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Acceptability and Preliminary Efficacy of a Lesbian, Gay, Bisexual, and Transgender-Affirmative Mental Health Practice Training in a Highly Stigmatizing National Context

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Abstract

Purpose: Lesbian, gay, bisexual, and transgender (LGBT) individuals in Romania encounter pervasive stigma and discrimination and there is a high need for LGBT-competent mental health professionals (MHPs). We tested the impact of a pilot LGBT-affirmative training for MHPs in Romania on these professionals' LGBT-relevant attitudes, knowledge, and perception of clinical skills.
Methods: We conducted a 2-day training for MHPs in Bucharest. Fifty-four attended and 33 provided training evaluation data at baseline and follow-up.
Results: The majority of trainees were female (90%) and heterosexual (73%) with a mean age of 36.4 ($SD = 7.7$). From baseline to follow-up, trainees demonstrated a significant increase in perceived LGBT-relevant clinical skills ($P < 0.001$) and perceived knowledge ($P < 0.05$). LGBT-affirmative practice attitudes ($P < 0.05$) and comfort in addressing the mental health of LGBT individuals ($P < 0.01$) increased significantly, and homonegative and transnegative attitudes decreased significantly ($P < 0.01$). Negative attitudes toward LGBT individuals were low at both baseline and follow-up. The majority of trainees reported being highly interested in the training (84%), which they reported had prepared them to interact with and care for LGBT individuals (74%).
Conclusion: This pilot training appeared to be effective in increasing perceived LGBT competence among participating MHPs. This type of training model needs to be tested further in a randomized controlled trial with longer follow-up periods to assess intervention durability and implementation of clinical skills. Future trainings can be incorporated into existing curricula. National accreditation bodies might consider encouraging such training as part of standard educational requirements.

Keywords: homophobia, intervention, LGBT, mental health, training

Introduction

Lesbian, gay, bisexual, and transgender (LGBT) individuals in Romania encounter pervasive stigma and discrimination,[1–3] while resources to sustain their physical and mental health are lacking.[4–8] In Romania, negative attitudes toward gender and sexual minorities are among the highest in Europe,[9,10] leading many LGBT individuals to conceal their identities from healthcare providers and avoid seeking healthcare, which is widely recognized as being unresponsive to LGBT health concerns.[10–12] Stigma-related barriers to healthcare exacerbate sexual orientation-based health disparities, including increasing HIV and sexually transmitted infection (STI) incidence.[4–7,10,13] Two international sexual health surveys indicate that HIV prevalence among Romanian men who have sex with men (MSM) was 5% in 2008[14] and 18% in 2014,[15] suggesting a potential recent increase in HIV infection. Romanian LGBT individuals report some of the highest rates of health services dissatisfaction, barriers to healthcare, and mental health problems (e.g., depression, anxiety, and suicidality), yet indicate the highest desire to use LGBT-affirmative healthcare, among their European peers.[10]

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Despite Romania's decriminalization of homosexuality in 2001, which was required to enter the European Union (EU), homonegative attitudes remain endemic, exemplified by a recent three-million signature campaign to ban same-sex marriage.[16,17] Over 85% of the population is Christian Orthodox, and the church promotes firm homophobic views. Stigmatizing practices against LGBT individuals remain widespread, resulting in overt verbal and physical victimization.[4] Laws against hate speech are not enforced,[4] and Romania ranks in the 23rd percentile on the International LGBTI Associations' human rights index,[18] with 75% of MSM being out to no one or only a few people.[19,20]

Although data on Romanian LGBT individuals' healthcare experiences are limited, reports indicate pervasive discrimination upon identity disclosure.[21] International surveys show low rates of HIV testing,[14,15] attributed to verbal abuse from healthcare staff.[10] Data also reveal frequently reported depression, anxiety, isolation, and identity concealment in healthcare settings (Lelutiu-Weinberger C, Manu M, Lăscut F, et al.: Preliminary efficacy of the first mobile health intervention to reduce HIV risk among MSM in Romania. Article submitted for publication, 2016). Despite low healthcare utilization, Romanian LGBT individuals rank the highest among EU members in their desire to use LGBT-competent healthcare,[10] including LGBT-competent mental health services. However, Romanian LGBT individuals' physical and mental healthcare are compromised by discrimination and lack of psychosocial support, which have been associated with sexual risk, substance use, and depressive symptoms.[11,12,22–29] Furthermore, previous findings indicate that mental health disorders, alcohol use, and sexual risk increase with a lack of protective laws (i.e., same-sex marriage, nondiscriminatory housing and employment) for LGB individuals.[30] While mental healthcare is provided through both the national healthcare system and privately, utilization of mental health services remains stigmatized.[31–33] Notably, however, seeking counseling services is gradually becoming normative in European countries,[34,35] resembling a U.S.-based model of individual counseling. Yet, there is a high need for LGBT-competent mental health professionals (MHPs) in Romania.

