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Roberto Andrés Lasso Báez
Complutense University of Madrid
Mateo Bernal Navas
Autonomous University of Madrid
Marta Evelia Aparicio García
meaparic@ucm.es

Complutense University of Madrid

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Beyond the Therapist's Self-Perception: Development and Validation of the Spanish Version of the Patient-Perceived LGB Clinical Competence and Sensitivity Scale (ECCS-LGB-P)

Roberto Andrés Lasso Báez[1], Mateo Bernal Navas[2], Marta Evelia Aparicio García[3*]

[1*]Faculty of Psychology, Complutense University of Madrid, Madrid, Spain.
[2]Department of Biological and Health Psychology, Faculty of Psychology, Autonomous University of Madrid, Madrid, Spain.
[3]Feminist Research Institute (INSTIFEM), Department of Social, Work and Differential Psychology, Faculty of Psychology, Complutense University of Madrid, Madrid, Spain.

*Corresponding author(s). E-mail(s): meaparic@ucm.es;
Contributing authors: roblasso@ucm.es; mateo.bernal@uam.es;

Abstract

The effectiveness of psychotherapy is well documented, but its negative effects are a little-explored topic, especially in stigmatized populations like LGBTQ+ individuals. For this group, treatment usefulness depends largely on perceived therapist attitudes and competence. This study aimed to develop and validate the Spanish version of the Patient-Perceived LGB Clinical Competence and Sensitivity Scale (ECCS-LGB-P) to assess therapists' competence from their patients' perspective. Data were collected from 203 Spanish-speaking LGB adults. Exploratory Factor Analysis (EFA) yielded a two-factor structure: sensitivity/positive clinical competence and microaggressions/discriminatory practices. The final 30-item scale showed excellent internal consistency (alpha = .96) and a good model fit. Convergent validity indicated a significant positive correlation between the ECCS-LGB-P and therapeutic alliance (rho = .552, $p < .001$), suggesting that perceived competence is a key component in establishing a strong therapeutic bond. Although ECCS-LGB-P scores did not correlate with symptomatic mental health indicators, lower levels of microaggressions were

associated with greater life satisfaction. These findings validate the ECCS-LGB-P as a reliable tool for clinical practice, research, and training, highlighting the importance of the patient's perspective for quality care and patient safety.

Keywords: Cultural competence, Therapeutic alliance, LGBT, Scale validation, Clinical sensitivity

1 Introduction

The effectiveness of psychological therapy in the treatment of mental disorders and improving mental health is well documented [1–3]. However, less attention has been paid to its negative effects [1, 4]. This is concerning since up to 5% of patients may experience persistent psychological distress after therapy [5], and 1 in 20 report some type of adverse effect [4]. Accurate estimation of these negative effects is hampered by the lack of clear definitions of what constitutes a "negative effect" in this context. Furthermore, there is no evidence on the psychometric properties of instruments designed to measure them adequately [6].

A major source of information on the negative effects of therapy can be found in studies of sexual and ethnic minorities, as these populations report adverse effects more frequently [4]. In several studies involving members of the LGBTQ+ community, the usefulness of psychotherapy is associated with the patient's perception of the attitudes of their therapist toward LGBTQ+ individuals. Negative attitudes are a predictor of lower satisfaction [7] and affect adherence and the development of the therapeutic alliance [8, 9]. The latter is fundamental, considering that the therapeutic alliance is a measurable factor that significantly impacts treatment outcomes [10], is positively related to therapy success [9, 11], and stands out as a robust predictor of treatment results [12].

Although the perception of positive attitudes and knowledge on the part of the therapist is closely related to greater satisfaction in therapy [9, 13], this does not always imply that the professional has the skills and competencies necessary for effective work, even if their intentions are good [14]. This disconnect can be particularly problematic when working with historically marginalized populations. Therefore, to prevent negative effects in psychotherapy, improve the quality of therapeutic processes, and strengthen the therapeutic alliance with specific groups, such as the LGBTQ+ community, it is crucial to develop cultural competence. This competence becomes a fundamental requirement for adequately caring for patients with diverse cultural experiences [15, 16].

The tripartite model of cultural competence [17] remains the most widely recognized and researched theoretical framework [18]. In this model, cultural competence is defined as the understanding of cultural influences to provide adequate care to patients from a diverse cultural group, which may or may not differ from the clinician's reference group [19]. However, in recent years, critical perspectives have emerged that question the adequacy of the cultural competence model as the sole explanatory framework. Concepts such as cultural sensitivity, compassionate cultural competence, and

cultural humility offer alternatives that highlight more continuous, dynamic, and relational processes in psychological care. These approaches emphasize the importance of cultivating an attitude of openness, self-criticism, and continuous learning, recognizing one's own limitations, and seeking to balance power dynamics in the therapeutic relationship [20, 21].

