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Walden University

College of Social and Behavioral Sciences

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Sean P. Meyer

has been found to be complete and satisfactory in all respects,
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Walden University
2020

Abstract

Rehabilitation Counseling Students' Perceived LGB Competence:

Implications for Curricula Development

by

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MPhil, Walden University, 2019

MS, University of Hawaiʻi at Mānoa, 2015

BHA, University of North Florida, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Walden University

December 2020

Abstract

Previous research has consistently showcased disparities in the prevalence of physical and psychiatric disabilities amongst individuals in the lesbian, gay, and bisexual community when compared to the general population. As a profession focused on assisting persons with disabilities achieve full participation in society, there is a strong likelihood that rehabilitation counselors will encounter a client who identifies as both LGB and as a someone with a disability. Therefore, multicultural counseling competence is paramount in ensuring rehabilitation counselors are prepared to provide culturally appropriate services to their clients.

Applying a social cognitive theory framework, 204 graduate-level students were recruited from accredited programs to participate in a quantitative study to examine their multicultural competence in addressing the intersection of sexual orientation and disability status. Using a combination of Pearson's *r* and one-way analyses of variance, a significant relationship was found between the completion of a multicultural counseling course and outcome scores on the Sexual Orientation Counselor Competency Scale (SOCCS). Additionally, a positive relationship between a participant's program type and outcome scores on the SOCCS was also confirmed. Finally, significance was found between participants who had completed additional training hours compared to those who had not, in relation to outcome scores on the SOCCS. Collectively, the findings of this study may promote social change by offering academic programs with suggestions as to how best to address limitations in multicultural counseling curricula to better prepare professionals to work with clients with intersecting minority statuses.

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Dedication

This dissertation is dedicated to my family, friends, and loved ones. Thank you all so much for your encouragement, support, and helping me to see my true potential. This dissertation process could not have been possible without each and every person in my life. With much love and appreciation!

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I could likely dedicate another 50-pages to acknowledging each and every person that helped me to get to where I am today, but in the interest of closing the chapter on this

journey, I will simply say: Thank you to everyone for all of the love, support, and encouragement you have shown me over the past several years!

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Chapter 1: Introduction to the Study

In today's global and ever-changing world, the need for rehabilitation counselors to possess multicultural counseling competence is paramount. Previous studies have sought to explore multicultural competence in relation to a mental health professionals' competence in an applied setting, such as in the context of a clinical encounter during psychotherapy; however, few if any studies have ever sought to explore multicultural competence in terms of two intersecting minority statuses – sexual minority and disability. Furthermore, there are even fewer studies that specifically address how well-prepared rehabilitation counselors are to render culturally appropriate services during the rehabilitation process. The believed disparity between preparation and reality is troubling in that lesbian, gay, and bisexual (LGB) persons have been found to disproportionately experience acquired disabilities, as opposed to congenital, and use mental health services, therefore qualifying them as having a psychiatric disability in the context of the Americans with Disabilities Act of 1990, and thus increasing the likelihood that they may encounter a rehabilitation counselor that is not sufficiently prepared to assist them.

Background of the Study

McAllan and Ditillo (1994) suggested that when seeking services and support for disabilities, congenital or acquired, the rehabilitation counselor is often the first professional figure to whom a client reveals his or her sexual identity. The reaction of the rehabilitation counselor, through acceptance or nonacceptance of the client's sexuality, can have a profound impact on the client's willingness to discuss their sexual identity

with not only the rehabilitation counselor, but perhaps other professionals (McAllan & Ditillo, 1994).

The most successful therapeutic relationships revolve around a strong therapeutic alliance (e.g., Kelley, 2015; Longhofer, 2013; Spengler, Miller, & Spengler, 2016). With this in mind, one might surmise that clients likely will be more comfortable opening up about their presenting issues and their needs and desires, when they feel they are in a safe, supportive, and non-judgmental environment. Clients made to feel comfortable through this therapeutic alliance may disclose their full identity and life stressors to rehabilitation counselors, perhaps leading to a better rehabilitation outcome tailored to the client.

Significant emphasis has been placed on multicultural counseling in the disciplines of counseling and psychology (Kelsey & Smart, 2012; Matrone & Leahy, 2005); despite broad adoption of multicultural counseling curricula in graduate programs, there remains a paucity of research assessing how well multicultural counseling curricula prepare rehabilitation counseling students to work with diverse populations. Perhaps even more alarming is that there is a dearth of empirical literature from the field of rehabilitation counseling on multicultural counseling competencies or counselor self-efficacy, let alone literature that addresses these topics as they apply to LGB clients with disabilities (Gauler & Meyer, 2014; Kelsey & Smart, 2012; Matrone & Leahy, 2005; Meyer & Gauler, 2015). Despite the inclusion of multicultural counseling coursework in programs, a review of multicultural counseling text books reveals that constructs, such as

sexual orientation and disability, are often discussed in a single chapter, if discussed at all (e.g., Hays & Erford, 2017; Orozco & Lee, 2014; Sue & Sue, 2015).

The role of today's vocational rehabilitation counselor has changed considerably in terms of the need for multicultural counseling competence when working with marginalized populations. Multicultural counseling has garnered significant attention in the disciplines of counseling and psychology; however, there are few contributions from the vocational rehabilitation field that address counseling with LGB persons. Nevertheless, despite the broad adoption of multicultural counseling curricula in graduate programs, there has been little research that assesses the role that multicultural counseling curricula plays in fostering multicultural competence in vocational rehabilitation counseling students.

Research Problem Statement

Many rehabilitation counseling programs are conferring degrees upon students, often sending them into the field with insufficient preparation to provide culturally appropriate counseling services to LGB clients with disabilities (Dispenza & Hunter, 2015). This is problematic because failing to promote multicultural competence, and more specifically, LGB-affirmative practices, through the rigorous combination of theoretical and experiential coursework, can impact all facets of the therapeutic alliance between counselor and client and the client outcome (Bidell, 2013). The research suggests that a relationship exists between the breadth and depth of multicultural counseling and experiential coursework and counseling outcomes (Bidell, 2013; Meyer & Gauler, 2015). Learning more about the relationship between coursework aimed at

preparing students for multicultural counseling and competency in rendering culturally appropriate counseling services offers a way to explore how rehabilitation counseling programs can better prepare students to not only work with disability populations but also populations with intersecting minority statuses (e.g., sexual minority with disabilities). It is not apparent that the completion of a single course in multicultural counseling adequately prepares rehabilitation counseling students to address sexual diversity in disability populations, compared to completing additional coursework on sexuality and disability status, or by participating in workshops aimed at increasing competency through greater exposure to the population.

Purpose of the Study

The purpose of this study was to examine whether multicultural training and additional coursework in graduate training programs improves a counselor's competency, and thereby self-efficacy, in working with LGB clients with disabilities. Research conducted by Stajkovic and Luthans (1998) and by Moritz, Feltz, Fahrbach, and Mack (2000), on the relationship between self-efficacy and performance, along with studies on academic performance (e.g., Moritz et al., 2000; Multon, Brown, & Lent, 1991), when collectively evaluated, demonstrate a correlation between competency and self-efficacy. For the purpose of this research study, this researcher elected to include only sexual orientation for examination. Adding gender identity (i.e., transgender and gender-nonconforming) with sexual orientation often results in conflation on the two, something researchers have cautioned against because gender identity is a complex diversity issue in its own right. After conducting a literature review and revealing gaps in the research on

multicultural counseling preparation, which likely hinders the efficacy of counseling, this researcher proposed to design and conduct empirical research using quantitative analysis of measures to examine rehabilitation counseling students' competency and self-efficacy in providing services to LGB clients with disabilities.

Although there have been similar studies that examined multicultural counseling competence levels among clinical mental health counseling students and psychology students when working with LGB clients (e.g., Bidell, 2013; Bonjo, 2013; Farmer, Welfare, & Burge, 2013; Grove, 2009), this study is perhaps novel in that it explores the topic of intersectionality, the convergence of sexuality and disability, and examining this construct exclusively with rehabilitation counseling students. In contrast to other counseling professions, rehabilitation counseling programs place a greater emphasis on preparing students to work with intellectual, psychiatric, and physical disabilities, whereas other counseling professions focus almost exclusively on mental health disorders, or psychiatric disabilities.

In addition to the differences in specializations or focus areas, the degree requirements for rehabilitation counseling programs are often different from other counseling programs. For example, whereas traditional clinical mental health counseling programs require students to complete 60-credit hours prior to conferral of a degree, the vast majority of rehabilitation counseling programs currently require a mere 48-credit hours. Students enrolled in 48-credit hour programs who wish to pursue licensure as a professional counselor or mental health counselor are often afforded the opportunity to

complete elective courses to meet many states' licensure requirements of completing a 60-credit hour program (e.g., University of Hawai‘i at Mānoa, 2015).

There is significant disparity in experiential coursework between rehabilitation and clinical mental health counseling programs. Prior to the merging of the Council on Accreditation of Counseling and Related Educational Programs (CACREP) and the Commission on Rehabilitation Education (CORE), vocational rehabilitation counseling programs required students to complete fewer practicum and internship hours for degree conferral; specifically,750 hours total versus 1,000 hours total (CACREP, 2017). Some programs that have sought and received accreditation by both CACREP and CORE may now require students to meet the more stringent standards set forth by CACREP; however, some may have been granted temporary waivers to transition from a 48-credit-hour program to a 60-credit-hour program.

Research Questions and Hypotheses

In the present, quantitative study, this researcher explored the self-perceived level of competence of graduate-level trainees currently enrolled in various phases of their counselor education programs leading towards conferral of a master's degree in rehabilitation counseling or comparable programs offering a cognate in rehabilitation counseling. Five research questions were explored in this study:

RQ1. Do rehabilitation counseling students who have completed a multicultural counseling course differ in self-perceived counseling competence in working with LGB clients, from rehabilitation counseling students who have not completed a multicultural

counseling course, as measured by the score on the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005)?

$H_0$1: The completion of a multicultural counseling course will not influence students' competence in rendering culturally appropriate services to LGB clients, as measured by scores on the SOCCS.

H_a1: Students who have completed a multicultural counseling course will have higher scores on the composite score of the SOCCS.

RQ2. For rehabilitation counseling students, to what degree does counselor competence in rendering culturally appropriate services to LGB clients, as measured by the SOCCS, predict competence in addressing the broader intersection of disability and sexuality, as measured by scores on Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale (KCAASS; Kendall, Fronek, & Geraghty, 2003)?

$H_0$2: The attainment of higher scores on the SOCCS will not influence students' scores on the KCAASS on a statistically significant level.

H_a2: Students who attain higher scores on the SOCCS will attain higher scores on the KCAASS at a statistically significant level.

RQ3: How does the number of hours completed in a graduate training program relate to outcome scores on the SOCCS?

$H_0$3: Additional hours of coursework will not influence scores on the SOCCS at a statistically significant level.

H_a3: Additional hours of coursework will influence scores on the SOCCS at a statistically significant level.

RQ4: How does the completion of additional hours in workshops, cultural immersion events, conferences, and training sessions beyond hours spent in a graduate program influence the outcome scores on the SOCCS?

$H_0$4: The completion of additional hours in workshops, cultural immersion events, conferences, and training sessions beyond hours spent in a graduate program will not influence outcome scores on the SOCCS.

H_a4: As the number of hours spent in workshops, cultural immersion events, conferences, and training sessions increases, there will be a positive correlation to higher scores on the SOCCS.

RQ5. To what extent will outcome scores on the SOCCS and KCAASS correlate with outcome scores on the CASES as a measure of self-perceived competence when presented with a clinical vignette?

$H_0$5: Higher scores on the SOCCS and KCAASS will not predict a higher degree of self-efficacy of rendering culturally appropriate services, as measured by scores on the CASES, in response to clinical vignettes describing diversity in sexual orientation and disability type.

H_a5: A positive correlation will exist between outcomes scores on the SOCCS, KCAASS, and CASES in response to clinical vignettes describing diversity in sexual orientation and disability type.

Theoretical Framework

In reviewing the existing literature on multicultural counseling competence, among the many theoretical positions that have guided such research, Bandura's (1977,

1982, 1986, 1997, 2001) social cognitive theory has emerged as a promising framework that for the purpose of this study, appeared to offer the most valuable theoretical vantage point from which multicultural counseling competence could be examined, in the context of LGB-affirmative practices with persons with disabilities. Social cognitive theory, as postulated by Bandura (1986), explains that much learning occurs by merely observing others, and that such social learning may be enhanced through vicarious reinforcements, that is, individuals are more inclined to learn and be motivated to perform a behavior when the behavior is positively reinforced (Bandura, 1986).

Given the significant stigma that has historically surrounded diversity in sexual orientation in the United States, social cognitive theory has been found to be both an appropriate and effective framework when examining topics related to the LGB community. For example, in a study conducted by Bonds-Raacke, Cady, Schlegel, Harris, and Firebaugh (2007) to examine participants' attitudes towards gay men and lesbians, the researchers found that participants who were asked to recall media portrayals of gay or lesbian characters endorsed more positive attitudes towards gay men and lesbian characters when the characters were portrayed more favorably. In contemporary times, with considerable progress having been made in destigmatizing diversity in sexual orientation and greater visibility of and exposure to LGB persons, it is believed that the behavior-learning features of social cognitive theory might explain and provide for a better understanding of how people's attitudes and behaviors towards LGB persons are formed and perpetuated in a clinical setting by influencing or moderating counselor

competence. A more detailed examination of social cognitive theory is included in Chapter 2.

Nature of the Study

For the present study, a quantitative research design was proposed and adopted to evaluate the influence of multicultural counseling coursework, formal coursework and formal and informal experiential training opportunities, on graduate-level students' perception of competence in working with LGB clients with disabilities. The rationale for adopting a quantitative research design was substantiated by Creswell's (2009) suggestion that this form of research is often ideal for examining statistical comparisons between measures.

The study employed a survey research design, which used convenience sampling, whereby students were initially presented with a clinical vignette that described an intake session between a rehabilitation counselor and a client, randomizing the sexuality and disability type of the client, followed by asking the participant to complete several measures to assess competence in working with the client presented in the clinical vignette and sexual minority clients and clients with disabilities. Qualtrics was used to host the survey, and all data were exported to SPSS for data analyses.

Language and Definitions

The language and terms used to both describe the target population being examined in this study – individuals who identify as lesbian, gay, or bisexual who also identify as being a person with a disability – and the constructs that impact both of these populations are language and terms derived from a combination of contemporary

research emphasizing affirmative practices when working with marginalized populations, the Americans with Disabilities Act (ADA), or sources that align with professional standards set forth by professional organizations such as, the American Psychological Association (American Psychological Association), the American Counseling Association (ACA), The Council for Accreditation of Counseling and Related Educational Programs (CACREP), the Council on Rehabilitation Education (CORE), and others recognized as promoting the needs of both individuals of the LGB community and persons with disabilities.

Following are definitions that are accepted as appropriate by the majority of academia and professionals working in the field when conducting research with LGB groups, individuals, and communities, and the disability community:

Bisexual: A term used to describe an individual who experiences emotions, romantic, or sexual attractions in relation to more than one sex or gender, or who engages in romantic or sexual relationships with more than one sex or gender (American Psychological Association, 2020).

Diversity: Refers to the dimensions of personal identity and individual differences (Arredondo et al., 1996).

Gay: A term used to describe a male who experiences emotions, romantic, or sexual attractions in relation to the same sex or gender, or who engages primarily in romantic or sexual relationships with the same sex or gender (American Psychological Association, 2020).

Intersectionality: A term used to describe the concurrent experiences of convergent identities such as gender, race, sexual orientation, and socioeconomic status and the ways these multiple minority statuses create systems of oppression, domination, and discrimination (Shin et al., 2017).

Lesbian: A term used to describe a female who experiences emotions, romantic, or sexual attractions in relation to the same sex or gender, or who engages primarily in romantic or sexual relationships with the same sex or gender (American Psychological Association, 2020).

LGB: An acronym used to describe individuals that identify as lesbian, gay, or bisexual, or the community composed of individuals who identify as lesbian, gay, or bisexual.

