Defining Mental Health Practitioners' LGBTIQ Cultural Competence in Thailand

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Abstract

This study investigated what competencies are crucial for culturally competent practice for mental health practitioners with LGBTIQ clients in Thailand. The study used two-round Delphi methodology to aggregate views of mental health practitioners with expertise on LGBTIQ issues (n = 14), and of LGBTIQ individuals who had used mental health services (n = 13). Participants proposed competencies in Round 1 through interviews or an online questionnaire, and rated these competencies' importance in another online questionnaire in Round 2. Various competencies were rated: 41 knowledge competencies, 35 awareness/attitude/belief competencies, 14 skill competencies, and 35 action competencies. Among key themes were understanding gender/sexual diversity and issues affecting LGBTIQ people and their families, and being able to assist on these issues; accepting gender/sexual diversity, respecting clients' self-determination, and communicating this to clients; being aware of the impact of one's beliefs, attitudes, identities, and values; recognizing and rejecting stereotypes; being open, humble, and willing to learn more; knowing how to use feminist counseling techniques and other specific techniques; refraining from offending actions; social justice action; and obtaining information sensitively. Developing these competencies is likely to improve the appropriateness of mental health services for LGBTIQ clients and should be included in mental health practitioners' training in Thailand.

Keywords

Cultural competence; Delphi methodology; LGBTIQ; mental health; Thailand

Introduction

The role of universal versus specific ingredients in psychotherapy has long been debated in the mental health field (Patterson, 1996; Wampold, 2015). Meta-analytic research highlights the importance of *common factors* shared by effective therapies (Wampold, 2015). Yet, research on the experiences of gender and sexual minority clients suggests that practitioners need *specific* competencies to provide appropriate and acceptable services for these clients (Boroughs et al., 2015). This article contributes to these debates by describing a study that identified competencies of mental health practitioners in delivering services to lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ) clients in Thailand. We argue that common factors are important, but they may not function with LGBTIQ clients unless practitioners have *LGBTIQ cultural competence*, which comprises several specific competencies.

Common factors of effective psychotherapy

Meta-analyses have indicated that common factors shared by all effective therapies are crucial for good therapy outcomes, whereas treatment differences are associated with smaller outcome differences. In summarizing multiple meta-analyses, Wampold (2015, p. 273) listed goal consensus/collaboration; practitioner's empathy for the client; therapeutic alliance; therapist's positive regard and affirmation of the client; therapist differences; and therapists' congruence/genuineness as the most potent common factors underlying positive therapy outcomes, with effect sizes (Cohen's d) of 0.5 or higher. Differences between treatments, therapists' technical competence, adherence to protocol, and specific treatment ingredients had a minor impact on treatment outcomes ($d \leq 0.2$). Wampold (2015) also proposed a contextual model, grouping common factors into (1) the real relationship between client and therapist, (2) clients' expectations, and (3) specific therapy ingredients that enact healthier intrapersonal and interpersonal actions. Wampold's (2015) summary suggested that the first two pathways (relationship factors & clients' expectations) play a major role in determining outcomes.

LGBTIQ mental health

LGBTIQ populations suffer disproportionately from mental health problems. Meyer's (2003) meta-analyses indicated that LGB groups were 1.6-2.3 times more likely than non-LGB groups to have mood, anxiety, and substance use disorders. Minority stress theory explains that these disparities result from the additional stress that LGBTIQ groups experience as minority groups (Meyer, 2003). Belonging to a minority group causes stress directly through experiences of violence and discrimination, and indirectly through expectations of rejection, having to conceal one's identity, and internalized homophobia (Meyer, 2003). Mental health outcomes are also influenced by social support and coping skills, how important being LGBTIQ is to the individual, how they feel about it, and how they integrate it into their overall identity (Meyer, 2003). Later meta-analyses have supported the validity of the minority stress model (Plöderl & Tremblay, 2015). Some outcomes are context-dependent; for example, disclosing one's sexual orientation is associated with psychological benefits only in less hostile contexts (Sattler & Lemke, 2019).

Mental health practice with LGBTIQ clients

LGBTIQ individuals are more likely than non-LGBTIQ people to need mental health services, but they encounter specific problems when using such services (King et al., 2007). A British study reported that 63% of 466 transgender participants had experienced unwanted interactions related to being transgender with mental health providers (McNeil et al., 2012). Some practitioners refused to treat transgender patients, denied they were transgender, belittled, or ridiculed them for being transgender; some participants felt they wasted time educating practitioners about transgender issues (McNeil et al., 2012). These examples highlight the need to educate practitioners on LGBTIQ issues.

Affirmative approaches

In improving mental health services for LGBTIQ individuals, the term *affirmative* is a prominent keyword. According to a systematic review (King et al., 2007, p. 7), affirmative therapy meant that "therapists regarded LGBT lifestyles positively, were knowledgeable and non-prejudiced about LGBT issues and provided therapy that did not pathologise minority sexual identities." However, the term has been critiqued for theoretical ambiguity, leading to problems in research and practice (Johnson, 2012).

Cultural competence

Another option in conceptualizing LGBTIQ-friendly mental health services is cultural competence. The term is widely used in healthcare fields to describe practitioners' readiness to serve ethnic minorities; various frameworks usually incorporate practitioners' knowledge, awareness, and skills (Alizadeh & Chavan, 2016). The *Multicultural and Social Justice Counseling Competencies* guidelines (Ratts et al., 2016) incorporate action as a fourth domain, noting that including action helps to operationalize the other three domains; actions include counseling and social justice actions, within and beyond counseling sessions.

The similarity of ethnic and sexual minority experiences (e.g., discrimination, self-stigma, specific identity development) means that cultural competence is a useful framework for improving services for sexual minority clients (Israel & Selvidge, 2003). Following Sue et al. (1982), LGBT-related applications have typically focused on knowledge, awareness, and skills. Boroughs et al. (2015, p. 157) summarized that LGBT cultural competence consists of at least:

> *(a) awareness of one's own beliefs, biases, and attitudes regarding LGBT populations, (b) knowledge and understanding of LGBT populations, including expectations for the counseling relationship and how one's own sexual orientation and gender identity come into play, and (c) skills and tools to provide culturally sensitive interventions for LGBT populations.*

Adapting the Boroughs et al. (2015) terminology, we refer to LGBTIQ cultural competence.

