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Katie Messier
Clinician's Perceptions about
Working with LGBTQ Military
Personnel and Cultural Competency

ABSTRACT

This qualitative exploratory study was completed to investigate clinician's perceptions of working with LGBTQ military personnel in a therapeutic setting. Secondly, this study explored the concept of cultural competency as it relates to working with the LGBTQ military population.

Using semi-structured interviews with clinicians currently in practice with military clients this study found that all nine participants felt competent in their work with LGBTQ clients. This study also found that although clinicians were aware of some specific issues LGBTQ military clients might face, there was a lack of more specific knowledge related to this population.

This study also found a general consensus of lack of training regarding this population, denial of bias or homophobia with the population and absence of community changes since the repeal of Don't Ask, Don't Tell and the Defense of Marriage Act. This study concluded that educational workshops or trainings are the key to developing more culturally competent work with LGBTQ military personnel. Therefore, this study suggests that further research regarding work with LGBTQ military personnel and cultural competency is critical so that graduate schools can enhance their curriculum, graduate students can feel more competent and prepared, clients can feel more connected and less stigmatized in therapy and clinicians can feel more prepared and educated regarding key issues of this population.

**Clinician's Perceptions about Working with LGBTQ Military Personnel and Cultural
Competency**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements for
the degree of Master of Social Work.

Katie Messier

Smith College School for Social Work
Northampton, Massachusetts 01063

2014

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CHAPTER I

Introduction

The purpose of this study is to explore perceptions of currently practicing clinicians with military clients regarding therapy with LGBTQ military clients and notions of cultural competency. This research subject is being explored because of my own interest in the relevancy of this topic for social workers and my belief of the necessity for clinicians to practice with more humility in the realm of therapy and cultural competency. This belief is based from experiences colleagues have described in which they did not exhibit humility. I have been, and continue to be, an activist for civil rights of the LGBTQ community, particularly in regards to marriage equality and health rights. Included in the realm of health rights is the ability to access psychological and psychiatric resources without being stigmatized. The DSM has come a long way with the removal of homosexuality as a disorder and the dismissal of conversion therapies, but there is still more progress to be made. In speaking with friends and colleagues regarding their experiences as an LGBTQ identified individual and homophobia in therapy, I became interested in exploring clinicians' perceptions of this phenomenon, particularly those working with military clients since there has been a long history of stigma within the military culture.

There appears to be various degrees of research regarding the different areas of therapy with LGBTQ clients, as well as research regarding perceived competence by graduate students with this population. However, there is a specific lack in literature looking deeper into students' perceptions related to cultural competency with this population. Further, there is a lack in

research regarding perceived competence by clinicians regarding therapy with LGBTQ clients. Even further, there is a lack in research regarding work with LGBTQ military clients. The literature I reviewed in the realm of graduate students' perceived competency and military clients appears to primarily reflect heterosexual individuals with more scarce information regarding LGBTQ clients. In fact, according to Pachankis and Goldfried (2013), there is currently little research in the area of therapy with LGBTQ individuals even though the author claims that this population is one of the highest seen in therapy. This lack becomes even more apparent when intersecting clinical work with military clients. While research is abundant in the realm of counseling with military personnel, again there is a missing piece relating to LGBTQ military personnel. Therefore, there is a need for further research regarding this intersection of LGBTQ identity and military identity and how clinicians perceive they are prepared to work with this population.

One chapter in a book working with military couples recommends we focus on the need for cultural competency in this field of work (Porter & Gutierrez, 2012). Cultural competency in this research will be defined by Davis as “the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes” which may be practiced by an individual or an entire organization (as cited in Flaskerud, 2007, p.122). Cultural competency is particularly important for the profession of social work since “social workers should have an understanding, knowledge base and sensitivity to their clients’ cultures and differences therein” (Mulé, 2006). Moreover, with the recent repeal of Don’t Ask Don’t Tell in September of 2011 (Bumiller, 2011) and Defense Of Marriage Act in

June of 2013 (Savage, 2013), there is a great need for a concentration and deeper understanding of cultural competency as it is applied to the LGBTQ military community.

This research attempts to further understand clinicians' perceptions of working with LGBTQ individuals who are also military personnel. The findings from this research are intended for professionals in the field to further understand and improve cultural competency with LGBTQ military personnel seeking therapy. It may also assist in understanding the needs of this population and how to best provide therapeutic resources without further segregating this population. Overall, with the limited research regarding the area of LGBTQ military personnel and cultural competency (Porter & Gutierrez, 2012) the research question I am focusing on is what are the perceptions of clinicians regarding working with LGBTQ military personnel.

This is where my study on the perceptions of clinicians regarding LGBTQ military personnel and the availability of those resources comes into necessity. Through the research, I hope to raise awareness of social work professionals about the need to investigate how one works with their clients, particularly in reference to cultural competency. The outcome of this research is intended to inform social work practice for professionals in deeply understanding one's own personal ideas of cultural competency and gaining further insight into one's own possible prejudices in doing this work. There were limitations in this research due to the difficulty finding clinicians working with LGBTQ military clients, willingness to speak on this subject and possible skewing from clinicians exhibiting social desirability bias.

Using an exploratory research design and qualitative methods to collect data, I conducted nine interviews in order to examine the perceptions and biases of practicing clinicians regarding cultural competency and therapy with LGBTQ military personnel. Open-ended questions were used during semi-structured interviews to gather data about experience working with LGBTQ

military personnel, transparency regarding sexual orientation, cultural competency and perceived awareness of bias and perceptions. These interviews also contained questions about each participant's input for improving culturally competent work with LGBTQ military personnel. Coding was used to interpret the data and four major themes of the research were identified.

The following chapters explore the current literature in order to discuss the theoretical and empirical basis for this study, the methodology used to explore the research question highlighting the implementation of the study and any issues that may have been encountered, the qualitative findings, as well as a discussion section that attempts to make meaning of the findings to include recommendations for further study.

CHAPTER II

Literature Review

The purpose of this study is to gain a deeper understanding of cultural competency and biases within the context of clinical social work practice. This study will examine clinician's perceptions of working with LGBTQ military personnel, active duty or veteran status. This literature review will be separated into several sections. The first section will examine the history of homosexuality and mental health stigma in the military in order to form a foundation for understanding aspects that may shape clients' attitudes towards seeking therapy. The second section will look at research regarding therapy with LGBTQ individuals and therapy with military individuals. I will then discuss the limited empirical and theoretical research available regarding LGBTQ military personnel. This section will detail help-seeking behaviors, unique issues presented within these two populations and the guiding ideas of cultural competency. The final section will give an overview of gay affirmative therapy and cultural competence which is the conceptual framework for this study. Throughout this chapter I will highlight both the strengths and weaknesses of the literature in order to establish the need for my study.

History of Homosexuality in the Military

Homosexuals have always served in the military; albeit unknown or unacknowledged. As times changed, the military began to sanction against "sodomy (usually defined as anal and sometimes oral sex between men)" ("Don't Ask, Don't Tell," n.d.) and in 1920 Congress amended Article 93 of Article of War to consider sodomy a crime ("USNI Logo," n.d.). Thus for

years, while sodomy was considered a criminal offense the military refused to allow homosexuals to serve if sodomy charges were brought against them.

As the U.S. prepared to enter WWII, psychological screening, within the medical examination of prospective recruits, became a routine part of screening. Within this screening, psychiatrists examined not only homosexual behavior but homosexual people and started the process of excluding these identified people from the military. Only when enlisted numbers were diminished did the military allow homosexual persons to serve, but as numbers began to increase individuals who identified as homosexual found themselves suddenly removed from their service (Hoge et. al, 2005). In 1982, the Department of Defense (DOD) decided that homosexuality went against the military's values and was not compatible with the ability to serve ("General Accounting Office", 1992a) effectively barring them from service:

Homosexuality is incompatible with military service. The presence in the military environment of persons who engage in homosexual conduct or who, by their statements, demonstrate a propensity to engage in homosexual conduct, seriously impairs the accomplishment of the military mission. The presence of such members adversely affects the ability of the military services to maintain discipline, good order, and morale; to foster mutual trust and confidence among service members; to ensure the integrity of the system of rank and command; to facilitate assignment and world-wide deployment of service members who frequently must live and work under close conditions affording minimal privacy; to recruit and retain members of the military services; to maintain public acceptability of military service; and to prevent breaches of security. (DOD Directive 1332.14, 1982, Part 1, Section H)" (Johnson & Buhrke, 2006).

As the numbers dramatically increased of those were being discharged due to their homosexuality, grassroots gay and lesbian civil rights groups began to speak up against the policies put in place by the DOD.

While President Clinton was in office he attempted to put an end to the discrimination in the military service, but was met with opposition. As he worked diligently to figure out a plan, a compromise was drafted in 1994 known as “Don’t Ask, Don’t Tell, Don’t Pursue (DADT).” This document was intended to keep service members from being discharged due to their sexual orientation and would keep screenings from occurring, but it still allowed for discharge if individuals were found to be conducting homosexual behavior while enlisted. DADT was also unable to stop discharges for openly admitting homosexuality or even engaging in homosexual behavior. According to Cochran, Balsam, Flentje, Malte & Simpson (2013), “for LGB service members serving under DADT, the policy often created unique stressors including, but not limited to, needing to conceal important personal information, enduring harassment, and facing discharge or fear of discharge” (p.424). It was not until 2011 that DADT was repealed and individuals were allowed to freely express their sexual orientation without fear of discharge (“Don’t Ask, Don’t Tell,” n.d.).