Multicultural competence: Attributes related to a counselor's awareness of their own personal beliefs, values, biases, and attitudes, their awareness and knowledge of the worldview of culturally diverse individuals and groups, and their utilization of culturally appropriate intervention skills and strategies (Sue & Sue, 2013).

Multiculturalism: Refers to the historical and sociopolitical context, in the United States, of race, ethnicity, and culture, focusing on four racial-ethnic minority groups, including Asian, Black or African American, Hispanic, or Native American individuals (Arredondo & Glauner, 1992).

Persons with disabilities: A person-first term used to describe individuals living with a physical, psychiatric, or intellectual disability (Falvo, 2009).

Rehabilitation counselors: A profession dedicated to assisting individuals with disabilities achieve and maintain independent living (U.S. Bureau of Labor Statistics, 2020).

Self-efficacy: A term, that in the context of the present study, refers to the judgements counselors have about their capabilities to perform in specific situations (Bandura, 1977).

Sexuality: A broad term used to describe all aspects of human sexual behavior, including gender identity, orientation, attitudes, and activity (American Psychological Association, 2020).

Sexual orientation: A term referring to an individuals' enduring pattern of emotional, romantic and/or sexual attractions to men, women, or both sexes (American Psychological Association, 2020).

Assumptions

In reviewing the existing literature, albeit sparse when focusing exclusively on the field of rehabilitation counseling, there is undeniably a deficiency noted in how well-prepared counseling students believe they are in rendering culturally appropriate clinical services when working with diverse populations. Contrasting with previous research, the present study sought to explore whether rehabilitation counseling students, who upon graduating from their respective programs, should be equipped and prepared to work with disadvantaged populations (i.e., persons with disabilities).

While it was assumed, though not specifically examined in the present study, that rehabilitation counselors may endorse higher levels of competence in working with

persons with disabilities, where disability status is a singular variable or characteristic, when introducing topics of human sexuality *and* disability, it was assumed that rehabilitation counseling students would endorse lower levels of competence. Similarly, and congruent with previous findings in other counseling professions, it was assumed that even after having completed a multicultural counseling course, students would endorse comparable (as compared to previous studies) or lower levels of competence in working with LGB persons. Thus, it was assumed that students would endorse comparable (as compared to previous studies) or lower levels of competence when working with LGB clients with disabilities.

Previous research (see Bellini, 2002; Bidell, 2012; Hope & Chappell, 2015; Prosek & Michel, 2016; Shannonhouse, Myers, Barrio-Minton, 2018) has showcased correlates between the type and quantity of participation in workshops, cultural immersion events, conferences, and training sessions beyond graduate program requirements, in relation to multicultural competence. Additionally, differences between CACREP- and CORE-accreditation standards (i.e., scope of the program) and the number of credit hours required for conferral of a master's degree (i.e., 48- or 60-credit hours), which has varied both before and after these accreditation agencies merged (see Leahy & Tansey, 2008; Mackay, Suedmeyer, Schiro-Geist, West, & Strohmer, 2018) could influence counselor professional outcomes, to include multicultural competence. Further substantiating this assertion, previous studies have proposed that differences in program delivery, such as distance, hybrid, or traditional in-person, may impact counselor

preparation (e.g., Cardidad-Alvarez & Domenech-Rodríguez, 2020; Leech & Holcomb, 2004, etc.).

It is with this understanding that in the present study, it was assumed that a positive correlation would be found in students' multicultural competence when having participated in additional elective training opportunities, the numbers of hours spent participating in these opportunities, and the number of hours required to complete their respective programs. Further, and drawing upon the theoretical framework of this study, Bandura's (1977, 1982, 1986, 1989, 1997, 2001) social cognitive theory, Tajfel and Turner's (1979) social identity theory, and research exploring how individuals perceive minorities once they have engaged with minorities (e.g., Degner, Essien, & Reichardt, 2016; Mullen, Brown, & Smith, 1992; Roth & Steffens, 2014, etc.), it was assumed that students who are familiar with a family member or friend who identifies as LGB or is a person with a disability, would demonstrate a higher degree of competence in working with LGB persons with disabilities.

Scope and Delimitations

The scope of this study was limited to graduate-level students enrolled in a clinical mental health counseling program with a specialization in rehabilitation counseling or graduate-level students enrolled in a rehabilitation counseling program. The topic was limited to student competence in working with individuals who identify as lesbian, gay, or bisexual, and have a psychiatric or physical disability.

Given the existing contributions to the research addressing multicultural counseling competence with traditional clinical mental health counseling and psychology

students, these students were ineligible for participation. The focus of this study excluded gender identity, diversity in human sexuality (e.g., asexuality, pansexuality, etc.), and intellectual disabilities.

Limitations

Limitations have been described as weaknesses or handicaps that serve as a threat to the validity of a study's results (Pyrczak & Bruce, 2000). At the outset of the study, it was assumed that several significant limitations could influence participation in this study. First, the study involved exploring LGB-centric topics, which are often very emotionally charged topics for some, despite the country's progress in demarginalizing this population. Therefore, the stigma associated with this topic may have influenced participation; a possible effect of structural stigma impacting research in the social sciences, which Hatzenbuehler and Link (2014) described as being, "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized" (p. 2). Second, it was believed that one of the constructs being explored, multicultural counseling coursework, could have been perceived as an appealing or unappealing topic to prospective participants, therefore either encouraging or discouraging participation rates or perhaps skewing the data collected in the study, when considering that only impassioned participants might complete the study. Furthermore, it was believed that a participants' level of comfort in exploring topics of human sexuality could have served as a limitation.

Limitations in the delivery of the study included the fact that the survey was administered online, where participants may or may not have had the skills necessary to

navigate the Qualtrics survey, or lacked the ability to back-track in the survey to recall information that had been presented on a previous screen. Whereas participants were asked to carefully read and complete aspects of the survey, ideally in a private space, external distractions could impaired their ability to focus. While every effort was made to ensure an inclusive research study, the online mode of delivery may have served as a limiting factor in recruiting participants with visual limitations.

Another limitation was the nature of the data: it was self-reported. Unfortunately, the collection of self-reported information could not be controlled for in the research design adopted, aside from evaluating participants' response patterns in response to a social desirability scale. Self-reported data could introduce bias into the research and ultimately jeopardize the reliability of the data (Graham, Carney, & Kluck, 2012). The quality of data could also have been influenced by the confounding variables in the sampled population, such as the participant's level of religiosity or the degree of opportunities participants had to gain exposure to diverse clientele. Such factors simply could not be controlled for in the present study. According to Bidell (2014) a relationship between the level of conservative religiosity influences multicultural counseling skills when working with LGB clients. According to Farmer, Welfare, and Burge (2013), previous exposure to one subgroup of the overall LGB community might moderate competence in working with that subgroup; however, this was not able to be explored in the present study due to limitations associated with conducting sexual minority research using inclusive grouping.

It is also worth noting the limitations associated with a research study on the convergence of multiple minority statuses. In this study, there were limitations in the number of characteristics that could be manipulated to assess a participant's multicultural competence (i.e., clinical vignettes only depicted straight, lesbian, and gay clients with either a physical or psychiatric disability). Variables, such as age, ethnicity, or socioeconomic status in the "presenting client," which previous research has shown as being factors that might serve as moderators in a counselors' self-perceived multicultural competence (e.g., Tomko & Munley, 2013; Whitehead, 2003, etc.) could not be evaluated. Further, when considering age and ethnicity in conjunction with sexual orientation and disability statuses, the convergence of three or more minority statuses would likely involve an exhaustive investigation to fully understand and offer recommendations on how best to address any potential deficiencies in multicultural counseling curricula.

Significance of the Study

There has been a movement within the counseling and psychology fields to bolster multiculturalism and multicultural counseling competence. Such efforts have included a greater emphasis on research aimed at investigating unique factors that contribute to mental health disparities impacting marginalized populations' (e.g., stigma, ostracism, minority stress, etc.) and the inclusion of evidence based standards within education programs seeking to improve competence amongst students (i.e., multicultural counseling curricula). Nevertheless, there remains many opportunities for improving both students', and ultimately, clients' outcomes.

This study sought to contribute to the research available on multicultural competence within the field of rehabilitation counseling by exploring limitations while identifying evidence-based recommendations on how rehabilitation counseling programs might improve their curricula to bolster student competence in working with LGB clients with disabilities. Additionally, this study explored and proposed how recommendations may correlate to improvements in clinical practice, client experiences, and most importantly, client outcomes in the rehabilitation process.

Summary

In Chapter 1, this researcher presented an introduction to the study by showcasing and explaining limitations that exists within rehabilitation counseling programs, likely contributing to rehabilitation counseling students being sent into the field lacking the necessary preparation to work with clients that identify as sexual minorities with disabilities. Unique to this study was the focus on multicultural competence in rehabilitation counseling students. Few, if any, contemporary studies have examined multicultural competence amongst rehabilitation counseling students, and no available studies have focused on exploring such competence when working with LGB clients with disabilities (i.e., the intersection of multiple minority statuses).

For this study, five research questions and hypotheses were proposed and explored, guided through the theoretical framework of Bandura's (1982) social cognitive theory, using a quantitative research design. Despite the limitations identified, it is believed that this study will be a significant contribution to the field of rehabilitation counseling, to not only guide multicultural counseling curricula development, but also

offering practical recommendations to the field – clinical implications – to improve and enhance the quality of service delivery.

In Chapter 2, a literature review will be presented exploring the tumultuous historical context of psychology and psychiatry and the LGB community, a review of existing literature exploring multicultural competence with LGB persons, and research focused on exploring the intersection of multiple minority statuses. Chapter 3 will discuss the research methods applied in the study. Chapter 4 will present the results of the study, and Chapter 5 will present the discussion, conclusions, and recommendations based on the data collected and analyzed.

Chapter 2: Literature Review

Introduction

Based on the existing literature, which have identified limitations in multicultural competence in students enrolled in applied, clinical social sciences programs, similar limitations are believed to exist in rehabilitation counseling programs, especially when considering the convergence of multiple minority statuses. Accordingly, these programs are failing to sufficiently prepare rehabilitation counseling students to provide culturally appropriate clinical services to their clients who identify as both a sexual minority and as a person with a disability. This study examined whether multicultural counseling coursework, in conjunction with additional training hours beyond program requirements, might improve counselor competency in working with LGB clients with disabilities. The following chapter explains the literature search strategy that was employed, offers a deeper analysis of the theoretical framework adopted for this study, and presents a comprehensive review of the existing literature on multicultural competence and self-efficacy.

Literature Search Strategy

Preliminary research in this area has indicated that while there is a demand for greater exploration on topics of multicultural counseling competence with LGB clients with disabilities from the field of rehabilitation counseling, there remains a dearth of contributions from scholars in the field. Working alongside a colleague, a program director of a rehabilitation counseling program, to compose a manuscript exploring scholarly contributions spanning several decades, an abbreviated review of the journal

databases was performed. Since the early 1990s, less than a dozen journal articles addressed derivative search terms for "rehabilitation counseling" and "lesbian, gay, and bisexual." In an unpublished manuscript, this researcher, along with his research colleague, contacted several editors via electronic mail, inquiring if there was an interest in this topic or if a lack of submissions might explain the dearth of publications. The resounding response from journal editors was that there was a strong interest in the topic, but that few individuals have submitted articles for review exploring the topic (Meyer & Yamamoto, 2016).

As a result of this lack of research from the field of rehabilitation counseling, the majority of this literature review is derived from contributions to the interdisciplinary literature. This researcher accessed the databases PsycINFO, Sage Journals, and Academic Search Complete to search for articles using the following terms: *LGB*, *multicultural counseling*, *rehabilitation*, *disability*, *sexuality*, *gay*, *lesbian*, and *intersection*. As previously discussed and discovered in similar research, the articles spanned the early 1990s to the present, with relatively few contemporary contributions on the multicultural competence of rehabilitation counseling students.

Whereas the humanistic approach to psychology is often referred to as the *third force* in psychology, many consider multiculturalism to be the *fourth force* in psychology (Carroll & Gilroy, 2002; Cassel, 2001). It is the hope of this researcher that studies such as this one will serve as a catalyst for the fourth force in psychology to take root in the field of rehabilitation counseling, promoting LGB disability studies to further the understanding, and improve the services available to clients.

Theoretical Foundation

The present study adopted the theoretical framework of social cognitive theory, as proposed by Bandura (1977, 1982, 1986, 1989, 1997, 2001). Social cognitive theory draws upon Miller and Dollard's (1941) theory of social learning, which as originally proposed during the time, was a revolutionary attempt at better understanding and explaining human behavior, deviating greatly from theoretical approaches of the time that were heavily rooted in behaviorism (Pajeres, 2002; Schunk, 2012). Drawing upon social learning theory, Bandura (1982) proposed a new theory of social cognitive learning, which suggested that human behavior development could not be adequately understood or explained through one-sided determinism; rather, a triadic model of mutual determinism should be the linchpin of how we understand learning (Schunk; Phillips & Orton, 1983). Serving as a moderator, learning is gained through social environments; it is in these social environments where interactions occur precipitating the acquisition of knowledge, skills, strategies, beliefs, rules, and attitudes (Schunk, 2012). These observations and interactions with others, influences: our understanding of what is appropriate versus inappropriate, our perception of usefulness, and our conceptualization of consequences in relation to our behaviors (Schunk).

In further explaining Bandura's (1977, 1982, 1986, 1989, 1997, 2001) triadic model of reciprocal determinism, Bandura (1982) described that several factors influence human behavior – bidirectionally – to include the reciprocal causation of behavior, cognition, other personal factors, and environmental influences. Bandura (1982) believed that human thoughts, affect, and actions were the determinants of human behavior,

suggesting that thoughts and beliefs influence physical actions and emotional responses to stimuli – schemas. Schemas, which are influenced by an individual's beliefs, expectations, and cognitive abilities, are believed to be formed through prior social learning, and are believed to determine action, reaction, and reactivity (Bandura, 2001).

In reviewing the literature on the application of social cognitive theory as a theoretical framework, several studies were identified that have effectively applied this framework towards exploring counselors' multicultural competence. Notably, Alessi, Dillon, and Kim (2015) adopted a social cognitive theory framework in their study to assess the influence of counselors' attitudes towards LGB individuals, their self-efficacy in applying LGB-affirmative practices, and to explore their beliefs about affirmative practices. Utilizing a path analysis to examine the associations between counselors' hours of training, their attitudes, their self-efficacy in applying LGB-affirmative practices, their beliefs, and their engagement in affirmative practice, Alessi and colleagues found that counselors' beliefs and self-efficacy in applying LGB-affirmative practices were moderated by their associations between attitudes and engagement in affirmative practice. Furthermore, they found that self-efficacy moderated the relationship between training hours and engagement in LGB-affirmative practice.

Linking their study to the theoretical framework adopted – social cognitive theory – Alessi and colleagues (2015) found that counselors' attitudes towards LGB clients were influenced by higher levels of self-efficacy in applying LGB-affirmative practices and positive beliefs, which influences counselor engagement in affirmative practices. Additionally, greater hours of training, which often involves greater exposure to the

population being studied, also correlated to greater engagement by the counselor in rendering affirmative practices.

In a similar study, which had also adopted a theoretical framework based on Bandura's (1986) social cognitive theory, Dillon, Worthington, Soth-McNett, and Schwartz (2008) sought to examine the influences of gender self-confidence and sexual identity exploration and commitment plays on counselors' self-efficacy in rendering LGB-affirmative practices. Salient to their study, and relevant to the application of social cognitive theory in the present study, Dillon and colleagues found that professional experience, whereby a counselor has likely gained greater exposure to LGB clients, was predictive of greater self-efficacy in both more broadly working with and in the application of knowledge relevant to successful work with LGB clients. Furthermore, Dillon and colleagues argued that their findings substantiated previous research which had found that there is indeed a positive association between professional experience (exposure) and LGB self-efficacy. As part of their recommendations for improving LGB-affirmative practices, it was suggested that developing and offering continuing education and supervision programs, based upon social cognitive theory, may greatly influence the LGB-affirmative practices of counselors in the field (Dillon et al.).

