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ORIGINAL RESEARCH

Clinician experiences on training and awareness of sexual orientation in NHS Talking Therapies Services for Anxiety and Depression

Jason Kai Yu Ho[1,2], Christopher O'Rouke[3], Allán Laville[4], Marie Chellingsworth[5] and Patrick Callaghan[1]

[1]London South Bank University, London, UK, [2]Present address: Institute of Psychiatry, Psychology, and Neuroscience, Kings College London, London, UK, [3]Dorset Healthcare University NHS Foundation Trust, Bournemouth, UK, [4]Vice Chancellor's Office and School of Psychology & Clinical Language Sciences, University of Reading, Reading, UK and [5]School of Psychology, Faculty of Social Sciences, Arden University, Coventry, UK
Corresponding author: Allán Laville; Email: a.laville@reading.ac.uk

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Abstract

Previous research that explored sexual minority service users' experiences of accessing NHS Talking Therapies for Anxiety and Depression Services highlighted the need for specific sexual orientation training. Inconsistent or lack of training may contribute to disparities in treatment outcomes between sexual minority service users and heterosexual service users. The aim of the study was to explore clinicians' competencies working with sexual minority service users, their experiences of sexual orientation training, their view of current gaps in training provision, and ways to improve training. Self-reported sexual orientation competency scales and open-ended questions were used to address the aims of the study. Participants ($n = 83$) included Psychological Wellbeing Practitioners (PWPs) and high-intensity CBT therapists (HITs). Responses on competency scales were analysed using Kruskal–Wallis tests and thematic analysis was used to analyse qualitative responses. Participants who identified as 25–29 years old had higher scores on the knowledge scale than 45+-year-olds. Bisexual participants also had higher scores on the knowledge subscale than heterosexual participants. Three over-arching themes were identified: (a) training received on sexual minority issues by Talking Therapies clinicians, (b) clinicians' experiences of accessing and receiving sexual minority training, and (c) perceived gaps in current sexual minority training and ways to improve training. Findings were linked to previous literature and recommendations to stakeholders are made throughout the Discussion section with the view of improving sexual orientation training.

Key learning aims

(1) To understand current training provision of sexual orientation training across NHS Talking Therapies courses and services in England.
(2) To consider clinicians' experiences of challenges and barriers that may prevent them from accessing or implementing sexual orientation training in clinical practice.
(3) To understand clinicians' views of the current gaps in training and ways to improve training provision.
(4) To make recommendations to NHS Talking Therapies for Anxiety and Depression courses and services in ways to improve training on sexual orientation to better meet the learning needs of clinicians and service users.

Keywords: Cognitive behavioural therapy; Improving Access to Psychological Therapies Programme (IAPT); High intensity; Low intensity; Sexual orientation; Training

Introduction

Overview of sexual minority mental health

Individuals identifying as a sexual minority (e.g. lesbian, gay, bisexual, queer and plus; LGBQ+) have a greater risk of experiencing mental health difficulties, or receiving a diagnosis of a mental health condition, in comparison with heterosexual individuals (Kirk, 2022; Plöderl and Tremblay, 2015; Semlyen *et al.*, 2016). Minority stress theory is a well-known framework that attempts to provide an explanation for these disparities (Meyer, 2003). The theory suggests that a key source of psychological distress is chronic exposure to 'minority stress' which exists on a continuum from proximal to distal stressors. Distal stressors are structural, externally influenced experiences such as victimisation, stigma, and discrimination in relation to individuals' sexual minority identity status. By contrast, proximal stressors are internal processes including expectation of experiencing discrimination or rejection, concealment of one's own sexual orientation and internalised homophobia. Research has highlighted ways in which minority stress theory can be incorporated into a cognitive behavioural therapy (CBT) framework. For instance, having an awareness of the theory could be helpful for clinicians to structure their assessment questions based on the different parts of the model when working with service users whose presenting difficulties are related to their sexuality (Laville, 2022). This could allow for thorough information gathering. Pachankis and colleagues (2022b) further illustrated ways in which CBT interventions can be adapted by incorporating LGBQ-affirmative principles. For instance, this might include normalising experiences of mental health difficulties as a response to minority stress in a heteronormative society during collaborative formulation and psychoeducation in treatment sessions. One randomised controlled trial found that incorporating these principles to adapt CBT led to greater improvements in symptoms of psychological distress such as anxiety and depression among sexual minority men when compared with treatment as usual (Pachankis *et al.*, 2022a). Hatzenbuehler (2009) extended the theory and proposed that exposure to minority stressors may lead to an increase in emotional dysregulation, social or interpersonal problems, and cognitive processes such as negative self-evaluation. Research has found that these processes in turn elevate sexual minority individuals' vulnerability to developing mental health problems including depression (e.g. Argyriou *et al.*, 2020; Lattanner *et al.*, 2022), anxiety disorders (e.g. Hu *et al.*, 2022; Mahon *et al.*, 2022); and substance dependency (e.g. Fitzpatrick *et al.*, 2020; Rogers *et al.*, 2017). Introducing clinicians to these theories would be important to support them in adapting their work, when necessary, with sexual minority service users during sessions of CBT.

While there may be overlapping issues that impact the LGBQ+ community, it is important to acknowledge the differences that exist within this diverse population. Individuals with 'multiple minority statuses' such as those identifying as both a racial-ethnic and sexual minority experience even greater levels of stress compared with their LGBQ+ White peers. In addition to sexual orientation-based discrimination, racial-ethnic minority individuals experience racial discrimination and rejection within the LGBTQ+ community or their wider cultural group (Ghabrial, 2017; Cyrus, 2017). Bisexual individuals are more likely to have their sexual orientation questioned or disregarded, which may lead to even higher levels of psychological distress within this group (Pennasilico, 2019). Furthermore, individuals identifying as both LGBQ+ and trans or gender diverse experience an additional layer of stress including being victims of gender-based violence (Erickson-Schroth *et al.*, 2020) and the lack of access to trans-affirmative or gender affirmative healthcare (Clark *et al.*, 2019; Wright *et al.*, 2021).

Consequently, it is imperative that mental health services: (a) understand the difficult socio-political and interpersonal challenges that sexual minority individuals may have to navigate, (b) have the resources to support service users in this community, and (c) be responsive to their needs.

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NHS Talking Therapies for Anxiety and Depression Services

In England, adults can access psychological support through a nationwide programme called NHS Talking Therapies for Anxiety and Depression (formerly Improving Access to Psychological Therapies, IAPT and hereafter referred to as NHS Talking Therapies). This programme follows a stepped-care model (Bower and Gilbody, 2005) where, dependent on factors such as: treatment history, severity and longevity of symptoms, treatment response, and NICE Guidelines, patients can have support in the form of low-intensity cognitive behavioural therapy (CBT), supported by a Psychological Wellbeing Practitioner (PWP), or at a high-intensity level, typically supported by a high-intensity CBT therapist (HIT) but can also include other modalities such as counselling or brief psychodynamic psychotherapies.

A UK government report published in 2016 found that LGBTQ+ individuals are more likely than heterosexual individuals to access mental health services in the UK (Hudson-Sharp and Metcalf, 2016). However, whether they are more likely to access NHS Talking Therapies than heterosexual individuals cannot be clearly ascertained. For instance, Baker (2018) found that around 3% of those who accessed NHS Talking Therapies in 2016–2017 identified as a sexual minority, yet information on sexual orientation was only collected for 67% of individuals and no information was available for those identifying as trans or gender diverse. When sexual minority individuals do access services, recent data showed that they are less likely to recover or improve, and more likely to deteriorate in comparison with heterosexual individuals (NHS Digital, 2022).

A Stonewall (2018) report found that one in eight LGBTQ+ individuals experienced unfair treatment when accessing healthcare services. In the context of NHS Talking Therapies, sexual minority service users described experiences of struggling with clinicians making incorrect assumptions, such as assuming that they were heterosexual or that their difficulties were solely due to their sexual orientation (Morris *et al.*, 2022). The lack of understanding by some services may reinforce individuals' fear of discrimination, rejection, and contribute to individuals' mistrust in services (Foy *et al.*, 2019; Stonewall, 2018) This, in turn, may lead to poor access and disparities in treatment outcomes.

Two recently conducted qualitative studies explored sexual minority individuals' experience of accessing NHS Talking Therapies (Foy *et al.*, 2019; Morris *et al.*, 2022). Participants in both studies described similar themes including fears surrounding disclosure of sexual orientation and inadequate awareness and understanding of sexual minority individuals' experience amongst clinicians that acted as barriers to accessing services. Contrastingly, participants who had positive experiences of services revealed that they were supported by clinicians who demonstrated acceptance and understood issues or challenges that sexual minority individuals face. Another key overlapping finding was participants agreeing that services can be improved by providing adequate training on issues surrounding sexual orientation to clinicians. This is with the view of increasing their competence and confidence in handling issues surrounding sexual orientation that might arise throughout assessment and treatment. Based on the evidence, to date NHS Talking Therapies services do not appear to be adequately meeting the needs of sexual minority service users.

Current training provision on sexual orientation

According to Health Education England (HEE, 2022), training programmes for PWPs and HITs must include equality, diversity and inclusion issues across all teaching. As sexual orientation is one of nine protected characteristics under the Equality Act (2010), it is expected that clinicians receive adequate training to ensure that their ongoing work meets the above aims and more importantly, the needs of service users identifying as sexual minority individuals.

On the curriculum, HEE suggested structures that courses might follow in their delivery of the whole equality, diversity and inclusion (EDI) module. For PWPs, it was suggested that 15 days were provided by courses for lectures and practice-based learning with employers to provide

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additional self-directed studies. The competency for this module may be evidenced via recordings, presentations, practice outcomes, and written tasks. For high-intensity CBT courses, there is a need for clinicians to demonstrate at least 100 hours direct and structured learning of core competencies including working with diversity (BABCP, 2021). Issues surrounding EDI may be evidenced through case reports, case presentations, self-reflective portfolios, and tape recordings. Clinicians may also receive additional sexual minority training from their services upon completion of their training courses as part of continuing professional development (CPD). Unlike the content of the training year which must be guided by and meet the requirements of the training curriculum, the provision of CPD training on issues surrounding EDI vary across course providers. Services have greater flexibility when deciding topics to focus on for CPDs, which largely vary depending on local demographic and service needs.

Consequently, the amount and the quality of dedicated training that clinicians receive on sexual orientation may vary. This inconsistency may contribute to differences in competencies between clinicians when supporting service users identifying as sexual minority and subsequently leading to differences in treatment outcomes.

Present study

Research in the field tends to explore experiences of LGBTQ+ individuals under one collective group. However, this approach has been criticised as it conflates sexual orientation (i.e. referring to an individual's emotional, romantic, or sexual attraction to other people which may be independent of their gender identity) with gender identity (i.e. referring to a person's internal and individual experience of gender, which may be different from their assigned sex at birth). This may lead to the overlooking of unique issues that trans and gender-diverse individuals face (Ellis *et al.*, 2015). In addition to mental health needs, they also access healthcare services in relation to their gender identity status such as hormone therapy and gender affirming surgery. Healthcare professionals often serve as gatekeepers to such specialist treatment. Qualitative studies exploring trans and gender-diverse people's experience of accessing healthcare identified barriers such as mental health professional's lack of understanding of 'trans' issues, experiences of transphobia, lack of trans or gender-diverse healthcare policies, and long waiting times for treatment (e.g. Ellis *et al.*, 2015; Heng *et al.*, 2018; Ross and Castle Bell, 2017). As a result of these experiences, trans and gender-diverse people are at an even greater risk of developing mental health difficulties compared with sexual minority, heterosexual, and cisgender individuals (Crissman *et al.*, 2019; Moagi *et al.*, 2021). Yet, when they do access mental and physical health services, they are also more likely to have negative experiences, which leads to poorer treatment outcomes (Stonewall, 2018). It is vital for future research to explore the experiences of trans and gender-diverse individuals when accessing NHS Talking Therapies and experiences of training among clinicians. Thus, gender reassignment as a protected characteristic under the Equality Act warrants research in its own right. To ensure that the experiences of trans and gender-diverse people were not overlooked and erased, the focus of the present study was on sexual orientation as a separate protected characteristic under the Equality Act.

