2018

Experiences of Counselors Who Work With Sexual Minorities With a Serious Mental

Anthony Zazzarino
Walden University

Walden University

College of Counselor Education & Supervision

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Anthony Zazzarino

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Review Committee
Dr. Corinne Bridges, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. Geneva Gray, Committee Member, Counselor Education and Supervision Faculty
Dr. Jason Patton, University Reviewer, Counselor Education and Supervision Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
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Abstract

Experiences of Counselors Who Work With Sexual Minorities With a Serious Mental Illness

by

Anthony Zazzarino

MA, Monmouth University, 2007

BA, Wesley College, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Sexual minorities (SM) are at a greater risk for experiencing a serious mental illness (SMI) compared to their heterosexual counterparts. Furthermore, SM with a SMI continue to experience stigma and discrimination that leads to more negative outcomes and a greater need for counseling services. Current researchers have not adequately addressed the specific needs of SM with a SMI and how to prepare counselors to work with this population. Furthermore, most SM with a SMI find that counseling services are inadequate and do not meet their unique needs. The purpose of this transcendental phenomenological study, grounded in a Husserlian philosophical and Minority Stress Model conceptual framework, was to explore the experiences and perceptions of counselors who provide counseling services to SM with a SMI. Data was collected from six participants using a semistructured interview and followed a thematic data analysis process, ensuring thematic saturation. The results of this study highlighted many themes regarding the unique needs of SM with a SMI, such as their multiple minority stressors, negative counseling experiences, and the impact of family, as well as counselor's perception regarding the lack of preparation in graduate school to work with SM with a SMI. Study findings may improve counselors' understanding of the needs of SM with a SMI so they may provide more effective counseling services. Also, this study highlights the importance of training counselors to work with this population and may bolster the efforts of counselor educators.

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Dedication

This dissertation is dedicated to individuals who identify as a sexual minority and who have struggled over the years experiencing stigma, prejudice, and discrimination. Though the road may not have been easy, we will continue to persevere and overcome every obstacle because we are strong.

Acknowledgments

I cannot finish this process without acknowledging all of the people who supported me along the way. This was definitely not a one-person journey, and I am thankful for every ounce of support and guidance I received. First of all, I absolutely need to acknowledge my dissertation committee. Dr. Bridges has been an amazing support and mentor throughout my entire doctoral program. I am so privileged to have the opportunity to learn from her, work with her as her teaching assistant, and grow because of her. Throughout the dissertation process, Dr. Bridges has kept me grounded and focused, while helping me build my confidence. Dr. Grey has provided such valuable feedback on my content and helped me shape the focus of my literature review. Dr. Patton not only assisted me as my URR, but also helped me mold my dissertation in my Preparing for Dissertation course, emphasizing the importance of scholarly writing. Last, Dr. Haley, though not a part of my dissertation committee, has truly supported my scholarly writing, including accurate referencing, and emphasized the importance of self-care.

Second, I need to acknowledge my Walden friends that I have made along the way. Your texting, phone calls, video chats, and motivational venting sessions have been monumental in helping me achieve this goal. I know I could not have done this without each of you building me up and being a great support throughout all the ups and downs. I need to specifically acknowledge Deena Shelton, whose drive and focus from the very beginning of the program has helped me continue to be motivated. Deena has always been there to answer every question and has helped me continue to look ahead and plan

for success. Third, I need to acknowledge my family, who have had to deal with my sometimes crankiness and distance throughout this process. Even though you were not fully aware of what this process is like, you were all supportive and encouraging. Thank you to my Mom; my brother, Joe; my sister, Lori; and my nieces, Emma and Gianna.

Next, I need to give a special thank you to my friends who have dealt with my absence over the past few years. I know whenever I needed to take a self-care moment, you were there and were constantly encouraging and rooting for me from the sidelines. A special thank you to Kevin and Phyllis, who always took the time to check in and told me how proud they were of me. Last, I need to acknowledge my Rutgers University family, specifically Zakia and Ann, for all your guidance, encouragement, and support throughout this process. To anyone I may have forgotten, I greatly apologize, but know that I could not have done this without each of you.

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Chapter 1: Introduction to the Study

Sexual minorities (SM) are almost two times more likely to experience mental health issues that lead to an increase in depression, bipolar disorder, and other serious mental health diagnoses than their sexual majority counterparts (Bariola, Lyons, & Lucke, 2017). Additionally, SM with a serious mental illness (SMI) have higher levels of comorbid psychiatric disorders, which makes treatment and counseling more difficult (Mizock, Harrison, & Russinova, 2014). Sexual minorities with a SMI experience a double stigma based on their sexual orientation and mental health diagnosis, and many report that counseling services are often stigmatizing, inadequate, and discriminatory (Mizock et al., 2014). Furthermore, the factors of discrimination and internalized homonegativity make recovery more challenging for SM with a SMI (Bariola et al., 2017; Mizock et al., 2014). Thus, several intertwined factors complicate the treatment and recovery of SM with a SMI.

There is a greater necessity to understand the needs of SM with a SMI. Researchers have not fully explored these needs in depth, some scholars have noted (Kidd, Howison, Pilling, Ross, & McKenzie, 2016; Seeman, 2015). With additional research, counselors and counselor educators can begin to provide services that are more effective to SM with a SMI. Researchers and counselor educators need to continue their exploration of ways to educate culturally competent counselors so that counselors can fully address SM with a SMI, according to Bidell (2014). As part of their practice guidelines, counselors must adhere to the American Counseling Association (ACA, 2014)

Code of Ethics that encourages counselors to seek additional training to provide ethical service and practice within their boundaries of competence. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC; 2012) has highlighted specific competencies for counselors regarding SM. Yet, even though counselors also receive training in both the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5) and multiculturalism, there continues to be a lack of direct training that focuses on the specific needs of SM with a SMI (Kidd et al., 2016). Graham, Carney, and Kluck (2012) argued that counselor education programs must make the shift from providing education and awareness of the population to teaching skill development to increase counselor competence in working with SM with a SMI.

In this chapter, I will provide specific background information that illustrates the importance of exploring the experiences of counselors working with SM with a SMI. In addition, I will present the problem statement, purpose statement, research question, theoretical framework, and method for the study. Furthermore, I will provide definitions for key terms, highlight assumptions of the study, and discuss the delimitations and limitations of the study. Last, I will illuminate the significance of my study to the counseling field. The chapter ends with a summary of key points.

Background

Mizock et al. (2014) conducted a qualitative, narrative study of lesbian, gay, and transgender (LGT) individuals with a mental illness. Mizock et al. (2014) discussed how LGT individuals with mental illness struggle with the double stigma related to being both

a sexual minority and having a mental illness, both affecting the process of acceptance. The stigma that LGT individuals experience may be one factor leading to the discrimination within mental health settings. According to Mizock et al. (2014), LGT individuals with mental illness may feel unwelcome in mental health settings, have a reduction of openness and feelings of safety.

Mizock et al. (2014) explored 32 individuals with a serious mental illness, with a semistructured interview. Following the 32 interviews, the researchers read each transcription and completed a thematic analysis through a line-by-line coding process (Mizock et at., 2014). The researchers identified three specific case narratives of the 32 interviews to highlight the results related to LGT and mental illness stigma, as well as acceptance of mental illness (Mizock et al., 2014). Ultimately, Mizock et al. (2014) supported previous studies that LGBT individuals with a mental health diagnosis experience discrimination and unique obstacles that may be decreased by specialized services. The researchers identified several themes that included identity factors at the micro level, relational factors at the meso level, and systemic factors at the macro level (Mizock et al., 2014). Lastly, Mizock et al. (2014) encouraged a need for more extensive training for counselors working with LGT individuals with a serious mental illness, which is the research gap that my dissertation plans to fill.

Kidd et al. (2016) conducted a literature review to understand the factors and strategies that clinicians need to consider when developing services for individuals from sexual or gender minority groups who are experiencing severe mental illness. Kidd et al.

(2016) emphasized the importance of understanding how serious mental illness affects lesbian, gay, bisexual, and transgender (LGBT) populations due to the increase in stigmatization. More importantly, clinicians need a better understanding of the types of services that LGBT individuals with a diagnosis of a serious mental illness require.

Kidd et al. (2016) identified 27 publications that met their criteria: two published between 1990 and 1999, ten published between 2000 and 2009, and 15 published between 2010 and 2014. Of the limited research, it continues to demonstrate lower levels of service satisfaction among LGBT individuals and minimal evidence regarding specific interventions. Additionally, Kidd et al. (2016) highlighted the increased risk and discrimination, and the benefit of creating spaces where individuals can feel safe. Lastly, Kidd et al. (2016) illuminated the fact that counselors still need the training to provide specialized interventions; however, there remains a minimal training competency for service providers.

Seeman (2015) conducted a literature review specifically related to sexual minority women in treatment for serious mental illness. According to Seeman (2015), the treatment of the seriously mentally ill does not focus on an individual's unique needs, which is alarming since psychotic symptoms are present two and a half times more often in LGBT individuals. Seeman (2015) reviewed the literature from 2000-2014, looking at both quantitative and qualitative studies using search terms of "lesbian," "homosexual," "bisexual," "transgender," "sexual minority," in combination with "mental health," "psychosis," and "serious mental illness." After narrowing down the literature to 75 key

articles, Seeman (2015) was able to identify key issues in the literature related to effect on therapeutic relationships, effect on psychotherapy, involvement of family, medications, depression and self-harm, substance use, partner issues, sexual and reproductive issues, sexually transmitted disease, social support, and legal issues.

Overall, Seeman (2015) confirmed that LGBT individuals report being less satisfied than do heterosexual patients because their treatment does not meet their specific needs. Though the literature indicates counselors need to accept diversity, sexual orientation may not need to be the focus of the session (Seeman, 2015). Ultimately, to understand the stresses of the LGBT in treatment for serious mental illness, counselors need a better understanding of the minority stress from a negative self-image, isolation, intimacy, substance abuse, and medication side effects. Furthermore, future studies need to focus on training of counselors and specific interventions that target the minority stresses.

Stanley and Duong (2015) conducted a quantitative study that examined associations between sexual orientation and mental health service use among older lesbian, gay, and bisexual (LGB) adults. Since the number of older adults identifying as LGB will rapidly increase over the next few decades and older adults historically underutilize mental health service, Stanley and Duong (2015) attempted to understand the complexities of mental health service use in older LGB adults. The researchers analyzed data from a 2011 New York City Community Health Survey from 5,138 adults ages 50 and over (Stanley & Duong, 2015). Using logistic regression, Stanley and Duong (2015)

identified that among LGB older adults, 23.9% reported receiving counseling and 23.4% reported taking psychiatric medication in the past year; the percentages are significantly different than those of heterosexuals (x^2=20.06, df=1, p<.001; x^2=11.87, df=1, p=.001). Additionally, Stanley and Duong (2015) examined the factors of psychological distress, excessive alcohol use, and self-perceived poor gender medical health and found that neither factor mediated the association between sexual orientation and mental health service use. Therefore, the researchers posited that there will be an increase in older LGB adults over the next few decades, which will result in an increase in mental health service use. Therefore, researchers need to conduct more extensive research to ensure the current system could meet the needs of this population. Ultimately, counselors need to understand the specific needs of the population now to decrease the potential impact in the future (Stanley and Duong, 2015).

Holley, Tavassoli, and Stromwall (2016) conducted a qualitative, phenomenological study to explore perceptions of discrimination for lesbian, gay, and bisexual (LGB) adults and people of color when receiving treatment in a mental health program. LGB individuals report less satisfaction with mental health services, potentially due to the perceived discrimination that individuals often associate with negative physical and mental health outcomes. Perceived discrimination is often associated with negative physical and mental health outcomes and may be a contributing factor in the reports by LGB (Holley et al., 2016). Researchers interviewed 13 adults with a mental illness that experience stress related to the minority stress due to race or sexual orientation and seven

family members by asking three questions: (a) if they have ever experienced or seen mental health-related prejudice or discrimination in the behavioral health system (b) ways in which the system had supported their or their family members' recovery, and (c) knowledge of anti-stigma or anti-discrimination efforts of the behavioral health system (Holley et al., 2016). Of the 20 interviews, 18 were face-to-face and two by telephone. Of the 18 face-to-face interviews, 13 were at a university office, two at the participants' work place, two at the participants' homes, and one at a social service agency (Holley et al., 2016).

Holley et al. (2016) transcribed and coded each interview with first-level codes and then second-level codes. Through the second level-codes, the researchers highlighted themes and discussed any discrepancies to come to an agreement. Following the analysis of the data, five themes emerged: (a) ignoring/not listening, (b) not viewed as complex individuals, (c) condescension/lack of respect, (d) violations of privacy or other rights, and (e) presumed lack of intelligence. Moreover, the research suggests that staff need additional training to educate about discriminatory behaviors as a way to increase satisfaction with treatment services (Holley et al., 2016).

Barber (2009) is an earlier work that influences research on counselors working with LGB individuals with a serious mental illness. Barber (2009) used four case vignettes of individuals from varying ages, races, ethnicities, and sexual orientation to focus the reader on key issues for counselors working with LGB individuals with a SMI. Barber (2009) posited that there is a need for counselors to confront their potential bias

and that counselors need to make an effort to expand access to services that are safe and welcoming to LGBT individuals. Furthermore, Barber (2009) asserted that counselors must differentiate one's sexuality from the psychiatric illness. Though brief, Barber (2009) provided a strong case for further empirical data exploring the training of counselors and individual needs of LGB individuals with a serious mental illness, which researchers have yet to cover in depth.

Lucksted (2004) is an earlier work that explores providing services to LGBT individuals in the community. Lucksted (2004) conducted a qualitative, phenomenological study to address the dearth of literature related to LGBT people with a serious mental illness. Providing a historical component, Lucksted (2004) addressed the call for literature from as early as 1983. Lucksted (2004) highlighted the difficulty of researching LGBT people with a SMI due to the resistance from this population to participate and the multiple stigmas. Nevertheless, using a key informant method, Lucksted (2004) interviewed 35 individuals about their experiences as LGBT-identified users of various mental health services by asking the question, “What are the most important issues for LGBT people receiving services for serious mental illnesses, in the public system?” Following the interviews, Lucksted (2004) analyzed the data through conventional qualitative methods of data reduction, emergent coding, and iterative integration.

Lucksted (2004) highlighted major themes from the interviews: (a) little to no recognition of LGBT issues in most public/community mental health settings; (b) mental

health program and facilities often seem to view any sexuality in a client's life as disturbed or disturbing; (c) perceived high level of anti-LGBT stereotypes and ignorance among staff and programs in community mental health systems; (d) perceived experiences that mental health workers give the impression they do not understand, do not like, and do not want to deal with LGBT people; (e) LGBT people with a serious mental illness may not be able to rely on family members for support and need the support from the mental health system more; (f) continuing to pathologize LGBT individuals; and (g) a need for LGBT-affirmative services. Lucksted (2004) identified a clear need for further research, specifically related to the counselors that provide the services.

Mohr and Sarno (2015) conducted a quantitative, cross-sectional study that examined identity-salient experiences, proximal minority stressors, and affect within and between 61 LGB adults. Though most research has focused on ways minority stressors may account for some of the differences in the well-being of LGB people, Mohr and Sarno (2015) attempted to test a model of minority stress and support processes with a daily diary. Of the 61 participants, 22 were lesbian women, 15 bisexual women, 23 gay men, and one bisexual man. Furthermore, the participants were racially and ethnically diverse (Mohr & Sarno, 2015). For the three measures, Mohr and Sarno (2015) asked participants about the occurrence of positive events in the past 24 hours related to being an LGB individual or to sexual orientation issues. For proximal minority stress variables, the researchers utilized the Collective Self-Esteem Scale for internalized stigma and

expectations of rejection. Additionally, to measure affect, Mohr and Sarno (2015) used the Positive and Negative Affect Scale and provided a rating between one and five. Lastly, the researchers controlled for an additional variable to ensure the validity of the study.