As it relates to the current study, social cognitive theory is relevant in that it may explain the judgements counselors have with respect to their ability to perform in situations, which moderates competence (Bidell, 2000). According to social cognitive theory, competencies are derived from and modified by social influences (Bandura, 1989). In practice, competencies influence situational behaviors, thought patterns, and

emotional responses (Bidell, 2000). In fostering greater competence in multicultural counseling, Bidell (2000) argued that it is crucial for graduate training programs to support students' self-efficacy, thereby proportionately influencing their multicultural competence. This is often accomplished through coursework, exposure to diverse populations, field experiences, and quality supervision (Bidell, 2000; Bidell, 2012; Graham, Carney, & Kluck, 2012; Meyer & Gauler, 2015; Sue & Sue, 2013).

Literature Review

In recent years there has been a steady, albeit slow increase in the number of peer-reviewed journal articles and research studies assessing lesbian, gay, and bisexual-centric issues in mental healthcare (e.g., Bidell, 2013; Bonjo, 2013; Farmer, Welfare, & Burge, 2013; Grove, 2009, etc.). Despite this push towards understanding the mental health needs of LGB persons, the recommendations on how best to prepare students to effectively work with this population remains somewhat nebulous, with many graduate-level programs consolidating LGB topics, where the breadth of these topics are often summarized in a single chapter of a multicultural counseling textbook, into a single, foundational multicultural counseling course. Perhaps to the detriment of this population, especially when considering the prevalence of disability within the LGB community, topics on intersectionality – specifically sexual identity and disability – remain largely undiscussed in graduate training programs (Mona, Cameron, & Cordes, 2017). Perhaps most salient to this study, is the fact that even the field of rehabilitation counseling, which Rubin and Roessler (2010) described as being a profession specifically trained to work with persons with disabilities, remains mostly muted on the topic of working with LGB

clients with disabilities, focusing almost exclusively on the broader topic of disability (Kelsey & Smart, 2012).

Historical Context of Homosexuality

In order to gain a better understanding of the importance of the topic being explored in the present study, it is perhaps important to first discuss the historical context and understanding – from a psychological perspective – of same sex relationships (i.e., homosexuality). Whereas the American Psychological Association (2020) has advised against the use of heterosexual bias in language, such as using the term homosexual, for the purpose of this historical context – drawing upon historical literature on the topic – this term has been used.

Homosexuality has and remains a very contentious topic in the United States. Much of this can be attributed to the social stigma associated with homosexuality. The characteristics of homosexuality in humans has had a perplexing and often confusing history in terms of recognition and being defined as a psychopathology." Prior to 1973, the American Psychiatric Association classified homosexuality as a "psychopathological adjustment" disorder (as cited in Ross & Paulsen, 1988, p. 59). Theoretical perspectives in psychology, such as psychoanalysis, took years to reconsider and ultimately depathologize homosexuality (Goldberg, 2001). This designation was later expanded and revised by the American Psychiatric Association in the 1980 publication of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) by stating, "homosexuality itself is not considered a mental disorder" (as cited in Ross & Paulsen,

1988, p. 59). This ultimately served as the catalyst to re-defining “homosexuality” as “normal” and not “pathological.”

Sexual orientation – from a historical perspective – is a relatively recent construct in terms of formally defining and attaching meaning to the behavior. Herek (2010) asserted that it was not until 1868 that the word “homosexuality” was used; “heterosexuality” was introduced even later (p. 694). In the early 19th century, procreative acts were sanctified through heterosexual marriage; marriage at this time being an institution primarily for securing wealth and property rights; non-procreative acts were considered “animalistic” and condemned by religious and legal statutes. The construct of procreative acts and marriage did represent love or sexual desire, contrasting with contemporary notions of homosexuality and heterosexuality.

The late 19th century brought about a change in the importance of sexuality and introduced a belief that individuals be defined by their sexual attractions, which permeated psychiatric discourse of the time, most famously discussed in the works of Sigmund Freud, widely regarded as the “father of psychoanalysis” (Herek, 2010). Significant among his contributions to the understanding of sexuality, Sigmund Freud discussed the conceptualization of homosexuality and heterosexuality, suggesting neither orientation being “right” or “wrong,” emphasizing that homosexuality should not be described as an illness, rather, offering that bisexual tendencies were ever-present in humanity.

Disavowing the psychoanalytical framework established by Sigmund Freud in

understanding human sexuality, the American field of psychoanalysis embraced the belief that humans were naturally heterosexual, and that homosexuality represented a phobic response to the norm (Herek, 2010). By the 1940s, the field of mental health professions (encompassing psychology, psychiatry, and allied fields) was struggling to decipher the cause and possible treatments for homosexuality (Chiang, 2008). Motivated by the psychoanalytical community, a majority of the field adopted similar understandings that homosexuality was, indeed, a psychological ailment that combined an inner masochistic tendency with a psychological adaptation fear of the opposite sex, ultimately driving persons towards same sex orientations (Chiang, 2008).

Herek (2010) noted that, although the field of psychology contributed significantly to the depolarization of sex and love, it also created a contradiction by equating heterosexuality to “normalcy” and homosexuality with “disease” (p. 694). This fundamental understanding, accepted largely by the field, perpetuated throughout society evidenced in legal and religious condemnation of sodomy and same sex acts and desires, and the adoption of stigmatizing policies geared towards restricting opportunities for LGB persons.

During World War II, the homosexual illness model was adopted by the United States military, changing personnel policy from one which simply prohibited the act of sodomy and same sex activity to one that actively disqualified candidates who were homosexual, regardless of whether an act had been committed (Herek, 2010). Military psychologists and psychiatrists were tasked with screening recruits and detecting

homosexuality, though many turned a blind eye to this due to the demand of needing physically capable recruits.

Towards the end of World War II, the lax enforcement of homosexual screenings transformed into vigorously enforced “witch hunts,” resulting in LGB persons being forcibly discharged as “sexual psychopaths” (Herek, 2010). The disposition of these discharges were transmitted to individual’s hometowns, and prominently displayed on draft boards, ostracizing these people from their friends, family, and community. The ramifications of these characterizations of discharge led to social exclusion, denied veterans benefits, the inability to secure civilian employment, and in more severe cases, suicide (Herek).

Being classified as an illness, homosexuality’s status also created difficulties in the civilian sector (Herek, 2010). Lesbian, gay, and bisexual civilians risked arrest when gathering in discrete gay bars and other social settings, in addition to private gatherings in their homes. States quickly enacted laws categorizing homosexuals in the same category as rapists and child molesters, permitting indefinite psychiatric institutionalization (Herek).

Catalysts for change. The field of psychology, undoubtedly, played an integral role in the legitimization and perpetuation of heterosexism (Herek, 2010). Though many supported the doctrines on homosexuality, there were some who sought to challenge the orthodoxy in the 1940s and 1950s (Chiang, 2008; Herek, 2010). Igniting an intensive debate among mental health professional were the publications of Alfred Kinsey’s Sexual Behavior in the Human Male and Sexual Behavior in the Human Female (collectively

referred to as the "Kinsey Reports"; Chiang, 2008). The Kinsey Reports challenged the field's understanding of homosexuality as a psychopathology, providing statistical figures that captured the prevalence of same sex behavior in American society and questioned the field's understanding of "normalcy" (Chiang). Akin to the subsequent backlash within the scientific community when it was proposed that the Earth was not square but rather round, the mental health field was reluctant to accept Kinsey's findings and worked tirelessly to disprove his theories; interestingly, this ultimately fueled further discourse and research on the topic, perhaps contributing to the eventual abandonment of the pathology model applied to LGB persons.

Abandoning the pathology model. In addition to the Kinsey Reports, which analyzed interviews and found a one-third homosexual prevalence rate in male respondents, other studies were being conducted dispelling heterosexism (Herek, 2010). Others conducted research on cross-cultural and cross-specifies behaviors, concluding that same sex sexual behavior occurs in many animal species and this behavior was considered acceptable and socially acceptable in a majority of the societies studied (Ford & Beach, 1951; Herek, 2010).

Standard operating procedures of the time, that once touted the ability to "cure the homosexual affliction," were also called into question (Drescher, 2009). Using a controlled analytic study, Bieber and colleagues (1962) treated 106 homosexual men, claiming a 27% "cure" rate among patients through psychoanalysis; a decade later when challenged to reproduce these results, these researchers were unable to replicate their previous findings (Drescher). Similar to the unreliable results of psychotherapy,

behavioral therapists in the 1970s who had claimed to have cured homosexuality, admitted that few of their patients were able to remain "cured" for very long, showcasing a proclivity to relapse without on-going intervention.

In moving towards redefining the classification of homosexuality as a psychopathology, a study was conducted that further demonstrated there was no psychological condition underlying sexual orientation alone, which would warrant its inclusion as a psychopathology (Crown, 1980). In this study, psychological tests of a projective type were administered to 30 homosexuals and 30 matched heterosexuals, verified by an outside expert assessor as being "blind" test results. A systematic clinical comparison was conducted using 50 homosexuals with 50 neurotics seen in a psychiatric practice (Crown). In reviewing the two groups, it was noted that the groups were indistinguishable with respect to neurotic traits in childhood and family history of neurosis; sexual orientation was the only distinguishing factor.

Despite contrary empirical research and proof that methodologies once employed to "cure" homosexuality were, indeed, not valid approaches, there were factors which still existed that precluded an immediate reversal in course (Herek, 2010). Herek suggested that the field had committed themselves to a viewpoint that during the course of its support had inflicted detrimental harm on countless LGB individuals (p. 696). Finally, in 1973, after facing tumultuous backlash from LGB activists, mounting empirical research contradicting long-held beliefs, and studies disproving the efficacy of LGB treatment, the American Psychiatric Association's Board of Directors voted to remove homosexuality from the *DSM* (Bayer, 1987; Herek, 2010). Notably, this change

came four years after the publication of the 1968 edition of the *DSM* (American Psychiatric Association, 1968).

Psycho-Medical and Psycho-Social Implications

While homosexuality has been re-defined from being described as a psychopathology itself, there remains multiple jeopardies, uniquely impacting this population, which can contribute the diagnosis of a corresponding psychopathology. It has been suggested that these psycho-medical and psycho-social implications are the result of disparities which exist as a result of institutionalized prejudice, social stress, social exclusion (to include familial exclusion), anti-homosexual hatred and violence, and in some cases, a sense of shame about their sexuality (King et al., 2008). In addition to the external contributing factors, lifestyle factors such as substance abuse can increase the risk of morbidity, suicidal ideation, and/or non-suicidal self-injury, or in more severe cases contingent upon the extent of self-inflicted damage, borderline personality disorder (American Psychiatric Association, 2013; King et al., 2008).

To illustrate these multiple jeopardies, a systematic comparison of 89 gay men and 35 unmarried men was conducted, ensuring only nominal differences in the direction of increase in difficulties among the homosexual group (Crown, 1980). The conclusion of the study revealed the following in the homosexual group: (a) a slightly greater prevalence of manifest psychopathology and difficulty in coping with it, (b) a greater proportion had experience in psychotherapy, (c) had more trouble with excessive substance use, (d) a higher proportion of attempted suicide, and (e) an increased college drop-out rate (Crown).

Minority stress. Social stress theory postulates that socio-environmental demands have the propensity to tax or exceed an individual's psychological capacity to adapt and cope (Wight, LeBlanc, Dries, & Dretels, 2012). In addition to the normal socio-environmental stressors, there have been significant findings that indicate the theory of minority stress, impacts LGB persons, exposing individuals to unique stressors which can create added strain on the individual's psychological well-being (Wight et al.). The unique stressors faced by LGB persons, at the individual level, are psycho-social in nature, to include: the social stigma associated with homosexuality, the localized discrimination and/or prejudice against the individual, the internalized homophobia experienced by the individual, and the concealment of homosexual tendencies (Wight et al.). Societal stressors such as: exclusion from legal marriage, limited legal rights for same-sex partners, lack of access to informal care within traditional family networks, insensitivity to sexual minority health issues, and incongruent policies and practices in healthcare and long-term care settings, contribute to stressors on the individual (Wight et al.).

The unique stressors which affect LGB populations are greatly impacted by life-course experiences (Wight et al., 2012). Societal attitudes and events, such as exclusion for most of the 20th century and the gay rights movement of the 1960s, impacted midlife and older LGB persons whereas LGB youth today, live in a society where homosexuality is, for the most part, socially and politically recognized (Wight et al.). Another significant event which has impacted the broad cohort of midlife sexual minorities is the historical experiences of living with and not understanding HIV/AIDS. Wight and colleagues

suggested that the impact of HIV/AIDS in those midlife sexual minorities alive today, and representative in research into sexual minority stress, is simply profound; these individuals have outlived many of their peers as a result of the lack of knowledge of HIV/AIDS and have experienced diminishing social support networks (p. 503).

Where HIV/AIDS has disproportionately impacted one generation of the LGB community, another stressor continues to transcend ages. Perhaps one of the most complex issues, from a psychological perspective, contributing to stress of gay men and women is hiding one's sexual orientation, attributed to both a real and at times superficial fear of rejection, an issue that resembles both an internal and external conflict (Drescher, 2004). Clinical experiences with LGB persons have yielded insight into the developmental histories of gay men and women, suggesting that the homosexual identity often begins as an internal conflict and difficulty in acknowledging their own sexuality to a conflict from external factors, mainly the social perception (Drescher). Drescher suggested that anti-LGB attitudes, heterosexism, moral condemnations of LGB lifestyles and behaviors, and anti-LGB violence contribute to the "closet" (p. 1). The duality in conflicts often results in a psychological dissociation from the sexual identity, in LGB persons (Fink, 2009).

While everyone, regardless of sexual orientation, is capable of dissociation, the consequences with acknowledging homosexuality can be severe; coming out of the closet can result in estrangement from family, loss of employment, loss of home, loss of child custody, loss of opportunities, loss of status and blackmail (Fink, 2009). For many, the

cost and potential losses associated with disclosure are too much, and dissociation becomes the most viable option for survival (Fink).

Dissociation often necessitates that closeted LGB persons learn to reflexively speak and negate disclosing the gender of the person being discussed or provide gender-neutral details when discussing their personal lives, affecting social interaction (Fink, 2009). Some marry and live their lives as if they were heterosexual, and others may act on their homosexual tendencies and develop secret sexual lives – a double life – which may never be acknowledged. The psychological implications of these scenarios can become extremely stressful; continuously hiding significant aspects of the self or to work tirelessly to separate aspects of the self from others. Furthermore, the psychological effort required to maintain a double life can result in errors in judgment that increase stress and/or lead to compromising situations when engaging in secret activities (Fink).

For some, the psychological split can become unmanageable, resulting in the individual "coming out" of the closet (Fink, 2009). Similar to the reasons for remaining in the closet, coming out of the closet can be fraught with many of the same dangers associated with remaining closeted (Fink). Regardless of the consequences of disclosure, it is worth noting that self-disclosure can be affirming, relieving, and result in reduced amounts of stress (Dovidio, Hewstone, Glick, & Esses, 2010).

Improvements in societal inclusion. The mental health field made a significant contribution to the understanding of what contemporary society regards as "compassionate relationships" by linking and defining sexual attractions and the subsequent behaviors (Herek, 2010). However, in defining these relationships and

emphasizing their healthy expression, the field perhaps committed an incalculable injustice by supporting the belief that the optimal outcome in sexual development necessitated heterosexual expression. In supporting this belief and fervently advocating its adoption, discriminatory policies were adopted in the United States, ranging from the disqualification of military service for LGB persons to the systematic arrest and detention of many LGB persons. Many of these policies (e.g., “Don’t Ask, Don’t Tell”) remained in place and continued to stigmatize homosexuality well past the ratification to re-classify homosexuality as not being psychopathological in 1973 (Herek).