In summary, the different models and approaches to culturally sensitive care for LGBTQ+ individuals, as well as culturally competent compassion, share several key elements: (a) awareness of one's own beliefs, biases, and attitudes, including sensitivity to the impact of one's own values and prejudices on the perception of the patient, their problems, and the therapeutic relationship, alongside the development of positive, non-judgmental attitudes toward people of diverse cultural identities; (b) knowledge and understanding of people's cultural beliefs, behaviors, and needs, as well as the concepts, terminology, and culture of specific populations, such as the LGBTQ+ community, encompassing knowledge of health disparities, distinctive health needs, and lived experiences; and (c) skills and tools to effectively apply knowledge in clinical practice, including communication, assessment, and clinical management skills, as well as the application of culturally appropriate interventions [15, 17, 18, 21, 22].

In addition to these interconnected elements, there is a common emphasis on the concept of continuous development or cultural humility. This underscores that cultural competence is not an end state that is "mastered," but rather an ongoing process of learning, self-reflection, and self-criticism to address power imbalances and develop non-paternalistic partnerships with patients [20, 21]. These models are highly relevant given that patients who perceive their therapist as lacking these competencies are at greater risk of dropping out [23], whereas those who perceive them as competent report stronger therapeutic alliances [24]. Hence, there is a need to place greater emphasis on developing the therapist's clinical skills for working with stigmatized groups [4, 7].

Within this tradition, and specifically in relation to LGBTQ+ individuals, instruments have been designed and validated to measure therapists' self-perception, such as: The Gay Affirmative Practice Scale (GAP) [25], The Homonegativity Scale [26], The Sexual Orientation Counselor Competency Scale (SOCCS) [27], and the LGBT-DOCSS (Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale) [18]. However, while the development of these instruments represents progress in establishing quality standards in healthcare for the LGBT community, important limitations have been identified. These include therapists' tendency to overestimate their competence when measuring their self-perception, and the existence of implicit biases even in professionals who report positive attitudes. This highlights the importance of developing instruments that take into account the assessments of patients and supervisors [18]. Although these perceptions have been addressed through surveys, interviews, and some instruments, it is essential to explore additional avenues to deepen the understanding of clinical competence and LGBTQ+ sensitivity and their impact on the quality of care and the therapeutic alliance [7, 9].

Therefore, the objective of this research was to develop an instrument for assessing LGB patients' perceptions of their therapists' clinical competence and sensitivity: the Patient-Perceived LGB Clinical Competence and Sensitivity Scale (ECCS-LGB-P). This instrument represents a significant innovation, as it is the first questionnaire

designed specifically to assess, from the patient's perspective, the clinical competence of professionals working with the LGB population. Until now, most existing instruments have focused on the therapist's self-perception, which can lead to overestimation biases or dissonance between intention and clinical practice [9, 15, 18]. Including the voice of patients allows for a more accurate capture of subjective experiences that directly affect the quality of the therapeutic relationship.

The creation of the ECCS-LGB-P is highly relevant and useful on several fronts. First, it facilitates the documentation and measurement of negative effects in therapy, especially in historically marginalized populations such as the LGBTQ+ community, allowing for more accurate identification of when a therapist's lack of sensitivity contributes to adverse outcomes. Second, by providing a metric from the patient's experience, it serves as a valuable indicator for improving therapy processes, as greater perceived competence is associated with stronger therapeutic alliances [9]. In clinical practice, therapists themselves could send such questionnaires to their patients on a regular basis to obtain direct and valuable feedback. This would not only allow them to identify areas for improvement and optimize their work, but also foster open dialogue and a more transparent, patient-centered therapeutic relationship, as well as evaluate therapist training beyond self-administered measures [9, 15].

Finally, the ECCS-LGB-P represents a significant contribution to research in an emerging field, opening new possibilities for the study of variables related to quality of care and treatment outcomes in therapy with LGBTQ+ patients. Furthermore, its potential as a self-report measure could be explored in longitudinal and experimental studies as a predictor of clinical change, contributing to a more robust model of psychotherapeutic process and outcome assessment.

