

Original Article

Sexual Minorities' Experiences in Therapy Services in Puerto Rico: A Qualitative Study

Experiencias de Minorías Sexuales en los Servicios de Terapia en Puerto Rico: Un Estudio Cualitativo

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Received: January 26, 2023 | Accepted: February 14, 2023 | Published: June 20, 2023

WWW.REVISTACARIBENADEPSICOLOGIA.COM

Cite as:

Esteban, C., Francia-Martínez, M., Bruno-Ortiz, T., Santiago-Ortiz, A. M., Mattei-Torres, E., Jiménez-Ricaurte, C., Montalván-López, A., Irizarry-Rodríguez, A., & Hernández del Valle, S. (2023). Sexual minorities' experiences in therapy services in Puerto Rico: A qualitative study. *Revista Caribeña de Psicología*, 7, e7433. <https://doi.org/10.37226/rpc.v7i1.7433>

ABSTRACT

Studies have found that lesbian, gay, and bisexual persons (LGB+) find that their therapist does not have the necessary knowledge to work with their sexual orientation, they ignore their sexual orientation, they do not meet their needs, and they even conceptualize it as a problem. The purpose of this study was to explore the experiences of LGB+ people with therapeutic services received. This study was a secondary data analysis of the qualitative results of a mixed method study from a phenomenological exploratory scope. Eighty-seven (87) persons who identified their sexual orientation as LGB+ participated in this study. Thematic analysis was used as an analysis technique. Eight (8) main topics emerged that are exposed and justified in the results: preconceptions about the development of the sexual orientation, feelings about disclosure, signs of understanding or misunderstanding, personal qualities, professional qualities, religious experiences, homophobic and biphobic experiences, and heterosexist experiences. The repercussions of the findings are discussed and the curricular review of the disciplines and the professional acquisition of competencies and skills necessary for therapeutic practice with LGB+ people are recommended, as established by local and national guidelines.

Keywords: LGB/LGBT, psychotherapy, therapy barriers, therapy satisfaction, health barriers

RESUMEN

Estudios han encontrado que personas lesbianas, gays y bisexuales (LGB+) se encuentran con que su terapeuta no tiene el conocimiento necesario para trabajar con su orientación sexual, ignoran su orientación sexual, no cubren sus necesidades, y hasta le conceptúan como un problema. El propósito de este estudio fue explorar las experiencias de personas LGB+ con servicios terapéuticos recibidos. Este estudio fue de datos secundarios que analiza los resultados cualitativos de un estudio de método mixto desde un alcance exploratorio de tipo fenomenológico. Participaron 87 personas que identificaban su orientación sexual como LGB+. Como técnica de análisis utilizamos el análisis temático. Surgieron 8 temas principales que se exponen y justifican en los resultados: preconcepciones sobre el desarrollo de la orientación sexual, sentimientos ante revelación, muestras de comprensión o incomprensión, cualidades personales, cualidades profesionales, experiencias religiosas, experiencias homofóbicas y bifóbicas y experiencias heterosexistas. Se discuten las repercusiones de los hallazgos y se recomienda la revisión curricular de las disciplinas y la adquisición profesional de competencias y destrezas necesarias para la práctica terapéutica con personas LGB+ como establecen las guías locales y nacionales.

Palabras Claves: LGB/LGBT, terapia, barreras en terapia, satisfacción en terapia, barreras en salud

INTRODUCTION

Sexual minorities, individuals that identify as lesbian, gay, bisexual, among others sexual orientations (LGB+), have been a constant target of discrimination, marginalization, and social exclusion (Badgett & Frank, 2007). In Puerto Rico, the panorama is no different. Studies conducted on the island have found that LGB+ individuals, as well as trans and non-binary individuals, are constant victims of discrimination and mistreatment. Stigma towards LGB+ people has become institutionalized and permeates throughout government and private institutions and even within the family unit itself (Rodríguez-Díaz et al., 2016; Toro-Alfonso, 2007). In fact, research such as that of González and Pabellón-Lebrón's (2018) has found that LGB+ and trans (LGBT+) individuals tend to perceive more discrimination as a group rather than individually.

In line with experiences of discrimination, Rivera-Quinonez et al. (2013) conducted a study with individuals that identified as LGBT+ where they found the following: 13% of the sample felt unsafe in their homes, 54% felt unsafe in parks or recreational spaces, 82% felt unsafe towards the judicial system, and 87% felt unsafe towards the protection provided by the police. The study also showed that because of the participants' LGBT+ identity, 56% had received verbal insults, 16% had had objects thrown at them, 11% had been physically hurt (e.g., hit, kicked, or assaulted), 11% had been chased out of an establishment, and two people had been cast out of a dwelling, apartment, or lodging.

