QUEER STRENGTH IN THE SOUTH: A QUALITATIVE ANALYSIS OF LGBT/NB CLIENT-REPORTED STRENGTHS IN A COMMUNITY SETTING

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Abstract: Scholars in the field of counseling psychology have called for the implementation of positive psychology, specifically through emphasis on client strengths and resources (Seligman, 2002). Researchers and clinicians suggest the use of a strengths-based approach with lesbian, gay, bisexual, transgender, and nonbinary (LGBT/NB) clients in order to buffer against minority stress (Meyer, 2003). Furthermore, emphasizing LGBT/NB client strengths challenges the historical focus on deficits of sexual and gender minoritized individuals in psychology research and practice (Vaughan & Rodriquez, 2014). Scholars have specifically recommended that clinicians working with LGBT/NB clients include questions about strengths on the intake form (Lytle, Vaughan, Rodriguez, & Shmerler, 2014; Owens, Magyar-Moe, Lopez, 2015). However, after an exhaustive review of the literature, the author was unable to find any evaluation of the self-reported strengths of LGBT/NB clients at intake. This dearth of literature suggests that little is known about the way in which LGBT/NB clients identify their strengths and report them on intake forms. This study examined reported strengths from intake forms at a counseling clinic in a community setting. A research team of four conducted qualitative analysis of these strengths using a Consensual Qualitative Research – Modified (CQR-M) approach (Spangler, Liu, & Hill, 2014). A total of 173 strengths from 64 individual participants were coded into domains and categories. Six domains and four categories (noted in parentheses) emerged: Connection (Internal-Focused or External-Focused), Interpersonal Skills, Abilities and Achievements, Role-Oriented, Self-Efficacy and Resilience (Actions or Traits), and Reported No Strengths. For all participants, the most frequently reported domain was Abilities and Achievements (n = 40, 23.12%). In order from most to least frequently reported strengths for all participants, the domains and categories of reported were: Abilities and Achievements (n = 40, 23.12%), Connection External-Focused (n = 31, 17.92%), Interpersonal Skills (n = 31, 17.92%), Self-Efficacy and Resilience Traits (n = 29, 16.76%), Connection Internal-Focused (n = 19, 10.98%), Self-Efficacy and Resilience Actions (n = 16, 9.25%), Reported No Strengths (n = 4, 2.31%), and Role-Oriented (n = 3, 1.73%). Implications for clinical practice, training, and research are discussed.

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CHAPTER I

REVIEW OF THE LITERATURE

Introduction

Positive psychology, which emphasizes client strengths and resources over their deficits or pathology, has emerged as a critical force in counseling psychology in the last two decades (Seligman, 2002; Seligman & Csikszentmihalyi, 2000). While positive psychology has been applied to many historically marginalized groups (Pedrotti, Edwards, & Lopez, 2009), lesbian, gay, bisexual, transgender, and queer (LGBTQ+) research is still limited. LGBTQ+ persons are at elevated risk for mood disorders (Mays & Cochran, 2001), substance use disorders (McCabe, Hughes, Bostwick, West, & Boyd, 2009), and posttraumatic stress disorder (Hatzenbuehler, 2009; Mustanski, Garofalo, & Emerson, 2010). These deleterious health effects may affect transgender and non-binary individuals at an even greater rate (Fredriksen-Goldsen et al., 2013).

Minority stress theory (Meyer, 1995, 2003) is one explanation for the poorer physical and mental health outcomes experienced by LGBTQ+ communities. In this theory, proximal and distal social stressors contribute to poor health outcomes (Meyer, 2003). While difficulties facing LGBTQ+ persons are well-documented, less attention has been paid to this group's unique strengths and resources. This is particularly concerning given the historical marginalization of LGBTQ+ individuals through psychology practice and research (Owens, Magyar-Moe, Lopez, 2015; Vaughan &

Rodriquez, 2014). When psychology researchers focus on the problems experienced by a group, they risk further pathologizing that group. To combat this, clinicians in the field of psychology have encouraged the use of positive psychology through emphasis on a client's existing strengths (Vaughan & Rodriquez, 2016). In particular, researchers have recommended assessing for strengths on intake paperwork as a way to incorporate strengths early into the counseling relationship, as the intake form is often the first contact a client has with a clinician (Lytle, Vaughan, Rodriguez, & Shmerler, 2014; Owens et al., 2015). However, to date, little research has been conducted about the implementation of such a recommendation. This study aimed to address the gap in the literature related to how LGBTQ+ counseling clients self-identify their strengths.

LGBTQ+ Mental Health

An estimated 8 million adults, or 3.5% of the population in the United States, identify as lesbian, gay, or bisexual (Gates, 2011). Between 0.53% (Crissman, Berger, Graham, & Dalton, 2017) and 0.6% of adults identify as transgender (Flores, Herman, Gates, & Brown, 2016). Broadly, LGBT individuals face greater mental health problems and disparities than their heterosexual and cisgender peers. Gay and bisexual men experience increased risk for mood disorders, suicidal ideation and attempts (Mays & Cochran, 2001), and report greater substance use when compared to heterosexual men (Newcomb & Mustanski, 2010). Gay and bisexual men also have a higher prevalence of panic disorders and psychological distress (Cochran, Sullivan, & Mays, 2003). Lesbian and bisexual women have higher rates of anxiety and depressive disorders compared to heterosexual women (Cochran et al., 2003; Cochran & Mays, 2007). Across genders, gay and bisexual individuals have higher rates of mood and anxiety disorders compared to

their heterosexual counterparts (Bostwick, Boyd, Hughes, & McCabe, 2010; Burns, Ryan, Garofalo, Newcomb, & Mustanski, 2015). Additionally, post-traumatic stress disorder (PTSD) is more prevalent in lesbian, gay, and bisexual individuals than in heterosexuals (Hatzenbuehler, 2009; Mustanski et al., 2010). LGB individuals living in states that had previously banned marriage for same-sex couples or where amendments to discriminate against LGBT individuals were introduced have higher reported rates of PTSD diagnoses compared to those in other states (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Rostosky, Riggle, Horne, & Miller, 2009). Older LGBT adults have higher rates of suicide and substance use disorders compared to their heterosexual and cisgender peers (McCabe et al., 2009; Nuttbrock et al., 2010).

Transgender individuals experience higher rates of depressive symptoms and attempted suicides compared to lesbian, gay, and bisexual peers who are not transgender (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2014; Persson, 2009; Sue et al., 2016). Transgender adults report significantly higher levels of anxiety and depression compared to the general US population (Clements-Nolle, Marx, Guzman, & Katz, 2001; Kessler et al., 2005). Transgender respondents in one study had three times the incidence of depression compared to the general population (Nuttbrock et al., 2010). Transgender folks experience the highest rates of suicidality, with anywhere from one third to one half reporting suicidal ideation at some point in their life (Clements-Nolle, Marx, & Katz, 2006; Reisner, Perkovich, & Mimiaga, 2010). A recent survey reported that 41% of transgender respondents reported a past suicide attempt (James et al., 2016). Additionally, older transgender individuals are more likely to experience mental distress

than their cisgender lesbian, gay, and bisexual peers (Fredriksen-Goldsen et al., 2013).

Minority Stress and Internalized Stigma

Minority stress, or the additive chronic stress experienced by individuals in a minority group, is one phenomenon thought to contribute to increased rates of mental health issues and disparities in LGBT populations (Meyer 1995; 2003). Reports of higher levels of minority stress have also been correlated with higher levels of psychological distress in LGB individuals (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008). Minority stress is one phenomenon that researchers use to conceptualize high levels of depression in this population (McCarthy, Fisher, Irwin, Coleman, & Pelster, 2014). Researchers have found that increased mood, anxiety, and substance use disorders are related to increased levels of minority stress (Holloway, Padilla, Willner, & Guilamo-Ramos, 2015). Minority stress, defined in one study as LGB victimization and the stress of coming out, was correlated with increased rates of depression and suicidal ideation (Baams, Grossman, & Russell, 2015). Minority stress resulting from discrimination has been associated with increased odds of alcohol abuse, other substance use disorders, and nicotine use in LGB adults (Green & Feinstein, 2012; Hughes, Wilsnack, & Kantor, 2016; Slater, Godette, Huang, Ruan, & Kerridge, 2017). Older LGBT adults are at an even higher risk for experiencing minority stress, with 82% of individuals in one study reporting at least one lifetime episode of victimization (Fredriksen-Goldsen et al., 2015).

Higher reported rates of internalized stigma, or negative attitudes, stereotypes, or beliefs one has about their own social group, have also been found to correlate with increased risk for mental health problems in LGBT individuals (Crocker & Major, 1989; Newcomb & Mustanski, 2010). Newcomb and Mustanski (2010) found that reported

internalized homophobia – defined as societal anti-LGB attitudes, beliefs, and stereotypes directed towards one's self – is positively correlated with reported mental health concerns. Internalized ageism – or societal beliefs that aging adults are less attractive, sexual, intelligent, and productive, directed towards one's self – has been found to correlate with higher rates of reported stress and physical and mental health concerns (Allen, 2015; Levy, Slade, Kunkel, & Kasl, 2002; Wight, LeBlanc, Meyer, & Harig, 2015). Internalized homophobia coupled with internalized ageism in older LGBT adults was found to correlate with increased depressive symptoms (Fredriksen-Goldsen et al., 2012; 2013; Wight et al., 2015). Transgender individuals report higher rates of minority stress and internalized stigma and are at an increased risk of developing depressive symptoms compared to their cisgender LGB counterparts (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014; Testa, Habarth, Peta, Balsam, & Bockting, 2015).

Positive Psychology and Strengths

A cornerstone of counseling psychology is emphasis on the positive within psychology, including highlighting client strengths, resources, and potential (Gelso, Nutt, Williams, & Fretz, 2014; Magyar-Moe & Lopez, 2008). Seligman (2002) provided a framework for conceptualizing and classifying strengths through three pillars of strengths: positive emotion and positive subjective experiences (such as resilience); positive character, virtues, and character strengths; and positive social institutions (c.f., Seligman & Csikszentmihalyi, 2000; Seligman & Peterson, 2004). Seligman and Peterson (2004) further developed a taxonomy of character strengths that comprise the second pillar, which includes 24 basic character strengths under six virtues: wisdom and knowledge (creativity, curiosity/love of learning, open mindedness, perspective), courage

(integrity, bravery, persistence, vitality), humanity (kindness, love, social intelligence), justice (fairness, leadership, citizenship), temperance (forgiveness and mercy, humility and modesty, prudence, moderation, self-regulation), and transcendence (appreciation of beauty and excellence, gratitude, hope, humor, spirituality).

In a review of the literature, Lopez and colleagues (2006) found that 29% of articles in counseling psychology literature contained reference to a positive concept. They additionally suggest that positive psychology appeared to be increasingly prevalent in counseling psychology literature at the time of publication. However, in an updated review of the literature from 2004 to 2014, Magyar-Moe, Owens, and Scheel (2015) reported that only 13% of counseling psychology articles they randomly selected had a focus on positive psychology, demonstrating a decrease in emphasis on positive psychology in counseling psychology journals. Magyar-Moe and colleagues (2011) evaluated the role of positive psychology in counseling psychologists' work and found that 47-77% of clinicians reported using positive psychology at least half the time in their work. In a more recent survey, 83% of clinicians in clinical practice endorsed that their client assessment and conceptualization is informed by positive psychology; 92% endorsed using positive psychology in their counseling process in general, but 46% reported not using any specific theory or construct from positive psychology (Magyar-Moe et al., 2012).

Welfare and colleagues (2010) found that counselors struggled to identify strengths in clients with whom they perceived themselves to be less effective, suggesting that counselors' perceptions of their clients' progress may impact their ability to identify strengths. Pedrotti, Edwards, and Lopez (2009) encourage researchers and practitioners to

engage with positive psychology and strengths within a cultural context. One suggestion by these authors is to investigate strengths within a specific community or culture, particularly strengths related to well-being that serve as protective factors from minority stress. One such population for whom this could be particularly important is LGBT persons.