2 Materials and Methods

2.1 Design and Participants

This study utilized a cross-sectional design focused on the development and psychometric validation of the ECCS-LGB-P. The sample consisted of 203 LGB adults aged between 18 and 58 years ($M = 28.9$; $SD = 7.4$), all of whom had prior or current experience with psychotherapy. As shown in Table 1, participants were recruited from Spanish-speaking regions, with the majority residing in Spain (57.1%) and Colombia (29.1%), while the remaining 13.8% resided in other Latin American countries (e.g., Mexico, Dominican Republic). This distribution facilitates the assessment of the scale across diverse Hispanic cultural contexts. Regarding ethnicity, most participants identified as White (53.2%) or Latino/a (45.3%).

2.2 Instruments

To assess the therapist's perceived competence and convergent validity variables, seven standardized questionnaires were administered. All measures were used in their validated Spanish adaptations.

Table 1 Sociodemographic Characteristics of Participants

Sociodemographic Categories	*n*	%
Gender		
Cisgender Woman	115	57
Cisgender Man	60	30
Non-binary / Queer	23	11
Trans Woman	3	1
Trans Man	2	1
Sexual orientation		
Bisexual	91	45
Gay	56	28
Lesbian	56	28
Age (years)		
Mean (*SD*)	28.9 (7.4)	
Range	18–58	
Country of residency		
Spain	116	57
Colombia	59	29
Other	28	13.8
Ethnicity		
White / Caucasian	108	53
Latino/a	92	45
Other	3	1

2.2.1 Patient-Perceived LGB Clinical Competence and Sensitivity Scale (ECCS-LGB-P)

An instrument developed in the present study. It consists of 30 Likert-type items (1–5). High scores reflect greater clinical competence and LGB sensitivity of the therapist from the patient's perspective (see Table A4 in Appendix).

2.2.2 Working Alliance Inventory—Patient Version (WAI-P)

A 36-item questionnaire (7-point Likert scale) that assesses the therapeutic alliance across three dimensions: bond, goals, and tasks [28]. The Spanish adaptation validated by Andrade-González and Fernández-Liria [39] was used. Internal reliability in this sample was $\alpha = .94$.

2.2.3 Patient Health Questionnaire (PHQ-9)

A 9-item scale (4-point Likert scale, 0–3) that measures the presence and severity of depressive symptoms over the last two weeks [29]. The Spanish version by Diez-Quevedo et al. [40] was used. Internal reliability in this sample was $\alpha = .90$.

2.2.4 Generalized Anxiety Disorder-7 Scale (GAD-7)

A 7-item scale (4-point Likert scale, 0–3) that measures the frequency of cognitive symptoms of anxiety over the last two weeks [30]. The Spanish adaptation by García-Campayo et al. [41] was used. Internal reliability in this sample was $\alpha = .90$.

2.2.5 Satisfaction with Life Scale (SWLS)

A 5-item scale (7-point Likert scale) that assesses the global cognitive judgment of satisfaction with one's life [31]. The Spanish version validated by Pons et al. [42] was used. Internal reliability in this sample was $\alpha = .91$.

2.2.6 Suicide Behaviors Questionnaire-Revised (SBQ-R)

A 4-item measure that assesses suicide risk [32]. The Spanish adaptation by Sánchez-Álvarez et al. [43] was used. Internal reliability in this sample was $\alpha = .82$.

2.2.7 General Health Questionnaire (GHQ-12)

A 12-item screening tool for general psychological health [33]. The Spanish version validated by Rocha et al. [44] was used. Internal reliability in this sample was $\alpha = .92$.

2.3 Procedure

Initially, a theoretical review was conducted to define and operationalize the construct the scale would measure: specifically, clinical competence with LGB clients. To develop the items, similar instruments used in other populations and languages were considered [18, 25–27], and new items were generated specifically for this study, resulting in an initial pool of 48 items.

Subsequently, content validation was carried out by nine expert judges in psychometrics and LGB issues, with knowledge of the Spanish spoken in both Spain and Latin America. They evaluated the representativeness, comprehension, interpretation, and clarity of the items. Next, Aiken's V was calculated, and items showing insufficient validity in two or more dimensions were discarded or modified. As a result of this initial validation, a total of 33 items were retained for the initial piloting of the instrument.

Following this, an online survey was conducted using a non-probabilistic snowball sampling method [34], disseminated through social media and in collaboration with LGBTQ+ organizations, patients, and therapists, from September 2024 to January 2025. Inclusion criteria required participants to be over 18 years of age, self-identify as LGB, and have past or current experience with psychotherapy. The study was approved by the Ethics Committee of Complutense University of Madrid (protocol code CE_20250508_02_SOC, approval date: 29 May 2024).