LGBT+ discrimination also extends to the workplace. Luiggi-Hernández et al. (2015) found that 62% of their study sample reported experiencing discrimination during the employment recruitment process. Within the workplace, participants reported: hearing jokes about LGBT+ people (48%), derogatory comments about the LGBT+ community (37%), sexual harassment based on sexual orientation or gender identity (21%), and being asked to control their gestures (16%). In another study, Rodríguez-Polo et al. (2017) found significant relationships between managing sexual orientation in the workplace in three types of strategies (i.e., feigning, avoidance, and openness) and perceived organizational heterosexism. These results indicate that working/employed LGBT+ individuals opt to use feigning or avoidance strategies to manage their sexual orientation when perceiving a predominantly heterosexist work environment. On the other hand, when LGBT+ individuals perceived a less heterosexist environment, they showed a greater openness towards sexual orientation. Those who reported using an openness strategy reflected more positive psychological functioning.

Likewise, in another workplace-related study, Rodríguez et al. (2018b) found the following: 1) people between the ages of 21 and 40 present less negative attitudes towards the LGBT+ community, 2) people who identify with a religion present more negative attitudes towards the LGBT+ community than those who do not belong to a religion, 3) people who knew some LGBT+ people showed a less negative attitude toward them, and 4) people who had taken

diversity training also showed a less negative attitude toward LGBT+ individuals. In contrast, while investigating attitudes of prejudice and social distance of people employed in Puerto Rico, Rodríguez et al. (2018a) found that heterosexual individuals expressed greater attitudes of prejudice and social distance towards lesbians and gays than non-heterosexuals. Further, upon studying political and religious perspectives, conservative people showed more attitudes of prejudice and social distance than liberals, and those who attended weekly religious services more than those who did not.

Other studies have evaluated the attitudes and social distances towards the LGBT+ community in Puerto Rico, mostly focused on gays and lesbians. For example, Barbosa-Hernández (2013) surveyed education professionals from both public and private schools at the middle and high school level, and found that, on average, participants obtained a moderate prejudice score. On the other hand, a different study measured prejudice attitudes towards lesbians and gays in adult Puerto Rican parents. It found that most participants showed a moderate level of prejudice and a low level of social distancing (Tirado-Martínez, 2018).

Studies with Puerto Rican students have consistently found moderate attitudes of prejudice towards lesbians and gays over the years. Further, other studies in state universities have found high levels of prejudice and moderate social distance (Nieves-Rosa, 2012; Toro-Alfonso & Varas-Díaz, 2004), and moderate levels of both traits (Fernández-Rodríguez & Calderón-Squiabro, 2014).

In research specifically related to psychology, Vázquez-Rivera et al. (2012) explored the attitudes of both post-grad psychology students and professional clinical psychologists towards gay and lesbians. Six percent of the students and five percent of the professionals preferred not to serve gay and lesbian clients/patients, while 13% and six percent, respectively, indicated that they were not competent to attend this population. Vázquez-Rivera et al. (2018) also studied prejudice and social distance towards gays and lesbians from licensed psychology professionals on the island. They found positive attitudes, little social distance, and low levels of prejudice. However, three percent showed neutral attitudes.

Generally speaking, these studies have found that the variables that could influence having more negative attitudes or greater social distance towards the gay and lesbian community are: being older (Barbosa-Hernández, 2013; Rodríguez et al., 2018b), being male (Fernández-Rodríguez & Calderón-Squiabro, 2014; Rodríguez et al., 2018b; Toro-Alfonso & Varas-Díaz, 2004), not knowing any gays or lesbians (Rodríguez et al., 2018b; Tirado-Martínez, 2018), and attending religious services (Barbosa-Hernández, 2013; Fernández-Rodríguez & Calderón-Squiabro, 2014; Nieves-Rosa, 2012; Rodríguez et al., 2018a, 2018b; Tirado-Martínez, 2018; Toro-Alfonso & Varas-Díaz, 2004; Vázquez-Rivera et al., 2012, 2018).

These findings are just one angle of the complexity of variables that affect several areas of LGB+ people's lives. There is sufficient evidence to support that LGB+ people present more psychological symptoms associated with stress due to their sexual orientation, such as depression, anxiety, chronic stress, and suicidal attempts and ideation. LGB+ people are also more vulnerable to sexual, physical, and verbal abuse, and problematic substance abuse (Chow, 2013; Cochran & Mays, 2000; Martínez-Taboas et al., 2016; Seil et al., 2014). Consequently, therapy is sometimes one of the last alternatives for many LGB+ people, and it is imperative that it be a supportive resource without further exacerbating the minority stress already experienced or perceived (APPR, 2014; Meyer, 2003).