While the field has made significant strides in addressing the socio-political issues that arose as a result of classifying homosexuality as a psychopathology, there appears to be a paucity of research and development of methodologies for addressing the unique psychopathological multiple jeopardies of this minority group (Herek, 2010; Johnson, 2012; Meyer, Dietrich, & Schwartz, 2008; Mitchell, 2012). These issues can include a lack of consensus in therapeutic approaches (Johnson, 2012), ineffective rapport between LGB client and clinician (Mair & Izzard, 2001), and continued shortfalls in graduate level counseling training in dealing with LGB issues (Gauler, St. Juste, & Mirgon, 2012; Johnson, 2012). One trend which seems to transcend the issues encountered by LGB persons and warrants further consideration is the impact of the components of the minority stress model, which indicates a distinct correlation between stigma-related stressors on the minority group (Gold & Feinstein, 2012).

Contemporary understanding and approaches. Psychotherapy with LGB persons has evolved considerably over the past few decades. Professional organizations,

such as the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers have adopted new stances for both the classification and treatment of homosexuality (Johnson, 2012). Where reparative and conversion-type therapies were widely practiced in the 1980s and 1990s, aimed at treating a perceived “mental disturbance,” contemporary approaches have shifted towards acceptance model therapies, addressing life-span psychological and mental health concerns (Johnson). More recently, the American Psychological Association has adopted 16 guidelines in psychotherapy geared towards LGB clients and empirical research is beginning to shift to minority stress models in LGB therapy (Johnson, 2012; Rostosky, Riggle, Gray, & Hatton, 2007).

Despite the modern move towards life-span research and the affirmation that treatments aimed at treating homosexuality is counter-therapeutic, there still exist some in the mental health community who believe conversion therapies are viable options for treatment (Johnson, 2012). Johnson suggested that this gap between historical perspectives aimed at curing homosexuality and the efficacy of treatment initiatives is a result of the paucity in empirical research, exploring LGB issues, and graduate training programs, which prepare mental health professionals who will encounter LGB issues (p. 516). To illustrate this, a survey was conducted which found that: 42% of mental health professionals routinely dealt with LGB clients and their unique issues, and lesbian and gay men are the least acknowledged segment of society but are the most active consumers of psychotherapy (Johnson).

Gay affirmative practices. With limitations in the research contributing to the understanding of effective treatment approaches when working with LGB clients, the current literature suggests that many mental health professionals are increasingly adopting gay affirmative therapy with LGB clients (Bieschke, Perez, & DeBord, 2007). In contrast to what has traditionally defined "affirmative therapy," gay affirmative therapy has been described as being a more ethical approach to traditional affirmative therapy; an understanding between mental health professional and LGB client which is distinguished by the move from the pathological view of same sex relationships, instead emphasizing positive affirmation of the individual (Harrison, 2000; Johnson, 2012; Langdridge, 2007). Despite the common application amongst a faction of mental health professionals, it is worth noting that there has been little literature or research identifying theoretical or technical components of affirmative therapy as it applies to LGB persons.

Efficacy. In a qualitative study, Johnson (2012) sought to explore the subjective experiences of nine gay men who had experienced gay affirmative therapy, providing results that indicated participants found gay affirmative therapy to be positive and helpful. Furthermore, Lebolt (1999) discovered that the experiences with heterosexual psychotherapists were supporting and provided a corrective experience to counteract homophobic socialization (as cited in Johnson, p. 518).

In a separate qualitative study involving 14 gay men, Mair & Izzard (2001) found that several of the men in their sample did not believe their therapist knew how to integrate facets of their sexual orientation or identity into future therapy, despite acknowledging that they believed their therapist accepted their sexual orientations (p.

476). Johnson (2012) noted that the men in this study were not seeking therapy for any gay-specific issues, indicating a potential bias when comparing studies (p. 518).

In gauging the efficacy of psychotherapeutic practices, historically, randomized controlled trials are regarded as being the gold standard. Unlike therapies for general populations using randomized controlled trials for testing psychotherapy efficacy, one unique consideration that perhaps exemplifies the difficulties in translating the existing research, is the inability to find accurate representatives of the LGB community (Johnson, 2012). Until this can be accomplished, Johnson acknowledged that the use of gay affirmative therapy as a validated form of therapy will likely not be possible, and rather, it should remain an “approach” to demonstrate understanding, promote a therapeutic alliance and demonstrate cultural competence when working with LGB clients (p. 519).

Prevalence of Disability Amongst LGB Persons

Compared to the general population, research has consistently showcased a higher prevalence of disability amongst LGB persons (Cochran & Mays, 2007; Dispenza, Harper, & Harrigan, 2016; Dispenza, Varney, & Golubovic, 2017; Hanjorgiris, Rath, & O’Neill, 2004). In considering both psychiatric and physical disabilities, Lipton (2004) suggested that approximately 366,950 to 9,353,700 LGB persons are living with chronic health issues in the United States. Fredriksen-Goldsen, Kim, and Barkan (2012) found that LGB persons living with a disability were significantly younger in age, when compared to their heterosexual counterparts, with Dispenza, Varney, and Golubovic (2017) concluding that this population experiences higher disability rates across the lifespan.

In a study assessing health disparities among LGB older adults, Fredriksen-Goldsen and colleagues (2013) found that lesbians and bisexual women had greater adjusted odds of obesity, a significantly greater risk of asthma, and gay and bisexual men were at greater risk of asthma and diabetes. Fredriksen-Goldsen, Kim and Barkan (2017) pointed to state-level population-based data which showed that lesbians aged 50 years or older had higher rates of cardiovascular disease and obesity compared to heterosexual women.

While the research available has identified disparities in disability prevalence amongst LGB persons, there has been little research conducted exploring the definitive causes for these disparities. In addition to research previously discussed, exploring the risk factors associated with mental health issues amongst LGB persons, Fredriksen-Goldsen, Kim, and Barkan (2012) suggested that health-related behaviors such as smoking, lack of physical activity, obesity, other health conditions, and mental health issues may serve as moderators to acquired disabilities. Drawing upon these assumptions, Fredriksen-Goldsen and colleagues posited that higher rates of drinking and smoking, acquired arthritis and asthma, and mental health issues could explain the higher rates of disability amongst LGB persons. Giving credence to this assertion, in studies conducted by Frost, Lehavot, and Meyer (2015) and Lick, Durso, and Johnson (2013), the researchers found a positive correlation between exposure to minority stress and adverse health conditions, suggestive that the mere convergence of multiple minority statuses may contribute to at least acquired disabilities within the LGB population.

Counselor Competency and Self-Efficacy

Despite the inclusion of diversity topics in counselor education programs, the intersection of sexuality (broadly speaking) and disability topics are often insufficient in preparing counselors to work with LGB persons with disabilities (Easton, 2015; Meyer & Gauler, 2015; Mona, Cameron, & Cordes, 2017; Valvano et al., 2014), with some research suggesting that counselors in the field often report higher levels of discomfort in even more broadly discussing sexuality topics with their clients (Jaramillo, 2016), and even fewer expressing confidence in addressing topics of disability (see Olkin & Pledger, 2003 and Smart & Smart, 2006), let alone addressing the convergence of both minority statues – intersectionality. In order to better explore this topic and understand the factors contributing to this phenomena, it is important to discuss how counselor training programs are required to train their students, through adherence to accreditation and professional standards, and what programs have done to promote greater competence in working with individuals identifying as LGB with a disability.

Training and Professional Standards

Students often cite insufficient training as a primary concern when discussing their competency and self-efficacy in working with LGB persons (Bidell, 2013; Carroll & Gilroy, 2002; Meyer & Gauler, 2015) and persons with disabilities (Rivas & Hill, 2017; Smart & Smart, 2006). Traditionally, students enrolled in counseling or psychology programs must meet developmental benchmarks in their respective programs to successfully complete programs. In the context of sexuality, West and colleagues (2012) stated that these benchmarks often include coursework covering both the physiological

and biological components of human sexuality; however, it is worth noting that topics on disability are often omitted or abbreviated (Rivas & Hill).

In applied fields, such as clinical mental health counseling or psychology, synthesizing knowledge acquired through coursework is often showcased through experiential program requirements, such as fieldwork conducted during a practicum or internship experience, whereby students may encounter or be exposed to topics of sexuality. Despite the prevalence of disability in the general population, which the U.S. Census Bureau (2018) estimated as being 27.2% of the total U.S. population based upon the Social Security Administration (SSA) Supplement to the 2014 Survey of Income and Program Participation, disability-centric coursework is often not addressed, or skewed towards deficit-oriented or pathology-grounded understandings of disability (Pledger, 2003; Rivas & Hill, 2017; Smart & Smart, 2006), perhaps adversely influencing how students approach working with persons with disabilities.

In counseling programs, and perhaps to a lesser extent at the undergraduate level in psychology programs, training standards are enshrined by program accreditations and professional standards. For rehabilitation counseling programs, curriculum content was historically governed by CORE, which placed a great emphasis on disability-centric content. Today, programs may be accredited by CACREP with many programs aligning with the professional standards outlined by the American Counseling Association (ACA), both of which seek to promote a greater understanding of social and cultural diversity and aim to promote student competencies in working with minority populations (CACREP, 2016; ACA, 2014).

In their attempt to both meet accreditation and professional standards, graduate training programs in counseling often merge multicultural and LGB topics, despite being independent constructs, into a single course (Bidell, 2013; Israel & Selvidge, 2003; Meyer & Gauler, 2015). While this is perhaps not the ideal approach to preparing graduate students, Israel and Selvidge (2003) summarized the rationale of this approach by suggesting that although LGB persons are different from ethnic minorities (the population for which multicultural counseling was originally intended), they share many of the same stressors that counselors might encounter in the field, namely stereotyping, stigmatization, and institutional discrimination (i.e., minority stress). Unfortunately, no such standard exists in CACREP's (2016) accreditation standards, with respect to programs needing to address topics of disability; rather, CACREP has created specialized tracks under the broader counseling profession, some of which (i.e., clinical rehabilitation counseling and rehabilitation counseling) which must include course content on disability. Therefore, it is plausible that students completing a CACREP-accredited, traditional clinical mental health counseling program, may never be exposed – either through their academic or experiential coursework – to disability topics, particularly intellectual and physical.

Whereas the majority of accredited general mental health counseling programs provide for standards that students must meet towards achieving eventual licensure, and while no program likely has the ability to completely prepare students for every possible scenario they might encounter in clinical practice, it is alarming that students graduating from rehabilitation counseling programs often are even less-prepared to address issues of

diversity compared to students emerging from other professional training programs in mental and allied health (Yalamanchili, 2009). The disparity in preparation can be evidence in the fact that many rehabilitation counseling programs, while supplementing disability coursework for other core counseling content, often omit coursework that might be necessary when working with sexual minority clients, such as coursework in human sexuality or more in-depth explorations into sexual minority topics, such as the long history of pathologizing homosexuality.

Limitations in Preparing Students to Work with Sexual Minority Clients

In a study by Pebdani and Johnson (2015), the researchers sought to gain an understanding on the state of training, as it related to sexuality, within rehabilitation counseling programs. Employing a survey which was sent to program directors of rehabilitation counseling programs, Pebdani and Johnson solicited participation from a population of 312 graduate students enrolled in CORE-accredited programs. Utilizing descriptive data, Pebdani and Johnson found that of the sample, 40% reported having little to no graduate-level training on the topic of sexuality. Furthermore, the data yielded the finding that of this sampling, less than half of respondents had completed coursework on general human sexuality while in graduate school, and nearly one-third had completed training during their undergraduate education (Pebdani & Johnson).

Emphasizing the role that knowledge and exposure has on attitude formation, Eliason and Hughes (2004) applied an adapted version of the Attitudes Toward Lesbians and Gays instrument (Herek, 1994) to gain an understanding of attitudes amongst substance abuse treatment providers towards lesbian, gay, bisexual, and transgender

(LGBT) in urban and rural settings. Using the responses of 109 participants, and applying descriptive analyses of the categorical data collected, Eliason and Hughes found that there was perhaps a disparity in formal education provided, based upon residency in either an urban or rural setting. Eliason and Hughes' data suggested that respondents in urban practices, reported significantly higher levels of hours in formal education (11.5 hours) compared to respondents in rural practices (2.4 hours). Amongst other predictors (e.g., familiarity with LGBT persons, previous experience working with LGBT persons), this study found that education alone is insufficient in changing attitudes in counselors, therefore a multifaceted approach in training programs is warranted.

Korfhage (2005) argued that to effectively provide counseling services, counselors must recognize their competence and effectiveness in providing psychological interventions to specific populations. To achieve truly affirmative counseling practices, it is crucial that counselors are provided the appropriate training, specific to the contextual challenges that minority populations bring to the counseling relationship. Korfhage (2005) asserted that graduate training programs are responsible for laying the foundation for preparing students to work with diverse populations.

Drawing upon the same research study, Korfhage (2005) reasserted what Buhrke and Douce (1991) found, which is the need of counselor training programs to continually assess students for homonegativity. Furthermore, exposure to sexual minorities appeared to be a noted area for improvement within graduate training program. Korfhage (2005) posited could be improved upon through the active recruitment of LGB students into programs, and the inclusion of more information and training on LGB-centric issues than

currently being offered. Korfhage (2005) argued that failing to immediately address the disparities in counselor preparation for LGB-affirmative counseling could have profound impacts in the research, assessment and counseling services rendered by ill-prepared counselors.

Jennings (2014) conducted a study to assess the content of counselor training programs, as they relate to preparing counselors to work with sexual minority populations. The sample population for the study consisted of 60 counseling, of which 60% were accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP). The sample population was chosen based upon the following criteria: (a) each state had to have at least one public university with a counseling program, and (b) the sample needed to reflect geographic diversity within the United States. Additionally, the final sample population was limited to public university counseling programs to mitigate confounding influence resulting from religious affiliation or sectarian doctrine. The findings of the research detailed the percentage of time devoted to sexual orientation topics, the specific topics addressed, and the placement of topics throughout the curricula (Jennings, 2014).

For the purpose of this study, lesbian, gay, bisexual, and transgender topics were transgender topics were labeled as “gender-based” topics (Jennings, 2014). The survey instrument composed of an internet-based survey, allowing for participants to describe their respective programs. Participants were selected based upon their roles within the university; program coordinators or department chairs were determined to be leaders, actively engaged in the development of counseling curricula at their respective university.

Using statistical means to assess the behavioral priorities, the survey indicated the percentage of time spent addressing the diversity topics in descending order: race/ethnicity (34%), socio-economic status (15.6%), sexual orientation (14.6%), sex/gender (14%), special needs (13.4%), and language (9.2%).

Noteworthy from Jennings' (2014) study were the results addressing professionalism and counseling methods; while the majority of programs (86.7%) addressed student counselor attitudes and beliefs towards sexual minority populations, a mere 43.3% addressed the application of theoretical approaches to counseling as they apply to sexual minority populations. Thirty-one percent addressed assessment measures and methods and 30% cover the history of the counseling profession as they apply to sexual minority populations. Interestingly, the survey yielded findings that 20% of the programs covered the "validity of counseling methods aimed at changing a person's sexual orientation from homosexual to heterosexual."

With respect to curriculum placement and field experiences, 75% of the surveyed programs included sexual orientation content in their foundations courses, while 63% included this topic in their practicum component(s) (Jennings, 2014). One-fourth of the programs actively screened practicum sites for bias against sexual minorities and one-sixth screened to ensure sites actively affirm sexual minorities.

In critically examining the field, Jennings (2014) suggested that given the historical position of the counseling/psychology profession in defining homosexuality as a psychopathology or deviant behavior, more programs (30% were found to examine this topic) should be actively engaging their students in the history of counseling and

homosexuality. Jennings asserts that failure to address this relevant topic could result history repeating itself. In order to avoid the adoption of heterosexist assumptions/biases, counseling students should be afforded the opportunity to explore the implications of various approaches to sexuality, relationships, and social conformity. Furthermore, Jennings asserted that with less than one-half of programs examining counseling theory and assessment, as they apply to sexual minorities, programs have an opportunity to expand on these topics and better fulfill the intent of CACREP curriculum standards.