Positive and Strengths-Based Psychology with LGBTQ+ Clients

While strengths-based research within the LGBTQ+ community is still limited, it has received increasing attention from researchers over the past few decades (Vaughan et al., 2014). In a recent content analysis of strengths-based LGBT research, Vaughan and colleagues (2014) found that almost 18% of LGBT themed abstracts referenced strength terms in positive psychology; however, LGBT articles represented only 0.42% of all strength-based abstracts in the literature. The authors used the three-pillar model of positive psychology, described above, in this study to complete a content analysis of how positive psychology and strengths-based themes were addressed in articles about LGBT individuals. They found seven character strengths with substantial inclusion: love (virtue of humanity), integrity (virtue of courage), citizenship (virtue of justice), vitality (virtue of courage), fairness (virtue of justice), spirituality (virtue of transcendence), self-regulation (virtue of temperance), and creativity (virtue of wisdom and knowledge), along with the positive subjective experience of resilience. The researchers also found that the literature regarding LGBT persons increasingly incorporated strengths over the past five decades, with one in six LGBT-specific psychology articles highlighting strengths. However, fewer than 25% of these LGBT strength-based articles included transgender and gender non-binary individuals (Vaughan et al., 2014).

With the increasing attention paid to strengths in LGBTQ+ person over the last several decades, unique strengths have been identified in LGBTQ+ individuals (Vaughan & Rodriquez, 2014). In particular, Vaughan and Rodriguez (2014) suggest that resilience, stress related growth, creativity, bravery, authenticity, zest, love, social intelligence, citizenship, fairness, and positive institutions were strengths that promote psychological well-being in the LGBT community. Character strengths of creativity, integrity, vitality, love, citizenship and fairness, gratitude, and spirituality were found to be prevalent strengths in LGBTQ+ clients in a different study (Lytle et al., 2014). For LGBTQ+ individuals, developing a positive identity, strengths, and resources is not only associated with psychological well-being but may additionally assist LGBT folks in coping with minority stress and internalized stigma (Barr, Budge, & Adelson, 2016; Riggle, Mohr, Rostosky, Fingerhut, & Balsam, 2014; Vaughan & Rodriguez, 2014). Meyer (1995, 2003) posits that coping resources for minority stress include protective factors, such as a sense of group cohesion and positive identity.

Positive identity for LGB individuals was associated with increased LGB community connectedness and higher psychological well-being (Kertzner, Meyer, Frost, & Stirratt, 2009; Riggle, Rostosky, Black, & Rosenkrantz, 2017). Rostosky, Cardom, Hammer, and Riggle (2018) found that the five factors of positive LGB identity, authenticity, social justice, self-awareness, intimacy, and LGB community, were all associated with at least one domain of psychological well-being. The strongest association they found was authenticity with positive relations with others, followed by authenticity and self-acceptance, and authenticity with autonomy. Riggle, Whitman, Olson, Rostosky, and Strong (2008) evaluated positive aspects of gay or lesbian identity

and found three primary domains: disclosure and social support, insight into and empathy for self and others, and freedom from societal definitions of roles. However, researchers of the aforementioned studies did not include transgender and gender expansive (i.e., nonbinary, gender-fluid) individuals in their exploration of strengths. Similar unique strengths, such as resilience, relational strengths, and empathy, have been documented in transgender and gender expansive persons (e.g., Riggle & Mohr, 2015; Riggle, Rostosky, McCants, & Pascale-Hague, 2011; Taube & Mussap, 2019).

Given the unique experiences of minority stress in LGBTQ+ persons, growth related to stress may be an area of resilience for this population. Stress related growth (SRG), or experiences of psychological growth as a result of a stressful experience (Park et al., 1996) is believed to contribute to positive bisexual (Rostosky, Riggle, Pascale-Hague, & McCants, 2010; Vaughan & Waehler, 2010) and transgender identity (Riggle et al., 2011). In lesbians, resources from the LGBT community and social support served as protective factors for long-term relationship success in lesbian couples (Connolly, 2005). Additionally, Connolly (2005) reported that strengths of perspective, persistence, and interdependence helped foster resilience by maintaining relationship. For transgender women, higher levels of positive feelings about being part of the transgender community is related to lower levels of symptoms related to mental health; this connection to community is seen as a source of strength (Sánchez and Vilain, 2009). Counselors have a responsibility to assess for and integrate strengths into the counseling process, particularly for LGBTQ+ clients. One consideration is the evaluation of strengths from the beginning of the counseling relationship, starting with the intake.

Strengths-Based Intake Forms

Some of the first information that counselors receive about their clients is gathered through intake forms and an intake interview. This is the first opportunity that clients have to express themselves and share their personal information with their counselors. The intake process is considered essential for determining the degree to which the client is appropriate for counseling and subsequently setting a course of treatment (Fine & Glasser, 1996). Clients appear to benefit from an intake or single initial session, often reporting feelings of relief and decreased reported symptomology after only one session (Talmon 1990; Perkins 2006). Recommendations for intake paperwork include the inclusion of open-ended questions regarding individual and environmental strengths to assist psychological assessment and conceptualization (Owens, Magyar-Moe, & Lopez, 2015). In fact, in one study, intake forms that utilize solution-focused language regarding the purpose of the visit appeared to create hope and promote pretreatment changes on their own (Richmond, Jordan, Bischof, & Sauer, 2014). Although the intake may be beneficial on its own (Talmon 1990; Perkins 2006), Duncan (2014) suggests that counselors should assess for strengths at the intake session to build the therapeutic relationship and elicit a client's internal resources. One way in which to assist early counseling professionals in identifying client strengths is through intake forms (Welfare et al., 2010)

Tracy (1977) compared attrition, or client drop-out, with two different intake procedures and found that the clinician explicitly stating the client's personal strengths and resources from the intake may assist in increasing the client's motivation for treatment, thus decreasing attrition. The counselor's ability to identify client strengths

and resources and incorporate them into conceptualization are related to improved treatment outcomes, improved therapeutic relationship, and greater perceived efficacy of counseling from the clinician's perspective (Flückiger & Holtforth, 2008; Flückiger, Caspar, Holtforth, & Willutzki, 2009; Welfare, Farmer, & Lile, 2010).

Despite evidence indicating the importance of focusing on strengths, there is mixed consensus in the literature regarding the degree to which clinicians incorporate strengths in clinical intakes. For example, Meyer and Melchert (2011) evaluated use of a biopsychosocial model across 163 intake forms from clinics in Wisconsin and found that the evaluation of strengths in the intake were lacking across the psychological, sociocultural, and biopsychosocial domains. The authors additionally suggest that strengths were not collected consistently in these settings and recommended that clinicians prompt for strengths in the intake. However, Scheel, Davis, and Henderson (2012) determined that the six clinician participants in their qualitative study frequently utilized questions regarding strengths in the intake form and interview. More recently, a content analysis of private practices' intake forms indicated that fewer than 20% of 151 provider forms asked about client strengths (Liang & Shepherd, 2020). Therefore, while individual clinicians may be adept at identifying strengths in their clients during clinical intakes as suggested by Scheel and colleagues, the use of specific questions about strengths in provider intake forms does not appear to be widespread among counseling professionals.

The limited incorporation of strengths in the intake process is especially concerning given the importance of identifying strengths in minoritized clients (e.g., Sue & Sue, 2015). Clinicians who assess for strengths at intake are more attentive to diversity

and inclusion throughout the entire intake document compared with clinicians who do not (Liang & Shepherd, 2020). In fact, scholars recommend the use of a strengths-based approach in general when working with minoritized clients, such as racial, ethnic, sexual, and gender minority groups, in order to promote resiliency and change (Comas-Díaz, 2012; Sue & Sue, 2015). The identification of strengths in the intake for LGBT clients is especially important (Heck, Flentje, & Cochran, 2013), given that mental health disparities have been emphasized to the detriment of strengths in this population (Solomon, Heck, Reed, & Smith, 2017). In order to create an affirming environment for LGBTQ+ clients, intake forms should include client strengths, stressors, and resources (Lytle et al., 2014), including individual and family resources (Solomon et al., 2017). Because identifying strengths at intake is critical in working with LGBTQ+ clients, it is important to consider the best ways in which to do so.

To date, an exhaustive search of research databases has not revealed any researchers who have qualitatively analyzed strengths of LGBTQ+ clients at the intake. However, a similar analysis (though not specific to LGBTQ+ individuals) evaluated strengths in youth during intake admission to substance use treatment (Pagano, Raj, Rhodes, Krentzman, & Little, 2019). Pagano and colleagues used a qualitative approach to code strengths reported as answers to the question "What do you consider to be your most important strengths?" (p. 5). Themes were coded into categories using Gardener's Original 7 Multiple-Intelligences Categories and other categories that emerged were specified (Pagano et al., 2019). This study is similar to the present study, in that an open-ended question was asked on an intake form to collect client strengths and these strengths

were then analyzed qualitatively. Therefore, qualitative analysis may be most effective in beginning to explore the strengths of LGBTQ+ clients collected at intake.

Terminology and Overlapping Identities

While LGBTQ+ is often utilized as an umbrella term to characterize sexual and gender minoritized individuals, the distinction between LGB (and other sexual minoritized identities) and transgender and gender non-binary identities is important to acknowledge and understand in research and practice (Griffith et al., 2017; Nuru, 2014). The American Psychological Association (APA) in particular has used the term TGNC, which stands for *transgender and gender non-conforming* (APA, 2015) to distinguish trans and gender nonconforming identities from LGB+ experiences. This language is additionally well-documented in the literature (e.g., Chang, Singh, & Rossman, 2017; Dugan, Kusel, & Simounet, 2012; Testa et al., 2015). However, this acronym or terminology may not adequately capture identities that fall outside of the gender binary. Chang, Singh, and Rossman (2017) acknowledge that "though the term TGNC is intended to be inclusive of people whose gender identities do not fall within the gender binary system, some non-binary people identify as TGNC, whereas others do not… one could consider nonbinary identities predating the more commonly known TGNC identities as they emerged in the 20th century" (p. 21). Given the importance of using participants' own language to define their gender, the author of the present study will utilize the acronym T/NB to reference transgender and gender non-binary participants. In order to honor participant identities, the term "LGBT/NB" will replace LGBTQ+ in reference to the study sample.

Another important issue to consider in writing such a manuscript is the way in which to handle overlapping identities between sexual orientation and gender identity, or between LGB participants and T/NB participants. Across the literature, researchers have found significant overlap between transgender/gender non-binary identities and lesbian, gay, bisexual, and other sexual minoritized identities (c.f., Chang et al., 2017; Kuper et al., 2011; Reisner & Hughto, 2019). Feinberg (1992) argues of transgender communities and gay and lesbian communities that "the two huge communities are like circles that only partially overlap. While the oppression within these two powerful communities are not the same, we face a common enemy" (p. 206). In fact, most trans and non-binary individuals are additionally sexually minoritized persons (Kuper et al., 2011).

Despite the clear overlap in sexual and gender minority identities, it is critical to understand transgender and non-binary experiences as separate from that of cisgender sexual minoritized persons. While both groups may experience oppression through heterosexism and heteronormativity, transgender and non-binary persons additionally experience transphobia. Furthermore, taking an intersectional approach to understanding these experiences (e.g., Crenshaw, 1989), it is likely that the type of heterosexism experienced by transgender and non-binary persons may look very different from that experienced by cisgender LGB persons (Nadal et al., 2016). Therefore, to contribute to the body of literature on T/NB-specific strengths, this study additionally examined unique characteristics that emerged from the data on T/NB participants separate from LGB participants. In this study, there is overlap between LGB and T/NB participants, as all but 3 of the T/NB participants identified as LGB or queer. However, it is still worth

examining the self-reported strengths of T/NB participants, while acknowledging that those strengths cannot be used for comparison with LGB participants.

Purpose of the Study

Additional positive psychology research, particularly specific to LGBT/NB individuals, is critical to improving the delivery of clinical services (Magyar-Moe et al., 2015; Vaughan et al., 2014). When clinicians assess for and emphasize strengths in LGBT/NB individuals, they promote psychological well-being in their clients (Vaughan & Rodriguez, 2014) and may help buffer their clients against minority stress and internalized stigma (Meyer, 2003). Researchers do not have a strong understanding of how LGBT/NB individuals report and understand their strengths, particularly within a positive psychology framework (Vaughan et al., 2014). Positive psychology researchers and those promoting inclusive and affirming practice for LGBT/NB clients encourage the inclusion of questions about strengths and resources on intake paperwork (Lytle et al., 2014; Owens, Magyar-Moe, Lopez, 2015). Scholars have evaluated strengths reported on intake forms using qualitative analysis (Pagano et al., 2019), have analyzed LGBT/NB strengths from various strengths measures and qualitative interviews (e.g., Connolly, 2005; Riggle et al., 2011), and quantitatively evaluated strengths reported at intakes using strengths-related measures (Lehner, 2004; Painter, 2012). However, to date, the way in which LGBT/NB clients describe their strengths on intake forms has received little attention despite consistent recommendations to collect such information. In order to address this gap in the literature, this study addressed the following research question: How do LGBT/NB clients report their strengths on an intake form in a community setting?