Despite this, studies have reported that LGB+ people find that their therapist does not have the necessary knowledge to effectively work with their sexual orientation, ignores their sexual orientation, does not meet their needs, and even conceptualize their sexual orientation as a problem (Kelley, 2015; McCann & Sharek, 2014). Studies conducted in Puerto Rico have also found that therapists do not ask the patient's sexual orientation, even though research suggests that this is an essential part to improve treating LGB+ individuals (Quiñones et al., 2015). Further, it has been documented that some therapists use/include their religion as part of the therapeutic process and to justify the problem (Esteban et al., 2019).

Due to the scarce information about LGB+ people's experiences with their therapeutic processes, it is important to evaluate the perception that LGB+

people in Puerto Rico have of these experiences. Thus, we can encourage constructive criticism based on the experiences of this population, make recommendations on how to improve the quality of therapy processes, and offer suggestions for the training of future therapists.

Using a minority stress model (Meyer, 2003), the purpose of this study was to explore LGB+ people's experiences with therapy services. The question that guided this investigation was the following: "What experiences have led LGB+ people to have experiences of satisfaction or dissatisfaction in their therapeutic processes in Puerto Rico?"

METHOD

In this article, the team reports findings from a qualitative secondary data analysis of a mixed-method study with an exploratory phenomenological-type scope for the purpose of gaining insight into the therapy experiences of participants (Creswell & Creswell, 2018; Hernández-Sampieri et al., 2014). The study was anonymous, and participation was based on the participant's availability. Data were obtained in electronic format using the SurveyMonkey digital platform.

Procedure

This section describes the recruitment and data collection procedures. The study sample participated according to their availability. Recruitment was carried out via posters containing the inclusion criteria and the link to access the questionnaires. The poster was designed with rainbow colors to draw LGB+ people's attention. Social media was used, mainly Facebook, Instagram, and WhatsApp, and the poster was distributed throughout various LGBT+ pages in the country. Facebook Ads was also used to help promote the poster.

The SurveyMonkey platform was selected for data collection. Through this platform, participants were provided with the informed consent form and access to the instruments. Although the risk to participants was minimal, the informed consent form contained contact information for several resources where participants could go for psychological help in case it was needed.

The first part of the study consisted of completed several quantitative scale-type instruments. Upon completion, participants were given the option of answering the Qualitative Questionnaire on Therapy Experiences of LGB+ Individuals, which consisted of five open-ended questions. This study was approved by the Ethics Committee (IRB) of the Albizu University (Sum16-05).

Participants

The inclusion criteria for the study were: 1) being 21 years of age or older, 2) being a resident of Puerto Rico, 3) having received therapy services, and 4) identifying their sexual orientation as gay, lesbian, or bisexual+. Of the 197 Puerto Ricans who participated in the quantitative part of the study, 87 (44%) voluntarily answered the Qualitative Questionnaire on Therapy Experiences of LGB+ Individuals.

The majority of participants were men ($f = 49$, 56.3%) with an average age of 31. People from 44 municipalities on the island participated; 21.8% ($f = 19$) identified as lesbian, 49.5% ($f = 43$) as gay, and 28.7% ($f = 25$) as bisexual+. The bisexual category was used as an umbrella term that included participants who identified with various plurisexual categories (e.g., pansexual, demisexual). Of the participants, 55.8% ($f = 48$) were single, 23.3% ($f = 20$) had a partner but did not live together, 16.3% ($f = 14$) lived with their partner, 3.5% ($f = 3$) were married, and 1.2% ($f = 1$) were in a polyamorous relationship. Regarding income and education, 60.9% ($f = 53$) had an annual salary of \$12,000 or less, and 48.3% ($f = 42$) had a high school degree. Almost half of the study sample reported having a religious affiliation, 40.7% ($f = 36$). Finally, 44.8% ($f = 39$) of participants reported having at least one negative therapy experience and 8% ($f = 7$) reported not having a single positive therapy experience.

Instruments

Sociodemographic Data Questionnaire. This questionnaire was created by the research team and collected demographic information of the participants such as gender, sex, sexual orientation, marital status, age, income, and education. In addition, we collected information on religious/spiritual affiliation, frequency of attendance to religious services, city of residence, attendance to therapy, number of

negative and positive experiences in therapy, among others.