Accurate epidemiologic data are not available for Romanian LGBT individuals, at least, in part, due to identity concealment motivated by fear. Global cross-national research, however, has documented that LGBT individuals present higher anxious affect, cardiovascular disease, obesity, substance and tobacco use, suicidal ideation, and sexual victimization compared to heterosexual individuals.[36,37] Among LGBT individuals, poor mental health, specifically anxiety and depression, is associated with health risks.[22–25,38–41] Furthermore, individuals in same-sex relationships report significantly more barriers to healthcare access than individuals in opposite-sex relationships.[42] Based on data from other countries, these disparities might be attributable to minority stress, healthcare discrimination, and lack of LGBT-specific medical expertise.[22,25,40,43–50] By targeting mental health concerns through psychosocial interventions, physical health risk behaviors are concomitantly addressed.[51,52]

LGBT-competent mental healthcare, which is urgently needed given LGBT individuals' elevated prevalence of psychiatric disorders,[22,25–28,30,53] is lacking in Romania (Lelutiu-Weinberger C, Manu M, Lăscut F, et al.: Preliminary efficacy of the first mobile health intervention to reduce HIV risk among MSM in Romania. Article submitted for publication, 2016).[10] Neither universities nor continuing education programs in Romania address LGBT identities and health, while dominant discourses promote homosexuality as a dangerous anomaly in need of eradication.[54,55] We set out, therefore, to test the impact of an LGBT-affirmative training for MHPs in Romania. We hypothesized that training participation would decrease negative attitudes and increase knowledge regarding LGBT identities, address stressors and mental health needs, and improve trainees' perception of clinical skills in working with LGBT clients, while reducing biased preconceptions in this primarily homophobic national context.

Methods

Participants and procedures

This study stemmed from our prior intervention research in Romania (Lelutiu-Weinberger C, Manu M, Lăscut F, et al.: Preliminary efficacy of the first mobile health intervention to reduce HIV risk among MSM in Romania. Article submitted for publication, 2016). During the aforementioned study, we replicated previous research findings indicating the high need for LGBT-competent healthcare[10]; we also documented Romanian MSM's frequent alcohol use and condomless sex, their poor sexual health communication and healthcare utilization, and lack of sexuality disclosure in medical settings, and poor mental health (Lelutiu-Weinberger C, Manu M, Lăscut F, et al.: Preliminary efficacy of the first mobile health intervention to reduce HIV risk among MSM in Romania. Article submitted for publication, 2016).

To address these issues, in March of 2016, two Romanian psychologists distributed online and social media announcements of our training, including on Facebook and the professional networks to which they belong (e.g., graduate programs in Gestalt, Rogerian, and cognitive behavioral therapy; PsyEvolution, a national mental health provider network; and psychology student associations). The training announcement contained a link to an online registration. Two weeks before the first training, participants were sent a link to a Qualtrics survey containing the informed consent and the baseline questionnaire. The first page of this link contained the informed consent, which participants read and indicated their consent to participate in this research by clicking the appropriate box at the bottom of this page. Several participants contacted one of the authors with questions regarding the study, which she clarified before the beginning of the research. Only those who consented to participate in the research were directed to a separate baseline survey, which took between 20 and 30 minutes to complete. One week after the 2-day training, all consenting participants received a link to the follow-up survey, which was identical to the baseline questionnaire. All procedures were reviewed and approved by the Human Research Protections Program at the City University of New York.