CHAPTER II

METHODOLOGY

Setting

Data were collected from existing intake paperwork, or archival data, at the Al Carlozzi Center for Counseling, formerly the OSU-Tulsa Counseling Center. The Al Carlozzi Center for Counseling is a department training clinic for masters and doctoral counseling and counseling psychology students. While this clinic is the designated university counseling center for OSU-Tulsa, it additionally serves members of the community. In particular, the center has a longstanding relationship with the Dennis R. Neill Equality Center (OKEQ) in Tulsa, Oklahoma. Because the clinic offers low-cost services, such as the sliding scale options starting at $5 per session, many of the clients are referrals from OKEQ. Therefore, many of the clients served by the Al Carlozzi Center for Counseling are LGBT/NB persons.

Procedure

Intake forms were collected for 140 clients (n = 140) who sought counseling services from 2015 to 2019. The intake collected age, gender, marital status, highest education received, LGB identity, OKEQ referral, identified strengths, indicated social support, number of sessions attended, endorsed problem severity, endorsed likelihood that the problem will change, and a previous diagnosis of a mental health disorder. Notably, race or ethnicity was not asked in the intake form. Data were entered into an

Excel spreadsheet, with no identifying information collected. The data were stored on a password encrypted hard drive and stored in a locked room throughout the study.

Participants

The original sample of intake forms collected from the Al Carlozzi Center for Counseling included 76 clients who identified as cisgender and heterosexual and 64 total LGB and transgender or non-binary (T/NB) clients. For the purpose of this study, we focused only on the 64 LGBT/NB clients. Of the 64 total LGBT/NB participants, 20 identified as transgender or gender non-binary (17 of whom also identify as LGB), and 61 were lesbian, gay, or bisexual clients (17 of whom also identify as T/NB); only 3 T/NB clients did not identify as LGB. For the purpose of the study, only LGBT/NB clients were included in the analysis (n = 64). Ages for LGBT/NB clients ranged from 18 to 61 years old and the mean age was 33.7 years old. Only 11 of the 64 participants were not referrals from OKEQ. 56.2% (n = 36) indicated their relationship status as single, 26.6% as partnered (n = 17), 9.4% as divorced (n = 6), and 7.8% (n = 5) as married. Most had the highest education level as high school or an associate degree (n = 23), and many had a bachelor's degree (n = 17). 10 individuals had indicated they had some college experience. Of the 64 clients, 28% (n = 18) indicated they did not have social support, leaving 72% (n = 46) indicating they had at least one form of social support. In regard to endorsed problem severity, on a Likert type scale of 1 to 4, 92% (n = 59) endorsed their problem severity at a 3 or 4. A similar scale for likelihood the problem will change was asked, and 64% (n = 41) endorsed a 3 or 4, so a higher likelihood for the problem to change. Of the LGBT clients in this study, 54.7% (n = 35) had a previous mental health diagnosis, and 45.3% (n = 29) did not.

Instruments

Intake Form. Former clients completed the OSU-Tulsa Counseling Center (currently titled the Al Carlozzi Center for Counseling) Individual Counseling Intake Form prior to the in-person intake appointment. The form included questions about demographic information, previous counseling treatment, emergency contact information, a health background checklist, current medications, alcohol and drug use, a checklist of presenting issues, questions about problem severity and likelihood of change, past traumatic experiences, past and current suicidal ideation and homicidal ideation, financial concerns, legal problems, family background, strengths, weaknesses, hope for counseling, and reason for seeking counseling. Strengths were assessed on the intake from the question "What are your greatest strengths?"

Modified Consensual Qualitative Research

Consensual Qualitative Research (CQR) is a bottom-up, inductive research method that uses open ended questions and semi-structured interviews to collect and descriptively analyze small batches of data (Hill, 2015). The steps in CQR include developing a research question, conducting and transcribing interviews, developing domains, constructing core ideas for each domain, auditing domains and core ideas, cross-analyzing core ideas within domains to create categories, and then auditing to cross-analyses; at each step, the research team reaches full consensus before moving on to the next step (Hill, 2015).

Modified Consensual Qualitative Research (CQR-M) is a methodology that utilizes a bottom-up approach to code relatively simple data into categories that emerge from the data, while finding consensus among coders (Spangler, Liu, & Hill, 2014).

CQR-M is suggested for exploring new and unexpected ideas, develop on little studied phenomena in the literature, and expand a limited knowledge base (Spangler et al., 2014). Although traditional CQR uses sample sizes from 8 to15 people, CQR-M can accommodate larger sample sizes because it analyzes smaller amounts of qualitative data that offer a more comprehensive and complete understanding of a particular population (Spangler et al., 2014). CQR-M studies to date have had sample sizes between 67 and 132 participants (c.f., Spangler et al., 2014). Spangler and colleagues (2014) outline a structured, stepwise approach to conducting CQR-M, beginning with discussing expectations and biases about the content of the data. The next step is to derive domains and categories directly from the data, typically by pulling a small sample from the larger data as a whole. Domains describe a large theme within the data (Hill et al., 2005). Categories classify strengths that may fall within the same domain, but which may have important differences, requiring differentiation between different iterations of that domain (Hill et al., 2005). Spangler et al. then recommend that researchers edit domains and categories as more data from the dataset is included, followed by coding the data into domains and categories. As in traditional CQR, the team must reach consensus at each step of the process before they can move to the next. Two of the main departures in CQR-M from traditional CQR are the exclusion of an external auditor and the elimination of core ideas, due to the brevity and simplicity of responses being coded (Spangler et al., 2014). Another departure from CQR is that proportions are presented in CQR-M as opposed to frequencies being reported as general, typical, or variant (Spangler et al., 2014).

Research Team

The primary team in this study comprised of a white, lesbian, non-binary doctoral candidate in counseling psychology, a first-year white, gay, gender queer, aromantic doctoral student in counseling psychology, and a white, cisgender, female, straight second-year master's student in mental health counseling. Although an external auditor is not required in CQR-M, a Professor in Counseling and Counseling Psychology, who identifies as a white, cisgender, queer woman, served as an external judge for items that could not reach consensus within the primary team. The team met for a total of 11 times via Zoom between November 2019 and April 2020.

Biases and Expectations

As recommended in CQR (Hill et al., 2005) and CQR-M (Spangler et al., 2014), the team of four used the first five meetings to engage in reflexivity by discussing identities held by the individuals and the team as a whole, as well as biases and expectations related to the research study and questions. According to Hill and colleagues (1997), expectations are anticipated beliefs held by researchers, based on the literature, for how participants will respond. A bias is defined as a personal judgement, either positive or negative, that might make objectivity difficult for a researcher (Hill et al., 1997). These reflexive discussions are intended to promote objectivity. When objectivity is not possible, researchers are encouraged to bracket (acknowledge and set aside) their biases and expectations in an effort to minimize their impact on the coding and interpretation of the data (Hill, 2015; Hill et al., 1997).

Members of the research team identified many biases and expectations related to LGBT/NB clients and their strengths. All of the members of the research team reported

that they had extensive experience working with LGB and T/NB clients in a counseling setting. The primary coding team, consisting of both doctoral students and the master's student discussed in the previous section, additionally had practicum and internship experiences at the Al Carlozzi Center for Counseling. One team member expressed an expectation that, because the counseling center has a positive reputation in the LGBT/NB community in Tulsa, LGBT/NB clients may be more likely to report strengths than they would in a different setting. They believed that the positive reputation may contribute to a greater degree of comfort in seeking services at the center, which may make it easier for LGBT/NB clients to identify their own strengths. One team member stated that, in her clinical experience at the center, clients often reported only one or two strengths on the intake but could discuss these strengths in greater depth upon meeting with her. This observation led that team member to anticipate that, while LGBT/NB clients might be more likely to report strengths at this particular counseling center, these strengths might be terse or brief in nature on the written intake form. Another expectation of the team that arose from the literature and experience working with LGBT/NB clients was that strengths related to empathy, compassion, and/or relationships would be most commonly reported for LGBT/NB clients. Several team members also stated that they expected that strengths would be less gender-coded, meaning they would adhere less to social gender norms or gender expectations (Eckert, 2014), than they might be for cisgender, heterosexual clients.

In addition to specific expectations, the team discovered several biases in the first five meetings. One doctoral student reported that they had a positive bias toward non-binary clients compared to heterosexual, cisgender clients. In fact, this preference toward

working with non-binary clients over clients that identify in other ways even extended to LGBT clients who do not identify as non-binary. Several members of the team reported a similar bias toward non-binary clients, with one team member expressing that non-binary clients have a “special place in [her] heart.” Several members of the team additionally noted that, because they believed the Al Carlozzi Center for Counseling has a positive reputation within the LGBT/NB community in Tulsa, they might assume that clients would report more strengths. Therefore, the team noted that they might be more likely to interpret strengths generously than they would if the data came from a different site, introducing team bias. The team as a whole agreed that these identified biases might lead the team to “read into strengths” reported on intake forms. Specifically, they noted that they might make assumptions about what a strength meant that was not intended by the client who completed the intake form.

The team attempted to maintain objectivity throughout the coding process, especially when interpretive liberty was taken due to the brevity of responses and inability to clarify with participants. Because interviews were not conducted and archival data was used, clients could not be contacted to expand on ambiguous responses that did not clearly categorize into one domain. Therefore, some reported strengths that might have appropriately fit into multiple domains were categorized by the research team into the domain or category that was consensually determined to be the most fitting. For example, “leadership skills” was debated by the research team as being an Interpersonal Skill or an Abilities and Achievement strength. It likely could have fit in either domain, but was determined by the team to best fit in the Abilities and Achievement domain after inferring this strength was more related to an individual skill as opposed to an

interpersonal strength. However, there was no way to determine if this is what the client truly meant by the reported strength.

Data Analysis

Following the step-by-step guide for CQR-M provided by Spangler and colleagues (2014), the research team reviewed the data and created 10 preliminary domains based on initial impressions of the reported strengths. I provide detailed definitions and illustrations of the domains and categories below in the Results section. These domains were Interrelation/Connection, Relational Qualities Excluding Emotions, Outward Expression of Emotions, Skill/Achievement, Role-Oriented, None, Self-Efficacy, Flexibility, Rational, and Spirituality. The coders adjusted the domains as they initially reviewed the dataset, leading to eight edited domains: Connection, Interpersonal Skills, Abilities and Achievements, Role-Oriented/Specific Strengths, Reported No Strengths, Self-Efficacy, Resilience, and Spirituality. The team reviewed the dataset as a whole a third and final time. In this review, they randomly selected strengths from the dataset to test the coding. This final review led the team to reach consensus on a final domain set of six domains with four categories.

It is important to note here that according to Hill (2015), "there is no preset category structure that researchers seek; rather they attempt to describe what emerges as clearly and elegantly as possible" (p. 489). The research team determined that some of the domains, notably Connection and Self-Efficacy and Resilience, were too broad to appropriately capture some of the reported strengths. Therefore, the research team created four categories under the domains of Connection and Self-Efficacy and Resilience to more thoroughly describe the reported strengths. The coding group reached consensus

that the domain of Connection would have two categories, Internal Focused and External Focused. Similarly, Self-Efficacy and Resilience were combined to create one domain but were separated into the two categories of Actions and Traits. The four categories served as more distinct classifications of the domains Connection and Self-Efficacy and Resilience. Spirituality, which had previously existed as a separate domain, was determined to fall under the domain of Self-Efficacy/Resilience and the category of Traits. The final domains were: Connection, Interpersonal Skills, Abilities and Achievements, Role-Oriented, Self-Efficacy/Resilience, and Reported No Strengths. The final categories were Connection: Internal-Focused, Connection: External-Focused, Self-Efficacy/Resilience: Actions, Self-Efficacy/Resilience: Traits. As a team, the four judges coded the first 44 strengths and reached full consensus. The primary team of three then coded the remaining strengths individually. The primary investigator compared the three sets of codes. Any strength that did not have complete consensus was discussed in the full research team. When consensus could not be reached, the auditor joined the discussion to share her thoughts. The team discussed the strength in question until they reached consensus.