Qualitative Questionnaire on Therapy Experiences of LGB+ Individuals. This questionnaire was also created by the research team and consists of five open-ended questions. This instrument sought to collect the voices of LGB+ people in order to explore, learn, and deepen their experiences, and what elements have influenced their perceptions of the therapy process. The questions were: 1) How did you feel in therapy when you disclosed your sexual orientation to your therapist? How did your therapist react? 2) Do you think that your therapist understands the particularities of your sexual orientation? Why? 3) Can you tell me whether at any time you felt that your therapist ascribed your sexual orientation to some moment of trauma, diagnosis, or mental illness? 4) How would you describe your therapist's sensitivity to your sexual orientation in terms of acknowledging and validating it? 5) What has been your worst experience in therapy related to your sexual orientation? Why?

Data Analysis

To perform the data analysis, the participants' answers were exported from SurveyMonkey and imported to Microsoft Word. The data were cleaned, and monosyllabic answers (YES, NO) were eliminated. This was done because it would be impossible to perform a thematic analysis of these answers. Once available, the data were analyzed in the Nvivo program, version 11.

A thematic analysis technique was used, as it allows the identification of patterns or themes within qualitative data (Maguire & Delahunt, 2017). We performed the six steps described by Braun and Clarke (2016; 2018). First, we familiarized ourselves with the data for the purpose of creating first impressions. Second, we generated initial codes by organizing the data in a significant and systematic way and reducing a large amount of data into small portions of meaning. Third, we searched for themes by examining and re-examining the initial codes into broader themes. Fourth, we revised the themes by modifying and developing the preliminary themes identified in the previous step. Fifth, we defined and refined the themes and identified how they related to the research

questions. Finally, we generated discussion by presenting the themes, their analysis, and relevant conclusions.

The first and second steps in the thematic analysis technique allowed for the elimination of monosyllabic responses, as these did not allow to appreciate the participants' experience. In addition, the thematic analysis allowed the discussion to be limited to the identified themes rather than to the individual experiences of each participant.

We conducted a deductive thematic analysis using the purpose of the research as a reference to generate initial codes that were re-examined and modified as we worked with the data in the coding process. Only partially or completely answered questionnaires that provided descriptive information were coded. During the analysis process, codes, data, and themes were discussed among three members of the research team. Seventeen initial codes were developed based on the literature. Upon re-examination of the data, these codes were re-defined and only 14 were retained. The identified themes are discussed in the Results section of this article.

It is important to note, as part of the reflective process of the qualitative work, that those who worked on the analysis process have worked with the LGB+ community in Puerto Rico. They have impacted the LGB+ community in Puerto Rico through the provision of therapy services, research, and the offering of university courses and workshops on the topic. In addition, two of these three people are part of the LGB+ community in Puerto Rico and the other is an ally.

RESULTS

Through the questionnaire about LGB+ people's experiences in therapy, participants offered details about their therapeutic processes and how mental health professionals in the fields of psychology, psychiatry, and counseling had a role in facilitating or presenting challenges during these processes. Some of the developed themes contain sub-themes. These distinctions were made because some themes could be grouped within an overarching theme. For example, with regard to possible developmental origins of sexual orientation, the themes of childhood trauma, trauma from violence, or the presence of other diagnoses were identified. As these themes are related to

the origin or development of sexual orientation, these responses were grouped under "preconceptions about the development of sexual orientation."

The questionnaires collected expressions covering the following themes: preconceptions about the development of sexual orientation, feelings upon disclosure, signs of understanding or misunderstanding, personal qualities, professional qualities, religious experiences, and homophobic, biphobic, and heterosexist experiences. The themes and sub-themes are presented in Table 1.

Table 1

Developed Themes and Sub-themes.

Themes	Sub-theme
Preconceptions about the development of sexual orientation	Childhood or adolescent violence Trauma due to violence Diagnoses
Feelings upon disclosure Signs of understanding or misunderstanding	Signs of understanding Signs of misunderstanding
Personal qualities Professional qualities Religious experiences Homophobic and biphobic experiences Heterosexist experiences	

The findings relevant to each theme are presented below, along with some direct quotes from the participants related to the theme or sub-theme.

1. Preconceptions about the Development of Sexual Orientation

Participants reported that their therapists, psychologists, or psychiatrists associated their sexual orientation with situations that had a negative impact on their lives. The following sub-themes were identified in the data: childhood or adolescent trauma, trauma due to violence, and diagnoses.