In the current state of the military since the repeal of DADT, lesbian, gay and bisexual individuals are able to openly serve without fear of repercussion. Mental health policies within the military have changed to reflect the updated guidelines regarding the ability for individuals to openly present and discuss sexual orientation (“Homosexuality and Mental Health,” n.d.). Military members are now able to discuss sexual orientation to military mental health providers without fear of what this might mean in terms of their military career. However, these changes do not appear to have made a significant dent in the stigma that still exists.

Stigma

It has been known for some time that stigma exists for those who desire to seek therapy. For years, some people seem to feel embarrassed for seeking therapy because it appears to signify they are crazy, but the reality exists that many individuals who seek therapy are dealing with difficult life transitions or life challenges (Gionta, 2008). Stigma is an all too common aspect of the mental health field and something the professionals in the field have been fighting against, as well. Mental health issues are often seen as a negative and seeking services or being diagnosed with a disorder seems to mean something is wrong with a person. Erving Goffman (1997) describes different types of stigma that exist in the world, one of which accurately describes the type of stigma experienced by those seeking mental health services, discreditable blemishes of individual character.

This stigma is not unique to the civilian population in any way; it may even have a stronger presence in the military population. According to Kim, Thomas, Wilk, Castro & Hoge (2010), "Research on stigma in civilian populations asserts that individuals who perceive the stigmatizing behaviors of others as legitimate will have lower self-esteem. This belief and internalization of stigmatizing behaviors is likely to reduce treatment seeking by soldiers with mental illness" (p.579). The military even goes so far as to exclude those enlisting into the military with a psychiatric history. According to Hoge, et. al. (2002):

There is evidence that factors unique to the military environment, such as limitations in confidentiality and methods of referral, may influence psychiatric diagnostic practices. Although there is no standardized screening instrument for psychiatric disorders used routinely at the time of accession into the military, service members undergo a

comprehensive medical evaluation and are unlikely to be accepted into service if they report any significant psychiatric history (p.1579).

Psychiatric disorders within the military context are seen as weak and therefore many military personnel do not report such histories. Military personnel are encouraged to be strong and able to handle whatever may be thrown at them in combat. They are taught to be tough and work through whatever thoughts or feelings they may have in order to be combat ready. This mentality follows them after their time in the service and enforces the notion to be strong and solve problems on their own. According to Kim, Britt, Klocko, Riviere & Adler (2011):

A big factor in seeking treatment appears to be whether veterans believe that their problem is severe enough to warrant treatment and believing that they can and should handle psychological problems themselves. Service members may delay treatment in order to try and work out problems on their own, so they do not have to admit they could not handle the stress created by their work. Supporting this logic, the primary reason veterans gave for not getting treatment was that the problem was not severe enough to warrant treatment. This type of reason is likely a function of the belief that mental health difficulties should be handled oneself and therefore are not sufficiently severe to warrant seeking treatment from a professional (p.68).

Therefore, individuals in the military may be less likely to seek out services due to concerns of retribution or stigma. There appears to be numerous mental health problems and diagnoses among service members after combat, but research shows only about half of those experiencing these problems seek help within the first year returned. Seemingly, these low rates occur because of the stigma of mental health treatment among those in the military (Kim, Thomas, Wilk, Castro & Hoge, 2010). Military personnel can also be discharged from their

service because of a psychiatric problem, and this becomes especially difficult to bear for those individuals who hope to make a career out of the military.

On the other hand, mental health services may be enacted for mandatory purposes when a military person is in trouble for behaviors related to violence or substance abuse. This may be related to the military's efforts to avoid members getting into trouble with the law, so instead they seek to set them up with mental health services. According to Hoge et al. (2005):

With universal access to mental health services and a social environment in which service members often live and work together, these behavioral problems may intersect with psychiatric inpatient services differently than they do in civilian populations. Criteria for psychiatric hospitalization are similar in military and civilian settings (particularly threat to self or others). However, in the military there may be a higher likelihood of initially involving mental health services rather than law enforcement for behavioral control of misconduct such as aggression or substance abuse (p.1581).

These practices appear to be in place to assist military service members in receiving the help they may need rather than involving the law, but it also seems to be contradictory. I highlight this contradiction because the military culture appears to feed into the notion of mental health stigma by not allowing members with a history of psychiatric disorders, and also not allowing for service connected disability related to mental health disorders that are deemed present before military experience. This suggests the military's negative view on mental health needs, yet they endorse the benefits to seemingly protect their service members.

Another population that is greatly affected by the stigma of mental health is the LGBTQ community. This population is often forgotten because of a history of negative attitudes and lack of awareness and research. According to Fassinger (1991), "difficulties encountered in the

mental health system include diagnostic and treatment biases, lack of sensitive services and overt discrimination (p. 157).” Initially, homosexuality was considered a sociopathic personality disturbance in the first edition of DSM in 1953, and altered to be considered a sexual deviation in 1968 with the release of DSM-II. It was not until 1973 and 1975 when the American Psychiatric Association and American Psychological Association respectively removed homosexuality as a mental disorder (“When Homosexuality,” n.d.). Since not only society defiled the homosexual identity but the mental health field as well, it makes sense that LGBTQ individuals would be less inclined to seek therapy.

In 1973, when societal norms began to shift the American Psychiatric Association decided to remove the diagnosis of *homosexuality* as a mental disorder from the Diagnostic and Statistical Manual (DSM). However, in 1980 when the Third Edition of the DSM was printed the diagnosis was changed to *ego-dystonic homosexuality*, which further caused uproar in the mental health community for appeasing those who did not want homosexuality removed from the manual. Finally, in the 1986 when the DSM-III was revised, the diagnoses of homosexuality was completely removed with only a trace found under *Sexual Disorders Not Otherwise Specified* (“Homosexuality and Mental Health,” n.d.).

Decades later, the mental health field has shifted the focus from homosexual identity and sexual orientation to the unique problems experienced by those individuals including, but not limited, to experiences of societal homophobia (Fassinger, 1991). However, the changes in the mental health field have not necessarily made a change in the homophobia that can exist among clinicians because it is not a cause and effect solution. Homophobia still exists today and a shift in the mental health field’s focus does not necessarily cause a change in an individual person’s thoughts and fears. Since society functions in a hetero-normative design, there still exists the

possibility that those LGBTQ individuals who seek therapy will encounter biases and difficulties in therapy due to heterosexist assumptions that may arise.

It has been a concern in the history of social work that psychotherapists are perpetuating the system of blaming the individual and thus perpetuating hetero-normative ideas by not taking into account the role of the environment. Since traditional therapy was based on the individual changing some aspect of themselves, it has become a necessary shift, pushed by those seeking more sensitive therapies, for counselors to look at the role of the environment. The environment plays a key role in how the individual functions in society and ultimately interacts with the world around them, therefore it is necessary for the therapist to practice with a sense of knowledge that what may be affecting a client is beyond purely biological factors (Fassinger, 1991; Bouchard, 1994). When the role of the environment is not taken into account it is possible for the clinician to overlook the exceptional external stress a homosexual individual might be experiencing due to societal homophobia.

Lesbian, gay and bisexual men and women seek therapy more often than heterosexuals (Pachankis & Goldfried, 2013), therefore it is particularly important for clinicians to be perceptive of biases that may inhibit therapy with these individuals. Clinicians have been trained in a heterocentric environment with heterosexist based therapies, which in turn creates difficulties and biases when working with those who do not fit this mold. Therefore, it is the duty of all clinicians to educate themselves so as to not continue these biases and continue research so that all clinicians can become more competent in this arena.

There currently exists little research in the area of therapy with LGBTQ individuals even though this population is one of the highest seen in therapy. There are a unique set of stressors to this population due to remaining societal homophobia and heterocentric ideals such as, "identity

development, intimate relationships and parenting, family issues, the unique experiences of underrepresented sexual minority populations (e.g., ethnic minority, religious, older, and bisexual individuals), and legal and workplace issues” (Pachankis & Goldfried, 2013, p.55) that need to be researched further for more culturally sensitive therapies. Even a slight hint of homophobia or misunderstanding due to heterosexist ideals in therapy with LGBTQ individuals can create an irreparable break in the relationship. LGBTQ clients are unlikely to seek or continue seeking therapy if the clinician is not sensitive to the unique stressors that exist with this population (Pachankis & Goldfried, 2013). As society begins to work towards shifting away from such a heteronormative functioning, it is unclear how clinicians are working this population in this new era.

Therapy with LGBTQ Clients

Smith, Shin & Officer (2012) propose one of the barriers to counselors working with LGBTQ clients relates to language. They describe the ways in which heteronormativity and heterosexism are easily engrained into the macro level of society and processes of thought. Therefore, for a clinician who is not aware of the pervasive existence of heterosexim and heteronormativity, they may unknowingly make statements or express thoughts that are invalidating to LGBTQ clients. An example of this would include a clinician asking a new client if they were married, or asking a female client to tell them about their husband. Both of these scenarios assume the client is with a partner of the opposite sex and/or that they would be married. Many states still do not have laws in place to grant and protect marriage for same-sex couples, therefore assuming a client is married negates the possibility of a LGBTQ identified individual. Following the same line of thought it should also be a part of practice to utilize gender-neutral words. It can be a very easy thing for a clinician to plainly speak of instances or

examples in the context of he/she rather than in more neutral terms such as ‘one’ or ‘they’ when appropriate. Again, the use of assigning gendered words assumes a heteronormative stance and should be monitored (Smith, Shin & Officer, 2012).