CHAPTER III

RESULTS

A total of 173 strengths were reported by the 64 individual participants. Six domains and four categories (noted in parentheses) emerged from the data: Connection (Internal-Focused or External-Focused), Interpersonal Skills, Abilities and Achievements, Role-Oriented, Self-Efficacy and Resilience (Actions or Traits), and Reported No Strengths. The four categories were created as a way to further classify strengths that appeared to sort into two different sub-classifications within a particular domain. The team identified categories for the Connection domain and the Self-Efficacy and Resilience domain. The reported strengths in the Connection domain were either related to an internal experience, or an external manifestation of that internal experience. Therefore, the Connection domain was separated into the Internal-Focused and External-Focused categories. Similarly, the Self-Efficacy and Resilience domain contained strengths related to intrinsic traits and to actions as a result of difficult experiences. Therefore, the domain of Self-Efficacy and Resilience was separated into two categories, Traits and Actions. Only four participants endorsed that they had no strengths. These were not participants who left the strengths question blank; instead, they made some indication that they did not have any strengths to report, such as putting “none” or “N/A” in the space provided to answer the open-ended question regarding strengths.

The team created an operationalized definition for each domain and, when relevant, related category. The Connection domain was operationalized as strengths related to other people and relationships that involve emotional awareness or intelligence. Connection: Internal-Focused is operationalized as strength related to an internal experience of a relational connection to others, such as empathy or compassion. Connection: External-Focused is defined as a strength that is an external manifestation of the internal experience of connection Others likely receive or benefit from this strength, such as caring or kindness. Interpersonal Skills are relational qualities that are not related to emotions or emotional intelligence. These are likely action-oriented and do not inherently promote relational connection, like humor or listening. Abilities and Achievements are individual strengths that are skill oriented, like intelligence or sports. Role-Oriented strengths are defined as being identity based, such as friend or great parent. Self-Efficacy and Resilience are strengths that describe an individual's ability to bounce back from hard times or recover from difficulties. Self-Efficacy and Resilience: Actions are strengths that reflect a person's ability to assert control over one's self and environment through actions, like surviving or not giving up. Self-Efficacy and Resilience: Traits are qualities that enable a person to bounce back from hard times, such as flexibility and introspection. Finally, Reported No Strengths captures individuals who indicated they had no strengths or reported a lack of strengths. The definitions of the domains and categories described above are summarized in Table 1 (below), with examples to illustrate each domain and category.

For all LGBT/NB participants, the most common domain was Abilities and Achievements (n = 40, 23.12%). Domains and categories of reported strengths for all

participants in order from most to least common were: Abilities and Achievements (n = 40, 23.12%), Connection External-Focused (n = 31, 17.92%), Interpersonal Skills (n = 31, 17.92%), Self-Efficacy and Resilience Traits (n = 29, 16.76%), Connection Internal-Focused (n = 19, 10.98%), Self-Efficacy and Resilience Actions (n = 16, 9.25%), Reported No Strengths (n = 4, 2.31%), and Role-Oriented (n = 3, 1.73%). See Table 2 for frequency distributions for all participants. Table 3 and 4 also report frequency distributions for LGB and T/NB clients separately, to be sure these identities are acknowledged as separate constructs and honor differing experiences. However, the vast majority of T/NB participants identified as queer in regard to sexual orientation in some way, indicating some overlap between participants in Tables 3 and 4. Therefore, these results cannot be used for comparison between T/NB and LGB respondents.

Table 1.

LGBT/NB Reported Strengths on Intake: Domains, Categories, Definitions, and Examples

Domain	Category	Definition	Example
Connection	Internal Focused	Strength related to an internal experience of a relational connection with others; internal emotional awareness, emotional intelligence, or relational focus	Compassion, Empathy
	External Focused	Strengths related to an external manifestation of the internal experience of connection; others receive the relational strength	Caring, Kindness
Interpersonal Skills		Relational qualities not related to emotions; action oriented and skill based; does not incorporate an inherent increase in connection	Humor, Listening

Abilities and Achievements		Skill or achievement oriented that is not relationally focused; individualistic strengths	Intelligence, High Achieving, Sports
Role-Oriented		Describing relational roles; identity oriented	Friend, Great Parent
Self-Efficacy and Resilience	Actions	Reflects confidence in the ability to assert control over one's motivation, behavior, and social environment through actions; ability to bounce back from hard times through actions and/or as a result of experiencing difficulties	Not Giving Up, Surviving
	Traits	Traits and qualities that contribute to being able to navigate obstacles, bounce back from hard times, and recover from difficulties	Flexibility, Introspective, Tough
No Strengths		Indicated no strengths or a lack of strengths	None

Table 2.

Domain Frequency Distributions: Total Participant Frequencies

Domain	Category	Frequency	Percent
Connection	Internal Focused	19	10.98%
	External Focused	31	17.92%
Interpersonal Skills		31	17.92%
Abilities and Achievements		40	23.12%
Role-Oriented		3	1.73%
Self-Efficacy and Resilience	Actions	16	9.25%
	Traits	29	16.76%
No Strengths		4	2.31%

Table 3.

Domain Frequency Distributions: LGB Frequencies

Domain	Category	Frequency	Percent
Connection	Internal Focused	19	11.24%
	External Focused	31	18.34%
Interpersonal Skills		30	17.75%
Abilities and Achievements		37	21.89%
Role-Oriented		3	1.78%
Self-Efficacy and Resilience	Actions	16	9.47%
	Traits	29	17.16%
No Strengths		4	2.37%

Table 4.

Domain Frequency Distributions: T/NB Frequencies

Domain	Category	Frequency	Percent
Connection	Internal Focused	7	13.46%
	External Focused	8	15.38%
Interpersonal Skills		6	11.54%
Abilities and Achievements		19	36.54%
Role-Oriented		0	0%
Self-Efficacy and Resilience	Actions	4	7.69%
	Traits	6	11.54%
No Strengths		2	3.85%

CHAPTER IV

DISCUSSION

This study provides insight into the way in which LGBT/NB individuals identify and report their strengths on intake forms, based on a sample of Oklahomans in Tulsa referred from a local LGBTQ+ community center. To date, an exploration of the literature does not reveal any studies that qualitatively explored LGBT/NB reported strengths on paperwork at the intake session, despite recommendations by researchers and scholars to integrate strengths questions on forms for LGBT/NB clients (Lytle et al., 2014; Owens et al., 2015). This study addressed a specific gap in LGBT/NB positive psychology research by exploring self-identified LGBT/NB strengths.

I identified Abilities and Achievements, Interpersonal Skills, Connection: External Focused, Self-Efficacy and Resilience Traits, Connection: Internal Focused, and Self-Efficacy and Resilience Actions as themes of commonly reported strengths for LGBT/NB clients in this sample. The most frequently reported strengths for each separate domain and category were Abilities and Achievements (23.12%), followed by Interpersonal Skills (17.92%) and Connection: External Focused (17.92%). Therefore, strengths related to specific, individualistic talents, skills, and accomplishments and strengths related to interpersonal connections that are externally manifested may be more readily recognized by LGBT/NB clients than strengths in other categories, as they

reported these more often at intake. This finding also suggests that these strengths may be common in LGBT/NB clients, though further study is needed to determine if that applies outside of the setting of this study.

Historically, LGBT/NB clients have reported character strengths of love, integrity, citizenship, fairness, and creativity from the three-pillar model (Vaughan et al., 2014). The frequency of strengths categorized in the Abilities and Achievements domains provides support for these character strengths, as Vaughan and colleagues (2014) included “achievement” in their content analysis for the character strength of Love of Learning within the virtue Knowledge and Wisdom. However, this search only resulted in one publication that referenced this classification. Therefore, this result appears to introduce a unique character strength related to specific skills that has not been previously explored in the body of literature. A specific limitation of Vaughan and colleagues’ content analysis was the dearth of research incorporating transgender participants. In fact, none of articles included in their content analysis addressed or referenced individuals who identify outside of the gender binary at all. The present study found that transgender and non-binary participants endorsed strengths related to Abilities and Achievements at a rate that was higher than any other domain (36.54%). Because this is a novel finding, these particular strengths may have been overlooked in positive psychology research due to limited inclusion of transgender and non-binary individuals in this discipline.

Following the aforementioned domains and categories, the next most frequently reported strengths were in the Self-Efficacy and Resilience: Traits category (16.76%), Connection: Internal Focused category (10.98%), and Self-Efficacy and Resilience:

Actions category (9.25%). Strengths reported in these categories have been referenced in previous positive psychology research with LGBT/NB individuals, as they overlap with common traits of love, vitality, spirituality, and self-regulation (Vaughan et al., 2014).

The domains in which participants least frequently reported strengths were Reported No Strengths (2.31%) and Role-Oriented (1.73%). LGBT/NB individuals have indicated in previous research that they cannot identify positive elements of LGBT/NB identity in their lives (Riggle et al., 2008; Riggle et al., 2011). Difficulty identifying positive elements of LGBT/NB identity may extend to LGBT/NB clients' inability to identify strengths, as demonstrated in this study. While it is possible that participants specified that they did not have strengths due to the length of the intake form, this response could also indicate that the participant believed that they did not have strengths. Further assessment is required to determine the degree to which LGBT/NB clients are able to identify and report their strengths, particularly prior to entering the counseling relationship.

Strengths within the least frequently reported domain, Role-Oriented, have not been previously reported in the literature. There are several potential explanations for this oversight. First, other researchers may not have separated this strength from other interpersonal or relational domains. Additionally, this strength is not captured in the three-pillar model, which is the predominant model by which researchers examine strengths (Peterson & Seligman, 2004). Therefore, strengths specific to one's role may have been overlooked in other research. The data in this study suggest that Role-Oriented strengths are distinct entities from other connection-related strengths given their particular relevance to specific relationships. For example, one reported strength in this

category was “great parent.” This strength may not be applicable in other relationships, thus distinguishing it from general connectivity or relational strengths.

It should be noted that, when looking just at domains, Connection Strengths were the most commonly reported strengths (28.90%), followed by Self-Efficacy and Resilience (26.01%), then Abilities and Achievements (23.12%). When combined, these findings more closely resemble existing literature with the emphasis on relational strengths and resilience-based strengths. These results support previous findings that LGBT/NB individuals as a whole tend to report strengths related to connection and relationship and factors and traits that help them overcome adversity (Vaughan & Rodriquez, 2014; Vaughan et al., 2014).

Surprisingly, T/NB clients most frequently reported strengths in the Abilities and Achievements domain, even when accounting for the combined frequencies of the Connection and Self-Efficacy and Resilience categories. Much of the existing literature on LGBT/NB client strengths suggest that relational, courageous, and justice-related strengths are most commonly found in this community (Vaughan & Rodriquez, 2014). However, the present results suggest that researchers in the past may not have adequately assessed for strengths that fit within this category, particularly in T/NB clients. LGBT/NB clients often experience marginalization in the way that they are asked to define themselves, particularly for transgender and non-binary individuals (Riggle et al., 2011). Therefore, it is possible that identifying strengths in abilities and achievements can help LGBT/NB clients define themselves with something concrete that they can experience rather than a trait that is ill-defined.

The Role-Oriented domain comprised the fewest number of reported strengths; in fact, no T/NB participants reported any strengths in this category. Although LGBT/NB individuals in this study commonly reported strengths related to connection to others (28.90% for both Connection categories), this discrepancy might highlight the difference in strengths related to relationships and strengths defined by relationships. LGBT/NB participants in this study may value aspects of their identity that contribute to connection with others, placing less value on specific relationships or their roles in those relationships. Additionally, LGBT/NB participants in this study might value overall relational connection, but do not center their identity around a particular role they take in relationships.