Limitations in Preparing Students to Work with Persons with Disabilities

Recognizing the rising prevalence in disability amongst the general population and the limitations in preparing counselors to work with persons with disabilities, Rivas and Hill (2017) suggested that in reviewing the available literature on topics of disability and counseling, there appears to be a consensus amongst researchers that the counseling profession must expand their views, and therefore their teaching, of disability topics. Summarizing this research, Rivas and Hill pointed to Pledger's (2003) assertion that programs must embrace and impart students with a greater understanding of the historical foundations and terminology, as it relates to disability, and Reeve's (2000) assertion that students should be exposed to the social aspects of disability. Additionally, Rivas and Hill emphasized the importance of preparing students to avoid inadvertently infusing their nondisabled, biased perspectives when working with persons with disabilities.

In a phenomenological study aimed at evaluating the lived experiences of counseling interns, Rivas and Hill (2017) recruited 10 participants to gain a better understanding of how they perceived multicultural counseling training prepared them to

work with persons with disabilities. Rivas and Hill found that the participants endorsed having received little to no training – academic or otherwise – to prepare them to work with persons with disabilities and that they acknowledged having received inconsistent exposure to disability while enrolled in their programs; both of these findings being seminal to the present study. Additionally, Rivas and Hill's study perhaps corroborated earlier findings, finding that participants did indeed apply their own conceptualization of disability in the formation of approaches applied when working with persons with disabilities and that they believed their practice was greatly informed by the practical realities found in the field.

In the context of the current study and focus, Rivas and Hill (2017) identified the opportunity for learning about disability as perhaps being a moderating factor in the confidence participants in their study had when working with persons with disabilities. Participants in this study described topics of disability as being mostly absent or addressed briefly during classes on lifespan development or social and cultural diversity. Rivas and Hill emphasized that a common theme amongst the participants was the lack of coverage on disability-related topics in multicultural counseling coursework, adding that there appeared to be a disproportionate emphasis on certain cultures, leaving little opportunity to explore or even cover topics on other cultures. Interestingly – and diverging greatly from similar studies – Rivas and Hill found that when disability topics were covered, they were often covered in an isolated matter, detaching disability from other cultural identities. The ladder finding is of particular interest, in that the findings are suggestive that isolating disability status may in fact jeopardize a students' ability to

conceptualize and apply culturally appropriate interventions when a client identifies as having more than one minority status (i.e., intersectionality).

Rivas and Hill (2017) described inconsistency in exposure to disability amongst participants in their study, reporting that participants felt topics related to disability, whether they were in the classroom, during clinical supervision, or in dialogue with clients, were often initiated by others, perhaps by others with an interest or agenda in discussing the topic. Further, a common theme discovered was that participants disclosed that they believed that their exposure to disability topics outside of their graduate programs were likely the only knowledge or experiences that could have prepared them for situations encountered during their internships involving disability.

Limitations in Preparing Students to Address Sexuality and Disability

Where the research has consistently shown significant limitations in the breadth and depth of training for addressing sexuality and disability as independent variables in the delivery of clinical services, the research exploring the convergence of sexuality *and* disability appears to yield similar results. Valvano and colleagues (2014) undertook a study to assess how educational factors influences health professions students' attitudes towards the sexual health needs of individuals with physical disabilities. In their study, which drew upon responses from 479 participants in service-delivery healthcare fields (e.g., medicine, nursing, occupational therapy, psychology, etc.), students were asked to complete an educational and demographic questionnaire along with a 10-item instrument, the Beliefs About Sexual Health Concerns of Patients with Physical Disabilities

(BSHPPD), which measures the respondent’s knowledge, beliefs, attitudes, and practices related to patients with physical disabilities.

Valvano and colleagues (2014) performed a series of chi-square tests for independence to first examine whether students enrolled in certain health professions were more likely to be exposed to patients presenting with both sexual health topics and physical disabilities, and a one-way ANOVA to determine if there was significance in the difference in quality of sexual health education offered. This first analysis found that those students enrolled in nursing programs were found to have a higher rate of direct exposure when compared to other professions (Cramér's V = 0.15) and that students enrolled in allied health programs received the most coursework devoted to sexual health topics (Cramér's V = 0.12; Valvano et al.). Interestingly, based upon this initial analysis, Valvano and colleagues found that students enrolled in psychology programs received the least number of classroom hours devoted to topics of sexuality; psychology students were also found to receive the fewest opportunities direct exposure to patients presenting with sexual health concerns. In examining the potential differences in quality of sexual health education received, a one-way ANOVA found a significant difference amongst participants’ quality of sexual health education with a small effect size (eta squared = 0.06); a Turkey post hoc comparison yielded results that students enrolled in psychology programs rated their quality of training significantly lower ($M = 2.06$, $SD = 1.01$) when compared to other students (Valvano et al.).

In analyzing the results the BSHPPD, and the collective analyses, Valvano and colleagues (2014) found a lack of substantive sexual health education across all degree

programs sampled in their study, both in terms of previous training received and current training, and significant limitations in exposure to these topics, with students enrolled in psychology programs (69%) reporting having received zero hours of academic work related to sexual health topics and 94% reporting zero hours of direct patient contact exposing them to these topics. Further, students enrolled in psychology programs were found to endorse having received less quantity and quality in sexual health training, suggestive that students may be entering the field less experienced and equipped to confidently and competently address the intersection of sexuality and disability (Valvano et al., 2014).

Much like the deficiencies discovered in addressing sexuality – broadly – and disability, there has been a steady, albeit slow, outpouring of research suggestive that counseling and psychology students are often as ill-prepared to provide services when presented with sexual diversity and disability, or the convergence of multiple minority statuses (i.e., multiple jeopardies). Dispenza, Varney, and Golubovic (2016) conducted a qualitative study to examine the types of chronic illnesses and disabilities (CID) mental health practitioners were encounter amongst sexual and gender minority persons, the counseling and psychological approaches used with this population, and what the participants believed were the most effective strategies when working with this population. Sixty-three participants were recruited to participate in their study, with participants representative of all regions of the United States, having accumulated an average of 10.63 years in practice (*SD* = 9.63), possessing a minimum of a master's degree in their respective field, with representation from the fields of applied psychology

($n = 30$), counseling or counselor education ($n = 20$), social work ($n = 10$), and psychiatric nursing ($n = 3$), in a variety of clinical practices.

In their study, Dispenza and colleagues (2016) identified four overarching themes amongst participants, including competence in intersectionality, affirmative consciousness, social justice practice, and ethical values. While most participants endorsed practices and values that align with existing multicultural counseling practices (see Sue & Sue, 2013), integrate multiple knowledge sources into their clinical conceptualization when working with intersectionality, apply affirmative intersectionality practices, and utilize social justice (Dispenza et al., 2016), this study, nevertheless, identified several limitations both in exposure to diversity in disability, perhaps showcasing the challenges that students may face when attempting to gain practical experience working with sexual minority clients with varying disabilities, and limitations in education and synthesis of some affirmative practices.

Whereas the majority of participants indicated exposure to sexual minority clients with HIV/AIDS ($n = 36$) and psychiatric disabilities ($n = 43$) or substance abuse ($n = 42$), few participants endorsed exposure to having worked with clients having physical disabilities, such as deafness ($n = 9$) or limitations in vision ($n = 3$), or intellectual disabilities ($n = 14$) (Dispenza et al., 2016). Additionally, a large portion of the population sampled endorsed lesser competence in identifying risk factors ($n = 5$), awareness of internalized forms of oppression ($n = 5$), self-awareness of their own bias ($n = 6$), and perhaps illustrative of one of the challenges identified and being explored in the

present study, a dearth of medical knowledge preparing them to work with CID (n = 9) (Dispenza et al., 2016).

As addressed earlier, there remains very few empirical contributions specifically exploring the topic of the present study in the context of rehabilitation counselors, warranting an expansion of the literature review to encompass fields similar to rehabilitation counseling. It is, however, worth exploring rehabilitation counseling curricula development, as it directly relates to the overall preparedness of students when entering the field and encountering the convergence and diverse presentation of sexuality and disability.

McCray (2018) completed a doctoral dissertation aimed at exploring and presenting factors that impact rehabilitation counselor educators' infusion of sexuality and disability into program curricula; specifically, by exploring the extent to which these topics are addressed, assessing educators' attitudes, comfort level, and knowledge of these topics, and by exploring the determining factors that influenced the factors being included in program curricula. For this study, a convergent parallel mixed methods design was applied in the study, non-random sampling of participants (n = 27) who have taught or are now teaching in rehabilitation counseling programs through survey methodology, for the quantitative component of the study, and open-ended responses, for the qualitative component of the study (McCray). For the quantitative and qualitative components, McCray analyzed the data collected, including responses to the KCAASS, using MANCOVA and Thematic Analysis, respectively, merging the results of each to draw conclusions based upon the findings.

The findings of McCray's (2018) study yielded invaluable information on factors related to preparing rehabilitation counseling students to effectively work in the field, and more specifically, preparing them to address intersectionality. McCray reported that while rehabilitation program educators are indeed incorporating topics of sexuality and disability into course content, there appears to be a lack of uniformity in presenting these topics and lack of universal integration of these topics into related or relevant coursework, with less than 10% of participants indicating they discuss the topics across courses and within clinical supervision and less than 10% acknowledging to have incorporated case studies addressing these topics. Interestingly, McCray also found that similar issues were found within counselor education programs, where counselor education programs are those programs responsible for training and equipping counselors to educate other counselors.

Seeking to explain this fundamental disconnect between including topics of sexuality and disability and the limited inclusion or expansion of these topics across program coursework, McCray (2018) found the themes of systemic barriers and a lack of clear guidance on how best to address these topics was one potential explanation, based upon participants' responses. Chief amongst these systemic barriers, McCray argued that the academic culture of an institution might explain and influence the inclusion and expansion of these topics across courses. McCray additionally addressed a theme discovered involving a lack of clear guidance, which was described as being a lack of permeation or reinforcement of the topics of sexuality and disability throughout all relevant or related coursework in rehabilitation counseling programs. McCray further

expanded on this theme, suggesting that factors such as the maturity and matriculation level of students and faculty perception of students' attitudes and beliefs may contribute to the level of apprehension in addressing topics.

Noteworthy from McCray's (2018) study, comparing both the quantitative and qualitative data gathered, it was suggested that it is in fact that rehabilitation counselor educators' own limitations in both knowledge and competency about sexuality and disability that moderates their comfort level and willingness to address these topics within the classroom. McCray purports that participants in this study believe their prior training inadequately prepared them to address these topics. This finding is of particular concern in that it is suggestive that there appears to be a cyclical relationship between ill-prepared educators perpetuating poor preparation on entry-level clinicians about to enter the field. Whereas this cycle could be mitigated through accreditation standards, the limitations of which have been previously addressed, or local policies and procedures for programs to encourage and promote these topics, McCray emphasized that the ladder – based upon the data collected – appears to be absent within the participants' respective programs.

Multicultural Counseling Courses and Intersectionality

The empirical literature has consistently showcased that counseling and psychology students are often ill-prepared to address topics of sexuality and disability, both as independent and converging aspects of the human experience for many, and with significant disparities existing between whether programs require counseling and psychology students to complete coursework on human sexuality and disability topics,

coursework in multicultural or cross-cultural coursework appears to be a consistent component of most programs, accredited or not. These courses, while certainly not all-encompassing and possessing significant limitations in terms of their effectiveness in preparing students for field work and professional practice, nevertheless warrant some exploration.

In addressing the disparities which exists in the counseling and applied psychology professions for working with LGB persons, the primary response has been to develop and require multicultural counseling curricula for graduate students (Bidell, 2013). Though these courses offer benefits, Bidell (2013) suggested they have significant and inherent limitations; one-semester is not nearly enough time to adequately cover multicultural counseling theory, research, practice, and multiple minority groups, while concurrently promoting multicultural competence and awareness. In assessing previous research conducted analyzing multicultural course syllabi, variability in content, minority groups addressed, and pedagogical style, Bidell (2013) summarized that nearly a dozen nontraditional or non-ethnic populations were represented in the curricula. Given this trend, Bidell (2013) suggested that it is plausible that multicultural counseling courses have become diluted.

Multicultural education plays an important role in preparing students to address the mental health disparities experienced by not only ethnic minority individuals, but also LGB persons (Bidell, 2013). Despite this importance, Bidell (2013) asserted that there have been no published studies that provide evidence to support the relationships between multicultural curricula and LGB-affirmative counselor competency.

Attributing much of the disparity in counselor efficacy in working with LGBT clients to the lack of effective training, Bidell (2013) suggested that counselor training programs have an opportunity to better prepare counselors to work with this population. Despite the inclusion of multicultural counseling courses in counseling programs, which have been found to correlate to higher levels of professional multicultural competency, there remain several limitations. Bidell (2013) argued that in the multicultural coursework offered in counseling programs, syllabi reflect a high-level of variability in the topics covered, the minority groups addressed, and the pedagogical style employed.

The variability in multicultural counseling courses has been found to influence the competencies of specialties within the counseling professions (Bidell, 2013). In assessing various specializations, Bidell (2013) found that school counseling students reported lower levels of LGBT-affirmative counseling competencies when compared against students in community and clinical mental health counseling programs. To address these concerns, many programs have elected to supplement course work through specific LGBT training modalities. Examples of such modalities include advocacy projects, guest speakers, and experiential activities (Bidell, 2013). Despite this move towards incorporating LGBT training modules, Bidell (2013) argued that courses must be developed specifically to address LGBT mental health.

Variability in multicultural counseling curricula, presents a significant hurdle in addressing deficiencies across professions, and despite accreditation standards which seek to standardize content across accredited programs, appears to be pervasive. Similar findings to what had been evaluated in Bidell's (2013) study, has been previously

explored in the field of rehabilitation counseling. Stebnicki and Cubero (2008) performed a content analysis of multicultural counseling syllabi from 27 CORE-accredited rehabilitation counseling programs. Those participating in the study had been asked to complete a 10-item questionnaire, which included open-ended questions to elicit qualitative data for their study (Stebnicki & Cubero). Fifteen of 27 participating programs (56%) were found to offer a distinct multicultural counseling course taught by a rehabilitation counseling faculty member with at least a master's degree (Stebnicki & Cubero). The content analysis evaluating how syllabi aligned with accreditation standards showed that of 12 CORE-accreditation standards for multicultural counseling curricula, only 55% of programs addressed 11 of the standards, 82% addressed only 9 of the standards, and 55% only covered 6 of the standards (Stebnicki & Cubero). Notably, a mere 55% of participants ($n = 6$) addressed topics related to the role of ethnic/racial, spiritual, age, gender, sexual orientation, and socioeconomic status in the practice of rehabilitation counseling (Stebnicki & Cubero). Stebnicki and Cubero stated that the lowest rate of compliance with accreditation standards was in addressing topics related to psychological and social theory in developing strategies for rehabilitation interventions.

Additionally, there appeared to be great variability in terms of the content of courses and text books adopted for multicultural counseling courses; course activities ranged from 82% to 91% and included assigned readings, class participation, class attendance, and in-class presentations (Stebnicki & Cubero, 2008). The least frequent activities included ethnography or personal cultural analysis (36%), cultural immersion activities (55%), and attending cultural events (55%) (Stebnicki & Cubero). With respect

to textbooks adopted by programs, Stebnicki and Cubero found that 17 different books had been adopted, with four programs having adopted Sue and Sue (2003). Interestingly, when responding to the questions as to whether the instructor teaching the course had training preparing them to teach a multicultural counseling course, of the 10 programs opting to respond to this question, two acknowledged having no training; three acknowledged having attended at least one seminar on diversity or multicultural counseling over the last year; three reported having participated in at least two trainings; and, the remainder stated they had attended at least three trainings in the past year (Stebnicki & Cubero).

In a study designed to assess the impact of incorporating a full-credit LGBT graduate course into counseling programs, Bidell (2013) found that student competency and self-efficacy in working with LGBT clients increased as a result of completing a specialized course preparing students to work with this population. In his study, students were administered the Sexual Orientation Counselor Competency Scale (SOCCS), before and after completion of the LGBT graduate course (Bidell, 2013). Compared to the control group, the group who completed the LGBT graduate course self-reported higher levels of competency, therefore yielding showed statistically significant gains in competency (Bidell, 2013).