Previous research has explored the experiences of sexual minority individuals in accessing NHS Talking Therapies and identified that one key theme for improving service delivery is training for clinicians on working with sexual minority individuals. To the authors' knowledge, no studies have explored clinicians' experiences of sexual orientation training on NHS Talking Therapies courses and services in England. Therefore, the present study investigated the self-reported competencies of NHS Talking Therapies clinicians working with sexual minority service users, their experiences of sexual orientation training and their views of the gaps in training provision. Understanding the gaps in training will allow us to start identifying the steps that needs to be taken to ensure that NHS Talking Therapies training courses and services are providing sufficient training for clinicians on LGBQ+ issues.

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Method

Design

A concurrent mixed method design was utilised. This was due to our interest in measuring clinicians' self-reported competence working with sexual orientation using quantitative measures, while further understanding their experiences through qualitative responses. Data were collected through an online survey which consisted of two quantitative questionnaires and four qualitative open-ended questions. The first section of the survey collected demographic information including: gender, age, ethnicity, sexual orientation, the type of NHS Talking Therapies service that participants worked in, and the number of years post-qualification as a PWP and/or a HIT. Participants then completed two quantitative questionnaires where they were required to answer forced choice scales that examined skills and knowledge of working with sexual minority service users. Following this, participants were presented with four open-ended questions that explored their experiences of sexual orientation training before and after their PWP or HIT training. The full survey is available as part of the Supplementary material.

Participants

Participants were recruited via convenience sampling through social media platforms (including LinkedIn, Twitter and Facebook), email, and word of mouth between January and June 2022. Recruitment advertisements indicated that the purpose of the study was to examine CBT and PWP professionals' views on gaps in LGBQ+ understanding and training in IAPT. We received 84 responses at the end of the recruitment period. However, one participant did not complete the survey. As their data was missing, they were excluded from data analysis. Data were thus analysed on 83 participants. Demographic of participants are presented in Table 1.

Measures

Adapted Sexual Orientation Counselor Competency Scale

The Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005), originally developed in the United States, consists of 29 items among three subscales that measure skills, attitudinal awareness, and knowledge of counsellors working with sexual minority individuals. The Cronbach's alpha of the overall scale was reported to be 0.90, indicating high internal consistency (Bidell, 2005). The alphas of the skills, attitudinal awareness and knowledge subscales were .83, .83 and .84, respectively. Currently, there is a lack of existing competency scales that suitably assess HITs and PWPs' skills and knowledge of working with sexual minority individuals in the context of NHS Talking Therapies. Consequently, the quantitative questionnaires in our present study were adapted from the scale items within the SOCCS. Items from the questionnaires were adapted with full permission obtained from the author of the scale. Of the 29 items, we took 12 items from the skills and knowledge subscale and re-worded them for the purpose of our study. The skills subscale consisted of five items ($\alpha = .73$) and the knowledge subscale consisted of seven items ($\alpha = .80$). The overall internal consistency of our reworded scale was acceptable, with a Cronbach's alpha of .73.

In line with the SOCCS, our 12-item scale was a 7-point Likert scale (where 1 is 'not at all true', and 7 is 'totally true') that participants would use to rate the truth of a series of statements. Higher mean scores indicate greater levels of individuals' skills, knowledge, or overall competency working with sexual minority service users. As the data collection period preceded the rebranding of NHS Talking Therapy for Anxiety and Depression services, items within our subscales referred to its previous name, i.e. IAPT. Sample re-worded items from our subscales include 'I think that the current IAPT curriculum has adequately prepared me to support LGBQ+ service users' and 'I am aware of institutional barriers that may prevent LGBQ+ individuals from accessing IAPT services' (subscales are available on request from the lead author).

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Table 1. Demographics of participants

Demographic characteristic	Participants ($n = 83$)	
	n	%
Age (years)		
20–24	16	19.3
25–29	38	45.8
30–34	15	18.1
35–39	5	6.00
40–44	5	6.00
45+	4	4.80
Ethnicity		
White British	61	73.5
Asian/Asian British	5	6.00
Black/Black British	6	7.20
Mixed race	6	7.20
Prefer to self-describe[a]	5	6.00
Gender identity		
Women	69	83.1
Men	11	13.3
Prefer to self-describe[b]	3	3.60
Sexual orientation		
Heterosexual	55	66.3
Bisexual	11	13.3
Lesbian/gay woman	6	7.20
Gay man	5	6.00
Prefer to self-describe[c]	6	7.20
Role of participants		
Psychological Wellbeing Practitioner (PWP)	49	59.0
Cognitive behavioural therapists	21	25.3
Other[d]	13	15.7
Years of experience as a qualified clinician		
<1 year	27	32.5
1 year	14	16.9
2 years	11	13.3
3 years	9	10.8
4 years	5	6.00
5 years	5	6.00
>6 years	12	14.5
Work setting		
NHS commissioned services	76	91.6
Private providers of healthcare	5	6.00
Other	2	2.40

[a]This group included individuals who self-identified as Arab, Turkish, and from the Gypsy, Roma, Traveller community.
[b]This group included individuals identifying as non-binary and genderfluid.
[c]This group included individuals identifying as queer, pansexual, and those who preferred not to disclose their sexual identity.
[d]This group encompassed individuals who previously held roles as CBT therapists or PWPs but have since moved on to other positions (including assistant psychologists, trainee clinical psychologists, trainee high-intensity CBT therapists, PWP lead, and PhD student.

Open-ended questions

Additionally, four open-ended questions were devised to better understand the training that participants have received on issues surrounding sexual orientation and identifying other components that would be helpful for participants pre- and post-qualifying to support them in working with sexual minority service users. The questions were as follows: (a) 'During your training year, what training did you receive on LGBQ+ issues?', (b) 'Please comment whether there is anything that would have been helpful for courses to include to help you prepare for

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Table 2. Descriptive statistics of mean scores of skills subscale, knowledge subscale, and total sexual orientation competency for all participants ($n = 83$)

Measure	Mean	Mdn	*SD*
Total sexual orientation competency	4.30	4.33	.778
Skills subscale	3.03	3.00	1.07
Knowledge subscale	5.20	5.14	1.07

working with LGBQ+ service users?', (c) 'After qualifying, what training have you received on LGBQ+ issues that is different to the training you received during the course?', and (d) 'Please comment whether there is anything that would have been helpful for your IAPT services to provide to help you further your confidence in working with LGBQ+ service users?'.

Ethics and procedure

The study received ethical approval from the London South Bank University's Research Ethics Panel (SAS21-007). A link to the online survey was provided on the advertisement. Upon accessing the link, participants were presented with an information sheet detailing aspects of the study and what their participation would involve. Participants were also informed of confidentiality, their right to withdraw, dissemination of results, and contact details of the research team should they require further information prior to participating. Immediately following their reading of the participation information sheet, participants were presented with consent statements followed by a yes/no box that they had to tick to progress. Upon completion of the survey, information about sources of support were provided in the case of possible distress. This included signposting details to national crisis services such as the Samaritans, alongside contact details of the lead researcher and supervisors.

Data analysis

The data were extracted from Qualtrics to Microsoft Excel and input onto IBM SPSS version 26. The data were cleaned, and missing data were excluded from analysis. Mean scores for each subscale were obtained by adding individual responses and dividing by the number of items in the respective subscales. This yielded mean scores that ranged between 1 and 7 for the skills subscale and knowledge subscale, respectively. We obtained the combined mean overall scores of both subscales (which hereafter in this paper will be referred to as mean total sexual orientation competency score) by adding all responses and dividing by total number of items across both subscales. The mean total sexual orientation competency score ranged between 1 and 7, with higher scores indicating greater competency. Descriptive statistics were used to summarise responses for the whole sample (see Table 2).

Descriptive statistics were also summarised according to the different participants' demographic factors, as we were interested in exploring differences in performances between groups (see Appendices in Supplementary material). A Shapiro-Wilk test of normality was carried out to determine appropriate statistical methods to use when analysing the data. The test indicated that the mean score of skills subscale score and mean total sexual orientation competency score were normally distributed, whereas the mean score of knowledge subscale did not follow a normal distribution, $W(83) = .968$, $p = .039$. Further observation of normality for each factor within the different independent variables against the dependent variables revealed non-normal distributions. In addition to this, the overall sample size for the present study was relatively

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small ($n = 83$). We aimed to recruit at least 100 participants to ensure representative views. When the sample size is small and when there is evidence of non-normality in data, non-parametric tests would be recommended (Fagerland, 2012). As a result, the Kruskal-Wallis test appeared suitable to explore differences between groups on mean score of skills subscale scores, mean score of knowledge subscale, and mean total sexual orientation competency score. *Post-hoc* analyses such as Dunn's pairwise tests were used to identify where the group differences were.

Thematic analysis was adopted to analyse the open-ended responses to allow for a more detailed analysis of participants' experiences of the training (Braun and Clarke, 2006). The aim of our analysis was to explore common themes arising in relation to the training received by clinicians on LGBQ+ issues, experiences of clinicians in accessing and receiving training in this area, and the perceived gaps in current training provision on LGBQ+ issues. Our thematic analysis adopted a critical realist epistemological approach, with themes derived inductively at a semantic level. This meant that we identified themes based on surface level meanings of the data rather than interpreting the meanings beyond what was written.

While efforts were taken to avoid misconstruing the meaning of the participants' responses by our previous life experiences, we acknowledge that the inductive process of analysing responses would have been influenced by the researchers' differences in beliefs and prior life experiences. Consequently, to increase the transparency of the analysis and to allow readers to identify potential experiences and characteristics that may have influenced the analysis, we included the following information. The study was designed and run by the first author (J.H.), who is a trainee clinical psychologist and qualified PWP. He identifies as a gay man. In his previous role, he was the lead of his service's LGBTQ+ special interest team. He had negative experiences of accessing therapy for issues surrounding his sexual orientation in NHS Talking Therapies for Anxiety and Depression services. As a result of this, he was particularly interested in understanding what training clinicians currently receive on issues surrounding sexual orientation and ways to improve training. This was with the intention of supporting clinicians in feeling more confident when working with sexual minority service users and improving the experiences and outcomes of those who access NHS Talking Therapies Service. His own experience has therefore shaped this piece of research. Given this, he is aware of his own critical stance towards the limited training provided on LGBTQ+ issues. Data analysis of the qualitative data was conducted by the first author (J.H.) and second author (C.O.'R.). C.O.'R. identifies as a bisexual man and is a qualified PWP working as a supervisor and as the LGBTQ+ Champion for his service (an LGBTQ+ champion refers to a team member within a Talking Therapies Service who has specialist interest in the LGBTQ+ community. They may be involved in managing projects, engaging with stakeholders and local services, alongside providing training and supervision to increase recovery and reliable improvement as well as access rates from the LGBTQ+ community). He has no direct experience of accessing mental health services but has done previous qualitative work with the positive and negative experiences of LGBTQ+ patients. J.H. received training in thematic analysis from one of the research supervisors (A.L.), while C.O.'R. had already received training in thematic analysis from his previous research work.

