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Therapist Multicultural Orientation: Client Perceptions of Cultural Humility, Sexual Identity, and the Working Alliance

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Therapist Multicultural Orientation: Client Perceptions of Cultural Humility, Sexual Identity, and

the Working Alliance

By

Todd L. Jennings

A Thesis Submitted in Partial Fulfillment of the

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Therapist Multicultural Orientation: Client Perceptions of Cultural Humility, Sexual Identity, and the Working Alliance

Todd L. Jennings

This thesis has been examined and approved by the following members of the student's committee.

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Dr. Eric Sprankle, Advisor

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Dr. Jeffrey Buchanan, Committee Member

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Abstract

Research examining the benefits of cultural humility for diverse clients has increased dramatically over the last 10 years. However, little empirical research has applied therapist cultural humility to lesbian, gay, and bisexual (LGB) clients. In a sample of 333 LGB persons, the current study examined whether therapist cultural humility predicted a stronger client-therapist working alliance. LGB identity centrality (IC) and identity affirmation (IA) were considered as possible moderators of this relationship. Therapist cultural humility predicted stronger working alliances in the present sample; however, this association was not moderated by IC or IA. These results suggest that therapist cultural humility is a valuable therapeutic process for LGB individuals regardless of IC or IA. Future research should consider the benefits of therapist cultural humility for other sexual and gender diverse persons, such as transgender individuals. Continued investigation is needed to explicate how the interaction of cultural humility and identity may promote well-being among sexually diverse groups.

Therapist Multicultural Orientation: Client Perceptions of Culturally Humility, Sexual Identity, and the Working Alliance

The provision of therapy to lesbian, gay, bisexual, and transgender (LGBT) clients is complicated by minority stress processes (Bockting et al., 2013; Meyer, 2003) and the multidimensional nature of LGBT identity (Mohr & Kendra, 2011; Riggle et al., 2014; Riggle & Mohr, 2015). Strong therapist multicultural orientation (MCO) may be an effective means of incorporating the complex identities and experiences of LGBT persons into therapy. MCO theory posits that therapists can enhance their engagement with clients by respectfully integrating important aspects of a client's cultural background into therapy (Hook et al., 2013; Owen et al., 2014). If the premises of MCO theory hold, then therapists may enhance their engagement with LGBT clients by integrating aspects of their backgrounds into therapy. The current study examined whether therapist cultural humility, a component of MCO, benefits lesbian, gay, and bisexual (LGB) clients, while also considering how the multidimensional nature of LGB identity might influence this relationship. As far as the authors are aware, the current study was the first to consider how LGB clients may benefit from cultural humility in a therapy setting. Although the present study limited its analysis to LGB clients, future research should consider the benefits of therapist cultural humility for other diverse groups, such as transgender persons.

Therapist MCO consists of three components: (a) cultural humility; (b) ability to incorporate discussions of a client's cultural background into therapy; and (c) the ease with which these conversations can be held (Owen et al., 2011; Owen, 2013). Although each component of MCO is therapeutically valuable, only cultural humility was examined in the present study. Cultural humility consists of maintaining an other-oriented stance that involves respect, willingness to learn, and attunement to a client's cultural background (Hook et al.,

2013). A culturally humble therapist recognizes that their understanding of a client's culture is insufficient, motivating a desire to learn about the client's cultural experiences (Hook et al., 2013; Owen et al., 2014). Empirically, therapist cultural humility consistently predicts better working alliances and treatment outcomes (Hook et al., 2013). A theoretical explanation for these findings is that client trust and safety are enhanced when therapists engage in cultural dialogue using an other-oriented stance of openness (Hook et al., 2013).

