counselors' personal identities or experiences inform their work with clients, especially related to counselors holding queer identities.		
Foundations				235	49.9
	Access/Logistics		Clients have access to services, with consideration given to scheduling, cost, insurance, and location.	18	3.8

Table K1 Continued

Domain	Category	Subcategory	Definition	*n*	*%*
	Presenting Issues		Clients' specific reasons for seeking counseling, such as anxiety, depression, and grief.	27	5.7
	Foundational Expectations		Counselors respond with empathy are proficient in basic counseling skills and client conceptualization.	174	36.9
	Outward Displays of Support		Counselors are reputable within the LGBTQ+ community, have knowledge and connections to referrals, belong to organizations that support queer-identified individuals, and make readily known their support through physical representations such as flags or advertisements.	16	3.4

*Note: Emergent domains, categories, and subcategories from the community survey are bolded and include definitions. See Hightower et al., 2020 for definitions of pre-existing domains and categories. Percentages are for the overall sample of qualitative responses.

CONCLUSION

The lack of literature highlighting actionable counseling implications stands in contrast to the preferences of queer-identified clients. Current literature focuses on self-awareness and knowledge, highlighting aspects specific to the counselor; participants focused on tangible skills and relationship building as highlighted in the MSJCC action aspirational competencies. Bridging this gap through intentional practice and research grounded in client voice and counseling outcomes will enable professional counselors to better serve queer-identified clients and specialize care to the individual.

Moving forward, the results of these two manuscripts highlight the need for additional research that focuses on the needs of queer-identified clients, namely the way that we can apply and evaluate action-oriented skills and differentiate treatment based on client needs. According to these studies, there is a clear foundation from which to build; current literature is clear that counselors should be self-aware and knowledgeable. Participants are now calling for the next steps and ask that counselors be prepared to both enact that self-awareness and knowledge in session and be able to provide care specific to client needs. Researchers can use this as a guide in creating their research agendas, focusing on moving forward into outcome-based research with queer-identified clients and centering queer, client voices.

Professional counselors are equipped to work effectively and competently with members of the LGBTQ+ community and are ethically mandated to be prepared to do so. Furthering the research base in this area will help inform counseling practice by providing evidence-based recommendations and may help to bridge the gap in the mental health needs of the LGBTQ+ community.

VITA

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