MEXICAN PSYCHOLOGISTS AND PSYCHOLOGY STUDENTS' KNOWLEDGE AND ATTITUDES TOWARD LESBIANS AND GAY MEN

CONOCIMIENTO Y ACTITUDES DE ESTUDIANTES DE PSICOLOGÍA Y PSICÓLOGOS MEXICANOS HACIA GAYS Y LESBIANAS

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ABSTRACT

The lesbian and gay (LG) community in Mexico has faced a long history of homophobia and intolerance that invariably has influenced their interpersonal relationships with their families, friends and partners as well having an influence on mental health. In preparing future generations of clinicians for work in Mexico, specific research on local LG communities will be invaluable for improving clinical training and addressing the clinical implications of homophobia. As a starting point, this study seeks to better understand current attitudes and levels of knowledge about gays and lesbians among Mexican psychologists and psychology trainees. The participants were 15 practicing psychologists and 60 undergraduate psychology students (n=75) from Mexico City, Mexico. In the AGLP total scale, 2% (n = 1) had negative attitudes and 10.2% (n = 5) had ambivalent attitudes. In the KAIGL total scale, 50% had low scores from 0 to 59 (n=10), 35% had low scores from 60 to 69 (n=7), and 15% had average scores from 70 to 79 (n=3). In general, participants demonstrated positive attitudes toward the LG community, even though there is still some ambivalence and anxiety about providing services to the LG population. Clinical and training implications are discussed.

KEYWORDS: Gay, Lesbian, Psychotherapy, Clinical Training, Knowledge and Attitudes.

RESUMEN

La comunidad lesbiana y gay (LG) en México ha enfrentado una larga historia de homofobia e intolerancia que frecuentemente ha influido en las relaciones de la comunidad y la salud mental. En la preparación de futuras generaciones clínicas para trabajar en México, la investigación específica será de gran valor para mejorar la formación y abordar las implicaciones clínicas de la homofobia. Este estudio busca entender los conocimiento y las actitudes sobre lesbianas y gays entre los psicólogos y futuros psicólogos mexicanos. Los participantes fueron 15 psicólogos practicantes y 60 estudiantes de psicología (n = 75) de la Ciudad de México, México. En la escala total AGLP, el 2% (n = 1) tenía actitudes negativas y el 10.2% (n = 5) tenía actitudes ambivalentes. En la escala total de KAIGL, el 50% tenía puntuaciones bajas de 0 a 59 (n = 10), 35% tenían puntuaciones bajas de 60 a 69 (n = 7), y 15% tenían puntuaciones promedio de 70 a 79 (n = 3). En general, los participantes demostraron actitudes positivas hacia la comunidad LG, a pesar de que todavía hay cierta ambivalencia y ansiedad acerca de la prestación de servicios. Se discuten las implicaciones clínicas y de capacitación.

PALABRAS CLAVE: Gay, Lesbianas, Psicoterapia, Entrenamiento Clínico, Conocimiento y Actitudes.

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An unfortunate reality is that Mexico has had a significant history of homophobia and intolerance that has been directed toward the lesbian and gay (LG) community. Stereotypes, stigmatization, and discrimination of sexual minorities permeate all levels of Mexican society (Rodríguez, 2008). This remains true despite the significant strides for gay rights that have occurred in recent years. This reality can lead to a profound marginalization and stigmatization of members of the Mexican LG individuals and can have a negative effect on their lives, relationships, and mental health. Educational training programs are not exempt from being influenced by the dominant cultural biases, and little is known about how such biases may permeate mental health training programs in Mexico.

There have been important developments in Mexico in recent years in regards to gay rights that offer hope for a different future. For example, in 2009 gay marriage became legal in Mexico City and a year later Mexico's Supreme Court ruled that the rest of the nation must recognize those marriages. Additionally, the Mexico City legislative assembly also voted in 2009 in support of the right of gay couples to adopt children. It is also a significant fact that over 50,000 people participated in the 2014 gay pride parade in Mexico demonstrating an increasing openness and a growing voice of the gay community (France-Presse, 2014).