Cultural Humility and Minority Stress

Meyer's (2003) Minority Stress Model asserts that LGB populations experience stressors related to their stigmatized identity. There are distal stressors, or external events of prejudice, such as victimization or institutionalized discrimination (Meyer, 2003). There are also proximal stressors, or internal processes in response to external events of prejudice, such as identity concealment, anticipated discrimination, or internalized homophobia (Meyer, 2003). These experiences, in addition to the stresses of everyday life, compromise the mental well-being of LGB persons (Meyer, 2003). Humbly conversing with a client about their sexual identity and cultural experiences associated with their sexual orientation may enhance their feelings of alliance with their therapist. A culturally humble therapist may benefit LGB clients by countering minority stress processes with affirming behavior, such as asking questions when uncertain and not making assumptions about the client based on their sexual orientation. Minority stress perspectives have also been applied to transgender populations (Bockting et al., 2013), suggesting that cultural humility may also benefit clients with diverse gender identities.

Cultural Humility Research and the Social Bond Hypothesis

One of the most notable findings in cultural humility research has been that clients who perceive their therapist as culturally humble report stronger working alliances and treatment

outcomes over and above multicultural competencies (MCC; Davis et al., 2018; Hook et al., 2013; Owen et al., 2014, 2016). The findings mentioned above support the social bond hypothesis: the proposition that perceptions of humility regulate social bonds (Davis et al., 2018). A key indicator of the social bond between a therapist and their client is the working alliance (Davis et al., 2018). Clients who view their therapist as other-oriented, respectful, and attuned to their cultural identity are likely to also see their therapist as humbler, which promotes a stronger working alliance (Hook et al., 2016). The absence of culturally humble therapist characteristics is associated with less favorable perceptions from clients and poorer working alliances (Hook et al., 2016). A review of studies from Davis et al. (2018) found consistent support for the above findings, suggesting that the association between client perceptions of therapist cultural humility and the working alliance is well-documented.

Although these findings are promising, it remains unclear whether the positive association between client perceptions of therapist cultural humility and treatment outcome measures remain intact for various client populations. To address this gap in the literature, Owen et al. (2014) examined the extent to which client religious/spiritual commitment moderated the relationship between therapist cultural humility and therapy outcomes. Client perceptions of therapist cultural humility predicted stronger therapy outcomes for clients with higher religious/spiritual commitment, but not for clients with lower religious commitment (Owen et al., 2014). This finding suggests that cultural humility may provide more therapeutic benefit for a clients' most salient identities (Owen et al., 2014). The current study expanded upon Owen et al.'s (2014) findings by observing the moderating effects of LGB identity on the association between cultural humility and the working alliance in a sample of LGB individuals.

Dimensions of LGB Identity

      A theoretical underpinning of Owen et al.'s (2014) paper is that clients with salient

cultural identities benefit more from therapists they perceive as culturally humble. This thought

is similar to theorization on LGB minority stress. Meyer (2003) proposed that identity centrality,

or the extent to which part of a person's identity is central to their overall identity, may moderate

the relationship between minority stress and well-being. Conversely, identity centrality may also

moderate the association between affirming LGB experiences and well-being. If cultural

humility is conceptualized as an affirming experience for LGB clients, then an LGB client that

views their sexual orientation as central to their overall identity may benefit more from a

culturally humble therapist. Thus, the current study analyzed the moderation effect of identity

centrality (IC) on the relationship between LGB client perceptions of therapist cultural humility

and the working alliance. Identity affirmation (IA) is also analyzed as a possible moderator,

given recent calls to consider positive aspects of being an LGB person (Mohr & Kendra, 2011;

Riggle et al., 2014). An LGB client with high IA may greatly appreciate a culturally humble

therapist who engages with their identity using an other-oriented stance of openness and respect.

