

# Mental Health Treatment Experiences among Sexual and Gender Minority Individuals: Trauma Exposure, Barriers, Microaggressions, and Treatment Satisfaction

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### **Abstract**

Introduction: While trauma experiences and treatment-seeking are common among sexual and gender minority (SGM) individuals, little is known about their specific experiences in psychotherapy, including treatment types, characteristics (*e.g.*, length, episodes), barriers, satisfaction, and microaggressions.

Method: SGM individuals ( $N = 2685$ ) from a national cohort study completed a survey.

Result: The majority (87%) of participants endorsed past therapy, including for trauma (56%). Ratings of therapy barriers and microaggressions were low and satisfaction with therapy was high. However, therapy experiences differed based on sexual orientation, gender, and if the therapy was focused on trauma.

Conclusion: Effective treatments for trauma should be informed by the needs of the diverse groups that comprise the SGM community.

**Keywords:** Trauma, sexual minority, gender minority, psychotherapy

## **Treatment Experiences among Sexual and Gender Minority Individuals: Trauma Exposure, Barriers, Microaggressions, and Treatment Satisfaction**

Trauma and post-traumatic stress disorder (PTSD) are significant public health concerns among sexual and gender minority (SM and GM, respectively or SGM when considered together) individuals. Trauma exposure is estimated as high as 82% for SGM individuals (Goldstein et al., 2016; House et al., 2011; Roberts et al., 2010a; Shipherd et al., 2011), which is roughly twice that of the general population (Lukaschek et al., 2013). Rates of PTSD among SGM groups are conservatively estimated at 11-39% (Pantalone et al., 2020), and SGM individuals are more likely to experience PTSD than cisgender, heterosexual persons (Roberts et al., 2010b; Shipherd et al., 2011). This increased risk is partially explained by the higher prevalence of trauma exposure, especially interpersonal trauma, among SGM individuals (Roberts et al., 2010b, 2012a; Stenersen et al., 2019; Valentine et al., 2023). Relative to other trauma types, interpersonal traumas are associated with increased PTSD symptom onset (Roberts et al., 2010), severity, and duration (Chapman et al., 2012; Forbes et al., 2011, 2013; Smith et al., 2016).

In addition to increased exposure to events that meet Criterion A (exposure to or witnessing death, threat of death, serious injury, or sexual violence) for PTSD (American Psychological Association, 2013), SGM individuals report pervasive experiences of minority stress (Green et al., 2022; Meyer, 2003; Puckett et al., 2016; Timmins et al., 2017). Examples of minority stressors include incidents such as negative slights or insults, misgendering, sexualization, pathologizing SGM identities, endorsing or reinforcing heteronormativity, stereotyping, and dismissiveness (Bostwick & Hequembourg, 2014; Nadal et al., 2011; Nadal et al., 2012a). Even when these incidents do not meet the definition of trauma described in the

DSM-5 (Criterion A) minority stress can result in traumatic stress responses (Cardona et al., 2022). In a large sample of SGM participants from The PRIDE Study, an online survey confirmed that minority stress predicted symptoms of PTSD even after controlling for exposure to Criterion A traumatic events (Ceja et al., 2023). Similarly, studies using broader trauma exposure criteria found that SGM individuals reported clinically significant PTSD symptoms in response to prejudice, microaggressions, and other events that do not meet Criterion A (Alessi, Martin, et al., 2013; Alessi, Meyer, et al., 2013). Microaggressions are also associated with PTSD symptom severity (Robinson & Rubin, 2016) and appear to serve as trauma reminders (*i.e.*, “triggers”) for memories of traumatic discrimination (Helms et al., 2012). The activation of trauma memories, in turn, triggers maladaptive trauma-related cognitions (*e.g.*, self-blame, dangerous world cognitions), which are associated with worse PTSD symptoms (Dworkin et al., 2018).

### **Treatment Experiences among SGM Individuals**

Although the heightened risk for PTSD among SGM individuals is well-documented, little is known about the treatment experiences of SGM individuals who have trauma-related mental health needs. With regard to general mental health treatment, SGM individuals have reported both affirming and negating experiences (Berke et al., 2016); and to our knowledge, no studies have reported SGM client perceptions of trauma-focused treatment. Many community centers that offer mental health services to SGM individuals are described as “trauma-informed,” (Pachankis et al., 2021) but this descriptor tends to be ill-defined and not consistently evidence-based (Berliner & Kolko, 2016). The extent to which SGM individuals receive adequate, evidence-based PTSD treatment is unknown, and there have been no studies that we are aware of regarding client experiences with trauma treatment in these settings (Pachankis et al., 2021).

## **Barriers to Seeking Treatment**

SGM individuals are more likely than heterosexual, cisgender individuals to utilize mental health services (Burgess et al., 2007; Cochran et al., 2017; Grella et al., 2009; Platt et al., 2018), yet report significant unmet needs and treatment barriers (Burgess et al., 2007; Shipherd et al., 2010; Steele et al., 2017). These barriers include financial constraints (Ferlatte et al., 2020; Moore et al., 2020); scarcity of identity-affirming services (McIntyre et al., 2011; Moore et al., 2020; Veltman & Chaimowitz, 2014); concealment of identity (Currin et al., 2018); stigma; fear of discrimination; and mistrust of providers driven by historical and ongoing marginalization of SGM identities within the mental health system (Ansara & Hegarty, 2012; Daley & Mulé, 2014; Livingston et al., 2020a; McIntyre et al., 2011; Pachankis et al., 2021; Smalley et al., 2015). However, there is a dearth of research on barriers specific to trauma treatment. Given that accessing trauma treatment poses unique obstacles within the general population, understanding the barriers faced by SGM individuals in accessing trauma-specific care is necessary to inform interventions and services (Kantor et al., 2017).