Many of the positive changes that have occurred thus far within Mexico have been changes in the law. While these changes are a crucial part of the process, legal changes do not automatically lead to immediate changes in the dominant cultural landscape. For example, there is still far to go toward insuring LG Mexicans' basic human rights and dignity. The most extreme example of homophobia is the very real context of violence that exists in Mexico that targets members of the LG community. Much more needs to be done to just assure the physical safety of LG individuals. The National Commission on Human Rights of Mexico reported that Mexico, just behind Brazil, ranks second among Latin American countries in the number of crimes connected to homophobia (Ambriz-Padilla, 2013). A testament to this is the fact that between the years of 1995 and 2006, there were 420 reported murders linked to homophobia (Letra, 2009). These numbers do not reflect even a fraction of the full picture of violence experienced by sexual minorities given that most crimes go unreported in Mexico. There exists significant distrust of police and the legal system in Mexico, and this is likely to be even more common among sexual minorities given that hate crimes are rarely investigated. The "Comisión Ciudadana Contra los Crímenes de Odio por Homofobia" (Citizen Commission Against Homophobic Hate Crimes, 1999) has estimated that for each hate crime that has been documented there are at least three undocumented cases. The impunity that exists has obvious implications for the mental health of LG communities in Mexico, but unfortunately the clinical implications of this homophobia and violence on Latin American LG communities have largely been ignored (Deanet al., 2000).

Diversity and Mental Health Training in Mexico

In regard to mental health training and the preparation of students to address issues of diversity, there is a significant difference in the degree and type of focus on multicultural education between Mexico and the United States (U.S.) (Platt, 2014). While multicultural education in the United States is clearly U.S. centric and ignores international perspectives, U.S. mental health training programs generally do have multicultural competencies infused into curricula, coursework, and licensing requirements (Platt & Natrajan-Tyagi, 2014). While there is still significant room for improvement in this effort, most clinical training programs in the U.S. also include in multicultural education training the unique needs of sexual minorities (Jiménez, 2011; Stonefish & Harvey, 2005). In educational settings in Mexico, in contrast, multicultural training is not a central focus in mental health training. In particular, sexual

orientation as a topic is rarely spoken about and remains largely taboo as a focus (Esteban-Guitart, 2012; Macgillivray, 2006). The terminal degree for a clinician is an undergraduate degree that generally focuses strictly on the core aspects of psychology. Unfortunately, the majority of curriculums in mental health training programs in Mexico do not consider diversity as a core psychological framework, and thus most programs do not require coursework specifically on developing multicultural competencies. In many ways, the topic of sexual orientation remains fairly taboo in higher education in Mexico. A simple example is the fact that only a few institutions have gay student groups (Griffin, Lee, Waugh & Beyer, 2004; Macgillivray, 2006). It is a very real possibility that a psychology student in Mexico could graduate and begin providing services without ever having a single training on working with sexual minorities. Given this dearth of formal focus on LG issues in Mexican education, it will be important to better understand the ramifications that this has on clinical training and clinical work in Mexico.

In order to meet the clinical needs of sexual minorities in Mexico, it will be important to continue to decrease homophobia among future mental health providers and to increase their knowledge about the LG community. A challenge is that little is currently known about the mental health implications of homophobia on sexual minorities in Mexico. The vast majority of psychological research on LG communities that has been done in the world has been conducted within the United States (Arnett, 2009). Also, mental health approaches originating in Mexico and other Latin American are frequently underrepresented in the professional literature or are not depicted as being legitimate (Platt & Laszloffy, 2013). For example, a study was performed in Puerto Rico with 220 graduate clinical psychology students and 47 licensed clinical psychologists to evaluate their attitudes towards gays and lesbians in psychotherapy (Vázquez-Rivera, Sayers-Montalvo, Nazario-Serrano, 2012). The results show that 3% of students and none of the psychologists had negative attitudes according to the Attitudes Towards GL in Psychotherapy Total Scale. More specifically, 4% of students and none of psychologists felt anxiety in the interventions with LG, 6% of students and 5% of psychologists preferred not to engage in psychotherapy with this population, and 13% of students and 6% of psychologists negatively evaluated their competencies with LG clients. Also, this study found correlations between religion, number of gay and lesbian clients, and formal education, with the samples' attitudes towards the LG population.