The first stage of the analysis involved data familiarisation: both J.H. and C.O.'R. read all responses and generated initial codes in isolation, trying to keep close to the exact words of the participants. The researchers then followed an iterative process of comparing, refining, re-reading, and re-coding the responses until no further codes were generated. Themes were subsequently identified by grouping codes together, before being reviewed once more, defined, and named. Throughout this process, there was strong agreement between J.H. and C.O.'R. on the themes that were identified (Cohen's kappa ranged from 0.713 to 0.969 across themes). Where there were discrepancies, themes were reviewed, and the definitions were revised to achieve agreement on all themes. After all themes had been identified and agreed, the supervisors (P.C., M.C. and A.L.) reviewed the proposed themes and suggested no amendments.

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Results

Part 1: Comparing differences in mean scores of skills, knowledge, and total sexual orientation competency score across participant demographic factors

Below, we present findings from the statistical analyses according to the different participant demographic factors we felt were most relevant. All tables containing descriptive statistics for the different demographic characteristics can be found in the Appendices in the Supplementary material.

Age

A Kruskal-Wallis test found no statistically significant differences between age of participants on mean scores of skill subscale ($H(5) = 3.09$, $p = .686$) and total sexual orientation competency score ($H(5) = 10.7$, $p = .058$). This suggests no differences in self-perceived skills and overall competency in working with sexual minority individuals among clinicians across different age groups. However, a significant difference was found between age of participants on mean scores of knowledge subscale, $H(5) = 14.1$, $p = .02$. Dunn's pairwise tests found a significant difference between 25- to 29-year-olds and 45+-year-olds ($p = .04$, adjusted using Bonferroni correction). The mean ranks were 48.49 and 10.63, respectively. This suggests that the mean scores of knowledge subscale for 25- to 29-year-olds tend to be higher than 45+ years old. Thus, 25- to 29-year-olds perceived themselves to be more knowledgeable about issues surrounding sexual orientation compared with 45+-year-olds. However, the differences could be due to the significantly smaller sample size in the 45+-year-old group ($n = 4$) compared with the 25- to 29-year-old group ($n = 38$). Thus, we were not able to confidently draw this conclusion. There were no significant differences between other age groups.

Sexual orientation

The Kruskal-Wallis test found no statistically significant differences between participants' sexual orientation on mean scores of skills subscale ($H(4) = 3.35$, $p = .502$) and mean total sexual orientation competency score ($H(4) = 6.64$, $p = .156$). However, there was a statistically significant difference between participants' sexual orientation on mean scores of knowledge subscale, $H(4) = 18.6$, $p < .001$. Dunn's pairwise tests were carried out for the different sexual orientations. There was a significant difference ($p = .010$, adjusted using Bonferroni correction) between individuals identifying as bisexual and heterosexual. The mean score of knowledge subscale for bisexual participants (Mdn = 6.14) was significantly higher than heterosexual participants (Mdn = 4.86). This suggests that bisexual participants were more knowledgeable around issues surrounding sexual orientation compared with heterosexuals. There were no significant differences between other sexual orientations.

Role

The Kruskal-Wallis tests revealed no statistically significant differences between PWPs, HITs and other clinicians who previously worked as either a PWP or HIT on mean scores of skills subscale ($H(2) = .482$, $p = .786$), mean scores of knowledge subscale ($H(2) = 2.23$, $p = .328$), and mean total sexual orientation competency score ($H(2) = 2.56$, $p = .278$). This suggests that there were no differences in skills, knowledge and overall competency working with sexual orientation across different roles of participants.

Gender

The Kruskal-Wallis tests found no statistically significant differences between gender of participants on mean scores of skills subscale ($H(2) = 4.48$, $p = .106$), mean scores of knowledge

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subscale (H(2) = 4.42, $p = .110$), and mean total sexual orientation competency score (H(2) = .688, $p = .709$).

Work setting

The Kruskal-Wallis tests revealed no significant differences between the setting participants worked within (i.e. NHS commissioned services, private provider, other providers) on mean scores of skills subscale (H(2) = .482, $p = .786$), mean scores of knowledge subscale (H(2) = 2.23, $p = .328$), and mean total sexual orientation competency score (H(2) = 2.56, $p = .278$).

Years of experience

The Kruskal-Wallis test revealed no statistically significant differences between participants' years of experience on mean scores of skills subscale (H(6) = 2.60, $p = .857$). However, statistically significant differences were found between participants' years of experience on mean scores of knowledge subscale [H(6) = 17.0, $p = .009$] and mean total sexual orientation competency score [H(6) = 15.0, $p = .021$]. Dunn's pairwise tests were carried out to examine where the group differences were. There was significant difference ($p = 0.03$, adjusted using Bonferroni correction) between participants with 3 years of experience and 6+ years of experience on the mean scores of knowledge subscale. The mean scores of knowledge subscales for those with 3 years of experience (Mdn = 5.86) were higher when compared with those with 6+ years of experience (Mdn = 4.50). This suggests that those with 3 years of experience were more knowledgeable about issues surrounding sexual orientation compared with those with 6+ years of experience. However, there was no evidence ($p>0.05$, adjusted using Bonferroni correction) of a significant difference between clinicians' years of experience on the mean total sexual orientation competency score (see Appendix in Supplementary material for group differences in mean scores). One possible explanation for not finding a significant difference could be the significantly smaller sample size in groups with more years of experience. Future studies should aim to recruit participants with more years of experience to further investigate these differences.

Part 2: NHS Talking Therapies Clinicians' experiences of sexual minority training and their views of the gaps in training provision

Theme 1: Training received on sexual minority issues by NHS Talking Therapies clinicians

Amount of training received pre- and post-qualifying on issues surrounding sexual orientation. The amount of training received on issues surrounding sexual orientation during their training was mixed. Thirty per cent of participants ($n = 25$) reported not having had any teaching throughout their initial training, while 65% of participants ($n = 55$) alluded to having received some training. For those who had received training, the duration of training also varied. For example, one participant reported attending a '*pre-recorded lecture*' (P28, PWP) and others mentioned receiving '*half-days*' or '*one day*' of lectures. The remaining 5% ($n = 4$) of participants reported not recalling whether they had received any training:

> '*I honestly can't remember if we covered this. If we did, then that says a lot about the quality of the training surrounding this topic.*' (P2, PWP)

> '*I don't recall any (this doesn't necessarily mean there wasn't). There may have been a session we spent talking about minorities where LGBTQ+ issues were briefly discussed but not enough in my opinion.*' (P81, HI Therapist)

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From the responses available, there was no consensus as to whether PWP or HI training provided more coverage of LGBQ+ issues:

'*During my PWP training there was a module on "cultural competence", this covered all the protected characteristics. In my HI training I would say this was not covered.*' (P48, HIT)

'*As a PWP I had a day on diversity which covered LGBTQ+ issues, and during my CBT training we had a day on LGBTQ+ experiences as well.*' (P52, HIT)

'*As a PWP none. As a trainee* [HI therapist] *I had a half day lecture on LGBT issues*' (P53, HIT)

'*In both PWP & HI training it wasn't covered.*' (P65, HIT)

Similarly, the amount of training received post-qualifying also varied between participants; 35% of participants did not receive any further training post qualification ($n = 29$). However, one participant noted that they took the initiative to facilitate additional training for the team:

'*As a CBT therapist I myself have not attended additional training, but I have facilitated 2 additional trainings to all staff in my IAPT service for LGBTQ+ experiences of IAPT . . .*' (P52, HIT)

Of those who received further training ($n = 55$), a key difference noted was the training provider. The majority of participants described receiving in-house training in the form of continuing professional development (CPD) sessions, skills group, or discussions. A small number attended externally organised training arranged by their service:

'*We had an organisation providing counselling for the LGTBQ+ community come and talk to us*' (P45, PWP)

For others, it was less clear whether they had attended external specialist training of their own accord or whether it was included as part of their development as a clinician within the service:

'*I did attend a 3 (+/–) hour workshop run by the BABCP on working with diversity and a lot of the focus for the section I attended (3 consecutive days) was on LGBQ+ issues.*' (P50, PWP)

Specificity of diversity training. Another key issue that arose was the specificity of the training participants had received; 35% ($n = 19$) of individuals who had received training on their course highlighted that they did not receive specific training on issues surrounding sexual orientation but instead, it was covered very briefly as a protected characteristic in the diversity module:

'*None, aside from a lecture which vaguely touched upon "diversity".*' (P16, trainee clinical psychologist, previously a PWP)

'*I had a module on diversity which included the 9 protected characteristics, LGBTQ+ was touched on very briefly.*' (P20, PWP)

'*1 day session with the apprenticeship team on diversity and protected characteristics – not specifically LGBTQ+*' (P35, PWP)

'*Diversity course while training – very broad*' (P34, PWP)

'*I honestly can't remember. I think we touched on it in an equality & diversity module, but it was recognising wider protected characteristics also.*' (P40, PWP)

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Theoretical content. First and foremost, it is crucial to acknowledge that many participants reported not having received teaching on specific theoretical content in relation to sexual minority issues. However, based on those who did receive theoretical teaching, the most identified topics were psychosocial issues faced by sexual minority individuals, barriers to accessing IAPT services, historical and political contexts, and differential treatment outcomes between heterosexual service users and sexual minority service users.

> '*. . . a training highlighting the history, the socio-political context, the current issues, the impact on healthcare, discrimination, and differences in IAPT outcomes across different sexualities/ gender identities . . .*' (P52, HIT)

Practical content. Practical content referred to elements of teaching that supported participants in their clinical practice when working with sexual minority service users; 25% of participants ($n = 21$) described having received teaching on assessment and/or treatment adaptations, common factors in therapy (i.e. verbal competences and establishing a therapeutic alliance, using appropriate terminology), and signposting resources. However, only four of those individuals (19.0%) described what assessment and treatment adaptations entailed and whether these were specific to sexual minority service users or general principles when working with individuals from minoritised and marginalised backgrounds:

> '*. . . looking at adaptations eg asking how we could support and wearing a rainbow lanyard*' (P37, assistant psychologist, previously a PWP)

> '*We looked at things such as empathy statements, normalising to an extent (without invalidating the persons experience) but really being sensitive to their difficulties if they have had their mental health impacted by experiences linked to their sexuality.*' (P43, PWP)

> '*. . . ways to make people feel more comfortable especially at initial assessment due to first impressions, eg asking about pronouns, title preferences and whether their name on their account is the preferred name (as some people would give their birth name).*' (P45, PWP)

> '*Encourage to use a protected characteristics tree during every assessment to offer space for open conversations*' (P60, trainee HIT)

Theme 2: Experiences of NHS Talking Therapies clinicians in accessing and receiving sexual minority training

Barriers to learning and implementation. Barriers to learning included issues such as lack of opportunities to reflect or discuss issues in team meetings or cases in clinical practice, lack of mandatory online training, and supervisors lacking training or knowledge on issues surrounding sexual orientation:

> '*. . . more discussion in team meetings and in supervision . . .*' (P82, HIT)

> '*. . . not waiting until a case is brought to supervision to discuss the needs of LGBQ+ individuals when they could have been supported before initial assessment/triage*' (P12, PWP)

> '*Regular mandatory annual training would also be helpful.*' (P70, PWP lead)

> '*My supervisor for LGBTQ+ clients is a cis-straight individual with little understanding of the models and theories behind affirmative practice, which limits the usefulness of the space.*' (P47, PWP)