Mohr and Sarno (2015) found that the strongest correlations are between positive internal self-esteem of LGB and positive affect (*B=.26, p<.001),* internalized stigma and positive affect (*B=-0.46, p<.001),* and internalized stigma and negative affect (*B=.27, p<.001).* Therefore, Mohr and Sarno (2015) focus on the importance of mental health service to target the internalized stigma that LGB individuals may experience to work toward a healthier well-being. Nevertheless, the sample size of 61 was not large enough to detect small between-person effects. Using the information of the impact of stigma, my dissertation will include the minority stress model to support my data collection and analysis.

Bidell (2014) conducted a quantitative study to examine how specific forms of multicultural education relate to students' self- reported assessments of their LGB-affirmative and multicultural counselor competencies. Bidell (2014) substantiated the importance of multicultural counseling training to increase counselor awareness. However, expressed the extensive need to continue to examine these factors due to the important role that multicultural education plays in working with LGB and ethnic minorities (Bidell, 2014). Ultimately, Bidell (2014) reported students that seek additional

LGB courses or workshops have higher levels of multicultural and sexual orientation competencies.

Graham et al. (2012) conducted a quantitative study to examine graduate counselor education and counseling psychology students' competency working with LGB clients and the level of training they have received. Graham et al. (2012) demonstrated that an increase in training is associated with an increase in competence. Therefore, Graham et al. (2012) the need for counseling programs to continue to increase their multicultural counseling training for students.

Problem Statement

Researchers define a sexual minority member as an individual with a sexual identity other than heterosexual (Shipherd, 2015). Currently, there are approximately half a million SM with a SMI in the United States (Bostwick, Boyd, Hughes, West, & McCabe, 2014). In addition, there is a projected increase in the number of older U.S. adults who identify as a SM and who may be in need of counseling services (Stanley & Duong, 2015). Although it is often associated with schizophrenia (Kidd et al., 2016), a SMI can refer to any mental health diagnosis that requires inpatient and outpatient treatment and results in significant disability in a major life domain of living, learning, working, or social (Pratt, Gill, Barrett, & Roberts, 2015). Even though SM with a SMI are almost three times more likely than their heterosexual counterparts to report a mood and anxiety disorder, both nationally and internationally, SM with a SMI underutilize mental health services (Kidd et al., 2016; Seeman, 2016).

Of the SM with a SMI who seek treatment, many report that counseling services are often inadequate and stigmatizing (Kidd et al., 2016; Mizock et al., 2014). These clients experience more discrimination that leads to less satisfaction with treatment, Kidd et al. (2016) and Mizock et al. (2014) noted. SM with a SMI experience stigma in their lives from their sexual minority status and the mental health diagnosis. However, when SM with a SMI actually seek counseling, the counseling may not focus on that stigma; in fact, it may be a stigmatizing force itself (Seeman, 2016).

Evidence exists regarding the lack of service utilization by SM with a SMI and supporting the need for additional training of counselors working with SM with a SMI to increase service use and improve services (Kidd et al., 2016; Mizock et al., 2014). Counselor educators and supervisors are ill equipped to train counselors to provide effective treatment for SM with a SMI, which influences the quality of services that SM with a SMI receive, according to Mizock et al. (2014). Researchers and counselor educators need to continue their exploration of ways to educate culturally competent counselors so that counselors can fully address SM with a SMI (Bidell, 2014). Counselors must adhere to the ACA (2014) *Code of Ethics* that highlights counselors seeking additional training to provide ethical service and practice within their boundaries of competence. Even though counselors receive training in both the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and multiculturalism, there continues to be a lack of direct training that focuses on the specific needs of SM with a SMI (Kidd et al., 2016). Counselor education programs must continue to enhance their multicultural

training to increase counselor competence in working with SM with a SMI (Graham et al., 2012).

Purpose of Study

The purpose of this transcendental phenomenological study was to gather and explore the experiences and perceptions of counselors who provide counseling services to SM with a SMI. By understanding a counselor's experience, counselors and counselor educators can begin to gain a deeper understanding of the counselors' needs when working with SM with a SMI. Furthermore, understanding the needs of SM with a SMI may help counselor educators enhance their teaching, which may improve the services for SM diagnosed with a SMI (Kidd et al., 2016).

Research Question

Main Question

What are the experiences of counselors who provide counseling services to SM with a SMI?

Subquestion

What training competencies do counselors perceive as necessary to support SM with a SMI?

Theoretical Framework

I grounded this study in both a philosophical and conceptual framework. For my philosophical framework, I began by incorporating a Husserlian approach that focuses on the conscious knowledge of the participants (Moustakas, 1994). Additionally, a

Husserlian framework provides a foundation for participants to describe what they perceive, sense, and know (Moustakas, 1994). Because the focus remains on the lived experience of the participants, a Husserlian framework allowed me to suspend my opinions by using bracketing (Moustakas, 1994; Kafle, 2011). By bracketing, I was able to focus on the participant's experiences without any bias and ascertain the true essence of these experiences (Moustakas, 1994). Bracketing my opinions and ideas was critical to the study, so I did not let any personal experiences that I have as a counselor bias the results of the study (Chan, Fung, & Chien, 2013). By bracketing, it is possible to arrive at a single, essential, and descriptive presentation of the phenomenon (Kafle, 2011).

In addition to a philosophical framework, I also incorporated a conceptual framework to ground my study. The minority stress model is a conceptual framework that researchers use to explore multiple factors to help understand the various health disparities within minority groups (Meyer, 2003). The minority stress model provides a conceptual approach for counselors working with SM with a SMI because it: (a) provides a systematic way to address minority stress in the actual clinical situation, (b) highlights the clinical utility of examining the specific components of minority stress, and (c) demonstrates the use of SM-affirming psychotherapy for people struggling with minority stress (Alessi, 2014). Additionally, the minority stress model illustrates the process by which minority stress influences mental health for SM (Baams, Grossman, & Russell, 2015). Specifically, with SM, the minority stress model focuses on the external events that occur, the anticipation and expectation that the individual has about these events, and

the internalized negative attitudes and prejudices from society (Hendricks & Testa, 2012).

Nature of the Study

Based on my problem statement, purpose, and research question, a transcendental phenomenological approach was the most appropriate for the study. With a phenomenological approach, I attempted to explore a specific phenomenon with an expectation of reducing an individual's experience of the phenomenon (see Kafle, 2011). Since there is a dearth of literature that explores counselor preparation to work with SM with a SMI, I used a phenomenological approach to explore experiences and perceptions of counselors who provide counseling services to SM with a SMI, focusing more on their descriptions (see Kafle, 2011).

Furthermore, SM with a SMI experience more negative outcomes due to prejudice and other biases, ultimately affecting their recovery (Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; LaSala, 2015). Additionally, SM with a SMI have greater perceptions of discrimination related to mental health treatment (Mizock et al., 2014). Even though the research literature supports that SM with a SMI experience double stigma, there continues to be little information about the specific impact related to treatment outcomes (Kidd et al., 2016). Using a phenomenological approach helped explore counselors' perceptions related to the needs of SM with a SMI and training competencies that are necessary when providing effective services (see Moustakas, 1994).

For this transcendental phenomenological study, I interviewed professional counselors to collect the necessary data. More specifically, I used a semistructured, face-to-face, individual interview, lasting approximately 60 minutes in the counselor's office or online through Zoom videoconference (see Jacob & Furgerson, 2012; Qu & Dumay, 2011). A semistructured, face-to-face interview allowed me the opportunity to modify the pace and ordering of the questions and is often the most effective and convenient way to gather information (see Qu & Dumay, 2011).

This study began to illuminate the meaning of a phenomenon through the lens of the counselors' experiences. I used an interview protocol to review the purpose of the study, provide specific information related to the interview, and allow the participant to ask any clarifying questions (see Laureate Education, Inc., 2010). I began with six open-ended questions as a foundation for additional follow up and probing questions. Furthermore, I reiterated that the process is voluntary and the participant can stop at any time and for any reason or refuse to answer a specific question, all of which I reviewed during the detailed informed consent (see Laureate Education, Inc., 2010).

For my transcendental phenomenological study, I focused more on the description of the experiences of the counselors instead of my interpretations while assessing for thematic saturation (see Fusch & Ness, 2015; Moustakas, 1994). To start analyzing the data, I began discussing my personal experiences; a process known as epoche or bracketing (Kafle, 2011; Moustakas, 1994). By addressing my experiences early on, and

deliberately putting aside my experiences, I was able to redirect the focus to the counselors in the study and their experiences (Moustakas, 1994).

I used a line-by-line coding process with the support of NVivo. NVivo is a qualitative data analysis software that researchers can use to make sense of their qualitative data (Bernauer, Lichtman, Jacobs, & Robinson, 2013). I systematically read through and marked up the transcripts by indicating specific lines and passages for each code (see Gibbs & Taylor, 2010). By doing so, the codes allowed me to develop a better understanding of what the participant is trying to articulate (Patton, 2015). When I assign a code to a data set, NVivo also assigns the data to a node that allows for better organization and management of the data (Woods, Paulus, Atkins, & Macklin, 2015). With NVivo, specific tools in the software allowed me to identify overlapping themes and discrepancies in content (Bernauer et al., 2013). Lastly, NVivo allowed me to display clear patterns and conceptual relationships, as well as allowed me to manage the data in a different way and make me explore the data from a different perspective (Bernauer et al., 2013).

Definitions

My focus in this study was on SM and SMI. Researchers define a sexual minority as an individual with a sexual identity other than heterosexual (Shipherd, 2015). Therefore, for the purpose of this study, I used the term *sexual minority* to refer to any individual who identifies as lesbian, gay, or bisexual. When studying SM, it is also important to define terms like *closeted*, *coming out*, and *out*. The term *closeted* refers to

someone who has not disclosed his or her sexual identity to another person (Pachankis, Cochran, & Mays, 2015). The term *coming out* refers to a process during which individuals begin to tell others about their sexual minority status (Aranda, Matthews, Hughes, Muramatsu, & Wilsnack, 2015). Furthermore, the term *out* refers to the final step in the process where the individual is accepting of and comfortable discussing his or her sexual minority status (Crews & Crawford, 2015). Additionally, researchers often associate a SMI with schizophrenia (Kidd et al., 2016). However, a SMI can refer to any mental health diagnosis that requires inpatient and outpatient treatment and results in significant disability in a major life domain of living, learning, working, or social (Pratt et al., 2015). For this study, I highlighted individuals with a diagnosis of schizophrenia, major depression, or bipolar disorder who have a history of inpatient or outpatient treatment.

Assumptions

Several assumptions guided my data collection process. Since I have highlighted the lack of effective treatment for SM with a SMI and discussed the need to train counselors to work with this population in a more effective manner, I have assumed that my participants have not received adequate training. Therefore, I am assuming that the multicultural training that counselors receive during their graduate studies does not fully prepare counselors to work with SM with a SMI. Also, throughout my study, I am assuming that the services that the counselors are providing to SM with a SMI may be stigmatizing and inadequate. Lastly, since I collected data through a semistructured

interview, I am assuming that the participants were truthful with their experiences and provided me with accurate data.

Scope and Delimitations

Sexual minorities are at a greater risk for experiencing a SMI; however, they do not receive adequate treatment. The treatment that SM with a SMI do receive can often be stigmatizing and discriminatory. Though there have been some studies that explore SM with a SMI, studying the counselors who provide the services is severely lacking. Therefore, explored professional counselors who are currently working with or have recently worked with SM with a SMI within the past year. I specifically selected these participants so their experiences are more vivid and they can provide in-depth data during data collection. Furthermore, by studying the experiences of counselors, I started to understand potential educational and training competencies that counseling programs can incorporate to better train counselors and improve the services for SM with a SMI.

Limitations

For my transcendental phenomenological study, I am exploring the lived experiences of counselors who work with SM with a SMI. I have recruited a small sample size that meets data saturation, which is appropriate for a phenomenological study (see Fusch & Ness, 2015; O'Reilly & Parker, 2012). Therefore, I am not generalizing the experiences of this sample size to a larger population. I am only highlighting the specific experiences of this sample insofar as they can recollect the experiences (see Moustakas, 1994).

Finally, as the researcher, I am a professional counselor who has worked with SM with a SMI. Therefore, another limitation of this study may be researcher bias. However, throughout this process, I have focused on suspending my opinions and thoughts by bracketing (see Kafle, 2011). To reduce this limitation, bracketing allowed me to focus on the participant's experiences without any bias, getting the true essence of the experience (Moustakas, 1994). Bracketing my opinions and ideas were critical to the study, so I did not let any personal experiences that I have as a counselor bias the results of the study (see Chan et al., 2013).

Significance

Advocacy is a core function of social change (Laureate Education, Inc., 2009) and is important to create change for more effective treatment. Without advocacy, social change may never happen, leaving SM with a SMI to receive services that are discriminatory and less effective. My study provided empirical evidence for counselors and counselor educators, which will help advocate for better training to provide equal and fair treatment of every individual (Laureate Education, Inc., 2009). Additionally, my study provided information for organizations, such as the ALGBTIC and the Council for Accreditation of Counseling and Related Educational Programs (CACREP), to advocate for improved counselor education and treatment for SM with SMI.

Also, since SM with a SMI are currently underutilizing services because they believe the services are inadequate or stigmatizing, gaining a deeper understanding of counselors' experiences and their perceived training competencies will enhance training

for future counselors (Mizock et al., 2014). With better-trained counselors, SM with a SMI may receive better quality services that reduce the perceptions of discrimination and lead to an increase in the utilization of counseling services. Ultimately, increasing the utilization of counseling services can foster a greater well-being for this marginalized and disadvantaged population.

Summary

As discussed, even though there are many SM with a SMI, treatment does not account for their specific needs (Bariola et al., 2017). Furthermore, SM with a SMI report that counseling services are often inadequate and stigmatizing; these clients experience more discrimination that leads to less satisfaction with treatment (Kidd et al., 2016; Mizock et al., 2014). One aspect that may influence these factors is the lack of training and competency of counselors working specifically with SM with a SMI. In the following chapter, I will provide an in-depth literature review literature related to the current needs of SM with a SMI, impact of double minority stress, effects of the lack of counseling services, and current counseling preparation.

Chapter 2: Literature Review

Introduction

Sexual minorities with a SMI experience greater mental health issues due to the minority stress they face associated with the intersection of their sexual orientation and mental health diagnosis (Bostwick et al., 2014). Although they have an increased need for intensive services, SM with a SMI often do not seek counseling; those who do often find current counseling services to be stigmatizing and inadequate (Kidd et al., 2016; Mizock et al., 2014; Seeman, 2015). One potential barrier is the lack of training that counselors receive to provide services to SM with a SMI (Bidell, 2014; Mizock et al., 2014). Although counselors do receive training related to multicultural competence and diagnosis through the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), there is no specific education in counselor training programs in the United States on SM with a SMI (Bidell, 2014).

In exploring the experiences of counselors who work with SM with a SMI, I sought to contribute knowledge that counselor educators can use to prepare counselors to work with this population more effectively. The literature review includes four main sections: the needs of SM, the needs of individuals with a SMI, the needs of SM with a SMI, and counselor training. There is an overall focus on the impact of minority stress on the mental health, use of mental health services, relationships, suicide rates, and substance use of SM. In addition, I attend to the impact of minority stress on the quality of life, community integration, and sexuality of individuals with a SMI. Furthermore,

there is a focus on the impact of minority stress on mental health, mental health services, negative outcomes, lack of counseling, and community support on SM with a SMI. Last, when reviewing the literature on counselor preparation, I focus on SM training, SMI training, and SM with a SMI training. In the sections that follow, I will provide an overview of the literature search strategy I used to gather my literature and the theoretical and conceptual framework for my study before offering an in-depth review of the literature based on the four main aspects.

Literature Search Strategy

To conduct a thorough and extensive literature review, I strategically and methodologically searched through multiple databases, which included CINAHL, Scopus, LGBT Life with Full Text, PubMed, PsycINFO, Ovid Search, and Academic Search Premier. I searched these databases using the search terms *sexual minority*, *LGBT*, *gay*, *homosexual*, *lesbian*, *bisexual*, or *queer* and *serious mental illness*, *severe mental illness*, *psychosis*, *schizophrenia*, *major depression*, or *bipolar*, in combination. Tracking my search terms and databases allowed me to ensure I reached saturation in the literature.