Related studies and guidelines

Summary definitions of affirmative approaches and LGBTIQ cultural competence make them seem simple, but related studies and guidelines highlight their complexity. For example, Israel et al. (2003) conducted a Delphi study with 14 LGB counseling experts and eight LGB clients to identify competencies counselors need with LGB clients. Their 22 participants proposed 274 knowledge items, 120 attitude items, and 146 skills items, which were condensed into 31

knowledge, 23 attitude, and 31 skill categories. Drawing on existing research, the American Psychological Association (APA, 2012, 2015) issued guidelines for psychological practice with LGB and transgender or gender non-conforming clients; the former provides 21 guidelines, and the latter provides 16, each with extensive elaboration. Key themes include viewing LGBTIQ groups non-pathologically, recognizing the impact of stigma, supporting relationships, mindfulness of the impact of one's attitudes, and awareness of diversity (age, identity, HIV status, disability, ethnicity, etc.). These materials refer to both affirmation and cultural competence, suggesting that these frameworks differ in terminology rather than substance.

Other countries' guidelines reflect both similarities with American sources and contextual specificities, such as African culture (Psychological Society of South Africa, 2017) or Māori concepts and the impact of colonialism (Psychologists' Board of New Zealand, 2019). Thailand has considerable cultural differences from these countries, suggesting that definitions of LGBTIQ cultural competence require attention to the context.

Mental health services in Thailand

Thailand's mental health system begins with self-care, followed by services from village health volunteers, nurses and generalist physicians in primary care and community hospitals, and finally, mental health specialists in psychiatric hospitals (Pavasuthipaisit et al., 2016). Volunteers and general practitioners add entry points to services but may have limited mental health competence (Lotrakul & Saipanish, 2006). Specialists in state hospitals, especially psychiatrists, usually have heavy client loads and little time for discussion; private-sector services are less crowded but often prohibitively expensive (Ojanen et al., 2020). Counseling is also available at universities, addiction services, mental health hotlines, and non-governmental organizations (Tuicompee et al., 2012).

Cultural beliefs related to mental health in Thailand include Buddhist explanations about karma and merit, animist notions (e.g., loss of *khwan* [life spirit]), and possession by ghosts or spirits (Burnard et al., 2006). These cultural beliefs need attention in mental health services in general and sometimes play a role in how LGBTIQ issues are explained and treated by clients and their families (Ojanen et al., 2020).

Thai LGBTIQ groups and their mental health

Thai LGBTIQ groups are conceptualized as discrete and mutually exclusive groups, defined as *phet* [genders/sexes] based on fixed combinations of physical sex, gender identity/expression, and sexual orientation. A study of 2,070 students listed 11 LGBTIQ response options (transfeminine identities *kathoei, sao praphet song,* & *phu ying kham phet;* transmasculine identities *phu chai kham phet/transman* & *tom;* gay male identities *gay* & *chai rak chai;* lesbian identities *les, dee,* & *ying rak ying,* as well as *bi* – male or female bisexuals), but these were insufficient—some students chose the "other" option (Mahidol University et al., 2014).

Thailand's acceptance levels of LGBTIQ groups are average in regional (Manalastas et al., 2017) and global (Flores, 2019) comparisons. According to a United Nations Development Programme (UNDP, 2019) report, the social climate is better described as tolerance than inclusion or acceptance. Tolerance of visibly LGBTIQ persons depends on the situation, formal contexts being less inclusive (Ojanen, 2009). Discrimination in education, employment,

healthcare, and financial services are widespread (World Bank Group, 2018; UNDP, 2019). In a national study, over 50% of LGBT secondary students reported having been bullied for being LGBT over the past month (Mahidol University et al., 2014). Owing to experiences of stigma, discrimination, and violence, LGBTIQ individuals in Thailand suffer from additional mental health problems, as predicted by Meyer's (2003) minority stress model (Ojanen et al., 2020). Kittiteerasack et al. (2020) demonstrated that selected key elements of the minority stress model (general stressors, victimization, discrimination, identity concealment, & coping style) correlated with depression scores among 411 Thai LGBT adults.

LGBTIQ people and mental health services in Thailand

Thai LGBTIQ individuals experience problems in accessing health care. The World Bank Group (2018) reported that of 2,302 gay, lesbian, and transgender adults, 36.5% had been stereotyped by health service providers, 25.4% had been treated disrespectfully, 24.6% had been harassed or ridiculed, and 23.8% had been asked to leave because they were LGBTI. A qualitative study on gay and transgender women's experiences in mental health services suggested that the lack of understanding of psychologists and psychiatrists, and advice based on stereotypes were key LGBTIQ-specific problems (Ojanen, 2010).

Thailand's sole official guidance on mental health services with LGBTIQ groups is the *Clinical Practice Guideline in Management of Gender Dysphoria and Transsexualism 2009* (Royal College of Psychiatrists of Thailand, 2009). Compared to guidelines outside Thailand, its scope is narrow (mostly focused on diagnosing Transsexualism), and it uses stigmatizing and outdated terminology (Ojanen et al., 2016). Consequently, mental health practitioners in Thailand lack locally grounded guidance for serving LGBTIQ clients.

Rationale and research question

Thai LGBTIQ persons have elevated mental health needs but are likely to receive discriminatory or inappropriate treatment. However, it was unclear how LGBTIQ cultural competence should be defined in Thailand. Thus, a study was needed to identify competencies that service providers and their LGBTIQ clients agree on. The research question was: "What competencies are considered crucial for mental health practitioners' appropriate practice with LGBTIQ clients in Thailand?"

Method

This study used modified Delphi methodology, commonly used for finding plausible answers to research questions with no definite answers, by aggregating views of experts (Linstone & Turoff, 2002). Delphi studies often combine qualitative and quantitative elements. They are more sensitive to nuanced views than quantitative surveys but more rigorous than purely qualitative studies because they involve the quantitative ranking of proposed answers. They are less sensitive to social desirability, seniority, and conformity biases than focus groups because the experts do not meet in person or know who are the other experts (Jorm, 2015; West, 2011). Delphi studies are widely used in mental health research (Jorm, 2015), highlighting consensus and disagreement (Rowe & Wright, 2011).