> '*The management teams and supervisors didn't really have a clue*' (P53, HIT)

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Barriers to implementation referred to service-level difficulties that participants felt had prevented them from improving experiences of sexual minority service users in their clinical practice. Participants felt that they were not listened to and experienced a sense of resistance from services to implement changes that would ensure inclusive practice:

> '*I was part of the LGBTQ+ champion group but it would've been better if the champions were listened to. A lot of staff did not put their pronouns in their email signatures, and it wasn't spoken about too much within the wider team and trust.*' (P45, PWP)

> '*My service declined including a question on pronoun preference based on the fact it was time consuming. However, I've had transgender patients who still have records depicting their assignment at birth, so entire assessments happen until the end where they feel comfortable informing me of their status. This is not supportive.*' (P22, PWP)

Another barrier was the lack of training provided in services, but also the uncertainty around who is responsible to provide the training itself. The views on this issue were mixed. Some participants reflected that services should have a dedicated LGBTQ+ champion who could facilitate training, whereas others felt that the onus should be on services:

> '*Not sure this is for the service to do, probably more for a LGBTQIA+ Champion . . .*' (P70, PWP lead)

> '*I think training is definitely needed and we don't have a champion for LGBQ+ either so this could be helpful.*' (P33, PWP)

> '*. . . rather than training delivered by overworked PWPs who have limited knowledge.*' (P47, PWP)

However, it is also important to highlight that those identifying as LGBTQ+ themselves reported feeling a sense of burden or pressure from services to provide training due to their identity. This added responsibility was in addition to their existing workload but without remuneration. Crucially, participants also reflected on how this impacted their wellbeing and the lacking sense of support from management team:

> '*Have supervisors and senior management attend mandatory training to become aware of . . .* [also] *how to support their staff identifying as LGBTQ+ (e.g. because this identity might be seen as an asset and a way to uptrain the service, when that is not their job, minority stress at work).*' (P49, PWP)

> '*Queer people in NHS services have to do extra work and deal with constant micro-aggressions to push for LGBTQ+ training and development for no extra pay. It's exhausting.*' (P47, PWP)

Clinicians' perception on training. Overall, participants reflected on the unhelpful aspects of training. Some reported that the brief training that they received did not cover a range of sexualities:

> '*The lecture was very vague and mainly focused on homosexuality but did not look at the issues in* [wider] *terms. It was a poor quality lecture where no new information was given.*' (P1, PWP)

> '*She was lovely* [the educator]*, but knew less about various identities than many participants (i.e. she had never heard of pansexuality).*' (P13, PWP)

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Others mentioned that the training they received was just through '*one very brief 30-minute pre-recorded lecture*' (P74, PWP) or '*a study day with set questions to answer that was not graded or looked at*' (P67, PWP). One participant reflected particularly on the limited utility of didactic lectures when working with diversity meanwhile describing that experiential learning would be more helpful:

> '*It felt more like just considering LGBTQ for a day, but not actioning anything or doing anything, ironic really that this is what CBT is. But if felt like we were supposed to consider it/ understand it, so the University could tick the box that they've taught that part of diversity to us . . . when really it undermines the importance of learning and working with LGBTQ.*' (P43, PWP)

When one participant queried the course as to why training was not provided, they were told that '*they* [the course] *used to have a training on the LGBTQ+ community but pulled it because of time constraints*' (P47, PWP), which they described as '*absolutely outrageous*', suggesting a sense of frustration. For others, this lack of training left them feeling that they have been '*making it up at times*' (P77, PWP), '*not confident*' (P63, HIT) or '*not competent enough*' (P81, HIT) when working with sexual minority service users.

Clinicians' self-motivation to develop practice and policy. In response to the lack of training provided, some participants described having to take their own initiative to gain additional training to develop their own clinical practice. For instance, one participant reported that they had '*sought . . . and paid for* [their own training] *from the BABCP* [themselves]' (P22, PWP). Some also described that they had to find time to do '*extra reading*' (P38, PWP), and rely on their own existing '*knowledge and research*' (P84, HIT) or experiences from previous academic pursuits to support them in developing their practice. However, it was unclear whether the services had allocated protected time during working hours for these individuals to engage in these CPD-related activities. One individual also reflected that due to no training provision, they felt that they '*pushed for it* [experiences of sexual minority individuals] *to be discussed during clinical skills supervision and during seminars*' (P10, PWP).

When there was training '[gaps] *at service level*' (P50, trainee HIT), three participants described taking their initiative to develop and introduce new policies or frameworks to support staff working with sexual minority. This involved creating their '*own training with colleagues*' (P47, PWP), '[setting] *up a lead area with a focus on training staff and developing queer affirmative adaptations to treatment*' (P50, trainee HIT), and facilitating '*weekly consultations and* [developing] *an LGBTQ+ adapted Low Intensity Protocol*' (P47, PWP). However, one individual reflected that their efforts were not recognised by their service given that they were not provided with '*allocated time and minimal support given*' (P49, PWP) when developing these new frameworks.

Theme 3: Perceived gaps in current sexual minority training and ways to improve training

Clinicians' views on ways to improve training delivery. Participants described a range of learning format that they felt would improve training delivery such as lectures and peer learning. Peer learning includes spaces for peer reflective practice and supervision. One participant found that learning from peers' reflections and treatment cases through a '*q&a with them* [was] *very helpful*' (P1, PWP). Another individual (P52, HIT) felt that peer learning could help clinicians improve '*confidence in talking about sexuality and gender*' and '*to allow people to express their concerns or anxieties and reflect on where this may be coming from*'.

However, the majority of participants mentioned experiential learning ($n = 18$) and hearing from speakers with lived experience ($n = 20$). For some, the teaching on the course is '*far too rigid and is not representative of real life*' (P52, HIT); incorporating experiential learning methods into

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the curriculum such as role-plays could be helpful. Participants described that it would be helpful to have role-plays where sexuality is more explicitly spoken about and to provide examples of '*LGBT specific challenges and issues that can present in sessions*' (P28, PWP). Reflecting on this method of learning, one individual commented that this would give them the opportunity to apply skills practically as they would be able to '*quantify how* [they] *would work with that person*' (P43, PWP). Furthermore, providing a variety of case studies such as those '*where LGBTQ+ issues were addressed or needed to take into consideration during the treatment*' (P1, PWP) could also be helpful. It was also reflected that this '*would help to show us the variety of difficulties people identifying as LGBTQ face*' (P43, PWP).

Individuals reported that it would also be helpful for courses to invite speakers from the LGBTQ+ community to talk about specific challenges that they face as a sexual minority, or more specifically, service-users to share their experiences accessing mental health services. One individual reflected that this could help them learn from service user's experience to shape '*good or bad practice*' (P69, PhD student). Two participants reported that receiving teaching directly from staff identifying as LGBTQ+ would be helpful so that they can '*speak on what we can do to better support*' (P67, PWP) service users. For those who had received teaching from LGBTQ+ staff during their training year, two individuals reflected on their positive experience. One individual (P32, PWP) described that the speaker was an '*expert in* [the] *field with lived experience*' and consequently felt that the training was '*relatively comprehensive*'. The other individual described finding it helpful when the LGBTQ+ staff member picked up on trainees' '*blindspots . . . and educated them*' (P53, HIT).

Reflecting on the overall teaching, some participants felt that a '*standalone*' (P24, PWP) section for sexual orientation in diversity teaching would be an '*appropriate addition*' (P9, PWP) and one individual mentioned that '*interweaving diversity into all teaching rather than compartmentalising it to one lecture would have been better*' (P8, trainee clinical psychologist). Nevertheless, both views seem to suggest that more time and space should be dedicated to sexual orientation teaching in the training curriculum.

Post qualifying, 11 participants reported that having regular LGBTQ+-specific CPD or workshops in services would be helpful to support development in their clinical practice. A further nine participants also mentioned that having CPDs facilitated by service users with lived experience or having the opportunity to hear their feedback would be beneficial. Individuals reflected that listening to service users is the '*best way for PWPs to be educated on this subject*' (P17, PWP) and receiving feedback is '*helpful to make LGBTQ+ friendly services*' (P23, HIT). One participant also suggested that helpful CPD content might include service users sharing '*their experiences of mental health difficulties, how this interacted with their sexuality among other identity factors and social pressures, and their experience with mental health services (what was helpful and unhelpful)*' (P3, trainee clinical psychologist). Furthermore, six participants mentioned wanting specific LGBTQ+ reflective spaces incorporated into their work as it would allow '*for clinicians to explore stigmas etc that they may have when working with LGBTQ+ people*' (P27, PWP).

Systemic issues. In addition to training needs, participants described a range of 'systemic issues' that they feel would be important for services and courses to address to improve the workplace environment, experience of training and ongoing learning, and improving the experience of sexual minority service users accessing support.

One issue is the lack of diversity within the psychological workforce. One participant felt that '*Psychology as a whole is far too white, cis, hetero centric*' (P52, HIT) and another individual reflected that having a more diverse workforce who has the lived experience, training, or knowledge on LGBTQ+-specific issues '*would be a game changer to be able to offer more LGBTQ+ affirmative/targeted work*' (P47, PWP). This suggests that having a workforce that is reflective of the population could help improve quality of treatment and improve access as '*if we cannot create*

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an LGBTQ+ affirmative workspace how can we think about doing this in our therapy spaces' (P47, PWP).

Participants also highlighted that there is a need for courses and services to take a systemic approach to issues. Some reflected that there was an over-emphasis on an '*individualised approach*' (P80, HIT) and issues surrounding sexual orientation are not considered '[in wider] *terms*' (P1, PWP). Instead, services and courses should focus on encouraging the development of '*systemic thinking* [regarding] *promoting diversity/inclusion in* [Talking Therapies Services]' (P23, HIT). This could be helpful for both service users and clinicians alike. For instance, there would be '*less onus on individual change*' (P80, HIT) meanwhile allowing clinicians to develop an awareness of and acknowledge '*structural inequalities*' (P23, HIT) such as discrimination and microaggression that may impact the mental health of sexual minority service users.

Understanding local demographic needs of sexual minority service users and developing pathways within services felt important to participants. To help with understanding local demographic needs, some reflected that community engagement and outreach work is warranted. This '*would help clinicians to not only identify the barriers but also problem solve*' (P34, PWP). However, one participant reflected that there are discrepancies in recording demographic information: '*I now routinely ask a person their preferred pronouns . . . our Team Manager who said it's a good idea, but it's not a mandatory/standard part of our assessment and not all therapists do this*' (P43, PWP).

For others, developing pathways would mean services creating signposting resources for clinicians so that they are better aware of local support mechanisms ($n = 12$). One individual reflected that the lack of clear support pathways can leave clinicians to '*feel blind in supporting patients*' (P22, PWP). Additionally, there was also a feeling of uncertainty about the remit of Talking Therapies Services when it came to supporting sexual minority service users:

> '*Where the scope of practice lays to know we can no longer provide support and to refer elsewhere.*' (P22, PWP)

> '*When more specialist services may be useful and how to explore this with the patient.*' (P57, PWP)

This suggests that service users' ongoing needs may not be fully met if even clinicians are uncertain about whether Talking Therapies services can help or what local specialist support is available. Despite this, other participants reflected that there may also be a risk for clinicians to become over-reliant on signposting services which may ultimately contribute to the systemic issue of differential treatment of and access by sexual minority service users to Talking Therapies Services:

> '*. . . treatment can be offered to LGBTQ+ people, even if part of their presenting problem is related to their sexuality. Too often clients are being signposted away to LGBTQ+-specific counselling services as soon as they raise an issue with identity. This does not need to happen.*' (P52, HIT)

> '*. . . it is easy for practitioners to come across dismissive to patients by simply sending them info on other more specialised services.*' (P32, PWP)

Theoretical content. While some participants did receive teaching on the theoretical content mentioned below, the fact that others have not, indicates variation and a lack of consensus across courses as to a baseline requirement of what should be covered during training.