These results additionally illustrate the way in which LGBT/NB clients perceive, report, and describe their strengths prior to entering a counseling relationship. Researchers (c.f., Taube & Mussap, 2019; Vaughan et al., 2014) have explored strengths in LGBT/NB individuals both within the three-pillar framework described by Seligman and Csikszentmihalyi (2000) and outside of this specific taxonomy. Strengths classified within this framework that commonly appear with LGBT/NB individuals are love, integrity, citizenship, vitality, fairness, spirituality, self-regulation, and creativity; the corresponding virtues with these character strengths are humanity, courage, justice, courage, justice, transcendence, and temperance (Vaughan et al., 2014). Additionally, the subjective experience of resilience is commonly reported in LGBT/NB strengths literature (Vaughan et al., 2014). For transgender and non-binary folks, inquisitiveness, caring, and self-control were virtues that represented a three-factor model of character strengths (Taube & Mussap, 2019). Outside of the three-pillar model, authenticity, social

justice, self-awareness, intimacy, and community were factors related to positive LGB identity (Rostosky et al., 2018). Authenticity, intimacy/relationships, community, social justice/compassion, and insights/self-awareness were five commonly reported strengths for transgender individuals (Riggle & Mohr, 2015).

The present study extends the aforementioned findings to better help counseling professionals understand the unique strengths present in LGBT/NB clients. In particular, the virtue of humanity, defined as interpersonal strengths related to tending and befriending others (Peterson & Seligman, 2004), parallels the Connection domain in the current results. Character strengths in the Humanity virtue, defined as strengths involved to tending to and relating to others, include love, kindness, and social intelligence (Peterson & Seligman, 2004). Similarly, strengths in the Connection domain include kindness, loving, empathy, and compassion. These similarities suggest that the Connection domain may represent strengths accounted for by the Humanity virtue in the three-pillar model, thus providing support for that model as a standardized way of assessing strengths. Similarly, the domain Interpersonal Skills identified in our findings appears to be related closely to the virtue Justice, which is comprised of the character strengths fairness, leadership, and citizenship and operationalized as strengths that support a healthy community (Peterson & Seligman, 2004). Some strengths coded in the Interpersonal Skills domain included leadership, tolerance, unbiased, accepting, and honest. This association further supports the three-pillar model as a way to classify and assess strengths in LGBT/NB individuals, as commonly reported strengths at intake for this sample appear to fit within categories within this model.

Many strengths within the domain Abilities and Achievements map onto character strengths under the virtue Wisdom and Knowledge, which is defined as cognitive strengths (Peterson & Seligman, 2004). For example, creativity, curiosity, and love of learning are considered character strengths in the Wisdom and Knowledge virtue. This parallels to strengths coded in the Abilities and Achievements domain, which included creativity, intelligence, analytical, fast learning, and planner. The overlap between strengths in the present study and the virtue of Wisdom and Knowledge provides modest support for use of this element of the three-pillar model with LGBT/NB clients. Overall, the findings in this study provide support for these three virtues (Humanity, Justice, and Wisdom and Knowledge) as strengths that LGBT/NB individuals report based on the emergence of the parallel domains of Connection, Interpersonal Skills, and Abilities and Achievements.

Despite the similarities between the Abilities and Achievements domain to character strengths listed in Wisdom and Knowledge, there were notable differences that suggest this domain captures unique strengths unaccounted for by the three-pillar model. Many strengths reported that were coded in the Abilities and Achievements domain were specific talents outside of the Wisdom and Knowledge character strengths of Creativity, Curiosity, Open Mindedness, Love of Learning, and Perspective (Peterson & Seligman, 2004). For example, clients reported strengths like “story writing ability,” “tax accounting skills,” “good at my job,” and “good memory.” Based on definitions and examples provided by Seligman and colleagues (2000; 2004), these strengths do not fit within this virtue. Despite an exhaustive review of the literature, the researcher was unable to find any studies in which researchers capture this type of strength.

The inability of the three-pillar model to account for strengths in the Abilities and Achievements domain found in these results is especially striking, as it was the most commonly reported domain for the total sample (*n* = 23.12%), LGB clients (21.89%), and particularly T/NB participants (36.54%). This suggests a gap in positive psychology research, which has been largely conducted on cisgender and heterosexual individuals. This finding might suggest a need for a revised Three-Pillar model that incorporates character strengths and virtues specifically for LGBT/NB individuals, so as to not overlook strengths related to specific Abilities and Achievements.

In addition to the way in which the present findings diverge from the three-pillar model explored above, there is another important distinction between these results and the suggested model. The three-pillar model separates traits, positive subjective experiences, and positive institutions, specifically identifying traits as specific character strengths (Peterson & Seligman, 2004). In this model, resilience is considered to be a subjective experience rather than a character strength (Peterson & Seligman, 2004). However, this study found that participants identified resilience and self-efficacy as both an experience (or action) and an inherent trait in an individual. During data analysis, a division emerged between internal, inherent traits (such as flexibility, wise-minded, and introspective), and actions (such as not giving up, surviving, and struggling on the way to success) that contribute to self-efficacy and resilience. Although the Actions category of Self-Efficacy and Resilience maps well onto the positive subjective experience of resilience, there appear to be character strengths and traits that promote resilience as an attribute or quality of a person. The virtue of Courage (emotional strengths that help accomplish goals despite opposition; Peterson & Seligman, 2004) captures some of these

strengths reported in the Self-Efficacy and Resilience domain, such as determined, perseverance, and tough. However, this virtue does not fully incorporate trait-like strengths that additionally promote resilience. Therefore, the domain of Self-Efficacy and Resilience that emerged from this data appears to represent a unique grouping of strengths. Additionally, two participants specifically named resilience as a strength, suggesting that resilience may represent a unique strength in LGBT/NB individuals.

While many of the present findings support the use of the three-pillar model as a conceptual model for understanding LGBT/NB client strengths, there are important divergences that suggest that the use of a standardized model may not be the most effective way to capture LGBT/NB client strengths. It is particularly important to allow LGBT/NB clients to define themselves and their experiences outside of heterosexist societal norms and the normative experiences of cisgender and heterosexual individuals (Heck et al., 2013). Indeed, imposing a model of positive psychology that is not specific to LGBT/NB strengths might perpetuate harmful research and counseling practices of defining experiences for these clients (Meyer, 2003). While standardizing the use of a strengths model may be beneficial in conducting research, there are clear limitations in the three-pillar model for use with this population, particularly in clinical settings. Qualitative research that allows LGBT/NB clients to define their own strengths is certainly more time-consuming and potentially ambiguous. However, such research may also act as a form of resistance in a culture that politicizes and defines experiences for LGBT/NB clients. Therefore, it is critical to find a balance between use of standardized models that improve research rigor and social justice praxis in research.

Of particular note is the four participants who reported that they had no strengths. This could be for a myriad of reasons. Researchers encourage identification of strengths and resources, including identifying social support, as a way to manage minority stress and internalized homophobia (Rotosky et al., 2007; Cox et al., 2011). Therefore, people experiencing elevated minority stress or internalized homophobia/transphobia may have greater difficulty identifying their strengths. LGBT/NB persons are additionally more likely to experience depression and suicidal ideation compared with their cisgender, heterosexual counterparts (Baams et al., 2015; Cochran & Mays, 2015; Fredriksen-Goldsen et al., 2014). Scheel and colleagues (2012) indicated that clients may have greater difficulty adequately utilizing their strengths in times of crisis. Because LGBT/NB clients are at greater risk for suicidal ideation, they may be more likely to begin a counseling relationship in a distressed state (Baams et al., 2015; Cochran & Mays, 2015; Fredriksen-Goldsen et al., 2014). Therefore, it may be more difficult for such clients to endorse strengths at the intake.

Another barrier to LGBT/NB clients identifying strengths at the intake may be a lack of social support. Of the four individuals that reported no strengths, all indicated they had no social support on the intake paperwork. A particularly salient form of social support for LGBT/NB individuals is community connectedness, which relates to an LGBT/NB individual's ability to identify positive aspects of their identity and their own coping resources (Barr et al., 2016; Vaughan & Rodriquez, 2014). Without networks of support to highlight strengths, LGBT/NB clients may be unable to recognize their own resources. Although not measured in relationship to one another, higher self-criticism (the harsh, punishing evaluation of self) and lower community connectedness in sexual

minorities were both found to mediate variance in levels of psychological distress (Puckett et al., 2015). Therefore, LGBT/NB individuals without social support or community connectedness may experience greater psychological distress. Elevated psychological distress may hinder LGBT/NB individuals' recognition of their strengths or resources. Additional research is required to determine factors related to a perception of no individual strengths.

Limitations

One limitation associated with this study is that race and/or ethnicity was not collected on the intake form administered at the counseling center from which data was retrieved. Following Pedrotti, Edwards, and Lopez's (2009) recommendation to evaluate strengths within a cultural context, particularly for racial and ethnic minoritized individuals, the author's inability to account for race limits the degree to which analysis of client strengths can account for the contextual implications of race/ethnicity. Additionally, intersectional identities and LGBT/NB people of color have distinct experiences of minority stress and strengths, particularly resilience, compared to white LGBT/NB individuals (Balsam, Molina, Simoni, & Waters, 2011; Meyer, 2010). These experiences and differences will not be appropriately accounted for or explored as a result of this limitation in data collection.

An additional limitation is the setting from which the data were collected. The authors used archival intake data taken from one training clinic in Tulsa, Oklahoma, Therefore, results are not generalizable to clients in other clinical settings or outside of Tulsa, Oklahoma. Furthermore, participants were comprised of individuals already engaged in counseling services, primarily referred from a local LGBTQ+ resource center.

Both of these conditions may impact the reported strengths of clients. LGBT/NB clients in this particular study might have been more likely to report strengths at the intake because of the existing relationship of the Al Carlozzi Center for Counseling with the LGBT/NB community in Tulsa, Oklahoma. As noted in the Biases and Expectations section above, the center's reputation in that community might have led LGBT/NB clients to feel more comfortable identifying and reporting strengths than they might be in another setting. Because this type of disclosure might not be typical across settings, these results may not apply to LGBT/NB clients in other geographic locations or even those receiving services from another source in Tulsa, Oklahoma. Because qualitative research is used to explore phenomena and generate theories, the results of this study are not generalizable to the broad LGBT/NB population. Participants were also limited to the Tulsa and surrounding area and are therefore not representative of a larger LGBT/NB population. Additionally, most LGBT/NB participants in this study were referrals from the Dennis R. Neill Equality Center, which further limits generalizability to only LGBT/NB clients receiving referrals from that community center rather than LGBT/NB clients broadly in that geographic locale.

CQR and CQR-M both indicate that researchers should take a reflexive approach to their work (Hill et al., 2005). The importance of reflexivity extends to limitations of the study. For example, the primary coding team all had clinical experiences at the Al Carlozzi Center for Counseling. Additionally, the majority of the research team identified as queer and all members of the team were white. These factors likely contributed to interpretations and coding of the data that might have resulted in different classifications had the coding team consisted of members that identified differently. Specifically,

because the research team expressed expectations of a greater number of strengths related to compassion, empathy, and relational connection, implicit bias towards classifying strengths within those domains might have occurred during the coding process.

Although researchers attempted to maintain objectivity by reaching consensus and discussing biases and expectations, bracketing values is a complicated process. In fact, some believe that it is impossible to be entirely value neutral in practice or research (Harrist & Richardson, 2012). Therefore, it is unlikely that the coding process was entirely free from bias, despite the team's best efforts to maintain objectivity. The intentional acknowledgement of the team members' biases and expectation was one step toward preventing such beliefs from impacting their work.

Finally, this study is limited because the authors only explored strengths reported at intake. Clinicians' conceptualization of their clients tends to evolve over time, including in their ability to identify strengths (Welfare et al., 2010). Therefore, this study may not adequately capture the way in which LGBT/NB clients come to understand their strengths over the course of counseling. Similarly, it does not account for the insight developed in the counseling relationship and the contributions of the counselor to identification of strengths. Further study is needed to determine the degree to which strengths reported at intake are predictive of LGBT/NB clients' abilities to identify strengths throughout the counseling process.

Implications

The results of this study have clinical, training, and research implications for the field of counseling and counseling psychology. In particular, self-identified strengths should be used to guide clinicians in prompting and assessing for strengths with their

clients early on in the therapeutic process. It may be helpful for clinicians to attend to the types of strengths reported by LGBT/NB clients early in the counseling relationship. This study provides support for the inclusion of client strengths on intake forms (Lytle et al., 2014; Welfare et al., 2010). Given the historical marginalization of LGBT/NB individuals by counseling and psychology (Meyer, 2003; Vaughan & Rodriquez, 2014), inclusion of strengths on intake forms may allow clients to focus on their resources rather than their deficits.