Theoretical Framework

I grounded my study with a Husserlian approach that focuses on the intentional, conscious knowledge of the participants (Cooney, 2012; Moustakas, 1994). Intentionality specifically highlights the connection of the mind to the object, whereas the object exists solely in the mind (Moustakas, 1994; Pivcevic, 2014). Focusing on intentionality is the

foundation of a descriptive approach that concentrates on the participant's conscious awareness (Husserl, 1977; Moustakas, 1994). Therefore, a Husserlian framework provides a foundation for participants to describe what one perceives, senses, and knows in one's immediate awareness and experience (Moustakas, 1994). According to Husserl (1977), to fully understand and deduce an experience, researchers must suspend their thoughts and ideas in a process known as phenomenological reduction.

Because the focus remains on the lived experiences of the participants, a Husserlian framework allowed me to suspend my opinions with the use of bracketing (Moustakas, 1994; Kafle, 2011). Bracketing my opinions and ideas was critical to the study so that I would not let any personal experiences that I have had as a counselor impact or bias the results of the study (Chan et al., 2013). Bracketing allowed me to obtain truest experience from my participants that is essential, basic, and irreducible (Moustakas, 1994; Pivcevic, 2014). By using the bracketing process, researchers can arrive at a single, essential, and descriptive presentation of the phenomenon (Kafle, 2011). Using a Husslerian approach, I specifically explored the phenomena of counselors who work with SM with a SMI.

Conceptual Framework

The minority stress model provides a framework for exploring how minority stress influences mental health for SM. According to Meyer (2013), it is best to explore multiple factors to understand the health disparities among minority groups. Individuals who occupy marginalized minority statuses face institutional and interpersonal

discrimination, prejudice, and stigma (Bostwick et al., 2014). Because SM with a SMI occupy two minority-based intersecting identities, the minority stress model may support an exploration of mental health disparities resulting from stigma and discrimination (Talley, Tomko, Littlefield, Trull, & Sher, 2011).

The minority stress model provides a conceptual approach for counselors working with SM with a SMI because it: (a) provides a systematic way to address minority stress in the actual clinical situation, (b) highlights the clinical utility of examining the specific components of minority stress, and (c) demonstrates the use of SM-affirming psychotherapy for people struggling with minority stress (Alessi, 2014, p.49). Additionally, the minority stress model supports a process in which minority stress influences mental health for SM (Baams et al., 2015). According to Meyer (1995), individuals experience minority stress from three different processes. First, individuals experience stress from the environment and external events due to their minority status. Second, individuals begin to anticipate and project specific external events, becoming hyper vigilant (Meyer, 1995). Last, individuals tend to internalize the negative events and prejudices from the external factors (Hendricks & Testa, 2012).

Due to minority stress, SM with a SMI face experiences of institutional and interpersonal discrimination, rejection, prejudice, concealment of one's sexual orientation, stigma, and internalized homophobia (Baams et al., 2015; Bostwick et al., 2014; Stanley & Duong, 2015). A cursory relationship indicates a link between mental health disparities across sexual orientation groups to experiences of discrimination,

whereas the experiences of minority stressors are related to lower well-being and higher levels of depression and suicidal thoughts (Baams et al., 2015). Because the minority stress model suggests that the mental health of SM is adversely affected by the experiences of stress, the model can be applied to the clinical treatment of SM.

Literature Review Related to Key Variables and/or Concepts

Sexual Minorities

Mental health and mental health services. Sexual minorities have experienced trauma and oppression in the mental health system in the United States, which has historically classified homosexuality as a mental health disorder (Hellman, Klein, Huygen, Chew, & Uttaro, 2010). Although the American Psychiatric Association removed homosexuality as a mental health disorder in 1973, it was not until 1986 when homosexuality was fully removed as a diagnosable mental illness in the DSM–Third Edition (Scott, Lasiuk, & Norris, 2016). The World Health Organization did not delist homosexuality until 1990, a delay which prolonged the experience of stigma and prejudice for many SM (Scott et al., 2016).

The high rates of mental health issues can be directly correlated to the stigma, prejudice, and discrimination that many SM experience (Meyer, 2013). Stigma and discrimination related to an individual's minority stress may lead to chronic stress and exasperated mental health problems (Strutz, Herring, & Halpern, 2015). Researchers have documented the stress that SM experience, the expectations of discrimination, and how living in a heterosexist environment are the main contributing factors that lead to an

increased risk of developing mental health diagnoses (Rutherford, McIntyre, Daley, & Ross, 2012). In addition, expectations of rejection and experiences of heterosexism are also factors that lead to a reduced quality of life for individuals that identify as a SM (Sutter & Perrin, 2016). Many SM become hyper vigilant as they begin to anticipate and expect negative reactions from members of the dominant culture (Meyer, 2013). Therefore, some SM may conceal their sexual orientation, often creating an internal conflict that leads to higher levels of stress and anxiety (Meyer, 2013). Suppressing one's identity and masking specific behaviors and actions can impede social interactions and lead to further negative mental and physical health (Meyer, 2013). Over time, SM can experience feelings of shame and guilt, leading to internalized homophobia (Meyer, 2013).

Stigma, prejudice, and discrimination produce a hostile and stressful social environment that leads to poor mental health for many SM (Elliott et al., 2015). Many SM continue to be dissatisfied with mental health services due to their perceived experiences of discrimination (Rutherford et al., 2012). Additionally, SM experience mental health disparities due to stressors related to societal stigma and victimization (Burns, Ryan, Garofalo, Newcomb, & Mustanski, 2015). Even though SM have a greater likelihood of having a diagnosis of depression or anxiety and have greater mental health needs than their sexual majority peers, SM continue to report unmet mental health care needs (Lamoureux & Joseph, 2014; Simeonov, Steele, Anderson, & Ross, 2015).

Cochran and Robohm (2015) highlighted that SM can experience civil injustices and microagressions. Historically, SM have been the direct subject of many forms of prejudice throughout different communities (Meyer, 2013). Sexual minorities are twice as likely to experience a negative life event related to prejudice than heterosexual individuals (Meyer, 2013). Globally, prejudice against SM can result in abuse, torture, or death (Meyer, 2013). Based on the prejudice that many SM experience, researchers highlight anxiety as a major outcome (Britel & Crisp, 2012). The anxiety SM experience often results in avoiding contact, lowering communication quality, and increasing physiological and psychological stress (Britel & Crisp, 2012). At times, the prejudice leads to victimization that can then lead to even more severe psychological distress (Meyer, 2013).

Many SM experience distal and proximal stressors impacting their overall health (Mereish & Poteat, 2015). Distal stressors are often more objective such that they are not subject to the individual's perceptions; whereas, proximal stressors are more subjective (Meyer, 2013). For example, proximal stressors could be an expectation of being rejected, internalized sigma, or concealing one's sexual identity (Meyer, 2013; Mohr & Sarno, 2016). Being out or concealing one's sexual orientation appears to affect one's mental health (Pachankis et al., 2015). For example, sexual minority men who are out seem to have an increased risk for major depression and generalized anxiety disorder compared to gay men that are closeted (Pachankis et al.,, 2015). However, for sexual minority women, being closeted appears to be correlated with higher rates of depression

(Pachankis et al., 2015). These results may be a direct reflection on the societal prejudice differences between sexual minority men and women (Pachankis et al., 2015). These distal and proximal stressors also may lead to relational and social disconnections (Mereish & Poteat, 2015).

Furthermore, the greater level of stress associated with these events leads to a greater impact on mental health of SM (Meyer, 2013). Being victimized alters and interferes with one's perception about the world and its order that leads to self-devaluating thoughts (Meyer, 2013). Current researchers highlight a strong correlation between environmental factors with minority stress and the well-being of SM (Cochran & Robohm, 2015). Additionally, minority stress is also linked to greater physical issues and complaints such as tension, asthma, and activity limitations (Mereish & Poteat, 2015; Strutz et al., 2015).

Relational problems. Many SM can also experience relationship challenges due to the experience of minority stress (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014). Consequently, there is a greater likelihood that SM will be ignored by parents, family members, and close supports instead of validated, nurtured, and celebrated like their heterosexual counterparts (Gamarel et al, 2014). Therefore, SM may develop heightened internal stigma that may negatively impact their mental health (Gamarel et al., 2014). Without the social connections, many SM have a lower sense of belonging to a community and an increase in loneliness, ultimately leading to shame (Mereish & Poteat,

2015). The lack of community and sense of connection are key factors that lead to an increase in suicide (Baams et al., 2015).

Suicide. Sexual minorities are almost two and a half times more likely to complete suicide than sexual majority individuals (Baams et al., 2015; Simeonov et al., 2015). Stress and victimization related to one's sexual identity are correlates to suicidal behavior that lead to SM's higher rates of attempted suicide (Baams et al., 2015; Sutter & Perrin, 2016). Though SM status is directly correlated with higher suicide attempts and completions, mental disorders are another strong predictor of suicide attempts and completions (Sutter & Perrin, 2016). Individuals with a mental illness have three to nine times increase in one's risk for a suicide attempt, as well as experiences of discrimination (Sutter & Perrin, 2016). Specifically, discrimination and rejection from parents puts SM at an eight times greater risk for attempting suicide (Sutter & Perrin, 2016).

Substance use. Sexual minorities experience higher rates of substance use at approximately three times more than their heterosexual peers' using substances such as alcohol, cigarettes, cocaine, ecstasy, and marijuana (Goldbach et al., 2014). Due to the increase is substance use, SM are at greater risk for trouble at work or school and risky sexual experiences leading to greater HIV exposure (Goldbach et al., 2014). Researchers suggest that the increase in substance use in SM cost an estimated $151.4 billion annually in physical damages and loss of productivity (Goldbach et al., 2014)

Legal system. Due to the many negative factors that impact the lives of SM and lack of support, SM may become an active member in the legal system. Unfortunately,

even under the support and environment of the legal system, many SM continue to experience victimization and oppression. According to Beck, Berzofsky, Caspar, and Kreps (2013) SM have the highest rates of sexual victimization in jails and prisons. Furthermore, Maschi, Rees, and Klein (2016) noted that SM with a mental health diagnosis experience the highest rates of inmate-on-inmate sexual victimization. Because of the fear of being assaulted, many SM individuals do not participate in the rehabilitative services in prisons leading to a more difficult transition into the community (Maschi, Rees, Klein, & Levine, 2015). Regardless, when SM individuals do participate in these services, they services do not address their unique concerns or are not trauma informed (Maschi et al., 2016). Therefore, SM continue to experience oppression in the legal system, often creating barriers for SM in the community gaining access to health care, housing, employment, or benefits (Maschi, Morgen, & Westcott, 2014).

Future research. Most researchers explore SM from a deficit-focused approach that can blur the results and further impede SM to receive adequate care (Gahagan & Colpitts, 2016). Additionally, most research compares SM to their cis-gendered, heterosexual counterparts, which diminishes the unique experiences of SM (Gahagan & Colpitss, 2016). Therefore, Gahagan and Colpitss (2016) illuminated the need for researchers to take a strengths-based health promotion approach to truly understand the needs of SM. However, researchers are highlighting that the perceptions of negative experiences for SM receiving counseling is beginning to decrease (Simeonov et al., 2015).

Serious Mental Illness

Quality of life. Having a SMI is a debilitating condition that impacts the quality of one's life and ultimately decreasing one's level of productivity (Scott et al., 2016). According to the Substance Abuse and Mental Health Services Administration (2014), 4% of the total population has a SMI, which is approximately 9.3 million Americans. Individuals with a SMI appear to have the lowest quality of health compared to individuals with other chronic illness (Scott et al., 2016). Recovery for individuals with a SMI is a complex, individualized process that focuses on hope and independence (Pratt et al., 2014; Roberston, Pote, Byrne, & Frasquilho, 2015). Individuals with a SMI appear to have lower socio-economic status, often making them reliant on State and Federal support (Rubin, Menon, & Vanek, 2012).

For many individuals with a SMI, perceived stigma is related to adverse effects in social functioning and mental health (Meyer, 2013). The stigma associated with a SMI affects one's ability to form and develop relationships (Rubin et al., 2012). An individual with a diagnosis of schizophrenia is often viewed as dangerous and unpredictable (Rubin et al, 2012). Overall, individuals with a SMI perceive that most people do not value them as individuals and can discriminate against them, leading to low self-esteem and sense of worth and belonging (Rubin et al., 2012). Also, individuals with a SMI experience greater rates of labeling and discrimination that are heightened through movies, television, news, and social media (Rubin et al., 2012). The labeling and discrimination

leads to stigma regarding the person's mental health diagnosis that can impact almost every aspect of the person's life (Rubin et al., 2012).

Community integration. Individuals with a SMI focus on reintegrating into the community (Wong, Stanton, & Sands, 2014). To focus on community integration, counselors need to move past the traditional aspects of function and satisfaction and focus on self-directed capabilities to support valued life roles in the community (Wong et al., 2014). According to Pratt et al. (2014), community integration is a multifaceted construct consisting of physical, social, and psychological integration. Therefore, counselors should focus on employment and occupational services to support the recovery process (Pratt et al., 2014). Many individuals with a SMI are unemployed, missing the financial and social benefit of work (Rubin et al., 2012). Additionally, being unemployed leads to a lack of structure, contact with others, goals, and motivation that may be essential for one's recovery (Rubin et al., 2012).

Another way to enhance one's community integration is through the provision of safe and affordable housing. Because of the intensity and severity of symptoms, there is an increased need for individuals with a SMI to seek safe and affordable housing in the community (Rubin et al., 2012). Living in the community requires independent living skills; therefore, individuals with a SMI may need support with activities of daily living, medication, skill developing, or transportation (Rubin et al., 2012). Financially, individuals with a SMI may receive benefits from Social Security Disability Insurance or Supplemental Security Income and most receive medical insurance through Medicaid

(Barber, 2009; Rubin et al., 2012). Based on financial and medical benefits, mental health services for individuals with a SMI are limited and lacking (Pratt et al., 2014). As the system continues to evolve, counseling services for individuals with a SMI are shifting to a more holistic nature, with a focus on work, relationships, and sexuality (Barber, 2009).

Sexuality. Individuals with a SMI are often regarded in a child-like state and viewed as asexual (Barber, 2009). Furthermore, the onset of one's diagnosis often occurs in adolescences or early adulthood, which is when most individuals define their sexual identity and begin to have a sexual life (Barber, 2009). Therefore, frequent hospitalizations, episodic symptoms, and medication side effects have affected the formation of sexual identity and sexual wellness of many SM with a SMI (Barber, 2009). A counselor working with an individual with a SMI needs to focus on the sexuality needs; however, not mistake one's sexuality with one's mental illness (Barber, 2009).

Sexual Minorities with a Serious Mental Illness

Mental health. The prevalence and needs of SM with a SMI are multifaceted and are often a result of the stigma, prejudice, and discrimination that this population experiences based on their multiple minority statuses (Scott et al., 2016). Sexual minorities are at a greater risk for experiencing a SMI (Bariola et al., 2017). Currently, there are approximately half a million SM with a SMI throughout the United States that need counseling services (Holley et al., 2016). There are higher rates of depression, anxiety disorders, post-traumatic stress disorder, substance use disorders, and suicidal

thoughts and behaviors (Barber, 2009; Bidell, 2016). Many SM appear to struggle with a SMI at an earlier age as compared to their sexual majority counterparts (Mizock et al., 2014). While SM experience rates of childhood adversity, SM adults also experience higher rates of adulthood adversity due to stigma and prejudice that leads to harmful effects on mental health (Seeman, 2015). Current estimates indicate psychotic symptoms are present in SM at a rate of two and a half more times it is imperative to understand the current needs of SM with a SMI (Seeman, 2015). According to the United States Department of Health and Human Services (2015) there is a need to reduce the mental health disparities in SM individuals.