Understanding the experience of LG communities in Mexico may also be limited given that most research to date regarding gay and lesbian (LG) communities has primarily only occurred in industrialized nations (Ortiz-Hernández & Granados-Cosme, 2006). Theories developed based on and for the wealthy elite within the United States are often a mismatch for those living in developing countries (Martín-Baró, 1994; Platt, 2010). While lesbians and gays in the U.S. are not necessarily wealthy, there are different socio-cultural characteristics between the U.S. and Latin America worth considering when applying U.S. originating approaches. The intersection of sexual orientation and economic level has significant relevance in Mexico given that 45.5% of Mexicans currently live below the poverty line (Cohen, 2013). Currently insufficient academic research exists specifically on Mexican LG populations; therefore Mexican institutions, including mental health training programs, are often left to rely on unreliable data, such as that found on the internet (Mercado-Mondragón, 2009). In preparing future generations of clinicians for work in Mexico, specific research on local Mexican LG communities will be invaluable for improving clinical training and addressing the clinical implications of homophobia. As an initial step toward this aim, this study seeks to better understand current attitudes and levels of knowledge about gays and lesbians among Mexican psychologists and psychology trainees.

METHOD

Participants

The participants were 15 practicing psychologists and 60 undergraduate psychology students (n=75) from Mexico City, Mexico. All participants were associated with the "Licenciatura en Psicología" dual degree program that is offered in collaboration between the Universidad de Londres (Mexico) and the California School of Professional Psychology (a U.S. institution with a campus in Mexico City). Participants were selected by availability at a psychology professional development training hosted by and held at the Alliant campus. Both the consent form and the verbal explanation (a culturally important step in a country where verbal communication is valued over written communication) emphasized that participation is anonymous, voluntary, and subject to no rewards or retribution. In addition to meeting APA ethical guidelines and U.S. standards for research practice, we ensured that our research adhered to guidelines outlined within the code of ethics from the "Sociedad Mexicana de Psicología", Mexico's equivalent of the APA.

Instruments

- Socio-demographic Information Questionnaire. This instrument contained 17 questions in Spanish that asked about gender, age, sexual orientation, marital status, income, religion, psychology program, years of clinical practice, and exposure to gays and lesbians in respondents' personal and professional life.

- Attitudes toward Gays and Lesbians in Psychotherapy Scale (AGLP; Vázquez-Rivera & Sayers-Montalvo, 2012). The instrument of 28 items in the Spanish language was developed and validated with 101 Hispanic/Latino clinical psychology doctoral students in Puerto Rico to identify the attitudes related to providing psychotherapy services to gays and lesbians by clinical psychology students while in clinical practice. The scale has an internal consistency of α=.96. This scale has three subscales: 'Preference of therapeutic services' ['Preferencia de servicios terapéuticos'] (8 items, α= .94), 'Anxiety about providing therapeutic interventions' ['Ansiedad hacia la intervención terapéutica'] (13 items, α= .93) and 'Self-assessment of clinical competencies ['Auto evaluación de competencias clínicas'] (7 items, α= .85).

- The Knowledge towards Issues and Intervention with Gays and Lesbians (KAIGL) is a Spanish language scale developed by Vázquez-Rivera, Sayers-Montalvo, Nazario-Serrano and Esteban (2012) measures the knowledge towards issues of the gay and lesbian community, psychotherapeutic interventions with this population and clinical competencies with the LGB population. It has 50 items and the psychometric factors are unknown since it has not been validated. The scale contains three subscales: General Knowledge towards the LG Population subscale which measures how much information the person has about lesbians and gay men; the Intervention Knowledge towards LG Population' subscale which measures the knowledge about psychotherapeutic interventions appropriate when providing treatment to lesbians and gay men; and the Clinical Competence towards the LG Population subscale which measures the clinical competencies the therapist possesses as it relates to the services provided to the LG population. Items are answered using a Truth or False and Multiple Selection (4 points) format. This measure was selected after an extensive literature review was conducted and no other validated scale was found.