The findings of this study also may provide a framework by which clinicians can explore and emphasize strengths in their LGBT/NB clients. Generally, the domains of strengths for LGBT/NB individuals found in this study either related to connection or relationship to others, self-efficacy and resilience, interpersonal skills, and/or specific abilities and achievements. Clinicians should utilize the results of this study to develop specific prompts to help their LGBT/NB clients identify and recognize their strengths throughout the counseling process. The field of psychology has historically focused on negative experiences and psychological effects as a result of having an LGBT/NB identity (Meyer, 2003; Vaughan & Rodriquez, 2014). While it is critical that clinicians understand the deleterious effects of marginalization on LGBT/NB clients mental and emotional health, failure to adequately balance that understanding with an examination of strengths may lead to clinicians neglecting positive aspects of a client's identity. When clinicians do not incorporate LGBT/NB client strengths and resources in their clinical treatment, they risk perpetuating cisgender and heterosexual norms through which LGBT/NB clients have been historically pathologized (Owens et al., 2015; Vaughan & Rodriquez, 2014). Therefore, these results should provide a beginning framework by

which clinicians can intentionally assess for strengths throughout the counseling process, as suggested by Welfare and colleagues (2010). Of the domains that emerged from the data, clinicians and researchers should attend to strengths related to Abilities and Achievements in particular. The entirety of the research team had clinical experience working with LGBT/NB clients, and the majority of the team identified as queer. Even so, expectations for the data did not include strengths related to specific abilities and talents. Given its relative absence from the body of literature, this domain of strengths appears to be overlooked by researchers and clinicians. In fact, even clinicians with extensive experience working with LGBT/NB clients (such as the researchers involved in the present study) may fail to identify strengths within this category. Clinicians should consider specifically prompting clients to discuss strengths within this domain, particularly for transgender and non-binary clients for whom this domain was most frequently reported.

Another important implication of these results relates to the intake process. Intakes are often the first contact an LGBT/NB client has with a counseling center or clinic; therefore, it is critical that this process is reflective of queer experiences and highlights queer strengths. Although most counseling clinics assess for strengths in some way in the intake process, these documents should have a more robust strengths assessment that is inclusive of LGBT/NB experiences. Clinicians can accomplish this by using language specific to findings from this study. For example, rather than prompting clients to report strengths through a generic question (such as "What are your greatest strengths?"), intake forms could include a greater range of more specific questions. Examples include, "What are your greatest strengths?," "What strengths do you see in

yourself related to how you connect with others?," "What specific abilities or achievements do you have?," and "What qualities contribute to your resilience?" Such questions might facilitate a richer and more individualized conversation about the client's strengths, and therefore lead to greater rapport building at the intake session.

The results of this study also have implications for training. In-house clinics, departmental clinics, and university counseling centers routinely serve as first opportunities for practicum students and internship students to work with clients exploring their sexual orientation and gender identity (Beemyn, 2003, 2012). Therefore, practicum and internship may represent unique opportunities to train counseling psychologists and other counseling professionals to emphasize strengths in this population rather than deficits, particularly for LGBT/NB clients. Intentionally emphasizing strengths at the intake and incorporating these into the counseling process is one way by which training clinics and clinicians can encourage emerging counselors and psychologists to engage in reparative and strengths focused work with a historically minoritized population.

Finally, the results of this study provide several important research implications. First, continued evaluation of differences in strengths between LGB and T/NB clients is necessary. This will be imperative in the development of LGBT/NB-specific strengths assessments. Furthermore, understanding the differences between strengths that emerge in LGB and T/NB clients will provide greater insight into the way in which these strengths function in people's lives and how they buffer against minority stress, as the minority stress experiences of sexual and gender minority groups differ. Future research should also explore ways in which LGBT/NB client strengths do and do not fit into

Peterson and Seligman's taxonomy, given the limited support these results provide to this taxonomy in its application to LGBT/NB clients. Future research should additionally evaluate the relationship between community connectedness/social support and the ability to identify one's strengths. While the number of clients who did not report any strengths is relatively low, future research should explore factors related to low perceived strengths in LGBT/NB clients.

Conclusion

Scholars encourage the utilization of positive psychology through an emphasis on strengths and resources with LGBT/NB clients as way to combat minority stress and other factors related to lower psychological well-being in this community (Meyer, 2003; Vaughan & Rodriquez, 2014). One recommendation for the application of positive psychology in practice has been the inclusion of questions that assess for strengths on intake forms (Lytle et al., 2014). However, the implementation and impact of this suggestion with LGBT/NB clients has received little attention to date. This study aimed to address this gap in the literature through CQR-M analysis of LGBT/NB client-reported strengths on an intake.

Domains and categories that emerged from this sample of data included, in order from most to least frequently reported, Abilities and Achievements, Connection External-Focused, Interpersonal Skills, Self-Efficacy and Resilience Traits, Connection Internal-Focused, Self-Efficacy and Resilience Actions, Reported No Strengths, and Role-Oriented. Vaughn and Rodriguez (2014) encouraged the use of the three-pillar model of positive psychology (Seligman & Csikszentmihalyi, 2000) within LGBT/NB research to establish a consistent framework for conceptualizing strengths in this population. The

present study's findings both support and diverge from the three-pillar model, particularly within the Abilities and. Achievements domain that emerged from this dataset. The taxonomy of character strengths proposed by Seligman and Peterson (2004) has primarily been normed on cisgender and heterosexual individuals. This model does not appear to adequately account for the types of strengths that were frequently reported in this study by LGBT/NB clients. However, the current study's findings corroborated frequently reported strengths for this population in the body of literature, such as those related to connection and relational skills (Vaughan et al., 2014). Similarly, resilience-based strengths both support the use of the three-pillar model with LGBT/NB clients and are consistent with other researcher's findings related to LGBT/NB strengths (Vaughan et al., 2014).

Strengths in LGBT/NB clients should be identified early and integrated throughout the counseling process in order to strengthen the counseling relationship, buffer against minority stress, and leverage the existing strengths and resources of the individual to help them achieve their goals. The domains and categories that emerged from this study may be useful to clinicians as a way to probe for and highlight specific strengths that were reported in this sample of LGBT/NB clients. These findings additionally suggest that, while the three-pillar model applied to LGBT/NB participants in this study in many ways, there are unique strengths in LGBT/NB persons that cannot be adequately accounted for by this model. Clinicians should ensure that they utilize evidence-based practice, such as the three-pillar model, while allowing for LGBT/NB clients to identify unique strengths that emerge as a result of their identities. Future

research should continue to explore these unique strengths to better arm clinicians with the tools they need to effectively work with this population.

CHAPTER V

EXTENDED LITERATURE REVIEW

LGBTQ Mental Health

An estimated 8 million adults, or 3.5% the population in the United States, identify as lesbian, gay, or bisexual (Gates, 2011). Between 0.53% (Crissman, Berger, Graham, & Dalton, 2017) and 0.6% of adults identify as transgender (Flores, Herman, Gates, & Brown, 2016). Broadly, LGBTQ individuals face greater mental health problems and disparities than their heterosexual and cisgender peers. Gay and bisexual men experience increased risk for mood disorders, suicidal ideation and attempts (Mays & Cochran, 2001), and report greater substance use when compared to heterosexual men (Newcomb & Mustanski, 2010). Gay and bisexual men also have a higher prevalence of panic disorders and psychological distress (Cochran, Sullivan, & Mays, 2003). Lesbian and bisexual women have higher rates of anxiety disorders than heterosexual women (Cochran et al., 2003) and are more likely to have a diagnosis of a depressive disorder when compared to heterosexual women (Cochran & Mays, 2007). Across genders, gay and bisexual individuals have higher rates of mood and anxiety disorders compared to their heterosexual counterparts (Bostwick, Boyd, Hughes, & McCabe, 2010; Burns, Ryan, Garofalo, Newcomb, & Mustanski, 2015; Lelutiu-Weinberger et al., 2013).

Additionally, post-traumatic stress disorder (PTSD) is also more prevalent in lesbian, gay, and bisexual populations compared to their heterosexual peers (Burns et al.,

2015; Hatzenbuehler, 2009; Mustanski, Garofalo, & Emerson, 2010). These rates are even higher for some populations. For example, LGB individuals living in states that had previously banned marriage for same-sex couples or where amendments to discriminate against LGBT individuals were introduced have higher reported rates of PTSD diagnoses (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Rostosky, Riggle, Horne, & Miller, 2009). Older LGBT adults living with HIV are much more likely to have higher rates of depression, anxiety, suicidal ideation, and substance use issues (Beatie, Mackenzie, & Chou, 2015; Fredriksen-Goldsen, Hoy-Ellis, Muraco, Goldsen, & Kim, 2015). One survey found that LGBT adults have rates of depression two to three times greater than the general population and almost one half of older transgender adults screened met the criteria for depression (Fredriksen-Goldsen et al., 2015). Older LGBT adults also have higher rates of suicide rates and substance use disorders compared to their heterosexual and cisgender peers (McCabe, Hughes, Bostwick, West, & Boyd, 2009; Nuttbrock et al., 2010; Shippy, Cantor, & Brennan, 2004).

Transgender individuals specifically experience higher rates of depressive symptoms and attempted suicides when compared to lesbian, gay, and bisexual peers who are not transgender (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2014; Persson, 2009; Sue et al., 2016). Transgender, or *trans*, adults also report significantly higher levels of anxiety and depression compared to the general US population (Clements-Nolle, Marx, Guzman, & Katz, 2001; Kessler et al., 2005). This population also experiences the highest rates of suicidality, with anywhere from one third to one half of transgender individuals reporting suicidal ideation at some point in their life (Clements-Nolle, Marx, & Katz, 2006; Reisner, Perkovich, & Mimiaga, 2010). A recent survey reported that 41%

of their trans respondents reported a past suicide attempt (James et al., 2016). Transgender individuals have also been found to have three times the incidence of depression compared to the general population, and over half of respondents in one study met the criteria for clinical depression (Nuttbrock et al., 2010; Reisner, Perkovich, & Mimiaga, 2010). Older transgender individuals are more likely to experience mental distress than their cisgender lesbian, gay, and bisexual peers (Fredriksen-Goldsen et al., 2013).

Minority Stress and Internalized Stigma

Minority stress, or the additive chronic stress experienced by individuals in a minority group, is one phenomenon thought to contribute to increased rates of mental health issues and disparities in LGBT populations (Meyer 1995; 2003). Reports of higher levels of minority stress have also been correlated with higher levels of psychological distress in LGB individuals (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008). Minority stress is one phenomenon that researchers use to conceptualize high levels of depression in this population (McCarthy, Fisher, Irwin, Coleman, & Pelster, 2014). Researchers have found that increased mood, anxiety, and substance use disorders are related to increased levels of minority stress (Holloway, Padilla, Willner, & Guilamo-Ramos, 2014). Minority stress, defined in one study as LGB victimization and the stress of coming out, was correlated with increased rates of depression and suicidal ideation (Baams, Grossman, & Russell, 2015). Minority stress resulting from discrimination has been associated with increased odds of alcohol abuse, other substance use disorders, and nicotine use in LGB adults (Green & Feinstein, 2012; Hughes, Wilsnack, & Kantor, 2016; Slater, Godette, Huang, Ruan, & Kerridge, 2017). Older LGBT adults are at an

increased risk for experiencing minority stress, with 82% of individuals in one study reporting at least one lifetime episode of victimization, and 64% reporting at least three or more episodes (Fredriksen-Goldsen et al., 2015).

Higher reported rates of internalized stigma, or negative attitudes, stereotypes, or beliefs one has about their own social group, have also been found to correlate with increased risk for mental health problems in LGBT individuals (Crocker & Major, 1989; Newcomb & Mustanski, 2010). Newcomb and Mustanski found that reported internalized homophobia – defined as societal anti-LGB attitudes, beliefs, and stereotypes directed towards one's self – is positively correlated with reported mental health concerns (2010). Internalized ageism – or societal beliefs that aging adults are less attractive, sexual, intelligent, and productive, directed towards one's self – has been found to correlate with higher rates of reported stress and physical and mental health concerns (Allen, 2015; Levy, Slade, Kunkel, & Kasl, 2002; Wight, LeBlanc, Meyer, & Harig, 2015). Internalized homophobia coupled with internalized ageism in older LGBT adults was found to correlate with increased reports of depressive symptoms (Fredriksen-Goldsen et al., 2012; 2013; Wight et al., 2015). Additionally, many older LGBT adults have experienced higher rates of minority stress and internalized stigma due to living a majority of their life prior to recent shifts in acceptance and treatment advancement for this population (Yarns, Abrams, Meeks, & Sewell, 2016). Transgender individuals report higher rates of minority stress and internalized stigma and are at an increased risk of developing depressive symptoms compared to their cisgender LGB counterparts (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014; Nemoto, Bodecker, & Iwamoto, 2011; Testa, Habarth, Peta, Balsam, & Bockting, 2015).

Positive Psychology and Strengths

A cornerstone of counseling psychology is emphasis on the positive within psychology, including highlighting client strengths, resources, and potential (Gelso, Nutt, Williams, & Fretz, 2014; Magyar-Moe & Lopez, 2008). Seligman (2002) provided a framework for conceptualizing and classifying strengths through three pillars of strengths: positive emotion and positive subjective experiences (such as resilience); positive character, virtues, and character strengths; and positive social institutions (c.f., Seligman & Csikszentmihalyi, 2000; Seligman & Peterson, 2004). Seligman and Peterson (2004) further developed a taxonomy of character strengths that comprise the second pillar, which includes 24 basic character strengths under six virtues: wisdom and knowledge (creativity, curiosity/love of learning, open mindedness, perspective), courage (integrity, bravery, persistence, vitality), humanity (kindness, love, social intelligence), justice (fairness, leadership, citizenship), temperance (forgiveness and mercy, humility and modesty, prudence, moderation, self-regulation), and transcendence (appreciation of beauty and excellence, gratitude, hope, humor, spirituality).

In a review of the literature, Lopez and colleagues (2006) found that 29% of articles in counseling psychology literature contained reference to a positive concept. They additionally suggest that positive psychology appeared to be increasingly prevalent in counseling psychology literature at the time of publication. However, in an updated review of the literature from 2004 to 2014, Magyar-Moe, Owens, and Scheel (2015) reported that only 13% of counseling psychology articles they randomly selected had a focus on positive psychology, demonstrating a decrease in emphasis on positive psychology in counseling psychology journals. Magyar-Moe and colleagues (2011)

evaluated the role of positive psychology in counseling psychologists' work and found that 47-77% of clinicians reported using positive psychology at least half the time in their work. In a more recent survey, 83% of clinicians in clinical practice endorsed that their client assessment and conceptualization is informed by positive psychology; 92% endorsed using positive psychology in their counseling process in general, but 46% reported not using any specific theory or construct from positive psychology (Magyar-Moe et al., 2012).

Conoley, Padula, Payton, and Daniels (1994) evaluated the second, third, and fourth counseling sessions and found that using client strengths in a treatment recommendation was a predictor of implementation of end-of-session homework given by the clinician. Though different from the intake, this might still have implications for an initial session. Similarly, Welfare and colleagues (2010) found that counselors struggled to identify strengths in clients with whom they perceived themselves to be less effective, suggesting that counselors' perceptions of their clients' progress may impact their ability to identify strengths. Pedrotti, Edwards, and Lopez (2009) encourage researchers and practitioners to engage with positive psychology and strengths within a cultural context. One suggestion by these authors is to investigate strengths within a specific community or culture, particularly strengths related to well-being that serve as protective factors from minority stress. One such population for whom this could be particularly important is LGBT persons.

Positive and Strengths-Based Psychology with LGBTQ+ Clients

While strengths-based research within the LGBTQ+ community is still limited, it has received increasing attention from researchers over the past few decades (Vaughan et

al., 2014). In a recent content analysis of strengths-based LGBT research, Vaughan and colleagues (2014) found that almost 18% of LGBT themed abstracts referenced strength terms in positive psychology; however, LGBT articles represented only 0.42% of all strength-based abstracts in the literature. The authors used the three-pillar model of positive psychology, described above, in this study to complete a content analysis of how positive psychology and strengths-based themes were addressed in articles about LGBT individuals. They found seven character strengths with substantial inclusion: love (virtue of humanity), integrity (virtue of courage), citizenship (virtue of justice), vitality (virtue of courage), fairness (virtue of justice), spirituality (virtue of transcendence), self-regulation (virtue of temperance), and creativity (virtue of wisdom and knowledge), along with the positive subjective experience of resilience. The researchers also found that the literature regarding LGBT persons increasingly incorporated strengths over the past five decades, with one in six LGBT-specific psychology articles highlighting strengths. However, fewer than 25% of all strength-based articles included transgender and gender non-binary individuals (Vaughan et al., 2014).

With the increasing attention paid to strengths in LGBTQ+ person over the last several decades, unique strengths have been identified in LGBTQ+ individuals (Vaughan & Rodriquez, 2014). In particular, Vaughan and Rodriguez (2014) suggest that resilience, stress related growth, creativity, bravery, authenticity, zest, love, social intelligence, citizenship, fairness, and positive institutions were strengths that promote psychological well-being in the LGBT community. Character strengths of creativity, integrity, vitality, love, citizenship and fairness, gratitude, and spirituality were found to be prevalent strengths in LGBTQ+ clients in a different study (Lytle et al., 2014). For LGBTQ+

individuals, developing a positive identity, strengths, and resources is not only associated with psychological well-being but may additionally assist LGBT folks in coping with minority stress and internalized stigma (Barr, Budge, & Adelson, 2016; Riggle, Mohr, Rostosky, Fingerhut, & Balsam, 2014; Vaughan & Rodriguez, 2014). Meyer (1995, 2003) posits that coping resources for minority stress include protective factors, such as a sense of group cohesion and positive identity.

Positive identity for LGB individuals was associated with increased LGB community connectedness and higher psychological well-being (Kertzner, Meyer, Frost, & Stirratt, 2009; Riggle, Rostosky, Black, & Rosenkrantz, 2017). Rostosky, Cardom, Hammer, and Riggle (2018) found that the five factors of positive LGB identity, authenticity, social justice, self-awareness, intimacy, and LGB community, were all associated with at least one domain of psychological well-being (positive relations with others, personal growth, self-acceptance, purpose in life, autonomy, and environmental mastery). The strongest association they found was authenticity with positive relations with others, followed by authenticity and self-acceptance, and authenticity with autonomy. However, researchers of the aforementioned studies did not include transgender and gender expansive (i.e., nonbinary, gender-fluid) individuals in their exploration of strengths.

Taube and Mussap (2019) found that, in a sample of Australian transgender and gender non-binary individuals, the virtues of inquisitiveness, caring, and self-control on the Values in Action Classification of Strengths (Park, Peterson, & Seligman, 2004) represent a three-factor model of character strengths. This finding suggests that these three virtues may be unique representations of strengths for this population. The authors

further found that these three virtues contributed to the variance in both resilience and trans-specific positive identity. Riggle, Rostosky, McCants, & Pascale-Hague (2011) found eight themes of positive transgender identity related to individual strengths and resources: "congruency of self; enhanced interpersonal relationships; personal growth and resiliency; increased empathy; a unique perspective on both sexes; being beyond the sex binary; increased activism; and connection to the GLBTQ communities" (p. 150). Following this study, Riggle and Mohr (2015) utilized exploratory factor analysis to develop a measure of positive identity for transgender individuals with five factors (decreased from the eight proposed by Riggle and colleagues in 2011): authenticity, intimacy/relationships, community, social justice/compassion, and insights/self-awareness.

Given the unique experiences of minority stress in LGBTQ+ persons, growth related to stress may be an area of resilience for this population. Stress related growth (SRG), or experiences of psychological growth as a result of a stressful experience (Park et al., 1996) is believed to contribute to positive bisexual (Rostosky, Riggle, Pascale-Hague, & McCants, 2010; Vaughan & Waehler, 2010) and transgender identity (Riggle et al., 2011). In lesbians, resources from the LGBT community and social support served as protective factors for long-term relationship success in lesbian couples (Connolly, 2005). Additionally, Connolly (2005) reported that strengths of perspective, persistence, and interdependence helped foster resilience by maintaining relationship. For transgender women, higher levels of positive feelings about being part of the transgender community is related to lower levels of symptoms related to mental health; this connection to community is seen as a source of strength (Sánchez and Vilain, 2009).

Riggle, Whitman, Olson, Rostosky, and Strong (2008) evaluated positive aspects of gay or lesbian identity and found three primary domains: disclosure and social support, insight into and empathy for self and others, and freedom from societal definitions of roles. The eleven themes within these domains were: belonging to a community, creating families of choice, forging strong connections with others, serving as positive role models, developing empathy and compassion, living authentically and honestly, gaining personal insight and sense of self, involvement in social justice and activism, freedom from gender-specific roles, exploring sexuality and relationships, and enjoying egalitarian relationship (Riggle et al., 2008). Counselors have a responsibility to assess for and integrate strengths into the counseling process, particularly for LGBTQ+ clients. One consideration is the evaluation of strengths from the beginning of the counseling relationship, starting with the intake.

Strengths-Based Intake Forms

Some of the first information that counselors receive about their clients is gathered through intake forms and an intake interview. This is the first opportunity that clients have to express themselves and share their personal information with their counselors. The intake process is considered essential for determining the degree to which the client is appropriate for counseling and subsequently setting a course of treatment (Fine & Glasser, 1996). Clients appear to benefit from an intake or single initial session, often reporting feelings of relief and decreased reported symptomology after only one session (Talmon 1990; Perkins 2006). Recommendations for intake paperwork include the inclusion of open-ended questions regarding individual and environmental strengths to assist psychological assessment and conceptualization (Owens, Magyar-Moe,

& Lopez, 2015). In fact, in one study, intake forms that utilize solution-focused language regarding the purpose of the visit appeared to create hope and promote pretreatment changes on their own (Richmond, Jordan, Bischof, & Sauer, 2014). Although the intake may be beneficial on its own (Talmon 1990; Perkins 2006), Duncan (2014) suggests that counselors should assess for strengths at the intake session to build the therapeutic relationship and elicit a client's internal resources. One way in which to assist early counseling professionals in identifying client strengths is through intake forms (Welfare et al., 2010)

Tracy (1977) compared attrition, or client drop-out, with two different intake procedures and found that the clinician explicitly stating the client's personal strengths and resources from the intake may assist in increasing the client's motivation for treatment, thus decreasing attrition. The counselor's ability to identify client strengths and resources and incorporate them into conceptualization are related to improved treatment outcomes, improved therapeutic relationship, and greater perceived efficacy of counseling from the clinician's perspective (Flückiger & Holtforth, 2008; Flückiger, Caspar, Holtforth, & Willutzki, 2009; Welfare, Farmer, & Lile, 2010).

A clinician's emphasis on strengths or problems on intake paperwork, in the form of questions asked, appears to additionally impact the perceptions of counselor-trainees (Barlieb, Wlazelek, & Scandell, 2003). This study found that counselor-trainees who reviewed strengths-focused, as opposed to problem-focused, pre-intake information perceived the client as having less severe presenting problems and pathology and perceived the case as less difficult. Counselor-trainees who reviewed the problem-

focused pre-intake information rated the client's case as more attractive (Barlieb et al., 2003).

Despite evidence indicating the importance of focusing on strengths, there is mixed consensus in the literature regarding the degree to which clinicians incorporate strengths in clinical intakes. For example, Meyer and Melchert (2011) evaluated use of a biopsychosocial model across 163 intake forms from clinics in Wisconsin and found that the evaluation of strengths in the intake were lacking across the psychological, sociocultural, and biopsychosocial domains. The authors additionally suggest that strengths were not collected consistently in these settings and recommended that clinicians prompt for strengths in the intake. However, Scheel, Davis, and Henderson (2012) determined that the six clinician participants in their qualitative study frequently utilized questions regarding strengths in the intake form and interview. They also found that clinicians in their study often identified resiliency as a strength in the intake assessment. More recently, a content analysis of private practices' intake forms indicated that fewer than 20% of 151 provider forms asked about client strengths (Liang & Shepherd, 2020). Therefore, while individual clinicians may be adept at identifying strengths in their clients during clinical intakes as suggested by Scheel and colleagues, the use of specific questions about strengths in provider intake forms does not appear to be widespread among counseling professionals.

The limited incorporation of strengths in the intake process is especially concerning given the importance of identifying strengths in minoritized clients (e.g., Sue & Sue, 2015). Clinicians who assess for strengths at intake are more attentive to diversity and inclusion throughout the entire intake document compared with clinicians who do not

(Liang & Shepherd, 2020). In fact, scholars recommend the use of a strengths-based approach in general when working with minoritized clients, such as racial, ethnic, sexual, and gender minority groups, in order to promote resiliency and change (Comas-Díaz, 2012; Sue & Sue, 2015). The identification of strengths in the intake for LGBT clients is especially important (Heck, Flentje, & Cochran, 2013), given that mental health disparities have been emphasized to the detriment of strengths in this population (Solomon, Heck, Reed, & Smith, 2017). In order to create an affirming environment for LGBTQ+ clients, intake forms should include client strengths, stressors, and resources (Lytle et al., 2014), including individual and family resources (Solomon et al., 2017). Because identifying strengths at intake is critical in working with LGBTQ+ clients, it is important to consider the best ways in which to do so.

The inclusion of an open-ended question regarding strengths, as described above, is one way that clinicians can concretely identify strengths. However, some researchers have instead evaluated strengths at intake using a particular measure. Such measures include the Child and Adolescent Needs and Strengths -Trauma Exposure and Adaptation Version (CANS-Trauma; Ellis et al., 2012), the Behavioral and Emotional Rating Scale (BERS-2; Ellis et al., 2012), and the Strengths and Difficulties Questionnaire (SDQ; Wofford, 2018), particularly with children with a trauma history (Ellis et al., 2012; Painter et al., 2012; Wofford, 2018). An example of an adult questionnaire given at intake to evaluate strengths is The Adult Needs and Strengths Assessment (ANSA; Lehner, 2004). The diversity of these scales can be helpful in identifying client strengths. However, these measures also reveal that there is not yet consensus in the evaluation of client strengths. Additionally, there is a dearth of instruments with which to evaluate

strengths in adults which may be limiting for clinicians working primarily with people over the age of 18.

To date, an exhaustive search of research databases has not revealed any researchers who have qualitatively analyzed strengths of LGBTQ+ clients at the intake. However, a similar analysis (though not specific to LGBTQ+ individuals) evaluated strengths in youth during intake admission to substance use treatment (Pagano, Raj, Rhodes, Krentzman, & Little, 2019). Pagano and colleagues used a ground-up inductive qualitative approach to code strengths reported as answers to the question "What do you consider to be your most important strengths?" (p. 5). Themes were coded into categories using Gardener's Original 7 Multiple-Intelligences Categories and other categories that emerged were specified; themes included interpersonal, intrapersonal, moral, grit, sociocultural, and generic intelligence related strengths (Pagano et al., 2019). This study is similar to the present study, in that an open-ended question was asked on an intake form to collect client strengths and these strengths were then analyzed qualitatively. Therefore, qualitative analysis may be most effective in beginning to explore the strengths of LGBTQ+ clients collected at intake.

Terminology

While LGBTQ+ is often utilized as an umbrella term to characterize sexual and gender minoritized individuals, the distinction between LGB (and other sexual minoritized identities) and transgender and gender non-binary identities is important to acknowledge and understand in research and practice (Griffith et al., 2017; Nuru, 2014). The American Psychological Association (APA) in particular has used the term TGNC, which stands for *transgender and gender non-conforming* (APA, 2015) to distinguish

trans and gender nonconforming identities from LGB+ experiences. This language is additionally well-documented in the literature (e.g., Chang, Singh, & Rossman, 2017; Dugan, Kusel, & Simounet, 2012; Testa et al., 2015). However, this acronym or terminology may not adequately capture identities that fall outside of the gender binary. Chang, Singh, and Rossman (2017) acknowledge that "though the term TGNC is intended to be inclusive of people whose gender identities do not fall within the gender binary system, some non-binary people identify as TGNC, whereas others do not… one could consider nonbinary identities predating the more commonly known TGNC identities as they emerged in the 20th century" (p. 21).

Specific language, such as nonbinary or genderqueer, is critical to honoring the language research respondents utilize for themselves, and such language should be utilized in writing (Griffith et al., 2017). For example, genderqueer appears to be a common self-identifier for individuals who do not identify on the gender binary; 55.1% of participants in a survey of non-cisgender respondents identified genderqueer as one term that could be used to describe their gender (Kuper, Nussbaum, & Mustanski, 2011). In a survey of 27,715 transgender adults, non-binary (31%) and genderqueer (29%) were the second and third most frequently endorsed gender identity terms respectively, comprising a total 60% of the participants (James et al., 2016). The prevalence of these identities in transgender communities indicates that umbrella terms, such as LGBTQ+ or TGNC, may be limiting in fully understanding research participant identities.

In fact, while many researchers have used TGNC in the title of publications to describe their sample, they often use language in their discussion and methods sections that are more indicative of the actual terms participants use whom identify outside the

gender binary. For example, Chang and colleagues (2017) titled an article, "Gender and Sexual Orientation Diversity within the TGNC Community," but utilized "gender nonbinary" (p. 19) throughout the article to describe respondents who identified outside of traditional transgender and cisgender classifications (i.e., man or woman). Additionally, Puckett and colleagues (2017) use the term gender nonconforming in their article tittle, but utilize the terms genderqueer, non-binary, agender, androgyne, bigender, and the option to self-identify to collect gender identities in their survey.

In a recent review of the literature of individuals who do not identify within the gender binary, the authors used the terms "gender non-binary" and "genderqueer" as opposed to gender nonconforming, arguing that such language is reflective of terminology used by the community (Matsuno & Budge, 2017). This is especially telling given the author's own identity and community membership; E. Matsuno identifies outside the gender binary and uses they/them/their pronouns. Similarly, emerging research in psychiatry has utilized various identities such as pangender, agender, neutrois, bigender, two-spirit, gender fluid, and hermophrodyke (Richards et al., 2016). Richards and colleagues (2016) argue that the aforementioned identities are often placed under the "umbrella" terms of non-binary or genderqueer. There is a clear precedent in the literature for the use of accurate language to describe research participants, even if those identities do not use academic language such as TGNC.

While there are compelling arguments for the use of specific identity terms in academic writing, there are also important arguments against the use of certain umbrella terms for transgender and nonbinary communities. One such argument is that people who identify on the gender binary who are transgender might also be "gender

nonconforming,"(p. 1, Reisner & Hughto, 2019) while people identifying outside of the gender binary may not necessarily be "gender nonconforming" (Reisner & Hughto, 2019; p.1). In a recent survey of non-binary and binary transgender adults, the authors Reisner and Hughto (2019) found that 37.8% of non-binary participants endorsed "low visual nonconformity" (p. 9) and only 27% endorsed "high visual conformity" (p. 9). Additionally, 25.6% of binary transgender participants endorsed "moderate visual nonconformity" (p. 9) and 14.6% endorsed "high visual nonconformity" (p.9). The term gender nonconforming may fail to include people outside of the gender binary while overlapping with binary transgender identities.

Finally, professional organizations have provided guidance to their members on the use of language for trans and nonbinary identities in research. Division 17 of the American Psychological Association (APA), the Society of Counseling Psychology, recently formed a Special Task Group to create a trans and nonbinary pipeline into the field of counseling psychology (Society of Counseling Psychology, 2020). The use of trans and nonbinary in the task force name suggests that this language is increasingly utilized in professional organizations. In fact, the use of gender non-binary and genderqueer appears to be replacing the use of TGNC as an umbrella term to describe this population in counseling and psychology literature. Furthermore, the Standards of Care for Research with Participants Who Identify As LGBTQ+ state:

> "researchers and scholars respect language use of participants by employing language mirroring that used by participants in regard to expression of identity throughout all stages of research. Researchers and scholars should not attempt to

merge participant identities under what the researcher might assume to be inclusive umbrella terminology" (Griffith et al., 2017; p. 4).

Given the importance of using participants' own language to define their gender, the author of the present study will utilize the acronym T/NB to reference transgender and gender non-binary participants. In order to honor participant identities, the term "LGBT/NB" will replace LGBTQ+ in reference to the study sample. The researcher elected not to incorporate the term genderqueer because, while frequently used as a gender identity (c.f., Matsuno & Budge, 2017; Richards et al., 2016), this term appears to reflect a specific identity. Therefore, genderqueer may not be inclusive of all individuals who do not identify on the gender binary. Additionally, while the word queer has been reclaimed and is thus less controversial in the LGBT/NB community, some people may still consider that word to be a slur and prefer not to be identified in such a way (Brontsema, 2004; Khayatt, 2002).

Overlapping Identities

Another important issue to consider in writing such a manuscript is the way in which to handle overlapping identities between sexual orientation and gender identity, or between LGB participants and T/NB participants. Across the literature, researchers have found significant overlap between transgender/gender non-binary identities and lesbian, gay, bisexual, and other sexual minoritized identities (c.f., Chang et al., 2017; Kuper et al., 2011; Reisner & Hughto, 2019). Feinberg (1992) argues of transgender communities and gay and lesbian communities that "the two huge communities are like circles that only partially overlap. While the oppression within these two powerful communities are not the same, we face a common enemy" (p. 206).

In fact, most trans and non-binary individuals are additionally sexually minoritized persons (Kuper et al., 2011). For example, in a survey comprised of only transgender participants, only 15% identified as straight or heterosexual (James et al., 2016). In this same study, 21% identified as queer, 18% as pansexual, 16% as gay, lesbian, or same-gender-loving, 14% as bisexual, and 10% as asexual (James et al., 2016). Similarly, in Kuper and colleagues' (2011) study, only 14% of transgender and gender non-binary participants identified as straight or heterosexual, while 20.6% identified as pansexual and 17.1% as queer. These authors also state that trans individuals may be more likely to endorse their sexual orientation in non-binary terms because of their experiences with gender challenging societal norms. Puckett and scholars (2018) reported that, in a sample of transgender and non-binary participants, only 6.6% identified as straight or heterosexual, 6.6% as asexual, 6.3% endorsed an option not listed, and the remaining 80.5% indicated some degree of same-gender attraction. In Reisner and Hughto's (2019) study, the vast majority of non-binary and transgender participants identified as a sexual minority (only 1.6% of the non-binary sample did not identify as such, while this percentage was 19.5% for the transgender sample).

Despite the clear overlap in sexual and gender minority identities, it is critical to understand transgender and non-binary experiences as separate from that of cisgender sexual minoritized persons. While both groups may experience oppression through heterosexism and heteronormativity, transgender and non-binary persons additionally experience transphobia. Furthermore, taking an intersectional approach to understanding these experiences (e.g., Crenshaw, 1989), it is likely that the type of heterosexism experienced by transgender and non-binary persons may look very different from that

experienced by cisgender LGB persons (Nadal et al., 2016). These differing experiences may lead to different understandings of one's resources, strengths, and difficulties.

Given these differing experiences, researchers argue that nesting the T/NB community within the LGB+ community further isolates and perpetuates invisibility of the unique perspectives of T/NB individuals (Nadal et al., 2016). Kuper and colleagues (2011) suggest that researchers and clinicians should be sensitive to differences in identities within the LGBT/NB community. Trans experiences are unique and warrant independence from sexual orientation within research when possible, despite the inevitable overlap between these identities (Fassinger & Arseneau, 2007). In the Standards of Care for Research with Participants Who Identify As LGBTQ+ document, Griffith and colleagues (2017) suggest that "researchers and scholars contemplate and acknowledge ways in which intersectional identities of participants may be pertinent to research…and recognize the complexity of participant identities" (p. 3). Overall, specific literature on T/NB participants suggests understanding these as unique identities where possible, despite the overlap between LGB and T/NB communities. Therefore, to contribute to the body of literature on T/NB-specific strengths, this study additionally examined unique characteristics that emerged from the data on T/NB participants separate from LGB participants. In this study, there is overlap between LGB and T/NB participants, as all but 3 of the T/NB participants identified as LGB or queer. However, it is still worth examining the self-reported strengths of T/NB participants, while acknowledging that those strengths cannot be used for comparison with LGB participants.

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