Training setting, structure, and content

We adapted the largely U.S.-derived empirical scholarship regarding LGBT identities, health needs, and clinical practice to the Romanian context through knowledge gained during our previous work in Romania. This includes consultations with 22 members of the LGBT community, three mental healthcare providers working with LGBT individuals, three medical care providers, and our own supervision of mental

and behavioral healthcare to young gay and bisexual men in Romania from 2015 to 2016 as part of a National Institutes of Health-funded trial. Given the Romanian context of high stigma toward LGBT people and relatively low knowledge regarding sexual and gender diversity, the training addressed the existence and impact of structural stigma toward LGBT people in Romania (e.g., lack of legal protection against employment or housing discrimination and low public acceptance of LGBT people) and identity-related facts (e.g., normative identity development and biopsychosocial models of sexual and gender identity formation), in addition to the standard content outlined below.

The training occurred over 2 days in early June 2016 at the American Corner at the National Library of Romania in Bucharest, which contained state-of-the-art audio–visual technology. The training was conducted in English with parallel Romanian translation for two trainees. The training contained both didactic instruction and interactive case discussions. Audience members were invited to submit questions to the trainers anonymously for review during the training. The training had three core components: (1) LGBT identities and stressors, (2) LGBT disparities and health needs, and (3) LGBT-affirmative clinical/therapeutic principles and techniques, using both didactic and experiential (e.g., case study) approaches. The modules included case studies, such that each theoretical and practical aspect of the training was paired with real-life cases of LGBT-competent therapy examples (e.g., from our Romanian clinical research). Otherwise, the training content was based on previous research and clinical scholarship regarding LGBT mental health,[27,52,56–61] direct clinical practice experience in the United States, and our provision of similar trainings, workshops, and seminars in the United States.

Module 1: LGBT identities and common stressors. This module presented the diversity of sexual and gender identities, behaviors, and attractions as a normal continuum rather than a deviance. Theories of sexual and gender identity (including how they are distinct from each other and cannot be conflated or interchangeable), development, and appropriate social supports were discussed, alongside clinical guidance for integrating these considerations into practice.[52,58,62,63] We presented theoretical and empirical evidence documenting associations between stigma-related stressors and barriers to healthcare, and poor health outcomes.[43,64]

Module 2: LGBT disparities and mental and sexual health needs. This module illustrated health disparities experienced by LGBT individuals[22,25,30,65] due to barriers to healthcare, paucity or lack of competent healthcare, and discrimination leading to avoidance of and delays in care. It is essential that mental health providers (in any context or country) integrate mental and physical health (including sexual health) in their approach to treatment for both sexual and gender minorities, given their increased risk for STI and HIV[25,66–68] and the previously documented link between poor mental health and sexual risk.[29,39,69] The module focused on the role of MHPs in counseling LGBT individuals to seek preventive healthcare (e.g., annual exams and HIV/STI testing[70–73]) and treatment (e.g., follow-up on test results and medication adherence). The module trained MHPs to teach clients about the biology of HIV transmission and the role of stigma in increasing risk,[12] and oriented MHPs to the scarcity of LGBT-competent medical services in Romania.

Module 3: LGBT-affirmative therapeutic principles and techniques. This module presented counseling models that affirm and support LGBT individuals to reduce psychological distress arising from stigma and nonaffirmative healthcare.[52,58–60,62,63] Providers were trained in helping LGBT clients find supportive communities and relationships. The module reviewed self-affirming communication skills, building safe networks to overcome isolation and depression; safe disclosure of sexual orientation (when and to whom, including in healthcare contexts); and navigation of hostile contexts.

Measures

The Qualtrics-based baseline and follow-up surveys were identical except for follow-up training acceptability measures. The surveys included demographic information and other personal characteristics, such as age, gender, sexual orientation, level of education, current profession, former or current LGBT client load, prior participation in LGBT-related trainings, and religiosity. There is a dearth of scales, including in the United States, designed to assess MHPs' (or any healthcare professionals') attitudes toward and beliefs about transgender individuals. We therefore adapted scales originally designed to assess health professionals' attitudes and beliefs regarding lesbian, bisexual, and gay individuals to include attitudes and beliefs toward transgender persons.

Efficacy of training

Attitudes, perceptions of clinical practice skills, and knowledge. The Sexual Orientation Counselor Competency Scale[74] (26 items and three subscales) measured MHPs' attitudes, skills, and knowledge related to LGBT clients. Although this scale originally applied only to sexual orientation, we modified its items to include gender variance. For example, we modified original items such as ''I am aware that counselors frequently impose their values concerning sexuality upon LGB clients'' to become ''I am aware that counselors frequently impose their values concerning sexuality upon LGBT clients.'' The items were scored on a five-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. Example items are: ''I believe that being highly discreet about their sexual orientation or gender identity is a trait that LGBT clients should work towards.'' (from the 10-item ''attitudes'' subscale, $\alpha = 0.88$); ''At this point in my professional development, I feel competent, skilled, and qualified to counsel LGBT clients'' (from the 8-item ''skills'' subscale, $\alpha = 0.81$); and ''I am aware that counselors frequently impose their values concerning sexuality upon LGBT clients'' (from the 8-item ''knowledge'' subscale, $\alpha = 0.79$).

Personal homonegativity and transnegativity were measured with the modified Modern Homonegativity Scale[75] (11 items, $\alpha = 0.86$). The items were scored on a five-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree, and included statements such as ''LGBT individuals have become far too confrontational in their demand for equal rights'' or ''LGBT individuals should stop complaining about the way they are treated in society and simply get on with their lives.'' LGBT-affirmative practice attitudes were assessed with the Gay Affirmative Practice Scale[76] (15 items, $\alpha = 0.98$). This scale was

modified to address transgender-affirmative practice, in addition to its original focus on sexual orientation. The items were scored on a five-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree, and included statements such as ''Discrimination creates problems that LGBT clients may need to address in treatment.'' or ''Practitioners should challenge misinformation about LGBT clients.'' Last, comfort with providing LGBT therapy was assessed with one question: ''Today, how comfortable do you feel in addressing the mental health care needs of LGBT patients.''[77] Response options ranged from 1 = very uncomfortable to 5 = very comfortable.

Acceptability of training

Acceptability measures included both a qualitative inquiry and seven quantitative questions in the follow-up survey. Examples of the latter included questions such as ''How interested were you in the training'' (from 1 = not interested at all to 5 = highly interested); ''How informative was the training?'' (from 1 = not at all informative to 5 = extremely informative); and ''How helpful were the sessions in helping you feel motivated to make changes in your interactions with LGBT individuals?'' (from 1 = not at all helpful to 5 = extremely helpful). In addition, we asked participants to list what they perceived to be the most important lessons of the training by asking an open-ended question at the end of the follow-up survey: ''What are the most important things you learned during this training?''

Analyses

Descriptive statistics were obtained for demographic variables. Before computing mean scale scores, necessary items were reverse coded. To detect possible changes from baseline to follow-up in our outcomes of interest, we conducted bivariate analyses in the form of both parametric (paired samples *t*-tests) and nonparametric tests (Wilcoxon signed rank tests), given the sample size. Significance level was set at $P < 0.05$; however, we report differences if the *P*-value was below 0.10, because differences may indicate trends of change in the desired direction, which could become significant in a larger sample. Analyses were conducted using SPSS 23 (IBM SPSS Statistics, IBM Corporation, Armonk, NY).[78]

To identify the most important lessons that MHPs learned from the training, we used thematic coding[79,80] to identify assertions about training impact. We assumed an *axial coding* approach guided by the three overarching categories derived from the main training components: LGBT Identities; LGBT Health; and Clinical Approaches. Concomitantly, we employed *open coding* to identify themes emerging from participants' perspectives,[81] as operationalizations of the three main training components, such as ''general identity comprehension and understanding how LGBT individuals are stigmatized'' under LGBT Identities; ''stigma's impact on health'' under LGBT Health; and ''case example reference'' under Clinical Approaches. Although some qualitative data segments fit more than one theme, to avoid redundancy, we present data coding in relation to its most representative category. The text was written directly in English by the trainees and the author, who is fluent in Romanian, made minor edits as needed, to maximize clarity (e.g., typos, adding missing words, or removing distracting fragments). The edits were minimal and did not change the original meaning of the text written by trainees. The author who made the edits revisited them several times to ensure maintenance of the original text.

Results

Sixty-six individuals registered for the training. Of these, 54 attended. Approximately half of those who registered and did not attend reported scheduling conflicts. Forty individuals provided evaluation data at baseline, 39 at follow-up, and 33 at both baseline and follow-up; we report demographic data for the full baseline sample ($N = 40$) and conducted efficacy analyses with data from 33 participants who provided two data points.

Demographic distribution

Table 1 describes the sample, 45% of whom reported being in their 30s (M age = 36.4, $SD = 7.7$, range 25–54); 90% of whom reported being female and having a graduate degree; and 73% of whom reported having a heterosexual orientation. The majority of the sample indicated being a clinical psychologist (87%), with three being in training (8%); two participants were psychiatrists (one practicing and one in training). Notably, 27% ($n = 13$) of the sample had provided psychological care to LGBT individuals for an average of 2 years (range 7 months to 3 years). However, only three individuals had been exposed to LGBT-related training in the past, with one reporting a total of 8 hours of training and one reporting a total of 29 hours of training.

Table 1. Trainee Demographic Characteristics ($N = 40$)

	n *(%)*
Age	
25–29	9 (23)
30–39	18 (45)
40–49	4 (10)
50 and above	3 (7)
Not reported	6 (15)
Education	
Master's or medical school student	4 (10)
Graduate degree	36 (90)
Gender identity	
Female	36 (90)
Male	4 (10)
Sexual identity	
Gay or lesbian	2 (5)
Bisexual	3 (8)
Heterosexual	29 (73)
Other	1 (2)
Not reported	5 (12)
Occupation	
Psychologists (practicing)	34 (87)
Psychologists (in training)	3 (8)
Psychiatrists (practicing or in training)	2 (5)
Level of religiosity	
None to low	12 (34)
Moderately to high	23 (66)

Not every respondent provided answers to each question; therefore the *n* for each category varies.

Table 2. Reported Lesbian, Gay, Bisexual, and Transgender-Related Attitudes, Skills, and Knowledge from Baseline to Follow-Up ($N = 33$)

	Baseline mean (SD)	*Follow-up mean (SD)*	*Test statistic*
LGBT-related provider competency			
Negative attitudes	1.7 (0.7)	1.6 (0.9)	$t(32) = 1.27$
Clinical skills	2.9 (1.1)	4.1 (0.9)	$t(32) = -6.10$***
Knowledge of LGBT clinical issues	3.1 (0.6)	3.4 (0.6)	$t(31) = -3.32$*
Comfort with addressing mental health needs of LGBT individuals	3.9 (1.1)	4.5 (1.0)	$t(28) = -3.26$**
LGBT-affirmative practice attitudes	4.3 (0.5)	4.5 (0.5)	$t(29) = -1.7$[a]
Homonegative and transnegative attitudes	2.3 (0.6)	2.1 (0.6)	$t(29) = 2.84$**

*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.
[a]Marginal significance found in parametric analyses ($P = 0.10$), while a nonparametric Wilcoxon Ranks Test indicated statistical significance ($Z = -1.99$, $P < 0.05$).
LGBT, lesbian, gay, bisexual, and transgender.

Attitudes, skills, and knowledge

Table 2 provides the results of the pre–post training efficacy. Perceived knowledge of and skill in treating LGBT individuals increased significantly from baseline to follow-up ($M = 3.1$, $SD = 0.6$ vs. $M = 3.4$, $SD = 0.6$, $P < 0.05$; and $M = 2.9$, $SD = 1.1$ vs. $M = 4.1$, $SD = 0.9$, $P < 0.001$, respectively). Negative attitudes toward LGBT individuals remained the same; however, both baseline and follow-up scores were low (means of 1.7 and 1.6, respectively, on a five-point scale).

Participants reported significant increases in their comfort addressing the mental health needs of LGBT individuals ($M = 3.9$, $SD = 1.1$ vs. $M = 4.5$, $SD = 1.0$, $P < 0.01$). Marginal increases in LGBT-affirmative practice attitudes were found in parametric analyses ($M = 4.3$, $SD = 0.5$ vs. $M = 4.5$, $SD = 0.5$, $P = 0.10$); while nonparametric analyses indicated that this increase was significant ($Z = -1.99$, $P < 0.05$). The mean scores for the modified Gay Affirmative Practice Scale were high both at baseline and follow-up (4.3 and 4.5, respectively, on a five-point scale). Last, homonegative and transnegative attitudes were significantly reduced from baseline to follow-up ($M = 2.3$, $SD = 0.6$ vs. $M = 2.1$, $SD = 0.6$, $P < 0.01$).

Training acceptability

The majority of trainees reported being highly interested in the training (84%), which they found to be extremely informative (58%) (Table 3). The majority of the MHPs also found the modules to have been highly helpful for gaining more knowledge (55%), in feeling motivated to make changes in their interactions with LGBT individuals (52%), in developing a better understanding of LGBT identities (68%), and in preparing them to interact with and care for LGBT individuals (74%).

Lessons learned

The most common themes reported by trainees in response to ''What are the most important things you learned during this training'' are reported in Table 4, which contains direct participant quotes at the follow-up assessment. These are organized by what we identified to be three main categories reflective of the training content (using ''axial coding''), and most common themes that emerged from participant data (using ''open coding'') under each of these categories. The first category pertains to *LGBT Identities*, with two themes indicative of new knowledge gains in (1) general LGBT identities comprehension and understanding how LGBT individuals are stigmatized (e.g., ''Homosexuality is a natural expression of sexuality in humans'' and ''The effects of social opinion on individual's self-perception.'') and (2) attitude shifts (e.g., ''The concept of internalized homophobia was of great importance to me.'') The second category by which participant responses were organized was related to *LGBT Health*, which includes two themes, specifically (1) minority stress impact on health (e.g., ''More details about the effects of shame on one's self-confidence, the difficulty of being different and its effects on the whole life and society, the negative discrimination risks and implications.'') and (2) stigma's impact on health (e.g., ''More about LGBT individuals' experiences (with more stress and few support sources) [which negatively impact their health].'')

Last, under the third category, participants referenced learning about *Clinical Approaches* to support LGBT individuals, which encapsulates two themes: (1) addressing LGBT mental health affirmatively (e.g., ''[I learned] about Affirmative Therapy for LGBT [individuals]. Now, I understand the big picture and—[at] the same time—the details

Table 3. Trainee Session Evaluation Ratings

	Highly/ extremely (%)	*Very (%)*
How interested were you?	84	13
How informative was it?	58	36
How knowledgeable were the trainers?	74	23
How helpful were the sessions in…		
…helping you gain more knowledge?	55	39
…helping you feel motivated to make changes in your interactions with LGBT individuals?	52	42
…developing a better understanding of LGBT identities?	68	26
…preparing you (further) in interacting with and caring for LGBT individuals?	74	16

Table 4. Most Important Lessons Taken Away from the Training

Topic	*Theme*	*Participant comments*
LGBT identities	General identity comprehension and understanding of LGBT stigmatization	''Homosexuality is a natural expression of sexuality in humans.''
		''To better understand the LGBT people. Being gay/lesbian is not a choice, [it] is about attraction.''
		''I've learned about LGBT lifestyle, types of LGBT individuals.''
		''In this training I learned that LGBT identity is not a choice [it] is an orientation.''
		''Information about the gay community here in Romania.''
		''The effects of social opinion on individual's self-perception, the process and manifestations of internalized homophobia.''
	Attitude shifts	''I knew that this category of people—LGBT—is different from us, the straight ones … but we have to understand those differences … we must learn a great deal from them: after all, we are people with needs and all of us suffer sometimes in our life, all of us have desires, dreams or failure, broken dreams. Why is it so hard to understand?! Why do we have to compare and have prejudices??? Yes … we are different… but also the same in our humanity.''
		''Those with LGBT identity are not 'sick' or abnormal and may or must be healed. I learned about homophobic stigma that may be 'criminal' and any man regardless of his sexual orientation, should not go through this.''
		''The concept of internalized homophobia was of great importance to me.''
		''There were two enlightening [pieces of] information for me in regards with the social stigma and internalized homophobia.''
		''Understanding is the best way for a good life!!!''
		''To be tolerant and to help LGBT individuals.''
		''I learned that LGBT persons have the same needs and feelings as hetero people.''
		''Knowing and learning is the best way to improve yourself and understand how important is to look at life from the right perspective.''
		''In my opinion the most important thing that I learned during this training is that the LGBT people have a strong community and with the increase of the specialists [who can support them] it can be much stronger.''
		''[Being] LGBT is not an illness or a choice—psychologists have no information and training in LGBT [issues].''
LGBT health	Minority stress impact on health	''Better understanding the multilevel issues regarding LGBT status.''
		''Statistics about homophobia [in the context of health disparities due to minority stress].''
		''The concept of internalized homophobia comes into mind.''
		''To understand LGBT problems.''
		''I've learned about how an LGBT person feels.''
		''More details about the effects of shame on one's self-confidence, the difficulty of being different and its effects on the whole life and society, the negative discrimination risks and implications.''
	Stigma's impact on health	''Consider the negative impact of stigma''
		''I learned about …. HIV''
		''The clear data about how LGBT [individuals are] affected in terms of mental illness.''
		''The consequences of minority stress.''
		''Stigma is the most important trigger of distress.''
		''More about LGBT individuals' experiences (with more stress and few support sources) [which negatively impact their health].''
		''[Health] risks of unprotected sex, info about HIV.''
		''The risk and the treatment of HIV.''
		''[I learned] about LGBT mental health; about genetic causes.''