2.4 Data Analysis

For the content validity of the original 48-item instrument, Aiken's V coefficient [35] was calculated, supplemented with 95% confidence intervals using SPSS Statistics

software (Version 27). The evaluation was performed by nine judges, and values of $V \geq .79$ were considered acceptable, according to criteria suggested by Penfield and Giacobbi [46].

To assess structural validity, an Exploratory Factor Analysis (EFA) was conducted using the FACTOR program [45]. Adequacy measures included the Kaiser-Meyer-Olkin (KMO) test [36, 37] and Bartlett's test of sphericity [38]. Given that the data were derived from a 5-point Likert scale, they were treated as ordinal; therefore, polychoric correlations were used to ensure appropriate analysis. Factor parameters were estimated using the Unweighted Least Squares (ULS) method, recommended for ordinal data that may violate normality assumptions. To determine the number of factors, multiple methods were employed, including parallel analysis, the eigenvalue method, the scree plot, and the evaluation of goodness-of-fit indices. Subsequently, an oblimin rotation was performed to aid in results interpretation.

Finally, the internal consistency of the instrument was evaluated, and correlations were calculated to assess convergent validity between the ECCS-LGB-P, the therapeutic alliance, and mental health indicators.

3 Results

3.1 Content Validity Through Expert Judgment

In general, the items presented adequate levels of content validity (greater than 0.79). However, those that showed weak validity ($V \leq .78$) in two or more properties were discarded or modified (see Table A1 in Appendix). Finally, confusing or redundant items were eliminated or modified, based on qualitative feedback from the judges, resulting in a 33-item instrument for final application.

3.2 Exploratory Factor Analysis

The Kaiser-Meyer-Olkin (KMO) sample adequacy index was .94, indicating excellent suitability of the data for factor analysis. Bartlett's sphericity test showed significant results ($\chi^2(528) = 2189.4$, $p < .001$), indicating that the correlation matrix is suitable for factor analysis. Parallel analysis, the eigenvalue method, and the scree plot (Figure 1) suggested retaining two factors. The results of the eigenvalue method show that the first two dimensions explain 71.72% of the total variance (Table A2 in Appendix), indicating a clear factorial structure. Therefore, we proceed with a two-factor solution. Factor loadings and communalities for the complete item set are reported in Table A3 in Appendix.

Regarding the goodness-of-fit indices, the two-factor model presents excellent values, with GFI and AGFI indices close to 1 (0.994 and 0.993, respectively). In addition, the RMSR obtained was 0.0484, lower than the expected value of 0.0704 according to Kelley's criteria. To improve the quality of the instrument, it was decided to eliminate those items with factor weights $< .4$ and those that significantly saturated more than one factor, discarding items 1, 16, and 22. After this refinement, the final 30-item instrument was obtained (Table A4 in Appendix). After the rotation process,

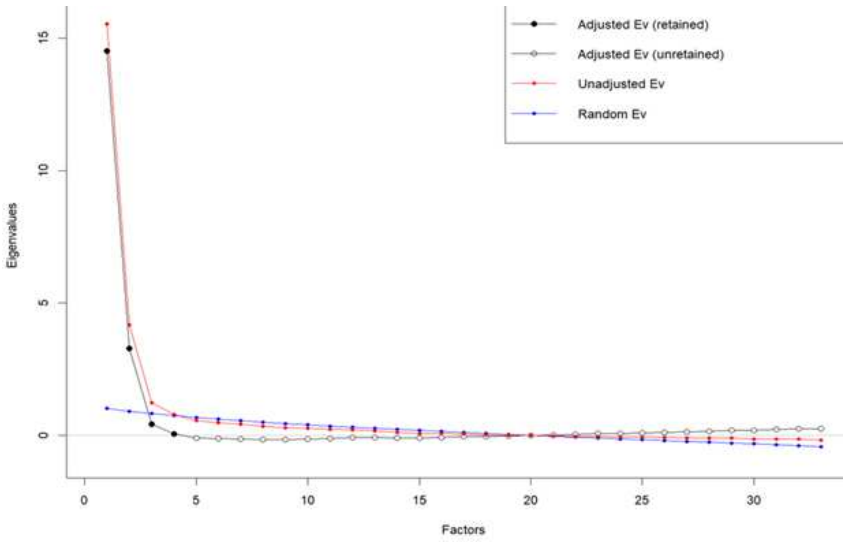


Fig. 1 Comparison of real and random eigenvalues for factor retention using parallel analysis.

the two factors are interpreted as follows: Factor 1 refers to a perception of affirmation and positive clinical competence, including items that reflect respect, validation, tools, knowledge, and support (items 2, 3, 4, 8, 9, 10, 13, 17, 18, 19, 20, 21, 23, 24, 25, 27, 28, 29, 30, 31), and Factor 2 refers to discriminatory practices and microaggressions, with items reflecting prejudice, rejection, and/or pathologization of LGB identity (items 5, 6, 7, 11, 12, 14, 15, 26, 32, 33) (Figure 2).