## **Microaggressions in Therapy**

Microaggressions are considered a distal minority stressor (Shipherd et al., 2019); therefore, microaggressions perpetrated by the therapist and/or the therapeutic environment contribute to a patient's experience of minority stress in treatment (Spengler et al., 2016). Such microaggressions have a negative impact on therapeutic outcomes such as therapeutic alliance, treatment satisfaction, emotional experiences, attitudes towards therapy, treatment attrition, beliefs about therapy effectiveness, and future help-seeking (Anzani et al., 2021; Nadal et al., 2011; Owen et al., 2011; Rees et al., 2021; Seelman et al., 2017; Shelton & Delgado-Romero, 2011; Sue & Sue, 2012). Notably, like microaggressions outside of therapy, microaggressions

that occur in psychotherapy vary thematically based on specific identities with some unique themes emerging for bisexual (Eady et al., 2011) and transgender clients (Mizock & Lundquist, 2016; Morris et al., 2020). As such, it is important to investigate whether the effects of microaggressions in trauma-focused treatment vary by specific sexual orientation and gender identities rather than assuming a homogenous experience for all SGM individuals.

The literature on microaggressions is largely comprised of qualitative studies that have provided rich, descriptive information on the experiences of SGM individuals in psychotherapy. However, without complementary quantitative research, estimating the extent of the problem and quantifying its effects on treatment experience, therapeutic alliance, and outcomes is difficult. Additional research is needed to better understand these relationships (Budge et al., 2017). Furthermore, the prevalence, typology, and impact of microaggressions in trauma-focused treatment with SGM clients has not been investigated.

### **Treatment Satisfaction**

Treatment satisfaction is a critical aspect of psychotherapy experience and has been shown to be a predictor of PTSD treatment outcomes (Gros et al., 2013). A recent review found variability in satisfaction with mental health treatment among SGM clients (Filice & Meyer, 2018). Minority stress experienced by SGM individuals before and during trauma treatment (like other forms of treatment) may impact treatment satisfaction and related outcomes (Rees et al., 2021; Shelton & Delgado-Romero, 2011). Other factors such as seeking services in SGM-specific clinics or in states with LGBTQIA+ anti-discrimination legislation have been associated with greater satisfaction (Baldwin et al., 2017; Benjamin et al., 2021; Pachankis et al., 2021). Additional research is needed to understand the satisfaction with trauma-focused treatments,

particularly using diverse and representative samples of SGM trauma survivors such that differences in subgroups can be explored.

### **Trauma Treatment**

The existing literature (Livingston et al., 2020b; Salomaa et al., 2023; Shipherd et al., 2019) indicates that, in order to address trauma-related mental health concerns in SGM individuals, psychotherapies must be trauma-focused and informed by the unique experiences that SGM individuals have with trauma exposure, microaggressions, and treatment satisfaction. Several existing trauma-focused therapies effectively treat PTSD and other trauma-related symptoms among SGM individuals (*e.g.*, Watkins et al., 2018). Various professional organizations, including the American Psychological Association (APA), have established practice recommendations for the use of effective PTSD therapies; those with a strong recommendation from the APA include cognitive behavioral therapy (*e.g.*, Trauma-Focused CBT, Skills Training in Affective and Interpersonal Regulation-Narrative Therapy), Cognitive Processing Therapy, cognitive therapy, and Prolonged Exposure. (American Psychological Association, 2019; Forman-Hoffman et al., 2018). It has been suggested that trauma-focused treatment for SGM individuals needs to be better informed by an understanding of minority stress and to account for continued threats to safety experienced by SGM people (Livingston et al., 2019; Shipherd et al., 2019).

Few studies have examined outcomes of trauma-related treatments provided to SGM participant groups (O’Cleirigh et al., 2019; Pachankis et al., 2015; Williams et al., 2013). One study examined PTSD as a secondary outcome to a trauma-informed CBT intervention for an SGM-specific sub-sample of men who have sex with men and found reductions in PTSD total symptoms at post-treatment (O’Cleirigh et al., 2019). Additionally, one case study found that

adapting PE and CPT helped address PTSD symptoms and negative beliefs associated with identity-related traumas in two SGM individuals (Pantalone et al., 2017).

There is a paucity of research on the experience of SGM clients in trauma therapy, particularly considering the burden of trauma exposure within this population (*e.g.*, Livingston et al., 2019). No studies to our knowledge have reported the extent to which SGM individuals have received these evidence-based trauma treatments or other kinds of trauma treatment. It is unknown if SGM individuals experience unique barriers and microaggressions in the context of trauma treatment compared to other kinds of treatment and if satisfaction with trauma treatment mirrors satisfaction with other kinds of therapy.

### **The Present Study**

Trauma exposure and minority stress in the SGM community have been well documented (Bostwick & Hequembourg, 2014; Ceja et al., 2023; House et al., 2011; Jillian C. Shipherd et al., 2021; Livingston et al., 2019; Nadal et al., 2012b; Nadal et al., 2011; Roberts et al., 2012b; Stenersen et al., 2019; Susan D. Cochran et al., 2017). Efforts to connect evidence-based trauma treatments to SGM individuals with PTSD and other trauma-related difficulties may be enhanced by a deeper understanding how SGM individuals perceive trauma treatment and their prior experiences of seeking and participating in therapy. The present study had five main aims: (1) describe treatment experiences (*i.e.*, times, types, length, characteristics, and modalities of psychotherapy encounters) among SGM adults; (2) describe barriers to treatment reported by SGM adults; (3) describe the frequency and type of microaggressions that SGM adults have experienced in treatment; (4) describe the degree to which SGM adults are satisfied with their treatment; and (5) examine differences in barriers, microaggressions, and satisfaction across SGM subgroups, race/ethnicity, and reason for seeking treatment (trauma or PTSD; stress or



another mental health concern). We hypothesize that the relationship between SGM identities and therapy satisfaction will be mediated by microaggressions that occur in therapy.

### **Method**

This study utilized an online survey distributed by The Population Research in Identity and Disparities for Quality (PRIDE) Study, a national, longitudinal cohort study of SGM adults (age  $\geq 18$ ) (Lunn et al., 2019). The PRIDE Study collects participants' health information annually. Within The PRIDE Study, participants are offered the option to participate in additional surveys throughout the year, such as this survey, which was offered as an ancillary survey was made available to The PRIDE Study participants. Demographic data were collected from the PRIDE Study annual survey, and the remaining data were collected in the ancillary survey. Among those who finished this survey, median time of completion was 13.3 minutes. All participants provided informed consent, and the study was approved by the University of California, San Francisco and Stanford University IRBs. The current primary IRB is the WIRB-Copernicus Group (WCG) IRB.