The present study had two rounds of data collection. While three rounds are ideal (Trevelyan & Robinson, 2015), two rounds were chosen because of concerns about participant attrition. Previous Delphi studies on LGBTIQ-related competencies (Godfrey et al., 2006; Israel et al., 2003) have also used two rounds.

Participants

In contemporary Delphi studies, the definition of experts is increasingly broad. Besides professionals, experts often include former clients to highlight their needs and concerns (Jorm, 2015). We also recruited both mental health practitioners and former clients as participants. Practitioner participants had to (1) have worked as mental health practitioners in Thailand for at least two years, *and* had to (2a) be working at an LGBTIQ-focused service unit *or* (2b) have researched LGBTIQ mental health in the past 10 years. Client participants had to (1) self-identify with an LGBTIQ identity, (2) be at least 18 years old, *and* (3) have received mental health services in Thailand at least once in the past five years.

The first author's contacts were used to create initial lists of prospective participants and LGBTIQ organizations for recruiting practitioner participants. Client participants were also found through advertisements in Thai Facebook groups on LGBTIQ issues or mental health. Twenty prospective practitioner participants were identified through a systematic literature search on Google Scholar, using a combination of LGBTIQ-related terms in Thai and English, the fields of interest (psychology, psychiatry, psychiatric nursing, & social work), and the word Thailand (in the English-language search). Two were recommended by client participants. Prospective participants were contacted through email, Facebook, or in person. The study had 27 participants (13 practitioners & 14 clients) in Round 1, and 23 participants (11 practitioners & 12 clients) in Round 2 data collection.

Most practitioner participants had a background in psychology (counseling, clinical, health, or psychotherapy), and two had nursing qualifications. Ages ranged from 25 to 53 (mean = 36.7, SD = 8.1) and practice experience from two to 30 years (mean = 9, SD = 7.7 years). Five were affiliated with universities (clinic, faculty, or both), three with sexual health clinics, two with LGBTIQ organizations, one with a school, a rehabilitation center, and an integrated medical center. Three had a bachelor's degree, six had a master's degree, three had a doctorate, and one had postdoctoral training. Nine lived in Bangkok, two abroad, and the rest elsewhere in Thailand. They were of diverse gender and sexual identities: Five identified as women (2 were transgender, and 3 were cisgender), three as *gay* males, two as *ying rak ying* [lesbian], one as a bisexual woman, and one with the transfeminine identities *sao praphet song* and *phu ying kham phet,* respectively. Most of the practitioner participants were Buddhists.

Client participants' ages ranged from 19 to 46 (mean = 29.7, SD = 6.6). They used mental health services from one to 80 times (mean = 21.2, SD = 21.1) in private and public, psychiatric, general hospitals, university counseling clinics, and a rehabilitation center. Three identified as *gay* males, three were trans men, two were *bi*-identified females, one was a *bi*-identified male; *kathoei,* queer, non-binary, and woman were each stated as one participant's main identity. One participant used no identity label. Seven identified as Buddhist and five as non-religious. Six lived in Bangkok, another six elsewhere in Thailand, and one abroad. Most had middle-class occupations; some were students.

Data collection and analysis

In Round 1, participants chose to propose competencies through an online form (Google Forms) or an interview. Twenty-three participants (12 clients & 11 practitioners) used the form, and five (3 clients & 2 practitioners) gave an interview (one did both). In both cases, participants were asked about competencies practitioners need when providing services to LGBTIQ clients. Separate questions were asked for each competency domain: (1) knowledge; (2) awareness, attitudes, and beliefs; (3) skills; and (4) actions. The first three domains are included in most cultural competence frameworks (Alizadeh & Chavan, 2016); the action domain was added following Ratts et al. (2016). Interviews were transcribed verbatim. The resulting transcripts and completed online forms were content analyzed using ATLAS.ti 5.0 by coding text segments as tentative competencies in Thai with English translation. A list of codes was exported and copied to MS Excel, one domain per tab, where redundant items were combined, and lengthy wordings were shortened. This analysis resulted in 41 knowledge items, 37 awareness/attitude/belief items, 14 skill items, and 35 action items compiled into a Thai-language Google Forms survey. Proposed non-LGBTIQ specific competency items were initially extracted. These were not included in the Round 2 questionnaire to maintain the study's LGBTIQ-specific focus and keep the length of the Round 2 questionnaire manageable.

In Round 2, a link to the Google Forms survey was sent to participants. They were asked to rate each proposed competency on a scale from 1 (most harmful) through 4 (not beneficial, not harmful) to 7 (most beneficial). Twenty-three participants (12 clients & 11 practitioners) completed this rating. Mean scores, interquartile ranges (IQRs), and minimum scores were obtained for each competency using IBM SPSS 23.0. IQRs are a measure of disagreement not sensitive to outliers. Using these scores, competencies in each domain were organized into four agreement levels: (1) *consensus of benefit* (client & practitioner IQRs not higher than 1.5; no individual scores below 5); (2) *majority agreement of benefit* (overall mean no lower than 5, overall IQR no more than 1.5); (3) *contested* (overall IQR 1.6–2.9); and (4) *highly controversial* (overall IQR 3 or higher). Due to space limitations, IQRs are not reported in this article (for IQRs & further methodological detail, see Ojanen, 2019). Finally, similar competencies were grouped into competency themes.

Ethical considerations

The study was reviewed and approved by Mahidol University Social Sciences Institutional Review Board (2019/021.0502). As the board recommended, verbal rather than written informed consent was obtained from interview participants; those who began their participation online gave consent using the form. All participants were at least 18 years old and legally able to consent. All participants remain anonymous to each other and the public. Participants received an incentive of 500 baht. The study can be expected to benefit both LGBTIQ persons in Thailand and mental health practitioners working with them.