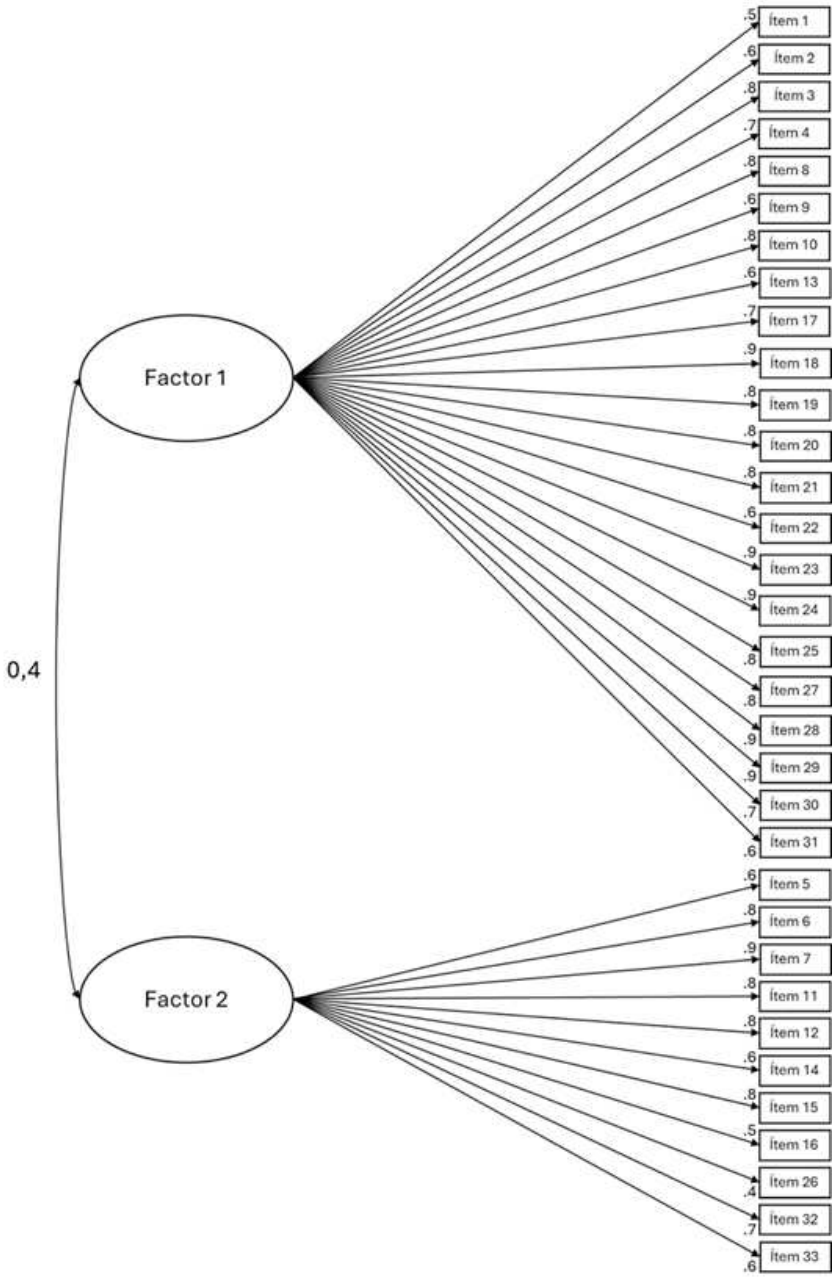


Fig. 2 Factor structure of the ECCS-LGB-P.

3.3 Internal Consistency

The Cronbach's alpha index for the complete 33-item questionnaire was $\alpha = .97$, indicating excellent internal consistency. After removing items, the final 30-item questionnaire maintained internal consistency with a value of $\alpha = .96$.