Many SM with a SMI experience multiple stressors due to presenting with multiple marginalized identities: sexual identity and mental health diagnosis (Mizock et al., 2014). Sexual minorities with a SMI often experience minority stress resulting in the form of undue stress, stereotyping, negative reactions, and stigmatization by psychological, social, and cultural discrimination (Graham et al., 2012; Meyer, 2013). According to Meyer (2013), minority stress involves chronic and acute prejudice-related events, stigma, internalized homophobia, and concealment of their identity. The minority stress model provides a framework for how stigma-related stress impacts SM with a SMI (Gevonden et al., 2014; Meyer, 2013). The multiple levels of minority stressors may impede the acceptance process and hinder the recovery process (Mizock et al., 2014). As a result, SM with a SMI face more negative outcomes and are at a greater needed for counseling services to help overcome barriers and work through the recovery process.

Mental health treatment. Within the SMI population, SM experience the greatest level of discrimination (Hellman et al., 2010). Sexual minorities with a SMI can feel alienated due to their double minority status (Barber, 2009). Sexual minorities with a SMI often end in psychiatric settings due to limited financial choices and lack of counseling services in the community (Hellman & Klein, 2004). The increase in discrimination may lead to a disturbance in diagnostic impressions and skewed clinical rapport, ultimately impacting adherence to psychiatric treatment (Hellman et al., 2010). Historically, SM with a SMI had to choose to stay in mainstream treatment facilities that were not emphasizing affirmative treatment approaches (Hellman & Klein, 2004). Furthermore, psychiatric settings that provide counseling services for SM with a SMI have limited training, resulting in SM keeping their sexual orientation oppressed or not committing to the treatment goals (Hellman & Klein, 2004).

The treatment environment, staff, and clinical support staff can impact the engagement of SM with a SMI in clinical services (Hellman et al., 2010). Due to the historical nature of homophobia, many SM individuals with a SMI find it difficult to discuss their intimate relationship needs with clinical staff (Roberston et al., 2015). However, over the past few years, there have been various initiatives to help improve the mental health for SM (Robertson et al., 2015).

Negative outcomes. Sexual minorities with a SMI experience many negative outcomes that impact the recovery process. Sexual minorities with a SMI have barriers due to prolonged symptoms, increased hospitalizations, and delayed treatment that

impacts their social status, social network, and self-esteem (Mizock et al., 2014; Sirey et al., 2001). The lack of empathy by society and the lack of support are major contributing factors that lead to SM with and SMI completing suicide (Mizock et al., 2014). Furthermore, since many SM with a SMI experience hospitalizations at an early age, there are obstacles with dating and finding a life partner (Barber, 2009). The double stigma that SM with a SMI face interferes with their ability to build and form relationships, both romantically and socially (Mizock et al., 2014).

Due to higher rates of stigma and discrimination, SM with a SMI can also experience higher rates of violence and trauma that may impact their recovery (Mizock et al., 2014) The aftermath of violence and trauma tend to lead to negative coping strategies for SM with a SMI (Gevoden et al., 2014). As a result, many SM with a SMI are at a greater risk for addiction and eating disorders (Gevonden et al., 2014). Additionally, many SM with a SMI experience barriers in various aspects of their lives, such as employment, insurance, and partner benefits that creates more financial stress and worsening mental health (Mizock et al., 2014). Overall, SM with a SMI experience greater negative outcomes that warrant the need for counseling services.

Lack of counseling services. Since many SM with a SMI experience more stigma and negative outcomes, as well as find it difficult to rely on family or friends, counseling services are the major support system for this population (Borden, 2014). However, despite the apparent need and negative life outcomes that many SM with a SMI experience, there continues to be a lack of tailored counseling services that meet their

unique needs (Seeman, 2015). Sexual minorities with a SMI report that counseling services are often inadequate and stigmatizing leading to a decrease in satisfaction with treatment (Holley et al., 2016; Kidd, et al., 2016). Also, sexual minorities with a SMI reported feeling ignored or unheard due to counselors not viewing them as complex individuals (Holley et al., 2016). Additionally, SM with a SMI reported a lack of respect, whereas counselors violate their privacy and rights and assume a lack of intelligence (Holley et al., 2016). Furthermore, the lack of services leads to more negative physical and mental health outcomes (Holley et al., 2016). Most importantly, SM with SMI appear to have difficulty building a therapeutic rapport with their counselor based on clinical bias that leads to an interference with a client's trust, acceptance, and participating in counseling services (Mizock et al., 2014). Trust is a major factor in counseling services for the client to engage in services and follow through with recommendations (Seeman, 2015).

Sexual minorities with a SMI face institutional and interpersonal discrimination, which lead to many mental health disparities (Bostwick et al., 2014). Even when SM with a SMI attempt to engage in counseling services, they may experience heterosexism and homophobia that limits their ability to be open and feel safe (Mizock et al., 2014). Many SM with a SMI noted that there is minimal recognition of SM issues in community mental health settings (Luckstead, 2004). Many SM with a SMI have experienced negative or mixed reactions once they disclose their sexual orientation due to individuals

working in the mental health field possibly holding prejudicial attitudes towards SM due to conservative, socio-political, or religious beliefs (Bidell, 2016; Roberston et al., 2015).

Furthermore, mental health staff, such as counselors, do not have the competencies to effectively service this population (Mizock et al., 2014). As a result, there is a pressing need to understand the experiences of SM with a SMI and an emphasis on preparing counseling to work with this population (Kidd et al., 2016). Having a culturally meaningful environment may support recovery for SM with a SMI (Hellman et al., 2010).

Community support. Due to having a SMI, many SM may lack the support from other SM, since many do not understand or have experiences with individuals having a SMI (Hellman & Klein, 2004). Therefore, many SM with a SMI have extreme difficulty feeling like they fit in or belong in any community due to the perceived lack of understanding, which decreases the likelihood of reaching out for support (Hellman et al., 2010). Communities for SM with a SMI are important for recovery (Pilling et al., 2017). A sense of community creates a safe space where SM with a SMI feel accepted and connected (Pilling et al., 2017). Furthermore, communities help SM with a SMI feel empowered and work to overcome discrimination (Pilling et al., 2017). Additionally, these safe communities allow for SM with a SMI to adhere to treatment more even with the ongoing practice of pathologizing nonnormative sexualities (Pilling et al., 2017).

Counselor Preparation

Though much of the current literature focuses on SM with a SMI health disparities, there has been much less focus on the specific needs of learners and teachers interested in working with SM with a SMI (Kidd et al., 2016; Shipherd, 2015). Counselors are tasked with providing counseling services within the confines of the ACA (2014) *Code of Ethics*. As such, counselors must practice within their boundaries of competence; therefore, it is imperative for counselors to continue to seek knowledge and information on working with SM with a SMI (ACA, 2014, C.2.a.). Specifically, the ACA indicates that counselors must "gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competing counselor in working with a diverse client population" (ACA, 2014, C.2.a., p. 8). To do so, counselors often seek additional training opportunities to enhance their competence (ACA, 2014, C.2.f.). Since the number of SM with a SMI continues to increase, it is likely that counselors will be providing services to this population throughout their career, making it necessary to increase their level of competence (Graham et al., 2012). According to the 2016 CACREP standards, counseling training programs much focus multicultural aspects throughout their curriculum (CACREP, 2016).

Sexual minority training. Counselors are responsible for creating a safe, welcoming environment for all clients to increase the trusting relationship (Barber, 2009). In doing so, it is important for counselors to differentiate their client's sexuality from their psychiatric illness (Barber, 2009). Many counselor-training programs now offer

courses on multiculturalism; however, many multicultural courses focus on knowledge and awareness from the counselor perspective (Bidell, 2014). Current research does indicate that current courses in multiculturalism do enhance a counselor's level of awareness (Bidell, 2014). However, there is very limited research that focuses on the impact to the client (Bidell, 2014). Counselors often highlight the lack of specific training being a direct result of their low-level SM clinical competence (Bidell, 2013). There is a need for faculty and the learning institution to support and affirm the needs of SM in counseling programs (Cochran & Robohm, 2015). Through developing multicultural competence, counselors need to honor the differences of SM instead of just accepting or looking past the differences (Cochran & Robohm, 2015).

Counselors need to shift their focus from knowledge and awareness to skill development and interventions (Graham et al., 2012). To support the enhanced training of counselors related to SM with a SMI, counselors need to understand the specific needs of this population and counselor education programs need to enhance their training with more skill based interventions (Graham et al., 2012). Cochran and Robohm (2015) supported the 3x3 multicultural competency asserted by Sue, Arredondo, and McDavis (1992). The 3x3 competency consists of three characteristics by three dimensions (Sue et al., 1992). The three characteristics are: (a) counselor's awareness of their assumptions, values, and biases, (b) understand the worldview of the culturally different client, and (c) developing appropriate interventions (Sue et al., 1992, p. 481). Additionally, the three dimensions are: (a) beliefs and attitudes, (b) knowledge, and (c) skills (Sue et al., 1992).

Therefore, according to Sue et al. (1992), there are nine competency areas for counselors to be culturally competent. However, Cochran and Robohm (2015) expound on these ideas to include student, faculty, and institutional level interventions. Often, counseling programs discuss the needs of SM in one week; however, for more effective training, conversations about SM need to be integrated throughout the curriculum (Cochran & Robohm, 2015). For example, curriculum can focus on assessments that are appropriate to SM in an assessment course, mental health disparities of SM in a psychopathology course, or the higher rates of substance use in an addiction course (Cochran & Robohm, 2015). However, the most beneficial way to address the unique needs of SM is through an independent course in a counseling program (Cochran & Robohm, 2015)

Many multicultural counseling courses are a direct result from seeing the need to address the needs of many ethnic minority client groups (Bidell, 2013). However, even though research supports the positive outcome of just one multicultural counseling course, research also supports that the content of multicultural counseling courses varies greatly (Bidell, 2013). These differences may be a direct correlation to counselors feeling unprepared, poorly trained, and marginally competent to provide SM-affirming counseling and mental health treatment (Bidell, 2013).

Many counselors must rely on personal experiences, workshops, or conference presentations to acquire the professional training that specifically address the needs of SM client (Rutherford et al., 2012). Therefore, counselors must take an active role in their own education pursuits to provide or enhance the services for SM clients

(Rutherford et al., 2012). As a result, there continues to be a push by counselors for counseling education programs to include content focused on the needs of SM into the curricula (Rutherford et al., 2012). More specifically, counseling education programs need to focus on the difference between sexual orientation, sexual behavior, and gender identity, as well as the basic terminology and resources (Rutherford et al., 2012).

Since positive psychology is grounded in a strengths-based approach, counselor education programs can incorporate positive psychology to enhance counselor training to work with SM (Lytle, Vaughan, Rodriguez, & Shmerler, 2014). In doing so, counselor education programs can include didactic coursework that emphasizes the diverse experiences of SM (Lytle et al., 2014). Being positive, knowledgeable, and affirming of sexual orientation is crucial for counselors to build rapport and great a safe environment (Lamoureux & Joseph, 2014).

Additionally, the ALGBTIC noted specific competencies for counselors that match the 2009 CACREP standards (ALGBTIC, 2012). Therefore, throughout each graduate level course, counselors should be made aware of specific issues related to SM to promote awareness and competence (ALGBTIC, 2012). Furthermore, ALGBTIC (2012) discussed specific language and definitions so that counselors are speaking the same language and not using language that continues to oppress or marginalize SM.

Serious mental illness training. Most counselors do receive training in the *DSM;* however, counselors do not receive training within the context of the SM population. Therefore, the ALGBTIC specifically addressed the need for counselors to be more

competent when assessing sexual minorities (ALGBTIC, 2012). Related to mental health training, the ALGBTIC highlighted the issues regarding the mental health community's pathologizing SM (ALGBTIC, 2012). As such, the ALGBTIC (2012) generated a 16-point list of skills that competent counselors will possess when assessing clients for a mental health diagnosis. By developing this competency list, the ALBTIC highlights the lack of awareness for most counselors related to SM with a SMI and attempts to enhance a counselor's much-needed competence in this area.

Crowe and Averett (2015) commented that counselors have a lower stigmatizing view of individuals with a SMI; however, stigma still exists. One option to decrease the stigma when working with individuals with a SMI is to increase training and awareness for counselors (Crowe & Averett, 2015). Counselors working with individuals with a SMI must receive the knowledge, skills, and values necessary to engage, assess, develop, and implement the specific plans to support an individual's recovery (Rubin et al., 2012). Furthermore, researchers continue to highlight one of the major barriers to mental health care is lack of training for counselors (Eliezer, 2014).

Sexual minorities with serious mental illness training. Understanding the training for SM and individuals with a SMI separate from one another does not target the specific needs of SM with a SMI with the many facets of their minority stressors. A lack of clinical awareness related to SM and SMI can pose many barriers to treatment (Mizock & Fleming, 2011). Instead, counselor educators must begin to teach these concepts as intersections of an individual's life. Intersectionality helps counselors understand the

relationship between multiple social groups, sexual identity, and mental health diagnoses (Cho, Crenshaw, & McCall, 2013; Cole, 2009; Mizock & Fleming, 2011). Additionally, a focus on intersectionality can help one examine combined levels of oppression based on multiple minority statuses as counselors learn how to effectively serve SM with a SMI (Mizock et al., 2014). It is imperative that future research continues to focus on preparing counselors to work with SM with a SMI. Using a strengths-based approach can help inform adequate interventions for counselors working with different intersecting minority statuses (Gahagan & Colpitss, 2016).

For counselors to provide equal access and barrier-free services, it is important to explore the needs and perspectives of marginalized and underserviced groups, such as SM and individuals with a SMI (Lamoureux & Joseph, 2014). The unique needs of SM with a SMI often go overlooked (Lamoureux & Joseph, 2014). Counselors continue to neglect to value the intersectional inclusion for SM with a SMI during treatment (Pilling et al., 2017). For example, counselors fail to recognize the larger context of structural homophobia within treatment communities that can lead to alienation, and lack of trust (Pilling, et al., 2017).

It is important for counseling education programs to highlight the importance of a multidimensional approach to support optimal health for individuals that experience minority stress (Strutz et al., 2015). Current research supports training programs that focus on cognitive-behavioral stress management to increase a sense of community and hope for individuals that may experience discrimination (Sutter & Perrin, 2016).

Additionally, counselors in training need to learn the importance of focusing on the experiences of SM with a SMI and the way minority stress is impacting their life (Sutter & Perrin, 2016).

A capabilities approach is grounded in a strengths perspective; therefore, counselors need to have a strong foundation in a strengths focused counseling approach to work effectively with SM with a SMI (Wong et al., 2014). A strengths-based approach to training counselors supports working with both a SM and an individual with a SMI (Hellman et al., 2010; Pratt et al., 2014). Therefore, understanding the current training needs for counselors will enhance their preparation and ultimately provide better services to SM with a SMI (Mizock et al., 2014). It is clear that the experiences of counselors providing counseling services to SM with a SMI is limited. Therefore, this transcendental phenomenological study will help add to the current literature and hope to expand counselor's competencies for working with SM with a SMI.

Summary and Conclusions

Throughout the literature, it is clear that minority stress is a major factor that affects SM with a SMI. Furthermore, the unique needs of SM with a SMI often lead this population to seek additional counseling, yet counseling is often inadequate and stigmatizing. By conducting a transcendental phenomenological study, I will begin to understand the experiences of counselors working with SM with a SMI, which will allow a deeper understanding of counseling preparation and hopefully provide better counseling to SM with a SMI. In the following chapter, I will highlight my research method and

design to support my research problem, purpose, research question, and address the gap in the literature.

Chapter 3: Research Method

Introduction

The purpose of this transcendental phenomenological study was to gain a deeper understanding of the experiences of counselors who work with SM with a SMI. Having a greater understanding of the counselors' experience may help counselor educators to shape future training for counselors who work with the population. Furthermore, with better training and more competency, counselors who work with SM with a SMI may begin to increase and enhance the services for the population that will ultimately improve the quality of life for SM with a SMI. This chapter includes the research design and rationale for this study, the role of the researcher, an in-depth review of my methodology, a discussion of issues of trustworthiness, and the ethical procedures of my study.