Results

In this section, we present the results of the study. Participants proposed and rated 41 knowledge competencies, 35 awareness/attitude/belief competencies, 14 skill competencies, and 35 action competencies. Most proposed competencies received at least a majority agreement of being beneficial for work with LGBTIQ clients. In Tables 1-4, we present these

competencies grouped into themes, together with average ratings by all participants as well as client and service provider participants separately. We also report the four-tier agreement level for each competency. In explaining the tables, we describe the major themes in each domain with examples of specific competencies. Some participants felt that no LGBTIQ-specific competencies are needed; these statements were rated alongside the proposed competencies, but they were controversial and are not included in the themes.

Knowledge competencies

Knowledge competencies (Table 1) comprised two themes: *(1) understanding gender/sexual diversity* and *(2) understanding issues affecting LGBTIQ people and their families*. *Understanding gender/sexual diversity* means understanding related concepts (sex, gender, sexuality, sexual orientation, gender identity/expression, sexual fluidity, & gender socialization). It means understanding related identities and groups (e.g., trans people or MSM), their lifestyles, and knowing the implications of the above for managing specific groups as clients. *Understanding issues affecting LGBTIQ people and their families* means recognizing that mental health providers' role is to help LGBTIQ people with their problems (which may or may not be related to them being LGBTIQ), rather than trying to change their identity or sexuality. It means understanding specific health concerns, including mental health, gender transitioning, sexual health, HIV, and other physical health issues. It means understanding the oppression LGBTIQ people face in various contexts (families, friends, work, education, state agencies, & human rights advocacy), which may be linked to intersectional characteristics such as age, and the minority stress this causes. Practitioners also need to understand the issues affecting the parents or children of LGBTIQ individuals.

Awareness/attitude/belief competencies

Awareness/attitude/belief competencies (Table 2) comprised five themes: *(1) accepting gender/sexual diversity,* (*2) respecting clients' self-determination, (3) awareness of the impact of one's beliefs, attitudes, identities, and values, (4) recognizing and rejecting stereotypes,* and *(5) openness and willingness to learn more about gender/sexual diversity*. Two items in Table 2 were accidentally left out of the Round 2 survey and were consequently not rated; these are included under a relevant theme and marked with NR for "not rated."

All participants agreed on the importance of *accepting gender/sexual diversity* in general and seeing each gender as equally valuable. Specifics included viewing it as a normal aspect of human nature and not judging LGBTIQ clients. This was linked to *respecting clients' self-determination* of identity and behavior – believing that the state should not require medical gate-keeping or physical transitioning as conditions of recognition, and not expecting them to behave in a certain way or to reveal their identity. *Awareness of the impact of one's beliefs, attitudes, identities, and values* covered the practitioner's characteristics that might impact service provision to LGBTIQ clients if the practitioner is unaware of them. Examples included practitioners' attitudes toward each gender, religious beliefs, values related to collectivism or individualism, practitioners' own gender identity, as well as unconscious sexism and heterosexism. *Recognizing and rejecting stereotypes* featured prominently; stereotypes were diverse, including LGBTIQ people as unable to find true love, sexually promiscuous, at-risk for HIV, violent, sexually confused, drug abusers, or less capable employees. *Openness and willingness to learn more about gender/sexual diversity* included practitioners' openness toward gender/sexual diversity and fluidity, and willingness to revise existing knowledge based on research and clients' input.

Skill competencies

The skill competencies (Table 3) represented three themes. *Skills in communicating an accepting and professional stance* were the most highly agreed-on skills; they included artful communication on gender/sexual diversity issues, communicating acceptance, and maintaining a neutral demeanor. *Skills in assisting on specific issues* included making sense of family and social problems, identifying how LGBTIQ people feel about themselves, providing sexological counseling, and assisting family members of LGBTIQ clients. *Skills in using feminist counseling techniques* were proposed but contested.

Table 1: Mean ratings and agreement levels of knowledge competencies

	Level	Mean rating		
		Overall	Client	Provider
Understanding gender/sexual diversity				
LGBTIQ psychology for giving correct advice and treatment	2	6.435	6.333	6.545
Basic understanding of gender/sexual diversity	2	6.391	6.167	6.636
Sex, gender, sexual orientation, gender identity, and gender expression are all non-binary	2	6.364	6.167	6.6
Concept of gender/sexual fluidity	2	6.348	6.25	6.455
Sexual lifestyles of each LGBTIQ group, which have more detail than just how people have sex	2	6.348	6.167	6.545
SOGIE—Sexual orientation and gender identity/expression	2	6.304	6.083	6.545
Division of sexuality into (1) sex, (2) gender, (3) sexual orientation, (4) gender identity, and (5) gender expression	2	6.304	6.25	6.364
Up-to-date knowledge about specific LGBTIQ identities and lifestyles, and the sensitivities and problems of each group	2	6.304	6.333	6.273
How to manage transgender clients respectfully in inpatient wards	2	6.217	6.167	6.273
If a service provider has specific knowledge about client groups such as MSM, sex workers, or transgender people, it will expedite discussing their issues	2	6.216	5.917	6.636
Concept of gender socialization	2	6.174	5.917	6.455
SGS—sex, gender, and sexuality	2	6.091	5.75	6.5
Concept of queer	3	5.682	5.583	5.8
Some people are asexual	3	5.565	5.917	5.182
Some people are born with ambiguous birth sex (intersex)	3	5.5	5.636	5.364
Understanding issues affecting LGBTIQ people and their families				
Mental health treatment for LGBTIQ groups is for addressing clients' problems, not for changing their identity or sexuality	1	6.652	6.667	6.636
Diverse needs of LGBTIQ clients	2	6.522	6.5	6.545
Minority stress: Various factors (e.g., social inequality, family rejection, lack of friends) causing LGBTIQ people to have a higher risk of mental health problems (e.g., depression, suicidality) than the general population	2	6.478	6.25	6.727
The characteristics of oppression each LGBTIQ group faces in society	2	6.318	6.083	6.6
Specific challenges each LGBTIQ group might face in making decisions about coming out	2	6.304	6.083	6.545
Problems that LGBTIQ individuals face in childhood and youth, for example, being ridiculed or bullied	2	6.261	6.167	6.364
Problems that older LGBTIQ people face	2	6.261	6	6.545
Medical gender transitioning processes (e.g., surgical methods, hormones, & other drugs, why trans people need these processes, & their bodily & mental impact)	2	6.261	6.083	6.455
Understanding the problems and characteristics of clients is particularly important in contexts providing specific services (e.g., HIV testing for gay men, specific services for trans people)	2	6.217	6.083	6.364
Problems that each LGBTIQ group faces in the workplace or in looking for work (e.g., discrimination, being forced to wear a uniform according to one's birth sex)	2	6.174	5.917	6.455
Problems that each LGBTIQ group faces with their parents, siblings, and other relatives	2	6.147	5.833	6.545
Basic understanding of LGBTIQ rights and the impact of being a human rights defender	2	6.174	6.083	6.273
Physical health problems that are particularly common among LGBTIQ people	2	6.136	5.909	6.364
Problems that each LGBTIQ group faces in educational contexts	2	6.13	5.833	6.455
Clients' problems or sensitivities might be linked to sexual orientation, gender identity, or not linked to gender/sexual diversity at all	2	6.13	5.833	6.455
Psychosocial problems that children of LGBTIQ persons experience	2	6.087	5.583	6.636