While multicultural counseling courses are effective in preparing students to work with diverse populations, compared to no training at all, exploring and understanding counseling students' personal beliefs and attitudes also moderates competencies and self-efficacy in working with diverse populations. Bidell (2014) suggested that the topic of

sexual orientations can evoke considerable emotional reactions, based upon personal beliefs and conflict with professional standards. Despite the dramatic change in societal acceptance of LGB persons, conservative religious and sociopolitical ideologies continue to be pervasive, adding to the stigmatization of LGBT individuals (Bidell, 2014).

In research aimed at exploring LGB-affirmative counselor competence among religiously conservative counselors, Bidell (2014) found that counselors who identified as religiously conservative, reported lower levels of LGB-affirmative counselor competence than their counterparts. One in three participants in the study demonstrated a significant connection between conservative religious beliefs and sexual orientation counselor competence (Bidell, 2014). Additionally, religious fundamentalism was found to be the strongest negative moderator of LGB-affirmative practice, regardless of having completed multicultural counseling courses (Bidell, 2014).

As previously discussed, there have been few contributions examining multicultural counseling competencies of students enrolled in rehabilitation counseling programs, with those studies that have examined this, finding that similar to other fields, students often showcase limitations in their multicultural competence. Having identified this limitation, over a decade ago, Donnell (2008) sought to explore competency development, in the context of knowledge, skills, and awareness, in a study involving 68 rehabilitation counseling students enrolled in graduate programs across six universities, utilizing the Multicultural Awareness Knowledge Skills Survey (MAKSS; D’Andrea, Daniels, & Heck, 1991).

Whereas a minimum score of 69 indicates a "fair" level of competence, Donnell's (2008) study found that participants achieved the highest scores in the awareness domain ($M = 59.05$, $SD = 5.43$), with the lowest scores in the knowledge domain ($M = 53.10$, $SD = 6.42$); the data yielded similar findings within the skills domain ($M = 54.60$, $SD = 10.41$). Follow-up analyses yielded no statistical difference in scores when considering the participants' gender or length of time within their program; however, when evaluating for the participants' ethnicity, Donnell found significance between both ethnicity and awareness ($p = .001$) and skills ($p = .007$), suggestive of heightened skills and awareness by participants of color. Additionally, a significant effect (Wilks' $\Lambda = .632$, $F(3,48) = 1.56$, $p = .16$) was found for the importance of multicultural counseling training; however, despite 57% of participants having previously completed multicultural counseling coursework, there was no significant effect on perceived competence by participants who had previously completed a course (Wilks' $\Lambda = .856$, $F\,(3,49) = 1.29$, $p = .26$) (Donnell). The results of this study, while certainly alarming in terms of the degree of scores achieved by participants across all domains measured, appears to showcase what many have discovered when exploring this topic within comparable fields.

Implications Associated with the Delivery of Rehabilitation Services

Whereas the role of a rehabilitation counselor may vary greatly, depending upon the setting they work, one common theme that transcends this profession and distinguishes it from other counseling professions is the emphasis that is placed on assisting persons with disabilities to achieve independence. A cornerstone of rehabilitation counseling, as prescribed by the civil rights laws that have been passed to

assist persons with disabilities (e.g., the Smith-Fess Act of 1920, the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990, the Rehabilitation Act Amendments of 1992, etc.), is the understanding of the importance of gainful employment as a means of achieving greater independence for persons with disabilities. The majority of rehabilitation counselors working in the public sector are employed by state and federal divisions of vocational rehabilitation, offering a variety of services aimed at accomplishing this feat (Herbert, Zhai, & Coduti, 2020). It is within this context that it is important to understand how multicultural counseling competence, challenges previously discussed in relation to LGB persons, and rehabilitation counseling converge to create threats in the delivery of services to LGB persons with disabilities utilizing rehabilitation services.

Threats to rehabilitation counseling. Chung (2003) argued that within the past 50-years, the focus of rehabilitation counseling has evolved considerable from an emphasis on exploring middle-class men, to women's career development, to a new focus on advancing the studies in vocational rehabilitation for LGB persons. In the late 1980s, conceptual and practical application research began to emerge discussing career development for LGB persons, followed by theoretical approaches for achieving this (Chung). Similarly challenging in honing multicultural competence when working with LGB persons, and despite significant strides in a relatively short amount of time towards understanding the unique challenges associated with vocational rehabilitation with LGB persons, Chung suggested that there remains much work needed to assist LGB persons

with disabilities in achieving the same level of gainful employment as heterosexual persons with disabilities.

Much research has been devoted to exploring the role and importance of establishing a therapeutic alliance and how a strong therapeutic or working alliance can positively influence client outcomes (e.g., Anderson, Bautista, & Hope, 2019; Leibovich, Front, McCarthy, & Zilcha-Mano, 2020; Lustig, Strauser, Rice, & Rucker, 2002, etc.). Nearly all research on the topic of therapeutic alliances involves, amongst other things, a collaborative relationship between clinician and client, necessitating open communication (Lustig et al.). Lustig and colleagues described that the 1998 Amendments to the Rehabilitation Act stipulates that individuals receiving services through public rehabilitation systems, must be “active and full partners” in all facets of the rehabilitation process. Particularly challenging for LGB persons with disabilities in seeking services from a public rehabilitation counselor, whom have not only experienced marginalization by society but also perpetuated by the government and social sciences professions, is that according to McAllan and Ditillo (1994) public rehabilitation counselors may be the first professional and governmental figure for which they may reveal their sexual orientation. Therefore, when considering their reluctance to disclose their sexual orientation or the rehabilitation counselor’s response to this disclosure, either by acceptance or non-acceptance, the formation of a strong therapeutic alliance becomes threatened, potentially jeopardizing the client’s outcome.

Threats to sustained gainful employment. In a study undertaken by Botkin and Daily (1987), a cross-sectional study of college students to explore what types of jobs

might be considered *more interesting* for gay men versus heterosexual men, the top three responses for gay men were photographer, interior decorator, and nurse, whereas the top three for heterosexual men were physician, photographer, and engineer (as cited in Heatherington, Hillerbrand, & Etringer, 1989, p. 454). While societal attitudes towards LGB persons have shifted considerably since 1987, pervasive stereotypes, both broadly applied and in the context of work-related impression formation, continue to exist. For example, Steffens, Niedlich, Beschorner, and Köhler (2019) found similar perceptions amongst their participants when studying the suitability of work for heterosexual men versus gay men. Further, studies, such as that conducted by Burn (2020), have found a significant relationship between prejudicial views towards gay men and the disparity that exists between wages paid for heterosexual and gay men working in the same field (i.e., wage penalty). Yet slower in catching up with the evolving attitudes of society are the legal protections afforded to LGB persons in the workplace; it was not until 2020 that the U.S. Supreme Court ruled that employment discrimination based on sexual orientation or gender identity were in violation of the Title VII of the Civil Rights Act of 1964. Notably, at the time of this study and despite this ruling, transgender persons remain prohibited, as President Donald Trump touted on Twitter in 2017, “to serve in any capacity in the U.S. military” (as cited in Manuel, 2020, p. 76).

Smith and Ingraham (2004) stated that stereotypes, discrimination, and stressors may influence the ability for LGB persons to achieve gainful and sustained employment; thus, these factors pose a clear and undeniable threat in achieving what the Americans with Disabilities Act of 1990 seeks to ensure for persons with disabilities, and in the

scope of the topic being examined in this study, LGB persons with disabilities. Aside from the obvious effects of workplace harassment and discriminatory practices – implicit or explicit – LGB persons (broadly) face additional challenges that their heterosexual counterparts in the workforce do not encounter. Such challenges include identity management, whereby LGB persons may manage their mannerisms to conform with heterosexist norms, and modifying pronouns in conversations with colleagues to appear as though they are in an opposite sex relationship or associate more or less with the opposite gender (Bosson, Haymovitz, & Pinel, 2004; Bowen & Blackmon, 2003). It has been suggested that this constant self-guarding behavior can develop into a stereotype threat, or the fear that one will be judged based on their true identity, which has been found to correlate to degraded work performance and social isolation amongst peers or even isolation from individuals within their own community (Block, Koch, Liberman, Merriweather, & Robertson, 2011; Bosson et al.).

Similar to the aforementioned studies examining gay men and employment, Hetherington and Orzek asserted that lesbians often encounter difficulties in achieving gainful employment, finding that lesbian career development is often curtailed due to negative stereotypes and discrimination not only because of their sexual orientation, but also their gender (as cited in Gedro, 2009, p. 59). Further, Gedro pointed to a study conducted by Degges-White and Shoffner that found several examples of career counselors steering their clients away from positions working with children after their clients had disclosed their sexual orientation. Whereas many of these challenges within the place of employment cannot be controlled by the rehabilitation counselor, factors

such as a strong therapeutic alliance and multicultural competence contributing to appropriate rehabilitation goals, along with unique competencies that Kelsey and Smart (2012) identified as being part of the rehabilitation counseling profession including, promoting social justice, could certainly reduce the risk of exposure and promote inclusiveness.

Perception of Satisfaction with Rehabilitation Services

Much research has been presented examining the historical context of the population for which this study ultimately benefits, the standards guiding curricula development in training programs, the education and field experiences counselor trainees receive in their training programs to prepare them to work with LGB clients with disabilities, and how these apply to professionals working in the field of rehabilitation counseling. It is important to also consider clients' perceptions of rehabilitation services; that is, how does the client perceive the services they have received?

Dispenza and Hunter (2015) conducted a study to examine both the use of and level of satisfaction with rehabilitation services by lesbian, gay, bisexual, and transgender persons with disabilities. Of the participants recruited for this study (n = 59), the average age of participants was 33.49 (SD = 13.4, range = 20-70), with cisgender men (n = 36), cisgender women (n = 18), and transgender persons (n = 5) composing the sample (Dispenza & Hunter). Twenty-five participants identified as gay, 10 identified as lesbian, and 19 identified as bisexual. The ethnic composition of the sample population predominately European American (n = 29); of this population, 10 identified as Native American, nine identified as Asian, five identified as multiracial, three identified as

Latin/Hispanic, and three identified as African American (Dispenza & Hunter). Qualifying disabilities included medical illnesses, such as HIV/AIDS or musculoskeletal ($n = 16$), psychiatric ($n = 11$), intellectual ($n = 11$), neurological issues ($n = 9$), sensory deficits ($n = 6$), and developmental disabilities ($n = 6$) (Dispenza & Hunter).

Data analysis in this study consisted of three separate Pearson's chi-square tests to ascertain differences in the level of satisfaction participants had as a function of gender identity, sexual orientation, or employment status (Dispenza & Hunter, 2015). Dispenza and Hunter found a significant interaction ($p = .021$) of moderate effect ($p = .021$) regarding gender, a significant reaction ($p = .002$) of large effect ($p = .002$) regarding sexual orientation, and no significance in the satisfaction of employment. Seventy-three percent of bisexual and 70% of lesbian participants acknowledged overall dissatisfaction with rehabilitation services, compared to 24% of gay participants reporting overall dissatisfaction (Dispenza & Hunter).

Drawing upon the results of the study, Dispenza and Hunter (2015) discussed that the results are suggestive that counselors are not prepared to affirmatively work with LGBT clients with disabilities, suggesting that previous research they had conducted, could explain this overall dissatisfaction in that these individuals may have been exposed to stigma and oppression regarding their rehabilitation goals in relationship to their sexual orientations. While this study had innate limitations, in terms of the design (i.e., cross-sectional), outcome factors explored, and satisfaction being measured as a single dichotomous item (Dispenza & Hunter), this study is nevertheless a more recent exploration of a similar study as the present study, and certainly contributes the limited

research currently available exploring rehabilitation counseling with LGB clients with disabilities, showcasing relatively moderate utilization rates amongst LGB persons with disabilities (Dispenza & Hunter), and certainly demonstrating the need for multicultural competence for rehabilitation counselors.

Summary

In Chapter 2, a review of the relevant literature was presented showcasing that while there is indeed a desire for empirical contributions on the topic of multicultural counseling competency amongst rehabilitation counselors and students, at least from the perspective of scholarly journal publications, there remains a fundamental paucity of contributions aimed at exploring and explaining deficiencies that have been noted across most social sciences fields in addressing factors contributing to this important phenomena. Despite this noted limitation in available research – specific to the field of rehabilitation counseling – as noted, there have been some benchmark studies over the past several years attempting to explore and explain this phenomena, albeit limited and often limited to examining multicultural counseling competency in relation to a single minority status, in the fields of clinical mental health counseling, psychology, and other social sciences fields.

Whereas few contributions in research have been made, perhaps mostly notably those studies conducted by Bidell (see Bidell, 2000; 2005; 2011; 2012; 2013; and 2014), have all demonstrated that the breadth and depth of multicultural counseling coursework is simply insufficient in preparing students to work with LGB clients; other studies (see Mona, Cameron, & Cordes, 2017; Easton, 2015; Meyer & Gauler, 2015; Valvano et al.,

2014) have further showcased significant limitations in the preparation students receive in addressing sexuality and disability. These studies and contributions, when evaluated collectively, are suggestive that rehabilitation counseling students are likely being conferred degrees without the necessary preparation to address topics of intersectionality, and more specifically, working with LGB clients with disabilities.

Chapter 3 discusses the research methodology of the present study.

Chapter 3: Research Method

Introduction

Few studies have been conducted on the construct of intersectionality, and even fewer (if any) on sexual orientation and disability status. To that end, this researcher selected a combination of sexuality- and disability-centric measures to help understand how well-prepared students believed they were to render culturally appropriate services to LGB clients with disabilities. Chapter 3 explains the selected research design and rationale, outlines the research questions and hypotheses, discusses the methodology, and explores the threats to validity.

Research Questions and Hypotheses

RQ1. Do rehabilitation counseling students who have completed a multicultural counseling course differ in self-perceived counseling competence in working with LGB clients, from rehabilitation counseling students who have not completed a multicultural counseling course, as measured by the score on the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005)?

$H_0$1: The completion of a multicultural counseling course will not influence students' competence in rendering culturally appropriate services to LGB clients, as measured by scores on the SOCCS.

H_a1: Students who have completed a multicultural counseling course will have higher scores on the composite score of the SOCCS.

RQ2. For rehabilitation counseling students, to what degree does counselor competence in rendering culturally appropriate services to LGB clients, as measured by

the SOCCS, predict competence in addressing the broader intersection of disability and sexuality, as measured by scores on Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale (KCAASS; Kendall, Fronek, & Geraghty, 2003)?

$H_0$2: The attainment of higher scores on the SOCCS will not influence students' scores on the KCAASS on a statistically significant level.

H_a2: Students who attain higher scores on the SOCCS will attain higher scores on the KCAASS at a statistically significant level.

RQ3: How does the number of hours completed in a graduate training program relate to outcome scores on the SOCCS?

$H_0$3: Additional hours of coursework will not influence scores on the SOCCS at a statistically significant level.

H_a3: Additional hours of coursework will influence scores on the SOCCS at a statistically significant level.

RQ4: How does the completion of additional hours in workshops, cultural immersion events, conferences, and training sessions beyond hours spent in a graduate program influence the outcome scores on the SOCCS?

$H_0$4: The completion of additional hours in workshops, cultural immersion events, conferences, and training sessions beyond hours spent in a graduate program will not influence outcome scores on the SOCCS.

H_a4: As the number of hours spent in workshops, cultural immersion events, conferences, and training sessions increases, there will be a positive correlation to higher scores on the SOCCS.

RQ5. To what extent will outcome scores on the SOCCS and KCAASS correlate to outcome scores on the CASES as a measure of self-perceived competence when presented with a clinical vignette?

$H_0$5: Higher scores on the SOCCS and KCAASS will not predict a higher degree of self-efficacy of rendering culturally appropriate services, as measured by scores on the CASES, in response to clinical vignettes describing diversity in sexual orientation and disability type.

H_a5: A positive correlation will exist between outcomes scores on the SOCCS, KCAASS, and CASES in response to clinical vignettes describing diversity in sexual orientation and disability type.