Hypotheses

      This study examined the degree to which clients viewed their therapist as culturally

humble toward their LGB identity. We proposed that perceived cultural humility would predict

stronger client-therapist working alliances in a sample of LGB individuals who had previously

attended, or were currently attending, therapy (Hypothesis 1). Moreover, we posited that the

association between perceived cultural humility and the working alliance would be moderated by

IA and IC. That is, the association between perceived cultural humility and the working alliance

should be greater for clients whose LGB identity is more central to their overall identity than for

clients whose LGB identity is not as central (Hypothesis 2). The association between perceived

cultural humility and the working alliance should be greater for clients who demonstrate stronger

LGB identity affirmation compared to LGB clients with lower IA (Hypothesis 3).

Methods

Participants

The sample consisted of 333 adult participants who identified as LGB and were currently

in therapy, or who had been to therapy in the past but were not currently seeing a therapist.

Participants identified as gay/lesbian ($n = 57$; 17.1%), mostly gay/lesbian ($n = 23$; 6.9%),

bisexual ($n = 232$; 69.7%), or as LGB broadly, but uncertain as to which option best represented

their sexual orientation ($n = 21$; 6.3%). The mostly gay/lesbian response category, as well as the

option to indicate LGB identity uncertainty, were used to be more inclusive of participants that

identify as LGB, but not with the bisexual or the lesbian/gay sexual orientation categories.

Additionally, research suggests that persons with mostly gay/lesbian identities show unique

patterns of attraction and partner selection that are distinct from bisexual or gay/lesbian persons

(Vrangalova & Savin-Williams, 2012). The average age was 28.6 ($SD = 7$) with an age range of

18 to 55. Participants' sexual attractions ranged from 1 ("Exclusively attracted to people of the

same gender") to 7 ("Exclusively attracted to people of the other gender"; $M = 3.4$, $SD = 1.4$).

Sexual behaviors over the past year ranged from 1 ("Exclusively with people of the same

gender") to 7 ("Exclusively with people of the other gender"; M = 4.2, SD = 2.5). Remaining

demographic information can be seen in Table 1.

Table 1

Demographic Characteristics of Participants

Variable	*n*	*%*
Race/Ethnicity		
White	245	73.6
Multiracial	33	9.9
Hispanic or Latino	26	7.8
Asian	11	3.3
Black or African American	6	1.8
Native Hawaiian or Other Pacific Islander	1	.3
Other	9	2.7
Gender		
Cis Female	222	66.7
Cis Male	54	16.2
Gender queer/nonbinary	36	10.8
Trans Female	6	1.8
Trans Male	4	1.2
Other	11	3.3
Sexual Orientation		
Bisexual	232	69.7
Gay/Lesbian	57	17.1
Mostly Gay/Lesbian	23	6.9
LGB broadly, but uncertain	21	6.3
In Therapy		
Currently in therapy	166	49.8
Not currently in therapy	167	50.2

Measures

Beginning Severity

The severity of participants' presenting problems for which they attended therapy was measured using the approach in Hook et al. (2013). Participants rated the severity of the presenting problem that brought them to therapy from 0 = *absent* to 4 = *severe* ("When you began therapy, how severe was your presenting problem for which you attended therapy?"). Some participants were not currently in therapy, and their ratings of beginning severity were therefore retrospective. However, self-reported retrospective ratings of beginning severity provide valuable estimates of the distress clients were experiencing before beginning therapy (Moore & Owen, 2014).

Working Alliance Inventory-Short Revised

The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) is a 12-item questionnaire that assesses three aspects of the therapeutic alliance: tasks of therapy (e.g., "What I am doing in therapy gives me new ways of looking at my problem"); goals of therapy (e.g., "My therapist and I collaborate on setting goals for my therapy"); and an affective bond with one's therapist (e.g., "I feel that my therapist appreciates me"). Participants responded to each of the questions on a 5-point Likert scale from 1 = *Seldom* to 5 = *Always* (See Appendix A for the complete measure). Hatcher and Gillaspy (2006) provided evidence supporting the internal consistency and factor structure of the WAI-SR. Higher scores indicate a stronger client-perceived alliance with their therapist. In this study, the Cronbach's alpha coefficient for the full scale was .94 (95% CI [.93, .95]).