- Marlowe Crowne Social Desirability Scale. (Crowne & Marlowe, 1960). The Marlow Crowne Social Desirability Scale (MCSDS) is one of the most used social desirability scales in research studies (Beretvas, Meyers, & Leite, 2005) and the Spanish version available was administered. The scale of 33 items measures the need to "... obtain approval by responding in a culturally appropriate and acceptable manner" (Crowne & Marlowe, 1960, p.353). Studies have demonstrated an internal consistency of .72 to .96 (Crowne & Marlowe, 1960; Loo & Thorpe, 2000).

Research Design

A non-experimental transactional correlational design was chosen (Hernández-Sampieri, Fernández-Collado & Baptista-Lucio, 2003). The dependent variables measured in this study were the attitude of participants about providing psychotherapy services to gays and lesbians and their knowledge about the lesbian and gay population.

Procedures

The administration of all instruments took place in an auditorium after a professional development training related to LG topics at a university in Mexico City. Participants were instructed to read the consent form and if they agreed to what it stated to sign, initial, or to make an "X" mark. The consent form was separated from the other documents and was placed by the investigator in a distinct manila envelope to ensure confidentiality. Participants were instructed to complete the questionnaire and both scales.

Statistical Analyses

Quantitative analyses of the variables were conducted using Statistical Package for the Social Sciences (SPSS) version 17.0. The analyses included descriptive analyses such as frequencies, mean, dispersions statistics, total scores of the whole scale and of each of the sub scales, and correlations between the scales. Inferential statistics such as t-Student tests for independent samples and analysis of variance (ANOVA) were also conducted. An alpha of .05 was used in all procedures to determine the significance of the findings.

RESULTS

Demographic Information

Most of the participants were female (90.7%), heterosexual (90.7%), from Mexico City (69.7%), single (85.1%), had an income less than $12,000 Mexican Pesos (45.2%), Catholics (74%), and attended religious service at least once a month a (74%) (see Table 1). Participants' mean age was 22 (SD=5), and the mean time in clinical practice was 1 year (SD=2.06).

When asked if they knew someone gay, 93.7% answered affirmatively and when asked the same for lesbians, 81.3% also answered "yes." Regarding clinical experiences with the gay and lesbian communities, 4% expressed that they have performed psychotherapy with gay clients and 2.7% with lesbian clients. The sample reported having a minimum of 0 and a maximum of 10 gay clients and a minimum of 0 and a maximum of 15 lesbian clients.

AGLP, KAIGL and MCSDS Scales

In order to assess the relationship between the AGLP Scale, the KAIGL Scale, and the MCSDS, a Pearson Product-Moment correlation (r) was performed to evaluate the relationship between the AGLP Total Scale and the MCSDS and the KAIGL Total Scale and MCSDS. It was found that these scales do not have a statistically significant relationship ($r = -.16$, $p = .27$, AGLP Scale and MCSDS; $r = .12$, $p = .62$, KAIGL and MCSDS).

Descriptive statistics of the AGLP Scale and subscale scores were determined through frequency analyses, performed to

determine the sample's attitudes towards the LG community in psychotherapy. In the AGLP total scale, 2% (n = 1) of participants reported negative attitudes. In the subscale "Anxiety towards the therapeutic intervention", 3.7% (n = 2) of participants had negative attitudes. In the subscale "Preferences towards therapeutic interventions", 1.7% (n = 12) of participants reported negative attitudes. In the subscale "Self-evaluation of clinical competencies", 3.1% (n = 2) of participants informed negative attitudes (see Table 2).

TABLE 1.
Demographic Characteristics of the Sample.