1.1 Childhood or Adolescent Trauma

Some participants reported that their therapists, psychologists, or psychiatrists associated the development of their LGB+ sexual orientation with possible affective deficits or traumatic events that took place during childhood or adolescence. Examples of these deficits were: lack of paternal or maternal figures, lack of figures of the same gender as those

involved in their upbringing, and the divorce of their caregivers. The following quotes exemplify this:

(P. 270, female, lesbian, 23) "Of course the psychologist attributed everything to my parents' divorce, and the lack of an example to follow of what an ideal man is. In any case, his conclusion was that I was hurt and that was the reason I did not want to have relationships with men."

(P.93, male, gay, 21) "A clinical psychologist tells me that I probably had not socialized with boys adequately, and that closing myself off to having sexual relationships with women is what made me label myself as a homosexual."

(P.92, female, pansexual) "They assumed that my mother did not give me the affection I expected in my childhood and, consequently, I sought it from other women in adulthood."

1.2 Trauma due to Violence

In other instances, participants shared that their therapists, psychologists, or psychiatrists believed that surviving experiences of violence could be associated with the development of sexual orientation. The following quotes exemplify this:

(P.192, female, bisexual, 23) "She mentioned that, in some cases, women who have been raped or abused can become lesbians. That was it."

(P.228, female, bisexual, 35) "Yes, he indicated that I was bisexual because I was raped by a man and abused by a woman in my family."

1.3 Diagnoses

Some therapists, psychologists, or psychiatrists' beliefs regarding diagnoses, particularly mental health and/or their medication, were identified as responsible for triggering a person's sexual orientation. One participant mentioned the following:

(P.263, female, bisexual, 29) "He told me that I was bipolar and that, if I took Lithium, I did not have to engage in 'risky behaviors' or 'broad sexual behavior.'"

2. Feelings Upon Disclosure

Participants offered their perspectives on how they perceived their therapists, psychologists, or psychiatrists when they disclosed their sexual orientation, and the impact on their feelings. These were categorized into positive and negative feelings.

2.1 Positive Feelings

Generally, within this sub-theme, participants expressed feeling comfortable, accepted, and perceived their experience was received normally by their therapist when disclosing their sexual orientation. The following quotes exemplify this:

(P.1, female, bisexual, 27) "I felt nervous. However, my therapist knew how to guide me through the process and reacted with acceptance."

(P.7, male, gay, 21) "At the beginning of therapy, I did not know how to approach [the subject]. My therapist was receptive and accepting of my sexual orientation...his attitude was positive."

(P.35, male, gay, 32) "The psychologist was very professional and dealt with the issue in a sensitive way. She showed her empathy, respect, and love for helping others."

2.2 Negative Feelings

On the other hand, some participants also perceived and/or faced prejudice, rejection, or discomfort when disclosing their sexual orientation to their mental health professional. The following quotes exemplify this:

(P.162, male, gay, 28) "When I came out to him, the last therapist got uncomfortable (it seemed like he was worried I liked him or something). The second to last one, he referred me to an 'ex-gay' support group sponsored by a Catholic monastery."

(P. 192, female, bisexual, 23) "The first one was a very Christian woman of an advanced age, about 45 years old. On the second appointment, I got up and claimed to her that I did not come looking for psalms, that church was cheaper. I never went back."

(P. 270, female, lesbian, 23) "My therapist's reaction was to convince me that I experienced a moment of confusion and that it was wrong."

3. Signs of Understanding and Misunderstanding

In this theme, we explore participants' perceptions of the level of understanding and knowledge of their therapists, psychologists, or psychiatrists on issues concerning LGB+ people, and/or their interest and openness to learn about the topic together with the participants as patients. According to the questionnaires, LGB+ people who have gone to therapy perceive that if their therapist shares their sexual

orientation, this has a positive impact on both the participant's disclosure process and the therapeutic alliance in general terms.

3.1 Signs of Understanding

The perception of being understood was described by participants as a positive element in the therapeutic process. The following quotes exemplify this:

(P.1, female, bisexual, 27) "Yes. First of all, because they are homosexual and has had similar experiences to mine and, on the other hand, because they have shown receptivity in our discussions."

(P.7, male, gay, 21) "Yes. He understands different situations and seems aware of various issues in the LGBT+ community."

(P.26, male, gay, 29) "Even though the therapist was educated on the subject and did not show prejudice, she also learned about the particularities or my sexual orientation in the process."