Research Design and Rationale

This research study was designed to explore the effect of training and how it might influence competency in rendering culturally appropriate counseling services to LGB clients with disabilities. To examine this, a quantitative survey research design was adopted to ascertain students' (a) multicultural competence (knowledge, skills, awareness domains) in relation to rendering services to LGB individuals, as measured by the outcomes scores on the SOCCS; (b) knowledge and clinical application of disability-centric topics of sexuality, as measured by the outcomes scores on the KCAASS; and (c) self-efficacy in applying helping skills with LGB clients with disabilities.

Bordens and Abbott (2014) described quantitative research designs as being those focused on examining social phenomena using statistical data. Whereas a qualitative or mixed-methods design for this study could have yielded invaluable information

contributing to phenomena being explored, Bordens and Abbott suggested that quantitative research designs are appropriate where relationships can be explored through quantitative data. As such, a quantitative design was adopted which would allow the collection of numerically formatted data to provide for a better understanding of the research questions and hypotheses proposed in this study.

For the purpose of this study, the following variables were manipulated (independent variables): (a) gender, (b) sexual orientation, and (c) disability. The following variables were identified as dependent variables: (a) the Sexual Orientation Counselor Competency Scale, (b) the Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale, and (c) the Counselor Activity Self-Efficacy Scales. The following were identified as attribute variables, which were collected in the demographic questionnaire: (a) participant's gender, (b) participant's age, (c) participant's ethnicity, (d) participant's sexual orientation, (e) participant's year in their graduate program, (f) number of courses completed in their program, (g) program hours requirement (i.e., 60 credits versus 48 credits), (h) completion of a multicultural counseling course, (i) completion of a practicum or internship, (j) number of hours completed in practicum, internship, or combination, and (k) number of hours completed in voluntary continuing education (e.g., seminars, conferences, etc.).

Methodology

The primary source of data for this study was graduate-level students enrolled in rehabilitation counseling programs. Students were recruited based upon their enrollment in a program awarding a master's degree in rehabilitation counseling, and enrollment in

either a 48-credit hour program or 60-credit hour program. Participants were recruited from programs either accredited by the Council on Rehabilitation Education (CORE) or the Council for Accreditation of Counseling and Related Educational Programs (CACREP). This researcher used the CORE and CACREP program directories to identify programs to solicit participants through an email invitation to program directors. Additionally, this researcher solicited participation through electronic mail distribution lists of professional organizations. These professional organizations included: (a) the National Council on Rehabilitation Education, (b) the Commission on Rehabilitation Counselor Certification, (c) the American Rehabilitation Counseling Association, (d) the Council of State Administrators of Vocational Rehabilitation, (e) the International Association of Rehabilitation Professionals, (f) the National Association of Multicultural Counseling Rehabilitation Concerns, and (g) the Florida Division of Vocational Rehabilitation.

The study employed a nonprobability sampling of counseling students currently enrolled in a CACREP- or CORE-accredited program. The rationale for selecting CACREP- and CORE-accredited programs was based upon the fact that these accrediting bodies include multicultural counseling competencies, which programs must incorporate into their counselor education programs (CACREP, 2008; CORE, 2008). Frankfort-Nachimas and Nachimas (2008) suggested that the use of nonprobability samples is of particular benefit when a research lacks access to lists of the population being researched. Unfortunately, neither CACREP nor CORE provide access to current demographic information for rehabilitation counseling students in their programs, which precluded

probability sampling. It is worth noting, that the sampling procedure employed allowed for the capture of diverse responses, as sampling included participants from institutions across the United States, allowing for greater generalizability.

Participants were recruited through an email invitation submitted to program directors and faculty of university's offering a CACREP- and CORE-accredited, graduate-level programs, either conferring a degree in rehabilitation counseling or a specialization in rehabilitation counseling. Contact involved an invitation that introduced this researcher, the purpose of the study, the time commitment anticipated, and information for contacting this researcher directly if participants were interested or had further questions. Specific criteria for participation was that the participant must have been currently enrolled as a degree-seeking student in a master's degree counseling program or similar program leading to a specialization in rehabilitation counseling. A copy of the recruitment e-mail can be found in Appendix A.

A 2 (gender of client) X 2 (sexual orientation of client) X 2 (disability status) between-subjects factorial design was used as the first step in this study. A total of eight vignettes were created, varying the gender, sexual orientation, and disability type of the client. Each participant was provided one, randomly generated version of the vignette, whereby they were provided with a brief intake scenario (i.e., psychosocial intake) of an individual applying for rehabilitation services. Participants were asked to envision that they were working with the presenting client, and to rate their self-efficacy in rendering services to the client, while being cognizant of future encounters, to include: (a) determining the client's eligibility for services, (b) plan development, (c) placement, (d)

follow-up, and (e) counseling and case management throughout each step of the rehabilitation process.

Upon completing 15-questions derived from the CASES, in response to the vignette, the following measures were administered (dependent variables): (a) the Sexual Orientation Counselor Competency Scale (SOCCS), (b) Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale (KCAASS), (c) the Counselor Activity Self-Efficacy Scales, and (d) a social desirability scale. Of note, the Kinsey Scale was administered during the demographic collection process and analyzed during data analysis.

Measures

All instruments and materials used in this study were provided to participants electronically during the completion of the study through Qualtrics.

Kinsey Heterosexual-Homosexual Rating Scale. The Kinsey Heterosexual-Homosexual Rating Scale (Kinsey Scale; 1948) is a 7-point, Likert-style scale, where 0 is "exclusively heterosexual," and 6 is "exclusively homosexual," which will be used in the study to determine whether student participants will be placed in a homosexual, heterosexual, or bisexual sampling. According to Klein (1978), the Kinsey Scale is a scale which not only considers a respondent's overt sexual experiences, but also takes into account psychological (fantasy) experiences. Weinrich (2014) in detailing the Kinsey Scale, asserted that the detailed psychometric properties of the original scale remain unestablished.

Sexual Orientation Counselor Competency Scale. A modified version of the SOCCS has been identified, which appears more congruent with the population that will be studied, as the original SOCCS was developed to measure the competency of professionals in the field, rather than students currently enrolled in a graduate program. Bidell (2005) stated that his original measurement instrument was developed to assess the attitudes, skills, and knowledge of counselors working with LGB clients. Utilizing 29 items, spanning three subscales, the scale employs a 7-point Likert scale, whereby scores are converted to the Likert format with scores of 1.00 to 2.00 representing low competency, 3.00 to 5.00 representing moderate competency, and 6.00 to 7.00 representing high competency. It is noteworthy that some items on the instrument are reverse scored (denoted with "R") in order to translate respective values to align with the composite meaning of the SOCCS (higher scores suggestive of greater competence). According to Bidell (20005), higher composite scores represent higher degrees of self-reported competency by participants. An example item from this measure's coursework subscale includes, "I learned about the presence of heterosexual bias) i.e., the act of conceptualizing human experiences in heterosexual terms, thereby discounting LGB experiences and relationships) in my family therapy training program."

Carlson, McGeorge, and Toomey (2013) revised the original SOCCS, modifying five items to be more relevant to a student population; specifically, they revised the wording on five items within the skills domain, ultimately achieving a similar alpha coefficient for the skills subscale as the original SOCCS. Additionally, the original 7-point Likert scale was converted to a 6-point scale in order to remove neutral or middle

points in the scale (Carlson et al., 2013). The internal consistency (Cronbach's alpha) for this slightly revised SOCCS was found to be .90 (Carlson et al., 2013).

Bidell (2005) argued that the criterion, concurrent, and divergent validity of the SOCCS have been established. When initially employed, Bidell suggested that the internal consistency of the SOCCS was .90, and a 1-week test-retest reliability was .84. In a study by Graham, Carney, and Kluck (2012) utilizing the SOCCS to assess counseling student's competency in working with LGB clients, the authors found similar reliability, with one-week test-retest reliability coefficients ranging from .83 to .85 on the total SOCCS and subscales. Bidell (2011), in a follow-up study, found that the coefficient alpha was .90 for the overall SOCCS, .88 for the attitude subscale, .91 for the skills subscale, and .76 for the knowledge subscale, with a one-week test-retest of .84 for the overall SOCCS.

Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale. Kendall, Fronek, and Geraghty (2003) sought to develop a tool which would encompass staff knowledge, comfort, and attitudes towards sexuality following spinal cord injuries. Utilizing 45 items, spanning four subscales, the scale employs a 4-point Likert scale. For the Knowledge subscale, responses include 1 (no knowledge), 2 (limited knowledge), 3 (sound knowledge), and 4 (excellent knowledge). For both the Comfort and Approach subscales, responses include 1 (nil comfort), 2 (low discomfort), 3 (medium discomfort), and 4 (high discomfort). The Attitude subscale responses include 1 (disagree strongly), 2 (disagree), 3 (agree), and 4 (agree strongly). Kendall and colleagues (2003) asserted that the means and standard deviations for all subscales calculated, resulted in internal

consistency values of 0.92 (Knowledge), 0.97 (Comfort), 0.802 (Approach), and 0.83 (Attitudes). The Cronbach alpha for the composite score was found to be 0.96 (Kendall et al., 2003). An example item from this measure's attitude subscale includes, "People with a physical disability are not sexually attractive to others."

Counselor Activity Self-Efficacy Scales. The Counselor Activity Self-Efficacy Scales (CASES), is a 10-point Likert-style scale, which range from 0 (no confidence at all) to 5 (some confidence) to 9 (complete confidence) (Lent, Hill, & Hoffman, 2003). The CASES consists of 41 total items, divided into six subscales: (a) Exploration Skills, (b) Insight Skills, (c) Action Skills, (d) Session Management, (e) Client Distress, and (f) Relationship Conflict (Lent et al., 2003). Lent and colleagues (2003) described the scales as being measures to self-assess the performance of helping skills, managing the counseling process, and reacting to challenging situations which may arise in the course of a counseling session. An example item from this measure's part one subscale includes identifying how confident the participant is that they could use a particular skill effectively with most clients over the course of a week, to include the skill of attending (orienting one's self physically toward the client).

Lent and colleagues (2003) calculated internal consistency, test-retest reliability, convergent validity, and discriminate validity of the CASES. Internal consistencies were found to be: .97 for the total score, .79 for the Exploration Skills, .85 for the Insight Skills, .83 for the Action Skills, .94 for Session Management, .94 for Client Distress, and .92 for Relationship Conflict (Lent et al., 2003). The total CASES score Cronbach alpha coefficient was .97, and test-retest reliability estimates ranged from .59 to .76 (Lent et al.,

2003). Furthermore, Lent and colleagues (2003) indicated good convergent validity and discriminate validity in the measure.

Social Desirability Scale. Due to the sensitive nature of the topic of this investigation (i.e., sexual minority and disability populations), it was plausible that participants' responses may be confounded by social desirability response biases. That is, participants may respond to the survey items in a manner that appears to be in a socially desirable manner, or what seems to be the best answer to make them appear good. Therefore, participants were administered Stöber's (1999, 2001) Social Desirability Scale-17 (SDS-17), to learn response styles. High responders were reviewed and considered for possible exclusion or inclusion as covariance during the preliminary and main data analysis process.

In an effort to provide a more contemporary update to the popular Marlow-Crowne Social Desirability Scale (1960), Stöber (1999; 2001) developed the SDS-17. This instrument is a self-report measure, which affords researchers the ability to assess and gain insight into a research participant's social desirability bias and social desirability responding (Stöber, 1999). The SDS-17 was developed and validated in German, with follow-up studies in English, validating this measure as being a viable measurement of social desirability in contemporary American society (Blake, Valdiserri, Neuendorf, & Nemeth, 2006).

The SDS-17 is a 16-item, true-false dichotomous answer format scale (Stöber, 2001). The SDS-17 has an adequate internal consistency of reliability with a Cronbach

alpha between .72 (Stöber, 2001) and .75 (Stöber & Dette, 2002). The test-retest correlation was found to be .82 after four weeks (Stöber, 2001).

Demographic Questionnaire. Participants were administered a short demographic questionnaire after completion of all other measures. Participants were instructed to complete responses to such items as age, gender, sexual orientation, marital status, race/ethnicity, and religious affiliation. Descriptive statics were employed to reveal characteristics about the sample composition, including means and frequencies.

Sample Size and Power

In reviewing previous studies which had used the instruments being employed in the current study, a minimum medium effect size of .250 was adopted based upon the lowest of the subscales being considered. In an effort to approximate the number of participants for the current study, an a-priori power analysis was performed using G*Power version 3.1 (Faul, Erdfelder, Buchner, & Lang, 2009; Faul Erdfelder, Lang, & Buchner, 2007). Parameters used included an estimated effect size of .250, power of .80, 8 groups, and numerator degrees of freedom (df) = 1. The calculations resulted in an estimated sample size of 200 participants. Considering the possibilities of missing data, this researcher selected a target sample size of 250 participants.

Data Analysis Plan

This researcher proposed and collected surveys through Qualtrics, with the data being imported into SPSS for data analyses. A preliminary analysis was conducted to ascertain the potential impact of social desirability responding on the instruments employed in this study; t tests were conducted to determine significance. In the event

social desirability responding significantly affected one or more study variables, the social desirability scale was considered for inclusion as a covariate during the respective segment of data analysis.

Procedures

Participants were recruited through the use of one of two approaches. Direct outreach emails were sent to program directors and faculty of relevant counseling programs, soliciting participation in the study by requesting that these faculty offer students the opportunity to participate either directly or through other program faculty members. Other students were recruited through an email invitation distributed through the aforementioned professional organization's distribution lists (e.g., National Council on Rehabilitation Education, the American Rehabilitation Counseling Association, etc.). The brief invitation letter provided faculty and students with information about this researcher and what this researcher was studying – the construct of intersectionality, and that the current study sought to understand how multicultural counseling coursework influences perceived self-efficacy and competency in rendering services to lesbian, gay, and bisexual individuals with psychiatric or physical disabilities. Informed consent was obtained prior to participation in the study, and participants had an option of immediately opting out of the study or opting out of the study at any point during the administration.

Participants were instructed to complete all survey-related instruments and forms on Qualtrics, which purports to offer a platform for the development of surveys, data collection, and preliminary analysis. Qualtrics allowed for an anonymous environment for completion of the questions in this study. Participants were kept uninformed as to the

exact nature of this study; after completion of the survey, participants were informed as to the purpose of the investigation. Participants were randomly assigned to one of eight groups/conditions (heterosexual female/male physical disability, heterosexual female/male psychiatric disability, gay/lesbian physical disability, gay/lesbian psychiatric disability), in which they were asked to complete different versions of a single-page transcription of a psychosocial intake session. All participants were debriefed about the study immediately following their participation.

Threats to Validity

Internal Validity

Prior to executing the present study, it was important to consider potential threats to the internal validity of the study. Fassinger and Morrow (2013) described threats to validity as encompassing the testing used in a study, the statistical analyses performed, the process of participant selection, and experimentation and maturation, as applicable. Perhaps the most significant threat to internal validity, identified at this stage in the study, involved the measures selected and adjustments made to select measures to tailor them for this study. As briefly discussed earlier and expanded later, unfortunately there were no measures designed specifically to assess counselor competence in addressing the intersection of sexual minority and disability statuses. As such, subscales were selected from existing measures and minor modifications to verbiage were made to another measure to evaluate competence in applying knowledge to topics of sexuality and disability. A further discussion of these limitations has been addressed in Chapter 5.

External Validity

Contrasting with internal validity, Frankfort-Nachmias and Nachmias (2008) described external validity as being the threats associated with applying a study's findings to the broader population. As described above, the target population being recruited and examined in this study was graduate-level students enrolled in an accredited rehabilitation counseling program (or comparable). This limited sample population undoubtedly served as a threat to external validity in that the demographic characteristics of the population would likely not be indicative of the general population. For example, data published by CACREP (2018) highlighting the vital statistics of their accredited programs showed a disproportionate representation of accredited programs by regions in the United States; 71 programs were accredited in the North Atlantic region, 90 programs were accredited in the North Central region, 18 programs were accredited in the Rock Mountain region, 138 programs were accredited in the Southern region, and 31 programs were accredited in the Western region.