Personal Information	Sample (%) n=75
Gender	
Masculine	9.3
Feminine	90.7
Sexual Orientation	
Heterosexual	90.7
Homosexual	6.7
Bisexual	2.7
Marital Status	
Single	85.1
Consensual Relationship	10.8
Married	1.4
Separated	1.4
Divorced	0
Widowed	1.4
Annual Income	
Less than $12,000	45.2
$12,000 to $24,000	17.7
$24,001 to $34,000	11.3
$34,001 to $44,000	16.1
$44,001 to $54,000	1.6
More than $54,001	8.1
Religion	
Catholic	74.0
Protestant	0
Other	2.7
None	23.3
Attendance at Religious Services	
Never	26
Less than once a month	52.1
Once a month	8.2
Twice a month	2.7
Three times a month	2.7
Once a week	6.8
More than once a week	1.4
Residence	
Federal District (DF)	69.7
Outside DF	30.3

Note. The sample answered a demographic questionnaire including information about their gender, sexual orientation, marital status, annual income, religion, attendance to religious services, and where they reside

TABLE 2.
Sample's Attitudes Towards LG Population in Psychotherapy.

Scales and subscales	Attitudes	f	%
AGLP	Positive	43	87.8
	Neutral or Ambivalent	5	10.2
	Negative	1	2.0
Anxiety towards therapeutic interventions	Positive	44	81.5
	Neutral or Ambivalent	8	14.8
	Negative	2	3.7
Preferences towards therapeutic services	Positive	51	86.4
	Neutral or Ambivalent	7	11.9
	Negative	1	1.7
Self-evaluation of clinical competencies	Positive	45	69.2
	Neutral or Ambivalent	18	27.7
	Negative	2	3.1

Note. The sample that answered the questionnaire varied between the scales (AGLP Total Scale: n=49, 'Anxiety towards therapeutic interventions' subscale: n=54, 'Preferences towards therapeutic services' subscale: n=59, and 'Self-evaluations of clinical competencies' subscale: n=65)

Additionally, descriptive statistics of the KAIGL Scale and subscale scores were determined through frequency analyses performed to determine the sample's knowledge towards the LG population. In the KAIGL total scale, 50% of participants had low scores from 0 to 59 (n=10), 35% had low scores from 60 to 69 (n=7), 15.0% had average scores from 70 to 79 (n=3), and none had high scores from 80 to 100 (n=0). In the General Knowledge towards the LG Population subscale, 33.9% of participants had low scores from 0 to 59 (n=20), 27.1% had low scores from 60 to 69 (n=16), 22% had average scores from 70 to 79 (n=13), 11.9% had high scores from 80 to 89 (n=7), and 5.1% had high scores from 90 to 100 (n=3). In the 'Intervention Knowledge towards LG Population' subscale, 41.9% of participants had low scores from 0 to 59 (n=13), 32.3% had low scores from 60 to 69 (n=10), 25% had average scores from 70 to 79 (n=8), and none had high scores from 80 to 100 (n=0). In the Clinical Competence towards the LG Population subscale, 57.7% of participants had low scores from 0 to 59 (n=30), 25% had low scores from 60 to 69 (n=13), none had average scores from 70 to 79 (n=0), 17.3% had high scores from 80 to 89 (n=9), and none had high scores from 90 to 100 (n=0) (see Table 3).

We also conducted mean comparisons between the AGLP scale and subscales and the KAIGL scale and subscales. Independent sample t-tests were performed to examine statistically significant difference between participants who know someone lesbian and gay and the scales and subscales utilized in this study. Regarding the AGLP total scale, participants who knew a lesbian had significantly better attitudes towards LG population [$t(6.45) = -2.23$, $p < .01$]. In the "Anxiety towards the Therapeutic Intervention" subscale, participants who knew a person who identifies as lesbian had significantly better attitudes towards the LG population [$t(7.97) = -2.34$, $p < .05$]. In the "Preferences towards Therapeutic Interventions" subscale, participants that knew a person that identifies as lesbian had significantly better attitudes towards the LG population [$t(9.67) = -2.33$, $p < .001$]. On the contrary, the "Self-evaluation of clinical competencies" subscale was not statistically significant regarding this

variable [t (65) = -2.64, p = .90]. These analyses were not performed with the "knowing someone gay" variable since only 1 participant did not know a gay person (see Table 4).

TABLE 3.
Sample's Knowledge of LG Population.

Scales and subscales	Grade	f	%
KAIGL	A (90%-100%)	0	0
	B (80%-89%)	0	0
	C (70%-79%)	3	15.0
	D (60%-69%)	7	35.0
	F (0%-59%)	10	50.0
General knowledge towards LG population	A (90%-100%)	3	5.1
	B (80%-89%)	7	11.9
	C (70%-79%)	13	22.0
	D (60%-69%)	16	27.1
	F (0%-59%)	20	33.9
Intervention knowledge towards LG population	A (90%-100%)	0	0
	B (80%-89%)	0	0
	C (70%-79%)	8	25.0
	D (60%-69%)	10	32.3
	F (0%-59%)	13	41.9
Clinical competencies towards the LG population	A (90%-100%)	0	0
	B (80%-89%)	9	17.3
	C (70%-79%)	0	0
	D (60%-69%)	13	25.0
	F (0%-59%)	30	57.7

Note. The sample that answered the questionnaire varied between the scales (KAIGL Total Scale: n=20, 'General knowledge towards LG population' subscale: n=59, 'Intervention knowledge towards LG population' subscale: n=31, and 'Clinical competencies towards the LG population' subscale: n=52).

TABLE 4.
Mean Comparison between the AGLP Scale and Subscales and the Knowing Someone Lesbian Variable.

Scales and subscales	Know a lesbian		Does not know a lesbian	
	M	SD	M	SD
AGLP Scales	38.67	9.38	55.70	19.88
Anxiety towards the therapeutic intervention	18.85	5.75	26.75	9.25
Preferences towards therapeutic services	9.84	2.68	14.60	6.35
Self-evaluation of clinical competencies	10.95	4.22	14.50	4.27

Note. Statistical differences exist ($p < .05$) between the means of all scales and subscales except 'Self-evaluation of clinical competencies'.

Additional independent sample t-tests were performed with the variable "knowing someone lesbian" and the KAIGL scale, however no statistically significant differences were found ['General Knowledge towards the LG Population' Subscale, t (31) = -.16, p = .611; "Intervention Knowledge towards LG Population" Subscale, t (39) = -.41, p = .131; "Clinical Competence towards the LG Population" Subscale, t (50) = -.57, p = .172; "Knowledge towards LG Population" Scale, t (20) = -.11, p = .287]. These analyses were not performed with the "knowing someone

gay" variable since only 1 participant did not know a gay person.

DISCUSSION

It was found that participants answered both scales (AGLP and KAIGL) without the need for approval, responding in an accepted and culturally appropriate manner. However, some resistance can be interpreted, as some participants did not complete every scale of the questionnaire. The KAIGL Scale had fewer participants completing it than any of the other scales. When looking at the KAIGL subscales, the 'Intervention Knowledge towards LG Population' had fewer participants than any other subscale. Religion was identified as one of the descriptive variables that could have played an important role in how participants chose to answer the scales, since most of the participants identified as being practicing Catholics. As discussed in the literature review, Catholicism is a religion that emphasizes traditional religious values that include a more conservative and traditional view of the gay lifestyle, when compared with the values of secular individuals (Danna, 2010). These values may have influenced the participants' decision not to answer all of the scales. The lack of formal training on this topic may be another variable that we may consider as having influenced the low participation in answering all of the scales. Individuals who are not knowledgeable on the topic may choose not to answer some of the questions.

In contrast, almost everyone in the study knew someone gay and most of the participants knew someone who identifies as lesbian, implying some openness to the LG population. This was not evident in clinical settings, as participants who were aware of providing services to gay or lesbian clients were scarce. This could be due to the clinicians not being assigned gay or lesbian clients or that the clinical settings do not include a sexual orientation question in the intake interview. Consequently, knowing someone gay or lesbian does not translate into the appropriate delivery of effective psychotherapeutic services to gays and lesbians.