Research Design and Rationale

The main research question for the study was: What are the experiences of counselors providing counseling services to SM with a SMI? The subquestion was: What training competencies do counselors perceive as necessary to support SM with a SMI? Based on my research question, I determined that a transcendental phenomenological approach was the most appropriate for the study. With a phenomenological approach, the researcher attempts to explore a specific phenomenon with an expectation of reducing an individual's experience of the phenomenon (Heinamaa, Hartimo, & Miettinen, 2014; Pivcevic, 2014). There is a dearth of literature on counselor training for working with SM with a SMI (Kidd et al., 2016). A transcendental phenomenological approach, thus,

allowed me to explore the experiences and perceptions of counselors who provide counseling services to SM with a SMI. In addition, I used the minority stress model as a conceptual framework to support and enhance the overall study because the framework highlights the experiences of SM (see Anfara & Mertz, 2015; Baams et al., 2015; Patton, 2015).

More specifically, I used a transcendental phenomenological approach to explore the experiences of counselors. This specific approach allowed me to focused more on their descriptions (see Heinamaa et al., 2014; Patton, 2015). Using a transcendental phenomenological approach was important because I focused more on the descriptive experiences from my participants and did not let any experiences that I had as a counselor bias the results of the study (see Heinamaa et al., 2014). It was important to address my biases early in the study by bracketing my thoughts, so I could fully focus on the experiences of my participants (see Chan et al., 2013; Moustakas, 1994).

Furthermore, SM with a SMI experience more negative outcomes due to prejudice and other biases which ultimately affect their recovery (Goldbach et al., 2014; LaSala, 2015). Additionally, SM with a SMI have greater perceptions of discrimination related to mental health treatment (Mizock et al., 2014). Even though the research literature supports that SM with a SMI experience a double stigma, there continues to be little information about the specific impact of stigma related to treatment outcomes (Harris & Licata, 2000; Kidd et al., 2016). The phenomenological approach allowed me to begin to explore the experiences of counselors and the training competencies that are necessary

when providing services for SM with a SMI (see Patton, 2015). By understanding the experiences of counselors, counselors and counselor educators may be able to better grasp the needs of SM with a SMI, which may decrease the perceived stigma of this treatment population.

Role of the Researcher

As the researcher in this study, I was the main data collection tool. Because I directly interviewed the participants, it was important to maintain professional boundaries and reduce biases that I may have (see Moustakas, 1994). I relied on my philosophical framework to attempt to withhold my own thoughts so I could truly focus on the experiences of my participants (see Kafle, 2012; Moustakas, 1994). Additionally, some of my participants were colleagues or peers whom I have worked with in the past. Therefore, I had to ensure that I followed all ethical guidelines and the dictates of Walden University's Institutional Review Board (IRB). Additionally, I made sure that none of my participants were counselors whom I directly supervise, to avoid any direct conflict.

Methodology

Sample Size

For my phenomenological study, I recruited six counselors who were working with SM with a SMI at the time of the study. The recruitment of six participants allowed me to collect enough data for thematic saturation (see O'Reilly & Parker, 2012). When identifying and selecting an adequate sample size, I focused on the depth of information instead of a specific number (see O'Reilly & Parker, 2012). By focusing on the

connections between ideas and evidence in the research, I explored different representations and a range of opinions related to the issue (see Emmel, 2013; O'Reilly & Parker, 2012). I aimed for a sample size that reached thematic saturation; thematic saturation occurs when the participants are repeating common themes, and there is enough information to replicate the study (see Fusch & Ness, 2015; O'Reilly & Parker, 2012).

The purpose of my phenomenological study was to gather and explore the experiences and perceptions of counselors who provide counseling services to SM with a SMI. Phenomenological method experts recommend a sample size of at least three participants so that the researcher can assess for thematic saturation; however, many other researchers support gathering data from at least six individuals (see Englander, 2012; Patton, 2015). As a result, an appropriate sample size is one that sufficiently answers the research question and reaches saturation (Fusch & Ness, 2015; O'Reilly & Parker, 2012).

To determine the sample size for this qualitative study, I reviewed other qualitative studies related to SM with a SMI. In other phenomenological studies related to SM and SM with a SMI, researchers have varied their sample size. Robertson, Pote, Byrne, and Frasquilho (2015) conducted a phenomenological study in which they conducted semistructured interviews with six SM to explore their experiences on acute mental health wards related to intimate relationship needs and recovery. Also using a phenomenological approach, Holley et al. (2016) interviewed 13 people with mental

illness with intersections of race, ethnicity, and sexual orientation to explore their perceptions of discrimination in mental health treatment. Last, Mizock et al. (2014) conducted a narrative approach and selected three narratives from a larger study of 32 participants to understand the acceptance process for SM with a SMI.

Sampling Method

Sampling is a core issue for qualitative researchers for the overall success of the study (O'Reilly & Parker, 2012). To recruit the six participants, I used a purposive sampling method. Researchers use purposive sampling so that they can select individuals who can purposefully inform an understanding of the research problem and central phenomenon in the study (Patton, 2015). In a phenomenological study, the intention of selecting participants is to find individuals who have experienced the phenomenon being studied and able to discuss the experience to the researcher (Patton, 2015). Therefore, I utilized criterion sampling along with snowball sampling methods (see Patton, 2015).

Participants for this study met the following criterion: (a) professional counselor currently working with a SM with a SMI, (b) the client will self-identify as a SM, and (c) the client will have a SMI diagnosis. Using this criterion to select the population for the study was important for my phenomenological study because all the participants have a shared experience of what it is like to work with SM with a SMI (Patton, 2015). Researchers define SM as an individual with a sexual identity other than heterosexual (Shipherd, 2015). Therefore, for this study, I used the term SM to refer to any individual that identifies as lesbian, gay, or bisexual. Additionally, researchers often associate a

SMI with schizophrenia (Kidd et al., 2016). However, a SMI can refer to any mental health diagnosis that requires inpatient and outpatient treatment and results in significant disability in a major life domain of living, learning, working, or social (Pratt et al., 2015). For this study, I highlighted individuals with a diagnosis of schizophrenia, major depression, or bipolar disorder that have a history of inpatient or outpatient treatment.

In addition to criterion sampling, I used snowball sampling methods for the study. Snowball sampling identifies cases of interest from people who know people who know what cases are information-rich (Patton, 2015). Snowball sampling is useful when studying hard to reach populations like SM with a SMI due to the stigma that many people experience (Patton, 2015; LaSala, 2015). Recently, Eliason, Dibble, and Robertson (2011) utilized snowball sampling to understand LGBT physicians' experiences in the workplace. Snowball sampling allowed the researchers to explore experiences from a sub-group that may not have eagerly volunteered for the study. Also, Rispel, Metcalf, Cloete, Moorman, and Reddy (2011) highlighted the usefulness of snowball sampling for men who have sex with men and the fear of expressing their sexual relations and how it impacts health utilization services.

To begin, I gained approval for my data collection procedures and made any recommendations from the Walden University's IRB. For the IRB approval, I obtained a letter of agreement from a local community mental health provider. This community mental health provider offers individual and group counseling to adults and has many clients who identify as SM with a SMI. Once I received approval from the IRB (02-27-

18-0560579**)**, I provided staff at this agency an e-mail to distribute to the professional counselors at their location (see Appendix A). When I secured one participant that met the criteria, I asked the participant to refer me to any other counselors that fit my study. Combining both criterion and snowball sampling provided a better sample and enhance my overall study.

Data Collection

I used an interview to collect my data. Conducting an interview has become one of the most widely used data collection procedures in qualitative research (Englander, 2012). More specifically, with a transcendental phenomenological study guided by a Husserlian philosophy and the minority stress model, an interview helped to understand the meaning of a phenomenon through the lens of the counselor's experiences (see Englander, 2012). The main purpose of an interview is to understand the lived experience of people by making meaning to the participant's experience (Seidman, 2014). The minority stress model and a phenomenological study are interested in the subjectivity of a phenomenon; therefore, an interview is an important tool to get a description of the counselors' experiences (Englander, 2012).

Since qualitative research focuses on the depth and richness of data and not frequencies, I used effective interviewing strategies (Jacob & Furgerson, 2012; O'Reilly & Parker, 2012). Effective interviewing strategies provide clear explanations and information; use open-ended questions and probes; balance rapport and neutrality; and use appropriate body language (Laureate Education, Inc., 2010). I completed my 60-

minute, semistructured interviews on an individual basis, one time, using Zoom video conferencing (see Englander, 2012; Jacob & Furgerson, 2012; Qu & Dumay, 2011). Using a semistructured interview is often the most convenient and effective way for researchers to gather information with interviews (Qu & Dumay, 2011). A semistructured interview allowed me to be flexible with my prepared questions and modify the pace and ordering of the questions (see Qu & Dumay, 2011).

Once I obtained an eligible participant, I e-mailed her the informed consent document to review, sign, and return via e-mail. I requested the participant to return the signed document with the statement "I consent" in the email. After I received the signed informed consent, I scheduled a 90-minute meeting that was convenient for the participant. The 90-minute meeting consisted of 15 minutes to go over the informed consent again and answer any additional questions, followed by a 60-minute semistructured interview, and 15 minutes to wrap up the interview. Also, I used an interview protocol (see Appendix B) to review the purpose of the study, provide specific information related to the interview, and allow the participant to ask any clarifying questions (see Laureate Education, Inc., 2010). Furthermore, I reiterated that the process is voluntary and the participant can stop at any time and for any reason or refuse to answer a specific question (see Laureate Education, Inc., 2010).

For the specific interview questions, I ensured each question was open-ended and allowed for engagement with the participant (Jacob & Furgerson, 2012). It was important that the interview questions were written well, which means that I previously

practiced my questions with peers and refined them before the actual interview (Patton, 2015). When developing the interview questions, I reviewed the type of question and the specific purpose for each question, as it relates to my research question (Qu & Dumay, 2011). I started with an introductory question, to establish rapport, and allow the participant to feel more comfortable (Qu & Dumay, 2011). The rapport between the researcher and participant is an important aspect of the interview; therefore, introduction questions are an effective way to build rapport with the participant and decrease any anxiety (Laureate Education, Inc., 2010c; Qu & Dumay, 2011). Also, with a semistructured interview, I had more flexibility to ask follow-up and probing questions rather than using a structured interview. By using a follow-up or probing question, I gained in-depth information from the participant about a specific question that I could use during data analysis (see Qu & Dumay, 2011).

Throughout the interview, I took very brief notes about the participant's body language and appearance; however, I audio recorded the entire interview, which negates the need to record detailed notes (Qu & Dumay, 2011). I made sure I was comfortable with the recording device and have a backup in case the one does not work (Laureate Education, Inc., 2010). After each interview, I securely saved the file on my laptop with a password and backup the file on an encrypted flash drive.

As discussed, I took the time to debrief with my participants. The debriefing process not only supported the participant, but also helped my role in future interviews (see Nelson, Onwuegbuzie, Wines, & Frels, 2013). The debriefing included my plans for

transcribing and analyzing the data. Following the transcription process, I provided my participants with a summary of the interview, in case they want to clarify or provide more information about an answer, a process known as member checking (Birt, Scott, Cavers, Campbell, & Walter, 2016). I thanked them again for participating in the study, let them know that I can provide them with a copy of my results, checked to make sure the participants did not experience any distress, and that they can contact me if they have any additional questions. The participants did not report experiencing distress so there was no need to provide them with a referral to another community mental health agency to seek debriefing and additional counseling services (see Englander, 2012; Nelson et al., 2013).

Data Analysis Plan

I focused more on a description of the experiences of the counselors instead of my interpretations (see Patton, 2015). To start analyzing the data, I began discussing my personal experiences; a process known as *epoche* or bracketing (Moustakas, 1994). As a counselor who has worked with SM with a SMI, I have my own thoughts and ideas. By addressing my experiences early on, and deliberately putting aside my experiences, I redirected the focus to the counselors in the study and their experiences (see Patton, 2015). Furthermore, bracketing my experiences decreased any influence on the counselor's interpretation of the questions (see Chan et al., 2013; Tufford & Newman, 2010).

Following the interviews, I prepared and organized the data by transcribing each interview (see Patton, 2015). Before transcribing, I listened to each interview one time, so I can be fully ready for transcription and immerse myself in the data. After transcription, I read the transcripts to gain a general understanding of some major themes related to the research question and a general understanding of the interviews (see Gibbs & Taylor, 2010; Patton 2015). Following my first read, I read the text again, paying special attention to repetitive and descriptive words (see Gibbs & Taylor, 2010). I systematically read through and mark up the transcripts indicating specific lines and passages for each code (see Gibbs & Taylor, 2010). These codes are my preliminary meaning units. By doing so, the codes allowed me to develop a better understanding of what the interviewee is trying to articulate (see Patton, 2015). I began to combine my preliminary meaning units based on similarity to generate themes. These themes directly supported my research question and subquestion.

I used NVivo to support the data analysis process. NVivo is qualitative data analysis software that researchers can use to make sense of their qualitative data (Bernauer et al., 2013). When I assigned a code to a data set, NVivo also assigns the data to a node that allows for better organization and management of the data (Woods et al., 2015). With NVivo, specific tools in the software allowed me to identify overlaps and discrepancies in content (Bernauer et al., 2013). Furthermore, NVivo allowed me to organize codes in a hierarchical manner and the ability to merge codes more easily (Bernauer et al., 2013). Lastly, NVivo allows me to display clear patterns in the data and

conceptual relationships (Bernauer et al., 2013). Since I am the only researcher on this study, having computer software to assist in organizing the data strengthens my study.

Issues of Trustworthiness

For this study, I ensured evidence of quality, trustworthiness, and credibility in my data analysis. One way was I followed a structured approach when analyzing and writing up the study (see Patton, 2015). In the process, I used using member checking to enhance the trustworthiness of my data collection (Birt et al., 2016). Even though I did not collect data from multiple methods, I focused on building trust with the participant and took time to learn personal information, which may have increased the trustworthiness of their data (see Fassinger & Morrow, 2013; Patton, 2015). Furthermore, it was important to provide adequate descriptions in my research report about my methods of data collection; increasing a level of transparency in my study (see Gunawan, 2015). Trustworthiness can also lead to better credibility of an overall study (see Gunawan, 2015).

The credibility of qualitative research depends on of four factors: (a) systematic, in-depth fieldwork, (b) systematic and conscientious analysis of data, (c) credibility of the inquirer, and (d) readers' and users' philosophical belief in the value of qualitative inquiry (Patton, 2015). To support the credibility of my research proposal, I began detailing the specific method and procedure that I used to collect the data. Once I finished the data collection, I highlighted multiple sources of data during analysis to support my interpretation (see Patton, 2015). I supported each theme with multiple words and

phrases that I identified from my interviews with my participant. Another aspect to ensure evidence of quality, trustworthiness, and credibility was to seek the opinion of others (Patton, 2015). For my study, I did this through my literature review. I supported my ideas and themes with other researchers that may have experienced similar ideas. However, I was open to criticism regarding my study and discussed ways that my research study highlights aspects of the subject matter that I may not have explored. I addressed potential criticisms in limitations of the study and future directions. Furthermore, I asked for guidance from a two peers to review my data collection and analysis techniques, as well as my overall research structure to ensure the credibility of my study (Patton, 2015). These peers have conducted qualitative research studies and have completed a qualitative research and advanced qualitative research course in their doctoral program. Additionally, I sought guidance from both my two dissertation committee members regarding my research process, thematic analysis, and strategies to support and enhance my themes.

Ethical Procedures

There are many different ethical concerns that I needed to be mindful of throughout the entire study. Guiding my ethical practice is the 2014 ACA *Code of Ethics*. Section G of the ACA *Code of Ethics* (2014) highlights guidelines that researchers must follow for research and publication. During the planning and implementation of the study, I followed all ethical principles, federal and state laws, IRB regulations, and scientific standards. I completed and followed the guidelines outlined in

Walden University's IRB. One aspect of the Walden University's IRB that I followed was gaining consent from my participants. In the consent, I highlighted background information; procedures; voluntary nature of the study; risks and benefits in the study; payment; privacy; contacts and questions; and a signature and date to confirm consent (see ACA, 2014; Walden University, 2016).