Lesbian, Gay, and Bisexual Identity Scale

The present study used two subscales from the Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011) to measure LGB identity centrality (e.g., "My sexual orientation is a central part of my identity") and identity affirmation (e.g., "I'm proud to be part of the LGB community"). Participants responded to questions on a 5-point Likert scale from 1 = *Disagree Strongly* to 6 = *Agree Strongly* (See Appendix B for the complete measure). The Cronbach's alpha coefficient was .86 (95% CI [.83, .88]) for the identity centrality subscale and .89 (95% CI [.86, .91]) for the identity affirmation subscale.

Cultural Humility Scale

The Cultural Humility Scale (CHS; Hook et al., 2013) has two portions. The first section assesses the salience or centrality of aspects of one's cultural background (e.g., sexual orientation, gender, race, ethnicity, religion, etc.). Given that the present study measured aspects of LGB identity with the LGBIS that are similar to identity salience (identity centrality and identity affirmation), the first portion of the CHS was not used. The second part of the CHS consists of 12 items that assess client perceptions of their therapist's humility toward core aspects of their cultural background. This portion of the CHS is comprised of a positive cultural humility subscale (e.g., "Is genuinely interested in learning more") and a negative cultural humility subscale (e.g., "Assumes he/she already knows a lot"). Notably, before responding to the survey, participants were asked to consider their sexual orientation (e.g., "Regarding the core aspects of my sexual orientation, my therapist..."). Participants responded to each of the questions on a 5-point Likert scale from 1 = *Strongly Disagree* to 5 = *Strongly Agree* (See Appendix C for the complete measure). The Cronbach's alpha was .93 (95% CI [.92, .94]) for the full scale.

Procedure

Participants were recruited through two approaches. The first was to email university LGBT+ student club presidents and advisors asking if they would send the survey to club members via their electronic mailing lists. The largest public university from each state in the United States was selected for contact. If a given university did not have an LGBT+ student club, then the next largest public university in the state was contacted. Universities from the Campus Pride Index of LGBTQ-friendly universities were also contacted (Campus Pride, 2020). If a student club had not responded after approximately one month, a reminder email was sent. The survey remained open for an additional month following the reminder email. The second contact approach was through advertisement on various social media websites, including Twitter, Instagram, and Facebook. In both the emails to university LGBT+ centers and social media posts, potential participants were notified that to be eligible for the study, they had to identify as LGB and have been to therapy in the past or currently be attending therapy. Participants were provided with a link taking them to inclusion criteria questions regarding their sexual identity and therapy history. If participants met the inclusion criteria, they were directed to a consent form (See Appendix D for the complete consent form). If not, they were taken to a page thanking them for their time.

<div align="center">

Results

</div>

Correlations and descriptive statistics of the main variables in the study can be seen in Table 2. Most assumptions were within an acceptable range; however, the data were slightly heteroscedastic. Results of the present study were either quite strong or completely non-significant, suggesting that slight heteroscedasticity did not influence the primary results. All analyses were conducted using SPSS version 20.

Table 2

Bivariate Correlations and Descriptive Statistics

	1	2	3	4
1. Working Alliance	—			
2. Cultural Humility	.77*	—		
3. Identity Centrality	.02	.10	—	
4. Identity Affirmation	.05	.06	.45*	—
Means (*SD*)	3.51(.92)	4.05(.85)	4.28(1.01)	5.21(.82)
Possible Range	1.00 to 5.00	1.00 to 5.00	1.00 to 6.00	1.00 to 6.00

Note. *$p < .001$

Hypothesis 1 was tested using a hierarchical regression, with working alliance as the criterion variable. Results are presented in Table 3. Race, gender, sexual orientation, beginning severity, and whether the client was currently in therapy or not were entered into step 1 to control for these variables. Cultural humility was entered in step 2. In step 1, clients in therapy predicted higher WAI-SR scores ($\beta = .32$, $p < .001$). The remaining control variables were not significant predictors of the working alliance. In step 2, the analysis revealed that cultural humility positively predicted working alliance scores even after controlling for the variance in the other variables ($\beta = .75$, $p < .001$). Being in therapy no longer predicted higher WAI-R scores in step 2. Scores on the CHS were moderately correlated with whether the client was currently in therapy or not ($r = .38$, $p < .01$), suggesting that these variables accounted for some of the same variance in working alliance scores.