Furthermore, there were concerned noted – potential threats to the internal validity of the study – in terms of the participants' electing to participate in the study and the impact this may have on their responses; specifically, participants who were perhaps motivated to participate based upon their interest or passion for topics in multicultural counseling and participants who may exhibit greater multicultural awareness prior to completing multicultural counseling coursework or additional training. Thus, the data collected could be more reflective of those students with interests in multicultural counseling or suggestive of higher levels of multicultural awareness.

In addition to the disparity in regional representation of accredited programs, CACREP (2018) also provided demographic characteristics of students enrolled in their programs in 2017, which further substantiated and showcased a potential threat to the external validity of the present study. In 2017, for example, a mere 2.97% of students enrolled in an accredited program identified as African American male compared to 15.42% that identified as African American females. European American males represented 10.56% and European American females represented 49.12% of students enrolled in accredited programs in 2017 (CACREP, 2018). These data showcase characteristics that are clearly not indicative of the broader population, with skewness in at least the gender representation of participants that would be recruited in the present study.

Ethical Procedures

Prior to commencing the current study, an Institutional Review Board (IRB) application was submitted to Walden University's IRB, ultimately culminating in their approval on November 21, 2018 with the approval number 11-21-18-0532612. Notably, there were few ethical concerns in performing the current study, as several precautions were taken to ensure the ethical delivery of the study.

In the interest of maintaining privacy and promoting candor, participants were not asked to provide any contact information, which might otherwise link them to their responses. Participants wishing to complete the study, as part of the consent form they were instructed to read and indorse prior to participation, were provided a comprehensive overview of the study, a disclosure of the voluntary nature of the study, a risks and

benefits statement attesting to the minimal risk of their participation, detailed information on the privacy of the study, and how they might seek assistance in both completing the survey or reporting any concerns to the Walden University IRB. In ensuring the privacy of data collected, consistent with the consent form, all data was collected on a secure server and downloaded on this researcher's personal computer. Data collected was completely anonymous and will be stored for a period of at least 5-years, as required by Walden University. A copy of the consent form has been included in Appendix B.

Summary

In Chapter 3, the research methodology applied to the present study was discussed. In this study, research participants were recruited from CORE- and CACREP-accredited programs conferring degrees in clinical mental health counseling with a specialization in rehabilitation counseling or rehabilitation counseling programs. Prior to participating in the present study, students were informed of the general topic being studied – multicultural counseling – and asked to indorse their informed consent to participate in the study, demographic questionnaire, and the Kinsey Scale, which was incorporated as part of the demographic questionnaire.

After acknowledging informed consent and completing the demographic questionnaire, participants were presented with a randomized clinical vignette of a psychosocial intake session. Participants were asked to imagine themselves as being the clinician conducting the psychosocial intake session with the perspective client, where variables such as gender, sexuality, and type of disability (physical or psychiatric) were manipulated (i.e., randomly generated and presented to the participant). Following their

exposure to the clinical vignette, participants were asked to provide responses to the helping skills subscale of the CASES, to assess their confidence in applying helping skills with the client depicted in the clinical vignette. Upon completing the helping skills subscale of the CASES, participants were then asked to complete the SOCCS and knowledge subscale of the KCAASS to assess their general competency in working with LGB clients and their knowledge of applying clinical skills when working with clients with disabilities, respectively. Finally, the potential for social desirability bias in response patterns was evaluated by the administration of a social desirability scale, the SDS-17.

Chapter 4 presents the results of this study.

Chapter 4: Results

Introduction

The overarching purpose of this study was to examine factors that may influence a counselor's ability to render culturally appropriate services to clients with disabilities who also identify as a sexual minority. A secondary purpose, guided by the research questions and hypotheses, was to examine the relationships between independent and dependent variables of a counselor's competency in addressing topics related to intersectionality, specifically, the convergence of sexual minority and disability statuses. This chapter presents the results of the study.

Data Collection

Description of the Sample

Two-hundred-and-thirty-two graduate students from CORE- or CACREP-accredited programs offering graduate degrees in rehabilitation counseling, or a specialization in rehabilitation counseling, participated in the study. Data were collected over the course of 9 months spanning the IRB authorization period. Twenty-eight participant responses were omitted from the original sample size of 232 during the data clean-up process because participants had either abandoned the survey or had not completed a sufficient number of responses to make it suitable for data imputation approaches. The remaining 204 completed surveys comprised the data used for all statistical analyses in this study, ultimately meeting the estimated number of participants needed. Tabled, aggregate demographic information of participants are presented in Table 1.

Age and gender distribution. Participants' ages ranged from 23 to 42 years, with a mean of 30 years (M = 30.20, SD = 4.65). Seventy percent of participants identified as female (n = 143), 29% of participants identified as male (n = 60), and 0.5% of participants identified as gender non-binary (n = 1).

Racial and ethnic distribution. In terms of the ethnic distribution of participants, the majority, 63%, identified as European American (n = 129), 13% identified as African-American (n = 28), 8% identified as Hispanic (n = 17), 7% identified as Asian-American (n = 16), 5% identified as "other" (n = 12), and 1% identified as Native American (n = 2).

Sexuality distribution. Participants' sexual identity was described along a number of dimensions when responding to the Kinsey Homosexuality Scale (Kinsey, Pomeroy, & Martin, 1994). Of the total participants, 64.7% identified as exclusively heterosexual (n = 132), representing the majority; 13.7% were predominantly heterosexual, incidentally homosexual (n = 28); 6.9% were predominantly heterosexual, but more than incidentally homosexual (n = 14); 6.9% were equally heterosexual and homosexual (n = 14); 1.5% were predominantly homosexual, but more than incidentally heterosexual (n = 3); 1.5% were predominantly homosexual, incidentally heterosexual; and, 4.9% were exclusively homosexual (n = 10).

Religion distribution. Seventy-nine percent of participants (n = 167) identified as being Christian, whether Baptist, Catholic, Protestant, or non-denominational. Four percent of participants identified as "other" (n = 10), representing the second highest religious grouping, while 0.5% of participants identified as being Mormon (n = 1) and

1% identified as being "none" (n = 2) representing the lowest religious grouping. Participants identifying as Agnostic (n = 8) and Atheist (n = 7) represented 3% each of the total population.

LGB and disability familiarity distribution. Seventy-five percent (n = 154) indicated having a friend or family member who identifies as lesbian, gay, or bisexual. Twenty-four percent (n = 50) denied having a friend or family member who identifies as LGB. Thirty percent (n = 63) endorsed having a friend or family member who has a disability. Sixty-nine percent (n = 141) denied having a friend or family member who identifies as having a disability.

Table 1

Participant Demographic Characteristics

Demographic	*n*	%
Gender		
Male	60	29.4
Female	143	70.1
Gender Non-Binary	1	0.5
Total	204	100
Ethnicity		
African American	28	13.7
Asian American	16	7.8
European American/White	129	63.2
Hispanic/Latino	17	8.3
Native American	2	1.0
Other	12	5.9
Total	204	100
Religion		
Agnostic	8	3.9
Atheist	7	3.4
Baptist	26	12.7
Buddhist	3	1.5
Catholic	26	12.7
Christian, Non-Denominational	81	39.7

Jewish	4	2.0
Mormon	1	0.5
Muslim	2	1.0
Protestant	34	16.7
Other	10	4.9
None	2	1.0
Total	204	100
Sexual Orientation		
Exclusively heterosexual	132	64.7
Predominately heterosexual, incidentally homosexual	28	13.7
Predominately heterosexual, but more than incidentally homosexual	14	6.9
Equally heterosexual and homosexual	14	6.9
Predominately homosexual, but more than incidentally heterosexual	3	1.5
Predominately homosexual, incidentally heterosexual	3	1.5
Exclusively homosexual	10	4.9
Total	204	100
Family or Friend Exposure to Sexual Minorities		
Knows a family member or friend that is LGB	154	75.5
Does not know a family member or friend that is LGB	50	24.5
Total	204	100
Family or Friend Exposure to Disability		
Knows a family member or friend that has a disability	63	30.9
Does not know a family member or friend that has a disability	141	69.1
Total	204	100

Graduate program information distribution. Fifty-nine percent of participants (n = 122) reported being enrolled in a 48-credit hour rehabilitation counseling program, compared to 29% of participants indicating they were enrolled in a 60-credit hour clinical mental health counseling program (n = 60). Ten percent of participants indicated that they were enrolled in an “other” program (n = 22); these participants were presumed to be eligible for participation in the current study based upon eligibility criteria disclosed during the onset of the study.

Of these participants, the majority of students (35%) reported being in their first year of their program (*n* = 72), followed closely by 32% of students being in their second year of their program (*n* = 66). Seventeen percent of students described being in an "other" year of their program (*n* = 36), whereas 14% indorsed being in their third year of their program (*n* = 30). The majority (49%) indicated that by this point in their program they have at least completed a single practicum experience (*n* = 101), followed closely by 35% reporting having completed both a practicum and internship experience (*n* = 73). Only 14% indicated they have only completed a single internship experience (*n* = 30).

Multicultural experience distribution. Sixty-five percent of participants (*n* = 134) endorsed having completed a course in multicultural or cross-cultural counseling. Thirty-four percent (*n* = 70) denied having completed a course in multicultural or cross-cultural counseling. Forty-four percent (*n* = 91) had participated in elective courses, professional development, non-program training, or conferences that seemingly had a focus on the intersection of sexuality and disability, compared to 55% percent that denied any such participation (*n* = 113). When asked to describe how many contact hours in elective courses, professional development, non-program training, or conferences that have explored the intersection of sexuality and disability, responses ranged from 0 to 12 hours, with a mean of 7 hours (*M* = 7.22, *SD* = 2.37).

Tabled, aggregate education and exposure demographic information of participants in the present study are presented in Table 2.

Table 2

Participant Education and Familiarity Demographic Characteristics

Demographic	*n*	%
Type of Graduate Program		
60-credit hour clinical mental health counseling	60	29.4
48-credit hour rehabilitation counseling	122	59.8
Other	22	10.8
Total	204	100
Stage of Program		
First year	72	35.3
Second year	66	32.4
Third year	30	14.7
Other	36	17.6
Total	204	100
Completion of Multicultural Counseling Course		
Has completed a course in multicultural counseling	134	65.7
Has not completed a course in multicultural counseling	70	34.3
Total	204	100
Completion of Elective Experiences		
Has completed elective coursework or experiences	15	7.4
Has not completed elective coursework or experiences	189	92.6
Total	204	100

Data Analyses

Participants in the present study were asked to read one of eight clinical vignettes, where gender (male/female), sexual orientation (straight or gay/lesbian), and disability (physical/psychiatric) were manipulated. The assumptions of this study were that variables, such as the type of counseling program a student was enrolled in, whether a student had completed coursework in multicultural counseling, or whether students' participation in non-program training, might influence their self-efficacy, thereby their competence, in rendering culturally appropriate clinical services to LGB clients with disabilities.

Preliminary Analyses

Once the necessary number of participants had completed the survey, results were downloaded from Qualtrics and imported into SPSS. Consistent with Frankfort-Nachimas & Nachmias (2008), data cleaning was performed to assess and adjust for any errors noted in the data collected, to include assessing for incomplete or partially completed surveys, ensuring data was accurately imported from Qualtrics to SPSS, spot-checking, visually examining data using scatter plots to assess for any potential outliers, and examining participants' response patterns in relation to the SDS-17 to assess for social desirability response bias. Data gathered on the distribution of all eight clinical vignette conditions were examined to ensure that random assignment through the Qualtrics survey had placed a sufficient and similar number of participants within each condition (i.e., even distribution). Additionally, as part of the data cleaning process, data was evaluated to determine levels of skewness and kurtosis, where distributions are considered normal if their absolute values are less than two time their standard deviation. Where necessary, logarithmic transformations were conducted accordingly. Data collection resulted in an adequate and similar distribution across all clinical vignettes (see Table 3).

Table 3

Distribution of Clinical Vignettes Across Sample Population

Vignette Version	*n*	%
1. Straight, male, psychiatric disability	26	12.7
2. Straight, male, physical disability	25	12.3
3. Gay, male, psychiatric disability	25	12.3
4. Gay, male, physical disability	25	12.3
5. Straight, female, psychiatric disability	27	13.2
6. Straight, female, physical disability	25	12.3

7. Lesbian, female, psychiatric disability	25	12.3
8. Lesbian, female, physical disability	26	12.7

During the data cleaning process, of the 232 original participants, 12 were omitted due to having not completed the survey and 16 were omitted due to having submitted an incomplete survey. Unfortunately, there were insufficient responses in incomplete submissions for a missing data imputation approach to be considered. The resulting 204 completed surveys were determined to be suitable for the purpose of this study and were included in all data analyses. Additionally, Levene's tests of equality of error variances were performed and examined to ensure the error variance for each dependent measure was equal across groups; the results did not yield statistically significant findings.

Social Desirability Scale

Participants were administered the SDS-17 to determine whether there was a potential influence of social desirability response in relation to their responses to measures administered in the study. Responses were coded and tallied according to Stöber's (1999; 2001) instructions for the SDS-17. Scores obtained ranged from 2 to 16, $M = 9.41$, $SD = 2.91$. Outlier distribution was visually inspected, and the findings showcased a normal curve distribution. For the purpose of social desirability classification, aligning with the Marlowe-Crowne (Crowne & Marlowe, 1960) scale, composite scores were separated into two descriptive categories, where scores ranging 1 to 9 were classified as low-average and scores ranging from 10 to 16 were classified as high.

Sixty percent of participants (n = 124) were categorized as having scored within the low-average range on the SDS-17, and 39% of participants (n = 80) scored within the high range. An independent-samples t-test was performed to determine if there were differences in SOCCS outcome scores between low-average and high social desirability responses. SOCCS outcome scores amongst participants with low-average social desirability responses (M = 2.10, SD = .07) and amongst participants with high social desirability responses (M = 2.09, SD = .07) were not found to be of statistical significance, M = .01, 95% CI [-.01, .03], t(202) = .757, p = .302.

A second independent-samples t test was run to determine if there were differences in KCAASS outcome scores between low-average and high social desirability responses. KCAASS outcome scores amongst participants with low-average social desirability responses (M = 31.69, SD = 5.16) and amongst participants with high social desirability responses (M = 30.69, SD = 5.17) were not found to be of statistical significance, M = 1.0, 95% CI [-.46, 2.46], t(202) = 1.35, p = .812.

A third independent-samples t test was run to determine if there were differences in CASES outcome scores between low-average and high social desirability responses. CASES outcome scores amongst participants with low-average social desirability responses (M = 88.67, SD = 18.94) and amongst participants with high social desirability responses (M = 85.34, SD = 17.75) were not found to be of statistical significance, M = 3.32, 95% CI [-1.90, 8.6], t(202) = 1.25, p = .511.

Based upon these findings, the SDS-17 was not included as a covariate during the analyses for hypotheses 1 through 6 for the dependent variables.

Kinsey Scale

Despite having gathered self-reported sexual orientation responses in the demographic questionnaire, participants were nevertheless asked to provide responses to the Kinsey Scale to gain a better understanding of their sexual orientation. A breakdown for each category has been included in Table 1.

Instrument Reliability

Instrument reliability was assessed by evaluating the Cronbach's alpha of each published instrument or variable. For the SOCCS, Bidell (2005) found the full-scale alpha to range from .84 to .90; Graham (2009) found the full-scale alpha to be .87. Bidell (2005) found the coefficient alpha for the three subscales to range from .85 to .88 for Awareness, .83 to .91 for Skills, and .76 to .84 for Knowledge; Graham's study found the Cronbach's alpha to be .91, .86, and .71, respectively. Table 4 compares the reliabilities of the results from previous studies (i.e., Bidell, 2005 and Graham, 2009) with those from the present study.

Table 4

Reliability Analyses for SOCCS

	Bidell (2005) Cronbach's alpha	Graham (2009) Cronbach's alpha	Current Study Cronbach's alpha
Awareness subscale	.85 to .88	.91	.78
Skills subscale	.83 to .91	.86	.76
Knowledge subscale	.76 to .84	.71	.89
Overall	.84 to .90	.87	.88

For the KCAASS, Kendall and colleagues (2003) found the Cronbach's alpha of the knowledge subscale to be .926. In the present study, the Cronbach's alpha of the knowledge subscale was found to be .724. