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Sexual Orientation Competence: Psychologists' Perceived Competence and Relationships to Multicultural Competence, Training, Engagement, and Exposure to Lesbian, Gay, and Bisexual Individuals

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SEXUAL ORIENTATION COMPETENCE: PSYCHOLOGISTS' PERCEIVED COMPETENCE AND RELATIONSHIPS TO MULITCULTURAL COMPETENCE, TRAINING, ENGAGEMENT, AND EXPOSURE TO LESBIAN, GAY, AND BISEXUAL INDIVIDUALS

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Abstract

Attitudes toward sexual orientation, specifically towards those who identify as lesbians, gay men, and bisexual (LGB) individuals, have varied temporally. Given the pervasiveness of heterosexism in American culture, it becomes quite important to understand if we, as psychologists, could unintentionally create heterosexist environments with our clients. This study looked at the following research question: What are the unique contributions of the predictor variables: exposure to persons of sexual minority status, training experience in sexual minority populations, perceived multicultural competence, and engagement in sexual minority specialization and practice to the criterion variable perceived sexual orientation competence within United States (US) licensed psychologists?

Keywords: sexual orientation, competence, sexual minority, multicultural

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Chapter I

INTRODUCTION

Attitudes toward sexual orientation, specifically towards those who identify as lesbians, gay men, and bisexual (LGB) individuals, have varied temporally throughout the history of psychology. Of specific interest to me were the attitudes of the practitioners of psychology. It is necessary to provide a brief historical account of psychological opinion about homosexuality in order to understand how attitudes have arrived where they are today, what undercurrents may exist, and where attitudes are headed within the psychological community with regard to treatment of LGB individuals. Additionally, it is necessary to highlight the importance of this research.

Statement of the Problem

Research has shown that there is a lack of empirical studies that have been conducted by counseling psychologists in the area of LGB individuals (Fassinger, 1991; Gelso & Fassinger, 1990). Furthermore, it has been suggested that the subjects of multicultural counseling and LGB counseling often have limited space available in graduate training programs (Israel & Selvidge, 2003). Sue, Arredondo, & McDavis (1992) have suggested that multicultural counseling may be inclusive of LGB individuals. Whereas other writers have suggested that multicultural counseling merely provides a template for the development of LGB .competencies (Israel & Selvidge, 2003). In recent years, measures have been developed to measure competence in gay affirmative counseling specific to lesbians and gay men (Crisp, 2006b), as well as sexual orientation competence with LGB individuals (Bidell, 2005). To date, measures looking at LG individuals have been utilized to assess graduate students and social workers (Bidell, 2005, Crisp, 2006b). Psychologists have been assessed as to their understanding of the use of gay

affirmative practice (Crisp, 2006a). However, the current literature is void of data regarding the sexual orientation competence of licensed school, clinical, and counseling psychologists in the United States to work with LGB individuals.

Research suggests that internalized heterosexism in gay and bisexual men can lead to poor health-related decision-making (Kashubeck-West & Szymanski, 2008; Szymanski, Kashubeck-West, & Meyer, 2008). These health-related behaviors include substance use and risky sexual activities. Furthermore, internalized homophobia was found to be related to psychological stress in lesbians (Szymanski & Kashubeck-West, 2008). Given the pervasiveness of heterosexism in U.S. culture, it is quite important to understand if psychologists are creating heterosexist environments with their clients. Having competence in working specifically with LGB individuals would provide a framework from which psychologists could assess their own skills, knowledge, and attitudes that can either reinforce or help to correct internalized the heterosexism experienced by our clients.

Background

A historical view of the earliest theorists was beyond the scope of this work, however, it should be noted that the psychoanalytic views of homosexuality have varied from pathologizing it to acceptance (Fassinger, 1991, pp. 165-166). This greatly impacted the tenor of treatment of LGB individuals prior to, and after, recent efforts toward greater acceptance within the psychological community. I utilized the 1970s as a transitional period of attitudinal change in the psychological community. The hallmark event that began the shifts in attitudes towards sexual minorities was the vote in 1973--and the subsequent removal of the diagnosis of homosexuality in 1974--from the *Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM-II)* (Jones, 1999, p. 209). This change was followed by a statement by the

American Psychological Association (APA, 1975) that stated that "homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities [and further, the American Psychological Association urges] all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations" (p. 633). Although the removal of the diagnosis of homosexuality from DSM-II was heralded as a great advancement by the gay rights movement, the community soon realized that the diagnosis was replaced with sexual orientation disturbance (Spitzer, 1981). A new diagnosis, ego-dystonic homosexuality, was used in *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III, 1980)* to replace sexual orientation disturbance (Davison, 2005, p. 27). Ego-dystonic homosexuality was removed from the 1987 *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised (DSM-III R)*, when other references to sexual orientation, such as orientation concerns specific to paraphilias, were dropped as well (Davison, 2005, p. 27). In 1994, the APA released the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*; American Psychiatric Association, 1994). Noticeably, in this edition and in the recent *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV TR)*, formal diagnoses for homosexuality are largely absent. The one remaining diagnosis for which there is some argument is the possible use of sexual disorder not otherwise specified. Again, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013) is free of a diagnosis for homosexuality.

The historical variation of diagnostic approaches to homosexuality shows that the psychological community was not truly free of a diagnosis for sexual orientation until 1987 with the release of *DSM-IV*. At the time of this writing, there were only 28 years during which the

diagnostic guidelines were free of a diagnosis for sexual orientation. It should be mentioned that the diagnosis of ego-dystonic sexual orientation still exists in the International Statistical Classification of Diseases and Related Health Problems (ICD; Drescher, 2010, p. 435). However, the World Health Organization (as cited in Drescher, 2010) has specified that homosexuality is not a diagnosis by itself; it being removed in 1992. Regardless, the fact that these diagnoses remain in existence can have a profound impact on the underlying thoughts about pathology with regards to homosexuality and still are means to diagnose LGB individuals. This is of profound importance since many hospitals utilize ICD codes for diagnosis and billing. Additionally, it is expected that by the fall of 2015 all mental health practitioners will be required to utilize the ICD for coding diagnoses.

Although we have moved to a time when LGB individuals are less pathologized in psychotherapy, there is still a range of attitudes, approaches, and deliveries by psychologists. The National Association for Research & Therapy of Homosexuality (NARTH) presents one of the more prominent displays of homonegativity. This organization supports the rights of clinicians to engage in conversion therapy; assisting individuals who would like to change their sexual orientation. Although NARTH veils their statements with language that suggests part of their mission is to support scientific data and open discourse in considering client choice, it is evident that they have a clear position on homosexuality: "Tolerance must also be extended to those people who take the principled, scientifically supportable view that homosexuality works against our human nature" (National Association for Research & Therapy of Homosexuality, *n.d.*, para. 6). Comments of this type can be found throughout NARTH writings and may be more indicative of the true beliefs of its members than the indirect language used to support its position. Although NARTH does not represent the entirety, or even the majority, of

psychological opinions, it is important to note that the majority of the 12 officers and board of directors are psychologists. Also, it is important to note that there is enough support within the community to sustain an organization like NARTH.

The psychological community has made great strides since the 1973 removal of homosexuality from the *DSM-II*. The Society for the Psychological Study of Lesbian and Gay Issues, Division 44 of the American Psychological Association, was founded in 1985. This organization proposes to contribute to LGB populations by: advancing basic and applied research, promoting education and training, promoting development and delivery of services, advancing public interest and welfare, and informing the general public about these areas.

In addition to Division 44, other divisions have created gay affirming subgroups. Division 17 of APA, the Society of Counseling Psychology, created the Section for Lesbian, Gay, Bisexual, and Transgender Issues. The goals of this society include: encouraging research, creating opportunities for networking and career development, and developing discourse between the psychological community and work and community leaders (American Psychological Association, Division 17, n.d.). The creation of the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns was another critical and significant contribution by APA. The goals of this committee include: studying and evaluating how issues and concerns of lesbian, gay male, bisexual, and transgender psychologists can best be dealt with; encouraging objective and unbiased research; and making recommendations to integrate lesbian, gay, transgender, bisexual, and questioning (LGTBQ) issues into the activities of APA (American Psychological Association Committee on Lesbian, Gay, Bisexual, and Transgender Concerns, 2014).

Another level of advocacy can be found at state-level psychological associations. An example is the New Jersey Psychological Association (NJPA), which offers resource groups--

one that is specifically for LGBTQ concerns. This group offers access to experts and is made available to the board, members, and staff of NJPA.

APA (2011) also offered guidelines for practice with LGB individuals These guidelines provide direction with regards to: "Attitudes Toward Homosexuality and Bisexuality," "Relationships and Families," "Issues of Diversity," "Economic and Workplace Issues," and "Education and Training [and] Research," (American Psychological Association, 2013). These APA guidelines are more comprehensive than the existing sexual orientation competence or gay affirmative therapy models, which generally look at knowledge, skills, and attitudes with some exceptions.

These national, divisional, and state organizations, as well as the guidelines provided from APA and a number of other counseling associations, highlight the affirmative direction in which the psychological community is moving.

Part of the importance of measuring sexual orientation competence is to understand if this is merely a facet of multiculturalism or a unique entity unto itself. If there is something unique about sexual orientation competence, it has implications for training and eventually for defining specialization in this area. From a general multicultural competence model, multicultural competence consists of knowledge, awareness, and skills (Arrendondo, 1999; Arrendondo et al., 1996; Israel & Selvidge, 2003; Kocarek & Pelling, 2003; Pedersen, 1988; Sue, Arrendondo, & McDavis, 1992). Additionally, the multicultural counseling relationship itself was identified as a fourth factor (Sodowsky, Taffe, Gutkin, & Wise, 1994).

The multicultural models and the three factors of skills, knowledge, and attitudes have been used to create models that measure sexual orientation competence. Fassinger and Sperber Richie (1997) suggested that existing models of multicultural competence set the stage for the

conceptualization of competence in working with LGB clients. This was utilized by Crisp (2006b) as a framework in the development of the Gay Affirmative Practice Scale (GAP). This measure was designed to assess cultural competence with gay and lesbian clients. An additional measure, by Bidell (2005), was developed to assess the attitudes, skills, and knowledge of clinicians who work with LGB clients. Although there is little literature about competence in working with LGB clients, these scales provide a means to begin an extremely important dialogue about the psychological practitioners' competence in this area. Assessments of social workers (Crisp, 2006a) and graduate students and supervisors (Bidell, 2005) have been conducted and provide a useful framework from which to begin this conversation. The importance of this assessment will also be discussed in the section on graduate training.

This chapter began with highlights of the pathologizing of LGB individuals. As was stated earlier, the DSM has only been truly free of diagnostic criteria for LGB individuals for 28 years. Although many psychologists view the 1973 removal of homosexuality from the DSM as the year the LGB population stopped being pathologized, additional diagnostic categories were added and subtracted up until 1987. From a social justice perspective, it can be suggested that the psychological community not only needs to work from this recent affirmative model, but it also needs to take a further step of advocacy in order to undo the very systems that it reinforced until 1994. There are two recommendations from the social justice literature that I would like to highlight. The first was offered by Green (2007): "Gay-affirmative therapy involves actively challenging society's negative attitudes towards homosexuality that are contributing to the problems" (p. 125). This suggests that in order for psychologists to be gay affirmative, they not only need to meet clients where they are, utilizing the necessary and sufficient conditions outlined by Rogers (1957), but take an active stance to undo the societal and institutional

heterosexism that the psychological community contributed to and learned from, and that it now must work tirelessly to rectify. The second point involves social justice in a more general light: as part of the work of psychologists as advocates: "Advocacy can take three forms: helping clients to advocate for themselves (i.e., empowerment), advocating directly with institutions or policymakers, or advocating indirectly through training or educating professionals" (Vera & Speight, 2007, p. 376). This point helps to understand the ways in which the role of psychologists can be utilized if they are attempting to be gay affirmative in a social justice lens. This research is necessary to further develop the core competencies of psychologists with regard to sexual orientation competence and to ensure that social justice is part of this competency.

Then, the chapter presented heterosexist undercurrents. Heterosexism, as with all biases, is pervasive and often is beneath our conscious awareness. Regardless of a psychologist's self-identified sexual orientation, heterosexism can impact his or her opinions and work. Green (2007) suggested that: "Didactic information is not sufficient to override unconscious prejudice that has been acquired over a lifetime" (p. 141). As this dissertation presents in Chapter II, exposure to LGB individuals contributes to gay affirmative competence. In Chapter II it is argued that exposure may be a necessary component to competence. Although this is not a new concept in the world of counselor education, LGB exposure may be more limited due to: (a) the unaware heterosexist bias of faculty that prevent exposing students to the topic, (b) the ability and choice of clients, acquaintances, and coworkers to choose not to disclose their sexual orientation, and (c) the fear of disclosing ones sexual orientation status to classmates. Programs often require attendance at 12-step meetings for substance use courses in order to expose students to the population. However, this same technique is not utilized to expose students to other populations. Often exposure is attempted within the classroom setting by encouraging

students to discuss their own diversity and by allowing the diversity within the classroom to provide exposure to individuals different from one's self. Due to the aforementioned fear of disclosure of sexual orientation, programs may need to find unique ways to allow for exposure to LGB populations during graduate training. This current study is necessary in order to provide recommendations to graduate training programs about how to better prepare students to become proficient in sexual orientation competence.

Then the chapter highlighted the affirmative direction of the psychological community. Although this chapter has already addressed some of the areas of social justice and advocacy necessary to be truly affirmative and competent with sexual orientation, a reminder of some of the ways in which to do this is necessary. This chapter highlighted some of the many organizations, chapters, and divisions of our professional organizations that support gay affirmative work. If psychologists are presenting themselves as competent in sexual orientation practice, it may behoove the clients and the psychologists who offer therapy to these clients to understand what sexual orientation competence entails. A basic search for clinicians in the New York City area resulted in 1621 therapists, with various levels of training, who identified themselves as having a specialty in "gay issues." This is a staggering number of clinicians to have truly specialized in this area. Consumers must be overwhelmed with how to choose a truly competent clinician. Psychologists may want to ask themselves in what way they have adhered to the ideas of competent practice outside of simply accepting LGB clients into their practice. Are psychologists engaging in the available organizations that promote sexual orientation competence? The current research is necessary to understand if psychologists with higher levels of certain variables (to be identified later in the dissertation) are more competent than those who do not score higher on these same variables.

Finally, the chapter addressed gay affirmative practice as a part of multiculturalism. Some authors have considered whether sexual orientation competence is part of a larger multicultural lens: "As such, multicultural counseling would include not only racial and ethnic minorities, but also women, gays and lesbians, and other special populations" (Sue, Arredondo, & McDavis, 1992, p. 478). Fassinger and Sperber (1997) suggested that the framework of multiculturalism provides a template from which to explore sexual orientation competence. This research is necessary to understand if general multicultural competence is sufficient to produce psychologists that are competent in the area of sexual orientation.

Limitations of Existing Studies

There is very little empirical research on LGB individuals and their experiences of therapy (Pachankis & Goldfried, 2004) or counselor competency with LGB individuals (Perosa, Perosa, & Queener, 2008). Therefore, there is very little information about how clients are receiving therapy or about what counselor competence is with regards to this population. Additionally, some articles exist that offer theoretical ideas of how to work with LGB individuals and, more specifically, how to provide competent practice with this population. A thorough examination of the literature revealed some research that assessed the competence of students and supervisors with LGB individuals (Bidell, 2005; Graham, 2009; Rutter, Estrada, Ferguson, & Diggs, 2008). This limitation in the research suggests a reticence to conduct research in this area or a reservation to question the competence of psychologists in this area. Based on this limitation, there is currently no data that provide statistics of psychologists' competence in sexual orientation.