	Level	Mean rating		
		Overall	Client	Provider
HIV pre-exposure prophylaxis (PrEP), for advising gay or transgender clients about reducing their risk of acquiring HIV	2	6.087	5.750	6.455
Problems that each LGBTIQ group faces with their friends	2	6.087	5.667	6.545
Psychosocial problems that parents of LGBTIQ persons experience	2	6.043	5.5	6.636
Concept of intersecting disadvantage or oppression (intersectionality)	2	6	5.75	6.273
Sexual health, sexually transmitted infections, and HIV have specific aspects among LGBTIQ people	2	5.913	5.5	6.364
Problems that each LGBTIQ group faces with state agencies	3	6.043	5.75	6.364
Sexual health problems associated with surgically created sexual organs	3	5.957	5.833	6.091
Perspectives of various social groups toward LGBTIQ people and gender/sexual diversity issues	3	5.957	5.833	6.091
Impact of the belief in karma, in particular, the belief among clients or their nearest who believe that they were born LGBTIQ because they did something wrong in their past lives	3	5.652	5.667	5.636
(No LGBTIQ-specific knowledge needed)				
Service providers do not need knowledge about LGBTIQ clients as long as they can provide services without judging the client	4	4.391	4.330	4.455

Note: Level: (1) Consensus; (2) Majority agreement; (3) Contested; (4) Highly controversial

Table 2: Mean ratings and agreement levels of awareness/attitude/belief competencies

	Level	Mean rating		
		Overall	Client	Provider
Accepting gender/sexual diversity				
Accepting gender/sexual diversity	1	6.739	6.583	6.909
Believing that each gender is equal, not seeing any gender as superior	1	6.739	6.667	6.818
Not considering being LGBTIQ as a matter of abnormality, illness, or as something strange, but as a part of human nature	2	6.783	6.583	7
Not judging LGBTIQ clients on the basis of religious, political, or other personal beliefs, or standards of heterosexuality	2	6.565	6.333	6.818
Not judging clients on the basis of HIV, which is often linked to perspectives about gay men	2	6.391	6.083	6.727
Respecting clients' self-determination				
Not expecting clients to behave in a certain way based on their birth sex or gender	2	6.478	6.083	6.909
Believing that people are free to determine their own identity, including gender and sexuality	2	6.435	6.25	6.636
Believing that trans people should not need medical certificates for gender recognition (e.g., waiver of male military conscription, gender-affirming uniforms)	2	6.435	6.25	6.636
Not expecting that LGBTIQ people need to come out immediately and in all situations	2	6.304	5.917	6.727
Believing that the legal recognition of transgender individuals' gender should not require any surgeries or hormonal treatments	3	6.087	5.667	6.545
Awareness of the impact of one's beliefs, attitudes, identities, and values				
Awareness of one's attitudes toward each gender so as to provide services that are in the best interest of the client	1	6.696	6.5	6.909
Awareness that gender/sexual diversity has more dimensions than just having sex	2	6.565	6.417	6.727
Awareness of how one's lack of full acceptance of a client could affect the effectiveness of the services provided	2	6.391	6.083	6.727
Confidence that one is able to provide services to LGBTIQ clients on an equal basis with others	2	6.391	6.417	6.364
Having a gender lens in interpreting the issues of LGBTIQ clients	2	6.348	5.917	6.818
Awareness of one's potentially hidden heterosexism and sexism that may affect the therapeutic alliance and service quality	2	6.217	5.667	6.818
Awareness of how one's values related to collectivism or individualism affect one's provision of services to LGBTIQ clients	2	6.182	5.909	6.455
Awareness of how one's religious beliefs (e.g., in karma or sin) affects one's service provision to LGBTIQ clients	2	6.091	5.636	6.545
Awareness of one's own gender identity	3	5.857	5.4	6.273
Recognizing and rejecting stereotypes				
Believing that LGBTIQ people are well capable of working	2	6.522	6.25	6.818
Not viewing LGBTIQ groups through stereotypes based on sex, gender, sexual orientation, or gender identity	2	6.391	6.083	6.727
Not stereotyping LGBTIQ groups as sexually promiscuous	2	6.348	6.167	6.545