### **Participants**

Participants included 2,685 adults who identify as SGM and completed the ancillary online survey in early 2022. Participants who completed any part of the ancillary survey were included in this study. Of the 2,685 participants, 90% identified as White, 5.44% as Hispanic, Latino, or Spanish, 4.66% as Asian, 3.17% as Black, African American, or African, 2.78% as American Indian or Alaskan Native, 1.42% as Middle Eastern or North African, 0.26% as Native Hawaiian or Pacific Islander, 1.53% as another race, and 10.09% of participants reported more than one race or ethnicity. The mean age was 37.73 ( $SD = 15.08$ ). Sexual orientation and gender identity were assessed in two different ways. First, participants were given the opportunity to

endorse multiple sexual orientations and gender identities; then second, participants were asked to select the term that best described their identity from sets of mutually exclusive response options (see list below). We then used the mutually exclusive sexual orientation and gender variables to enable comparisons by sexual orientation and gender identity where the participant, as opposed to the researcher, determined their relevant category. In terms of sexual orientation, 37.88% participants identified as gay/lesbian, 23.28% as bisexual/pansexual, 20.34% as queer, 7.49% as asexual/demisexual/gray-ace, 1.27% as straight/heterosexual, and 0.30% as another sexual orientation. The gender makeup of the participants included 26.18% cisgender women, 23.28% cisgender men, 20.48% non-binary people, 11.96% transgender men, 5.36% transgender women, and 3.20% reported another gender identity. For a full summary of sample demographics characteristics, see Table 1.

## Measures

### *Trauma Exposure and Treatment Experiences.*

*Trauma Exposure and Treatment Experiences Survey Items.* Survey items were created to assess characteristics of treatment experiences including the number of treatment episodes (one or more sessions with a provider), types, length, characteristics (*e.g.*, treatment setting, provider characteristics, delivery method), and modalities of psychotherapy encounters for trauma, PTSD, and other concerns. Participants were asked to report if they had experienced something “frightening, horrible, or traumatic” (from Prins et al., 2016, designed to screen for criterion A trauma exposure) and how many times. Participants indicated current or past PTSD diagnosis by a healthcare provider. Participants were provided with descriptions of evidence-based treatment types and asked to indicate if they had participated in these types of treatments (*e.g.*, “Cognitive Behavioral Therapy: Usually brief [12-16 sessions], CBT targets unhelpful trauma-related

thoughts and behaviors with a goal to change them). The items assessing the characteristics of treatment experiences and the descriptions of treatment types were developed by experts in trauma treatment research and in SGM mental health. These items were then reviewed by a stakeholder group that included SGM patients, clinicians, and clinic administrators from agencies that provide medical and mental health services to SGM patients.

*Abbreviated Posttraumatic Stress Checklist (PCL-6; Lang & Stein, 2005).* The abbreviated PCL is a 6-item self-report measure of DSM-5 PTSD symptoms. Items are rated on a 5-point Likert scale with higher scores indicating greater severity. A cutoff score of 14 indicates probable PTSD (Lang et al., 2012). In the current sample, internal consistency was good (Cronbach's  $\alpha = 0.86$ ).

### ***Barriers to Treatment***

*Barriers to Access to Care Evaluation, Version 3 (BACE-3)* is a self-report measure of treatment barriers to psychotherapy/counseling that was adapted and validated for SGM respondents (Ferlatte et al., 2019). Eighteen statements describing barriers are rated on a 4-point Likert scale with higher scores (ranging from 18-72) indicating greater barriers to accessing care. Minor modifications (e.g., added “or identity” to “Professionals from ethnic, cultural or identity group not available;” changed *SGM* to *LGBTQ+* for consistent phrasing) were made for the current study. The BACE-3 has demonstrated good reliability and validity (Clement et al., 2012). In the current sample, internal consistency was acceptable (Cronbach's  $\alpha = 0.79$ ).

### ***Microaggressions***

*Adapted Racial Microaggressions in Counseling Scale (RMCS; Constantine, 2007).* The original RMCS is a 10-item self-report measure of racial microaggressions. Items are rated on the following 3-point scale: 0 = *This never happened*, 1 = *This happened, but it did not bother*

*me at all*, and 2 = *This happened and I was bothered by it*. For our study purposes, we adapted instructions to refer to “identity and personal characteristics,” changed “cultural group” to “identity” or “identity group,” and revised “counselors” to “psychotherapist/counselor” for consistent phrasing. Examples of microaggressions in counseling included in the RMCS include “avoided discussing or addressing identity issues,” “thought at times that I was overly sensitive about identity issues,” and “offered therapeutic assistance that was inappropriate or unneeded based on my identity group.” The original RMCS has demonstrated acceptable reliability (Constantine, 2007). In the current sample, internal consistency was excellent (Cronbach’s  $\alpha = 0.90$ ).

### ***Treatment Satisfaction***

*Satisfaction with Therapy and Therapist Scale- Revised* (STTS-R; Oei & Green, 2008).

The STTS-R is a 13-item self-report measure consisting of two factors: satisfaction with therapist and satisfaction with therapy. Items are rated on a 5-point Likert scale with higher scores indicating greater satisfaction. Participants rated their agreement from 1 = *Strongly disagree* to 5 = *Strongly agree* on statements describing their opinion of therapy. The STTS-R has demonstrated strong reliability and validity (Oei & Green, 2008). In the present study, internal consistency was excellent for the ‘satisfaction with therapy’ subscale (Cronbach’s  $\alpha = 0.91$ ) and the ‘satisfaction with therapist’ subscale (Cronbach’s  $\alpha = 0.92$ ).

### **Statistical Analyses**

Descriptive analyses examined rates of utilization for various types of treatment, modalities of treatment, therapy/therapist specializations, and interventions. Differences in barriers, microaggressions, and satisfaction based on type of counseling, sexual orientation, gender identity, and race/ethnicity were tested using general linear modeling (GLM) and least

squares mean (LSM) pairwise comparisons. To investigate whether the total number of microaggressions experienced in psychotherapy mediated the relations between identity (*i.e.*, gender identity and sexual orientation) and satisfaction (*i.e.*, with therapy, therapist, and overall), a path model was tested using MPlus version 8.6 (Muthén & Muthén, 1998-2021). Significance for two-tailed tests was set at alpha of .05.

## Results

### Aim 1: Treatment Experiences

Of the 2,685 participants, 56.46% endorsed DSM-5 Criterion A trauma exposure. Many participants (23.50%) were previously diagnosed with PTSD by a health provider or had a current PTSD diagnosis (16.13%). Average scores on the PCL-6 indicate symptom severity slightly below the screening cutoff of 14 for likely PTSD ( $M = 13.77$ ,  $SD = 5.23$ ), and 44.92% participants screened positive for potential PTSD. Almost all participants (87.26%) had been in psychotherapy at some time in their life. Of the participants who had been in psychotherapy, 44.60% participated in counseling for concerns not related to trauma, and 55.83% had participated in counseling for trauma or PTSD. One quarter of participants who had been in psychotherapy reported 10 or more separate episodes of psychotherapy, and 45.88% reported having attended more than 100 sessions of psychotherapy in their lives. Over half (61.72%) of the participants who had been in psychotherapy reported having an episode of psychotherapy in the past year. The most frequently reported delivery methods were in-person (94.84%) and video conference (61.12%).

Of participants who endorsed prior counseling, 85% indicated that they had a therapist who was knowledgeable about trauma/PTSD; 6.44% had received care at a trauma/PTSD clinic; 44.94% indicated they had an LGBTQ+ therapist; 78.36% had an LGBTQ+-friendly therapist;

and 13.06% had received care at a LGBTQ+ clinic. Participants endorsed receiving a wide variety of treatments common to evidence-based, trauma-focused care including “Another Counseling or Psychotherapy” (37.0%), Cognitive Behavioral Therapy (35.17%), Interpersonal Therapy (26.89%), Eye Movement and Desensitization Therapy (13.06%), Exposure Therapy (6.74%), and Brief Eclectic Psychotherapy for PTSD (5.38%). For medication treatment, participants reported having received selective serotonin reuptake inhibitors (SSRIs) or serotonin and norepinephrine reuptake inhibitors (SNRIs; 37.06%) and benzodiazepines (17.62%). For a full summary of the descriptive results, see Table 2.

### **Aim 2: Barriers to Treatment**

On average, participants endorsed 4.14 barriers to accessing psychotherapy ( $SD = 3.36$ ,  $Median = 4.0$ ). The mean BACE-3 total score was 33.05 ( $SD = 8.93$ ) for the sample. Most barriers were endorsed by fewer than 25% of the participants, but the most commonly endorsed barriers were: “waiting to solve the problem on my own” (45.81%), “not covered or insufficient coverage by insurance” (43.09%), “not being able to afford financial cost” (42.38%), and “being unsure of where to go” (33.63%).

Analysis of differences in barriers based on types of treatment indicated that participants who had psychotherapy for trauma or PTSD reported significantly greater barriers to treatment ( $p < .001$ ) than those who had no psychotherapy ( $p < .001$ ) and those who had only non-trauma-focused psychotherapy ( $p < .001$ ). Additionally, participants who engaged in general psychotherapy reported greater barriers to treatment than those with no psychotherapy ( $p < .001$ ).

Participants who were bisexual/pansexual reported fewer barriers than those who were asexual/demisexual/gray-ace ( $p = .009$ ) and queer ( $p = .007$ ). Additionally, participants who were gay/lesbian reported greater barriers than all other sexual orientations including

asexual/demisexual/gray-ace ( $p < .001$ ), bisexual/pansexual ( $p < .001$ ), queer ( $p < .001$ ), straight/heterosexual ( $p = .02$ ), and another sexual orientation ( $p = .03$ ). Gender comparisons indicated that cisgender men reported fewer barriers than all other genders (all  $p < .001$ ). Cisgender women reported fewer barriers than nonbinary individuals ( $p < .001$ ), transgender men ( $p < .001$ ), and participants who endorsed another gender identity ( $p < .001$ ). Finally, transgender women reported fewer barriers than nonbinary individuals ( $p = .001$ ), transgender men ( $p = .006$ ), and participants who endorsed another gender identity ( $p < .001$ ). There was not an overall difference in BACE-3 scores based on race/ethnicity ( $F[8, 2506] = 1.67, p = .10, R^2 = .005$ ). BACE-3 scores are summarized by subgroup in Table 3.

### **Aim 3: Microaggressions in Treatment**

The mean rating of microaggressions on the RMCS was 4.31 ( $SD = 5.69$ ) out of 20. The most commonly reported microaggressions in the present study included therapist thinking client was oversensitive about identity issues (18.40%), therapist over-identifying with client's experiences related to identity (27.74%), and therapists being unaware of the reality of identity issues (36.58%).

Comparisons of microaggressions between types of treatment revealed that participants who had counseling for trauma or PTSD reported significantly more microaggressions in psychotherapy than those who had only non-trauma-focused counseling ( $p < .001$ ). Differences in microaggressions based on sexual orientation indicated that gay/lesbian participants endorsed fewer microaggressions compared to those who were asexual/demisexual/gray-ace, bisexual/pansexual, and queer (all  $p < .001$ ). Additionally, participants who were queer endorsed more microaggressions compared to straight/heterosexual ( $p = .03$ ) and bisexual/pansexual ( $p < .001$ ) participants. Gender comparisons revealed that cisgender men endorsed fewer

microaggressions compared to all other genders (all  $p < .001$ ). Additionally, cisgender women reported fewer microaggressions than nonbinary individuals ( $p < .001$ ), transgender men ( $p < .001$ ), and participants who endorsed another gender identity ( $p = .04$ ). Non-binary individuals endorsed more microaggressions than transgender women ( $p < .001$ ) and those who endorsed another gender identity ( $p = .04$ ). Additionally, transgender men endorsed more microaggressions than transgender women ( $p = .001$ ). In terms of race/ethnicity, there was not an overall difference in number microaggressions ( $F[8, 2228] = 1.94, p = .050, R^2 = .007$ ).

Microaggressions scores are summarized by subgroup in Table 3.