With little research specific to techniques to working with LGBTQ couples, it is most important for clinicians to educate themselves and be aware of issues common to this population. According to Spitalnick and McNair (2005), there are distinct issues that homosexual couples face over heterosexual couples. Some of these differences might include difficulties with shame, isolation, secrecy and fear, sexuality and gender roles and living day-to-day in a heteronormative society that often devalues their very existence. This is where the idea of cultural competency becomes important because the process of clinicians becoming self-aware, educating themselves on key issues pertinent to the LGBTQ community and validating their clients’ experiences is necessary to do this work.

Therapy with Military Clients

According to the American Psychiatric Association, one in five Iraq and Afghanistan veterans is diagnosed with Post Traumatic Stress Disorder (PTSD), mental health disorders are the main cause of hospitalizations for active-duty military personnel, and the suicide rates of veterans are double that of the civilian population; about 8,000 veterans are thought to commit suicide each year (“Military,” n.d.). Military personnel deal with an extreme amount of stress and therefore are more susceptible to PTSD, depression and substance abuse (“Veterans and Military Health,” n.d.) than the general population. Military personnel have access to mental health services in the military, but may be less likely to utilize those services due to fear of how it might affect their military career (“Military,” n.d.).

There are several different therapies used when working with military clients based on varying conditions common to traumatic experiences including, but not limited to, Eye Movement Desensitization and Reprocessing (EMDR) and Cognitive Processing Therapy (CPT) (Monson, Schnurr, Resick, Friedman, Young-Xu & Stevens, 2006; Silver, Rogers & Russell, 2008). These therapies are seen as particularly useful for military personnel due to the intense conflict, anxiety and trauma experienced by the armed-forces. These are unique experiences for military personnel and thus are a unique population to work with in the mental health field due to the high rates of PTSD, depression, suicide and substance abuse (Cochran et. al., 2013). Therefore, to work effectively with this population, the mental health field must continuously gather research regarding the outcomes of various forms of therapies used, and determine the most useful strategies.

Theoretical and Conceptual Framework

When thinking of the research that I would like to conduct it is vital to look at the theoretical frameworks founded in previous literature around the phenomenon of working with the LGBTQ population. Two theories that may be applicable to my research include relational theory and queer theory.

Stephen A. Mitchell is one of the first authors in the field of relational theory, beginning in 1983. Relational theory is a relatively new concept that encompasses ideas based in object relations theory and self-psychology by creating a further subset of psychoanalysis that focuses on the relational aspects of two or more people interacting. According to Segal (2013), “Relational theorists agree that interactions between individuals inevitably occur in the relational matrix, which refers to the field encompassing self, other, and the space between” (p.381). This follows the idea that consciously and unconsciously working within the people involved in the

relationship and the new entity created from that relationship can allow healing in a therapeutic setting. This healing occurs based on a two-person change theory regarding meaning making and reciprocity influenced by each individual's relational patterns and past experiences.

Another relatively new and evolving theory today is queer theory which encompasses ideas based in feminist theory and anti-patriarchal gender concepts. The term was originally coined in 1990 by Teresa de Lauretis. According to Jagose (2009), "For de Lauretis, queer theory offered a way of thinking about lesbian and gay sexualities beyond the narrow rubrics of either deviance or preference, 'as forms of resistance to cultural homogenization, counteracting dominant discourses with other constructions of the subject in culture' (1991: iii)" (p.162). The basis of queer theory is situated in the ability to provide an opportunity to reflect on gender identity and the various possible meanings these identities could have on an individual.

As various theories develop over time to expand to the changing societal and political norms new theories are also developed and combined. Kassoff (2004) describes the ways in which relational theory and queer theory have come to intersect in psychoanalysis:

Queer theory is a descendant of lesbian/gay studies and feminist critiques of heterosexuality and patriarchal gender relations as a norm. Relational theory is an outgrowth of a theoretical shift from a one-person to a two-person psychology, in which the analyst is not just an observer of the patient, but an active participant in co-constructing the analysis with the patient...The particular intersection of gendered introspection and relationship in relational psychoanalysis has profoundly changed clinical discussions of openness to, the usefulness of, and the possibility of judicious self-disclosure in erotic transference and countertransference (p.163).

If we follow these ideas it is possible to see how these two theories work together to create an open therapeutic space for LGBTQ clients and the clinician. This space allows for the exchange and discussion regarding transference and countertransference in the room during sessions and creates a therapeutic alliance that will be useful to the client and clinician. However, in order for this concept to be applied, the clinician must be willing to deeply work with his concept of queer theory and relational theory under the basis of cultural competency.

Another relatively new theory for working with LGBTQ clients that would encompass similar ideas of cultural competency is gay affirmative therapy. Gay affirmative therapy is a concept that has been emerging at a rapid rate within the clinical context. Although there happens to be a lacking in a specific operational definition of the therapy or outcome measures for gay affirmative therapy, it was originally defined by Ruperto Perez in the field of psychotherapy (Johnson, 2012). According to Johnson (2012), the current definition for gay affirmative therapy is, “the integration of knowledge and awareness by the therapist of the unique development and cultural aspect of LGBT individuals, the therapist’s own self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy skills at all stages of the therapeutic process” (p.518). However, this definition does not provide a unique way of working with the LGBTQ population, therefore, it is apparent gay affirmative therapy may be best understood as a sort of cultural competency since it seems to contain core concepts rooted in the ideas of cultural competency.

Cultural competency as defined by Davis is, “the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes” which may be practiced by an individual or an entire organization

(as cited in Flaskerud, 2007, p.122). Cultural competence began as an understanding within the health care system to assist immigrants and individuals from other cultures adjust to western norms, and to encourage health care providers to develop knowledge regarding their patients' cultural norms to assist with care. Further, providers were encouraged to examine their own cultural history and influences since both the patient and provider bring unique cultural understandings to the table. It should also be noted that the ideas of cultural competence that emerged in the 1970s were originally formulated for issues specific to race and ethnicity, not to include issues of gender, sexual orientation, age and other aspects of human identity (Saha, Beach & Cooper, 2008).

It is possible to see the similarities in the understandings of cultural competency and gay affirmative therapy in which both require an integration of knowledge of a group of people in order to increase effectiveness of services. According to Rostosky and Riggle (2011):

Many counseling psychology programs have increased the attention to training and research in LGBTQ issues in recent years; some evidence indicates that many clinicians and clinical supervisors still feel unprepared to address the needs to same-sex couples...when counseling psychologists have engaged in their own self-reflection and consciousness raising regarding heterosexual privilege, they are more likely to effective in supporting and challenging their same-sex-partnered clients (p.966).

It also appears that within and outside of this framework of gay affirmative therapy, LGBTQ clients have continued to identify the therapeutic alliance as the best predictor of client-perceived satisfaction (Johnson, 2012). The therapeutic alliance has been an aspect of psychoanalytic work since the beginning of its use, and studies have continued to show the effectiveness of the

therapeutic alliance in sessions beyond the specific population. (Falkenström, Granström & Holmqvist, 2013; Bhola & Kapur, 2013; Goldberg, Davis & Hoyt, 2013).

Empirical Review

The need for my research becomes viable when reviewing the literature available regarding counseling LGBTQ military personnel. There appears to be a growing amount of literature regarding therapy with LGBTQ clients and a growing amount of literature of work with military clients, but very little in the area of LGBTQ military clients. The one study I found regarding LGBTQ military clients examined the mental health characteristics of veterans who identified as LGBTQ through a quantitative study with a sample size of 409 and comparative sample size of 1500. The participants were 64.7% male, 27.2% female, and 8.1% transgender or other. The average age of participants was 45, and regards to sexual orientation 93.2% of participants identified as lesbian or gay, 5.7% of participants identified as bisexual, 0.3% of participants identified as heterosexual, and 0.8% of participants identified as other. When reporting race or ethnicity, 87.3% of participants identified themselves as European American or White, 4.4% identified as multiracial or other, 3.7% identified as Latino or Hispanic, 2.2% identified as African American or Black, 1.0% identified as Native American or American Indian, and 1.2% identified as Asian American or Pacific Islander. This study found these veterans (n=409) to have higher rates of depression, PTSD alcohol use and suicidal thoughts and behaviors as compared to the Veteran Administration's sample (n=1500). The findings did not support their hypothesis linking alcohol use to military experience, which the authors found to be surprising. They also linked the higher rates of depression and PTSD to anxiety from concealment of sexual orientation identity (Cochran et. al., 2013).

Also, much of the research I have found regarding LGBTQ clients has centered on discussions with clinicians or students regarding their perceived competency and training (Carlson, McGeorge & Toomey, 2013; Farmer, Welfare & Burge, 2013; Graham 2010; Graham, Carney & Kluck, 2012; Rock, Carlson & McGeorge, 2010), while only a couple articles focused on the client's experience of helpful and unhelpful aspects of therapy (Cochran et. al., 2013; Israel, Gorcheva, Burnes & Walther, 2008).

Only one study focused on practicing clinicians (Farmer, Welfare & Burge, 2013) regarding their self-perceived competency with LGB clients, while others focused primarily on students and their perceived competency working with LGBTQ clients based on affirmative training (Carlson, McGeorge & Toomey, 2013; Graham 2010; Graham, Carney & Kluck, 2012; Rock, Carlson & McGeorge, 2010).