3.4 Convergent Validity

Regarding the therapeutic alliance (WAI-P), low negative correlations were observed with general malaise (GHQ; $\rho = -.203$, $p = .004$) and depression (PHQ; $\rho = -.175$, $p = .013$). In contrast, the ECCS-LGB-P did not show significant associations with mental health indicators (GAD, PHQ, SBQ, GHQ), but it did show a moderate positive correlation with the therapeutic alliance ($\rho = .552$, $p < .001$). Taken together, these results suggest that perceived cultural competence is primarily related to the quality of the therapeutic bond, rather than to mental health indicators.

Additionally, correlations between the total score and the three dimensions of the WAI-P were analyzed: tasks ($\rho = .529$, $p < .001$), bond ($\rho = .561$, $p < .001$), and goals ($\rho = .438$, $p < .001$), and no relevant associations were found with indicators of anxiety, depression, suicidal ideation, or general distress. This would indicate that the ECCS-LGB-P scale is sensitive to the relational nuances of the therapeutic alliance regardless of the level of symptomatology.

Regarding the subscales, the dimension of affirmation and positive clinical competence also correlated significantly with the therapeutic alliance ($\rho = .552$, $p < .001$) and its components. The subscale assessing microaggressions and discriminatory practices also showed significant correlations with the therapeutic alliance ($\rho = .440$, $p < .001$) and with life satisfaction ($\rho = .152$, $p = .030$), indicating that a lower degree of perceived invalidation in the therapeutic relationship is associated with better subjective experiences of the process and greater life satisfaction. Neither of the two subscales was significantly associated with the clinical variables.

4 Discussion

The present study aimed to develop and validate an instrument for assessing LGB patients' perceptions of their therapists' clinical competence and sensitivity. The psychometric results indicate that the Patient-Perceived LGB Clinical Competence and Sensitivity Scale (ECCS-LGB-P) is a reliable and valid instrument. Exploratory factor analysis (EFA) revealed a two-factor structure that reflects the key dimensions of the construct: Sensitivity and Positive Clinical Competence, and Microaggressions and Discriminatory Practices. The excellent model fit indices (GFI = .994; AGFI = .993) and high internal consistency ($\alpha = .97$) provide robust evidence of the scale's validity and reliability.

The two-factor structure of the ECCS-LGB-P explicitly captures the diverse range of experiences LGB individuals may encounter in therapy. The first factor, Sensitivity and Positive Clinical Competence, quantifies the beneficial and affirmative aspects that foster a safe, understanding, humble, and respectful therapeutic environment. In contrast, the second factor, Microaggressions and Discriminatory Practices, assesses

negative experiences that can erode trust and pose a risk to the therapeutic process. Unlike measures that focus solely on the "deficit" or mere "presence" of general skills, this scale provides a comprehensive view by assessing both harmful and constructive behaviors. This dual approach aligns with the culturally sensitive care perspective in clinical psychology [9, 15, 21, 22].

These findings suggest that the ECCS-LGB-P is a valuable tool with significant implications for both clinical practice and research. The scale addresses recommendations by authors such as Bidell [18] and Herzog et al. [6], representing an advancement in measuring constructs relevant to LGB healthcare. Furthermore, it enables the quantification of harmful experiences that may occur within therapeutic processes, which are often overlooked by therapist self-reports. At the research level, the ECCS-LGB-P has the potential to deepen our understanding of cultural competence and humility. It also serves as a crucial tool for evaluating the impact of training programs, allowing for the objective measurement of changes in attitudes and practices over time, thus offering a more reliable alternative to subjective self-assessment [9, 18].

Regarding convergent validity, the findings demonstrate that both the total score of the ECCS-LGB-P and its two subscales are significantly associated with the therapeutic alliance. This reinforces the notion that the patient's perception of the therapist's competence is a critical component in establishing a strong therapeutic bond, consistent with previous literature [8, 9, 13]. In particular, the strong association between the total ECCS-LGB-P score and the three dimensions of the WAI-P (Tasks, Bond, and Goals) suggests that patients who perceive greater validation and understanding from their therapists also report a more positive and collaborative therapeutic experience, aligning with findings by Jennings and Sprankle [24].

However, the absence of significant correlations between the total ECCS-LGB-P scores and mental health indicators (depression, anxiety, suicide risk) implies that perceived clinical competence may impact the relational and experiential aspects of the therapeutic process more directly than the patient's current symptomatology. Alternatively, perceived competence might be a necessary but not sufficient condition for symptomatic change. Notably, an exception was observed in the Microaggressions subscale, which showed a significant relationship with life satisfaction. This suggests that recognition (or the absence of invalidation) within the therapeutic space may have effects on identity and existential aspects of well-being, extending beyond clinical symptoms. Taken together, these results suggest that the therapist's cultural competence—measured both globally and differentially—is a key component in promoting a sensitive, affirmative, and quality therapeutic experience.