#### **Aim 4: Treatment Satisfaction**

On 5-point scales, participants reported high satisfaction with psychotherapy ( $M = 4.19, SD = .79$ ) and high satisfaction with therapists ( $M = 4.08, SD = .83$ ). Participants who had counseling for trauma or PTSD reported significantly greater satisfaction with psychotherapy and greater satisfaction with the therapist than those who had only non-trauma-focused counseling ( $p < .001$  for both).

Gay/lesbian participants were more satisfied with psychotherapy compared to asexual/demisexual/gray-ace participants ( $p = .02$ ), bisexual/pansexual participants ( $p = .02$ ), and participants who identified with another sexual orientation ( $p = .02$ ). Additionally, queer individuals reported greater psychotherapy satisfaction than those who identified as asexual/demisexual/gray-ace ( $p = .03$ ), bisexual/pansexual ( $p = .04$ ), and another sexual orientation ( $p = .02$ ). Bisexual/pansexual participants endorsed greater psychotherapy satisfaction compared to those who identified with another sexual orientation ( $p = .046$ ). In terms of therapist satisfaction, pairwise comparisons revealed that gay/lesbian participants were more satisfied than bisexual/pansexual ( $p = .02$ ) and asexual/demisexual/gray-ace ( $p = .006$ ).



participants. In addition, queer participants reported greater therapist satisfaction compared to asexual/demisexual/gray-ace ( $p = .01$ ) participants. Gender comparisons of psychotherapy satisfaction indicated that participants who endorsed another gender identity were less satisfied than all other genders ( $p$  ranging from  $< .001$  to  $.02$ ). Additionally, nonbinary participants reported less psychotherapy satisfaction compared to cisgender women ( $p = .02$ ), cisgender men ( $p = .01$ ), and transgender women ( $p = .01$ ). In terms of therapist satisfaction, those who endorsed another gender identity were less satisfied compared to cisgender women ( $p = .005$ ), cisgender men, ( $p = .005$ ), and transgender women ( $p = .001$ ). In addition, non-binary individuals reported less therapist satisfaction than cisgender women ( $p = .004$ ), cisgender men ( $p = .005$ ), and transgender women ( $p = .001$ ). Transgender men reported less satisfaction compared to transgender women ( $p = .01$ ). In terms of race/ethnicity, there was not an overall difference in satisfaction with psychotherapy ( $F[8, 2264] = 1.91, p = .055, R^2 = .008$ ). Satisfaction scores are summarized by subgroup in Table 3.

### **Aim 5: Mediation Analyses**

The final path analysis examining experiences of microaggressions as a mediator between identity and treatment satisfaction is presented in Figure 1. Fit indices suggest that the model fit the data well ( $\chi^2(6) = 22.83, p = .001, CFI = .997, TLI = .99, RMSEA = .04, 90\% CI = 0.02$  to  $0.05$ ). There was a significant association between gender identity and microaggressions ( $\beta = 0.81, SE = 0.09, p < .001$ ) but not sexual orientation and microaggressions ( $\beta = 0.16, SE = 0.13, p = .21$ ). Microaggressions were inversely associated with satisfaction ( $\beta = -0.03, SE = 0.002, p < .001$ ). The indirect effect of microaggressions as a mediator of the relationship between sexual orientation and satisfaction was not significant ( $\beta = -0.01, SE = 0.004, p = .21$ ). In contrast, the indirect effect of microaggressions as a mediator of the relationship between

gender identity and satisfaction was significant ( $\beta = -0.02$ ,  $SE = 0.003$ ,  $p < .001$ ). Accounting for the mediating role of microaggressions, sexual orientation had a significant direct effect on satisfaction ( $\beta = 0.04$ ,  $SE = 0.01$ ,  $p = .002$ ), whereas gender identity did not ( $\beta = 0.001$ ,  $SE = 0.01$ ,  $p = .89$ ), indicating that number of microaggressions experienced in psychotherapy fully mediated the relationship between gender identity and satisfaction, but it was not a mediator of the relationship between sexual orientation and satisfaction.

### Discussion

The primary aim of this study was to describe experiences of seeking and receiving psychotherapy for SGM individuals including those who have been exposed to trauma and/or sought trauma/PTSD treatment. As in previous studies (*e.g.*, House et al., 2011), there were high rates of trauma exposure among our sample. Nearly all respondents had participated in psychotherapy, which is consistent with high rates of mental healthcare utilization reported in other surveys (Carter et al., 2020; Grella et al., 2009). Participants reported having been in therapy for many sessions and in various modalities (*i.e.*, in-person and telehealth). It was common for participants to seek a therapist who was LGBTQ+ or LGBTQ+-friendly and who had knowledge about trauma.

Despite the availability of evidence-based trauma-focused treatments, a relatively small proportion of participants received these interventions. Although the treatments were described briefly in the survey, participants may not have known which interventions they have received. It is possible that many SGM individuals with PTSD symptoms are not receiving evidence-based, effective trauma-focused treatment. Research has indicated that community providers have insufficient training to provide evidence-based trauma-informed treatment, and some may not even use these treatments after receiving adequate training (Finley et al., 2018). Furthermore,

SGM clients and providers may be mistrusting of evidence-based trauma treatments due to the lack of SGM representation in past studies and the absence of studies that have specifically tested trauma treatments with SGM clients or in SGM-serving settings (Wynn & Reavis, 2022).

Reported barriers to treatment in the overall sample were fairly low with an average of roughly four of eighteen possible barriers endorsed. This finding is consistent with the high reported utilization of psychotherapy within our sample. Although it is possible that barriers were underestimated and utilization was overestimated in this study given that the recruitment materials advertised the study being about treatment experiences, these findings are consistent with previous research indicating that SGM individuals utilize psychotherapy at disproportionately higher rates compared to non-SGM individuals (*e.g.*, Filice & Meyer, 2018). Participants reported high rates of satisfaction with therapy and with their therapists and relatively low microaggression ratings, which means that either microaggressions were uncommon in psychotherapy and/or participants were not bothered by (or were unaware of) them when they occurred. Although no other studies have reported the frequency of microaggression in therapy for SGM clients, studies of racial/ethnic minority clients have demonstrated slightly higher ( $M = 5.60$ ; Constantine, 2007) and somewhat lower ratings ( $M = 1.77$ ; Hook et al., 2016) of microaggressions in therapy.