Farmer, Welfare and Burge (2013) surveyed 468 participants to include counselors from school and community practice, counseling students, and counselor educators. When asked about experience counseling an LGB client, some said they never have, several reported having counseled one to five LGB clients and some participants had experience counseling more than five LGB clients. The mean age of participants was 41; 15.8% of participants identified men and 84.0% identified as women. In terms of racial identity, 83.1% of participants identified as Caucasian, 12.0% as African American, 0.6% as American Indian, 0.4% as Asian, 1.7% as Hispanic, 0.2% as Hawaiian or Pacific Islander and 1.7% identified as multiracial or other. Regarding sexual orientation, 94.0% identified as heterosexual, 1.5% identified as lesbian, 1.1% identified as gay, 1.1% identified as bisexual, 0.2% identified as questioning, and 0.9% identified as other. This study utilized the Sexual Orientation Counselor Competency Scale (SOCCS), the MC-C to assess authenticity of participants' responses and an informational questionnaire for

demographic and professional background purposes. This study found “counselors perceived themselves as most competent in their attitudes toward LGB clients and lowest in their skills to work with LGB clients” (Farmer, Welfare & Burge, 2013, p.203).

Carlson, McGeorge and Toomey (2013) surveyed 117 faculty members from accredited family therapy programs utilizing the ATI-F, Affirmative Training Inventory-Faculty tool. The mean age of participants was 47; 60% of participants identified as women; 70% identified as white and 76% identified as heterosexual. Additionally, 89% reported working with and LGB identified individual or couple in therapy. According to Carlson, McGeorge and Toomey:

The results of this study support the validity and factor structure of the ATI-F as a measure of the level of LGB affirmative training that occurs in clinical programs as well as faculty members’ beliefs about the role of LGB affirmative training in preparing future therapists. Additionally, our results support the validity of the three subscales of the ATI-F (i.e., teaching, program, and experience). The establishment of this measure is important given that no previous scale exists that measures the integration of LGB affirmative therapy training from the perspective of faculty members (p.218)

Graham, Carney and Kluck (2012) surveyed 234 master’s and doctoral level counseling students utilizing the SOCCS and a demographic questionnaire. The mean age of participants was 31; 82.5% identified as female and 15.4% identified as male. Approximately 76% of participants identified as heterosexual, 8.1% as bisexual, 4.3% as gay men, 4.7% as lesbian, 3.0% as queer and 1.7% as other. In regards to racial and ethnic background, 7.7% identified as African American/Black, 7.3% as Latino, 71.4% as Caucasian, 4.3% as Asian, 5.6% as biracial/mixed, 0.4% as Native American and 3.4% as other or did not respond. According to Graham, Carney and Kluck, the findings of this study were as follows,

Participants indicated having a moderate level of self-perceived general counseling competency when working with LGB clients. In addition, participants endorsed a high level of self-perceived counseling competency in awareness but a more moderate level in the knowledge domain and a low to moderate level of self-perceived counseling competency in the skills domain (p.13).

Rock, Carlson and McGeorge (2010) surveyed 190 master's and doctoral level Couple and Family Therapy graduate students utilizing a modified version of the SOCCS and the Affirmative Training Scale. The participants were predominately female (76.3%), White (81.1%), and identified as heterosexual (88.4%). Of the participants, 62.6% were enrolled in a master's program and 36.8% were enrolled in a doctoral program. The mean age of participants was 30 and 61.1% of the participants reported working with at least one LGB client in the course of their clinical careers. According to Rock, Carlson and McGeorge, the results of this study were as follows,

60.5% of the participants reported they had received no training on affirmative therapy practices and 62.6% of the participants reported they had received no training on LGB identity development models; participants perceive themselves to be somewhat competent when working with LGB clients; overall level of affirmative training received predicts participants' overall self-reported clinical competency when working with LGB clients; finally, the amount of course content on affirmative therapy was predictive of students' overall self-reported clinical competency related to working with LGB clients (p.180).

All of the studies from the provider's perspective used quantitative methods, specifically the Sexual Orientation Counselor Competency Scale (SOCCS) created by Bidell in 2005

(Carlson, McGeorge & Toomey, 2013; Farmer, Welfare & Burge, 2013; Graham, Carney & Kluck, 2012; Rock, Carlson & McGeorge, 2010), and only one study using mixed methods with qualitative interviews included (Graham 2010). However, all of these studies focusing on the provider's perspective yielded similar results. These results included participants feeling less prepared to work with LGBTQ clients based on their skills, but more prepared based on awareness of specific issues and knowledge base (Carlson, McGeorge & Toomey, 2013; Farmer, Welfare & Burge, 2013; Graham 2010; Graham, Carney & Kluck, 2012; Rock, Carlson & McGeorge, 2010).

Not surprisingly, the study that focused on LGBTQ clients' perspectives of therapy utilized qualitative methods using interviews with a smaller sample to gain a deeper understanding of different variables that contribute to helpful and unhelpful aspects of therapy. Israel, Gorcheva, Burnes, and Walther (2008) interviewed 42 LGBT individuals who have been in therapy. In terms of sexual orientation, 6 participants identified as bisexual women, 6 as bisexual men, 9 as lesbian, 12 as gay men, 6 as transgender and 3 as gender-queer. The participants self-reported their ethnicity as follows, 23 as European American/White, 6 as African American/Black, 5 as Asian American/Pacific Islander, 3 as Hispanic/Latino, 4 as multiracial and one as other. Participants also ranged in age from 20 to 56 years with a mean age of 36. According to Israel, Gorcheva, Burnese and Walther (2008),

Participants had been in counseling an average of 4.55 times. All participants had been in counseling as adults; in addition, 35.7% had been in counseling as adolescents, and 21.4% had been in counseling before age 13. Participants had participated in individual (n = 42), group (n = 13), and couples/family (n = 8) counseling. Of the total sample,

66.7% described their overall experience in counseling as positive, 9.5% as negative, and 23.8% as mixed (p.298).

This study found that basic counseling skills and relationships were the main determining factor in satisfaction with therapy. Also, therapist factors such as experience and attitudes towards sexual orientation, as well as “client variables such as stage of identity development, health status, and social support; and environmental factors such as confidentiality of the therapy setting” affected LGBTQ client satisfaction with therapy” (Israe,l Gorcheva, Burnes &Walther, 2008, p.302).

Although the articles that focused on the provider’s perspectives (Carlson, McGeorge & Toomey, 2013; Farmer, Welfare & Burge, 2013; Graham, Carney & Kluck, 2012; Rock, Carlson & McGeorge, 2010) all used surveys to gather their data, I am hoping to gain a deeper understanding through more personal open-ended questions. Much of the information gathered from the Sexual Orientation Counselor Competency Scale, or SOCCS, yielded the same results, and I am hoping to offer the opportunity for a different perspective and understanding. Therefore, I plan to use qualitative methods through interviews in order to gather my data.

The limitations for these articles include possible bias in self-selection of completing the surveys, possible sway in results due to self-reporting and the desire to say socially acceptable responses and low diversity. The studies also mainly focused on graduate students and their perceived preparedness without much experience in the field. Also, only one study also used interview questions to further gauge life experiences in relation to perceived competency (Graham, 2010). Therefore, there is a need for a broader study that allows participants to answer in their own words, as well as the need to speak with clinicians who are already practicing in the field. The more obvious limitation includes the lack of studies regarding competency with

LGBTQ military personnel. The military aspect has been neglected to be researched as much, which may be related to the very recent repeal of DADT and DOMA, and is an area in need of further research. This where the importance of my study becomes clear since I used qualitative methods to interview clinicians working with military clients regarding their perceptions of working with LGBTQ military personnel in a clinical setting.

In conclusion, this literature review is meant to explore the current research relevant to the research question: *What are clinicians' perceptions of working with LGBTQ military personnel and cultural competency?* Much of the literature discusses stigma, counseling with LGBTQ clients and counseling with military clients. Also, most of the available studies focus on student, faculty and professional counselor's attitudes towards working with LGBTQ clients from a quantitative standpoint with little research utilizing qualitative methods. Therefore, future research is needed to explore the combination of the LGBTQ and military populations, while specifically utilizing qualitative methods. This literature has provided a foundation for my research study and the next chapter will outline my plans for securing a sample population and the methodology of my data collection.

CHAPTER III

Methodology

Introduction

This chapter outlines the methodology that was used to conduct the study. I begin by explaining the research method and design, then describe sampling, then discuss possible sources of bias, followed by ethical concerns. I then explain data collection methods, discuss methodological weaknesses, the nature of the study, personal perspectives and lastly, data analysis.

Research Purpose

The purpose of this study is to explore clinicians' perceptions of therapy with LGBTQ military personnel and cultural competency. A qualitative, exploratory study was conducted using interviews with practicing clinicians with military personnel as a percentage of their clientele. Semi-structured, open ended questions were used to elicit meaningful responses regarding perceptions, biases, conversations regarding sexual orientation and notions of cultural competency. Studies are beginning to research cultural competency with LGBTQ clients more as society changes its views regarding homosexuality and its acceptance. For the studies that are must currently researched in this area, the ideas of cultural competency, a combination of relational and queer theory and gay affirmative therapy are all being discussed for theoretical purposes.

However, there is limited research on clinical perceptions of cultural competency with LGBTQ population. The studies also mainly focus on graduate students and their perceived preparedness without much experience in the field. Also, only one study used interview questions to further gauge life experiences in relation to perceived competency (Graham, 2010). Therefore, there is a need for a broader study that allows participants to answer in their own words, as well as the need to speak with clinicians who are already practicing in the field. There is a complete lack of studies regarding competency with LGBTQ military personnel. The military LGBTQ population has been neglected in research, which may be related to the very recent repeal of DADT and DOMA, and is an area in need of further research. With the relatively recent acceptance of gay and lesbian service members in the military, there is a need for more research on clinician competency in this practice setting. This research proposes to address the need for deeper research from the practicing clinician's perspective, and more specifically with those working with military clients. The research question asks, What are clinicians' perceptions of working with LGBTQ military personnel and cultural competency?

Research Method and Design

The majority of articles reviewed that focused on providers' perspectives when working with LGBTQ clients (Carlson, McGeorge & Toomey, 2013; Farmer, Welfare & Burge, 2013; Graham, Carney & Kluck, 2012; Rock, Carlson & McGeorge, 2010) all used surveys to gather their data. I sought to gain a deeper understanding through open-ended questions. Much of the information gathered from the SOCCS, Sexual Orientation Counselor Competency Scale, yielded the same results, and I am hoping to offer the opportunity for a different perspective and understanding. Therefore, I used qualitative methods through semi-structured interviews in order to gather my data. From my understanding of the literature I have read and what I hope to gain

from my research, interviewing seems to be most useful method of data collection to gain a deeper understanding of the phenomenon by allowing participants to explain in their own words what their experience is rather using scaling or other forms of quantitative measures (Graham, 2010). Using interviews allows the researcher to speak with participants on a personal level, allows for adaptations to questions based on responses, and also allows the researcher to check with participants to make sure that their points in the interviews are correctly understood. The biggest limitation to using interviews, is the chance for social desirability bias, because the interviews are in person and about a sensitive subject, participants may not want to participate or answer completely honestly to the interview questions.

Sample

For my research I chose specific selection criteria. The primary criterion was that the participants were clinicians that work with military personnel. I was interested in including varying professions for clinicians (i.e. MSW, LCSW, LMHC, MHC, Psychologist, etc.) in order to examine if there are any differences in responses due to training or profession when analyzing my data. I also wanted to be sure that the clinicians I interviewed ranged in age from 25-70 which would allow for a diverse amount of experience and understanding. I excluded anyone who obtained their degree outside of the United States and those whose primary language is not English. These individuals were excluded due to possible training differences and cultural ideologies, as well as possible barriers to understanding terms, concepts or questions. The sample characteristics were chosen to minimize possible biases by including varying ways of knowing/training and experience. My intended sample size was 11-15 participants, although I was only able to gather 9 interviews.

In order to find these participants, I used non-probability sampling through purposive and snowball techniques. The main with snowball sampling is there could be bias from people referring me to possible participants with similar values and ideas to their own, resulting in an unintentional skew of the data. In this case, I decided to utilize deviant sampling if I noticed I was getting the same ideas and types of answers in order to try to search for difference by seeking out those with various degrees and practice settings. I was able to do this by using the Tricare health insurance website to search for clinicians in the area. From that point I was able to read information regarding their backgrounds and interests and contact those with various qualifications. Another limitation is that all participants lived and practiced in a certain region of the United States. The region in which these interviews were conducted was in Texas, which is considered a conservative state and does not currently allow gay marriage.

I began recruiting participants on February 4th, 2014 by searching on the Tricare health insurance website for providers in my area. From there I wrote down various clinicians' phone numbers and contacted them to determine if they fit the inclusion and exclusion criteria. I was able to determine their appropriateness for participation by utilizing the recruitment email (Appendix A) and telephone/email interview screening guide (Appendix D). After having little success finding participants through my search on TriCare's website, I posted flyers in at the Community Counseling Center (Appendix B) and provided one participant with a flyer to pass out at their next group supervision meeting. I was also unsuccessful in gathering participants through flyers, so I then gathered names and email addresses via my faculty field advisor and internship supervisor as a snowball technique. Once I received these names and information I would email possible participants with my initial recruitment email and await their response (Appendix A). Depending on the response I received I then set up a time and date to conduct the

interview. Once a clinician was deemed fit for my study and they agreed to participate I would set up a time to conduct the interview. I explained that the information would be confidential and used to gain a deeper understanding about cultural competency in order to help alleviate any initial anxiety about participation. Through my initial recruitment process utilizing the TriCare website, I was able to obtain 5 participants. When I used snowball sampling through the help of my supervisor and faculty field advisor, I was able to gain 4 more participants. I ended recruitment with the completion of 9 interviews due to time constraints. Two interviews were conducted over Skype, 3 interviews were conducted over the telephone and four interviews were conducted in the clinician's office.

Sources of Bias

I am aware that there was sampling error and bias when compiling the information due to the relatively small pool I was working from. A large percentage, about 45%, of participants was obtained through snowball sampling. It would have been beneficial to be able to find clinicians who were not professionally connected, but this was not feasible given my time constraints and my limited contacts in this region

Ethical Concerns

There were ethical considerations that had to be taken into account when conducting my research due to the LGBTQ community in the military possibly being considered an at risk population and the sensitivity required of clinicians working with this community. The military personnel may have emotional disturbances due to traumatic experiences and may be sensitive to counseling. The LGBTQ community is a community that experiences stigma and discrimination, so doing research in this area could be particularly sensitive. Combine the two, LGBTQ military

personnel, and the population is especially sensitive to work within and ethical considerations within sensitivity and who the study will benefit need to be taken into account.

Although, since I only interviewed clinicians during my research, this is a low risk study. As far as ethical considerations are concerned all participants were over the age of 18 and none are considered part of a vulnerable population since they are all clinicians rather than clients. I chose not to advertise or recruit clinicians within my field placement agency, Audie Murphy VA Hospital in San Antonio, TX, to minimize ethical problems. Other ethical concerns included making sure to keep all participant information confidential by coding identifying information and keeping original documents in a safe and locked location. Also, any presented information in my research project and dissemination was kept confidential through speaking about participants in the aggregate.

Benefits and Risk of Study

Participants informed the researcher that they were interested in participating by contacting the researcher by phone or email. They then were given the informed consent (Appendix C) by email, fax or in person in order to allow participants to understand the purpose of the research and nature of participation. They were also informed the interviews would be audio recorded. An interview time was scheduled at participants' convenience. Participants signed the informed consent in person, faxed or mailed a copy to the researcher prior to the interview. The study was low risk, meaning no serious risk was anticipated from participation. The benefits of participation include insight into own ideas about cultural competency and possible bias about working with LGBTQ military personnel, and chance to discuss an area of professional interest that is timely. This study also focuses on a core aspect of clinical practice

which is to understand culture and how to conduct clinical work with those both of similar and different cultures than our own.

Data Collection Methods

Prior to collecting any data, a thorough Human Subject Review application was submitted and approved by the Smith College School for Social Work Institutional Review Board (Appendix F). Data Collection began on February 11th and ended on April 8th when I was no longer able to gather more participants. Each interview lasted between 25 and 35 minutes and was conducted either in the clinician's office or via phone or Skype. Participants were asked to review the informed consent and sign if they agreed to participate (Appendix C). Once signed, I would begin recording and conduct the interviews. I collected a few demographic questions during my interviews in order to get a sense of who I was speaking with and possibly look for any identifiable differences when analyzing the data. Demographic data included participants' professional background, years of practice, practice setting, race, sexual-orientation gender, age and spiritual background. There was always the possibility that any of these demographic questions could have been misconstrued or taken in the wrong way, but since I was conducting qualitative interviews I was able to provide explanations and answer questions throughout the process.

In order to address my research questions, I collected qualitative data through open-ended interviews (Appendix E). I took into account the length of time it could take to conduct these interviews, and informed participants about the time commitment prior to the interview. Since the interviews being conducted were qualitative, they were semi-structured. There were a few core questions that were asked, but there was also room for additional questions and prompts

where necessary. The responses were audio-recorded and there were notes taken during the interviews as well.

Methodological Weaknesses

Factors that could affect the quality of the data I collected include clarity of the questions, a sense of understanding from the participants, a mis-attunement on my part, or a lack of diversity within the participants and data. Bias or participant worries could also skew the data. When conducting interviews, there is often the possibility of participants not answering completely truthfully or even lying, because of concerns of face-to-face interviewing in which they might feel judged or want to say the 'right' thing to the interviewer, also known as social desirability. When completing the interviews, it did not appear that participants had difficulty with clarity or understanding of questions. There was a lack of diversity regarding race, ethnicity, age, profession and sexual orientation. This lack of diversity may have also contributed to less variance between responses.

Another possible of my weakness of my study is related to the interview questions that I posed to participants. The interviews lasted about 35-40 minutes and did not produce as much data as I had originally assumed. This might be related to a lack of depth in the questions I chose, or reluctance on participants' parts to be more descriptive in their responses. This study may have also benefited from additional questions that may have elicited a more detailed discussion with participants.

Personal Perspectives.

During my data collection and research process, I used member checking in order to diminish the effect of my own personal perspectives causing biases by summarizing clients' responses at the end of each question. Through this process I attempted to make sure that I did

not use my own point of view on how I would like the world to be culturally competent and accommodating for working with LGBTQ military personnel to influence how I interpreted the interview responses.

Data Analysis

For this research project I used thematic analysis of the qualitative data to summarize and find meaning within the participants' responses. In order to analyze my qualitative data that was collected through the face-to-face interview questions, first I created full written transcriptions based from audio recorded interviews so that all the data was recorded. The interviews were transcribed within 72 hours of contact and were done so in a Word document. There were also written notes from the interviews that were helpful during the analysis process and clued me onto possible themes based on participants' facial expressions and tone of voice. My second step in analysis was to read through each interview and to code the responses in order to organize and reduce the data. I chose to separate each question for this step and to code the data for all the interviews by question. Finally, I analyzed the codes and used an inductive process to apply themes that captured the patterns or meaning within groups of codes. I went through the transcriptions making notes of themes I noticed throughout responses and looked for manifest and latent content. As I made note of themes and wrote memos, I noticed frequencies, magnitudes, processes, etc. about the information I coded. Through this process I had themes and information to present that speak to my question of clinician's perceptions about working with LGBTQ military personnel. For the demographic information I created demographic codes to identify demographic groupings rather than relying on quantitative methods or percentages. After creating my themes I reviewed them in light of the demographic groupings to examine if

any of the themes seemed to vary in relationship to demographic groupings. The findings from the analysis of the data will be discussed in the following chapter.

CHAPTER IV

Findings

This chapter contains the findings of nine interviews collected from participants who are practicing clinicians, with at least a master's degree, with current military clients. This qualitative study asked participants to explore ideas of personal awareness of bias and readiness to work with LGBTQ military clients, as well as concepts regarding cultural competency. The interview questions were structured to learn about participants' professional background, history of work with military and LGBTQ clients, and ideas of bias and cultural competency as they relate to working with LGBTQ military clients. They were also asked to provide suggestions for improving culturally competent work with this population. This chapter will begin with a demographic profile of the participants, followed by perceptions of working LGBTQ military clients. Next, findings on clinicians' perceived bias and homophobia with LGBTQ military clients as well as changes in their work with military clients since the repeal of the Don't Ask, Don't Tell and the Defense of Marriage Act legislation, and perceived cultural competency with the LGBTQ military population will be presented. The chapter will conclude with a summary of the findings.

Demographic Information

The participants in this study were clinicians with at least a master's degree in clinical practice with at least some portion of their clients belonging to the military population, active duty or veteran status. There were four male participants and five female participants.

Participants were asked to report how they identify their sexual orientation. One participant identified as “lesbian”, the rest identified as either “heterosexual” or “straight”. All participants are currently in private practice in a major metropolitan area in Texas and have a small percentage (20% or less) of military clients, active duty or veteran status. Their ages ranged from 39 to 69; 8 identified as white/Caucasian and one identified as Choctaw Indian. Participants were also asked how they identify their religious/spiritual background. One participant identified as “southern Baptist”, two identified as “agnostic”, two identified as “atheist” and four identified as “Christian”.

Some limitations of these demographics include a lack of racial/ethnic diversity and age. As most participants identified as Caucasian this could have a significant impact on the responses that were given. Also, the data is skewed toward the older population with participants over the age of 39, which also contributes to the amount of practice experience each clinician had in their respective settings.

Perceptions of Working with LGBTQ Military Clients

After answering demographic questions, participants were asked to speak about their perceptions of working LGBTQ military clients. Some participants appeared to have difficulty answering this question stating, “I don’t know what that means”, while others quickly answered regarding the need for work within this population. One participant stated, “My perceptions, a tremendous need. They’ve been traumatized, stigmatized, disenfranchised, um, there’s just so much, they just have so many challenges. My perception is I’m glad to see more openness in society, so that they are able to access services, particularly in the military.”

Further, participants were asked to speak on their perceived preparedness to work with this population in clinical practice. All participants stated that they feel prepared to work with

LGBTQ military clients within their realm of practice. It should also be noted that all participants stated having worked with at least one identified LGBTQ military client in their career. All participants work with military clients currently, all have had a LGBTQ identified client outside of the military and all have had a LGBTQ identified client within the military population. The only variance occurred when asked to report whether the LGBTQ identified client(s) were active duty or veteran status. In this variance, three participants stated all LGBTQ identified clients were veteran status, four stated all LGBTQ identified clients were active duty and two reported seeing both active duty and veteran status LGBTQ identified clients. When asked to further explain why they feel prepared to work with this population the responses varied. Some participants spoke about general mental health knowledge and work with the military population. One participant stated,

I started working with mental health about 42 years ago and have done lots of stuff lots of places doing different things working for the department of defense and working for the Army. I worked as a police psychologist for about 7 years. The issue is always figuring out what does this person need and is there a good match there.

Some participants spoke about experience working with the LGBTQ population within the community and also work with the military population that contributed to their feelings of preparedness.. One participant stated,

Because I worked with that population extensively, um and, not in the military but veterans and certainly in the community. For about 6 years I worked solely with HIV/AIDS clients so I've had a lot of, not with military some of which where veterans, but I've had a lot of experience with that community so, you know, I know I have a

colleague who was in the service, and I have people to go to when I don't, those kinds of things no I'm not familiar with, I'm real up front with that I have no problem with that...

Participants were also asked to report whether they had received any educational training regarding working LGBTQ clients. All participants described some type of training they had received, mostly post-graduate level conferences, but were only able to identify either receiving training regarding work with the military or the LGBTQ community. Only one participant spoke about a course during graduate school that taught about cultural competency, and they stated there was a lack of in-depth discussion regarding training with either the LGBTQ community or military population. No participants were able to identify any educational training regarding the intersection of the two groups, LGBTQ and military. This is evident through one participant's response, "not specifically military. I've done various trainings and was certified HIV counselor and various kinds of things. Nothing recently but have done continuing education."

Perceived Bias and Homophobia with LGBTQ Clients

Participants were then asked to speak on their ability to identify any experiences of homophobia with their clients, as well as any personal bias towards the LGBTQ military population. All participants denied any experiences of homophobia or bias with their clients. The general attitude can be reflected in one participant's response, "No. I might have some and not be aware of them, but I don't think so." From this response, it became apparent that participants all appeared believe they do not have any conscious level of bias towards LGBTQ military clients. Two reported thoughts of possible unconscious bias, as noted in the above response, but most participants simply stated "no" to the idea of any bias toward the LGBTQ military population.

Participants were also asked to speak about their willingness to discuss sexual orientation with their clients. I also began to ask participants how that conversation occurs based on

responses from the first two interviews. All participants stated they are open to discussing sexual orientation with their clients, although the ways in which this discussion may occur varied. When first conducting the interviews, participants gave a response regarding only discussing sexual orientation if it was part of the presenting problem. One participant stated, “Um, it's not a big deal in most cases. It's not, I have several ladies that are in same-sex relationships and it's not a big deal for me, it's not why they're coming, not part of the presenting problem.” Other participants reported they as the therapist would not bring up the conversation, but were willing to discuss sexual orientation if the client wished to discuss sexual orientation. One participant stated, “I’m not initiating but when it comes up I’m open to talking about it.” Another participant stated, “Usually clients bring it up and have to do with why they’re there due to relationships. I have worked with couples that identify as gay or lesbian so that would be related to why they are coming in.” Another small portion of participants reported discussing sexual orientation by either therapist initiation or client initiation. One participant stated, “It occurred by either bringing it up myself to the client, or the client puts it on the table”. Therefore, the majority of clinicians conveyed the client is more likely to bring up sexual orientation, rather than the clinician.

Further, participants were asked to report any knowledge of specific issues to the LGBTQ military population. All participants were able to name a few issues, specifically shame, secrecy, coming out and fear of detriment to their professional military career. One participant stated,

Definitely shame, isolation, um a sense that they can’t be authentic and they basically have to live to different lives one at work and one at home and the stress that that engenders. And a sense that I’m good enough to serve my country and people respect me for this, but yet there’s this other part of me that’s unacceptable.

Another participant stated, “Some might be privacy issues, fear of detriment to their profession, secrecy or coming out issues. Coming out issues are particularly difficult when affiliated with the military.”

Changes Since the Repeal of Legislation

Subjects were asked to report any noticed changes in practice or dialogue within the mental health community since the repeal of Don't Ask, Don't Tell (DADT) and the Defense of Marriage Act (DOMA). All participants stated they had not noticed a change in dialogue or practice since the repeal of these two pieces of legislation. Some participants spoke about generally not noticing any change, particularly within the geography of where the study took place, which is a Southern state with many conservative values. One participant stated, “Within the mental health community...let's see, I wish I could say yes but I really haven't, not here.”

Other participants talked about the historical aspect of homosexuality and mental health, but also with a lack of difference since legislative change. One participant stated,

Um, no I really haven't. What I've noticed more historically is that the view of the mental health community has changed over time. I'm old enough to remember when being homosexual was a disorder and people trying to do the change therapies and so forth.

Other participants identified isolation within the private practice setting to contribute to a lack of noticing change of attitude within the mental health community since the repeal of DADT and DOMA. One participant stated, “You know I don't ever talk to other practitioners about it so I don't know. In my practice it hasn't affected anything. I can't say for others since I haven't spoken with them about it.” Overall, participants were not able to identify any tangible differences within the mental health community since the repeal of DADT and DOMA. There

were no reported changes in access to services, increase or decrease in clientele or discussions occurring among colleagues within the mental health community.

Cultural Competency within the LGBTQ Military Population

Participants were also asked to give their personal definition of cultural competency. All answers revolved around two themes to include gathering knowledge and learning from the clients' experiences. All participants identified the need to gather information personally through education regarding various cultures, as well as speaking with the clients about their own personal experiences and understandings of their culture. One participant stated,

I guess I would say, first and foremost self-awareness, being aware of your biases if any, being open-minded and curious so that if you are working with a population you don't understand taking the time and effort to read about it and maybe talk to some people to educate yourself if you're going to venture into it. But also being aware of your limitations if you don't have experience or knowledge then maybe you say no or you let the person know up front 'hey this is new to me, but I'm willing to learn will you teach me about your culture' and you're open to that but self-aware in being aware of your limitations and biases.

Another participant stated,

Being able to appreciate the characteristics and variables of an individual's culture and experience, and to understand that some behaviors and attitudes are not a personality facet but a cultural facet. So, therefore you have to understand the person within their culture.

A third participant stated,

I would say gathering information about cultural norms, traditions, barriers, and also being willing to find out about specific experiences. It is important to get to know the cultural from the client's perspective and how they perceive their connection to their culture.