	Level	Mean rating		
		Overall	Client	Provider
Awareness that social understandings about the risks of gay and bi men and trans women acquiring HIV are a combination of facts and stigma	2	6.348	6.083	6.636
Awareness of LGBTIQ stereotypes that are common in society	2	6.304	6.083	6.545
Not stereotyping bisexuals as being sexually confused	2	6.261	6.083	6.455
Not stereotyping LGBTIQ groups as more likely to use violence than other groups	2	6.217	6	6.455
Not stereotyping LGBTIQ groups as being prone to being involved with illegal drugs	2	6.217	6.083	6.364
Not stereotyping LGBTIQ people as unable to find true love	2	6.217	6	6.455
Not stereotyping lesbians as unable to find a husband and hence turning to women	3	6.13	5.917	6.364
Not assuming that every client is straight, to begin with	NR			
Openness and willingness to learn more about gender/sexual diversity				
Willingness to learn new things about gender/sexual diversity from clients, not holding onto one's previous knowledge	1	6.696	6.583	6.818
Openness to gender/sexual fluidity	1	6.652	6.5	6.818
Openness to gender/sexual diversity	2	6.565	6.417	6.727
Willingness to learn new things about gender/sexual diversity from research, even from works that have a different epistemological paradigm from one's own (e.g., service providers with a strong belief in positivism should be open to reading research based on narratives)	2	6.348	6.167	6.545
Awareness that the issues LGBTIQ people face are important and affect their mental health	NR			
(No LGBTIQ-specific attitudes, awareness, or beliefs needed)				
Service providers do not need to feel that LGBTIQ people are a special group or differ from men and women in general	4	5.348	5.417	5.273
Service providers don't need to have any attitudes in particular when providing services to LGBTIQ clients	4	5.261	5.167	5.364

Note: NR: Not rated; Level: (1) Consensus; (2) Majority agreement; (3) Contested; (4) Highly controversial

Table 3: Mean ratings and agreement levels of skill competencies

	Level	Mean rating		
		Overall	Client	Provider
Skills in communicating an accepting and professional stance				
Verbally communicating artfully and sensitively about gender/sexual diversity and related sensitive issues (e.g., sex, family, bullying)	1	6.87	6.833	6.909
Communicating an accepting stance to allow clients to feel safe enough to come out to the service provider	1	6.826	6.75	6.909
Behaving neutrally with clients of all sexes/genders/sexualities	1	6.696	6.583	6.818
Skills in assisting on specific issues				
Making sense of the family and social problems that LGBTIQ groups face	1	6.609	6.5	6.727
Identifying the feelings LGBTIQ clients have about their gender and identity	1	6.522	6.5	6.545
Identifying the hidden impact of otherness, stigmatization, and discrimination among LGBTIQ clients	1	6.435	6.333	6.545
Providing sexological counseling to LGBTIQ clients	2	6.304	6.083	6.545
Assisting family members of LGBTIQ clients (e.g., parents, siblings)	2	6.261	5.917	6.636
Assisting children of LGBTIQ persons	2	6.261	6	6.545
Skills in using feminist counseling techniques				
Applying feminist counseling skills together with the practitioner's main approach	2	6.217	5.833	6.636
Gender intervention, as in feminist counseling	3	6	5.667	6.364
Gender analysis, as in feminist counseling	3	5.955	5.727	6.182
Empowering clients (e.g., to participate in social life), as in feminist counseling	3	5.826	5.333	6.364
(No LGBTIQ-specific skills needed)				
No need for specific skills—generic skills are sufficient in providing services to LGBTIQ clients if the practitioner is able to apply them to a given client	4	4.391	4.417	4.364

Note: Level: (1) Consensus; (2) Majority agreement; (3) Contested; (4) Highly controversial

Action competencies

Action competencies (Table 4) were divided into six themes: *(1) communicating acceptance and respect for clients and their self-determination, (2) expressing humility and recognizing the limits of*

one's knowledge, (3) refraining from actions that offend clients, *(4) social justice action*, *(5) obtaining information sensitively*, and *(6) using specific techniques*.

Communicating acceptance and respect for clients and their self-determination means using communication skills to express an accepting attitude for clients' identities and life choices (e.g., clothing, sexual lifestyle, coming out), and patience with clients who are not ready to make certain choices. LGBTIQ-specific signage and practitioner self-disclosure were contested. *Expressing humility and recognizing the limits of one's knowledge* includes being upfront with clients about one's level of expertise with LGBTIQ clients and referring clients on if one cannot accept or understand them. It also means informing clients that one can be corrected if one uses an incorrect term or espouses stereotypes.

Table 4: Mean ratings and agreement levels of action competencies

	Level	Mean rating		
		Overall	Client	Provider
Communicating acceptance and respect for clients and their self-determination				
Showing respect to the identities and genders that their clients exhibit	1	6.826	6.75	6.909
Striving to understand sensitivity toward gender/sexual diversity in particular	1	6.739	6.5	7
Explaining to clients that gender and sexuality are diverse and there are no right or wrong types	1	6.739	6.75	6.727
When clients are unsure of their sexual orientation or gender identity, service providers should assure them that it's normal	1	6.739	6.667	6.818
Not pressuring LGBTIQ clients to come out right away, but inviting them to evaluate their readiness for it	1	6.739	6.583	6.909
Asking clients which names and pronouns they feel comfortable with and using these words in further discussions with the client	1	6.696	6.5	6.909
Providing counseling on clients' problems, not trying to change their identity	2	6.609	6.5	6.818
Using gender-neutral terminology (e.g., asking about a "partner" rather than "husband" or "wife" if unsure of a partner's gender)	2	6.522	6.333	6.636
Being patient with LGBTIQ clients even if they are not ready yet to open up about what bothers them	2	6.478	6.333	6.727
Supporting clients to dress in the way they have chosen, including in the case of various uniforms	2	6.478	6.417	6.545
Treating LGBTIQ clients no different from other clients, using the same standards and methods	2	6.348	6.417	6.273
If a client tells aspects of their sexuality (e.g., multiple partnerships, HIV) that shock the service provider, they should try to normalize the issue	2	6.304	6.25	6.364
Having signage and symbols indicating that the service provider welcomes LGBTIQ clients	3	5.609	5.167	6.091
If a service provider is LGBTIQ, they can disclose their identity to the client so as to expedite the creation of a therapeutic relationship	4	5.609	5.167	6.091
Expressing humility and recognizing the limits of one's knowledge				
If a service provider does not understand or cannot accept an LGBTIQ client, they should refer the client to another suitable professional	1	6.652	6.667	6.636
Informing clients that if one uses an incorrect term or express a stereotypical understanding of the client's identity, the client can alert one about this	2	6.478	6.417	6.545
Service providers should inform their clients how much expertise and experience they have on working with LGBTIQ clients	3	5.783	5.583	6
Refraining from actions that offend clients				
Not using the personal title of transgender clients to avoid causing them embarrassment	1	6.783	6.667	6.909
Not addressing a trans person as a member of their birth sex	2	6.96	6.5	6.909
Not judging or stigmatizing LGBTIQ clients in any case	2	6.739	6.5	7
Not making decisions based on the birth sex of the client	2	6.652	6.417	6.909
Not asking clients sensitive and irrelevant questions (e.g., how trans men have sex, has the trans client had gender-affirming surgery, is the gay client a top or a bottom) just because the service provider wants to know	2	6.652	6.5	6.818
Not commenting that a transgender client looks "very similar" to persons who are their gender by birth, because saying so indirectly denies that they are that gender	2	6.609	6.333	6.909
When clients reveal their sexual orientation, gender identity, or other dimensions of their sexuality to a service provider, the service provider should not express surprise or a sense of shock to the client	2	6.565	6.333	6.818