Results included many encouraging findings—*e.g.*, high psychotherapy utilization rates, high treatment satisfaction, and low numbers of barriers and microaggressions in therapy. These results remind us that exclusively focusing on only problems that exist in the context of therapy for SGM people may overlook what is going well. Research on positive outcomes reveal what is working; this is equally informative to improving treatment. Future research could benefit from a

positively-oriented approach that investigates facilitators of treatment and highlights the optimistic outcomes that may exist.

Participants who received treatment for trauma or PTSD reported more barriers and microaggressions related to psychotherapy than participants who had counseling for other problems. The nature of trauma-related symptoms such as avoidance and interpersonal difficulties may make it particularly challenging to initiate psychotherapy (Smith et al., 2020). Among trauma-exposed individuals, hypervigilance symptoms might heighten attunement to microaggressions, which may, in turn, trigger re-experiencing symptoms. Participants who sought psychotherapy for trauma/PTSD also reported higher satisfaction with psychotherapy and therapists than participants who had non-trauma-focused therapy only. This difference indicates that it may be more difficult for clients needing trauma treatment to initiate therapy, but ultimately, treatment may be more helpful. One possible explanation for these challenges is that among experts in trauma-focused treatment, specialized training in SGM-affirming treatment may be less common compared to general mental health providers. Notably, nearly one in four participants indicated that they had never had a therapist who was “LGBTQ+-friendly”. Similarly, therapists with specialized training in SGM-affirming care may have less training in evidence-based trauma-focused treatment. In other words, perhaps there is not enough overlap between trauma-focused specialists and LGBTQ+-affirming specialists. Collectively, our findings highlight the importance of employing trauma interventions that directly target trauma symptoms through an SGM-affirming approach that acknowledges the interaction between trauma and minority stress.

There were differences in reported barriers to treatment, microaggressions experienced during counseling, and satisfaction with both psychotherapy and therapist based on sexual

orientation and gender identity. Several interesting patterns emerged in group comparisons.

Unsurprisingly, of all gender identities endorsed, cisgender individuals reported better experiences seeking and receiving treatment. Among GM individuals, transgender women reported the best experiences seeking and receiving treatment: they reported the fewest barriers and microaggressions, and highest psychotherapy and therapist satisfaction among the GM groups. Similar patterns emerged for sexual orientation. Heterosexual individuals reported better experiences compared to SM individuals. Additionally, gay/lesbian participants reported better experiences than bisexual/pansexual, queer, and asexual/demisexual/gray-ace individuals.

Previous studies have found similar identity-specific variations in microaggressions experienced by SGM individuals; for example, bisexual (Bostwick & Hequembourg, 2014) and transgender individuals experience unique types of microaggressions (*e.g.*, denying transphobia or endorsing binary culture) and higher rates of PTSD compared to cisgender SM persons (Ceja et al., 2023; Nadal et al., 2012b). Previous studies have found similar differences in treatment satisfaction between SGM subgroups with bisexual and GM clients experiencing unique challenges. For example, Page (2004) suggests that bisexual clients experience lower treatment satisfaction with concerns related to sexual orientation than gay and lesbian clients. In another study, despite comparable ratings of treatment satisfaction, bisexual participants were found to be less likely to come out to their mental health provider than their gay and lesbian counterparts (Baldwin et al., 2017a). Although relatively less research has focused on treatment satisfaction among clients for other sexual minority identities, initial evidence indicates that clients who identify as queer are more likely to report a prior negative treatment experience than their gay, lesbian, and bisexual counterparts (Ferlatte et al., 2019). Similarly, pansexual clients reported greater stigma or misunderstanding from mental health providers (McNair & Bush, 2016).

These trends are potentially driven by exposure, familiarity, education, and increased acceptance towards SGM identities with the most visibility (i.e., gay/lesbian cisgender individuals; Flores et al., 2018). This familiarity may contribute to, for example, better clinician competence working with cisgender individuals, transgender women, heterosexual persons, and gay and lesbian clients, compared to bisexual and nonbinary individuals. This explanation could also be supported by the fact that the most frequently endorsed microaggression types among our sample included therapist insensitivity about identity, therapist stereotypes related to an identity, and lack of therapist awareness around the reality of identity issues. For instance, asexual/demisexual/gray-ace clients may experience microaggressions in trauma psychotherapy when a provider assumes that their identity is a result of trauma (Herbitter et al., 2021). Consistent with our aim to capture the diversity of treatment experiences among SGM individuals, all participants in this study identified with a sexual and/or gender minority group; there are no cisgender heterosexual individuals included in the comparisons described.

We found partial support for our hypothesis that microaggressions in therapy would mediate the effect of gender identity and sexual orientation on satisfaction with psychotherapy. Microaggressions fully mediated the relationship between gender identity and satisfaction with psychotherapy but not the relationship between sexual orientation and satisfaction. These results suggest that individuals with GM identities experience more microaggressions in treatment and experiencing these microaggressions leads to lower satisfaction in counseling. However, this was not the case for sexual orientation. Similar to trends observed in pairwise comparisons, providers may be more competent in working with SM groups compared to GM groups, potentially making microaggressions less likely to occur. Instead, the relationship between sexual orientation and satisfaction might be better explained by other factors such as degree of outness

and minority stress related to management of a concealable identity (Pachankis et al., 2020). The magnitude was small for several of the significant findings for group differences and the mediation relationships, indicating that the group differences may be important but small. Potential mediators of the relationship between sexual orientation and satisfaction should be explored in further research.

### **Limitations**

One limitation of the present study is the underrepresentation of racial/ethnic minorities. No differences by race or ethnicity were found on any treatment-related measures, including barriers to treatment, microaggressions in treatment, satisfaction with psychotherapy, and satisfaction with therapist. It is possible that in a more racially diverse sample, there would have been sufficient power to detect racial and ethnic identity group differences. A second limitation is that our large sample size may have enabled us to detect small effects that are not clinically significant. A third limitation relates to how we assessed the use of evidence-based trauma treatments with SGM clients. Clients be unlikely to accurately identify which specific treatment(s) they have received, even with the brief descriptions provided. To further explore the degree to which evidence-based treatments are being offered to SGM clients, information should be collected from electronic medical records or directly from clinicians who provide treatment to trauma-exposed SGM clients about their use of trauma-focused interventions and fidelity to the interventions. Similarly, participants' recall for the length and other characteristics of psychotherapy episodes across their lifetime may be limited by memory or bias. Assessing satisfaction and microaggressions that may occur in psychotherapy could be further enhanced by studies embedded in various types of treatment settings with current SGM clients.