3.2 Signs of Misunderstanding

Some narratives, on the other hand, reflected instances when mental health professionals showed little or no knowledge, resistance, rejection, or outright disinterest in the particularities of their patients' sexual orientation. These were described as negative by the study participants. The following quotes exemplify this:

(P.19, female, lesbian, 31) "The first psychologist showed fairness around sexual orientation, but there was never a deep or thoughtful discussion about it. It was only touched on once or twice in a superficial way."

(P.167, male, gay, 23) "I don't think so. On more than one occasion I felt like he avoided talking about it or he did not elaborate much. At least not in the way I expected him to."

(P.204, female, bisexual, 25) "None of the professionals I have been to, understood the particularities of being bisexual, even of being LGBT. They might not have elaborated due to lack of knowledge. They did not provide me with the pertinent information so that I could externally receive another particular service where I could be treated in relation to my sexual orientation. They simply limited themselves to appear respectful or ignore the subject."

4. Personal Qualities

The personal qualities of therapists, psychologists, or psychiatrists regarding the understanding of the particularities of sexual orientation were re-categorized under positive and negative experiences.

4.1 Positive Experiences

Experiences described as positive occurred when participants perceived their therapists as honest people with good verbal and non-verbal communication skills that made them feel validated. The following quotes exemplify this:

(P.190, male, gay, 25) *"I feel validated and recognized. My therapist has shown a great deal of sensitivity beyond what she tells me, and with her body language as well. In talking to her, I feel she understands what I want to say and confirms it when she responds."*

(P.7, male, gay, 21) *"I would say that the experience was very positive and affirmative. He was always very direct in telling me I was valid and legitimate."*

(P.154, female, bisexual, 30) *"His sensitivity and empathy go beyond whether I am bisexual or not. He has the philosophical ability and skill to not squeeze someone into a little box of characteristics."*

4.2 Negative Experiences

In relation to the negative experiences regarding therapists' personal qualities, these were perceived as being insensitive to the problems presented by the participants and trying to pathologize the participants. The following quotes exemplify this:

(P.200, male, gay, 26) *"In two out of three experiences, I felt some degree of pity. As if my homosexuality was a sad situation that I have to work on so that it would not give me depression. There was sensitivity, but I did not feel like the approach was the right one."*

(P.93, male, gay, 21) *"Therapy with the psychologist was very insensitive, as she told me that I could not know I was homosexual if I had never tried with a woman. She did not validate my homosexuality."*

5. Professional Qualities

This theme encompasses positive and negative experiences insofar as it allows to contrast how they influence the participants' perception of their therapists' ability to understand their experiences related

to sexual orientation compared to the experiences of heterosexuals.

5.1 Positive Experiences

Regarding positive experiences, participants identified sensitive professionals when they perceived their therapists had the necessary preparation and knowledge to attend LGB+ people. Participants also described experiences as positive when their sexual orientation was not problematized, as it was not related to the main issue that brought them to therapy in the first place. The following quotes exemplify this:

(P.26, male, gay, 29) *"He has been the person I have felt the most comfortable with to discuss my sexuality. Extremely professional and able to work with a gay male couple."*

(P.53, female, bisexual, 30) *"Normal. The emphasis was not so much on sexual orientation, but more so on the actual reason I went."*

(P.110, female, lesbian, 26) *"She has been very open in talking about it. She mentions my partner by name and we have spoken about the challenges of two women being in a relationship versus a heterosexual relationship."*

5.2 Negative Experiences

Contrary to the experiences described above, participants identified insensitive professionals as those with a lack of preparation and knowledge about LGB+ communities. While the normalization of LGB+ experiences and identities are perceived as positive, participants perceive a line between normalization and invisibilizing their sexual orientation. The following quotes exemplify this:

(P.66, male, bisexual, 32) *"I feel that, in trying to normalize it so much, they were not sensitive to how difficult or meaningful it was for me."*

(P.154, female, bisexual, 30) *"As for my therapist, I had my reservations about disclosing [my sexual orientation] because I could barely handle and understand other everyday issues I wanted to work on. I do not think he/she/they knew the difference between gender and sexual orientation."*

(P.38, male, gay, 27) *"In the process of recognizing my sexual orientation, I remember going to therapy. When I expressed my discomfort with being confused, she laughed. I did not return to therapy and handled my crisis alone."*

6. Experiences with Religion

The element of religion or spirituality is sometimes integrated into therapeutic processes for patients who use religion as support. If there were instances when therapists' religious beliefs influenced their interventions, participants deemed these as negative experiences. Participants also described the use of religious texts as part of their therapy and attempts at evangelization. Per the participants, the use of this component as a resource during therapy services for LGB+ people have had a negative impact on the way they have perceived their process. Some therapists have shared that LGB+ sexual orientations are not to the liking of the Christian god and have recommended that patients 'experience/try' heterosexual relationships. The following quotes exemplify this:

(P.204, female, pansexual, 25) "Not being able to talk about the issue because the supposed professional was dedicated to evangelizing and imposing a single point of view: his own, centered on the figure of God and his religion."