Table 3

Hierarchical Regression Results for Working Alliance Scores

Variable	β	ΔR^2
Step 1		.13
Race	-.03	
Gender	-.003	
Beginning Severity	.11	
Sexual Identity	.03	
In-Treatment	.32**	
Step 2		.48**
Race	-.04	
Gender	-.04	
Beginning Severity	.08*	
Sexual Identity	.05	
In-Treatment	.04	
Cultural Humility	.75**	

Note. *$p < .05$; ** $p < .001$

Hypothesis 2 examined the moderating effect of LGB identity centrality on the

relationship between therapist cultural humility and the working alliance. The demographic

variables controlled for in step 1 were similarly controlled in testing hypotheses 2 and 3. WAI

scores were predicted by CHS scores, IC scores, and the interaction of CHS and IC scores. No

significant moderation effect was found ($\beta = .02$, $p = .64$). Hypothesis 3 examined the

moderating effect of LGB identity affirmation on the relationship between therapist cultural

humility and the working alliance. WAI scores were predicted by CHS scores, IA scores, and the

interaction of CHS and IA scores. No significant moderation effect was found ($\beta = .02$, $p = .51$).

These results do not support hypotheses 2 and 3.

Discussion

The present study aimed to extend the cultural humility literature to a sample of LGB

persons and investigate whether LGB identity dimensions help identify which individuals might

benefit most from therapist cultural humility. Consistent with the literature (Davis et al., 2018;

Hook et al., 2013), the present study found a large positive association between client

perceptions of cultural humility and the working alliance. Moreover, this finding was replicated

in a sample of lesbian, gay, and bisexual participants, which is a population that has yet to

receive extensive attention in the cultural humility research literature. Documentation of this

relationship, even after controlling for several variables, adds strength to the notion that therapist

cultural humility is beneficial for LGB clients. The second purpose of this study was to examine

the moderating effect of LGB identity variables on the association between cultural humility and

the working alliance. However, the present results suggest that LGB identity centrality and

identity affirmation do not moderate this association.

A few interpretations arise from these results. First, LGB clients may prefer therapists

who are culturally humble toward their sexual orientation, regardless of their reported IC or IA.

Cultural humility may be a positive therapeutic process for LGB persons that does not depend on

certain LGB identity dimensions. It will, however, be important to examine the possible

moderating influence of other LGB identity constructs on the link between cultural humility and

the working alliance. For example, LGB identity uncertainty or internalized homophobia (Mohr

& Kendra, 2011) may moderate the relationship between cultural humility and the working

alliance, even though IC and IA may not.

Secondly, the findings of the present study contrast with those of previous research

showing that salient cultural religious/spiritual commitments moderate the relationship between

cultural humility and therapy outcome. Owen et al. (2014) found that religious/spiritual

commitment strengthened the relationship between therapist cultural humility and therapy

outcome, although that association vanished at lower levels of religious/spiritual commitment.

Conversely, the present study did not find that IA or IC had a moderating effect on the

relationship between cultural humility and the working alliance. The divergence in results could be due to several factors, including differences in sample composition, measurement choice, and study design. Therefore, clarifying when therapist cultural humility is most useful for a diverse clientele represents an important future research direction. Identity salience and related constructs may be indicators of how much a given client may benefit from therapist cultural humility; however, the results of the present study indicate that this may not hold true for certain identity constructs.