When analyzing the attitudes of the participants towards gays and lesbians in psychotherapy, almost all attitudes were positive. These results have been supported by the literature on psychologists or psychology students-in-training's attitudes towards the LG population (Jones, 2000; Vázquez-Rivera, & Sayers-Montalvo, 2011; Vázquez-Rivera, Nazario-Serrano & Sayers-Montalvo, 2012). Almost no anxiety towards the intervention with this population was reported, and practically no preferences towards performing therapy with heterosexuals, rather than homosexuals, were found. In general, the participants considered that they had the competencies to provide psychotherapeutic interventions to gays and lesbians. Additionally, 'knowing someone lesbian' category was found to be related to better attitudes in all of the scales except to 'Self-evaluation of clinical competencies.' These results are somewhat supported by a similar factor (having lesbian clients) which correlates with better attitudes (Vázquez-Rivera et al., 2012).

While the participants felt competent to provide services, the outlook changes somewhat when we focus on the answers comprising the category of ambivalent attitudes. It was found that 10.2% of participants had ambivalent attitudes towards the LG population; 14.8% felt ambivalent towards feeling anxious in therapeutic interventions with this population; 11.9% felt ambivalent towards their preference in offering therapeutic services to heterosexuals rather than homosexuals; and 27.7% felt ambivalent when self-evaluating their clinical competencies in LG issues. A notable number of participants showed ambivalent attitudes related to providing services to the LG community and about their competence

in providing such services. The LG community does not benefit from ambivalence towards psychological services offered to their community.

Similarly, when assessing participants' LG related knowledge and competencies, it was clear that most did not possess either one. Some participants lacked general knowledge, intervention knowledge, and clinical competencies related to LG population issues. It is important to note that even though most participants had positive attitudes toward the LG population, they did not possess the appropriate knowledge or clinical competencies to provide effective psychotherapeutic interventions.

CONCLUSION

In general, participants demonstrated positive attitudes toward the LG community, even though there is still some ambivalence and anxiety about providing services to the LG population. Psychologists and psychology students-in-training that provide services to the LG community must have a positive attitude towards this population, as it will impact the therapeutic alliance and the therapeutic process outcome. If a therapist has ambivalence and negative attitudes towards the LG population, it can translate into counter transference, inadequate therapy goals, and ultimately, poor outcomes (Green, 2003).

It can also impact in a negative way the therapist-client relationship. Psychologists and psychology students-in-training should develop a safe space for the LG client to process the negative experiences they encounter such as homophobic and violent actions against them. Psychologists and psychology students-in-training should be able to develop a trusting and accepting relationship with their LG clients. If a supportive environment is created, LG clients are more likely to stay in therapy and will not end prematurely their psychological treatment.

In this study, Mexican participants demonstrated low knowledge about the LG community and about therapeutic interventions. This demonstrates the need for psychologists and psychology students-in-training to be educated and exposed to the issues of the LG community and how to best provide psychological interventions. Programs that train psychologists should assume the responsibility to educate students and help them develop self-awareness about diversity issues including those related to sexual orientation and the client's cultural context. This responsibility includes the integration of LG topics within the program's curriculum and continued education for faculty and alumni.

In addition, psychologists must apply best practices and ethical treatment in their professional work as they relate to the specific needs of the LG Latino experience. Therefore, psychologists should acquire the necessary knowledge and develop the appropriate skills to provide services that comply with the ethics of the profession and current best practices.

There are a number of important limitations that were identified in this initial study that were primarily related to the sample size, clinical experience, and method of participation selection. The sample was small, and most of the participants were inexperienced in providing clinical services. This also limited some of the statistical analyses that could be performed. The sample in this study was obtained by availability, making the results specific to the population. It is also important to note that the questionnaire utilized did not include questions evaluating if the education about LG was formal or informal. And finally, the KAIGL scale was not previously validated for Mexican populations, which makes its outcomes purely descriptive.