(*continued*)

TABLE 4. (CONTINUED)

Topic	*Theme*	*Participant comments*
Clinical approaches	Addressing LGBT mental health affirmatively	''[I learned] methods of affirmative therapy.'' ''Practice guidelines for LGB clients.'' ''How to work with LGBT clients in an affirmative framework.'' ''Approach an LGBT client in a respectful and affirmative way—the challenges that a psychotherapist/counselor caring for LGBT clients may encounter—how to express my feelings when working with LGBT clients—ethical challenges when caring with LGBT clients—therapy with a LGBT person is no different from therapy with straight clients (in many ways)—the most important issue to be understood in the relationship with LGBT clients is the stigma attached to their status, which is sometimes their main issue.'' ''How to better help a client if he or she is LGBT in counseling.'' ''[I learned the] 'know how's' about how I could actually help them.'' ''The most important things that I learned … was that I realized that I have the best profession in the world. I respect all my clients no matter if they are straight, transgender, LGB, adolescents, … women or men.'' ''What implies being an affirmative therapist—the challenges of providing therapy for LGBT clients.'' ''[I learned] about affirmative therapy for LGBT [individuals]. Now, I understand the big picture and–[at] the same time —the details that compose it. This session helped me to get all the information I need about LGBT persons. Now, I have the knowledge of what to do in a psychological intervention to a LGB person.''
	Case example references	''Sexual compulsivity, about internal homophobia and I also learned a lot from the cases presented.'' ''Be honest, supportive.'' ''The challenges that a psychotherapist/counselor caring for LGBT clients may encounter.'' ''I will remember [from] now [on] that helpful question: ''Do you date men, women or both?'' ''Things that need to [be] address[ed] in therapy, like the stress of stigma, finding the anchors, building supportive relationship[s] and validate the strengths [that LGBT persons] have… We need to do something that will make our society feel more comfortable with LGBT people.'' ''Most important for my profession, I learned the best approach for those with LGBT identity.'' ''I loved how [the trainers] presented information about LGBT people, how, who and when we can help them and be supportive.'' ''Internalized homophobia should be addressed.'' ''Most valuable [was the trainers'] direct experience … Quite impressive work … and great example of effective practice. … It gave me a reliable image of the issues that LGBT community confronts daily and better tools and understanding of how to build an effective and warm relationship with an LGBT person.''

Brackets indicate additions by the authors to increase clarity; parentheses appear as they were inserted by the participants themselves as they provided written comments.

that compose it'';) and (2) learning through case examples (e.g., ''I will remember [from] now [on] that helpful question: 'Do you date men, women, or both?''' or ''Things that need to [be] address[ed] in therapy, like the stress of stigma, finding the anchors, building supportive relationship[s], and validate the strengths [that LGBT persons] have … We need to do something that will make our society feel more comfortable with LGBT people.''

Discussion

To ameliorate the normative dearth of LGBT-affirmative mental health expertise in Romania, we developed and delivered a training, and evaluated its impact on participating MHPs in a one-group pre–post intervention design. Participation in the 2-day training significantly increased MHPs' perceived clinical skills and knowledge of LGBT mental

health concerns, as well as their reported comfort with providing care to LGBT individuals. The trainees reported significant reductions in homonegative and transnegative attitudes and rated the acceptability of the training as high. Besides the quantitative assessment of possible changes in trainee attitudes, MHPs' comments on the ''most important lessons'' learned indicated that they retained overarching knowledge of LGBT-affirmative mental health practice conveyed during the training. These lessons entailed an increase in understanding about LGBT identities, awareness of the effects of stigma, particularly physical and mental health needs of LGBT individuals, and affirmative modalities to address these needs.