(P.236, male, gay, 24) "We knew each other from church, and I asked her if there was no conflict of interest, to which she replied that she studied our relationship and understood there was no conflict because she did not have a friendly relationship with me or my family members. My father wanted a second opinion on whether my sexual orientation was not a mental illness in the end, she told me: 'I am not telling you this as a psychologist, I am telling you this as a friend. Do not stop going to church.'"

(P.202, female, lesbian, 26) "I remember having a psychologist who rejected me a little bit and was more religious-based. That was about five years ago. I left therapy for that reason."

7. Homophobic and Biphobic Experiences

In some experiences, participants perceived their therapists, psychologists, or psychiatrists as homophobic or biphobic. Participants indicated that their sexual orientation was associated with mental illness, lack of experience with the sex or gender they are not attracted to, or were described as phases. They expressed experiences of censorship, invisibilization, and discrimination by their therapists. The following quotes exemplify this:

(P.93, male, gay, 21) "A horrible experience. The psychologist told me that being homosexual was not a

synonym for 'leprosy' and that I had to try with women to see if I was sure, since I labelled myself a homosexual."

(P.188, female, bisexual, 27) "A therapist asked me how I knew I liked women if I had never been with one sexually. But I had never been with a man sexually either. She also asked how I knew I did not like men if I had never been with one, because in that moment I was discovering my attraction to women, but in reality, I had not been with either."

(P.259, female, lesbian, 21) "I disclosed to a social worker, who was going to assign me a psychologist, that being lesbian was an insecurity for me. He told me that I did not have to tell everyone that I was gay, just like he did not have to announce to everyone that he was straight. It bothered me that his reaction to a difficult issue for me was to not discuss it anymore."

8. Heterosexist Experiences

Some participants described instances when their therapists, psychologists, or psychiatrists assumed heterosexist positions about their sexual orientation. These were considered negative experiences. Although some of these responses reflect homophobia and biphobia, we categorized them as heterosexist because they reveal instances when mental health professionals assumed participants' sexual orientation. The following quotes exemplify this:

(P.172, male, bisexual, 24) "My psychiatrist assuming I was heterosexual, telling him no, then assuming I was homosexual; telling him no again and then him not coming up with any other orientation or explanation."

(P. 190, male, gay, 25) "Before I found my current therapist, I called two other offices. All of them assumed that my partner and I were heterosexual. It was uncomfortable because of the awkward moment that followed after saying: 'no, we're gay.'"

(P.269, female, pansexual, 29) "His validation was null. He was always looking for ways to explain to me why I was wrong, using constant examples of what a woman does, which is pure machismo. Among his mistakes was also mentioning religion."

DISCUSSION

The purpose of this study was to explore the perception of LGB+ people regarding satisfaction with received therapeutic services. Overall, the data revealed that, even though some participants reported positive experiences with their therapists, others

encountered invalidation, lack of knowledge related to the LGB+ community, homophobic/biphobic experiences, and religious issues as psychological treatment. The following are some of the main findings and discussions in light of the current literature.

Regarding LGB+ experiences in the therapeutic process, though several participants had a positive perception of their therapist's attitudes towards self-disclosure, some indicated that they perceived their therapist reacted with discomfort to the information disclosed and felt misunderstood and invalidated in the process. This constitutes a barrier to the formation of a therapeutic relationship that is so necessary for successful therapy (Fluckiger et al., 2019).

On the other hand, in exploring personal and professional qualities, Rossman et al. (2017) found that among the most common reasons why LGB+ people did not feel comfortable disclosing their sexual orientation was because their therapists did not ask about this issue and because of the quality of the therapist-client relationship. In that study, it was a common experience for patients to report "no one asked me" or "this topic never came up in therapy." In the present research, participants reported the same problem. Also, participants perceived the following from their therapists: misunderstanding, lack of knowledge, avoidance of the topic, and feelings of belittling and invisibilization.