Future research on this topic should make an effort to address these limitations.

We would recommend that future research on this topic consider conducting the study with a larger randomized sample, validate the KAIGL scale with Latino populations, and conduct a study to compare Mexican samples with those from different national origins. It may also be valuable to repeat the study with more seasoned therapists as opposed to therapists in training. While this study was focused specifically on attitudes and knowledge about gays and lesbians, it may be valuable for future research to also include a focus on the knowledge and attitudes of Mexican psychologists about transgender, bisexual, and other sexual minorities.

Clinical and Training Implications

Psychologists' attitudes play an important role when providing psychotherapeutic and other mental health services. Examining psychologists' attitudes in a quantitative manner allows for mental health trainers to become aware of the areas where clinicians need further training in and the specific areas needing education as it relates to LG issues. Training programs must provide courses, clinical practicum experiences, and opportunities for their students to learn about the LG population, practice clinical skills, and assess their attitudes, readiness, and competence to provide services to the LG population. The influential role that psychologists' religious backgrounds can have is also important to explore. Training programs and clinical supervisors can assist trainees in exploring how their personal religious and cultural backgrounds inform what they do or do not do when providing clinical services to LG clients. What is most apparent from the findings of this study is that continued dialogue and exploration about how to best prepare Mexican mental health workers to provide clinical services to the LG community is needed. An important step for psychologists and psychology students-in-training is the need to engage in a more extensive exploration of their own views and assumptions about the LG community. Educators can assist in this effort by creating opportunities for dialogues aimed at gaining self-knowledge and a greater awareness of how biases can negatively influence treatment effectiveness. Toward this aim, we would like to offer an initial list of dialogue prompts based on the educational approach of Paulo Freire's critical pedagogy (Freire, 1992) that can be used with students-in-training and within clinical supervision (Figure 1). The objective of this educational approach is for members of communities to critically engage around a problem, in this case the barriers to providing clinical services to LG clients, through a process of listening, dialogue, and action (Freire, 1998; Gadotti, 1994; McLaren & Leonard, 1993). These questions should only be considered a starting point, and the community of local experts, faculty, and students should be free to add additional questions for consideration.

Freirean Informed Dialogue Prompts on Clinical Work with LG Communities

LG Communities in Mexico

1. What are the dominant views in Mexico about members of the LG community?
2. What are the significant factors that inform views held about LG communities in Mexico?
3. What are examples of bias and stigmatization that are experienced by members of the LG community in Mexico?
4. How do we make sense of the statistically high incidence of violence that occurs toward the LG community in Mexico?
5. How might the experience of a person who is gay/lesbian differ based on their economic level and/or experience of poverty or wealth?

Education, Supervision and Training

1. What are the core areas of knowledge that a mental health provider should have in order to work effectively with the LG community?
2. What are the unique challenges faced by the LG community in Mexico and how might these present in therapy?
3. What skills do supervisors need in order to prepare supervisees for clinical work with the LG community?
4. Are there educational differences in the needs of LG therapists in training versus straight therapists?
5. What are the best ways to assist mental health providers to recognize and address biases that may interfere with clinical effectiveness?

Self of the Therapist

1. What messages have you learned about the LG community from your family?
2. What were you taught in your religious community about the LG community?
3. How does your sexual orientation influence your clinical work and what you do or do not do in your role as a mental health provider?
4. What aspect of working with a member of the LG community would create the most anxiety for you and why?
5. If you were in therapy with a therapist of a different sexual orientation than your own, what would you want them to understand?

Additional Questions

1. How do you make sense that many people outside Mexico have strong reactions to Mexicans using the term "puto" in sporting events and consider it homophobic while most Mexicans do not view it as homophobic?
2. What additional questions should be part of this dialogue?

FIGURE 1.
Questions that can serve as dialogue prompts when training clinicians and psychology students on clinical work with Lesbian and Gay individuals and communities.

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