These findings are encouraging given that LGBT individuals are likely to need mental health support to an even greater extent than the general population as they present with disproportionately elevated rates of depression and anxiety, especially in LGBT discriminatory contexts.[26,30] Furthermore, good mental health is likely to have a positive effect on the health behaviors with which it is associated,[52] such as increased healthcare utilization (e.g., adequate HIV testing and medication adherence) and reduced health-risk behaviors (e.g., condom use and substance use).[82] As Romanian society becomes more accepting of seeking mental health services, building a cadre of LGBT-affirmative practitioners is increasingly necessary, given that LGBT people are significantly more likely than the general population to seek mental healthcare.[47,60,61]

Each of the variables we measured changed significantly, with the exception of negative attitudes, which showed trends in the desired direction. Notably, baseline and follow-up scores indicated few negative attitudes toward LGBT individuals, potentially reflecting the relative acceptance of sexual and gender diversity among our sample. This training model needs to be evaluated further and include longer term follow-ups (e.g., up to 12 months) and assessments of LGBT-affirmative clinical skill implementation. However, given the preliminary evidence of the potential efficacy of the training evaluated herein, such a training model might show promise in similarly homophobic national contexts globally.

Limitations

Our findings should be considered in light of several limitations. First, the training was delivered to one group, using a pre–post design; therefore, the impact of participation was not compared to a control group. Future research should include a control group in a randomized controlled trial to confirm the efficacy of the training to produce attitudinal and knowledge changes. Second, the participants were MHPs who willingly enrolled in this training; as such, self-selection bias may affect our findings. Results may differ if the training was to be delivered to a random selection of MHPs. However, despite potential self-selection bias, scores on all other outcomes shifted significantly in the desired direction from baseline to follow-up, indicating that change was needed and could indeed occur even within LGBT-supportive MPHs.

Because we did not assess the impact of our training on actual clinical practice, future research might collect patient treatment outcome measures to substantiate the real-world impact of this training. Given the potential for knowledge loss over time and the need to receive further training upon the implementation of new clinical skills, future research might also test the efficacy of including training boosters and ongoing supervision. The use of mobile technologies may also be considered to provide boosters or supervision efficiently across geographic boundaries. Future training models may consist of hybrid in-person and virtual meetings, where both didactic and interactive teaching and learning can occur. In addition, next iterations of this evaluation might include implicit measures of attitudinal shifts, given known biases of self-reported attitudes regarding sensitive social topics.[83] Finally, due to a dearth of scales assessing MHPs' (or any healthcare professionals') attitudes toward and beliefs about transgender individuals, we adapted scales originally designed to assess health professionals' attitudes and beliefs regarding lesbian, bisexual, and gay individuals. These original scales' focus was on sexual orientation rather than gender identity. The need to develop trans-specific measurement tools remains paramount. This limitation, however, may be reduced by the fact that one of the authors has applied these scales in a previous similar study focused on medical provider training to increase transgender health competency.[84]

Conclusion

Reductions in structural homonegativity and transnegativity ultimately require a multilevel intervention approach, including changing attitudes and practices among individuals, groups, and institutions.[25,37,48,50,85] The type of provider training tested herein possesses promise for effecting change at each of these levels, as this training affected the attitudes of individual participants directly and positively, and has the potential to change normative practice within mental health professions. Empowering individual practitioners to be agents of stigma reduction and LGBT-competent health practice increases the odds that the institutions to which they belong might follow suit as a matter of standard practice. For example, once a critical mass of practitioners recognizes the direct clinical and human rights benefits of LGBT-competent practice, they can advocate for the inclusion of LGBT-affirmative trainings in graduate and medical educational settings, with the collaboration of professional accrediting bodies. Ultimately, empowering respected professionals with the knowledge and skills to deliver LGBT-affirmative practice can improve not only the health of the LGBT individuals but also the structural climates that surround them and their health.

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