Another aspect of maintaining ethical research practices was confidentiality. I securely stored all interviews, files, and documents regarding this study in a password-protected file and on an encrypted universal serial bus (USB) that was locked in a secured cabinet. Since I used interviews to collect data and wanted to develop a good relationship with the participants, I maintained appropriate boundaries with the participants. Furthermore, before I started analyzing the data, I provided each participant with a summary of the interview to ensure the participant felt comfortable with the results of the interview and was able to articulate their ideas clearly. Doing so increased the accuracy of my results, which is critical when reporting (see ACA, 2014). Also, part of reporting the data, I ensured to keep the participant's identities confidential by using their initials (see ACA, 2014).

I made every effort to ensure the safety and wellbeing of the participants. I checked for any signs of distress or trauma the participants may have experienced. For example, I checked for increased or rapid speech, flushed face, disorganized thought process, and erratic behavior. Throughout the interviews, the participants did not report

or appear to experience any signs of distress; therefore, I did not provide the participant with contact information for additional support (ACA, 2014; Seidman, 2013).

Summary

Throughout this chapter, I have highlighted the research design and methodological strategies that I will use for my study. Additionally, I provided strong evidence to support my decisions and ways that I will conduct research ethically. Therefore, in the next chapter, I will use this research design and the identified methodology to conduct my transcendental phenomenological study on the experiences of counselors working with SM with a SMI.

Chapter 4: Results

Introduction

The purpose of this transcendental phenomenological study was to further explore the experiences and perceptions of counselors who provide counseling services to SM with a SMI. Additionally, by conducting this study, I sought to understand the competencies that counselors perceive as necessary to support SM with a SMI. By gaining a deeper understanding of counselors' needs when working with SM with a SMI, leaders of counselor education programs may be better able to prepare future counselors to work with this population. Furthermore, understanding the needs of SM with a SMI may help counselor educators to enhance their teaching, which may ultimately improve the services provided by counselors for SM diagnosed with a SMI. In this chapter, I will discuss the setting and demographics of my study and my data collection and analysis processes, provide evidence of trustworthiness, and present the results of my study.

Setting

I provided study participants with the option to conduct the semistructured interview face-to-face or through the Zoom videoconference platform. All six of my participants decided to use the Zoom videoconference platform in their office where there would be no distractions and they could focus on the interview. Using online video conferencing methods is becoming a popular way of conducting qualitative studies with its ability to reach various participants (Woodyatt, Finneran, & Stephenson, 2016). Using a video conferencing platform also makes some participants feel safer and more

comfortable to share information (Woodywatt et al., 2016). However, it is important to ensure that the video platform is safe and secure and that it upholds participants' privacy (Woodyatt et al., 2016). Zoom video conference is encrypted and secure, as well as being HIPAA-compliant (Zoom, 2018). It was still essential to build a relationship with my participants through the Zoom video conferencing platform to enhance the quality and richness of my data (Woodywatt et al., 2016). Zoom video conference is a high-quality resolution and easy connectivity allowing communication to be seamless and clear, making it easier than other videoconferencing platforms to build rapport (Zoom, 2018).

Demographics

This study consisted of six female individuals who hold a terminal counseling licensure in their respective states. At the time of the study, three of the six participants were living in New Jersey, one participant in Pennsylvania, one participant in Maryland, and one participant in Illinois. Five of the six participants were in their early to mid-40s, while one participant was in her early 30s. Additionally, four of the six participants graduated from a master's program that is accredited by the CACREP. Last, each participant has experience working with SM with a SMI across different settings: intensive outpatient counseling, outpatient counseling, clinical mental health setting, and private practice.

Data Collection

I began data collection by sending an e-mail to my recruitment agency seeking participants who met the criteria for my study (see Appendix A). When I received an e-mail of interest, I provided the participant with a copy of my approved informed consent document to review. I requested that each participant review the informed consent and, if interested, sign the document and e-mail the completed document back to me with the words "I consent" in the email. Once I received the signed informed consent document, I e-mailed the participants a list of dates and times during which I was available to conduct the interview and conveyed that each participant had the option of meeting face-to-face or through the Zoom videoconferencing platform, if possible. Upon finding an agreed upon date and time for the interview, I responded to each participant thanking her for her time and letting her know that I was looking forward to our meeting.

I conducted semistructured interviews to collect data from the six participants. I scheduled each interview for 90 minutes: 15 minutes to go through the informed consent document again and answer any questions the participant may have, 60 minutes for the actual interview, and 15 minutes to wrap up the interview and answer any remaining questions. I interviewed each participant one time through the Zoom videoconferencing platform and used the software to record the audio of each interview. I used the interview protocol to guide my interviews and ask specific open-ended questions to gather rich data (see Jacob & Furgerson, 2012; O'Reilly & Parker, 2012). I asked each participant the six main questions; however, using a semistructured format, I was able to

follow up with some additional probing questions (Qu & Dumay, 2011). After the first interview, I changed the order of my six interview questions so allow for a more natural flow and kept this order with the remaining five participants.

As each participant spoke, I took minimal notes as a reminder to myself to go back and ask for more specific information. By doing this, I was able to remain present during the interview and continue to build a positive relationship with the participant. Throughout this process, it was important that I ask the participants to elaborate on things they mentioned and not assume that I knew what they were talking about, especially since I have my own experience working with SM with a SMI. Additionally, to ensure that I was focusing on the experience of my participants, I used a reflective journal to bracket my ideas before and after each interview. Bracketing proved to be very important in this study, as I was able to write about my own experiences and refrain from skewing my questions or otherwise detract from the experiences of my participants (see Chan et al., 2013: Kafle, 2011; Moustakas, 1994).

Following the interview, I saved the audio file on my password-protected laptop, using a password-protected file, and then backed up the file on an encrypted USB that I stored in a locked cabinet. Also, I provided each participant with a summary of the interview and allowed the participant to provide feedback if she wanted to clarify or elaborate on an idea (see Birt et al., 2016). Other than rearranging the order of the interview questions after the first interview, I stuck very closely to my data collection

plan. Having this plan increased my confidence and comfort throughout the data collection process.

Data Analysis

To begin the data analysis process, I listened to each interview in its entirety to ensure the file was not corrupted and was able to be transcribed (Patton, 2015). I then completed a word-by-word transcription process of each interview and imported the transcribed interviews into NVivo for storage and data analysis (Bernauer et al., 2013). In NVivo, I read each interview once to gain a general understanding and immerse myself in the data (Gibbs & Taylor, 2010). With the research question and subquestion in mind, I read through the interviews a second time, this time paying careful attention to repetitive and descriptive words (Gibbs & Taylor, 2010; Moustakas, 1994). As I did read through the transcripts a second time, I highlighted specific words, lines, and passages of text and created a node in NVivo. These nodes are the preliminary meaning units in my data analysis and allow me to gain a better understanding of the participants' experiences.

After each interview, I printed out a list of my nodes and used these to guide my data analysis for the second interview, highlighting text and either creating new nodes or adding to an existing node. Following completing this step with all six interviews, I began to combine similar nodes to begin to generate my themes that directly supported my research question and subquestion. To ensure I was able to objectively generate themes from the nodes, I took a break in data analysis and came back with a clear, more objective mindset.

Going through all six interviews, I finalized a list of 82 nodes that NVivo organizes by each interview and the number of references. Sorting and combing these nodes, I was able to develop eight themes in support of my research question with two sub-themes and three themes in support of my subquestion. To support the research question of the experiences of counselors providing counseling services to SM with a SMI, the eight themes and two sub-themes are: (1) multiple minority stressors: external and internal stressors, (2) negative counseling experiences, (3) family impact, (4) counselor competency, (5) inclusive environment, (6) clinical supervision, (7) lack of education and preparation, and (8) active counselor competency. To support the subquestion of the training competencies that counselors perceive as necessary to support SM with a SMI, the three themes are: (1) develop a specific class, specialization, or certification, (2) fundamentals of counseling, and (3) population specific training.

Following the data analysis process, I used NVivo to create a folder of the themes for each research along with the supporting nodes. Therefore, there is a clear connection between data from each interview and the corresponding theme. Also, following the conclusion of data analysis, it was clear that I had reached thematic saturation because the participants were repeating common themes (Fusch & Ness; 2015). Therefore, I was able to end my data analysis at six participants, and there was no need to collect additional data. Some participants provided richer, in-depth data with their examples as evident by the higher nodes in those interviews. Nevertheless, each participant discussed their experience that collectively supported the overall themes in this study.

Evidence of Trustworthiness

To ensure trustworthiness in my data collection and analysis in this study, I began with the interview protocol to keep each process as similar as possible. Using a semistructured interview process allows for some flexibility with probing and follow up questions; however, I kept the six main questions consistent. Additionally, providing each participant with a summary of the interview allowed them to provide any clarification. Though no participant changed anything after the summary, member checking continues to be a valid method to enhance the trustworthiness of qualitative research (Birt et al., 2016).

Also, following a specific approach to data analysis and using NVivo to organize my data enhanced the trustworthiness of my data. Being clear, providing adequate descriptions, and being transparent about my study support the credibility of my results and trustworthiness. Furthermore, I sought the guidance of my committee members throughout and was open to feedback and recommendations to enhance this study. Being open to feedback allowed me to set up a structured, well-planned out study that can be replicated by other researchers.

Results

After conducting a thematic analysis, I identified eight themes to support the first research question, along with two subthemes. Additionally, I identified three themes to support the subquestion. I will present the results of my study based on each research question and provide data to support each theme. As I indicated in the informed consent

document, I will keep the participants confidentiality. Therefore, when presenting the findings, I will identify each participant with a corresponding number. Last, I will include direct quotes from the semi structured interviews as data to support each theme.

Research Question 1: What are the experiences of counselors who provide counseling services to SM with a SMI?

Theme 1: Multiple minority stressors. Sexual minorities with a SMI often experience multiple minority stressors due to their sexual orientation and mental health diagnosis (Meyer, 2013). Experiences of multiple minority stressors leads to greater physical issues and overall well-being of individuals (Cochran & Robohm, 2015; Mereish & Poteat, 2015). Sexual minorities experience multiple levels of minority stressors that hinder the acceptance process (Mizock et al., 2014). In this study, minority stress can be categorized by two separate sub-themes: external stressors and internal stressors.

External stressors. From the participants in this study, external stressors were most evident at work and at school. For example, participants summarized that at work, adult clients have feelings of being different or isolated can impact one's ability to fit in or seek professional advancement. Participant #2 noted:

> And I think it took her a really long time to feel comfortable in the workplace because of the social boundaries there. But I do feel like there was some, you know, some stress there for her. She feels like in some ways promotion wise and advancement wise, she was held back due to being a SM with a SMI.

Feeling like one's sexual minority status or mental health diagnosis hinders professional advancement or connection with other peers enhances the lack of trust in the workplace, leading to further stress and marginalization for a SM with a SMI (Hellman et al., 2010). Participant 4 noted

> It's the social and the environment in the workplace that creates not being accepted. A sexual minority, like any other minority, not being accepted and all that that encompasses. You know the microaggression of not being able to talk about your significant other when everybody else is talking about engagements, wedding anniversaries, and things like that. So I think for the adult client it's more so having to minimize or hide their relationship experience or sexual status, if that makes.

Further discussed by participants is the similarity between adult clients experiencing issues at work with adolescent clients experience stressors and stigma in school. For instance, participant #1 indicated:

> For the youth, I would say definitely their school has a huge impact. I will say it's like relationship building, friendship. Kind of the normal experiences that you have. But I think they're colored with but I'm a sexual minority or I have a mental illness, or I'm a sexual minority with a serious mental illness.

Each minority status impacts adolescent's experiences in school, which can lay the groundwork for further development in adult life (Meyer, 2013). Nevertheless, according to the participants in this study, external stressors from multiple minority statuses affects

their client's lives.

Internal stressors. Additionally, this study highlighted many internal stressors derived from multiple minority statuses. Participants discussed that during an adolescent's development, students are learning effective coping skills to work through their minority stressors. However, many SM with a SMI are having difficulty with appropriate coping skills that may lead to self-medicating behaviors, self-harm, or even suicide. Participant #6 commented:

> Also learning how to do with like learning coping skills, like how do I actually deal with this because she never really learned how to deal with her symptoms of depression or her symptoms of irritability or mania related to that. So I think part of that was really on a more basic level, how I actually cope with this where I'm not just turning to my girlfriend or turning to smoking weed or turning to feeling really isolated and depressed.

Regardless of the minority stressors, participants add that religious factors compounded these internal stressors. As participant #4 identified:

> The added stress if, you know, clients were raised in a religious or a household who doesn't embrace differences. The stress of maybe feeling feel lonely more so than maybe your average heterosexual person and feel truly accepted.

Through many of the interviews, discussions emphasized how the internal stressors continue to impact the individual. Many SM with a SMI have issues with low self-esteem and self-identity (Meyer, 2013). Participant #5 asserted:

> I think most [SM with a SMI] have very low self-esteem because of the ignorance of society. And I feel like building up their self-esteem and helping them understand that just the fact that they are who they are and have chosen to live their life the way they want to live their life speaks volumes about their resilience and their ability to be a role model for others who can't step up like that.

Utilizing a strengths perspective to overcome self-esteem issues may also support identity development for many SM with a SMI who have difficulty understanding who they are. As participants highlighted, there appears to be an impact on one's sense of identity as clients begin to or continue to explore who they are. Counselors continue to work through the minority stress and work with them to solidify a sense of identity. For example, participant #1 highlighted:

> Getting rid of the should language with clients. You know I should be? Or you know, they're telling me that I should be? And everybody wants me to be? So I think shedding those layers of I guess externally imposed identity and you know working through that conflict of this is what the world tells me I should be or this is who I'm supposed to be, but I don't feel that way and I know that I don't identify with that and that doesn't feel genuine to me.

Ultimately, SM with a SMI have a plethora of needs that are a direct result of both the external and internal stressors from the multiple minority statuses they hold (Kidd et al., 2016; Meyer, 2013).

Theme 2: Negative counseling experiences. Sexual minorities with a SMI have negative experiences with counseling that impact current and future counseling services (Kidd et al., 2016; Mizock et al., 2014). Many SM with a SMI report that counseling services are often inadequate and further stigmatizing, leading to underutilization of services (Kidd et al., 2016; Mizock et al., 2014). Often these negative experiences impact SM with a SMI to seek out future counseling or open up to their current counselor (Hellman et al., 2010; Robertson et al., 2015). For example, participant #1 noted:

> ... what I find is that in their effort to establish a relationship like they almost have to check with me to make sure that they're going to get the experience that they're looking for because they've had negative experiences in the past. So bad, they're coming to me already with some negative experiences from the past and looking for affirming counseling.

In this study, participants hypothesized that sometimes the negative experiences are a direct connection to the client feeling comfortable sharing specific topics and issues in session or feeling further stigmatized. Whether clients are feeling stigma based on their sexual minority status or their mental health diagnosis, the ability to feel comfortable is paramount. As participant #6 asserted:

> The client felt comfortable with me, but he also talked about how he didn't like a previous counselor that talked about. He just didn't feel comfortable talking about certain things. He didn't want to talk about having sex or being a bottom or a you know the issues related to cultural and diversity related to being okay with his

> own sexuality and didn't feel comfortable with that counselor whether it was something that was said by the counselor or whether it was like the counselor's demeanor in terms of body language and facial expressions.

Lack of comfort with one's identity can perpetuate one's internalized homonegativity, which can lead to greater mental health issues (Bariola et al., 2017). Also, lack of comfort with a counselor can make a client hesitant to open up (Robertson et al., 2015). Participants focused on how the hesitancy that SM with a SMI experience in counseling settings inhibits their ability to develop a trusting relationship. As SM with a SMI have greater negative experiences, they have more difficulty to build that trusting relationship with a counselor. As participant #5 highlighted:

> And if they've had more than one experience like that and several of my clients have then they are, they're not open to the process and it takes a while to trust. But honestly I think the more bad experiences they've had with the counselor the longer it takes for me to establish trust in and establish a safe environment for them.

Hesitancy and resistance with counseling not only impacts the client, but according to some of the participants also impacts the counselor. For instance, participant #1 highlighted:

> I think that [SM with a SMI] are always looking for that other shoe to drop you know. And I sense in myself in my work of self-awareness trying to make sure that I'm not offending or you know kind of and I don't want to say walking on

> eggshells, clinical eggshells, but I would say that they they withhold or like you when you can you can sense when a client is withholding or doesn't want to say everything.