4.1 Limitations and Future Directions

This research has several limitations that should be considered when interpreting the results. First, the measurement instrument was validated solely based on the experiences of lesbian, gay, and bisexual (LGB) individuals. Although the study explicitly focused on this population to ensure construct validity, the experiences and clinical needs of transgender and non-binary individuals are distinct and require their own measurement instruments. Despite recruitment efforts, a sufficiently large sample of

this group was not obtained to perform a robust factor analysis; therefore, future research should focus on developing tools specific to gender-diverse populations.

Second, regarding the sociodemographic composition of the sample, a high percentage of participants reported a university-level education. This overrepresentation of highly educated individuals may limit the generalizability of the findings to LGB populations with lower socioeconomic status or educational backgrounds. Future studies should aim to recruit more diverse samples to ensure the scale's applicability across different social strata.

Third, while the sample size was sufficient for the exploratory analyses conducted, a larger sample in future studies would allow for Confirmatory Factor Analysis (CFA) to provide more robust evidence of the scale's structure. Finally, although the inclusion of participants from Spain and Colombia strengthens the cross-cultural relevance of the instrument for the Spanish-speaking context, a measurement invariance analysis was not conducted. Future research should assess whether the scale functions equivalently across these national groups to ensure that the two-factor structure is stable across different Hispanic cultural contexts.

In summary, the findings of this study suggest that the Patient-Perceived LGB Clinical Competence and Sensitivity Scale (ECCS-LGB-P) is a valuable tool with important implications for both clinical practice and research. By incorporating the patient's voice, this instrument fills a critical gap in the Spanish-speaking context, where such validated measures were previously lacking. Ultimately, the widespread implementation of the ECCS-LGB-P can foster more ethical, effective, and affirming therapeutic environments, ensuring that psychological care serves as a source of support rather than a site of re-stigmatization for LGB individuals.

Supplementary information. Not applicable.

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Ethics approval and consent to participate: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of Complutense University of Madrid (protocol code CE_20250508_02_SOC, approval date: 29 May 2024). Informed consent was obtained from all participants involved in the study.

Consent for publication: Not applicable.

Data availability: The dataset used and analyzed in this study is available from the corresponding author upon reasonable request. The data are not publicly available in accordance with the ethical approval, which specifies that the dataset must be stored securely, in compliance with institutional data protection procedures.

Author contribution: Conceptualization, R.A.L.B. and M.E.A.G.; methodology, R.A.L.B., M.E.A.G. and M.B.N.; software, R.A.L.B. and M.B.N.; validation,

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Appendix

Table A1 Items and properties with weak content validity according to Aiken's V

Item	Property	Mean	Aiken's V	95% Confidence Interval	
				Lower Bound	Upper Bound
1	Comprehension	3.3	0.78	0.59	0.89
1	Interpretation	3.2	0.74	0.55	0.87
4	Representativeness	3.3	0.78	0.59	0.89
4	Interpretation	3.2	0.74	0.55	0.87
5	Interpretation	3.1	0.70	0.52	0.84
7	Comprehension	3.1	0.70	0.52	0.84
7	Interpretation	3.2	0.74	0.55	0.87
7	Clarity	3.3	0.78	0.59	0.89
29	Clarity	3.3	0.78	0.59	0.89
38	Interpretation	3.3	0.78	0.55	0.87
39	Comprehension	3.3	0.78	0.59	0.89

Note. Only items whose content validity, assessed using Aiken's V, was equal to or below .78 are presented. All remaining items obtained higher values.

Table A2 Eigenvalues and proportion of explained variance

Factor	Eigenvalue	Proportion of Variance	Cumulative Proportion
1	19.473	0.590	0.590
2	4.196	0.127	0.717
3	1.370	0.042	
4	0.879	0.027	

Only the first two factors were retained based on parallel analysis and interpretability criteria.