Research Question

This study examined the following research question: What are the unique contributions of the predictor variables: exposure to persons of sexual minority status, training experience in sexual minority populations, perceived multicultural competence, and engagement in sexual minority specialization and practice to the criterion variable perceived sexual orientation competence within U.S.-licensed psychologists?

Statement of Hypotheses

This study assessed the following five hypotheses:

- Hypothesis 1: Psychologists who report greater exposure to individuals of sexual minority status will have a significantly greater level of perceived sexual orientation competence.
- Hypothesis 2: Psychologists who report greater training experience with sexual orientation will have a significantly greater level of perceived sexual orientation competence.
- Hypothesis 3: Psychologists who have a greater level of perceived multicultural competence will have a statistically greater level of perceived sexual orientation competence.
- Hypothesis 4: Psychologists who have greater level of engagement in sexual minority specialization and practice will have a statistically greater level of perceived sexual orientation competence.

- Hypothesis 5: Exposure to persons of sexual minority status, training experience in sexual minority populations, perceived multicultural competence, and engagement in sexual minority specialization and practice will each have significant contributions to the dependent variable perceived sexual orientation competence.

Operational Definitions

This section defines the words directly related to this study. While in other areas the meaning of these terms could vary slightly, the definitions provided here are for the current study.

Heterosexism

Heterosexism is a system by which "heterosexuality is assumed to be the only acceptable and viable life option" (Blumenfeld & Raymond, 1993, p. 224). The term *heterosexism* is being utilized to encompass both heterosexism and homophobia, and it is considered a broader term for research purposes (Herek, 1994; Kite & Whitley, 1996). However, it should be noted that the type of stress associated with these forms of bias may be qualitatively different, and counselors would be well served to understand the extent of the sexual orientation competence that they are bringing to the counseling environment. To remain consistent with the existing literature, heterosexism will be utilized for the remainder of the paper.

Heteronormative

Heteronormativity is the unquestioned and largely unconscious assumption that everyone living in the society is heterosexual or should be (Rothblund & Bond, 1996).

Heterocentrism

Heterocentrism is the presumption of heterosexuality as the only normal sexual identity and behavior (Bieschke, et al., 2007).

Homophobia

Homophobia does not have an agreed upon definition in the literature, but the DSM provides criteria of a phobia being an irrational fear of homosexuality (American Psychiatric Association, 2013).

Exposure to Persons of Sexual Minority Status

Exposure to persons of sexual minority status is defined as the calculated score on the demographic questionnaire. A higher score will mean greater exposure to individuals of sexual minority status.

Training Experience in Sexual Minority Populations

Training experience in sexual minority populations is defined as the calculated score on the demographic questionnaire. A higher score will mean more training experience with sexual minority populations.

Multicultural Competence

Multicultural competence measures skills, attitudes, and knowledge (Arrendondo et al., 1996; Arrendondo et al., 1999; Arrendondo & McDavis, 1992; Israel & Selvidge, 2003; Kocarek & Pelling, 2003; Pedersen, 1988; Sodowsky, Taffe, Gutkin, & Wise, 1994; Sue, Arrendondo, & McDavis, 1992). Multicultural competence is defined as the score on the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002). A higher score on the MCKAS will suggest a higher level of self-reported multicultural competence. It should be noted that the MCKAS primarily assesses competence in working with racial and ethnic minorities.

Engagement in Sexual Minority Practice

Engagement in sexual minority practice is defined as the calculated score on the demographic questionnaire. A higher score will suggest greater engagement in sexual minority practice. This variable is not standardized and will be calculated as a continuous variable.

Sexual Orientation Competence

Sexual orientation competence is defined as the score on the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005). A higher score on the SOCCS suggests a higher level of self-reported sexual orientation competence.

Gay Affirmative Therapy

Gay affirmative therapy is defined as competence with gay and lesbian individuals. This term will be utilized specifically for studies that looked at gay affirmative therapy or studies that limited their target population to gay and lesbian individuals.

Summary

This chapter presented an overview of the history and status of the relevance of sexual orientation in the psychological community and the approach of the community to pathologizing or accepting sexual orientation diversity. Existing heterosexist approaches to sexual orientation diversity were discussed as the concurrently existing opinion to affirmation of sexual orientation diversity. The chapter presented the affirmative directions of the psychological community and the supports that exist within that community to assist with the continued efforts of affirmation of sexual orientation diversity. Due to the existing discrepant opinions about the pathology of diverse sexual orientations, it is important for research to extend the guidelines APA has set forth for working with LGB individuals by exploring what is happening in professional practice. More specifically, it is crucial to understand if and how the psychological community is utilizing

affirmative practices and working within a competent model across diverse settings and across the country.

The argument regarding sexual orientation as a form of multicultural competence was addressed, and questions were raised as to the appropriateness of including sexual orientation competence within a larger multicultural framework. Due to the evolving nature of competence frameworks, it is necessary to conduct research to determine if these two constructs (multicultural counseling competence and sexual orientation competence) are related and, if so, in what ways. Since there has been some research that suggests exposure to LGB individuals increases competence, exposure may need to be a factor that is considered when determining competence. If exposure to LGB individuals is found to be a significant factor, the sexual orientation competence model would need to be adjusted to reflect this difference from the multicultural models that utilize primarily knowledge, skills, and attitudes. This becomes quite important as the current methods of assessing sexual orientation competence and gay affirmative therapy competence are derived from the larger multicultural competence literature. Although some measures may assume that exposure to LGB populations exists, this study will help to determine if we need to develop measures specific to exposure. Due to the national focus of this survey, it was assumed that exposure to persons different from one's self varied geographically for a myriad of reasons.

The practice of professional psychology has been moving toward a competency-based model to understand the domains in which psychologists, and more specifically psychologists in training, have competency and qualifications to work as psychologists, and more specifically, in what areas (Fouad et al., 2009, p. S6). This study will further our understanding of sexual orientation competence and potentially lead to further revisions of the measurement of sexual

orientation competence. It is necessary for us to have the most theoretically solid and scientifically sound measures to assist in the movement toward competency-based measurement and practice.

Finally, the importance of sexual orientation competence is central as an increasingly diverse presentation of LGB client concerns is presented to psychologists. Some of the specific issues that may present themselves to psychologists include: LGB-identified military service persons or soldiers returning from duty; an increasing population of aging LGB individuals potentially struggling in areas like assisted living, health care, or living a closeted life; and rapidly changing formats for couples and family therapy, which now incorporates federal recognition of marriage and laws never before having pertained to LGB individuals. For this reason it is extremely important that we continue to refine our conceptualization of sexual orientation competence

Chapter II

REVIEW OF THE LITERATURE

Introduction

This chapter reviews the existing literature relevant to understanding sexual orientation competence. Specifically, the chapter reviews the literature in which sexual orientation competency has been conceptualized as a part of multicultural therapy. The chapter also includes an examination of the literature that suggests that gay affirming therapy may be a unique conceptualization that may not be encompassed in multicultural therapy. This was the basis for adding exposure, training, and specialization to this study, as the existing literature suggests that these may be important factors. Literature specific to psychologist competence in multicultural therapy, sexual orientation competency, and gay affirmative therapy are reviewed. This review shows the ways in which competency has been measured in these domains, and it identifies the current voids in the literature and how this study addressed some of these areas.

The psychological community has embraced a drive toward competency across all phases of training and education (American Psychological Association Task Force on the Assessment of Competence in Professional Psychology, 2006). There is substantial literature in this area, as well as in those of consultation, practice, research, and training. Additionally, there is substantial research in the area of multicultural competence. However, the research in sexual orientation competence is a fairly new development and, as such, is limited in its scope in comparison to other domains. This research included the existing relevant empirical research, but also considered conceptual material; as the construct of sexual orientation competency is conceptual. Including theoretical work permitted questioning of underlying theories to better determine if researchers are empirically measuring what they are intending to in their scientific pursuits.

Lesbian, Gay, and Bisexual Individuals

As part of the general knowledge necessary to work with LGB individuals, it is necessary to understand some basic information. It is quite difficult to determine exactly how many individuals in the US can be considered LGB. First, the way LGB identity is measured can consist of assessing self-identification, behaviors, or both. Second, it is likely that data is underreported due to the risk inherent in disclosure of sexual minority status in a predominately heterosexual and sometimes heterosexist society. Inevitably, questions are raised that make the issue even more complicated. At what level is same-sex sexual exploration part of normal development and at what point does it become part of a LGB identity? How does research account for individuals who do not adhere to the limited definitions for sexual orientation identities that are utilized in the US? In what ways can research statistically recognize individuals who do not yet self-identify as LGB, but may be in a process of sexual orientation identity development? These questions make this type of assessment extremely difficult. Regardless, some attempts have been made to estimate the number of LGB individuals in the US (Gates, 2011; Gebhard, Kinsey, Martin, & Pomeroy, 1953; Kinsey, Pomeroy, & Martin, 1948;). The most notable was done by Alfred Kinsey et al. (1948). This research found that gay men were approximately 4 to 10 % of the population, depending on the exclusivity of their behavior (Kinsey, Pomeroy, & Martin, 1948). They also suggested that lesbians comprised approximately 1 to 6 % of the population, depending on the exclusivity of their behavior (Gebhard, Kinsey, Martin, & Pomeroy, 1953). There has been much controversy over the Kinsey methods, and this is not addressed in the present research. However, I recognize and respect that Kinsey is one of the researchers that made this discussion even possible.

Since Kinsey, other attempts have been made at quantifying the number of LGB individuals in the population. The most recent and largest survey of LGB individuals was

conducted by The Williams Institute at the UCLA School of Law. This research sought to understand LGBT individuals. Since transgender is a gender identity and not a sexual-orientation identity, it has not been included in the present research. Therefore, the data from the present study is considered only a rough estimate of sexual orientation competence among licensed psychologists in the US. Regardless, the Williams Institute study used responses from 121,290 individual answers to their poll (Gates, 2011). This study looked specifically at individuals who self-identified as LGBT. The findings were that, of a sample representative of Americans, 3.4% of individuals identified as LGBT. More specifically, White individuals (3.2%) were less likely to self-identity as LGBT than Persons of Color (4.6% of African Americans, 4.3% of Asians, and 4.0% percent of Hispanics). Contrary to Kinsey's findings, women were more likely to identify as LGBT than men, 3.6% and 3.3% respectively. There also appeared to be a cohort difference in self-identification, with 6.4% of individuals between 18-29 years of age endorsing LGBT identity, 3.2% of individuals between 30-49 years of age endorsing LGBT identity, 2.6 % of individuals between 50-64 years of age endorsing LGBT identity, and 1.9% of individuals 65 years and older endorsing LGBT identity. This finding highlights the potential cohort effect of temporal attitudes of LGBT identity and their impact on self-identity (Gates, 2011).

It should be repeated that these data are rough estimates, and that accurate statistics of LGB individuals living in the US are likely to be impossible given the continued heterosexist attitudes that permeate U.S. culture. Additionally, it is only in recent years that there have been federally funded studies in the US that looked at sexual orientation status.

Psychological Impact of Heterosexism

Frost and Meyer (2009) discussed internalized homophobia. It should be noted here that in the present study, the term *heterosexism* is utilized when possible, and it is inclusive of

homophobia. However, with respect to particular articles, the language utilized by the authors will be matched. In their 2009 article, Frost and Meyer, conceptualized the experience of homophobia as a minority-stress model: "Stress theory posits that stressors are any factors or conditions that lead to change and require adaptation by individuals" (p. 2). This stress theory would suggest that individuals that face minority stress have stressors that are additional to those of majority individuals. This would be complicated enough if the individuals were White and did not have to face additional minority stressors. However, given the diversity of individuals it is common that individuals face multiple minority stressors. Referring back to the Gates (2011) research found that Persons of Color were endorsed LGBT identity at greater levels than Whites. This may suggest an increase in stressors related to multiple minority statuses. Specific results of a sample population of LGB individuals, including Persons of Color, were found with regard to symptomatology: "Internalized homophobia was associated with increased depressive symptoms, and increased depressive symptoms were associated with increased relationship problems" (Frost & Meyers, 2009, p. 104).

Kamen, Burns, and Beach (2011) also utilized a minority stress model when discussing LGB individuals: "A minority stress model has been advanced to describe the chronic anxiety and vigilance LGB individuals can experience as a result of their minority status" (p. 5). This research examined interpersonal, intrapersonal, and vocational stress. In regards to vocational stress, the researchers found that sexual orientation-related stress at work negatively impacted mental health and job satisfaction: "LGB individuals reporting heterosexist discrimination in the workplace, both directly (e.g., through anti-gay jokes) and indirectly (e.g., through assumptions of heterosexuality) report more depression, health problems, psychological distress, and job dissatisfaction" (Kamen, Burns, & Beach, 2011, p. 1374). However, unlike Frost and Meyers

(2011), the impact on romantic relationships was found to be less severe: "There was no evidence that minority stress constructs directly impact relationship satisfaction" (Kamen, Burns, & Beach, 2011, p. 1385).

It can be seen from the research that the minority stress associated with LGB identity, LGB identity management, and heterosexist environments is associated with psychological symptoms. This is one of the reasons that it is crucial to further research this area. Continued research will help clinicians and other researchers to better understand the stressors experienced by LGB individuals, to conduct future research to further understand this, and to develop culturally appropriate treatment for these individuals. Additionally, these findings may provide data regarding assumed heterosexuality and its negative consequences. These same negative consequences could play out in a therapeutic dyad actually contributing to the clients' concerns instead of working to help them.

Client Experience with Therapy

There is value in understanding the experience of therapy for LGB clients. Mair and Izzard (2001) conducted qualitative interviews with 14 gay men to better understand their experiences in therapy. The general findings were that therapy was helpful, but was lacking in the exploration of their LGB identities. This does not suggest that the individuals would have necessarily benefited from exploring this; it simply means that the participants felt that this part of their identity was silenced or ignored. Lebolt (1999) also conducted a qualitative study looking at the qualities of a therapist to whom LG individuals responded positively. The finding suggests that sensitivity, imagination, and experience were qualities that led to greater levels of perceived gay affirmative approach, according to the patients. Imagination and experience go hand-in-hand, as the competent therapist is not only able to accept a client's LGB identity, but is

also able to be so in touch with the experience of being a gay man that they are able to feel what the client is stating using "imaginative empathy" (Lebolt, 1999, p. 362). It was also suggested that LGB-identified clinicians serve additionally as role models for clients. Self-disclosure of therapists was positively viewed by clients overall.

These findings encourage researchers to question our conceptualization of what constitutes a gay affirmative therapist or a therapist that demonstrates sexual orientation competence. When researchers consider variables like competence, research needs to return to the three factors of multicultural therapy that led to the creation of sexual orientation competence, to determine if our current models are comprehensive enough to measure affirmative practice by psychologists.

Multicultural Therapy as Gay Affirmative Therapy

As is seen in the section on sexual orientation competence, this area of research is only 9 years old at the time of this writing. Sexual orientation competency can be argued as an extension of the earlier writings on gay affirmative therapy. Gay affirmative therapy may be considered an outgrowth of the earlier writings of multiculturalism that conceptualized sexual orientation as a possible element of multicultural therapy. Until the latter 1980s, writing regarding LGB individuals focused on pathology or issues in working with this population. In essence, the majority of authors separated LGB individuals as a distinct population. Another assumption in many of these writings was that sexual orientation was either the only, or the most salient, identity for the clients. However, in the late 1980s, there was an area of research looking at early ideas of gay affirmative therapy (Langdridge, 2007). Buhrke (1989) made a radical suggestion to incorporate LG individuals into multicultural training: "Lesbian women and gay men should be included among the various minority groups identified and studied. In addition, historical events, the politics of the lesbian and gay movement, and the background of these

groups should be presented" (p. 69). Since this suggestion, many authors have recognized LG or LGB individuals as part of their conceptualization of multiculturalism (Arredondo, 1999; Lowe, & Mascher, 2001; Ponterotto, Casas, Suzuki, & Alexander, 2009; Pope, 1995; Sue, Arredondo, & McDavis, 1992). The common theme in these writings is that LGB identities are a minority status just like other minority groups, such as Blacks, Hispanics, and Asians.

Gay Affirmative Therapy: A Unique Conceptualization

Although gay affirmative therapy is a fairly recent term, several authors (Johnson, 2012; Langridge, 2007; Pachankis & Goldfried, 2004) have attempted to define what is meant by gay affirmative therapy. The range of what constitutes gay affirmative therapy is quite wide and can leave the reader with as many questions as it does answers. This chapter shows that there are many ways to interpret gay affirmative therapy. Langridge (2007) provided a look at gay affirmative therapy and wrote directly about one of the salient issues that define it. In referencing some of the major gay affirmative researchers and writers, he stated: "None of them specifically advocate significant theoretical and/or technical modifications to the therapeutic process. Instead authors highlight the many problems that resulted in poor practice with LGB clients" (Langridge, 2007, p. 30). However, at least one author has taken a more direct stance as to what gay affirmative therapy is: "Gay affirmative therapy is an approach used by psychotherapists to show understanding, to demonstrate cultural competence, and to create a positive therapeutic alliance" (Johnson, 2012, p. 519).

One of the concerns in some writings on gay affirmative therapy is that a focus on sexual orientation may hinder clients' abilities to discuss concerns that they do not feel are related to their sexual orientation: "It is important for us as therapists to recognize that an LGB client's problems are not necessarily intrinsic to his or her sexual orientation. Instead, in working with

LGB individuals, we need to understand that LGB clients' problems may arise as the result of society's negative reaction to nonheterosexual orientations" (Pachankis & Goldfried, 2004, p. 229).

Although many of the aforementioned recommendations are helpful guidelines, research is still left with the question: What is gay affirmative therapy? The first thing that all psychologists should be aware of is the existence of *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* established by the APA (2012), as it "provides psychologists with (1) a frame of reference for the treatment of lesbian, gay, and bisexual clients and (2) basic information and further references in the areas of assessment, intervention, identity, relationships, diversity, education, training, and research" (p. 1). This document provides 21 guidelines for working with LGB clients to help ensure that psychologists adhere to professional practice standards, and provide ethically and culturally sensitive work. However, the justification for the guidelines can be found in the original document (American Psychological Association, 2012). The APA guidelines are divided into 6 categories including: attitudes towards homosexuality and bisexuality, relationships and families, issues of diversity, economic and workplace issues, education and training, and research.

The APA guidelines are quite comprehensive and provide a way of self-assessing one's abilities to work with LGB individuals. Future scale development efforts should consider aligning competence scales with these APA requirements. This would allow for psychologists to be assessed in their competencies in skills, knowledge, and attitudes, as well as the APA guidelines.

From a theoretical, conceptual, and practical perspective, Ritter and Terndrup (2002) provided an interesting and perhaps one of the most useful tools to conceptualize work with LG

individuals. Their model began with a framework constructed from gay and lesbian identity development models (Cass, 1984; Coleman, 1982; Grace, 1979; Troiden, 1988; Weinberg, Williams, & Pryor, 1995) to develop what they referred to as a "phase-specific psychotherapeutic intervention" (p. 169). This model takes the identity development framework and divides it into five phases of development. Within each phase are common client behaviors. These client behaviors are aligned with psychotherapeutic interventions that are suggested to be gay affirmative. Although this model has not been empirically tested, it provides one clear framework for how to work with LGB individuals. It should be noted that although the title of the text is, *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men* (Ritter & Terndrup, 2002), the model in the Ritter and Terndrup book is inclusive of bisexual individuals. By separating the phase of identity development, Ritter and Terndrup (2011) provide a framework that allows for constant and fluid assessment of what phase an individual is in, and that provides interventions for each stage. Again, this model has not been empirically tested. However, other models, like Motivation Interviewing (Miller & Rollnick, 2012), that have used phase appropriate models with great success. Thi is not to suggest that this would be the case with the Ritter and Terndrup (2011) model. However, there are other models that lend themselves to the theoretical underpinnings of this particular model. Additionally, this model provides a lens from which to consider how identity development may be one factor happening for a client and can be layered on to other modalities for non-identity related problems.

Facilitating Community Connection and Therapist Disclosure

Exposure to LGB individuals who can potentially become role models or representatives for the psychological community is an important part of gaining competence in gay affirmative therapy—and it is also paramount for those in therapy as it can play a role in helping them as

they seek to solidify their identities (Crisp & McCave, 2007; Harrison, 2000; Pachakis & Goldfried, 2004). In terms of working with clients, contact with positive LGB role models can contribute greatly to a client's resilience by promoting positive self-esteem and a supportive environment (Crisp & McCave, 2007, p. 405). This may require psychologists to be familiar with resources to help the client develop a specific social network that facilitates support and self-esteem. Additionally, there can be a great benefit to having a counselor who self-identifies as gay. Harrison (2000) stated that gay clients could benefit from having gay counselors "self-disclose their sexual identity and act as positive role models" (p. 39). This added benefit is two-fold as it may provide clients with the support, understanding, and empathy that they need: "Disclosure of the gay therapist's sexual orientation early in treatment appeared to help the participant feel accepted and understood" (Lebolt, 1999, p. 365). Also, it can affirm that "LGB individuals can live successful, fulfilling lives" (Pachakis & Goldfried, 2004, p. 237). This statement on disclosure should be considered with caution as is presumes that a positive message is conveyed to the client. Regardless, contact with a LGB individual who is confident and has traversed a number of obstacles that an individual client is facing can give him or her the assurance that the or she can conquer the same obstacles.

Even limited contact with other LGB individuals, such as through telephone helplines, has been found to provide great support and increase resilience as callers, "often find their call is answered by someone who has had similar experiences and can provide genuine compassion and affirmation of their experiences" (Crisp & McCave, 2007, p. 405), while, at the same time, helping callers find the resources they need to address their concerns. This can be an important aspect for those callers who are seeking not only help for concerns, but a connection to the LGB community; which gives them the added benefit of exposure. According to Crisp and McCave

(2007), having some sort of forum or space in order to connect to such individuals, such as support groups, provide "opportunities for support, socialization, information exchange, and education and contribute to heightened self-esteem" (p. 406). Support groups also help participants reduce shame and alienation (Fassinger, 1991, p. 170). Providing people with an opportunity to be exposed to other LGB individuals increases their knowledge of the community as a whole, thereby allowing them to enhance their knowledge of themselves.

Competence in Multicultural Therapy

Chapter III includes a discussion of the instruments selected for this study. Multicultural competence continues to be a critical concern in psychology. Many of the research studies in this area have utilized competency instruments that are based on the tripartite model of counseling (Sue, Arredondo, & McDavis, 1992). The Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991) was designed for supervisors to use to assess their supervisees' competence. The Multicultural Awareness Knowledge Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991) was revised in 2003 to become the Multicultural Awareness Knowledge Skills Survey-Counselor Edition-Revised (MAKSS; Kim, Cartwright, Asay, & D'Andrea, 2003). Both of these instruments assess knowledge, skills, and attitudes. However, the 1991 MAKSS scale may be dated in regards to current standards of multiculturalism, and the 2003 scale lost more than two-thirds of its predictability in its revision, and it is suggested that it is not a comprehensive measure (Kim, Cartwright, Asay, & D'Andrea, 2003). The Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994) consists of four scales: multicultural awareness, knowledge, skills, and multicultural counseling relationship. Due to the date of the original research this instrument may not match current multicultural counseling competencies. The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) is a revision of

the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996). The final MCKAS was selected for the present study and it is discussed in detail in Chapter III.

Competence in Gay Affirmative Therapy

Gay affirmative therapy or sexual orientation competence is a relatively young field in psychology. The current models of gay affirmative therapy are heavily based on models of multicultural competence and largely look at skills, knowledge, and attitudes: "[Multicultural] competence has been understood to include three overlapping areas: knowledge, awareness (counselor's own values and biases and client's world view), and skill/intervention strategies" (Kocarek & Pelling, 2003, p. 100). Israel and Selvidge (2003) suggested that the development or consideration of competencies in working with LGB clients would benefit from the framework established in the multicultural counseling literature. For example, the knowledge domain has included elements such as networks, lifestyle, homophobia, heterosexism, and therapeutic goals (Koracek & Pelling, 2003). Bidell (2005) suggested that the knowledge domain consist of mental health issues specific to LGB individuals. Crisp and McCave (2007) suggested that knowledge consist of terminology, demographics and diversity, symbols, historical dates, contemporary figures, experiences with oppression and policies that impact LGB youth, community resources, culturally sensitive practice models, coming out models, and identity as a LGB person.

Appleby and Anastas (1998, p. 36) identified several important ideas for gay affirmative practice. They are:

1. Avoid assuming that a client is heterosexual.
2. Sexual orientation is not the problem, but rather societal and client homophobia.
3. A positive outcome of the therapeutic process is the acceptance of an identity as a gay, lesbian, or bisexual person.

4. Decrease internalized homophobia and increased positive gay or lesbian identity.

5. Be fluent in the models for gay and lesbian identity development.

6. Be aware of your own homophobia and heterosexual bias.

At the time if this writing there is only one measure, by Crisp (2006a) that looks at gay affirmative therapy from a perspective that is consistent with--but not identical to-- the tenets of multicultural therapy. This measure includes two factors: behaviors and beliefs. The instrument has a total of 30 items (15 items for each factor) with a Cronbach's alpha of .95. This instrument is not valid for the assessment of work with bisexual individuals. Items in the instrument ask specifically about work with gays or lesbians. Mohr, Weiner, Chopp, and Wong (2009) found that bisexual individuals are at risk from clinician bias, in some cases, to a greater degree than lesbians and gay men. Although the instrument is psychometrically sound, it was not chosen for the present research because the factors are not consistent with existing multicultural frameworks, and this would complicate the relationship between instruments. Also, it was decided that bisexuals would be included in the sample for the present study, since they are also at risk for heterosexist treatment bias. As the instrument is designed for LG individuals and not for LGB individuals, it was not selected for this particular study. These two factors--it being inappropriate for use with bisexual persons and the lack of the three specific factors of competence--made it a poor fit for this study as it would not be able to be statistically compared to a general multicultural competence measure that adheres to these three factors.

Crisp (2006b) conducted a study that examined the difference between social workers and psychologists with regard to gay affirmative practice and homophobia. Although no significant difference was found between the two groups, it is informative to summarize the data on psychologists as reported in this study. The results indicated that only 59% of psychologists

were categorized as "most gay affirmative" in her sample (Crisp, 2006a). Another lens may be that over 40% of psychologists did not meet the criteria for the "most gay affirming" (Crisp, 2006a, p. 119). This would suggest that there is still work to do in the psychological community in terms of training and practice.

Sexual Orientation Competence

As previously mentioned, for this study sexual orientation competence is conceptualized as inclusive of bisexual individuals. In other words, sexual orientation competence should measure competence working with LGB individuals, as all three of these identities are at risk for heterosexist counseling environments. There is only one current instrument that measures sexual orientation competence that is consistent with the multicultural domains of knowledge, skills, and attitudes. This scale is the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005).

A major weakness of the SOCCS is that graduate students served as the reference norm group—although, this is a common sampling approach within the development of the multicultural counseling assessments. In fact, it can be argued that Bidell followed the established standards in developing the SOCCS. In the present study, the SOCCS was used to assess psychologist competence in working with non-heterosexual orientations.

Exposure to LGB Individuals

Although the areas of sexual orientation competence and gay affirmative therapy are relatively new, there have been some findings that suggest that contact with LGB individuals increases clinician competence. Crisp (2012) found that for clinicians, both the number of gay friends and the number of gay clients they had were positively correlated with gay affirmative practices. It is for this reason that exposure to gay men and lesbians through clinicians' personal

social networks and/or professional practices served as a predictor variable in this study to determine if the findings are consistent with Crisp (2012).

Godfrey, Haddock, Fisher, and Lund (2006), who studied participants who were chosen because of their expertise in LGB topics, argued that "allowing students to interact with panels of LGB persons would be critical" (2006, p. 500) to their learning process. In that study, the participants were asked to rate a variety of topics as to their importance for gaining competence in working with the LGB population. Exposure to, and contact with, LGB individuals was one of the topics the participants stressed, and it included themes such as: "the importance of getting to know LGB persons as opposed to LGB places or products. Being in relationships with LGB colleagues, friends, or coworkers and speaking with other LGB healthcare professionals were both items that received high ratings" (Godfrey et al., 2006, p. 498). The findings from both Godfrey et al. (2006) and Crisp (2012) suggest that it is crucial to overcome biases through first-hand interaction with LGB individuals. In order to become gay affirmative, one must have exposure, contact, and sustaining relationships with LGB individuals, as this can help challenge a counselor's deficient attitudes and beliefs.

In regards to training future counselors, one of the key components of gay affirmative therapy is what was termed by Godfrey et al. (2006) as, "self-of-the-therapist" work—which is, essentially, a therapist working on himself or herself to identify and acknowledge his or her own shortcomings, prejudices, and lack of expertise in working with certain populations. Part of the self-of-the-therapist works involves gaining an "awareness of one's self [which] may include a very personal exploration of one's own sexual orientation and beliefs about GLB people" (Kocarek & Pelling, 2003, p. 102). This exploration is important to gay affirmative competence as a whole, especially when working with clients to help them solidify their identities. A

counselor cannot effectively provide therapy to a client when he or she has hidden biases that can hinder them from truly empathizing with the client. Exposure to LGB individuals becomes vital here; as exploring one's potential biases and attitudes about the LGB community requires that psychologists gain experiential knowledge, which may challenge their belief systems.

Summary and Conclusion

This literature review has brought together empirical, theoretical, and conceptual writings in a discussion of sexual orientation competence and gay affirmative therapy. The review began with current statistics about the LGB community. Although these statistics are far from accurate, they provided a rough estimate of the population. These statistics are quite important when considering the likelihood of psychologists working with LGB individuals. When considering the statistics, it is especially important to keep in mind the sampling limitations. Due to the risks and processes involved in coming out, it is quite possible that a psychologist may work with a LGB client who does not reveal his or her sexual orientation. Sexual orientation competent practices by all psychologists may assist in creating therapeutic environments that are more welcoming to LGB clients even if the therapist does not know the client's sexual orientation.

The review presented the psychological impact of heterosexism. The literature suggests that there are a number of negative symptoms associated with heterosexism. The chapter provided an argument that questioned if we are recreating this normative environment in the therapeutic dyad. The lack of empirical research on sexual orientation competence suggests that the field of psychology is currently unaware of the level of competence among psychologists. If clinicians are not working within this competence, they may be inadvertently reinforcing heterosexist environments and norms.

Gay affirmative therapy and sexual orientation competence are considered within a larger multicultural competency focus, while yet being a unique and distinct domain under such umbrella. The importance of adhering to the APAs 2011 LGBT guidelines and recommended approaches to gay affirmative therapy and sexual orientation competence is paramount for ensuring competence in this area among psychologists and those in training. The research shows that there is a lack of empirical research addressing sexual orientation competence, and there is no research addressing sexual orientation competence among psychologists.

Finally, a discussion of exposure to the LGB population as a potential variable necessary to provide competent work was provided. Exposure to the LGB populations has not been incorporated into existing models; therefore, it is necessary for this research to incorporate this factor in order to determine how it is related to sexual orientation competence.

Chapter III

METHODOLOGY

Introduction

This study sought to understand psychologists' competence in gay affirmative therapy. Furthermore, the study sought to understand if psychologists' competence in multiculturalism and exposure to LGB individuals were related to their competence in gay affirmative therapy. It has been estimated that there are 9 million people in the United States that identify as lesbian, gay, or bisexual (Gates, 2011). However, as discussed by Gates (2011), there are difficulties inherent in obtaining accurate statistics regarding lesbian, gay, bisexual, and transgender individuals. With this in mind, it should be noted that the figure presented here is a rough estimate. Regardless, with an estimated 9 million people identifying as LGBT, it is likely that psychologists will work with lesbian, gay, or bisexual clients during their careers.

This chapter presents the participants in the present research, the data collection methods, the administration of the research survey, the psychometric properties of the instruments that were utilized in the research, the research design and related statistical analyses, as well as the power analyses for these statistical procedures.

Study Design

This study was a non-experimental correlation and multiple regression design. Statistical analyses were performed using the Statistical Program for Social Sciences (SPSS) Version 18.0 (2009). Participation in the study meant the completion of instruments via an online survey program titled ASSET Programming (2011). The online survey consisted of the demographic information, SOCCS, and the MCKAS. The approximate time to complete the survey was 30

minutes. The study was anonymous and the consent to participate was marked by the completion of the online survey.

Target Population

The purpose of this dissertation was to assess the perception of psychologists' competence to work with LGB individuals. The target population for this research was licensed, practicing psychologists across the United States. The study determined the known exposure of participants to persons identified as LGB, their training specific to working with LGB individuals, and their self-assessed perception of competence in both multiculturalism and sexual orientation.

Research Questions

This study examined the following research question: What are the contributors of the independent variables: (a) exposure to persons of sexual minority status, (b) training experience in sexual minority populations, (c) perceived multicultural competence, and (d) engagement in sexual minority specialization and practice to the dependent variable perceived sexual orientation competence within U.S. licensed psychologists?

Research Hypotheses

The following hypotheses were proposed for the research question.

- Hypothesis 1
    - Participants who report greater exposure to individuals of sexual minority status will have a significantly greater level of perceived sexual orientation competence.
- Hypothesis 2
    - Participants who report greater training experience with sexual orientation will have a significantly greater level of perceived sexual orientation competence.

- Hypothesis 3
    - Participants who have a greater level of perceived multicultural competence will have a statistically greater level of perceived sexual orientation competence.
- Hypothesis 4
    - Participants who have greater level of engagement in sexual minority specialization and practice will have a statistically greater level of perceived sexual orientation competence.
- Hypothesis 5
    - Exposure to persons of sexual minority status, training experience in sexual minority populations, perceived multicultural competence, and engagement in sexual minority specialization and practice to the dependent variable perceived gay affirmative competence will each have significant contributions to perceived sexual orientation competence.

Power Analyses

Power analyses were done to determine the sample size necessary to obtain significant or meaningful results. The likelihood of predicting significance, effect, in an analysis is defined as the statistical power (Witte & Witte, 2008). G-Power (Faul, Erdfelder, Lang, & Buchner, 2007) was utilized to obtain the power analyses.

Hypothesis 1

In order to have meaningful and interpretable outcomes, a power analysis was conducted. Exposure to LGB individuals was entered as the predictor variable and level of sexual minority competence as the criterion variable. This was tested using a correlation. A sample size of 67

was required to complete this analysis. This was determined utilizing an effect size of 0.30 and power of 0.80.

Hypothesis 2

In order to have meaningful and interpretable outcomes, a power analysis was conducted. Experience with LGB individuals was entered as the predictor variable and level of sexual minority competence as the criterion variable. This was tested using a correlation. A sample size of 67 was required to complete this analysis. This was determined utilizing an effect size of 0.30 and power of 0.80.

Hypothesis 3

In order to have meaningful and interpretable outcomes, a power analysis was conducted. Perceived multicultural competence was entered as the predictor variable and level of sexual minority competence as the criterion variable. This was tested using a correlation. A sample size of 67 was required to complete this analysis. This was determined utilizing an effect size of 0.30 and power of 0.80.

Hypothesis 4

In order to have meaningful and interpretable outcomes, a power analysis was conducted. Engagement in practice with LGB individuals was entered as the predictor variable and level of sexual minority competence as the criterion variable. This was tested using a correlation. A sample size of 77 was required to complete this analysis. This was determined utilizing an effect size of 0.30 and power of 0.80.

Hypothesis 5

In order to have meaningful and interpretable outcomes, a power analysis will be conducted. Exposure, experience, multicultural competence, and engagement in practice with LGB individuals were entered as the predictor variables and level of sexual orientation competence as the criterion variable. This was tested using a multiple regression. A sample size of 45 was required to complete this analysis. This was determined utilizing an effect size of 0.30 and power of 0.80.

Variables

Predictor Variable 1: Exposure

The variable, exposure to persons of sexual minority status, was assessed using the following indicators:

1. immediate family (someone in the family of sexual minority status),
2. friends of sexual minority status,
3. coworkers of sexual minority status; and
4. occupational history that includes working with persons of sexual minority status.

This variable, exposure to persons of sexual minority status, had four questions that are part of the demographic questionnaire. These questions were calculated to obtain a continuous score on this variable. This is a continuous variable and a higher score on this variable suggests a higher level of exposure to persons of sexual minority status.

Predictor Variable 2: Training with Sexual Minority Populations

The variable, training with sexual minority populations, looked at skills obtained specifically for working with sexual minority populations. This variable was assessed by gathering data on the following areas:

1. graduate training, including focus on sexual minority populations, including: externships, internships, fellowships, and coursework;
2. employer provided training;
3. continuing education, including: continuing education or certificate programs.

This variable, training in sexual minority populations, was measured by answers to three questions on the demographic questionnaire. These scores from these questions were calculated to obtain a continuous score on this variable. A higher score suggested a higher level of training with sexual minority populations.

Predictor Variable 3: Perceived General Multicultural Competence

The variable, perceived general multicultural competence, was measured by using the total scale score of the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002). This included scores from both the knowledge and awareness subscales.

This variable was calculated after reverse-scoring some items. A higher overall score was indicative of a higher level of perceived multicultural competence. The scale consists of two subscales: knowledge and awareness. A higher score on each subscale suggests higher levels of knowledge and awareness respectively.

Predictor Variable 4: Engagement in Sexual Minority Specialization and Practice

The variable, engagement in sexual minority specialization and practice, ~~incorporated~~ was measured by gathering data on the following:

1. postdoctoral employment specifically working with clients of sexual minority status;
2. involvement in professional associations or organizations regarding professional practice with clients of sexual minority status;
3. percentage of the psychologist's caseload in which they directly interact with clients of sexual minority status.

Note that this variable, engagement in sexual minority specialization and practice, had three questions that are part of the demographic questionnaire. These questions were calculated to obtain a continuous score on this variable. A higher score on this variable suggests a higher level of engagement in sexual minority specialization and practice.

Criterion Variable 5: Perceived Sexual Orientation Competence

The variable, perceived sexual orientation competence, was measured by using the total score on the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005). This variable was calculated by first reverse-scoring select items, and then by obtaining an overall score. A higher overall score was suggestive of a higher level of perceived sexual orientation competence. This measure also provides three subscale scores; knowledge, attitude, and skills. A higher score on each subscale suggests a higher level of knowledge, attitude, and skills, respectively.

Measures

There were two standardized measures and a demographic questionnaire developed for this dissertation. Authors of the respective instruments were contacted and permission to use these instruments was obtained.

SOCCS

The first instrument used was the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005). This is a 29 question multiple-choice scale. The questions require answers ranging from *not at all true* to *totally true*. A higher score on the SOCCS is associated with higher competency. The 29 questions comprise three factors. The first factor, skills, contains 11 items that assess clinical experience and skills in working with LGB individuals. The second factor, attitudes, contains 10 items that assess the clinician's attitudes and prejudices regarding LGB persons. The third factor, knowledge, contains 8 items that assess clinician knowledge of concerns that are specific to the LGB population.

A higher overall score on the SOCCS, as well as the subscales, suggests a higher level of sexual orientation competence. Bidell (2005) provided the psychometrics for this scale. The SOCCS had an overall mean score of 4.64 (SD = 0.89). The score range for the SOCCS was 2.52 to 6.90. The mean scores for the subscales were: Skills 2.94 (SD = 1.53, range 1.00 to 6.91), Attitudes 6.49 (SD = 0.79, range 3.10 to 7.00), and Knowledge 4.66 (SD = 1.05, range 1.63 to 6.88. There was a fairly low correlation between subscales, including: r=.29 between Attitudes and Skills, r=.29 between knowledge and attitudes, and r=.45 between Knowledge and Skills. The internal consistency of the scale is very good, with an overall Cronbach's alpha of .90. The alphas of the domains were: Attitudes, .83; Skills, .83; and Knowledge, .84.

Criterion validity was used to determine the impact of level of education and participant's sexual orientation on sexual orientation competence. It was found that LGB identified individuals scored higher on the SOCCS $F(1, 301) = 30.14$, $p < .005$, and on all three subscales, Attitudes $F(1, 301) = 8.27$, $p < .005$, Skills $F(1, 301) = 29.12$, $p < .001$; and Knowledge $F(1, 301) = 8.80$, $p < .005$, as compared to heterosexual respondents. Additionally, those with higher education scored higher on the SOCCS $F(3, 308) = 75.10$, $p < .001$.

Convergent validity was utilized to determine if the SOCCS had validity for measuring the construct compared to other scales. The Attitudes subscale was compared to the Attitudes Toward Lesbians and Gay Men Scale (ATLG; Herek, 1988), and this resulted in a correlation of -.78 ($p < .01$). The Skills subscale was compared to the Counselor Self-Efficacy Scale (CSES, Melchert, Hays, Wiljanen, & Kolocek, 1996) and this yielded a correlation of .65, ($p < .01$). Additionally, a regression analysis suggested that the MCKAS ($\beta = .41$), ATLG ($\beta = -.32$), and CSES ($\beta = .28$), significantly predicted the scores on the SOCCS. Finally, convergent validity between the SOCCS and the MCKAS resulted in the SOCCS overall score correlating with the MCKAS overall score $r\ (312) = .69$, $p < .01$; the SOCCS attitude subscale correlating with the MCKAS awareness subscale $r(312) = .50$, $p < .01$; the SOCCS skill subscale correlating with the MCKAS knowledge subscale $r(312) = .58$, $p < .01$; and the SOCCS knowledge domain was compared to the MCKAS knowledge subscale $r(312) = .63$, $p < .01$. The psychometrics suggests that the SOCCS is a sound measure of sexual orientation counselor competence (Bidell, 2005), and a significant relationship between the SOCCS and the MCKAS was expected. A study conducted by Bidell (2012) that utlized both the SOCCS and MCKAS to examine school counseling students' multicultural and sexual orientation competencies calculated Pearson product–moment correlation coefficients for the relationship between participants' SOCCS

scores and age (r=.07), gender (r=–.09), racial/ethnic background (r=.02), and sexual orientation (r=.32). Also, it was found that there were significant differences for SOCCS and MCKAS scores between counseling specializations when comparing school counselors and community agency counselors (Bidell, 2012, p. 205).

MCKAS

The second standardized instrument that was used in the present study was the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002). This scale was revised from the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996). The MCKAS is a 32-item assessment containing 2 factors. The first factor, knowledge, consists of 20 items. The second factor, awareness, consists of 12 items. The Cronbach's alpha for the knowledge factor was .85, similarly the Cronbach's alpha for the awareness factor was .85. However, as part of the scale revision, confirmatory factor analysis was used and aggregate variable were obtained resulting in a 2 factor model with the knowledge factor obtaining a coefficient alpha of .91 and the awareness factor obtaining a coefficient alpha of .80. Correlations were done between the MCKAS and the Multigroup, Ethnic Identity Measure (MEIM; Phinney, 1992), as well as the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994). In the 2002 revision of the MCKAS, the Knowledge/Skills domain from its predecessor was changed to Knowledge to better reflect the contents of the questions. However, the MCKAS knowledge subscale was correlated with the MCI skills subscale (r = .43) suggesting a medium effect size and correlation between these subscales.

Demographic Questionnaire

A third tool was utilized for the research, and this was a demographic sheet. This sheet was developed specifically for this study and included:

1. Gender was asked to determine if there is a gender difference, within this sample, with regards to the variables in the study.
2. Age of the participant was asked to determine possible cohort differences in the area of competence.
3. Sexual orientation was asked to understand if the sexual orientation of the participant is related to competence.
4. Birth sex was asked to establish changes in gender identity of participants.
5. Current sex was asked to determine if there was a transition from birth sex and how this may impact the overall gender distribution of the sample.
6. Race and ethnicity were asked in order to analyze racial/ethnic differences in competence.
7. Question to understand participant's exposure to LGB individuals including: (a) immediate family members of sexual minority status; (b) friends who are of a sexual minority status; (c) co-workers who are of a sexual minority status; and (d) clients who are of a sexual minority status.
8. Questions to understand specific training in working with LGB individuals including: (a) How many courses did you have that focused on lesbian, gay and bisexual individuals; (b) How many employer provided trainings have you been to that focus on lesbian, gay and bisexual individuals; (c) How many continuing education or certificate programs have you attended that focus on lesbian, gay and bisexual

individuals; and (d) How many courses, offered through a college or university, have you attended that focus on lesbian, gay and bisexual individuals?

9. Questions to understand to what extent participants have engaged in working with LGB individuals including: (a) How many years of postdoctoral employment have you had working specifically with lesbian, gay and bisexual individuals; (b) How many certificates have you obtained regarding practice with lesbian, gay and bisexual individuals; (c) What percentage of your caseload directly deals with lesbian, gay and bisexual individuals; and (d) How many cases do you supervise regarding lesbian, gay and bisexual individuals?

Data Collection Methods

Data was collected from licensed, practicing psychologists in the US. The survey was administered online utilizing ASSET, an internet based survey program. A solicitation letter was emailed to listserves of American Psychological Association divisions and state psychological associations, and email lists were obtained from state licensing boards. Permission to email the survey to members was sought from a number of diverse, relevant organizations, including the American Psychological Association divisions 20, 35, 44, and 45, in an effort to recruit participants from diverse backgrounds. Permission was denied due to recommendations to the divisions by APA.

In order to increase participation, several steps were taken including:

1. A conservative approach was utilized when selecting instruments to minimize participation time while directly looking at the study's variables.

2. The questionnaire was developed and presented in a professional and easy-to-use format utilizing a university-based survey system called ASSET. This system is able to adhere to IRB protocol.
3. Anonymity was ensured in the solicitation letter, as well as in the development of the survey.
4. The participants were informed of the average time required to complete the survey.
5. One month after the initial solicitation email was delivered, a follow-up email was sent to potential participants to attempt to capture those individuals who did not participate in the first wave of solicitation.

Method of Sampling

This research used nonprobability sampling. Specifically, purposive sampling was used to specifically target licensed, practicing psychologists. Even more specifically, expert sampling was utilized as all participants had expertise in the field of psychology (Trochim & Donnelly, 2008). The American Psychological Association reported in the 2012 annual report that their membership exceeded 134,000 (American Psychological Association, 2012, p. S27). Additionally, the 2010 Report of United States Bureau of Labor Statistics indicated that there were about 160,200 psychologists practicing in the United States (Bureau of Labor Statistics, U.S. Department of Labor, 2012). Due to the large size of the potential population, a criterion sampling method was used that incorporated an Internet administered survey.

Several criteria were used to determine if a particular psychologist qualified for participation in the study. They included:

1. Participants were licensed psychologists as evidenced by having passed their state licensure exam.

2. Participants were practicing in the field of psychology.
3. Participants were psychologists practicing direct clinical work.
4. Participants were selected from across the United States.
5. Participants were recruited from diverse ethnic backgrounds.

The following procedures were utilized to obtain participants. First, an extensive internet search was done to ascertain an approximate number of clinical or counseling psychologists currently affiliated with state psychological boards. Following this, the APA was contacted to obtain the number of current members.

Following this, the APA and its divisions were contacted and directions for soliciting research participants were obtained. Permission was sought from these divisions. Additional inquiries were sent to state psychological associations to determine the best method to reach their members regarding research participation. Additionally, state licensing boards were contacted to obtain instructions for contacting licensed individuals in their state.

Statistical Analyses

Correlation and multiple regression analyses were used in this study. This method permits the use of multiple variables to predict the measure of the criterion variable (Meyers, Gamst, & Guarino, 2006). It has been suggested that utilizing multiple predictor variables better represents the real world environment (Thompson, 1991). As this statistical method has a predictive quality, this model may help us ascertain the unique contributions to sexual orientation competence. The goal in a multiple regression model is to develop a model that best predicts the criterion variable (Meyers et al., 2006). As the models of gay affirmative therapy are still largely theoretical and derived from multicultural competence models, it is important to consider additional variables, like exposure, that have shown some statistical predictive value for gay

affirmative competence in previous research. After the multiple regression analysis correlations and simple regressions were completed on the individual predictor variables, further investigation regarding the relationships between them and the criterion variable were conducted. The statistical analyses conducted for each hypothesis are as follows:

- Hypothesis 1. Participants who report greater exposure to individuals of sexual minority status will have a significantly greater level of perceived sexual orientation competence. A correlation was conducted to understand the relationship between these two variables.
- Hypothesis 2. Participants who report greater training experience with sexual orientation will have a significantly greater level of perceived sexual orientation competence. A correlation was conducted to understand the relationship between these two variables.
- Hypothesis 3. Participants who have a greater level of perceived multicultural competence will have a statistically greater level of perceived sexual orientation competence. A correlation was conducted to understand the relationship between these two variables.
- Hypothesis 4. Participants who have greater level of engagement in sexual minority specialization and practice will have a statistically greater level of perceived sexual orientation competence. A correlation was conducted to understand the relationship between these two variables.
- Hypothesis 5. Exposure to persons of sexual minority status, training experience in sexual minority populations, perceived multicultural competence, and engagement in sexual minority specialization and practice to the dependent variable perceived gay affirmative competence will each have significant contributions to perceived sexual orientation

competence. A multiple regression was conducted to understand how each of these variables contributes to sexual orientation competence.

Summary

Based on the results of the power analysis, this study required a sample of 77 licensed psychologists. After data were collected, it was analyzed using SPSS version 18 (SPSS, 2009).

Chapter IV

RESULTS

Introduction

This chapter presents the descriptive statistics for the measures and variables utilized in the study. These include: Exposure to Persons of Sexual Minority Status, Training with Sexual Minority Populations, Multicultural Knowledge and Awareness, Engagement in Sexual Minority Specialization and Practice, and The Sexual Orientation Counselor Competency Scale. Descriptive statistics of the sample, results of the hypotheses, and a summary of the findings of the study are presented.

Purpose of the Study

The purpose of this study was to understand if the exploratory variables, exposure to persons of sexual minority status, training with sexual minority populations, and engagement in sexual minority specialization and practice, and the standardized variable, multicultural competence, contributed to sexual orientation competence. The total sample size for the study was 109 and included only participants who identified as U.S. licensed psychologists (N=109). All analyses were executed using Statistical Package for Social Sciences (SPSS Version 22 for Windows).

Data Screening

Data screening began with exporting the data from ASSET to SPSS Version 22. The data set was checked for missing data. Following this, descriptive statistics were run to check for outliers in the data set. The result was a data set of continuous and categorical items, no missing data, and values that were all within expected ranges. However, when screening the data, it was determined that some questions were problematic and removal from the data set needed to be considered prior to analyses. For the variable, determining exposure to LGB individuals, the

question, “What is your sexual orientation status?” was removed from the exposure variable. The sample population was largely heterosexual and it was thought that this question would not provide meaningful data. Another question was determined to be problematic within the specialization variable. The question, “How many postdoctoral courses, offered through a college or university, have you attended that focus on lesbian, gay, or bisexual individuals?” was removed due to it being highly correlated and potentially confusing with another question about number of courses that did not specify predoctoral. Finally, some variables required transformation due to expected differences in clinical experience, training, and exposure to LGB individuals. These transformations are discussed in the analyses.

Descriptive Statistics

The participants of the study, as shown in Table 1, consisted of clinical, counseling, and school psychologists licensed to practice in the United States. Participants were asked various demographic questions (see Table 1). First, they were asked to identify their age by selecting one of the following six categories. The categories and the percentage of the population that fell within each category are: 26-35 (14.7%, *n* = 16), 36-45 (25.7%, *n* = 28), 46-55 (22%, *n* = 24), 56-65 (23.9%, *n* = 26), 66-75 (11.9%, *n* = 13), and 76-85 (1.8%, *n* = 2). The mean age of participants was in the 36-45 year-old range. Participants identified their gender as male 37.6% (*n* = 41) or female 62.4% (*n* = 68). The birth sex of the participants was made up of 37.6% (*n* = 40) males, 62.4% (*n* = 68) females, and .90 (*n* = 1) intersex, whereas they identified their current sex as 35.8% (*n* = 39) males, 62.4% (*n* = 68) females, and 1.8% (*n* = 2) intersex individuals. Census categories were utilized when obtaining the race/ethnicity of the participants, and it was found that 93.6% (*n* = 102) White participants, .90% (*n* = 1) Black or African American participants, 1.8% (*n* = 2) Asian participants, .90% (*n* = 1) Native Hawaiian or Other Pacific

Islander participants, and 2.8% (*n* = 3) Other participants. Finally, the sexual orientation status of participants was 84.4% (*n* = 92) heterosexual, 6.4% (*n* = 7) gay, 4.6% (*n* = 5) lesbian, 2.8% (*n* = 3) bisexual, and 1.8% (*n* = 2) queer.

Table 1

Individual Characteristics as a Percentage of the Sample

Characteristic	*n*=109
Age	
26-35	14.7
36-45	25.7
46-55	22
56-65	23.9
66-75	11.9
76-85	1.8
Gender	
Male	37.6
Female	62.4
Birth Sex	
Male	37.6
Female	62.4
Intersex	.90
Current Sex	
Male	35.8
Female	62.4
Intersex	1.8
Race/Ethnicity	
White	93.6
Black/African-American	.90
Asian	1.8
Native Hawaiian or Other Pacific Islander	.90
Other	2.8
Sexual Orientation Status	
Heterosexual	84.4
Gay	6.4
Lesbian	4.6
Bisexual	2.8
Queer	1.8

Preliminary Analyses

Prior to running the analyses for the five hypotheses of the study, the demographic items of age and gender were analyzed with the SOCCS and MCKAS to better understand the ways these items related to sexual orientation competence and multicultural competence. Table 3 shows that, with regards to the MCKAS, there were no significant age differences found in subscale scores. A further post hoc analysis (seeTable 4) did not find a significant difference by specific age group. Regarding gender differences on the MCKAS, a t-test was computed and a significant gender difference was found on the Attitude subscale, with women scoring higher than men, $t(107) = -4.034$ $p \leq .05$. This suggests that, in this sample, women had more perceived awareness of multicultural counseling and specifically the Eurocentric bias that can impact counseling. Unfortunately, due to it being a predominately heterosexual, White sample, sexual orientation and race of the participant could not be analyzed with the MCKAS.

Gender and age were also analyzed with the SOCCS, and the results are displayed in Tables 2 and 4, respectively. A t-test was conducted and it was found that there was a significant difference in gender with regards to the Attitude subscale of the SOCCS; with women scoring higher than men $t(107) = -2.178$ $p \leq .05$. This suggests that women, in this sample, were more aware of their attitudes toward LGB individuals, as well as their prejudices. There was no significant difference between age groups with regards the overall score on the SOCCS. Older participants scored almost 10 points lower on the SOCCS than other groups. While this is not statistically significant, it may have practical importance for counselors. Table 3 shows the results of an ANOVA that showed when the effect of age was analyzed with the three subscales, there was a significant effect of age on the Knowledge scale, with older individuals reporting less knowledge that the other groups, $F(4, 104) = 3.69$, $p = .008$. This suggests that the lower degree

of competence among older individuals, as previously mentioned, may be due to a lower level of knowledge. Post hoc analysis of age was conducted and showed that participants between the ages of 66 and 75 were significantly different ($p \leq 0.05$) from participants in the 26-35, 36-45, 46-55, and 56-65 year old age groups. Finally, no interaction was found between age, gender, and the SOCCS. As with the MCKAS, sexual orientation and race could not be analyzed with this variable.

Table 2

Independent Samples Test of Gender

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	*t*	*df*	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
MCKAS Knowledge	Equal variances assumed	1.46	.22	-1.78	107	.07	-6.12	3.43	-12.93	.67
	Equal variances not assumed			-1.72	74.93	.09	-6.12	3.56	-13.22	.96
MCKAS Awareness	Equal variances assumed	2.62	.10	-4.03	107	.00	-2.89	.71	-4.31	-1.46
	Equal variances not assumed			-3.78	68.81	.00	-2.89	.721	-4.41	-1.36
SOCCS Skills	Equal variances assumed	.02	.86	.39	107	.69	1.20	3.05	-4.84	7.25
	Equal variances not assumed			.39	87.89	.69	1.20	3.01	-4.78	7.18
SOCCS Attitude	Equal variances assumed	9.85	.002	-2.17	107	.03	-3.02	1.38	-5.77	-.27
	Equal variances not assumed			-1.86	51.85	.06	-3.02	1.62	-6.27	.22
SOCCS Knowledge	Equal variances assumed	2.45	.12	-1.33	107	.18	-2.04	1.53	-5.09	.99
	Equal variances not assumed			-1.29	77.09	.19	-2.04	1.57	-5.19	1.09

Table 3

ANOVA of Age

		Sum of Squares	*df*	Mean Square	*F*	Sig.
SOCCS Skills	Between Groups	200.40	4	50.10	.20	.93
	Within Groups	2532.26	104	243.49		
	Total	25523.67	108			
SOCCS Attitude	Between Groups	95.04	4	23.76	.45	.76
	Within Groups	5417.89	104	52.09		
	Total	5512.93	108			
SOCCS Knowledge	Between Groups	813.94	4	203.48	3.69	.00
	Within Groups	5735.06	104	55.14		
	Total	6549.00	108			
MCKAS_Knowledge	Between Groups	723.54	4	180.88	.55	.69
	Within Groups	33798.56	104	324.98		
	Total	34522.11	108			
MCKAS_Awareness	Between Groups	142.71	4	35.67	.81	.52
	Within Groups	4583.72	104	44.07		
	Total	4726.44	108			

Table 4

Analysis of Variance Post Hoc Test of Age

Dependent Variable	(I) Age Category	(J) Age Category	Mean Difference (I – J)	Std. Error	Sig.	95% Confidence Interval of the Difference	
						Lower	Upper
SOCCS Skills	26-35	36-45	1.36	4.89	.78	-8.33	11.06
		46-55	3.02	5.03	.55	-6.96	13.00
		56-65	1.12	4.95	.82	-8.70	10.96
		66-75	4.33	5.60	.44	-6.78	15.45
	36-45	26-35	-1.36	4.89	.78	-11.06	8.33
		46-55	1.65	4.34	.70	-6.95	10.26
		56-65	-.23	4.24	.95	-8.66	8.19
		66-75	2.97	4.99	.55	-6.92	12.87
	46-55	26-35	-3.02	5.03	.55	-13.00	6.96
		36-45	-1.65	4.34	.70	-10.26	6.95
		56-65	-1.89	4.14	.66	-10.65	6.86
		66-75	1.31	5.13	.79	-8.86	11.50
	56-65	26-35	-1.12	4.95	.82	-10.96	8.70
		36-45	.23	4.24	.95	-8.19	8.66
		46-55	1.89	4.41	.66	-6.86	10.65
		66-75	3.20	5.05	.52	-6.82	13.24
	66-75	26-35	-4.33	5.60	.44	-15.45	6.78
		36-45	-2.97	4.99	.55	-12.87	6.92
		46-55	-1.31	5.13	.79	-11.50	8.86
		56-65	-3.20	5.05	.52	-13.24	6.82
SOCCS Attitude	26-35	36-45	-1.81	2.26	.42	-6.29	2.67
		46-55	-.39	2.32	.86	-5.01	4.22
		56-65	-2.37	2.29	.30	-6.91	2.17
		66-75	-2.22	2.59	.39	-7.37	2.91
	36-45	26-35	1.81	2.26	.42	-2.67	6.29
		46-55	1.41	2.00	.48	-2.56	5.39
		56-65	-.55	1.96	.77	-4.45	3.34
		66-75	-.41	2.30	.85	-4.99	4.16
	46-55	26-35	.39	2.32	.86	-4.22	5.01
		36-45	-1.41	2.00	.48	-5.39	2.56
		56-65	-1.97	2.04	.33	-6.02	2.07
		66-75	-1.83	2.37	.44	-6.54	2.87
	56-65	26-35	2.37	2.29	.30	-2.17	6.91
		36-45	.55	1.96	.77	-3.34	4.45
		46-55	1.97	2.04	.33	-2.07	6.02
		66-75	.14	2.34	.95	-4.49	4.78
	66-75	26-35	2.22	2.59	.39	-2.91	7.37
		36-45	.41	2.30	.85	-4.16	4.99
		46-55	1.83	2.37	.44	-2.87	6.54
		56-65	-.14	2.34	.95	-4.78	4.49
SOCCS Knowledge	26-35	36-45	.20	2.23	.93	-4.40	4.82
		46-55	-.187	2.39	.93	-4.94	4.56
		56-65	1.58	2.35	.50	-3.09	6.26
		66-75	**8.14***	2.66	.003	2.85	13.43
	36-45	26-35	-.20	2.32	.93	-4.82	4.40
		46-55	-.39	2.06	.85	-4.48	3.70
		56-65	1.37	2.02	.49	-2.63	5.38
		66-75	**7.94***	2.37	.001	3.22	12.65
	46-55	26-35	.18	2.39	.93	-4.56	4.94
		36-45	.39	2.06	.85	-3.70	4.48
		56-65	.76	2.10	.40	-2.39	5.93
		66-75	**8.33***	2.44	.001	3.48	13.18
	56-65	26-35	-1.58	2.35	.50	-6.26	3.09
		36-45	-1.37	2.02	.49	-5.38	2.63
		46-55	-1.76	2.10	.40	-5.93	2.39
		66-75	**6.56***	2.40	.008	1.78	11.33
	66-75	26-35	**-8.14***	2.66	.003	-13.43	-2.85
		36-45	**-7.94***	2.37	.001	-12.65	-3.22
		46-55	**-8.33***	2.44	.001	-13.18	-3.86
		56-65	**-6.56***	2.40	.008	-11.33	-1.78

Dependent Variable	(I) Age Category	(J) Age Category	Mean Difference (I – J)	Std. Error	Sig.	Lower	Upper
MCKAS_Knowledge	26-35	36-45	2.75	5.64	.62	-8.44	13.96
		46-55	5.52	5.81	.34	-6.01	17.05
		56-65	-1.00	5.72	.86	-12.36	10.35
		66-75	4.88	6.47	.45	-7.96	17.73
	36-45	26-35	-2.75	5.64	.62	-13.96	8.44
		46-55	2.76	5.01	.58	-7.18	12.70
		56-65	-3.76	4.90	.44	-13.50	5.97
		66-75	2.12	5.76	.71	-9.31	13.56
	46-55	26-35	-5.52	5.81	.34	-17.05	6.01
		36-45	-2.76	5.01	.58	-12.70	7.18
		56-65	-6.52	5.10	.20	-16.64	3.59
		66-75	-.63	5.93	.91	-12.39	11.13
	56-65	26-35	1.00	5.72	.86	-10.35	12.36
		36-45	3.76	4.90	.44	-5.97	13.50
		46-55	6.52	5.10	.20	-3.59	16.64
		66-75	5.89	5.84	.31	-5.69	17.48
	66-75	26-35	-4.88	6.47	.45	-17.73	7.96
		36-45	-2.12	5.76	.71	-13.56	9.31
		46-55	.63	5.93	.91	-11.13	12.39
		56-65	-5.89	5.84	.31	-17.48	5.69
MCKAS_Awareness	26-35	36-45	-.21	2.08	.91	-4.34	3.91
		46-55	-.08	2.14	.96	-4.33	4.16
		56-65	-2.07	2.10	.32	-6.26	2.10
		66-75	1.66	2.38	.48	-3.06	6.39
	36-45	26-35	.21	2.08	.91	-3.91	4.34
		46-55	.13	1.84	.94	-3.53	3.79
		56-65	-1.86	1.80	.30	-5.44	1.72
		66-75	1.88	2.12	.37	-2.33	6.09
	46-55	26-35	.08	2.14	.96	-4.16	4.33
		36-45	-.13	1.84	.94	-3.79	3.53
		56-65	-1.99	1.87	.29	-5.72	1.73
		66-75	1.75	2.18	.42	-2.58	6.08
	56-65	26-35	2.07	2.10	.32	-2.10	6.26
		36-45	1.86	1.80	.30	-1.72	5.44
		46-55	1.99	1.87	.29	-1.73	5.72
		66-75	3.74	2.15	.08	-.52	8.01
	66-75	26-35	-1.66	2.38	.48	-6.39	3.06
		36-45	-1.88	2.12	.37	-6.09	2.33
		46-55	-1.75	2.18	.42	-6.08	2.58
		56-65	-3.74	2.15	.08	-8.01	.52

*Bold. The mean difference is significant at the 0.05 level.

Instruments Scoring Procedures and Results

Measures

Exposure to persons of sexual minority status. Five questions were selected to operationalize this construct. The descriptive statistics are shown in Table 5. A higher score on this variable suggests greater exposure to persons of sexual minority status. The questions asked about the participant's: (a) own sexual orientation; (b) immediate family members of sexual minority status; (c) friends who are of a sexual minority status; (d) co-workers who are of a sexual minority status; and (e) clients who are of a sexual minority status. Item number 1, the study participant's own sexual orientation status, was removed due to the inherent difficulty in

coding this variable and meaningfully calculating it with the other four variables. Because the response scales for the remaining four items differed, the items were standardized-that is converted to z-scores (mean = 0, standard deviation = 1) in order to combine them into a composite Exposure score. While it might seem reasonable to submit these items to an internal consistency reliability analysis in order to determine whether they are sufficiently correlated with one another to justify generating a composite score, it is important to recognize that this type of analysis is more suitable for attitudinal items, which on a priori grounds, are usually expected to correlate. Note, however, that these are behavioral items, not attitudinal items, and there is no particular reason to expect, for example, that one's own sexual orientation would correlate particularly highly with the number of immediate family members with the same sexual orientation status and even less so with the number of coworkers or clients who share that same status. Due to a predominately heterosexual sample, question 1 about "the study participant's own sexual orientation" was removed, and this resulted in a variable with four questions.

Training with sexual minority populations. Study participants were asked four questions about the training that they had received with respect to working with sexual minority status clients and the descriptive statistics are shown in Table 5. A higher score on this variable was considered to suggest a higher degree of training in work with sexual minority populations. The questions include: (a) How many courses did you have that focused on lesbian, gay and bisexual individuals?; (b) How many employer provided trainings have you been to that focus on lesbian, gay and bisexual individuals?; (c) How many continuing education or certificate programs have you attended that focus on lesbian, gay and bisexual individuals?; and (d) How many postdoctoral courses, offered through a college or university, have you attended that focus on lesbian, gay and bisexual individuals? Unlike the exposure items, it is reasonable to suppose

that individuals can exercise choice and control over whether to receive more or less training in this area. Given this it seems reasonable to suppose that these four items should show evidence of behavioral or attitudinal constraint. For that reason, these items were submitted to an internal consistency reliability analysis after log transforming them in order to reduce, if not entirely eliminate, skewness in their distributions. The internal consistency reliability coefficient for this measure is ($\alpha = .70$) which is generally considered the lower boundary of acceptable reliability. Due to a potentially confusing question and a high correlation between questions 1 and 4,, question 4, "How many postdoctoral courses, offered through a college or university, have you attended that focus on lesbian, gay and bisexual individuals?", was removed and this resulted in a variable with three questions.

Multicultural knowledge and awareness. This is construct was operationalized using a standardized measure consisting of 32 Likert-type items (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002). There are two subscales in the MCKAS; Knowledge subscale contains 20 items and Awareness subscale contains 12 items. The descriptive statistics for this variable are shown in Table 5. A higher overall score suggests a higher level of perceived multicultural competence. These items were submitted to an internal consistency reliability analysis, which indicated that this measure has excellent reliability in this sample ($\alpha = .90$).

Engagement in sexual minority specialization and practice. Four items were used to assess the extent to which the study participants had elected to specialize in treating sexual minority populations. The descriptive statistics are shown in Table 5. A higher overall sore on this variable suggests greater engagement in sexual minority specialization and practice. The items included: (a) How many years of postdoctoral employment have you had working specifically with lesbian, gay and bisexual individuals?; (b) How many professional associations

or organizations are you involved with regarding professional practice with lesbian, gay and bisexual individuals?; (c) What percentage of your caseload directly deals with lesbian, gay and bisexual individuals?; and (d) How many cases do you supervise regarding lesbian, gay and bisexual individuals? Because these items exhibited some evidence of skewness, they were log transformed, standardized, and then submitted to an internal consistency reliability analysis. The internal consistency reliability analysis for this measure was ($\alpha = .63$), which is somewhat lower than the aforementioned value of .70, but is still, serviceable. Due to a low response rate for question 4, "How many cases do you supervise regarding lesbian, gay and bisexual individuals?", this item was removed, and this resulted in a three question variable.

The Sexual Orientation Counselor Competency Scale. This is a standardized measure that is comprised of 29 Likert-type items (Bidell, 2005). This scale is a 29 question multiple-choice scale. A higher score on the SOCCS is associated with higher competency. There are three factors in the SOCCS. The first factor has 11 items that assess skills working with LGB individuals. The second factor has 10 items that assess the clinician's attitudes and prejudices regarding LGB persons. The third factor has 8 items that assess clinician knowledge of concerns specific to the LGB population. The descriptive statistics are shown in Table 5. A higher overall score on this measure suggests a higher level of perceived sexual orientation competency. Its reliability, ($\alpha = .84$) is quite satisfactory as measured in this sample.

Table 5

Study Measures: Descriptive Statistics

		Exposure to Persons of Sexual Minority Status	Training in Sexual Minority Population	Multicultural Counseling Knowledge & Awareness	Engagement in Sexual Minority Specialization	Perceived Sexual Orientation Competence
N	Valid	109	109	109	109	109
	Missing	0	0	0	0	0
Mean		.00	-.007	5.67	.003	5.18
Median		-.04	-.15	5.75	-.16	5.27
Std. Deviation		.55	.71	.66	.70	.67
Skewness		.33	2.64	-.72	2.26	-.59
Kurtosis		-.24	10.60	-.09	6.45	.25
Minimum		-1.17	-.83	3.97	-.55	2.90

Hypotheses

Hypothesis 1

Participants who report greater exposure to individuals of sexual minority status will have a significantly greater level of sexual orientation competence.

In order to test this hypothesis, a Pearson correlation was computed. As seen in Table 6, these two variables, consistent with the claim made in this hypothesis, are positively and moderately correlated ($r = .320$, $p < .001$).

Hypothesis 2

Participants who report greater training in sexual orientation issues will have a significantly greater level of sexual orientation competence.

In order to test this second hypothesis, another Pearson correlation was computed. Prior to calculating this correlation, the training variable was rank transformed in order to "tamp

down" (author, year, page?) skewness in this variable. Left untransformed, the correlation computed would likely be distorted by this nonnormality.

As seen in Table 6, these two variables, consistent with the claim made in this second hypothesis, are positively and moderately correlated ($r = .503$, $p < .001$).

Hypothesis 3

Participants who have a greater level of multicultural competence will have a significantly greater level of sexual orientation competence.

As seen in Table 6, these two variables, consistent with the claim made in the third hypothesis, are positively and strongly correlated *(*$r = .728$, $p < .001$). Multicultural competence can be further broken into the subscales Awareness and Knowledge that make up the total scale. Awareness was positively and strongly correlated *(*$r = .552$, $p < .001$). Knowledge was also positively and strongly associated ($r = .665$, $p < .001$).

Hypothesis 4

Participants who have a greater level of engagement in sexual minority specialization and practice will have a significantly greater level of sexual orientation competence.

As was the case with the training variable, the engagement in sexual minority specialization and practice variable was also rank transformed in order to reduce the unwanted effect of skewness in the distribution of this variable.

As seen in Table 6, these two variables, consistent with the claim made in this hypothesis, are positively and moderately correlated *(*$r = .335$, $p < .001$).

Table 6

Correlation Matrix

		Exposure	Training	MCKAS	MCKAS Awareness	MCKAS Knowledge	Engagement	SOCCS	SOCCS Skills	SOCCS Attitude	SOCCS Knowledge
Exposure	Pearson Correlation	1	.24	.30	.25	.26	.28	.32	.24	.35	.12
	Sig. (2-tailed)		.01	.001	.007	.005	.003	.001	.01	.00	.20
	N	109	109	109	109	109	109	109	109	109	109
Training	Pearson Correlation	.24	1	.39	.12	.42	.19	.50	.49	.16	.31
	Sig. (2-tailed)	.01		.00	.19	.00	.04	.00	.00	.09	.001
	N	109	109	109	109	109	109	109	109	109	109
MCKAS	Pearson Correlation	.30	.39	1	.63	.95	.25	.72	.57	.37	.56
	Sig. (2-tailed)	.001	.00		.00	.00	.008	.00	.00	.00	.00
	N	109	109	109	109	109	109	109	109	109	109
MCKAS: Awareness	Pearson Correlation	.25	.12	.63	1	.39	.17	.55	.27	.55	.49
	Sig. (2-tailed)	.007	.19	.00		.00	.06	.00	.004	.00	.00
	N	109	109	109	109	109	109	109	109	109	109
MCKAS: Knowledge	Pearson Correlation	.26	.42	.95	.39	1	.23	.66	.59	.24	.49
	Sig. (2-tailed)	.005	.00	.00	.00		.01	.00	.00	.01	.00
	N	109	109	109	109	109	109	109	109	109	109
Engagement	Pearson Correlation	.28	.19	.25	.17	.23	1	.33	.28	.20	.19
	Sig. (2-tailed)	.003	.04	.008	.06	.01		.00	.002	.03	.04
	N	109	109	109	109	109	109	109	109	109	109

		Exposure	Training	MCKAS	MCKAS Awareness	MCKAS Knowledge	Engagement	SOCCS	SOCCS Skills	SOCCS Attitude	SOCCS Knowledge
SOCCS	Pearson Correlation	.32	.50	.72	.55	.66	.33	1	.83	.55	.68
	Sig. (2-tailed)	.001	.00	.00	.00	.00	.00		.00	.00	.00
	N	109	109	109	109	109	109	109	109	109	109
SOCCS: Skills	Pearson Correlation	.24	.49	.57	.27	.59	.28	.83	1	.17	.28
	Sig. (2-tailed)	.01	.00	.00	.004	.00	.002	.00		.07	.002
	N	109	109	109	109	109	109	109	109	109	109
SOCCS: Attitudes	Pearson Correlation	.35	.16	.37	.55	.24	.20	.55	.17	1	.30
	Sig. (2-tailed)	.00	.09	.00	.00	.01	.03	.00	.07		.002
	N	109	109	109	109	109	109	109	109	109	109
SOCCS: Knowledge	Pearson Correlation	.12	.31	.56	.49	.49	.19	.68	.28	.30	1
	Sig. (2-tailed)	.20	.001	.00	.00	.00	.04	.00	.002	.002	
	N	109	109	109	109	109	109	109	109	109	109

Hypothesis 5

Exposure to persons of sexual minority status, training experience in sexual minority populations, perceived multicultural competence, and engagement in sexual minority specialization and practice will each make unique and statistically significant contributions to the explaining variation in perceived sexual orientation competence.

In order to evaluate this hypothesis, a simultaneous multiple regression analysis is conducted. As seen in Tables 7 and 8, the set of four predictors, taken as a set, are significantly related to, that is predictive of, perceived sexual orientation competence ($R^2 = .64$, $F = 25.60$, $df = (7, 101)$, $p < .001$). Visual inspection of the standardized partial regression coefficients (β) found, contrary this hypothesis, that only three of the five predictors have unique and statistically

significant relationships to perceived sexual competence. More specifically, exposure to persons of sexual minority status (β = .031, p = .664) and engagement in specialization (β = .117, p = .126) were not significantly related to perceived sexual competence when the effects of the other predictors in this regression model were controlled. While each of the three remaining predictors was significantly related to perceived sexual competence, there were noticeable differences in the magnitude or strength of these relationships. That is to say, training experience in sexual minority populations (β = .231, p = .005) was found to be positively related to perceived sexual competence, but the magnitude or strength of this relationship is characterized as relatively modest. On the other hand, the relationship between perceived sexual orientation competence and multicultural competence knowledge subscale is moderate (β = .424, p < .001) and the relationship between perceived sexual orientation competence and multicultural competence awareness subscale was (β = .301 p < .001).

Table 7

Model Summary

						Change Statistics			
Model	*R*	*R* Square	Adjusted *R* Square	Std. Error of the Estimate	*R* Square Change	*F* Change	*df*1	*df*2	Sig. *F* Change
1	.80[a]	.64	.61	.42	.64	25.60	7	101	.00

Table 8

Regression of Perceived Sexual Competence on (a) Exposure to Persons of Sexual Minority Status, (b) Training Experience in Sexual Minority Populations, (c) Perceived Multicultural Competence and (d) Engagement in Sexual Minority Specialization and Practice

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients				
		B	Std. Error	Beta	*t*	Sig.	Collinearity Tolerance	Statistics VIF
1	(Constant)	-183850.2	422303.82		-.43	.66		
	Engagement	1.40	.91	.11	1.54	.12	.78	1.27
	Training	2.02	.70	.23	2.89	.005	.70	1.41
	Exposure	.04	.11	.03	.43	.66	.88	1.12
	MCKAS Knowledge	.51	.09	.42	5.54	.00	.74	1.34
	MCKAS Awareness	1.10	.26	.30	4.12	.00	.87	1.14

a. Dependent Variable: Perceived Sexual Orientation Competence

Secondary Analyses

Following the analyses of the initial hypotheses, additional analyses were conducted to understand the role of sexual orientation with regards to the SOCCS. A regression was completed with the two MCKAS subscales, training, engagement, and sexual orientation as predictors and the SOCCS as the dependent variable. The sexual orientation question was recoded to develop two groups, heterosexual and LGB. As shown in Table 9, there was a significant effect of the predictors, two MCKAS subscale, training, engagement, and sexual orientation, on the SOCCS ($R^2 = .61$, $F = 30.18$, $df = (5, 95)$, $p < .001$). Further analysis of the regression (seeTable 10) showed findings that were similar to the original model regression with

engagement in specialization (β = .055, p = .453) not significantly related to SOCCS. Training (β = .247, p = .002) was positively related to SOCCS, MCKAS Knowledge subscale is (β = .361, p < .001) and the MCKAS Awareness subscale is (β = .4.423, p < .001). New to this model was the addition of sexual orientation. This predictor resulted in a significant finding (β = -.222, p = .002), with LGB individuals reporting more competence in SOCCS than heterosexual individuals.

Table 9

Model Summary Adding Sexual Orientation

					Change Statistics			
Model	*R*	*R* Square	Adjusted *R* Square	Std. Error of the Estimate	*F* Change	*df*1	*df*2	Sig. *F* Change
1	.78[a]	.61	.61	.59	30.18	5	95	.000

Table 10

Regression of Perceived Sexual Competence on (a) MCKAS Knowledge, (b) MCKAS Awareness, (c) training, (d) Engagement in Sexual Minority Specialization and Practice, and (e) Sexual Orientation.

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	*t*	Sig.
1	(Constant)	35.996	18.634		1.932	.056
	Orientation	-12.268	3.918	-.222	-3.1.1	.002`
	Training	2.168	.666	.247	3.254	.002
	Engagement	.664	.881	.055	.753	.453
	MCKAS Knowledge	.438	.093	.361	4.718	.000
	MCKAS Awareness	1.102	.249	.299	4.423	.000

a. Dependent Variable: Perceived Sexual Orientation Competence

Finally, analyses were done to understand the roles of gender and sexual orientation with regards to the MCKAS with training and engagement held constant. As shown in Table 11, the overall model was found to be significant (R^2 = .285, F = 9.55, df = (4, 96), p < .001). The regression model (see Table 12) shows that engagement (β = -.062, p = .528) and gender (β = .198, p = .528) were each insignificant. Training remained significant (β = .420, p < .001). This model provides new information about the relationship between sexual orientation and MCKAS Knowledge subscale, with LGB individuals reporting greater knowledge (β = -.271, p = .004) than heterosexual individuals.

Table 11

MCKAS Knowledge, Gender, and Sexual Orientation

					Change Statistics			
Model	*R*	*R* Square	Adjusted *R* Square	Std. Error of the Estimate	*F* Change	*df*1	*df*2	Sig. *F* Change
1	.534[a]	.285	.255	14.07	9.55	4	96	.000[b]

a. Dependent variable: MCKAS Knowledge scale
b. Predictors: gender, training, sexual orientation, engagement

Table 12

Regression of MCKAS Knowledge on (a) gender, (b) training, (c) Engagement in Sexual Minority Specialization and Practice, and (d) Sexual Orientation.

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	*t*	Sig.
1	(Constant)	-8392247	3700325.5		-2.268	.026
	Orientation	-12.355	4.202	-.271	-2.94	.004
	Training	3.04	.679	.420	4.479	.000
	Engagement	-.619	.977	-.062	-.633	.528
	Gender	6.617	2.918	.198	2.268	.528

a. Dependent Variable: MCKAS Knowledge scale

The same analysis was run with the MCKAS Awareness subscale. Again the overall model, as shown in Table 13, was significant (R^2 = .144, F = 4.027, df = (4, 96), p = .005[b]). The regression analysis, shown in Table 14, found that sexual orientation (β = -.122, p = .227), training (β = .068, p = .507), and engagement (β = .127, p = .242) were each insignificant

predictors of the MCKAS Awareness subscale. However, gender (β = .329, p = .001) was a significant predictor with more women reporting MCKAS awareness than men.

Table 13

MCKAS Awareness, Gender, and Sexual Orientation

					Change Statistics			
Model	*R*	*R* Square	Adjusted *R* Square	Std. Error of the Estimate	*F* Change	*df*1	*df*2	Sig. *F* Change
1	.379[a]	.144	.108	5.076	4.027	4	96	.005[b]

a. Dependent variable: MCKAS Awareness scale
b. Predictors: gender, training, sexual orientation, engagement

Table 14

Regression of MCKAS Awareness on (a) gender, (b) training, (c) Engagement in Sexual Minority Specialization and Practice, and (d) Sexual Orientation.

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	*t*	Sig.
1	(Constant)	-4601657	1334988.1		-3.447	.001
	Orientation	-1.842	1.516	-.122	-1.215	.227
	Training	.163	.245	.068	.666	.507
	Engagement	.415	.353	.127	1.176	.242
	Gender	3.628	1.053	.329	3.447	.001

a. Dependent Variable: MCKAS Awareness scale

Conclusions

The results of the analyses partially supported the hypotheses of the study. Overall, it appeared that multicultural competence knowledge accounted for the largest amount of variance with regards to sexual orientation competence, followed by multicultural competence awareness. Although each hypothesis was supported, the understanding of the hypotheses changed when each predictor was placed into a multiple regression model. The regression suggested that, of the five predictors, training experience in sexual minority populations and multicultural competence varied with regard to unique contribution to the overall model. Exposure to LGB individuals and engagement in specialization were not significant in this model. This finding is discussed in Chapter V. However, training experience in sexual minority populations and multicultural competence were each significant with regards to their contribution to the model. Additionally, gender and sexual orientation appeared to impact the overall model. Additional insights regarding this finding are discussed in Chapter V.

Chapter V

DISCUSSION

Introduction

This chapter provides a summary and an interpretation of the results of the analyses. Limitations of the research are presented. Future research directions are considered. Finally, a conclusion, as well as a discussion of clinical and training implications, is provided.

Summary and Interpretation of Findings

For the first hypotheses, it was expected that exposure to LGB individuals would be related to sexual orientation competence. A Pearson correlation was conducted to understand this relationship. A moderately positive relationship ($r = .320$, $p < .001$) was found as a result of this analysis. Participants with greater exposure to LGB individuals rated themselves higher on sexual orientation competence. Hypothesis 1 is supported.

The findings for this hypothesis are consistent with the findings of Crisp (2012), who found that the number of gay or lesbian friends of a sample of clinicians was positively associated with the gay affirmative practice ($r = .35$, $p < .01$), and the number of gay clients also had a positive relationship ($r = .32$, $p < .05$). The findings of the present study support this previous research. Accordingly , psychologists may need exposure to persons of diverse sexual orientations to further develop their competence in this area.

Based on these initial findings, it would seem imperative that training programs, practicum sites, and internships consider ways in which trainees can be exposed to LGB individuals. To understand the biases of which a person might be unaware, participants in such a program should be encouraged to process any exposure to LGB individuals and reflect on how it differs from their expectations and what they learned about their own biases that may ultimately impact the therapeutic relationship.

A significant positive relationship between training in LGB issues and sexual orientation competence ($r = .503$, $p < .001$) was found. That is, participants who had a greater number of trainings in LGB issues and about LGB individuals scored higher in sexual orientation competence. Again, a Pearson correlation was conducted for this hypothesis. However sexual orientation competence required rank transformation to account for outliers. This hypothesis is supported.

The training variable was found to have a moderate relationship with sexual orientation competence. This is an important finding as it suggests that factors other than multicultural competence need to be considered during the training of students and the development of competence in professionals. This finding extends the understanding of how programs train in order to develop competence in this area. Previous authors have suggested that LGB individuals can be taught as one of the invisible minorities within a multicultural context (Arredondo, 1996; Lowe, & Mascher, 2001;Ponterotto, Casas, Suzuki, & Alexander, 2009; Pope, 1995; Sue, Arredondo, & McDavis, 1992). The data suggests that specific training in areas of LGB knowledge meaningfully contribute to clinician competence.

Training programs and training sites are advised to look at their course requirements and, when not already available, consider adding coursework relevant to this topic. Programs would are advised to consider the reasons that coursework has not existed in their program and the message this conveys to the trainees.

With regard to multicultural competence, hypothesis 3 postulated that participants with higher levels of reported multicultural competence would also have higher levels of reported sexual orientation competence. This hypothesis was explored using a Pearson correlation. There was a significant positive relationship between these two variables ($r = .728$, $p < .001$). The

awareness subscale was positively and strongly correlated ($r = .552$, $p < .001$) and the knowledge was also positively and strongly associated ($r = .665$, $p < .001$). The participants who reported higher levels of multicultural competence also reported higher levels of sexual orientation competence. Hypothesis 3 is supported.

Multicultural competence has been viewed by researchers as an important part of increasing competence with sexual orientation (Arredondo, 1996; Lowe, & Mascher, 2001; Ponterotto, Casas, Suzuki, & Alexander, 2009; Pope, 1995; Sue, Arredondo, & McDavis, 1992). Crisp (2006b) and Bidell (2005) utilized the tenets of multicultural competence in the development of scales to measure self-reports of gay affirmative practice and sexual orientation competence, respectively. The findings of the present study support the importance of general multicultural training in the development of sexual orientation competence. In this study, multicultural competence provided the largest unique contribution with regards to sexual orientation competence.

Programs should reflect on their training in multicultural competence and determine if competence is considered in a broad enough range to be inclusive of sexual orientation. Also, it is important for programs to consider migrating to a model where multiculturalism is embedded across coursework and not limited to specific classes.

Hypothesis 4 postulated that participants who had a higher level of engagement in sexual orientation specialization and practice would also have a higher level of reported sexual orientation competence. Once again, a Pearson correlation was used. As before, the engagement in sexual orientation specialization and practice variable required rank transformation to account for outliers in the data. There was a significant positive relationship between these two variables ($r = .335$, $p < .001$). Participants who were found to have higher levels of specialization in

sexual orientation practice also reported greater levels of sexual orientation competence. Hypothesis 4 is supported.

This specialization variable is important to recognize as the field of psychology continues to define specialties. The definition of specialties happens through organizations such as the American Board of Professional Psychology, among others. Although sexual orientation is not currently a board certified area with specific requirements for specialization, the findings of the present study suggest that a need for specialization in order to have a group of highly competent psychologists.

Additionally, individuals should consider this data while reflecting on their own competence. The data suggests that competence is developmental, and with greater specialization comes greater competence. Individuals should continue to reassess their competence across their careers to gauge where their work falls on the spectrum of competence.

Finally, it was hypothesized that exposure to LGB individuals, training in LGB issues, multicultural competence, and engagement in sexual orientation specialization and practice would each uniquely and significantly contribute to sexual orientation competence. This analysis utilized a multiple regression to understand the unique contribution of each predictor. All four factors together were significant with regards to sexual orientation competence (R^2 = .64, F = 25.60, df = (7, 101), p < .001). However, when the unique contribution of each was examined, exposur*e* to LGB individuals did not uniquely contribute to the model (β = .031, p = .664). Engagement in sexual minority specialization and practice was also not significant (β = .1617, p = .126). Training experience in sexual minority populations (β = .23, p = .005), multicultural competence knowledge subscale score (β = .424, p < .001), and multicultural

competence awareness subscale score ($\beta = .301$, $p < .001$) each significantly contributed to the model.

The data shows that the unique contribution of exposure to LGB individuals and engagement in specialization are not significant when put into a regression model with other variables. There are a number of possible reasons for this finding. The primary issue with both variables is that they are not standardized in either the current study or that of Crisp (2012). Both the present and previous research included other variables that have the potential for confounding this one. For example, it is difficult to say based on the current model how exposure to LGB individuals is related to specialization in sexual minority practice. That is to say, exposure to LGB individuals may have an impact on sexual orientation competence, but be better accounted for by one of the other variables. Corrections to this are discussed in the section on limitations of this study. Regardless, it is important to emphasize that exposure to LGB individuals was significant in the primary analysis, and that it may positively impact psychologists' competence with sexual orientation. Additionally, engagement shows a small relationship to training and the variable may need to be refined in future studies.

With regard to the other variables, training in LGB issues and multicultural competence, the data suggest that each made a significant, unique contribution to the model. Multicultural competence knowledge subscale score provided the largest contribution followed by multicultural competence awareness, and finally training. This results of the regression analysis provides solid data that suggests that training in sexual orientation competence may require more that general multicultural training alone.

The data presented here may indicate that competence in sexual orientation is more multifaceted than previously thought. This information should be considered when assessing

competence. The instruments used in the present study provided some measure of how competent an individual reported themselves to be, but findings from these instruments should be considered with caution, while future research refines the factors that lead to sexual orientation competence.

Additional analyses were run to better understand the impact that sexual orientation and gender may have on this model. LGB individuals report greater levels of competence on the SOCCS. This information is informative for programs and clinicians to further exam if LGB individuals are overly endorsing their competence in this area or if there is indeed a true difference based on sexual orientation. If there is a true difference, programs would be well advised to encourage activities that encourage heterosexual students toward greater competence in the areas assessed by the SOCCS. Practicing psychologists may consider their own sexual orientation, and how this may impact their competence to work with LGB individuals. However, the MCKAS Awareness subscale was not impacted by sexual orientation, whereas gender did have a significant impact. Women reported greater awareness on the MCKAS then men. These findings suggest that not all psychologists perceive their competence on the MCKAS in the same way. Being female or LGB may provide some additional insight into multicultural competence that lead to greater perceived competence in the areas assessed by the MCKAS. However, this should be considered with caution as these are self-reports and may not be reflective of actual practice.

An additional finding in the secondary analysis was that the MCKAS Knowledge subscale was not impacted by gender, but did show a significant impact with regards to sexual orientation. LGB individuals reported greater knowledge on the MCKAS than heterosexual individuals.

Limitations

As with all research, the present study has limitations. First, the study sought to reach a representative sample of U.S. licensed psychologists. At the time of this study there was no means available to obain a truly representative sample of this population. Several barriers were encountered when attempts to obtain a representative sample were made. APA has changed its policy regarding distribution of mailing lists for research. The current policy is that they will not release lists for research, as these lists are not considered representative samples. In addition, APA has issued a statement to divisions that specifies that they should not participate in research. Although it is true that APA members would not be representative of the population of psychologists, it is the largest collected group of psychologists in the US, and this limitation prevents the understanding the sexual orientation competence of psychologists that are members of APA. Each state board was contacted in an effort to obtain mailing lists of the psychologists licensed in their jurisdiction. Many states did not provide or did not have such lists, which limits access to psychologists in those states. This is a serious limitation as it would have provided the most accurate representation of licensed psychologists in the US.

An additional limitation is that the research was administered via an online survey. This can be problematic in that it may be that not every psychologist has access to the Internet. Additionally, use of an online survey prevents direct inquiry to help with the understanding of properly filling out the survey.

Self-report measures were utilized in this research, and use of such measures can result in socially desirable responding. Additionally, self-report measures can suffer in accuracy, as it is the participant's perception of his or her competence that is being obtained. This prevents a truly

objective measure and should be considered when reviewing the current findings. Additionally, participants are self-selected and this likely impacts the results.

Three of the five variables were created for this research, exposure to LGB individuals, training in LGB issues, and engagement in sexual orientation specialization and practice. As these variables are not normed, standardized measurements, it is unknown at this time exactly what they measure. Currently, such measure do not exist. The current study followed existing norms within the research to develop these questions. Nevertheless, acceptance of this limitation is often a necessary part of exploratory research.

Finally, the analyses that were used are not predictive of competence, but are a reflection of relationship of the variables to competence. It cannot be assumed, at this time, that the findings unequivocally show that these are the variables that lead to competence in sexual orientation. Rather, the data suggests that there are relationships between these variables and provide a point from which future research can explore further.

Future Research

The areas of future research in the area of sexual orientation are immense, as this is a largely under-researched area. For the purposes of this dissertation, the discussion of future directions is limited to research specific to sexual orientation competence. First, future research would benefit from standardized measures to assess exposure to LGB individuals and training in LGB issues. An additional benefit would be the development of a specific set of standards for specialization in working with sexual minority populations. Second, following the development of these measures, research should engage in studies to identify the factors that lead to competency in this area. Research would also benefit from a comparison of programs that provide immersive multicultural training across curriculum versus those which do not.

Additionally, programs that offer specific course work in LGB populations could be compared to programs that do not have this available. This would provide a direct look at training differences in sexual orientation.

Conclusions/Clinical Implications

The present study shows that exposure to LGB individuals, training in LGB issues, specialization in LGB practice, and multicultural competence may each play a role in sexual orientation competence. This is a stride toward a more robust understanding of competence with sexual orientation. The hope is that this research contributes to the existing body of literature, increases interest in this area, and ultimately guides training and future competency measures. Clinically, the exploration of competency and the actual completion of a competency inventory may in and of itself increase one's reflection about one's ability in this area. The further competency measures are advanced, the more the measures will be available to assess students in training and professionals throughout their career. The end result is the hope that this contributes to psychologists being able to provide the best possible service to sexual orientation minorities.

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Appendix A

Demographic Questionnaire

1. What is your age?
2. What is your gender?
    a. Male
    b. Female
    c. Trans
3. What is your birth sex?
    a. Male
    b. Female
    c. Intersex
4. What is your current sex?
    a. Male
    b. Female
    c. Intersex
5. What is your Race/Ethnicity?
    a. White
    b. Black or African American
    c. American Indian or Alaska Native
    d. Asian
    e. Native Hawaiian or Other Pacific Islander.
    f. Other
6. What is your sexual orientation status?

a. Heterosexual
b. Homosexual
c. Lesbian
d. Bisexual
e. Queer
f. Questioning

7. How many family members do you have that identify as lesbian, gay, or bisexual?
8. How many friends do you have that identify as lesbian, gay, or bisexual?
9. How many coworkers do you have that identify as lesbian, gay, or bisexual?
10. How many years have you worked in a job where you directly served lesbian, gay or bisexual individuals?
11. How many courses, externships, internship, and fellowships did you have that focused on lesbian, gay and bisexual individuals?
12. How many employer provided training have you been to that focus on lLesbian, gay, and bisexual individuals?
13. How many continuing education or certificate programs have you attended that focus on lesbian, gay, or bisexual individuals?
14. How many postdoctoral courses, offered through a college or university, have you attended that focus on lesbian, gay, or bisexual individuals?
15. How many years of postdoctoral employment have you had working specifically with lesbian, gay, and bisexual individuals?
16. How many LGB-specific professional associations or organization are you involved with regarding professional practice with lesbian, gay, or bisexual individuals?

17. How many certifications or licenses do you have specifically addressing the concerns lesbian, gay, or bisexual individuals?
18. What percentage of your caseload allows you to directly interact with lesbian, gay, or bisexual individuals?
19. How many "client clinical" cases do you supervise regarding lesbian, gay, or bisexual individuals?

Appendix B

S.O.C.C.S.

Instruction: Using the scale following each question, rate the truth of each item as it applies to you by circling the appropriate number. It is important to answer all questions and provide the most candid response, often your first one.

LGB = Lesbian, Gay, and Bisexual.

1. I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

2. The lifestyle of a LGB client is unnatural or immoral.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

3. I check up on my LGB counseling skills by monitoring my functioning/competency – via consultation, supervision, and continuing education.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

4. I have experience counseling gay male clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

5. LGB clients receive less preferred forms of counseling treatment than heterosexual clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

6. At this point in my professional development, I feel competent, skilled, and qualified to counsel LGB clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

7. I have experience counseling lesbian or gay couples.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

8. I have experience counseling lesbian clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

9. I am aware some research indicates that LGB clients are more likely to be diagnosed with mental illnesses than are heterosexual clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

10. It's obvious that a same sex relationship between two men or two women is not as strong or as committed as one between a man and a woman.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

11. I believe that being highly discreet about their sexual orientation is a trait that LGB clients should work towards.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

12. I have been to in-services, conference sessions, or workshops, which focused on LGB issues (in Counseling, Psychology, Mental Health).

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

13. Heterosexist and prejudicial concepts have permeated the mental health professions.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

14. I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

15. I believe that LGB couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine normal and traditional family values.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

16. There are different psychological/social issues impacting gay men versus lesbian women.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

17. It would be best if my clients viewed a heterosexual lifestyle as ideal.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

18. I have experience counseling bisexual (male or female) clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

19. I am aware of institutional barriers that may inhibit LGB people from using mental health services.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

20. I am aware that counselors frequently impose their values concerning sexuality upon LGB clients.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

21. I think that my clients should accept some degree of conformity to traditional sexual values.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

22. Currently, I do not have the skills or training to do a case presentation or consultation if my client were LGB.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

23. I believe that LGB clients will benefit most from counseling with a heterosexual counselor who endorses conventional values and norms.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

24. Being born a heterosexual person in this society carries with it certain advantages.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

25. I feel that sexual orientation differences between counselor and client may serve as an initial barrier to effective counseling of LGB individuals.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

26. I have done a counseling role-play as either the client or counselor involving a LGB issue.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

27. Personally, I think homosexuality is a mental disorder or a sin and can be treated through counseling or spiritual help.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

28. I believe that all LGB clients must be discreet about their sexual orientation around children.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

29. When it comes to homosexuality, I agree with the statement: ‘You should love the sinner but hate or condemn the sin’.

Not at all True			Somewhat True			Totally True
1	2	3	4	5	6	7

Appendix C

Multicultural Counseling Knowledge and Awareness Scale (MCKAS)

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

1. I believe all clients should maintain direct eye contact during counseling.

1 2 3 4 5 6 7

2. I check up on my minority/cultural counseling skills by monitoring my functioning – via consultation, supervision, and continuing education.

1 2 3 4 5 6 7

3. I am aware some research indicates that minority clients receive "less preferred" forms of counseling treatment than majority clients.

1 2 3 4 5 6 7

4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients.

1 2 3 4 5 6 7

6. I am familiar with the "culturally deficient" and "culturally deprived" depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination.

1 2 3 4 5 6 7

7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted.

1 2 3 4 5 6 7

8. I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illnesses than are majority clients.

1 2 3 4 5 6 7

10. I think that clients should perceive the nuclear family as the ideal social unit.

1 2 3 4 5 6 7

11. I think that being highly competitive and achievement oriented are traits that all clients should work towards.

1 2 3 4 5 6 7

12. I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions.

1 2 3 4 5 6 7

14. I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility.

1 2 3 4 5 6 7

15. I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment.

1 2 3 4 5 6 7

16. I am knowledgeable of acculturation models for various ethnic minority groups.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

17. I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups.

1 2 3 4 5 6 7

18. I believe that it is important to emphasize objective and rational thinking in minority clients.

1 2 3 4 5 6 7

19. I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups.

1 2 3 4 5 6 7

20. I believe that my clients should view a patriarchal structure as the ideal.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1 2 3 4 5 6 7

Not at All True	Somewhat True	Totally True

21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship.

1 2 3 4 5 6 7

22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs.

1 2 3 4 5 6 7

23. I am aware of institutional barriers which may inhibit minorities from using mental health services.

1 2 3 4 5 6 7

24. I think that my clients should exhibit some degree of psychological mindedness and sophistication.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1 2 3 4 5 6 7

Not at All True	Somewhat True	Totally True

25. I believe that minority clients will benefit most from counseling with a majority who endorses White middle-class values and norms.

1 2 3 4 5 6 7

26. I am aware that being born a White person in this society carries with it certain advantages.

1 2 3 4 5 6 7

27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients.

1 2 3 4 5 6 7

28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

29. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.

1 2 3 4 5 6 7

30. I believe that all clients must view themselves as their number one responsibility.

1 2 3 4 5 6 7

31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) which may dictate referral of the minority client to a member of his/her own racial/ethnic group.

1 2 3 4 5 6 7

32. I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions.

1 2 3 4 5 6 7

Appendix D

From: **Markus P Bidell** mbidell@hunter.cuny.edu
Subject: Re: touching base.research
Date: April 22, 2013 at 12:56 PM
To: Marty Cooper macoope@hunter.cuny.edu

MP

Of course – see attached files - Markus

Markus P. Bidell, Ph.D., LMHC
Associate Professor of Counseling
Educational Foundations & Counseling Department
Hunter College • 695 Park Ave. • New York NY 10065
• Director •
LGBT Social Science & Public Policy Center
www.hunter.cuny.edu/the-lgbt-center
mbidell@hunter.cuny.edu

"In order to earn for ourselves any place in the sun, we must with perseverance and self-discipline work collectively for the first-class citizenship of Minorities everywhere, including ourselves" Harry Hay, 1950

On 4/21/13 3:43 PM, "Marty Cooper" <macoope@hunter.cuny.edu> wrote:

> Hi Dr. Bidell,
> I am one of your adjuncts in the mental health counseling program as well as providing practicum and intern students my practice to gain experience in. However, I am currently writing you regarding research. I am currently working on my dissertation focusing on gay affirmative therapy. Specifically, I am looking to do a national assessment of psychologist competence in gay affirmative therapy as well as multicultural competence. I am curious if I would be able to view your instrument and original article to see if this would be appropriate for this study. On a side not I cannot believe our paths have not crossed before. I worked with Jeff for many years and have been in your department for several years now. It would be a pleasure to meet you at some point. Thank you for your consideration on this.
> Best,
> Marty
>
> Marty Cooper
> www.coopertherapy.com
> macoope@hunter.cuny.edu

SOCCS-Bidell_2013.pdf

Using the SOCCS

Thank you for your interest in the Sexual Orientation Counselor Competency Scale© (*SOCCS*, Bidell, 2005), a valid and reliable assessment of the attitudinal awareness, skills, and knowledge competency of mental health professionals working with Lesbian/Gay/Bisexual (LGB) client populations. The SOCCS integrates LGB-affirmative counseling and adheres closely to the multicultural counselor competency theory established by Sue, Arredondo, and McDavis (1992). Multicultural counselor competency theory invites mental health practitioners to explore and expand awareness of their biases and attitudes, to

Appendix E

From: **JOSEPH Ponterotto [Staff/Faculty [GSE]]** ponterotto@fordham.edu
Subject: Re: instrument request
Date: April 21, 2013 at 5:49 PM
To: Marty Cooper marty.cooper@student.shu.edu

JP

Hi marty,

My scale is a general multicultural competency self-assessment scale; you may want to examine Markus Bidel"s gay/lesbian couns competence adapation of the scale (you can easily find it in through google, I think). Be sure to calculate coefficeint alphas for any susbscale of any intrument you use (see pdf article, particualrly Table 3). I am attachingboth the MCKAs and QDI; let me know if you decide to use either ... and would love to see a copy of your Results in the end. Good luck; and a big hello to Ryan.

Sincerely,
joe ponterotto
On Sun, Apr 21, 2013 at 3:50 PM, Marty Cooper <marty.cooper@student.shu.edu> wrote:

> Hi Dr. Ponterotto,
> Dr. Ryan Androsiglio, my supervisor at Baruch College Counseling Center, suggested I reach out to you. I am currently starting my dissertation focusing on a national assessment of psychologists competence in gay affirmative therapy and how this compares to multicultural competence. I am very interested in using your multicultural competence scale for this research. If this is a possibility please let me know the best way to proceed. Thank you for your consideration.
> Best,
> Marty
>
> Marty Cooper, MA, LMHC
> marty.cooper@student.shu.edu
> Doctoral Student


Ponterotto & Ruckdesch…eliability.pdf


QDI Scale and score.doc

Appendix F

Solicitation Letter

Dear Psychologist,

I am a doctoral counseling psychology student at Seton Hall University in the College of Education and Human Services under the mentorship of Laura Palmer, PhD. I am sending you this letter to invite you to participate in my dissertation research. This research has been reviewed and approved by the Institutional Review Board (IRB) of Seton Hall University and questions regarding the IRB approval may be directed to irb@shu.edu.

I am looking to administer standardized measures to better understand the competence of psychologists' experience and competence working with diverse sexual orientation. For this study, I need licensed psychologists with doctoral level training in counseling, clinical, or school psychology. I request that all participants are currently engaged in direct clinical services. I am seeking a broad range of experience and ask that you consider participating even if sexual orientation is not an area of specialty in your practice.

During this study, you will be asked to complete an online survey that will take approximately 15 minutes.

The survey includes demographic questions (level of education, type of practice current engaged in, general knowledge of sexual orientation, etc.), the Sexual Orientation Counselor Competency Scale, and the Multicultural Counseling Knowledge and Awareness Scale.

Participation in this survey is completely voluntary.

Although it is difficult to ensure complete anonymity with online surveys, several measures are in place to increase your privacy. First, the survey is administered online allowing you to complete the survey in an environment that is private and comfortable. Second, no identifying information will be asked of you during this survey. Third, no email invitation collector will be utilized. This will ensure that I will have no idea if you choose to respond to the survey based on the email invitation. The completion of the online survey will complete your participation in the study.

All data collected will be stored on a USB memory key and kept in a locked cabinet at the College of Education at Seton Hall University.

If you choose to participate in the survey please follow the link below:

http://asset.tltc.shu.edu/servlets/asset.AssetSurvey?surveyid=6302

When you click the link you will be asked to input a user ID and password.

The user ID can be any initial and the password is: asset

Sincerely,

Marty A. Cooper, M.A.
Tel: (917) 714-3257
Email: marty.cooper@student.shu.edu

Appendix G

Informed Consent

Researchers' Affiliation

Marty Cooper is a student in the Counseling Psychology program at Seton Hall University. Laura Palmer, Ph.D. is a faculty member in the Counseling Psychology Program at Seton Hall University.

Purpose and Duration of Research

This study looks at the competence of licensed, practicing psychologists with regards to sexual orientation. The study will be conducted from March through June of 2014.

Procedures

Participants will go to the provided website to complete an online survey that will require approximately 15 minutes of time.

Instruments

The survey will include: the Sexual Orientation Counseling Competency Scale (SOCCS), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), and a demographic questionnaire. Sample questions are, "I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients." (selecting from a scale of 1 to 7) and "I believe all clients should maintain direct eye contact during counseling.".

Voluntary Participation

Participation in this study is completely voluntary. You may drop out of the study at any time without any consequences.

Anonymity Preservation

No identifying information will be collected during the survey.

Confidentiality Maintenance

All information will be collected in confidence and answers to questions will be kept in a safe place that is locked.

Record Retention

The researcher and the co-investigator will be the only ones who can see results. All results will be stored for at least three years, as required by Seton Hall University.

Anticipated Risks or Discomfort

In this research there is a risk of experiencing discomfort from answering questions regarding your personal experience with lesbian, gay, and bisexual individuals. This can result in a questioning of ones competence with sexual orientation.

Benefits to Research

The information that comes from this study will help to understand the state of competence in the industry and inform future research. The results can be used to help clinicians obtain the training necessary to work with sexual orientation.

Compensation

There is no compensation for this study.

Risks

This study involves minimal risk and no injury is expected in completing the survey.

Alternative Treatment Procedures

Other ways for your to be helped is regular counseling with a therapist.

Contact Information

If you have any questions about this study feel free to contact the researcher at (917) 714-3257 or the co-investigator, Dr. Laura Palmer at (973) 761-9441. Questions about the children's rights as subjects in research should be directed to the Director of the Institutional Review Board at Seton Hall University, Dr. Mary F. Ruzicka, Ph.D. at (973) 313-6314.

Marty A. Cooper, M.A.
Tel: (917)714-3257
Email: marty.cooper@student.shu.edu

Laura Palmer, Ph.D.
Tel: (973) 761-9441
Email: palmerla@shu.edu