As evidenced above, all responses were unique, but with the similar theme of understanding the culture from an educational standpoint while also taking information from the clients' personal experiences.

Participants were then asked to speak regarding cultural competency with the LGBTQ military community. Most participants identified cultural competency with the LGBTQ military community would be similar to cultural competency with other varying cultures. One participant stated,

The same as any other, any other difference whether it be religion, race, ethnicity, um I don't differentiate between any of them. I try not to, I'm pretty aware of, um, but there's so many and so many people that we encounter. I just relate to as any other difference in human experience.

Another subject spoke about the necessity to understand, from a cultural perspective, the unique culture of the LGBTQ military population and stated, "Oh, it is critical that clinicians have awareness of military life and how the LGBTQ community marriages within that system".

Subjects were then asked to report any suggestions for improving culturally competent work with LGBTQ military clients. The consensus appeared to be a need for training, and this could be done through required annual trainings or voluntary conferences. All participants suggested post-graduate trainings would be most useful. The content areas described most often

included the political and legislative changes impacting LGBTQ population. One participant stated,

Once a year [training] would be good, especially now with all the constantly changing political and social aspects. It would be important, I think, to require clinicians to attend training at least once a year to keep up with these changes and continue to educate ourselves and become better clinicians.

Another participant stated, “Maybe trainings like you just spoke about. Some conferences regarding the changing issues within the US and how that affects us as clinicians could also be useful”.

Another participant stated,

What I’m hoping, and maybe I’m too naïve and optimistic, but most of the clinicians I know are around my age most of them, we are only taking populations we are comfortable working with, so um I guess I’m just pitching for people to look at the code of ethics... and maybe trainings and certainly workshops, but I’m not real big on mandatory trainings.

There was also the suggestion that further research from the clients’ perspective about their needs and experiences in therapy would be beneficial. One participant stated, “I think asking people would a very good thing, and by that I mean asking the active duty or veteran [who identifies as LGBTQ] what their needs are, their perceptions, how they're being treated, what would they like to see what things are helpful or not helpful and try to learn from that.”

Summary

This chapter summarizes and presents the findings of nine interviews with practicing clinicians in the mental health community working with military clients, active duty or veteran.

The open-ended questions used throughout the interview were designed to elicit information about the various perceptions clinicians may have regarding working with LGBTQ military clients. Much of the information provided were similar responses that provided information regarding the general consensus of lack of training regarding this population, denial of bias or homophobia with the population, absence of community changes since the repeal of DADT and DOMA, and agreement that improvements could be made in cultural competency as it relates to the LGBTQ military community. In addition, these findings provided valuable information regarding the need for further trainings and culturally competent work with the LGBTQ military community, particularly as changes in legislation continue to occur. The next chapter will discuss the implications of these findings.

CHAPTER V

Discussion

The purpose of this study was to explore the various ideas about perceptions and cultural competency when working with LGBTQ military clients from the clinician's perspective. The narratives of these clinicians were gathered via face-to-face, Skype and telephone interviews, and the study was intended to elicit deeper dialogue about participants' experiences, possible biases and culturally competency as it relates to working with LGBTQ military clients in a clinical setting. The findings of this study offer a unique perspective from the practicing clinicians' point of view. Finally, this discussion chapter connects the study's findings to previously explored literature.

The discussion will include a summary of the following key findings: 1) Perceptions of working with LGBTQ military clients, 2) perceived bias and homophobia with LGBTQ clients, 3) changes in the mental health community since the repeal of various legislation and 4) cultural competency within the LGBTQ military population. The section will end with a brief discussion of limitations of the study, as well as the recommendations for policy and practice that arose from this research.

Perceptions of Working with LGBTQ Military Clients

One major component of this study explored clinicians' perceptions of working with LGBTQ military clients to include: any experience working with LGBTQ military clients, preparedness to work with the population and any training that they may have received. Since

much of the research I reviewed speaks to students and clients, rather than to clinicians who have been practicing for several years, there is little connection that can be made from participants' responses regarding perceived preparedness to work with this population. In the literature previously reviewed, study participants relayed competency to work with LGBTQ clients based on their awareness of issues but expressed a specific lack of skills (Carlson, McGeorge & Toomey, 2013; Farmer, Welfare & Burge, 2013; Graham 2010; Graham, Carney & Kluck, 2012; Rock, Carlson & McGeorge, 2010). However, in my research, clinicians spoke of competency to work with this population based both on their awareness of specific issues and their skills as a clinician. They did not express a lack of skills or competencies specific to working with this population.

In regards to the training aspect, the reviewed literature was most often conducted with graduate students still currently in programs and did identify a missing element in their training with the LGBTQ military population (Rock, Carlson & McGeorge, 2010). This is congruent with the responses in this study in which participants stated they had not received any educational training regarding work with LGBTQ military training. Many participants were able to name receiving training regarding work with military clients, some with LGBTQ clients but not with the combination of the two.

Bias and Homophobia with LGBTQ Clients

This study found that participants generally believe they do not experience any bias or homophobia towards LGBTQ clients, with the small possibility of unconscious elements. This finding is a positive, and possibly new, phenomenon since stigma towards LGBTQ clients in mental health has been a present aspect for many years (Fassinger, 1991). This is particularly important when reviewing the study that spoke to LGBTQ clients about their impressions of

therapy that found clinicians' attitudes towards a client's sexual orientation or gender identity was a key determinant in their view of helpful or unhelpful aspects of therapy (Israel, Gorcheva, Burnes, & Walther, 2008).

In regards to participants' decision to bring up sexual orientation with clients or create the space for clients to bring it up themselves, this finding can be correlated to clients' perceptions of therapy and what they find to be most useful. Since it appears clients believe therapy is most helpful when the clinician is attuned to their needs (Israel, Gorcheva, Burnes, & Walther, 2008), it may be important for clinicians to consider the therapeutic significance of creating the space for and discussing sexual orientation with clients. This is also important for clinicians to be aware of since clients have identified fears of heterosexism in the therapy and this could be a barrier for seeking mental health services (Pachankis, & Goldfried, 2013). However, the majority of clinician participants in the study did not initiate discussions of sexual orientation.

Participants in this study were also asked to discuss awareness of issues specific to the LGBTQ military population. Participants were able to identify some common issues clients may experience related to stigma to include: shame, secrecy, coming out and fear of detriment to their professional military career. These issues are congruent with the previously reviewed literature that describes some of the most salient issues for LGBTQ clients and military clients (Hoge, et. al, 2002; Kim et al., 2010; Fassinger, 1991).

However, there was a lacking acknowledgment of gender roles, sexuality issues particularly within the military context, isolation and access to services. These areas that were missing are areas that have been identified in research conducted as pertinent issues to the LGBTQ military population (Pachankis & Goldfried, 2013). One participant was able to identify this lack of knowledge stating, "I have kind of a general awareness but there's probably some

things that I don't know, I'm going to be pretty humble with that answer." Therefore, all participants identified some aspects of issues specific to this population, but were not able to fully identify many prominent concerns.

Changes in Attitude since the Repeal of Legislation

This study found that clinicians have not noticed a change in the mental health community since the repeal of Don't Ask, Don't Tell and the Defense of Marriage Act. One contributing factor, to this finding, that should be taken into consideration is the knowledge that this study was conducted in a more conservative southern state that still has a ban on same-sex marriage. This is one aspect that was also identified by a couple of participants as possible reasons for not noticing any changes. Participants also identified isolation within the private practice setting to be a possible reason for not discussing any changes or noticing any changes in practice or attitude in the mental health community. This finding was surprising to me as I expected participants to discuss elements found in the research related to the relief of not having to conceal their sexual orientation as military personnel to mental health professionals (Cochran et. al., 2013)

Cultural Competency with LGBTQ Military Clients

As indicated in the literature review, there are few empirical studies that explore the military population and the LGBTQ community, particular in reference to culturally competent work. When participants were asked to give their personal definition of cultural competency two themes of gathering knowledge and learning from clients directly about their experiences were identified. This is consistent with the definition I have used for cultural competency as my theoretical frame work, "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate

cultural settings to increase the quality of services; thereby producing better outcomes”. As discussed in the findings, each participant had a unique definition, but they all revolved around the same central idea. When participants were asked to speak regarding cultural competency with LGBTQ military personnel all identified that it should be treated the same as any other culturally competent work with various identities, such as race/ethnicity, age or religion. This idea may be linked to the research that demonstrates the importance of the therapeutic alliance as related to cultural competence (Falkenström et. al., 2013; Bholá & Kapur, 2013; Goldberg et. al., 2013).

Finally, as discussed above participants were asked to give any suggestions for improving culturally competent work. Participants all described various ideas for trainings and educational systems that should be put into place for clinicians to continue to work on their skills and improve their understandings of working with this population. The responses were congruent with the literature that supports the need for more training and education to improve work with the LGBTQ military population (Carlson, McGeorge & Toomey, 2013; Farmer, Welfare & Burge, 2013; Graham 2010; Graham, Carney & Kluck, 2012; Rock, Carlson, T. & McGeorge, 2010).

Limitations

The limitations of this research were that the sample size was small with only nine participants and thus, the findings of this study are not representative of all clinicians’ experiences, even within the geographical area in which the study was conducted. In addition, the sample was racially homogenous (eight out of nine identified as white/Caucasian, one as Choctaw Indian) and only one of the participants identified as homosexual. This study was also limited in its geographic diversity of participants, because all respondents currently live in a metropolitan area of Texas.