Third, the moderating role of IC in minority stress theory (Meyer, 2003) was not supported in the present study. Meyer (2003) theorized that IC may moderate the association between experiences of minority stress and well-being for LGB persons. The present study considered a similar theoretical claim: that IC may moderate the association between LGB affirming experiences (i.e., perceived therapist cultural humility) and well-being for LGB clients (i.e., working alliance). This formulation was not supported by the results of the present study. Although therapist cultural humility is likely an affirming experience for many LGB clients, it may also represent a general therapeutic process that would appeal to most LGB individuals, regardless of IC and IA. Future research should consider other variables that moderate the association between affirming experiences for LGB persons and well-being.

The above implications can inform clinical practice with LGB clients. In general, the present results suggest that LGB clients prefer therapists who are culturally humble toward their sexual orientation. Therapists who humbly converse with their LGB clients about their sexual orientation will likely enhance the working alliances they have with those clients. Theoretically, embodying characteristics of cultural humility affirms LGB clients' identities and creates a setting for them to consider how their experiences as LGB persons affect their well-being. This

exploration is critical. LGB persons experience minority stressors that disproportionately compromise their mental well-being (Meyer, 2003; Russell & Fish, 2016). Exploration of these experiences can be valuable for LGB persons in improving therapy and health outcomes (Pachankis et al., 2014). For example, The Effective Skills to Empower Effective Men (ESTEEM) protocol for gay and bisexual men encourages clients to consider how minority stress compromises their well-being. ESTEEM has received empirical support in the form of a randomized control trial (Pachankis et al., 2014). Therapist cultural humility likely facilitates affirming conversations surrounding LGB clients' experiences, including minority stressors. Therefore, cultural humility may be valuable in providing affirming evidence-based care to LGB clients.

Limitations

The interpretation of the reported findings should be considered with caution, as there are multiple limitations to the present study. A cross-sectional convenience sample of LGB participants recruited from LGBT+ student organizations and social media websites was used, which limits generalizability of the present findings. Additionally, the present study only sampled LGB participants. Future research is needed to examine cultural humility and the working alliance in other sexual and gender diverse samples. Additionally, there was an overrepresentation of White participants in the sample. Sexual and gender diverse people of color may respond differently to measures of LGB identity, cultural humility, and the working alliance than White LGB participants. Future research is needed to clarify how the cultural humility literature applies to participants with intersectional identities. Another consideration is that the present study measured therapist cultural humility differently than previous research (Owen et al., 2014). Owen et al. (2014) first screened for participants who indicated that

religion/spirituality was one of the most central aspects of their cultural identity before measuring religious/spiritual commitment. If the present study had limited the sample to LGB persons who indicated their LGB identity was one of the most important aspects of their identity, then IC and IA may have demonstrated a moderating effect.

Conclusion

In general, the present study adds to the body of research documenting a positive association between therapist cultural humility and the working alliance. Most importantly, this study extended this association to a sample of LGB persons and found a large positive relationship, suggesting that having a therapist who is culturally humble towards a client's sexual orientation is beneficial for LGB clients. Although moderating effects of IC and IA were not identified, future research should consider the role of other sexual and gender identity dimensions in moderating the link between cultural humility and the working alliance. The results of the present study suggest that clinicians should incorporate cultural humility into their practice when working with LGB clients. Continued investigation will be needed to best understand the influence of LGBT+ identity dimensions on the relationship between cultural humility and the working alliance.