Table A3 Factor loadings on the rotated matrix

Item	F1	F2
1. Respected my sexual orientation.	0.642	0.406
2. Was knowledgeable about issues in my daily life as an LGB person.	0.600	
3. Clearly showed understanding of my concerns as an LGB person.	0.831	
4. Helped me see that my problems are not due to my sexual orientation but to society's prejudices.	0.637	
5. Made me feel that my sexual orientation was something I should hide.		0.838
6. Made me feel that my sexual orientation was a mental illness.		0.972
7. Showed signs of wanting to change my sexual orientation.		0.925
8. Helped me develop tools to cope with stigma and discrimination in my environment.	0.831	
9. Respected my decisions regarding disclosing my sexual orientation to others.	0.634	
10. Understood the nature of romantic relationships between LGB people.	0.815	
11. Made me feel confused about my sexual orientation.		0.747
12. Made me feel that my sexual orientation was a passing phase.		0.777
13. Supported my decision to talk with my family/friends about my sexual orientation.	0.603	
14. Held prejudices toward my sexual orientation.		0.701
15. Humiliated and offended me because of my sexual orientation.		0.836
16. Avoided talking about my sexual orientation.	0.303	0.612
17. Told me about support resources for LGB people.	0.919	−0.385
18. Recognized the impact of living in a homophobic society.	0.913	
19. Recognized the existence of discrimination and its impact within the LGBT+ community.	0.816	
20. Helped me identify and confront negative beliefs I held about my sexual orientation.	0.877	
21. Helped me express feelings associated with the homophobic experiences I faced.	0.863	
22. Expressed respect for my lifestyle.	0.665	0.300
23. Was knowledgeable about diversity within the LGB community.	0.903	
24. Helped me develop a positive identity as an LGB person.	0.884	
25. Encouraged me to build a support network that accepted me as an LGB person.	0.840	
26. Avoided discussing problems caused by discrimination.		0.510
27. Showed interest in learning more about my reality as an LGB person.	0.862	
28. Was aware of the specific challenges faced by LGB families and/or couples.	0.914	
29. Respected my frustration regarding the stigma faced by LGB people.	0.902	
30. Made me feel safe expressing my sexual orientation.	0.704	
31. Used language that made me feel respected.	0.678	
32. Made me feel ashamed of my sexual orientation.		0.648
33. Made me feel that my sexual orientation was the result of negative experiences in my childhood.		0.754

Note. F1 = Sensitivity and Positive Clinical Competence; F2 = Microaggressions and Discriminatory Practices. Loadings below .30 are omitted for clarity. Items are presented in English for readability; the scale was developed, administered, and validated in Spanish. The original Spanish version is available from the corresponding author upon request.

Table A4 Final 30-item version of the ECCS-LGB-P

Instructions: Below you will find a list of statements. Please rate the degree to which you agree with each statement regarding your last therapy experience. Use the following scale: 1 = Strongly disagree, 2 = Disagree, 3 = Neither agree nor disagree, 4 = Agree, 5 = Strongly agree. My therapist. . .
1. Was knowledgeable about issues in my daily life as an LGB person.
2. Clearly showed understanding of my concerns as an LGB person.
3. Helped me see that my problems are not due to my sexual orientation but to society's prejudices.
4. Made me feel that my sexual orientation was something I should hide.
5. Made me feel that my sexual orientation was a mental illness.
6. Showed signs of wanting to change my sexual orientation.
7. Helped me develop tools to cope with stigma and discrimination in my environment.
8. Respected my decisions regarding disclosing my sexual orientation to others.
9. Understood the nature of romantic relationships between LGB people.
10. Made me feel confused about my sexual orientation.
11. Made me feel that my sexual orientation was a passing phase.
12. Supported my decision to talk with my family/friends about my sexual orientation.
13. Held prejudices toward my sexual orientation.
14. Humiliated and offended me because of my sexual orientation.
15. Told me about support resources for LGB people.
16. Recognized the impact of living in a homophobic society.
17. Recognized the existence of discrimination and its impact within the LGBT+ community.
18. Helped me identify and confront negative beliefs I held about my sexual orientation.
19. Helped me express feelings associated with the homophobic experiences I faced.
20. Was knowledgeable about diversity within the LGB community.
21. Helped me develop a positive identity as an LGB person.
22. Encouraged me to build a support network that accepted me as an LGB person.
23. Avoided discussing problems caused by discrimination.
24. Showed interest in learning more about my reality as an LGB person.
25. Was aware of the specific challenges faced by LGB families and/or couples.
26. Respected my frustration regarding the stigma faced by LGB people.
27. Made me feel safe expressing my sexual orientation.
28. Used language that made me feel respected.
29. Made me feel ashamed of my sexual orientation.
30. Made me feel that my sexual orientation was the result of negative experiences in my childhood.

Items are presented here in English for readability. The ECCS-LGB-P was developed, administered, and validated in Spanish. The original Spanish version is available from the corresponding author upon request.