Participants reported a range of content that they feel would be helpful to be incorporated into the teaching curriculum. Thirty-seven participants mentioned psychosocial issues faced by the

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LGBTQ+ community, including specific risk factors such as '*chemsex*' (P50, trainee HIT) and the role of '*drug use*' (P36, PWP) but also more generally minority stress and its impact on mental health. A further 11 individuals reported wanting more in-depth and specific teaching on understanding the barriers to accessing and engaging with services. Two individuals mentioned understanding the nuances and differing needs within the sexual minority community rather than grouping them together. Five individuals mentioned gender diversity or training on understanding issues faced by the trans community. A further three individuals felt that it would be important to understand the historical context and the culture in which LGBTQ+ individuals grew up.

Practical content. Individuals also reported a range of 'practical' content that they would find helpful for courses and services to include. The majority of participants described wanting further training and teaching on both assessment and treatment adaptations for LGBTQ+ service users.

Regarding assessments, some individuals alluded to wanting specific guidance on both general assessment but also 'common factors' skills. For instance, it was reflected that having guidance for '*how to conduct assessments for LGBT people – what questions to ask . . .*' (P28, PWP), '*how to sensitively approach helpful, validating conversations with service-users around this topic*' (P3, trainee clinical psychologist) and '*. . . how to respond when clients speak about discrimination*' (P36, PWP) would be beneficial.

Several participants mentioned that it would be helpful to understand '*queer-affirmative or queer-sensitive*' (P47, PWP) practice, but most reported wanting guidance on exploring and addressing issues surrounding sexual orientation in the context of interventions '*as relevant within the CBT and/or IAPT framework*' (P32, PWP). This '*would help people feel more confident*' (P52, HIT) and '*improve outcomes and LGBQ+ users' experiences*' (P19, PWP). Some individuals reflected on the need to move away from a one-size-fits-all approach and to facilitate culturally adapted sessions with additional time as '*it would be helpful to have space to explore any discrimination people experience rather than be expected to rush sessions and just tell people that they should try behavioural activation*' (P45, PWP). However, it is also important to strike a balance so as to avoid making assumptions and immediately adapting treatment based on an individual's identity. One participant reflected that treatment adaptations should be made '*if this feels relevant and important to the service-user*' (P3, trainee clinical psychologist).

Moreover, individuals mentioned wanting teaching on the use of inclusive language and appropriate terminology. One individual reflected that they find themselves '*out of touch with the correct & most respectful terminology & fear unintentionally upsetting someone*' (P70, PWP lead). Reflecting on suggestions, participants mentioned that teaching might include learning to know '*what to say and not to say*' (P18, trainee HIT), '*really clear guidance on how to check pronouns and avoid misgendering . . .*' (P40, PWP), but also role-playing '*how to respond appropriately if you use the wrong pronouns*' (P69, PhD student).

Discussion

Overall, the aim of this study was to investigate clinicians' views of sexual minority training within NHS Talking Therapies services and training courses. We asked participants to complete a set of rating scales (adapted SOCCS; Bidell, 2005) that examined competency (skills and knowledge) when working with sexual minority service users. Following this, clinicians' views of training were explored through their written responses to four qualitative open questions. Below we summarise the key findings in relation to the literature and make recommendations for courses and Talking Therapies Services to improve delivery of sexual orientation training.

We found that those who are 25 to 29 years old perceived themselves to be more knowledgeable on issues surrounding sexual orientation compared with those who were 45+ years old. No studies have explored age-related differences in competencies as measured by the SOCCS. However, our finding

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converges with previous qualitative research where young clinicians were perceived by sexual minority service users to be more knowledgeable and skilled than those who were older (Bishop *et al.*, 2022). This may be due to younger clinicians growing up in a society where attitudes towards LGBTQ+ individuals are becoming more accepting. Despite this, firm conclusions regarding age-related differences cannot be drawn given that there were significantly fewer participants within the 45+-year-old age group. More importantly, the bigger picture is the need for clinicians over the age of 45+ years to overcome this stereotypical view through regular up-to-date training.

We also found that bisexual clinicians reported greater self-perceived knowledge than heterosexual clinicians on issues surrounding sexual orientation. No previous studies have found this specific result. However, one study found that therapists who identified as LGBTQ+ themselves reported greater self-perceived levels of knowledge as measured on the SOCCS compared with heterosexual therapists (Bidell and Casas, 2001). In their study, the researchers grouped all LGBTQ+ therapists together and did not report further between group analyses. As such, there was no comparison between individuals with different sexual orientations. One possible explanation is that bisexual individuals are 'in-between' the two social identity groups of heterosexual and sexual minority. They may have a greater degree of self-awareness and acceptance towards other people's gender or sexual identities (Rostosky *et al.*, 2010). This in turn may allow them to have a deeper understanding and appreciation of the issues that both sexual minority individuals and heterosexual individuals face. However, we also acknowledge the significant smaller sample of bisexual participants compared with heterosexual participants within the study which limits our confidence to draw such conclusions.

Another intriguing finding was the lack of difference between PWPs and HITs in self-reported levels of competence. This is important as one would expect HITs to feel more competent given the additional diversity training that they should have received on their course. However, another possible explanation could be that for some HITs, the diversity training they received on the course could be their first training. This is particularly the case if they came from a core profession background. Previous research also suggested that therapists with more education and training scored higher on the SOCCS (Bidell, 2005; Graham *et al.*, 2012). Despite this, our qualitative findings may explain this particular result as participants reported a lack of specific training on sexual orientation issues during their HIT courses compared with PWP training. This perhaps reflects the need for HIT courses to review their diversity teaching and ensure that there is progression from the low-intensity course, given that majority of trainees would have previously been a PWP.

We also found that clinicians with 3 years of experience had greater knowledge than those with 6+ years of experience. One possible reason was that those with 3 years of experience had finished training more recently than those with 6+ years of experience. Thus, they may retain more knowledge about working with sexual minority service users in comparison. There was also a greater likelihood of receiving sexual diversity training in more recent cohorts. Furthermore, this finding suggests that regardless of years of experience or stage of career, the onus is on clinicians to regularly update their clinical knowledge through training and research. Despite this, we must be careful with drawing firm conclusions given the small sample sizes in both groups.

Training received on sexual minority issues by NHS Talking Therapies clinicians: link to literature and recommendations

The training received by clinicians in NHS Talking Therapies Services varied significantly in length and depth. Of note was the finding that 30% of clinicians reported not receiving any teaching throughout their initial training year. This is not best practice, given that the HEE curriculum suggests that training courses should ensure clinicians are aware of and should be able to work with all aspects of protected characteristics including sexual orientation (HEE, 2022). No previous studies explored the amount of sexual orientation training mental health clinicians in the UK receive. However, similar findings were found in recent reviews of LGBTQ+ teaching amongst

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medical students whereby majority of participants reported receiving no specific training on issues surrounding sexual orientation (Arthur *et al*., 2021; Parameshwaran *et al*., 2017). LGBTQ+ individuals are more likely to experience microaggression such as insensitive or inappropriate questioning by healthcare staff which may lead to poorer treatment outcomes and serve as a barrier for future access to services (Stonewall, 2018). The lack of specific training on sexual orientation may contribute to this. Specific training on sexual orientation is associated with improved knowledge and awareness when working with sexual minority service users (Graham *et al*. 2012). For instance, a 3-year follow-up study found that a half-day training on LGBTQ+ healthcare delivered to nursing, medical and dentistry students led to increased self-reported confidence and competence when working with LGBTQ+ service users (Taylor *et al*., 2018). This suggests that a minimum requirement of at least half-day teaching on sexual orientation issues across the curriculum could be helpful.

Clinicians' views on gaps in training provision and ways to improve training: link to literature and recommendations

Participants reported receiving teaching on a varying range of content to various degrees, with a consensus of wanting further training on both theoretical knowledge and practical guidance in making treatment adaptations. Firstly, clinicians reflected that training tends to focus on LGB identities and felt that there is a need to diversify training to cover a broader range of sexualities. Similar results were found among a sample of counselling psychology students who reported not receiving training on identities such as pansexuality and asexuality (Abbott *et al*., 2023). Research has highlighted the ways in which labels for sexual identities have expanded over time (Hammack *et al*., 2022). Monosexual identities refer to attraction in a singular direction encompassing individuals identifying as lesbian, gay or heterosexual) and plurisexual identities represent attraction to multiple genders (including bisexuality, pansexuality and queer). There are also labels that attempts to capture individuals' varying degree of sexual attraction which falls within the spectrum of asexuality. These might include identities such as graysexuality (individuals who experiences limited sexual attraction) and demisexuality (individuals who experience sexual attraction upon emotional attraction) (Hille *et al*., 2020). For best practice, it would be important for courses to provide awareness training of the different sexual identities so that clinicians feel able to explore them with service users in their practice.

The majority of participants reported that they would find it helpful to receive training on psychosocial issues faced by sexual minority service users, particularly specific risk factors within the community and minority stress (Meyer, 2003). Specific risk factors that queer and sexual minority individuals may face include a range of issues such as sexual risk taking, substance use, body image dissatisfaction, and homelessness (e.g. Ecker *et al*., 2019; Knight *et al*., 2019; Morrison *et al*., 2020). These issues may further put LGBTQ+ individuals at higher risk of developing physical and sexual health problems, common mental health difficulties such as depression and anxiety but also severe enduring difficulties such as eating disorders and psychosis (Campbell, 2012; Mongelli *et al*., 2019; Parker and Harriger, 2020; Moreno-Gámez *et al*., 2022). Understanding such issues may improve clinicians' confidence in exploring them with service users during assessments. It may also relieve the burden of service users needing to provide us with all the education (Foy *et al*., 2019). However, there is a need to maintain balance whereby clinicians should remain curious, avoid assuming the position of possessing all the knowledge and centre service users as experts of their own experience (Jennings *et al*., 2005). This ensures collaborative working and importantly, re-distributes the power imbalance that exists within a therapeutic relationship (Harding *et al*., 2011).

Clinicians within our study reflected on the tendency for CBT to individualise problems, which may leave service users feeling disempowered or 'blamed' for their difficulties (Eamon, 2008;

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Van Den Bergh, 1995). However, incorporating minority stress into the process of formulation may be a segue to incorporate systemic thinking into treatment. Furthermore, skilful use of CBT with sexual minority service users has been argued to be empowering as it supports individuals to take charge and cope effectively in the context of oppression (Eamon, 2008; Hays, 2009; Saleebey, 1996). To illustrate this, clinicians may work with service users during formulation to start piecing together experiences of minority stress that may have contributed to their presenting difficulty. This helps with distinguishing problems that arise from the environment (i.e. society) and those that may stem from dysfunctional beliefs (Craig *et al.*, 2013). It presents an opportunity for clinicians to provide psychoeducation to acknowledge and support service users in understanding that their experience is a normal response to minority stress and explore their views on systemic oppression (Pachankis *et al.*, 2022b). This takes away the attribution of problem away from the individual to reflect it on the injustice that exists within the society. It may serve as an empowering and emotionally validating therapeutic conversation with service users (Pachankis *et al.*, 2022b).