The authenticity a counselor brings to a session is important and when clients have negative experiences with other counselors, it often impacts everyone involved in creating a new relationship (Lamoureux & Joseph, 2014). Clearly, the experiences of the participants in this study supported Lamoureux and Joseph (2014) as they described the impact of a negative relationship for SM with a SMI in counseling.

Theme 3: Family impact. Family support may often be a protective factor to many SM with a SMI and impact the therapeutic relationship (Seeman, 2015). However, many SM with a SMI may not be able to rely on family members for support (Lucksted, 2004). Therefore, if possible, it is important to connect with family members. As participant #3 discussed:

> I think with what I have seen it definitely looks like bringing family in in order to create a supportive environment in order to get the family on the same page.

Through discussion, having all parties on the same page increases the consistency in and out of the counseling setting and allows for more reinforcement of counseling interventions. However, sometimes family members may be involved in the client' treatment and contradict the recommendations of counselors, truly impacting the client's recovery. For example, participant #1 noted:

> Their family members have a huge impact on the services and treatment that they receive. It ranges from family members who don't believe in medication at all and so they're not actively promoting their family members receiving medication management.

Therefore, it is important for counselors to explore the role of family support with SM with a SMI. Even though many SM with a SMI may find it difficult to rely on family members (Borden, 2014), seeking out the balanced support can help clients with their identity search. Participant #6 noted:

> Either the lack of family involvement or too much family involvement now definitely has an impact on what [SM with a SMI] need and what they don't need. Again that emerges that that also reinforces or you know takes away that sort of identity and so that has a huge impact on the narrative and information that they come into their session with them. Yeah that, that's the first I would say the, first line of attack is sometimes the family.

Though many SM with a SMI may not be able to rely on family support, counselors can explore support in hopes to increase another protective factor for SM with a SMI that have unique needs (Hellman & Klein, 2004).

Theme 4: Counselor competency. Throughout this study, it was clear that the specific skills of the counselors are important to provide services to meet the unique needs of SM with a SMI. Working with SM with a SMI, counselors are aware of the specific skill set that they bring to the counseling relationship. Since many SM with a

SMI encounter negative counseling experiences, participants in this study discussed the importance for counselors to recognize and understand how their skills impact the sessions. Rogers (1967) highlighted the importance of unconditional positive regard in developing relationships with clients. Participants mentioned the importance of having unconditional positive regard as a major strength for counselors providing positive support to SM with a SMI. For example, participant #5 discussed:

> I soon learned that my acceptance and unconditional positive regard for everyone allowed me to just excel in that area

Additionally, this theme is further supported by participant #5 comments:

> I think it goes back to my ability to unconditionally accept everybody for who they are and where they are.

Similar to unconditional positive regard, Rogers (1967) also highlighted empathy as an important aspect for counselors. As participant #3 noted:

> I think that the empathy and compassion piece for me comes from also my job training and just who I am as a person as well.

Empathy and unconditional positive regard are both important for the counselor to express verbally and non-verbally. Participant #4 illuminated:

> I feel that that any clinicians who are working with [SM with a SMI] really need to be that much more empathic and accepting and and I don't know in some ways whether it is verbally or even through nonverbal communication they really make it clear that they are judging in any way

To fully empathize with clients and provide unconditional positive regard, counselors need to be present and listen to their clients (Rogers, 1967). Supporting this, participants asserted that counselors bring the unique ability to block out all distractions of the outside world and be in the moment with their clients. Doing so can be extremely helpful for counselors working with SM with a SMI. As participant #1 stated:

> For me it helps to be present. Listen to that client if and even if there was some trauma in their lives that had an effect or had an impact, I can't necessarily connect the dots from that trauma to their sexual minority status or that trauma to their mental health status. I think it's about what the client says happened. What did the client say occurred? What did the client say produced this experience?

One participant focused on being in the moment and truly listening to the client allows counselors to begin to understand the client's experience and not make assumptions. Instead of assuming what SM with a SMI are feeling and experiencing, counselors can use their basic counseling skills to validate their clients. For example, as participant #1 identified:

> And so I think a large part of my role is at times normalizing it for the client but also validating their experience as unique and their own experience.

Therefore, listening to, validating, and normalizing the client's experience allows a counselor to build that therapeutic relationship that supports the client outside of the office (Rogers, 1967). Sometimes, counselors needs to be an advocate for their clients,

specifically when working with SM with a SMI according to one participant. Participant #5 asserted:

> And I'm very very much an advocate for them. I'd have to step outside the box and go to meetings at school districts with superintendents and things to advocate for proper treatment in a school setting.

Throughout the discussion, counselors need to remember the skills they bring to the relationship and the role the play in providing services to SM with a SMI. These skills can be used to help overcome client's past negative experiences, as well as match the unique needs that SM with a SMI bring into counseling.

Theme 5: Inclusive environment. As counselors utilize their skills to combat negative client experiences, it is important to use these skills to create an inclusive environment that is supportive and safe for SM with a SMI (Robertson et al., 2015). As participant #3 stated, " it's important to just create a really inclusive space". Creating an environment of inclusivity seeks to combat the external world where many SM with SMI experience discrimination and prejudice (Meyer, 2013). Expounding on this further, participants discussed the importance for counselors to be explicit when creating a safe environment, an environment that clients know is inclusive even before coming into counseling. Participant #4 commented:

> So I mean that's what I do. I make it clear on my menu of services that is something that, that I welcome and that's the population that I work with.

As clients seek and find counselors that promote a safe environment online, it is also important to promote inclusivity in the counseling environment. For example, participant #6 discussed:

> ...one thing is like the actual setting up the location in terms of like when the client walks into the office. Like what is in the office, is it geared towards a specific mission. Are the colors really like, are they neutral or are these geared towards a specific population? Are there pictures of people or pictures of people that relate to me? Are there resources only for whites? Young families? Or are there resources for everybody you know? Are you being all inclusive or not? I think that's something to increase counseling services for SM with a SMI.

Overall, there was a consensus that inclusivity and creating a safe environment helps clients feel more comfortable to open up to counselors and even adhere to counseling services. Ultimately, making sure the environment is inclusive of the needs of SM with a SMI may support more adequate services.

Theme 6: Clinical supervision. Participants in this study highlighted the importance for counselors working with SM with a SMI to seek and receive clinical supervision. Clinical supervision is an important aspect of counselor development and a core component of the counseling profession (Bernard & Goodyear, 2014). When counselors are working with SM with a SMI, relying on clinical supervision is helpful to navigate the various needs of this population. For example, participant #5 discussed:

> I think [clinical supervision] is huge. We are dealing with people and their issues every day, all day long and without someone to run things off of or to seek guidance from or just check in and see if we are on topic or on base with what we're doing with our skills. I think that, that it's very important. Supervision is extremely important.

With the extensive needs of SM with a SMI, clinical supervision may be used to direct services or to prevent burnout (Bernard & Goodyear, 2014). Nevertheless, as one participant highlighted, clinical supervision is seen as an important transformative process for counselors working with SM with a SMI. Participant #1 illuminated:

> Supervision for me has been the most transformative process of all of my training and education because it was you know that tandem, working with client and processing with a supervisor, working with a client or with a supervisor. Without that I would have not come to some of the realizations that I did about [SM with a SMI]. I would have not learned how to be a better me for those clients.

Participants highlighted that supervision affords the counselor the ability to be present and more supportive to their clients as well as increase their knowledge of SM with SMI. As participant #2 highlighted:

> Clinical supervision is a tremendous responsibility. As a counselor and clinical supervisor too, if it's not in my [supervisee's] repertoire how can I help you help [SM with a SMI]. How can I guide [the counselor] through that? How can I support [the counselor] through?

Therefore, clinical supervision is not just important to the counselor, but also important to the SM with a SMI receiving services.

Theme 7: Lack of education and preparation. Perhaps one reason counselors believe clinical supervision is important when working with SM with a SMI is due to the lack of education and preparation the perceive. It is clear that counselors receive training on multiculturalism; however, there continues to be a lack of training and skill development to work with SM with a SMI (Graham et al., 2012; Kidd et al., 2016). Counselors in this study believed there is a lack of education and preparation to work with SM with a SMI**.** Lack of education on a specific population can lead to ignorance that perpetuates stigma or a lack of confidence to support the population (Graham et al., 2012; Kidd et al., 2016). For example, participant #5 highlighted:

> I didn't feel like I was educated enough about sexual minorities with a serious mental illness to be able to be effective with them.

Sometimes, as pointed out in this study, the lack of training also leads to services that do not meet the needs of SM with a SMI or further marginalizes this population. As participant #1 commented:

> I think that [the lack of training] definitely needs to be addressed because the experiences of [SM with a SMI] in counseling, again like my own clients, have said themselves this is not always the best.

Additionally, lack of training may sometimes lead to a lack of comfort or confidence. For example, participant #3 noted:

> Because I think counselors are uncomfortable. Some counselors are uncomfortable talking about sex and sexual choices and sexual identity. You know I think it will give counselors more knowledge and with more knowledge and more practice comes a greater level of comfort addressing some of these issues that are just so difficult to address and they cause discomfort. You know for not only the counselors but also for the clients.

Changing this lack of training is imperative to increase a counselor's competency to work with SM with a SMI (Mizock et al., 2014); however, training can also be made on a systemic level. Participant #2 asserted:

> I understand that we need more education and that we do need to really be more inclusive with all of our training, but I think that in 2018 that the counseling profession really needs to catch up or we're going to be in trouble because things are moving at light speed and what are we going to do, drag our heels on this

As times change and the needs of our clients evolve, the profession needs to evolve as well. Since many counselors do not perceive adequate training or preparation to work with SM with a SMI, they often rely on those basic counseling skills and making a conscious effort to create a safe environment (Kidd et al., 2016; Mizock et al., 2014).

Theme 8: Active counselor competency. Since counselors do not perceive adequate training to work with SM with a SMI, they are tasked with taking an active role in seeking out knowledge and education. As the participants illuminated, counselors

figure out ways to increase their competence to better serve their clients. Participant #1 commented:

> I just kind of, I guess create my own knowledge, bed of knowledge and doing my own research with you know looking up articles and journals and doing my own like self-study of what does this population need or what we have to do to find out information about our clients.

Participants discussed taking an active role in increasing their competence by reading journals and engaging in self-exploration. Some continue to enhance their professional development using other modalities. For instance, participant #2 discussed:

> I pride myself on taking courses, listening to webinars, meeting with people if I think someone has, if I read a great book that someone you know wrote I'll try to contact the author or find out where they're speaking. I do go to a lot of conferences.

Additionally, participants highlighted conferences attendance as an effective method for counselors to take an active role in their professional development; specifically when seeking knowledge on SM with a SMI. Participant #5 asserted:

> I started going to ACA conferences my first year in my Master's program and I'm going every year since. So I looked at the sessions that were being offered and I still do this at conferences and I looked, I looked to get a little bit of everything, ethics, diversity, just a little bit of everything. Also, looking to those sessions where I feel like I'm at a deficit and where I really need to increase my skills.

As counselors continue to seek additional training and knowledge, there is an increase in competence working with SM with a SMI (Graham et al., 2010). Therefore, by increasing their competence to work with SM with a SMI, counselors are attempting to comport with the ACA (2014) *Code of Ethics*.

Subquestion: What training competencies do counselors perceive as necessary to support SM with a SMI?

The major emphasis of this study was more exploratory as a way to begin to understand the experiences of counselors working with SM with a SMI. Therefore, the themes identified below are just the beginning to identify specific competency for counselors to work with SM with a SMI. Nevertheless, through the semistructured interviews, I was able to identify three major themes to support this subquestion.

Theme 1: Develop a specific class, specialization, or certification. As highlighted in the data reported to support the last research question, counselors do not perceive adequate training to work with SM with a SMI. Therefore, counselors believe that counselor education programs need to increase their training and prepare counselor better to work with this population (Kidd et al., 2016; Mizock et al., 2014). One way to increase training, according to this study, is to possibly create a specialty just like the one that currently exists for drug and alcohol counselors or marriage and family counselors. For instance, participant #2 noted:

> ....why shouldn't it be a standard? It should be a standard, a standard of education or at least offered. I am not a licensed drug and alcohol counselor but I'm a

> licensed professional counselor and I can do drug and alcohol counseling but I feel like that's not my niche. Someone who does that I feel needs to have more expertise in the area and perhaps follow that track. You know, really gain all the terminal licensure in drug and alcohol counseling because I think that that's really important. And I think it's not separate, but I think it's an added, a therapist needs added experience in that and added knowledge and added education. And I also think that if marriage and family counseling is your specialty that you need to, that's what you're really passionate about. You know, licensed professional counselors can do couples counseling, we can do marriage and family counseling, but I would like more information about that. I'll take a few courses in that or take that track. You know I want to learn more about what I'm passionate about and the population that I serve. So why wouldn't [a specialty or class on SM with a SMI] be offered. I think it should be.

When working with populations that have specific needs or experiences, it is clear that counselors may need additional training or concentrate their studies (Cho et al, 2013; Mizock & Felming, 2011). Focusing on the unique needs of SM with a SMI through an independent course may be the most beneficial for counselor development. Participant #3 discussed:

> I think it is a good idea to have like a concentration or a specialization, whatever you want to call it that’s geared towards treatment of sexual minorities or treatment of sexual minorities that have mental illness. I think it's about a

> population that's not necessarily, I don't know I haven't done the research on it in terms of like how much research is on it, but it seems like there's not much research on it. I think it would be really great to have one class that focuses on the differences or similarities, stigma, and law related to the population. Something like that where there's like maybe three separate courses that focus on treatment of people that identify as sexual minority that also have a serious mental illness.

As the participants continue to describe what a course would look like, it is clear that more real-life examples and application would be helpful. Participant #6 commented:

> I think doing more like role plays are helpful in terms of like having an idea of what somebody may be going through and role-playing that out in terms of like, like how do you actually, like what's the right way to talk to somebody without offending them and without further stigmatizing them. They're already stigmatized by and by their families and by their friends and whoever else, by the media, counselors shouldn't be adding to that.

Focusing on educating counselors on ways to refrain from stigmatizing SM with a SMI can be important to not only increase counselors' competence but also increase counseling satisfaction for SM with a SMI (Mizock et al., 2014). Another aspect of education is increasing a counselor’s confidence to work with SM with a SMI. As participant #2 highlighted:

> The first thing I would say is I think counselors need to have a certain amount of confidence and confidence to ask the right questions. Confidence to not be afraid to say things or I don't know, I don't know what that means. Could you tell me what that means? Could you just tell me more about that?

It is the premise of the participants in this study that increasing ones confidence to ask the right questions may allow counselors to understand their clients better and increase their ability to empathize with their clients. In doing so, the increase in knowledge may lead to better services for SM with a SMI.

Theme 2: Fundamentals of counseling. Though there is a discussion regarding increasing training for counselors to work with SM with a SMI, there is not as much information about the specifics of the training. However, one thing is very important – the participants in this study believe it is important for training to focus on the fundamentals of counseling. Participant #5 discussed:

> I think there needs to be a stronger emphasis on the fact that people need to unconditionally accept everybody for who they are and not think that everybody comes out of a mold.

This holds specifically true of SM with a SMI based on the individuality and unique needs that this population presents (Sutter & Perrin, 2016). In addition to unconditional positive regard, the participants believe that being present with the client is such a valuable aspect that needs to be reinforced as it relates to working with SM with a SMI. For example, participant #1 commented:

> Being present with the client and in the here and now and just listening. I think going back to those very basic skills. That's what I find myself now doing with supervisees is bringing them back to those very fundamental skills of listening to your client, see what they're here for and what they're telling you what their needs are and then work your way to the best conclusions about how you can meet their needs.

Additionally, in this study, being able to practice listening skills and not take for granted what a SM with a SMI is experiencing will be important to enhance a counselor's competence. Therefore, refreshing counselors on those basic counseling skills, as it relates to SM with SMI, can be part of a certification or class.