### **Clinical Implications and Conclusions**

Our findings indicate that trauma exposure and symptoms of trauma-related distress are common among SGM individuals and that they are open to and readily seeking psychotherapy despite some barriers. Efforts are needed to increase the accessibility and responsiveness of psychotherapy to SGM clients seeking trauma psychotherapy. Future research should compare the effectiveness of evidence-based trauma treatments for SGM clients with PTSD and other trauma-related symptoms. Additional work should focus on creating pathways for these treatments to be disseminated and implemented in LGBTQ+-serving clinics and among providers who treat LGBTQ+ clients in other settings (*e.g.*, in the community, primary care, and universities). Widely accessible and effective treatments for trauma that are informed by the needs of the SGM community may help to support recovery, increase treatment satisfaction, and dismantle the effects of minority stress.



All participants completed informed consent. The study has been approved by the University of California, San Francisco and Stanford University IRBs, and the current primary IRB is the WCG IRB.

Due to ethical restrictions related to sensitive participant information, study data can be made available on request in accordance with certain data access conditions by contacting [research@pridestudy.org](mailto:research@pridestudy.org).

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**Table 1.** Summary of Sample Demographic Characteristics (*N*=2685).

	<i>Median</i>	<i>IQR</i>
Age	32.1	19.6
	<i>n (%)</i>	
Sexual orientation		
Asexual/Demisexual/Gray-Ace	201 (7.5)	
Bisexual/Pansexual	625 (23.3)	
Gay/Lesbian	1017 (37.9)	
Queer	546 (20.3)	
Straight/Heterosexual	34 (1.3)	
Another sexual orientation	8 (0.3)	
Unreported	254 (9.5)	
Gender		
Cisgender man	625 (23.3)	
Cisgender woman	703 (26.2)	
Non-binary	550 (20.5)	
Transgender man	321 (12.0)	
Transgender woman	144 (5.4)	
Another gender identity	86 (3.2)	
Unreported	256 (9.5)	
Race/Ethnicity*		
American Indian or Alaskan Native	73 (2.7)	
Asian	125 (4.7)	
Black, African American, or African	85 (3.2)	
Hispanic, Latino, or Spanish	146 (5.4)	
Middle Eastern or North African	38 (1.4)	
Native Hawaiian or Pacific Islander	7 (0.3)	
White	2420 (90.1)	
None of these fully describe me	41 (1.5)	

\*Participants could endorse more than one, so percentages do not add to 100%

**Table 2.** Descriptives of Trauma and Psychotherapy Experiences

	<i>n (%)</i>
PTSD and Reason for Treatment ( <i>N</i> =2685)	
Previous or current diagnosis of PTSD	433 (16.1)
Screened positive for likely PTSD	1206 (44.9)
Counseling type	
Any counseling	2343 (87.3)
Counseling for trauma	1261 (47.0)
Counseling for PTSD	760 (28.3)
Characteristics of Treatment ( <i>N</i> =2343; P's who endorsed past counseling)	
Episodes of psychotherapy <sup>a</sup>	
1	215 (9.2)
2-9	1485 (63.4)
10 or more	598 (25.5)
Sessions of psychotherapy	
1-2	41 (1.7)
3-10	199 (8.5)
11-20	208 (8.9)
21-100	777 (33.2)
More than 100	1075 (45.9)
Format of treatment received in any episode of treatment	
In-person	2222 (94.8)
Video conference	1432 (61.1)
Over the phone	728 (31.1)
Web-based with therapist	250 (10.7)
Web-based without therapist	177 (7.6)
Phone/tablet app with therapist	123 (5.2)
Phone/tablet app without therapist	199 (8.5)
Therapist/clinic expertise in any episode of treatment	
Therapist was LGBTQ+	1053 (44.9)
Therapist was LGBTQ+ friendly	1836 (78.4)
Therapist was knowledgeable about trauma and PTSD	1168 (49.9)
Clinic was focused on LGBTQ+ care	306 (13.1)
Clinic was focused on trauma and PTSD	151 (6.4)
Don't remember or don't know	173 (7.4)
Does not apply	139 (5.9)
Provider type in any episode of treatment	
Counselor	1608 (68.6)
Marriage and family therapist	675 (28.8)
Psychologist	1429 (61.0)
Psychiatrist	1060 (45.2)
Social worker	998 (42.6)
Spiritual or religious provider	267 (11.4)
Substance use counselor	118 (5.0)

Don't remember or don't know	107 (4.6)
Some other type of provider	71 (3.0)
Treatment modality in any episode of treatment	
Cognitive Behavioral Therapy	824 (35.2)
Exposure Therapy	158 (6.7)
Eye Movement and Desensitization Therapy	306 (13.1)
Interpersonal Therapy	630 (26.9)
Brief Eclectic Psychotherapy for PTSD	126 (5.4)
SSRI or SNRI	995 (37.1)
Benzodiazepine	473 (17.6)
Another counseling or therapy	867 (37.0)
Alternative treatment	522 (22.3)

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<sup>a</sup>. Episodes of psychotherapy may refer to counseling with different providers, or with the same provider at different points in time.

<b>Table 2.</b> Mean ratings of treatment related measures	
Treatment-related measures ( <i>N</i> =2343)	<i>M</i> ( <i>SD</i> )
BACE-3 <sup>a</sup>	
Number of barriers experienced	4.14 (3.36)
Total score	33.05 (8.93)
Number of microaggressions experienced in counseling	4.31 (5.69)
STTS-ST <sup>b</sup>	4.19 (0.79)
STTS-SWT <sup>c</sup>	4.08(0.83)

<sup>a</sup>. BACE-3 = Barriers to Access to Care Evaluation Version 3; Number of microaggressions refers to total score on Racial Microaggressions in Counseling Scale, adapted.

<sup>b</sup>. STTS-ST = Satisfaction with Therapy and Therapist Scale, revised version - Satisfaction with Therapy Subscale.

<sup>c</sup>. STTS-SWT = Satisfaction with Therapy and Therapist Scale, revised version - Satisfaction with Therapist Subscale.

**Table 3.** Comparisons of Barriers, Microaggressions, and Satisfaction by Counseling Type, Sexual Orientation, Gender Identity, and Race/Ethnicity

	BACE-3 <i>M (SD)</i>	MICRO <i>M (SD)</i>	STTS-ST <i>M (SD)</i>	STTS-SWT <i>M (SD)</i>	STTS-13 <i>M (SD)</i>
<b>Counseling Type</b>					
General counseling only <sup>(a)</sup>	31.67 (7.77) <sub>b, c</sub>	2.97 (4.56) <sub>b</sub>	4.10 (0.80) <sub>b</sub>	3.97 (0.85) <sub>b</sub>	4.03 (0.78) <sub>b</sub>
Trauma/PTSD counseling <sup>(b)</sup>	35.40 (8.94) <sub>a, c</sub>	5.37 (6.25) <sub>a</sub>	4.27 (0.78) <sub>a</sub>	4.17 (0.80) <sub>a</sub>	4.17 (0.79) <sub>a</sub>
No past counseling experience <sup>(c)</sup>	27.71 (9.33) <sub>a, b</sub>	--	--	--	--
<b>Sexual Orientation</b>					
Asexual/Demisexual/gray-ace <sup>(a)</sup>	35.69 (9.33) <sub>b, c</sub>	5.11 (6.17) <sub>c</sub>	4.09 (0.89) <sub>c, d</sub>	3.94 (0.89) <sub>c, d</sub>	3.96 (0.88) <sub>c</sub>
Bisexual/Pansexual <sup>(b)</sup>	33.86 (8.23) <sub>a, c, d</sub>	4.43 (5.56) <sub>c, d</sub>	4.15 (0.80) <sub>c, d, f</sub>	4.03 (0.85) <sub>c</sub>	4.08 (0.75) <sub>c, d</sub>
Gay/Lesbian <sup>(c)</sup>	30.48 (8.55) <sub>a, b, d, e, f</sub>	3.14 (5.04) <sub>a, b, d</sub>	4.25 (0.75) <sub>a, b, f</sub>	4.14 (0.79) <sub>a, b</sub>	4.16 (0.77) <sub>a, b, d</sub>
Queer <sup>(d)</sup>	35.23 (8.22) <sub>b, c</sub>	5.74 (6.23) <sub>b, c, e</sub>	4.25 (0.79) <sub>a, b, f</sub>	4.13 (0.83) <sub>a</sub>	4.13 (0.76) <sub>b, c, e</sub>
Straight/Heterosexual <sup>(e)</sup>	34.03 (11.46) <sub>c</sub>	3.28 (4.86) <sub>d</sub>	4.18 (1.07)	4.07 (1.14)	4.15 (0.97) <sub>d</sub>
Another sexual orientation not listed <sup>(f)</sup>	37.29 (9.72) <sub>c</sub>	5.00 (4.73)	3.58 (1.28) <sub>b, c, d</sub>	3.79 (1.05)	3.63 (1.69)
<b>Gender Identity</b>					
Cisgender man <sup>(a)</sup>	28.46 (7.62) <sub>b, c, d, e, f</sub>	2.27 (4.24) <sub>b, c, d, e, f</sub>	4.26 (0.68) <sub>c, f</sub>	4.14 (0.75) <sub>c, f</sub>	4.22 (0.70) <sub>b, c, f</sub>
Cisgender woman <sup>(b)</sup>	32.35 (8.00) <sub>a, c, d, f</sub>	3.36 (4.96) <sub>a, c, d, f</sub>	4.24 (0.80) <sub>c, f</sub>	4.14 (0.82) <sub>c, f</sub>	4.09 (0.79) <sub>a</sub>
Non-binary <sup>(c)</sup>	36.11 (8.52) <sub>a, b, e</sub>	6.12 (6.45) <sub>a, b, e, f</sub>	4.13 (0.84) <sub>a, b, e, f</sub>	3.99 (0.87) <sub>a, b, e</sub>	4.02 (0.80) <sub>a, e</sub>
Transgender man <sup>(d)</sup>	35.86 (8.58) <sub>a, b, e</sub>	6.09 (6.07) <sub>a, b, e</sub>	4.22 (0.80) <sub>f</sub>	4.04 (0.88) <sub>e</sub>	4.12 (0.83)
Transgender woman <sup>(e)</sup>	33.51 (9.18) <sub>a, c, d, f</sub>	4.12 (5.50) <sub>a, c, d</sub>	4.32 (0.74) <sub>c, f</sub>	4.26 (0.70) <sub>c, d, f</sub>	4.22 (0.73) <sub>c, f</sub>
Another gender identity not listed <sup>(f)</sup>	37.62 (8.81) <sub>a, b, e</sub>	4.73 (5.77) <sub>a, b, c</sub>	3.90 (1.02) <sub>a, b, c, d, e</sub>	3.86 (0.97) <sub>a, b, e</sub>	3.99 (0.90) <sub>a, e</sub>

*Note.*  $N = 2343$ . Subscripts indicate a significant difference from the groups with corresponding superscripts in pairwise comparisons for that outcome measure. Episodes of psychotherapy may refer to counseling with different providers, or with the same provider at different points in time. SSRI = Selective Serotonin Reuptake Inhibitors. SNRI = Serotonin and Norepinephrine Reuptake Inhibitors. BACE-3 = Barriers to Access to Care Evaluation, version 3. Number of microaggressions refers to total score on Racial Microaggressions in Counseling Scale, adapted. STTS-ST = Satisfaction with Therapy and Therapist Scale, revised version - Satisfaction with Therapy Subscale. STTS-SWT = Satisfaction with Therapy and Therapist Scale, revised version - Satisfaction with Therapist Subscale. STTS-13 = Satisfaction with Therapy and Therapist Scale, revised.