Participants in our study reflected on wanting practical guidance in making treatment adaptations within the context of protocols in Talking Therapies Services. To support this, educators could consider incorporating into teaching the learning from a paper written by Pachankis and colleagues (2022b) that provides detailed suggestions, guidance and ways to adapt evidence-based interventions such as CBT to include minority stress. Despite this, one key practical consideration is the feasibility of incorporating adaptions within time-limited sessions in Talking Therapies Services. At the present time, clinicians from one London-based Talking Therapies Service developed and implemented a novel low-intensity CBT LGBQ+ wellbeing group drawing upon minority stress theory (Hambrook *et al.*, 2022). Further information regarding the content of the group intervention can be found in Hambrook and colleague's paper (2022). Sexual minority service users who attended the group therapy reported a reduction in symptoms of anxiety, depression, and decreased functional impairment. This provides preliminary evidence of the beneficial outcomes and feasibility of incorporating adaptations to treatment sessions within Talking Therapies Services. The authors are also aware that there are ongoing studies to further the evidence-base within Talking Therapies Services. Courses and services may find it beneficial to cover content such as minority stress theory, specific risk factors, and evidence-based adaptations that draw from the above-mentioned theories. This could support clinicians in making practical adaptations to their treatment when supporting sexual minority service users.

The most reported methods of training were didactic lectures and discussions. Similar findings were reported in a review of training curriculum on 'diversity' or LGBTQ+ specific issues provided to psychologists, healthcare students, and professionals in the US (Benuto *et al.*, 2019; Sekoni *et al.*, 2017). While didactic training is important to help clinicians in gaining knowledge about the needs of diverse and marginalised groups, there may be an under-focus on practical skill-based training (Benuto *et al.*, 2019). Our findings converge with this as clinicians reflected on the unhelpfulness of only receiving didactic teaching. They described that a way to improve training is by including a more diverse range of learning formats, such as experiential learning. Experiential learning such as role-plays may improve engagement with adult learners (Merriam and Bierema, 2013). It also facilitates a safe environment where clinicians may practise applying the skills that they have gained through teaching. For example, clinicians could use role-plays to practise phrasing, sensitive questioning, and responding to issues surrounding sexual orientation. This could be helpful as there appeared to be feelings of apprehension amongst clinicians within our study who wanted practical guidance in approaching conversations around sexual orientation. Indeed, clinicians who are apprehensive of asking about issues surrounding sexual orientation may be perceived as unhelpful by sexual minority service users, thus negatively impacting the therapeutic alliance (Semp and Read, 2015). Research has shown that role-plays help improve development of communication skills, reduce therapist anxiety, and increase therapist confidence

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in using their skills (Fominykh *et al.*, 2018). Experiential learning is incorporated into core teaching of CBT skills within Talking Therapies courses with beneficial outcomes (Turton, 2012). It may therefore be helpful for courses and services to extend this method of learning to diversity teaching.

Clinicians' experiences and perception of barriers in accessing sexual orientation training: link to literature and recommendations

Our findings revealed a range of service level barriers that prevented clinicians from developing their learning on issues surrounding sexual orientation and implementing their learning into clinical practice.

With the support of more experienced staff, supervision is an important clinical space that allows for self-reflection and development of clinical skills through integrating theory into practice (Bernard and Goodyear, 2004). The HEE curriculum states that through supervision and training, clinicians should develop an ability to reflect on differences in identity and its impact on therapy. Our finding seems to contradict this as clinicians reflected on the lack of knowledge and understanding of issues surrounding sexual orientation amongst supervisors and management. This raises the question of how clinicians are expected to develop their own knowledge, and clinical and reflective skills when their supervisor lacks them? More importantly, how are clinicians able to ensure that the care they provide is meeting the needs of sexual minority service users? An affirmative supervisor is one who has knowledge of issues surrounding sexual orientation, is able to acknowledge biases, and supports their supervisees in becoming aware of their own beliefs or biases that may impact their therapeutic work (Pett, 2000). In affirmative supervision, supervisees are supported to understand the role of sexual orientation in relation to assessment, formulation and treatment. Burkard and colleagues (2006) found that participants who received affirmative supervision reported increased self-efficacy when working with sexual minority service users. This in turn may improve treatment outcomes of sexual minority service users through clinicians' ability to better empathise with clients in addition to drawing on theory that supports affirmative practice (Ritter and Terndrup, 2002). This highlights the need for supervisors and educators to continue developing their own awareness, knowledge and skills when working with sexual minority service users (Rutter *et al.*, 2008). Service managers should review learning needs of supervisors on a regular basis and agree on an action plan to address gaps in knowledge, skills or awareness working with sexual minority service users.

Opportunities such as becoming an LGBTQ+ champion and service development work are important to support clinicians in the development of new skills. It also ensures that services are addressing the needs of sexual minority service users. However, our findings suggest that due to the lack of organisational support and recognition, these added responsibilities were at the cost of staff wellbeing. In line with previous research, this is one major contributing factor to the high prevalence of burn-out within the Talking Therapies workforce, a recent estimate of 68.6% of staff (Westwood *et al.*, 2017). Clinicians feeling burnt out may lead to negative job satisfaction and emotional exhaustion (Steel *et al.*, 2015). This understandably may cause staff to leave roles, leading to high staff turnover and low retention, both of which are ongoing challenges that services face around the country (Vivolo, 2022). To tackle these issues, services should allocate protected time to staff engaging in service development work and formally recognise staff efforts. These efforts should also be remunerated for those who take on leadership responsibilities within services; for example, several trusts in London trialled Band 6 positions for 'Community Engagement PWPs'.

Another noteworthy finding was the lack of diversity within the psychological workforce. This appears to be an accurate reflection given that a recent report found only 4% of staff and 3% of

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senior managers within the NHS identified as LGBTQ+ (NHS England, 2022). Despite this, another possible reason for lack of representation could be staff members not wanting to disclose their sexuality at work due to fear of being discriminated, bullied, and/or a lack of trust with managers (LGBTQ+ Inclusion, 2021). Without a diverse workforce, the needs of minorities would not be adequately met. This would exacerbate the existing health disparities found among individuals from minoritised backgrounds (Castillo and Guo, 2011). Additionally, staff identifying as LGBTQ+ may have greater knowledge and skills when working with sexual minority service users due to their own lived experience (Anderson and Holliday, 2006). Thus, representation within the workforce is crucial to deliver a service that meets the needs of sexual minority service users. With limited LGBTQ+ staff representation, there may also be a sense of pressure and expectation on the few minoritised staff members to take on diversity and inclusion-related responsibilities due to their identity. A quote from a participant powerfully captured the impact of such experience:

> '*Queer people in NHS services have to do extra work and deal with constant micro-aggressions to push for LGBTQ+ training and development for no extra pay. It's exhausting.*' (P47, PWP)

Meanwhile, diversity and inclusion are everyone's duty, and change requires those in leadership positions to take charge and be willing to model this to everyone within the organisation (Priest *et al.*, 2015). It is essential for services to create a safe and inclusive environment for both sexual minority service users and staff. At a minimum, some immediate practical steps that services can take include implementing visual affirmative signs such as rainbow flags, staff usage of pronouns, and LGBTQ+ representation on service materials (Mind, 2016). Reflective spaces could be facilitated whereby LGBTQ+ clinicians could share their experiences of the workplace and other challenges that might arise from them (Cocks *et al.*, 2019). Additionally, the NHS confederation and LGBTQ+ Leaders Network co-produced a Health and Care LGBTQ+ Inclusion Framework to support organisations in taking practical steps to creating an inclusive environment for staff and service users (LGBTQ+ Leaders Network, 2022). They proposed six pillars: visible leadership and confident staff, creating a strong LGBTQ+ knowledge base, be non-heteronormative and non-cisnormative, take responsibility for collecting and reporting data, listening to service users, and proactively seeking out partners to co-deliver services. Services could self-assess using this framework to identify areas of improvement. Staff and service users should both be involved throughout this process to ensure that action plans are meeting their needs.

Our findings also suggest that clinicians who are uncertain of service remit may lead to signposting sexual minority service users away to alternative support. This corroborates previous findings whereby sexual minority service users accessing Talking Therapies were discharged or referred away to LGBTQ+ services despite wanting further treatment (Foy *et al.*, 2019). This may lead to service users feeling reluctant in disclosing their sexuality in treatment for fear of clinicians over-attributing difficulties to their identity (Foy *et al.*, 2019; Morris *et al.*, 2022). Consequently, this may limit services' ability to capture essential monitoring data on sexual orientation that could be used to identify potential differences in treatment outcomes. To quantify this, of those referred to services in 2016/17, there was 37% missing data on sexual orientation (Baker, 2018). Without these data, this raises the question as to how we can begin to understand the needs of our service users if we are not even capturing the correct information on who is using and accessing services. This keeps services trapped in a vicious cycle. To overcome this, clinicians would need to understand that just because a service user identifies as a sexual minority does not mean that they require specialist LGBTQ+ support. NHS Talking Therapies services should be equipped to support sexual minority service users regardless of whether their presenting difficulties are in relation to their sexuality or not.

The only case where signposting should be considered is if service users' needs are not best met at primary care, if they are requesting for specialist LGBTQ+ support (such as peer support

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groups), support from LGBTQ+ staff members, and only if such requests cannot first be met within Talking Therapies services.

Strengths and limitations

A key strength of our study is its novelty. To the authors' knowledge, it is the first study in the UK to explore experiences of sexual orientation training amongst a sample of clinicians working within NHS Talking Therapies Services. The results that we have reported have scope to inform course providers and services to improve their training curriculum. This would ensure that clinicians feel competent when working with sexual minority service users and more importantly, to meet their needs to address the differences in treatment outcomes.

There were also several limitations. Firstly, the sample size of our study was small. Our study may be under-powered to detect further significant between-group differences in their competency working with sexual minority service users as measured by the SOCCS. Even if we found statistically significant differences, the small sample size limited our ability to confidently draw meaningful conclusions. Future research should aim to recruit a larger sample to further explore therapists' age-related differences and sexual orientation differences (e.g. comparing competency of gay or lesbian therapists and heterosexual therapists). Another issue was that the majority of our study's participants identified as White. We acknowledge that this was a key limitation, as research consistently highlights differential treatment and outcomes of racial-ethnic sexual minority service users accessing psychological therapies services. Having a more racial-ethnically diverse and representative sample of therapists may lead to important ideas and ways to improve training that addresses the intersectional needs of racial-ethnic sexual minority service users.

Due to the lack of appropriate rating scales to assess competencies of working with sexual minority service users in Talking Therapies Services, we adapted statements on the SOCCS. As a result, our adapted scale has not been empirically validated and may lack construct validity. Self-report measures are inherently subject to social desirability bias. Anonymised participation may have potentially reduced this as we did observe a ranging level of self-reported competencies. Furthermore, the statements that we adapted did not include a broad range of sexualities within the spectrum. For instance, on the knowledge subscale, statements either combined LGBQ+ together or there was only a focus on differences in issues faced by lesbian, gay and bisexual individuals. This perhaps reflects current teaching where there is greater emphasis on LGB (i.e. lesbian, gay and bisexual) identities. Future studies should adapt scales so that they are more inclusive by including other sexualities such as pansexuality and asexuality, which are identities that receive less focus and attention in training.