By exposing the role of religion, it is understandable why many people in the LGB+ community prefer to remain silent about their sexual orientation. Religion in Puerto Rico has occupied a prominent place in the lives of many, and is filtered through such institutions such as education, family, and the government. During their therapy sessions, some participants encountered the use of religious beliefs and biblical texts from their therapists as a mechanism of persuasion to change their sexual orientation. Precisely replicating the same discourse of invalidation, criticism, and judgment they have received from their family, other institutions, and society in general. This is where the therapy space becomes a reproductive agent of heterosexist, homophobic, and biphobic messages, which could contribute to the worsening of the symptoms of the patients they are trying to treat.

Regarding recent findings about experiences disclosing sexual orientation in therapy, such as

adjudication and knowledge, a possible explanation for the negative experiences could be the social stigma that is generationally transmitted in Puerto Rico and the lack of necessary competencies and skills on the part of the health professionals. In Puerto Rico, graduate psychology programs do not have specialized core courses to successfully train future psychology professionals on this important topic (Esteban et al., 2016). This scenario is very similar in other programs that train health professionals. Therefore, we suggest the implementation of specialized courses at the core level on sex, gender, and sexual orientation diversity in the various graduate psychology programs in Puerto Rico. On the other hand, we know that LGB+ people grow up facing daily experiences of discrimination, microaggressions, and rejection (Aponte, 2016). These discriminatory attitudes and behaviors often range from subtle to explicit, verbal, and non-verbal. Therefore, when they perceive these same attitudes and behaviors in their therapists, this could constitute a major barrier that results in discomfort when talking in therapy, abandoning treatment, and assuming a pessimistic outlook for their future.

It should be noted that there were positive findings in the study. Among the positive qualities noted in therapists were: empathy, sensitivity, validation, non-pathologizing, and professional competencies for working with the LGB+ community (Romanelli & Hudson, 2017). These qualities are congruent with current standard recommendations for working with the LGB+ community (APA, 2021; APPR, 2014). Unfortunately, these positive qualities were only observed by a few of the study participants.

It is necessary to highlight some strengths and limitations of the study. Some of the strengths are: 1) a broad and varied sample was obtained in terms of diverse sexual orientations, 2) the study was anonymous and the questions were answered directly on the platform, without the mediation of a researcher, so participants could possibly answer without fear of being judged or social desirability, and 3) it was possible to document the lived experiences of the LGB+ community itself, which can help guide future prevention or promotion interventions. On the other hand, the limitations found are common limitations of the qualitative method, such as: 1) the bias or influence that could be reflected in the writing and

findings of the researchers, 2) only some verbalizations (those that provided greater detail) were chosen as evidence of the findings, and 3) the findings cannot be generalized or replicated.

As a recommendation for future research, efforts must be continued to explore the experiences of therapeutic services and other essential health services. In addition to therapy satisfaction, it is recommended to explore the barriers to receive these services, successful programs and models, and carry out interventions, especially with therapists to educate and increase knowledge and competence in working with LGB+ people and awareness of biases, including unconscious biases.

To close, we wish that the results of this study be heeded by health professionals, especially therapists in Puerto Rico, as they delimit some of the barriers that they themselves may be creating and interfering with their therapy services with people from the LGB+ community. For this reason, we recommend that health professionals take the necessary measures to minimize the impact of these barriers, such as adhering to national and international guidelines for psychological practice with LGB+ people (APA, 2021; APPR, 2014). Acquiring the necessary competencies and skills is essential to offer an ethical service tailored to the needs of these communities. In this way, we continue to contribute to a more equitable, sensitive, and competent society and profession for all people without distinction of characteristics.

Financing: This study was financed by the Sex, Gender, and Sexual Orientation Diversity Committee of the Puerto Rico Psychological Association.

Acknowledgments: We want to acknowledge the recruitment and distributing collaboration of other members of the Sex, Gender, and Sexual Orientation Diversity Committee of the Puerto Rican Psychological Association [SGSODC-PRPA], especially, to the Research Subcommittee of SGSODC-PRPA who made this project and article possible. In addition, special thanks to the Ponce Research Institute and the Office of Research and Development of the Ponce Health Sciences University for the translation, editing, and revision of the manuscript.

Conflict of Interest: The authors express that there were no conflicts of interest when collecting the data, analyzing the information, or writing the manuscript.

Approval of the Institutional Board for the Protection of Human Subjects in Research: This study was approved by the Ethics Committee (IRB) of the Albizu University (Sum16-05).

Statement of Data Availability: The database is available to the public upon request to the principal investigator.

Informed Consent: All participants completed an informed consent form.

Review Process: This study has been reviewed by external peers in double-blind mode. The editor in charge of the review process was Juan Aníbal González-Rivera.

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