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Appendix A

Working Alliance Inventory-Short Revised

Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your **most recent** therapist with an underlined space -- as you read the sentences, mentally insert the name of your **most recent** therapist in place of _____in the text. Think about your most recent experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

	Seldom	Sometimes	Fairly Often	Very Often	Always
1. As a result of these sessions, I am clearer as to how I might be able to change.	1	2	3	4	5
2. What I am doing in therapy gives me new ways of looking at my problem.	1	2	3	4	5
3. I believe___likes me.	1	2	3	4	5
4. ___and I collaborate on setting goals for my therapy.	1	2	3	4	5
5. and I respect each other.	1	2	3	4	5
6. ___and I are working towards mutually agreed upon goals.	1	2	3	4	5
7. I feel that___appreciates me.	1	2	3	4	5
8. _____ and I agree on what is important for me to work on.	1	2	3	4	5
9. I feel _____ cares about me even when I do things that he/she does not approve of.	1	2	3	4	5
10. I feel that the things I do in therapy will help me to accomplish the changes that I want.	1	2	3	4	5
11. _____ and I have established a good understanding of the kind of changes that would be good for me.	1	2	3	4	5
12. I believe the way are working with my problem is correct.	1	2	3	4	5

Tasks of Therapy Subscale: 1, 2, 10, 12; Goals of Therapy Subscale: 4, 6, 8, 11; Affective Bond

Subscale: 3, 5, 7, 9

Appendix B

Lesbian, Gay, and Bisexual Identity Scale

Some of you may prefer to use labels other than 'lesbian, gay, and bisexual' to describe your sexual orientation (e.g., 'queer,' 'dyke,' 'questioning'). We use the term LGB in this survey as a convenience, and we ask for your understanding if the term does not completely capture your sexual identity.

For each of the following questions, please mark the response that best indicates your current experience as an LGB person. Please be as honest as possible: Indicate how you really feel now, not how you think you should feel. There is no need to think too much about any one question. Answer each question according to your initial reaction and then move on to the next.

	Disagree Strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Agree Strongly
1. I prefer to keep my same-sex romantic relationships rather private.	1	2	3	4	5	6
2. If it were possible, I would choose to be straight.	1	2	3	4	5	6
3. I'm not totally sure what my sexual orientation is.	1	2	3	4	5	6
4. I keep careful control over who knows about my same-sex romantic relationships.	1	2	3	4	5	6
5. I often wonder whether others judge me for my sexual orientation.	1	2	3	4	5	6
6. I am glad to be an LGB person.	1	2	3	4	5	6
7. I look down on heterosexuals.	1	2	3	4	5	6
8. I keep changing my mind about my sexual orientation.	1	2	3	4	5	6

9. I can't feel comfortable knowing that others judge me negatively for my sexual orientation.   1   2   3   4   5   6

10. I feel that LGB people are superior to heterosexuals.   1   2   3   4   5   6

11. My sexual orientation is an insignificant part of who I am.   1   2   3   4   5   6

12. Admitting to myself that I'm an LGB person has been a very painful process.   1   2   3   4   5   6

13. I'm proud to be part of the LGB community.   1   2   3   4   5   6

14. I can't decide whether I am bisexual or homosexual.   1   2   3   4   5   6

15. My sexual orientation is a central part of my identity.   1   2   3   4   5   6

16. I think a lot about how my sexual orientation affects the way people see me.   1   2   3   4   5   6

17. Admitting to myself that I'm an LGB person has been a very slow process.   1   2   3   4   5   6

18. Straight people have boring lives compared with LGB people.   1   2   3   4   5   6

19. My sexual orientation is a very personal and private matter.   1   2   3   4   5   6

20. I wish I were heterosexual.   1   2   3   4   5   6

21. To understand who I am as a person, you have to know that I'm LGB.   1   2   3   4   5   6

22. I get very confused when I try to figure out my sexual orientation.   1   2   3   4   5   6

23. I have felt comfortable with my sexual identity just about from the start.   1   2   3   4   5   6

24. Being an LGB person is a very important aspect of my life.	1	2	3	4	5	6
25. I believe being LGB is an important part of me.	1	2	3	4	5	6
26. I am proud to be LGB.	1	2	3	4	5	6
27. I believe it is unfair that I am attracted to people of the same sex.	1	2	3	4	5	6

Acceptance Concerns Subscale: 5, 9, 16; Concealment Motivation Subscale: 1, 4, 19; Identity Uncertainty Subscale: 3, 8, 14, 22;

Internalized Homonegativity Subscale: 2, 20, 27; Difficult Process Subscale: 12, 17, 23; Identity Superiority Subscale: 7, 10, 18;

Identity Affirmation Subscale: 6, 13, 26; Identity Centrality Subscale: 11, 15, 21, 24, 25; Reverse Coded Items: 11 and 23

Appendix C

Cultural Humility Scale

Please think about your **most recent** therapist. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about your **most recent** therapist.