	Level	Mean rating		
		Overall	Client	Provider
Social justice action				
Mental health professionals who have an understanding of gender/sexual diversity should build an understanding of gender/sexual diversity issues within their profession	1	6.522	6.583	6.455
If an LGBTIQ client's parents expect that mental health treatment will turn their child into a cisgender heterosexual, the service provider should adjust their expectation so that they understand this to be impossible, but using the service might make their child's life better	2	6.478	6	7
Doing publicity work about one's services and disseminating information about gender/sexual diversity to encourage LGBTIQ individuals to use the services	2	6.435	6.417	6.455
Considering how one can increase equality in terms of gender/sexual diversity in society and advocating for one's chosen issues	2	6.227	6.182	6.273
Obtaining information sensitively				
If a service provider needs an answer to a sensitive question (e.g., the legal sex of a client), they should ask the client privately and sensitively	1	6.652	6.5	6.818
Considering which of a client's problems are related to gender/sexual diversity	2	6.391	6	6.818
Relying on discussions with the LGBTIQ client more than psychological tests in making sense of their identity	2	6.304	5.917	6.727
Seeking to find out if LGBTIQ clients suffer from being different	2	6.174	6	6.364
Using specific techniques				
Using the PLISSIT model program with LGBTIQ clients	3	5.227	5.455	5
Using hypnotherapy techniques with LGBTIQ clients to overcome obstacles posed by clients' strong adherence to their existing beliefs	4	4.773	5	4.545
(No LGBTIQ-specific actions needed)				
No need to do anything specific when giving services to LGBTIQ people	4	5	4.833	5.182

Note: Level: (1) Consensus; (2) Majority agreement; (3) Contested; (4) Highly controversial

Refraining from actions that offend clients includes counterproductive actions, such as judging or stigmatizing LGBTIQ clients, asking irrelevant yet sensitive questions, expressing shock when hearing about the client's lifestyle, or disregarding transgender clients' identity. *Social justice action* includes educating other members of one's profession about LGBTIQ issues, adjusting the expectations of LGBTIQ clients' parents, publicizing one's services to increase access, and broader social justice advocacy. *Obtaining information sensitively* means relying on sensitive questioning in private rather than on psychological tests, conceptualizing which problems are related to gender/sexual diversity, and finding out if clients suffer from being different. *Using specific techniques* (hypnotherapy & PLISSIT) was suggested, but both techniques were contested.

Discussion

This two-round Delphi study defined mental health practitioners' LGBTIQ cultural competence in Thailand by identifying constituent competencies. It aggregated views of LGBTIQ clients and mental health practitioners with expertise in Thailand. Forty-one knowledge competencies, 35 awareness/attitude/belief competencies, 14 skill competencies, and 35 action competencies were rated. The endorsed competencies emphasized practitioners' acceptance and understanding of LGBTIQ groups (which need to be communicated to clients), avoiding offensive actions, and using their knowledge about issues affecting LGBTIQ people to provide appropriate assistance, while recognizing the limits of their expertise. In this section, we discuss the implications of the findings to the debate about common factors versus specific effects in therapy; highlight the importance of both learning in advance of meeting LGBTIQ clients, and humility in practitioners' work; discuss the implications of including action competencies; compare the findings with previous research; acknowledge our limitations; and outline implications for LGBTIQ mental health development in Thailand.

LGBTIQ cultural competence enables common factors to operate

Comparing our findings with Wampold's (2015, p. 273) summary of meta-analyses on effective psychotherapy elements, enabling the operation of common factors seems crucial to why LGBTIQ cultural competence improves outcomes. *Goal consensus and collaboration* (also an element of *alliance;* Bordin, 1979) may be strengthened when practitioners understand gender/sexual diversity and issues affecting LGBTIQ people and their families; respect clients' self-determination; and have skills in assisting clients on specific issues (when relevant to the client). *Empathy* is more likely when practitioners understand clients' identities and issues; are not misled by stereotypes; and are aware of their own beliefs, attitudes, identities, and values (to counter bias). The bond component of *alliance* (Bordin, 1979) and *positive regard/affirmation* may be strengthened when practitioners accept gender/sexual diversity and respect clients' self-determination; have skills in communicating these to clients; and use these skills. Practitioners obtaining information sensitively, refraining from offensive actions, and engaging in LGBTIQ social justice action may help clients feel affirmed. When practitioners accept gender/sexual diversity, they may be perceived as acting with *congruence/genuineness* (rather than pretending to accept a client's lifestyle) and being more likable *therapists*. Knowledge of LGBTIQ groups and their issues, and skills for working on these issues, are crucial in the *cultural adaptation of evidence-based treatments*. LGBTIQ clients' *expectations* for improvement may be heightened when practitioners understand their issues because practitioners' conceptualization of their issues is then more likely to make sense to them.