Conclusions

The study highlighted that sexual orientation training varied across universities and NHS Talking Therapies Services. We found differences in self-perceived knowledge when working with sexual minority service users by clinicians' age, sexual orientation, and years of clinical experience. This suggests the need for course providers and services to provide additional training on issues surrounding sexual orientation for clinicians. Our findings also indicated current gaps and possible ways to improve current training provision on issues surrounding sexual orientation. Addressing these gaps will ensure that courses and services are meeting the requirements of relevant regulatory boards, help clinicians to feel more confident when working with service users, and most importantly meet the needs of sexual minority service users within NHS Talking Therapies for Anxiety and Depression services.

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Recommendations

Course providers and NHS Talking Therapies Services should consider:

(a) Implementing minimum hours on sexual orientation training.
(b) Incorporating more in-depth teaching on theoretical content (such as increasing focus of teaching on a broader range of sexual identities, specific sexual minority risk factors, minority stress theory) and practical adaptations when working with sexual minority service users.
(c) The benefits of experiential exercises such as role-plays in training.
(d) Ways to genuinely involve sexual minority staff and service users to create an inclusive environment.

Service-level recommendations include:

(a) Regularly reviewing competencies and learning needs of supervisors working with sexual minority service users.
(b) Allocating protected time to staff engaging in service development work and adequately renumerating their efforts.
(c) Assessing their service against the Health and Care LGBTQ+ Inclusion Framework (LGBTQ+ Leaders Network, 2022).
(d) Providing clear guidance on the remit of NHS Talking Therapies in supporting sexual minority service users.
(e) Creating clear service pathways for sexual minority service users whose needs may not be best met by NHS Talking Therapies.

Key practice points

(1) To support clinicians in becoming aware of relevant research literature and evidence that they can use in their day-to-day practice.
(2) To support courses and services in identifying clinicians' gaps in knowledge and skills so that they can provide adequate sexual orientation training to meet the needs of service users.
(3) To encourage courses and services to address the barriers and challenges that clinicians experience in accessing or receiving sexual orientation training.

Further reading

Bidell, M. (2005). The Sexual Orientation Counselor Competency Scale: assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education and Supervision*, *44*, 267–279. https://doi.org/10.1002/j.1556-6978.2005.tb01755.x

Foy, A. A. J., Morris, D., Fernandes, V., & Rimes, K. A. (2019). LGBQ+ adults' experiences of Improving Access to Psychological Therapies and primary care counselling services: informing clinical practice and service delivery. *the Cognitive Behaviour Therapist*, *12*, e42. https://doi.org/10.1017/S1754470X19000291

Hatzenbuehler, M. L. (2009). How does sexual minority stigma 'get under the skin'? a psychological mediation framework. *Psychological Bulletin*, *135*, 707–730. https://doi.org/10.1037/a0016441

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

Morris, D. D. A., Fernandes, V., & Rimes, K. A. (2022). Sexual minority service user perspectives on mental health treatment barriers to care and service improvements. *International Review of Psychiatry*, *34*, 230–239. https://doi.org/10.1080/09540261.2022.2051445

Pachankis, J. E., Soulliard, Z. A., Morris, F., & Seager van Dyk, I. (2022). A model for adapting evidence-based interventions to be lgbq-affirmative: putting minority stress principles and case conceptualization into clinical research and practice. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2021.11.005

Stonewall (2018). LGBT in Britain: Health Report. Available at: https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf (accessed 12 April 2023).

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Data availability statement. The data that support the findings of this study are available upon request to the lead author.

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References

Abbott, D. M., Vargas, J. E., & Santiago, H. J. (2023). Sexuality training in counseling psychology: a mixed-methods study of student perspectives. *Journal of Counseling Psychology*, *70*, 52–66. https://doi.org/10.1037/cou0000641

Anderson, S. C., & Holliday, M. (2006). How heterosexism plagues practitioners in services for lesbians and their families: an exploratory study. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research*, *19*, 81–100. https://doi.org/10.1080/10538720802131782

Argyriou, A., Goldsmith, K. A., Tsokos, A., & Rimes, K. A. (2020). Psychosocial mediators of the relations between sexual orientation and depressive symptoms in a longitudinal sample of young people. *Psychology of Sexual Orientation and Gender Diversity*, *7*, 142–153. https://doi.org/10.1037/sgd0000369

Arthur, S., Jamieson, A., Cross, H., Nambiar, K., & Llewellyn, C. D. (2021). Medical students' awareness of health issues, attitudes, and confidence about caring for lesbian, gay, bisexual and transgender patients: a cross-sectional survey. *BMC Medical Education*, *21*, 56. https://doi.org/10.1186/s12909-020-02409-6

BABCP (2021). Core Curriculum. Available at: https://babcp.com/Portals/0/Files/About/Core%20Curriculum%20Jul%202022.pdf?ver=2022-07-14-084929-547 (accessed 12 April 2023).

Baker, C. (2018). *Are NHS mental health therapies working for everyone?* https://commonslibrary.parliament.uk/are-nhs-mental-health-therapies-working-for-everyone/

Benuto, L. T., Singer, J., Newlands, R. T., & Casas, J. B. (2019). Training culturally competent psychologists: where are we and where do we need to go? *Training and Education in Professional Psychology*, *13*, 56–63. https://doi.org/10.1037/tep0000214

Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of Clinical Supervision* (3rd edn), pp. xvi, 416. Allyn & Bacon.

Bidell, M. (2005). The Sexual Orientation Counselor Competency Scale: assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education and Supervision*, *44*. https://doi.org/10.1002/j.1556-6978.2005.tb01755.x

Bidell, M. P., & Casas, J. M. (2001). *Measuring Counselor Competence with Lesbian/Gay/Bisexual Clients: Implications for Multicultural Training*. https://eric.ed.gov/?id=ED458454

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

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency. Narrative literature review. *British Journal of Psychiatry: The Journal of Mental Science*, *186*, 11–17. https://doi.org/10.1192/bjp.186.1.11

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Burkard, A. W., Johnson, A. J., Madson, M. B., Pruitt, N. T., Contreras-Tadych, D. A., Kozlowski, J. M., Hess, S. A., & Knox, S. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. *Journal of Counseling Psychology*, *53*, 288–301. https://doi.org/10.1037/0022-0167.53.3.288

Campbell, S. (2012). Sexual health needs and the LGBT community. *Nursing Standard*, *27*, 35–38. https://doi.org/10.7748/ns2013.04.27.32.35.e7250

Castillo, R. J., & Guo, K. L. (2011). A framework for cultural competence in health care organizations. *The Health Care Manager*, *30*, 205–214. https://doi.org/10.1097/HCM.0b013e318225dfe6

Clark, B. A., Veale, J. F., Townsend, M., Frohard-Dourlent, H., & Saewyc, E. (2019). Non-binary youth: access to gender-affirming primary health care. In *Today's Transgender Youth*. Routledge.

Cocks, L., Jonas, K. & Laville, A. (2019). Exploring LGBT mental health and recommendations for clinical practice. *CBT Today*, *47*, 10–11.

Craig, S. L., Austin, A., & Alessi, E. (2013). Gay affirmative cognitive behavioral therapy for sexual minority youth: a clinical adaptation. *Clinical Social Work Journal*, *41*, 258–266. https://doi.org/10.1007/s10615-012-0427-9

Crissman, H. P., Stroumsa, D., Kobernik, E. K., & Berger, M. B. (2019). Gender and frequent mental distress: comparing transgender and non-transgender individuals' self-rated mental health. *Journal of Women's Health*, *28*, 143–151. https://doi.org/10.1089/jwh.2018.7411

Cyrus, K. (2017). Multiple minorities as multiply marginalized: applying the minority stress theory to LGBTQ people of color. *Journal of Gay & Lesbian Mental Health*, *21*, 194–202. https://doi.org/10.1080/19359705.2017.1320739

Eamon, M. K. (2008). *Empowering Vulnerable Populations: Cognitive-Behavioral Interventions* (pp. xix, 388). Lyceum Books.

Ecker, J., Aubry, T., & Sylvestre, J. (2019). A review of the literature on LGBTQ adults who experience homelessness. *Journal of Homosexuality*, *66*, 297–323. https://doi.org/10.1080/00918369.2017.1413277

Ellis, S. J., Bailey, L., & McNeil, J. (2015). Trans people's experiences of mental health and gender identity services: a UK study. *Journal of Gay & Lesbian Mental Health*, *19*, 4–20. https://doi.org/10.1080/19359705.2014.960990

Erickson-Schroth, L., Wu, S. X., & Glaeser, E. (2020). Sexual and gender-based violence in lesbian, gay, bisexual, transgender, and queer communities. In V. Ades (ed), *Sexual and Gender-Based Violence: A Complete Clinical Guide* (pp. 113–126). Springer International Publishing. https://doi.org/10.1007/978-3-030-38345-9_6

Fagerland, M. W. (2012). t-tests, non-parametric tests, and large studies – a paradox of statistical practice? *BMC Medical Research Methodology*, *12*, 78. https://doi.org/10.1186/1471-2288-12-78

Fitzpatrick, S., Dworkin, E. R., Zimmerman, L., Javorka, M., & Kaysen, D. (2020). Stressors and drinking in sexual minority women: the mediating role of emotion dysregulation. *Psychology of Sexual Orientation and Gender Diversity*, *7*, 46–54. https://doi.org/10.1037/sgd0000351

Fominykh, M., Leong, P., & Cartwright, B. (2018). Role-playing and experiential learning in a professional counseling distance course. *Journal of Interactive Learning Research*, *29*, 169–190.

Foy, A. A. J., Morris, D., Fernandes, V., & Rimes, K. A. (2019). LGBQ+ adults' experiences of Improving Access to Psychological Therapies and primary care counselling services: informing clinical practice and service delivery. *the Cognitive Behaviour Therapist*, *12*, e42. https://doi.org/10.1017/S1754470X19000291

Ghabrial, M. A. (2017). 'Trying to figure out where we belong': narratives of racialized sexual minorities on community, identity, discrimination, and health. *Sexuality Research and Social Policy*, *14*, 42–55. https://doi.org/10.1007/s13178-016-0229-x

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

Hambrook, D. G., Aries, D., Benjamin, L., & Rimes, K. A. (2022). Group intervention for sexual minority adults with common mental health problems: preliminary evaluation. *Behavioural and Cognitive Psychotherapy*, *50*, 575–589. https://doi.org/10.1017/S1352465822000297

Hammack, P. L., Hughes, S. D., Atwood, J. M., Cohen, E. M., & Clark, R. C. (2022). Gender and sexual identity in adolescence: a mixed-methods study of labeling in diverse community settings. *Journal of Adolescent Research*, *37*, 167–220. https://doi.org/10.1177/07435584211000315

Harding, E., Pettinari, C. J., Brown, D., Hayward, M., & Taylor, C. (2011). Service user involvement in clinical guideline development and implementation: learning from mental health service users in the UK. *International Review of Psychiatry*, *23*, 352–357. https://doi.org/10.3109/09540261.2011.606802

Hatzenbuehler, M. L. (2009). How does sexual minority stigma 'get under the skin'? a psychological mediation framework. *Psychological Bulletin*, *135*, 707–730. https://doi.org/10.1037/a0016441

Hays, P. (2009). Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: ten steps for culturally competent practice. *Professional Psychology: Research and Practice*, *40*, 354–360. https://doi.org/10.1037/a0016250

HEE (2022). National Curriculum for Psychological Wellbeing Practitioner (PWP) Programmes. Available at: https://www.hee.nhs.uk/sites/default/files/documents/PWP%20Curriculum%204th%20Edition%202022%20.pdf (accessed 12 April 2023).