Theme 3: Population specific training. Part of increasing training and competence is providing education about the unique needs of SM with a SMI (Kidd et al., 2016; Mizock et al., 2014). One aspect the participants in this study highlight is related to educating counselors about the appropriate language. For example, participant #2 noted:

> Well I think {SM with a SMI] not only need, but deserve to have a clinician, or a therapist, or a group facilitator, or a psychiatrist to prescribe who are educated on sexual minorities with a serious mental illness, who are, who are understanding and you know who have educated themselves on the language.

The language within a population or a culture creates an ability to form a relationship and understand each other (ALGBTIC, 2012). Participant #6 illuminated:

> I think the language piece is a huge component of it. It's not being aware of what the culture is related to whether it's lesbian or gay community or whichever's sexual minority community it is not being aware of it. And so not having a language to use to actually talk to somebody about what that's like. And so if the counselor doesn't have the appropriate like street language, for lack of a better term, about this culture then the client is going to feel misunderstood and not wanting to necessarily communicate that with a counselor.

As training increases and counselors begin to feel more confident to work with SM with a SMI, the participants mentioned that part of the confidence might be asking questions about the language that is constantly evolving. For instance, participant #3 discussed:

> And give a counselor a language too. Because there's such a breath of language for things now that there wasn't and that and that breadth language speaks to that continuum type.

As a result of increasing education, counselors will continue to understand the unique needs of their clients, as well as develop the language to articulate their client's needs (Kidd et al., 2016; Mizock et al., 2014).

Summary

In this study, I was able to follow a specific data collection method and data analysis plan to explore themes related to my research question and subquestion. It is clear that SM with and SMI have unique needs that counselors are not receiving adequate training throughout their graduate program. Furthermore, though there are some ideas

regarding specific competencies and ways to improve training, this study is just a beginning. In the following chapter, I will provide a discussion of my findings, highlight the limitations of the study, discuss recommendations based on my study, and provide implications for my study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this transcendental phenomenological study was to explore the experiences of counselors who work with SM with a SMI. Understanding the experiences of counselors may help increase counselors' understanding of the unique needs of this population, as well as highlight specific ways to expand counselor competency to work with SM with a SMI. Findings from this study provide additional evidence that SM with a SMI experience stressors as a result of multiple minority stressors, which impact their recovery and that counselors possess a set of skills that are important to meet the unique needs of SM with a SMI. Yet, counselors perceive a lack of education related to SM with a SMI and often have to take an active role in seeking education to increase their competence. In this chapter, I will discuss the findings and the limitations of the study, offer recommendations, and consider the implications of the study.

Discussion of the Findings

Using a transcendental phenomenological framework, it is important to discuss the findings from the perspective and experience of the participants and not attempt to interpret the findings from my experience (Moustakas, 1994). Focusing on the experiences of the participants, I confirmed and extended the findings of this study. As Scott et al. (2016) noted, the needs of SM with a SMI are multifaceted. Due to their multiple minority identities, many SM with a SMI experience stress resulting in the form of stereotyping, negative reactions, and stigmatization (Graham et al., 2012; Meyer,

2013; Mizock et al., 2014). These factors were evident in this study and are highlighted in the first theme which emerged from the data analysis. The participants in this study expounded on multiple stressors, both internal and external, that are imposed upon SM with a SMI. Some of the stressors that the participants discussed were self-esteem issues, self-identity issues, lack of coping skills, stigma in school and the workplace, and societal pressures. The internal struggles highlighted in this study are similar to the identity and internalized homophobia that Meyer (2013) discussed throughout most of his research.

Additionally, the participants in this study illuminated the negative impact of past counseling services on recovery for SM with a SMI. Often, SM with a SMI feel alienated, stigmatized, and discriminated against, which leads to a perception of inadequate counseling services (Barber, 2009; Kidd et al., 2016). Many of the participants reported that a negative counseling experience leads to a lack of comfort, acceptance, openness, trust, and a lack of follow up. Furthermore, participants in this study noted that the more negative experiences SM with a SMI have with counseling, the more difficult it is to build rapport in the counseling relationship. These findings are congruent with the work of Hellman et al. (2010), who concluded that the discrimination SM with a SMI experience in treatment influences clinical rapport and adherence to treatment.

Furthermore, the results of this study support the importance of the creating a safe environment (Hellman et al., 2010). As Robertson et al. (2015) pointed out, historically many SM with a SMI find it difficult to discuss relationship needs with clinical staff due

to not feeling safe or fully secure. Therefore, as the participants commented, it is important to be explicit in the acceptance of all people to create an inclusive space and promote a safe environment. These findings support the various initiatives that are being put in place to improve the mental health of SM and create a safe space for individuals with a SMI (Roberston et al., 2015). For example, both the CACREP and the ACA have emphasized the importance of counselors of being more multiculturally competent to work with individuals who hold a minority status (ACA, 2014; CACREP, 2016). Additionally, leaders of the ALGBTIC highlighted specific skill competencies for counselors who work with SM and also emphasized that counselors should be more mindful and aware of affirming language (ALGBTIC, 2012). Last, both the National Alliance on Mental Illness (NAMI) and the Movement for Global Mental Health (MGMH) continue to address stigma associated with mental illness in anti-stigma, stigma free campaigns (MGMH, 2018; NAMI; 2018).

Throughout much of the literature, there is extensive commentary regarding a lack of tailored services to meet the unique needs of SM with a SMI (Kidd et al., 2016; Mizock et al., 2015; Seeman, 2015). Much of the literature supports the idea that the lack of services is directly correlated to the lack of focused training (Lamoureux & Joseph, 2014; Mizock & Fleming, 2011; Suttter & Perrink, 2016). The participants in this study supported this notion by commenting on the lack of specific training they received in their graduate studies. Additionally, the participants reinforced the need for counselors to receive more education and training to increase their comfort level when working with

SM with a SMI. To compensate, the participants noted the importance of taking an active role in gaining competence by attending conferences and trainings, immersing themselves in literature, and speaking to other peers.

Although many of the results confirm existing knowledge in the field, there is some information from this study that may contribute new knowledge related to counselors' work with SM with a SMI. Borden (2014) asserted that many SM with a SMI often find it difficult to rely on family or friends for support. However, the participants in this study expounded on the impact of family on SM with SMI. Participants highlighted the importance of counselors trying to incorporate family into services for more support, as many SM with a SMI are seeking family acceptance. Furthermore, the participants emphasized how many SM with a SMI are often neglected by family members, sometimes to the extent of being disowned.

Additionally, although Hellman et al. (2010) highlighted the importance of creating a safe environment for SM with a SMI, counselors working with this population appear to lack concrete skills to support this environment and the unique needs of the population. Therefore, this study expands on this topic by beginning to provide counselors a foundation of skills that may be effective in creating a safe environment. For example, the participants reiterated the importance of being authentic, empathetic, and providing unconditional positive regard for the client. Additionally, the participants mentioned being present with clients, being open to learning from the client, and having the awareness when additional resources are needed.

Furthermore, the participants in this study recalled the importance of clinical supervision when working with SM with a SMI. Participants recounted the experiences of clinical supervision in providing support and additional education as needed. Though supervision is an integral aspect of a counselor's development and the counseling profession, there does not appear to be extensive research supporting the need for clinical supervision when working with SM with a SMI.

Last, though there is evidence that additional training is needed for counselors to work with SM with a SMI, this study begins to elucidate specific areas in which to provide education and prepare future counselors. For example, the participants in this study mentioned the importance of reinforcing the core values and fundamental skills of counseling with counselors; specifically, a greater emphasis on skills that help counselors build rapport with their clients. Further, the use of various case studies or vignettes to help counselors apply these fundamental skills could prove effective. Additionally, the participants in this study postulated that counselors could use more education on the language that SM with a SMI use.

Limitations of the Study

One limitation may be a result of the small sample size. Though a sample size of six meets the recommendations of phenomenological researchers, especially since I reached data saturation (see Fusch & Ness, 2015; O'Reilly & Parker, 2012) the location of my participants may limit my study. For example, five of the six participants are living in more liberal areas of the country. Though phenomenological research is only

concerned about the perceptions and experiences of my participants and not about generalizing to the larger population (see Moustakas, 1994), perhaps experiences of counselors living in more conservative parts of the country would be different.

Additionally, the participants do not solely work with SM with a SMI. Therefore, they have many different experiences working with various clients. Furthermore, though my participants were either currently working with SM with a SMI or have worked with one in the past year, their recollection of their experiences may not be fully accurate. Nevertheless, I am only highlighting the specific experiences of this sample insofar as they can recollect the experiences (see Moustakas, 1994). As a result, the experiences of my participants may cloud their perceptions of working with SM with a SMI. However, seeing the themes of this study matching other research from the literature decreases the extent to which this is a limitation, strengthening this study.

Finally, another limitation of this study is my role as a researcher. I am a professional counselor who has worked with SM with a SMI. Therefore, I needed to bracket my opinions before and after each interview to reduce researcher bias (see Kafle, 2011). Bracketing my opinions and ideas was critical to this study, so I did not let any personal experiences bias the results of the study (see Chan et al., 2013). Doing so, I was able to redirect the focus on the experiences of my participants.

Recommendations

The purpose of this study was to gather and explore the experiences and perceptions of counselors who provide counseling services to SM with a SMI. From this

study, counselors can begin to understand the needs of counselor's working with SM with a SMI. Since the needs of SM with a SMI are so multifaceted (Scott et al., 2016) and individuals with a serious mental illness use an array of support services to improve their recovery (Pratt et al., 2014), a follow up study that focuses on the experiences of prescribers that work with SM with a SMI will provide a different perspective. With additional insight and understanding different perspectives, counselors have more knowledge of the needs and SM with a SMI; ultimately, increasing a counselor's understanding how to best serve this population.

Additionally, the results of this study illuminated the value and impact of family members of SM with a SMI. Since there is an understanding that most SM with a SMI have difficulty relying on family for support (Borden, 2014; Gamarel et al., 2014), gaining the perspective of family members and the role they play in supporting SM with a SMI may be helpful. If counselors understand the strengths, barriers, and stories of family members supporting SM with a SMI, they may have more knowledge on how to best support family members when attempting to incorporate them into their client's support system. Furthermore, counselors may gain a deeper understanding of the struggles that many families have experienced; therefore, helping their clients work through and learn skills to help repair some familial relationships.

Another recommendation of this study would be to explore the role of clinical supervision when working with SM with a SMI. Clinical supervision is important for the professional development of counselors (Bernard & Goodyear, 2014). Moreover, the

participants in this study identified clinical supervision as an important aspect of working with SM with a SMI. Therefore, I recommend exploring clinical supervisors that supervise counselors providing counseling services to SM with a SMI. Studying the supervisors may highlight specific skills or ethical dilemmas with which counselors struggle, leading to specific trainings and professional development courses to meet those needs.

Furthermore, the purpose of this study was to help counselor educators enhance their teaching, ultimately improving the services for SM diagnosed with a SMI. Though this study began to pinpoint specific areas in a counselor education program where counselors can increase their competence, additional research is needed to gather data that may shape the development of an elective course or certificate for counselors working with SM with a SMI. If I can begin to develop a specific course, I will be able to track a counselor's confidence and competence to work with SM with a SMI.

Implications

Ultimately, this research study and the recommendations could improve training and education for counselors working with SM with a SMI. With empirical evidence for counselors and counselor educators, counselors will be able to advocate for better training to provide equal and fair treatment of every individual (see Laureate Education, Inc., 2009). Additionally, this study provides information for organizations, such as the ALGBTIC and the CACREP to advocate for improved counselor education and treatment for SM with SMI.

Since SM with a SMI are currently underutilizing services because they believe the services are inadequate or stigmatizing (Mizock et al., 2014) having better-trained counselors, may improve the quality of services and reduce the perceptions of discrimination. With improved services, SM with a SMI may begin to adhere to counseling services, make better progress, and fulfill their definition of recovery. Ultimately, increasing the utilization of services can foster greater well-being for this marginalized and disadvantaged population.

Additionally, the themes I identified during data analysis that confirm the literature in the field validates the use of a Husserlian framework. Since a Husserlian framework provides a foundation for participants to describe what one perceives, senses, and knows in one's immediate awareness and experience (see Moustakas, 1994), I was able to capture the participants' descriptions of their experience to inform my research question and subquestion. Therefore, future researchers can utilize a Husserlian framework to structure their studies and gather rich data that will provide a deeper understanding of a topic.

Furthermore, the implications of this study support the notion that individuals experience stress due to minority status as discussed by Meyer (2013) in the minority stress model. Individuals that occupy marginalized minority statuses face institutional and interpersonal discrimination, prejudice, and stigma (Bostwick et al., 2014). From the results of this study, it is clear that SM with a SMI, holding double minority statuses, face discrimination, prejudice, and stigma. Since this study further validates the minority

stress model, researchers can continue to use this conceptual framework to ground future studies regarding marginalized populations.

Conclusion

Sexual minorities with a SMI are often a forgotten population, even though there are half a million individuals that identify as a SM and have a SMI diagnosis (Bostwick et al., 2014). With a lack of confidence stemming from a lack of competence, counselors may shy away from working with SM with a SMI or be hesitant to say the wrong thing. If we begin to enhance education and increase counselor preparation to work with SM with a SMI, we can make an impact in the lives of many people who feel like services are currently inadequate and further stigmatizing (Mizock et al., 2014). It is time to bring about change and begin to make a difference for SM with a SMI.

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Appendix A: Data Collection E-Mail

Dear (Name of Individual),

I hope this email finds you well. As you know, I am currently a PhD student in the Counselor Education and Supervision program at Walden University. Presently, I am completing my dissertation and conducting my research study on the "Experiences of Counselors Working with Sexual Minorities with a Serious Mental Illness". As part of my research study, I am looking for professional and rehabilitation counselors who are either currently working with or who have worked with sexual minorities with a serious mental illness within the past year.

For the purpose of this study, you will be asked to participate in a 60-90 minute semistructured interview that will be audio taped. If you agree, I will provide you with a more detailed informed consent document. I will ask you to sign to signify your voluntary participation in the research study. Furthermore, I will schedule a date, time, and location that we can meet for the interview.

Please let me know if you would like to participate or if you know any other counselors that fit the criteria and may be interested in participating. You can contact me by phone [redacted] or email [redacted] if you have any additional questions. Thank you very much and I look forward to your response.

Best wishes,

Anthony Zazzarino, MA, LPC, ACS, CPRP

Anthony Zazzarino, MA, LPC, ACS, CPRP

Appendix B: Interview Protocol

Date:
Time of interview:
Place:
Interviewer:
Interviewee:
Introductory Statement:

Good morning/afternoon. Thank you for agreeing to be interviewed for this research study that will explore the experiences of counselors working with sexual minorities with a serious mental illness. I appreciate your willingness to voluntarily participate in this study. Before we begin, I want to remind you of the topic we will be discussing. I will ask you questions about your experiences working with sexual minorities with a serious mental illness. This interview should last anywhere between approximately 60 minutes. As a reminder, I will be recording this interview and taking minimal notes so that I can transcribe the interview for my data analysis later. I will provide you with a summary of the interview when I am done so that you can review and clarify any statements. The recording will be safely stored with passwords for confidentiality. Your information will be kept confidential upon publishing of my data. If there are questions you do not want to answer, please let me know. If at any time and for any reason, you would like to end the interview, please let me know. Just a reminder, participation in this research study is voluntary and you can remove yourself at any time. Do you have any questions for me before we get started?

Interview Questions:

- Tell me about your experience working with sexual minorities with a serious mental illness?
- What has your experience been regarding the specific needs of sexual minorities with a serious mental illness?
- What is your experience related to your clients biggest struggles with stigma, prejudice, and discrimination?
- What has your experience been regarding training to work with sexual minorities with a serious mental illness?
- How can counselor education programs improve training for future counselors to work with sexual minorities with a serious mental illness?
- How can counseling services be improved to provide more effective services to sexual minorities with a serious mental illness?

Concluding and Closing Statement:

Thank you for your time today. I really enjoyed learning more about you. I will transcribe and analyze your interview within the next few weeks and will contact you to share the summary. Additionally, I may have a few more questions to ask you, depending on what themes emerge during my analysis of yours and other participants' interviews. Would it be okay if I contact you again? Do you have any questions for me as we wrap up? Please feel free to contact me following this interview with any additional questions or other possible participants for the study. Thank you.