Wampold (2015) identified three sources of treatment-specific effects on therapy outcomes: (1) differences between treatments; (2) specific treatment ingredients (revealed by dismantling studies); and (3) adherence and competence to follow a treatment protocol. Some participants proposed using specific treatments (hypnosis & PLISSIT), but other participants contested these suggestions. Participants' calls for practitioners to have skills in working on specific issues (e.g., coming out or sexual health) were more highly endorsed. These might prompt clients to "enact some healthy actions" (Wampold, 2015, p. 271), such as coming out, and in this sense, represent specific treatment ingredients. According to Wampold's (2015) summary, specific ingredients' impact on outcomes is negligible. However, meta-analytic research reports averages across populations, which might conceal a bigger impact on outcomes among LGBTIQ clients because they are a minority in the investigated samples, yet addressing minority stress merits specific action. Our findings did not call for adherence or competence to follow a treatment protocol.

Some client and practitioner participants believed that LGBTIQ-specific competencies are not *necessary*. However, they considered them *beneficial,* possibly because their professional training has instilled in them the belief that the approaches they have learned are universally applicable, and that treating clients differently might equal discrimination. We do not share their view; we believe that not having the LGBTIQ cultural competencies identified in this study would be detrimental to outcomes.

Learning before meeting clients and humility are both needed

Critics of cultural competence have cautioned that studying characteristics of specific client populations may lead to stereotyping clients and be counterproductive (Davis et al., 2018; Kleinman & Benson, 2006; Patterson, 1996). Rather than cultural competence, they have emphasized cultural humility (Davis et al., 2018; Kleinman & Benson, 2006), which refers to practitioners being upfront about the limitations of their knowledge and striving to learn what

matters to the client. In contrast, LGBT scholarship has shown that clients may feel misunderstood or that they are wasting their time if they have to educate practitioners about LGBT issues (King et al., 2007; McNeil et al., 2012).

Our findings suggest that posing cultural competence and humility as mutually exclusive is unhelpful. The participants emphasized practitioners' openness and humility but also acquiring knowledge of stereotypes in advance of meeting clients, so as not to stereotype them. Cultural humility can thus be considered a subset of cultural competence. Consequently, practitioners should learn about LGBTIQ groups and their issues in advance, as well as acknowledge the limitations of their knowledge and strive to learn more from clients.

Implications of including the action domain

We followed Ratts et al. (2016) in including action as a fourth competency domain. This choice enabled participants to propose and endorse specific conventions for working with LGBTIQ clients, which may increase the practical utility of our findings. While we did not set out with an explicit focus on social justice action, inclusion of this domain also enabled participants to propose and endorse social justice actions (e.g., LGBTIQ advocacy, educating other practitioners), resembling the social justice focus of Ratts et al. (2016) and may help practitioners to work for the benefit of LGBTIQ people in more diverse ways.

More similarities than differences across contexts

This study was initiated with the assumption that LGBTIQ cultural competence might comprise somewhat different competencies in Thailand than in Western countries. However, the identified competency themes resemble those identified in Western research, covering all elements in the characterization of affirmative therapy by King et al. (2007) and the description of minimum elements of LGBT cultural competence by Boroughs et al. (2015). The participants' endorsement of the role played by minority stress is in line with the APA guidelines (2012, 2015). Similar to an earlier Delphi study (Israel et al., 2003), clients and practitioners largely agreed on their ratings. Still, in both studies, clients gave lower ratings overall, perhaps perceiving a narrower range of issues.

Surprisingly, Thai cultural beliefs related to mental health (Burnard et al., 2006) were not represented in the identified competencies, perhaps because the participants were mostly urban and middle-class. The impact of practitioners' belief in karma was noted, but its relevance was contested. However, values related to collectivism were noted as important to recognize. For example, collectivist practitioners might believe it inappropriate to support LGBTIQ clients' self-determination when it conflicts with group norms or state regulations.

Compared with research and guidelines outside Thailand, the competencies were narrower in many ways. The APA guidelines (2012, 2015) emphasize further aspects of intersectionality (e.g., social class, ethnicity, religion, disability, HIV status). Those guidelines and another Delphi study (Godfrey et al., 2006) also emphasized understanding identity development and assisting clients' partners and families. Further areas identified by Israel et al. (2003) but not included in our findings included addiction issues, domestic violence, and LGBTIQ culture, community, and history. These topics might merit more attention from practitioners than the findings suggest. In contrast, our participants emphasized recognizing and rejecting

stereotypes and offensive practitioner actions with more specificity than the above Western materials.

Limitations

Delphi studies aggregate expert knowledge. Thus, their conclusions depend on what kinds of experts are included. Our inclusion criteria led to most practitioner participants having a psychology background, so the findings are applicable to psychologists' work. Our client and practitioner participants were diverse in terms of gender and sexuality, but did not include asexual or intersex participants, and the competencies provide little specific guidance for working with these groups. The participants were mostly urban, middle class, and well educated, so the findings may not apply as well to rural, working-class, or less educated clients, who might, for example, require more attention to Thai cultural beliefs on mental health (Ojanen, 2010). The findings are mostly based on Buddhist or non-religious views and may not fully apply to Christian or Islamic LGBTIQ clients. Two competencies were not included in the Round 2 survey. Future studies may expand these competencies with more diverse samples and research methodologies, and empirically investigate their linkages with treatment outcomes and intermediate variables.

Ways forward for LGBTIQ cultural competence in Thailand

The findings represent the first locally generated conceptualization of LGBTIQ cultural competence in Thailand. If practitioners have identified competencies, they are more likely to provide appropriate services to LGBTIQ clients. Thus, developing these competencies should be incorporated into mental health practitioner training curricula and continuing professional development. Health volunteers and general practitioners who serve LGBTIQ clients may also benefit from them; the non-technical nature of the competencies makes this entirely feasible. The broader study on which this article is based (Ojanen, 2019) also identified ways of developing these competencies and broadly endorsed experiential training methods, such as personal contacts with LGBTIQ individuals followed by further reflection, conceptualization, and in-session experimentation. Mental health practitioners in Thailand need up-to-date guidelines for practice with LGBTIQ clients. The identified competencies provide a basis for creating such guidelines. To ensure the appropriateness of mental health services for LGBTIQ clients, agencies responsible for mental health in Thailand (particularly the Department of Mental Health) should issue policies to develop and mainstream LGBTIQ cultural competence training in the mental health workforce.

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