Heng, A., Heal, C., Banks, J., & Preston, R. (2018). Transgender peoples' experiences and perspectives about general healthcare: a systematic review. *International Journal of Transgenderism*, *19*, 359–378. https://doi.org/10.1080/15532739.2018.1502711

Hille, J. J., Simmons, M. K., & Sanders, S. A. (2020). 'Sex' and the ace spectrum: definitions of sex, behavioral histories, and future interest for individuals who identify as asexual, graysexual, or demisexual. *Journal of Sex Research*, *57*, 813–823. https://doi.org/10.1080/00224499.2019.1689378

Hu, H., Mo, P. K. H., Ip, M., & Wang, Z. (2022). How is self-stigma associated with generalized anxiety disorder symptoms in men who have sex with men? Roles of perceived stress and negative affect in a longitudinal study. *Sexuality Research and Social Policy*, *19*, 1624–1635. https://doi.org/10.1007/s13178-022-00713-y

Hudson-Sharp, N., & Metcalf, H. (2016). *Inequality Among Lesbian, Gay, Bisexual and Transgender Groups in the UK: A Review of Evidence*. NIESR. Available at: https://www.niesr.ac.uk/publications/inequality-among-lesbian-gay-bisexual-and-transgender-groups-uk-review-evidence (accessed 12 April 2023).

Jennings, L., Sovereign, A., Bottorff, N., Mussell, M. P., & Vye, C. (2005). Nine ethical values of master therapists. *Journal of Mental Health Counseling*, *27*, 32–47. https://doi.org/10.17744/mehc.27.1.lmm8vmdujgev2qhp

Kirk, I. (2022). *LGBT+ Britons more likely to report suffering with mental health conditions*. YouGov. https://yougov.co.uk/topics/society/articles-reports/2022/07/04/lgbt-britons-more-likely-report-suffering-mental-h

Knight, R., Karamouzian, M., Carson, A., Edward, J., Carrieri, P., Shoveller, J., Fairbairn, N., Wood, E., & Fast, D. (2019). Interventions to address substance use and sexual risk among gay, bisexual and other men who have sex with men who use methamphetamine: a systematic review. *Drug and Alcohol Dependence*, *194*, 410–429. https://doi.org/10.1016/j.drugalcdep.2018.09.023

Lattanner, M. R., Pachankis, J. E., & Hatzenbuehler, M. L. (2022). Mechanisms linking distal minority stress and depressive symptoms in a longitudinal, population-based study of gay and bisexual men: a test and extension of the psychological mediation framework. *Journal of Consulting and Clinical Psychology*, *90*, 638–646. https://doi.org/10.1037/ccp0000749

Laville, A. (2022). LGBT+ History Month: the importance of awareness and understanding for LGBT+ considerations within clinical practice. *CBT Today*, *50*, 14–15.

LGBTQ+ Leaders Network (2022). Health and Care LGBTQ+ Inclusion Framework. Available at: https://www.nhsconfed.org/system/files/2022-10/Health-and-Care-LGBTQ%2B-Inclusion-Framework.pdf (accessed 12 April 2023).

LGBTQ Inclusion (2021). LGBTQ+ Staff Survey. Available at: https://se.leadershipacademy.nhs.uk/wp-content/uploads/sites/5/2021/12/SouthEast-LGBTQ-staff-survey.pdf (accessed 12 April 2023).

Mahon, C. P., Lombard-Vance, R., Kiernan, G., Pachankis, J. E., & Gallagher, P. (2022). Social anxiety among sexual minority individuals: a systematic review. *Psychology & Sexuality*, *13*(4), 818–862. https://doi.org/10.1080/19419899.2021.1936140

Merriam, S. B., & Bierema, L. L. (2013). *Adult Learning: Linking Theory and Practice*. John Wiley & Sons.

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

Mind (2016). Lesbian, gay, bisexual, trans and queer good practice guide. Available at: https://mindout.org.uk/wp-content/uploads/2016/11/Mind-LGBTQguide-2016-webres.pdf (accessed 12 April 2023).

Moagi, M. M., Wath, A. E. van D., Jiyane, P. M., & Rikhotso, R. S. (2021). Mental health challenges of lesbian, gay, bisexual and transgender people: an integrated literature review. *Health SA Gesondheid*, *26*, article 1. https://www.ajol.info/index.php/hsa/article/view/215927

Mongelli, F., Perrone, D., Balducci, J., Sacchetti, A., Ferrari, S., Mattei, G., & Galeazzi, G. M. (2019). Minority stress and mental health among LGBT populations: an update on the evidence. *Minerva Psichiatrica*, *60*, 27–50. https://doi.org/10.23736/S0391-1772.18.01995-7

Moreno-Gámez, L., Hernández-Huerta, D., & Lahera, G. (2022). Chemsex and psychosis: a systematic review. *Behavioral Sciences*, *12*, 516. https://doi.org/10.3390/bs12120516

Morris, D. D. A., Fernandes, V., & Rimes, K. A. (2022). Sexual minority service user perspectives on mental health treatment barriers to care and service improvements. *International Review of Psychiatry*, *34*, 230–239. https://doi.org/10.1080/09540261.2022.2051445

Morrison, T. G., Katz, J. W., Mirzaei, Y., & Zare, S. (2020). Body image and eating disorders among sexual and gender minority populations. In E. D. Rothblum (ed.), *The Oxford Handbook of Sexual and Gender Minority Mental Health* (pp. 73–85). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780190067991.013.8

NHS Digital (2022). Psychological Therapies, Annual Report on the use of IAPT services, 2021–22. NDRS. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22 (accessed 5 February 2023).

NHS England (2022). Trust Development Authority 2021/22 Annual Report. Available at: https://www.england.nhs.uk/wp-content/uploads/2023/01/nhs-trust-development-authority-ara-21-22.pdf (accessed 12 April 2023).

Pachankis, J. E., Harkness, A., Maciejewski, K. R., Behari, K., Clark, K. A., McConocha, E., Winston, R., Adeyinka, O., Reynolds, J., Bränström, R., Esserman, D. A., Hatzenbuehler, M. L., & Safren, S. A. (2022a). LGBQ-affirmative cognitive-behavioral therapy for young gay and bisexual men's mental and sexual health: a three-arm randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *90*, 459–477. https://doi.org/10.1037/ccp0000724

Pachankis, J. E., Soulliard, Z. A., Morris, F., & Seager van Dyk, I. (2022b). A model for adapting evidence-based interventions to be lgbq-affirmative: putting minority stress principles and case conceptualization into clinical research and practice. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2021.11.005

Parameshwaran, V., Cockbain, B. C., Hillyard, M., & Price, J. R. (2017). Is the lack of specific lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) health care education in medical school a cause for concern? evidence from a

survey of knowledge and practice among UK medical students. *Journal of Homosexuality*, *64*, 367–381. https://doi.org/10.1080/00918369.2016.1190218

Parker, L. L., & Harriger, J. A. (2020). Eating disorders and disordered eating behaviors in the LGBT population: a review of the literature. *Journal of Eating Disorders*, *8*, 51. https://doi.org/10.1186/s40337-020-00327-y

Pennasilico, A. (2019). *The Invisi_les: Biphobia, Bisexual Erasure and Their Impact on Mental Health*, 22–28. https://doi.org/10.19245/25.05.pij.4.1.4

Pett, J. (2000). Gay, lesbian and bisexual therapy and its supervision. In D. Dominic and C. Neal (eds), *Therapeutic perspective on working with lesbian, gay and bisexual clients* (pp. 54–72). Buckingham, England: Open University Press.

Plöderl, M., & Tremblay, P. (2015). Mental health of sexual minorities. A systematic review. *International Review of Psychiatry*, *27*, 367–385. https://doi.org/10.3109/09540261.2015.1083949

Priest, N., Esmail, A., Kline, R., Rao, M., Coghill, Y., & Williams, D. R. (2015). Promoting equality for ethnic minority NHS staff – what works? *BMJ*, *351*, h3297. https://doi.org/10.1136/bmj.h3297

Ritter, K., & Terndrup, A. I. (2002). *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men*. Guilford Press.

Rogers, A. H., Seager, I., Haines, N., Hahn, H., Aldao, A., & Ahn, W.-Y. (2017). The indirect effect of emotion regulation on minority stress and problematic substance use in lesbian, gay, and bisexual individuals. *Frontiers in Psychology*, *8*, 1881. https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01881

Ross, K. A., & Castle Bell, G. (2017). A culture-centered approach to improving healthy trans-patient-practitioner communication: recommendations for practitioners communicating withtrans individuals. *Health Communication*, *32*, 730–740. https://doi.org/10.1080/10410236.2016.1172286

Rostosky, S., Riggle, E. D. B., Pascale-Hague, D., & McCants, L. E. (2010). The positive aspects of a bisexual self-identification. *Psychology & Sexuality*, *1*, 131–144. https://doi.org/10.1080/19419899.2010.484595

Rutter, P. A., Estrada, D., Ferguson, L. K., & Diggs, G. A. (2008). Sexual orientation and counselor competency: the impact of training on enhancing awareness, knowledge and skills. *Journal of LGBT Issues in Counseling*, *2*, 109–125. https://doi.org/10.1080/15538600802125472

Saleebey, D. (1996). The strengths perspective in social work practice: extensions and cautions. *Social Work*, *41*, 296–305.

Sekoni, A. O., Gale, N. K., Manga-Atangana, B., Bhadhuri, A., & Jolly, K. (2017). The effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals: a mixed-method systematic review. *Journal of the International AIDS Society*, *20*, 21624. https://doi.org/10.7448/IAS.20.1.21624

Semlyen, J., King, M., Varney, J., & Hagger-Johnson, G. (2016). Sexual orientation and symptoms of common mental disorder or low wellbeing: Combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry*, *16*, 67. https://doi.org/10.1186/s12888-016-0767-z

Semp, D., & Read, J. (2015). Queer conversations: improving access to, and quality of, mental health services for same-sex-attracted clients. *Psychology & Sexuality*, *6*, 217–228. https://doi.org/10.1080/19419899.2014.890122

Steel, C., Macdonald, J., Schröder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical: burnout in therapists working within Improving Access to Psychological Therapy Services. *Journal of Mental Health*, *24*, 33–37. https://doi.org/10.3109/09638237.2014.971145

Stonewall (2018). LGBT in Britain: Health Report. Available at: https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf (accessed 12 April 2023).

Taylor, A. K., Condry, H., & Cahill, D. (2018). Implementation of teaching on LGBT health care. *The Clinical Teacher*, *15*, 141–144. https://doi.org/10.1111/tct.12647

Turton, W. (2012). Honing cognitive behaviour therapy skills through experiential learning. *Mental Health Practice*, *15*, 33–35.

Van Dan Bergh, N. (1995). *Feminist Practice in the 21st Century*. NASW Press.

Vivolo, M. (2022). *The Process of Building Resilience in the IAPT Psychological Wellbeing Practitioner Role: A Qualitative Grounded Theory study* [Doctoral thesis, University of East Anglia]. https://ueaeprints.uea.ac.uk/id/eprint/89837/

Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. *Journal of Mental Health*, *26*, 172–179. https://doi.org/10.1080/09638237.2016.1276540

Wright, T., Nicholls, E. J., Rodger, A. J., Burns, F. M., Weatherburn, P., Pebody, R., McCabe, L., Wolton, A., Gafos, M., & Witzel, T. C. (2021). Accessing and utilising gender-affirming healthcare in England and Wales: trans and non-binary people's accounts of navigating gender identity clinics. *BMC Health Services Research*, *21*, 609. https://doi.org/10.1186/s12913-021-06661-4

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