Regarding the core aspects of my sexual orientation, my therapist...

	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree
1. Is respectful.	1	2	3	4	5
2. Is open to explore.	1	2	3	4	5
3. Assumes he/she already knows a lot.	1	2	3	4	5
4. Is considerate.	1	2	3	4	5
5. Is genuinely interested in learning more.	1	2	3	4	5
6. Acts superior.	1	2	3	4	5
7. Is open to seeing things from my perspective.	1	2	3	4	5
8. Makes assumptions about me.	1	2	3	4	5
9. Is open-minded.	1	2	3	4	5
10. Is a know-it-all.	1	2	3	4	5
11. Thinks he/she understands more than he/she actually does.	1	2	3	4	5
12. Asks questions when he/she is uncertain.	1	2	3	4	5

Positive Subscale: 1, 2, 4, 5, 7, 9, 12; Negative Subscale: 3, 6, 8, 10, 11; Reverse Coded Items: 3, 6, 8, 10, 11

Appendix D

Informed Consent Form

Informed Consent
The purpose of this research is to better understand the experiences of lesbian, gay, and bisexual (LGB) persons in therapy. The results will be used to better train therapists to provide improved care to LGB persons. Dr. Eric Sprankle, an Associate Professor of Psychology at Minnesota State University, Mankato, is the principal investigator of this project. Todd Jennings is a clinical psychology graduate student helping to conduct this study.

Procedures
If you consent to participate, you will complete an online survey examining various aspects of your experience as an LGB person in therapy. Participation should last approximately 10-15 minutes.

Voluntary Nature of Study
Participation in this study is voluntary. Your decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato, and refusal to participate will involve no penalty or loss of benefits. If you decide to participate, you are free to stop at any time without penalty. You may stop the survey at any time by exiting the page.

Confidentiality
The surveys are anonymous and participant responses cannot be traced to any identifying information. Only Dr. Eric Sprankle and his research assistants will have secured access to the raw data. Although responses will only be viewed by the research team, whenever one works with online technology there is always the risk of compromising privacy, confidentiality, and/or anonymity. A couple ways to increase confidentiality is to use a secure internet connection and complete the survey in a private place. The surveys will be stored on a hard drive in Dr. Sprankle's office for 3 years, after which it will be destroyed. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager. You can also contact this office through email at ITSecurity@MNSU.edu.

Risks and Benefits
The risks you will encounter as a participant in this research are not more than experienced in your everyday life.   There are no direct benefits for participating. However, this research can be used to help improve the experiences of LGB persons in therapy by clarifying therapist characteristics that are important to LGB people.

Compensation
There is no compensation for participating.

Contacts and Questions

If you have any questions about this research study, contact Dr. Eric Sprankle (the principal investigator) at Minnesota State University, 103 Armstrong Hall, 507-389-5825, or by email at eric.sprankle@mnsu.edu. If you have any questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board, at (507) 389-1242.

Consent

By continuing on to the survey, you affirm that you are at least 18 years of age, have read the above information, and consent to participate. If you did not understand the information in this informed consent document, please do not participate in our survey. Participants have the right to obtain a copy of the consent form by contacting Dr. Eric Sprankle (the principal investigator) at Minnesota State University, 103 Armstrong Hall, 507-389-5825 or by email at eric.sprankle@mnsu.edu.

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