Another possible limitation to this research included the lack of diversity of age of participants with most participants working in private practice for over 10 years. It may have been beneficial to have a broader spectrum of age, particularly in reference to any training participants may have received for those who have not been in practice quite as long.

Another limitation to this research included the qualitative methods of the study that allowed for variance in depth of response and possible lack in specificity. The interviews lasted about 35-40 minutes and did not produce as much data as I had originally assumed. This might be related to a lack of depth in the questions I chose, or reluctance on participants' parts to be more descriptive in their responses. Therefore, this study may have benefited from additional questions that may have elicited a more detailed discussion with participants. Despite this inherent methodological limitation, the interviews gave each participant the opportunity to provide personal and meaningful information that provided more specific and varied data than may have been collected in a quantitative survey.

Implications and Conclusions

Implications for this study include the need for further research regarding clinical work with LGBTQ military clients and how cultural competency is related to this topic. While studies exploring each entity separately are important, as well as exploring graduate students' perceptions of competency with LGBTQ clients, it is critical that future researchers explore the intersection of the two identities of LGBTQ and military personnel. Future studies focusing on clinical work with LGBTQ military personnel could be used to help graduate schools enhance their curriculum, graduate students feel more competent and prepared to work with this population, clients feel more connected and less stigmatized in therapy and to provide continuing education for clinicians already in practice.

Investigating clinical work with LGBTQ military personnel and particularly how that relates to cultural competency may allow graduate schools and training programs the opportunity to further education regarding this population and the clinical profession's stance against oppression and stigma. Evidence in the literature and this study indicate more culturally competent work needs to be integrated with LGBTQ military personnel so graduate students and clinicians feel more sound in their skills, and this population faces unique challenges that continue to shift as policy changes occur. One way this might occur is through policy changes that would recommend that education include more information regarding work with LGBTQ clients, and particularly the subset of LGBTQ military personnel. Another way more culturally competent work with LGBTQ military personnel might be achieved is by, as suggested by participants in this study, providing annual trainings and workshops. This training would provide an opportunity for practicing clinicians to stay present with legislative policy changes regarding the military and LGBTQ populations, as well as collaborate with other clinicians regarding issues of disclosure and discussing regarding sexual orientation.

Another area of research that would be beneficial for further research is the inclusion of LGBTQ military couples as a subset. According to Spitalnick and McNair (2005), there are distinct issues that homosexual couples face over heterosexual couples. This research study was unable to explore this subset due to time constraints and there is currently little research regarding work with LGBTQ military couples. Therefore, this is an area that would benefit from further research, as well.

This study was important because it focused on a unique population that has very little current research, LGBTQ military personnel. This is a population that needs to have more focused research as legislation continues to change and societal norms continue to shift. This

study was also unique in its use of qualitative interviews to discuss bias, trainings and cultural competency with this population. The degree to which clinicians feel competent and provide culturally competent work with their clients, and this population in particular, is very important. Also, by valuing the professional responsibility to continue to educate ourselves and become more culturally competent clinicians, the mental health field can move towards higher satisfaction of LGBTQ military clients in counseling settings.

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Appendix A – Preliminary Recruitment Email

Dear friends and colleagues:

I am a Social Work intern at Audie L. Murphy VA hospital in San Antonio, Texas. I'm working on my Master's thesis for my MSW at Smith College School for Social Work. Will you please help me find participants to complete an interview as part of my thesis research?

My research topic is cultural competency when working with LGBTQ clients within the military context either active duty or veteran status. Cultural competency as defined by Davis (1997) is, "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes" which may be practiced by an individual or an entire organization (Flaskerud, 2007). I am interested in learning about clinicians' perceptions about working with LGBTQ military personnel. Are you a clinician who works with military personnel and/or veterans and has some familiarity with the concept of cultural competency in clinical practice? Would you be willing to be interviewed for up to an hour so that I could ask you more about your experiences and thoughts on this topic?

I would appreciate your participation, or your help in finding participants. Please pass this email on to anyone who might be eligible or interested. Feel free to get in touch with me for any reason.

Thank you,

Katie Messier

krmessier@smith.edu

(210) 949-3759

Appendix B- Flyer

Are you a Clinician Working with Military Clients?

A MSW research student is looking for participants! If you are a clinician working with military clients, have at least a Master's Degree and you are between the ages of 25 and 70, your input would be greatly appreciated.

A research student is looking for your help to gain knowledge regarding ideas of cultural competency and personal biases when working with military members who identify as LGBTQ. Cultural competency as defined by Davis (1997) is, "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services thereby producing better outcomes" which may be practiced by an individual or an entire organization (Fasker 2007).

This study is voluntary and participants will not be compensated for time. This study will include interview questions that may take up to an hour and will be scheduled at your convenience.

If so a you would willing to discuss your experience please contact me at krmes@smu.edu



Appendix C - Informed Consent



School for Social Work

Consent to Participate in a Research Study

Smith College SSW • Northampton, MA

.....

Title of Study: Clinician Perceptions about Working with LGBTQ Military Personnel in Couple's Therapy

Investigator(s): Katie Messier, Social Work Department [REDACTED]

.....

Introduction

- You are being asked to participate in a study of qualitative research using interviews to understand clinician perceptions of working with LGBTQ military personnel.
- You were selected as a possible participant because you are currently a practicing clinician working with military personnel, active duty or veteran status. You also have at least a master's degree in clinical work, are between the ages of 25 and 70, earned your degree within the U.S. and English is your first language.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to gain a deeper understanding of clinicians' perceptions of working with LGBTQ military personnel. As the researcher I am seeking to understand clinicians' perceptions of cultural competency and biases regarding work with this population. Cultural competency as defined by Davis (1997) is, "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes" which may be practiced by an individual or an entire organization (Flaskerud, 2007). Participants will complete face-to-face interviews with me as the researcher and will be asked to answer questions regarding cultural competence and their perception of working with LGBTQ military personnel.
- This study is being conducted as a thesis requirement for my master's in social work degree.
- Ultimately, this research may be published, presented at conferences or for dissemination purposes per completion of the thesis requirements.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: sit with the researcher in a safe location of your choice to conduct the interviews, answer chosen interview questions, with allowance of explanation of terms or meanings and variance in questions should the need arise, for about an hour. You will also answer follow up questions for about 10-30 minutes after all interviews have been collected at a later date.

Risks/Discomforts of Being in this Study

- The study is low risk, meaning no serious risk is anticipated from participation.

Benefits of Being in the Study

- The benefits of participation include insight into own ideas about cultural competency and possible bias about working with LGBTQ military personnel, and chance to discuss an area of professional interest that is timely.
- This study also focuses on a core aspect of clinical practice which is to understand culture and how to conduct clinical work with those both of similar and different cultures than our own.

Confidentiality

- The records of this study will be kept strictly confidential. Informed consents and contact information will be kept in a locked file, and all digital audiofiles and analysis files will be coded and secured using a password protected file. I will not include any information in any report we may publish that would make it possible to identify you.
- The data will be kept for at least three years according to Federal regulations. They may be kept longer if still needed for research. After the three years, or whenever the data are no longer being used, all data will be destroyed.

Payments

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researcher of this study or Smith College. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you choose to withdraw, the researcher will not use any of your information collected for this study. You must notify the researcher of your decision to withdraw by email or phone by *[March 3rd]*. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Katie Messier at krmessier [redacted] or by telephone at [redacted]. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix D – Telephone/Email Screening Questions

- Are you a practicing mental health professional with at least a Master's degree?
- Does your primary client base consist of military personnel, either active duty or veteran status?
- Are you between the ages of 25 and 70?
- Is English your first language?
- Did you earn your Master's or Doctorate degree in the United States?
- Are you willing to discuss issues regarding LGBTQ individuals in therapy, regardless of professional experience with this population?
- Are you able to schedule about an hour of time with me when I could audio record an interview with you?

Appendix E – Interview Question Guide

About You:

- Please describe your professional background.
 - How long have you been in practice?
 - How long working with military personnel? What percentage of your client base?
- Demographic information:
 - What is your religious or spiritual background?
 - How do you identify your race/ethnicity?
 - How do you identify your gender?
 - What is your age?
 - How do you identify your sexual orientation?
- Describe your clinical practice and setting—where do you work (hospital setting/outpatient clinic/private practice/ etc.)?

About your experience and perceptions

- Have you ever worked with a client who identifies as LGBTQ, civilian or military?
 - If so, what percentage were military personnel?
 - What percentage of LGBTQ military clients were active duty? What percentage were veterans?
- What are your perceptions of working with LGBTQ military clients?
 - Do you feel prepared to work with LGBTQ military clients?
 - Why or why not?
 - Have you received any educational background or training regarding work with this population?
- Have you encountered any personal homophobia with clients?

- Have you openly discussed sexual orientation with your clients?
- Are you aware of any personal biases in working with LGBTQ military personnel?
 - Would you consider working with LGBTQ military same-sex couples?
 - Why or why not?
 - Are you aware of issues specific to this population (i.e. shame, isolation, secrecy and fear, sexuality and gender roles and living day-to-day in a heteronormative society that often devalues their very existence)?
- Have you noticed any change in attitude or practice within the mental health community and/or within yourself since the repeal of 'Don't Ask, Don't Tell'
 - Since the repeal of the Defense of Marriage Act?
- What is your definition of cultural competency?
 - How do you feel cultural competency relates to working with this population?
 - Have you participated in any trainings or discussions regarding cultural competency with LGBTQ clients?
 - How does this affect your work as a clinician?
- Do you have any suggestions for improving culturally competent work with LGBTQ military clients?

Appendix F- HSR Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 15, 2014

Katherine Messier

Dear Katie,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee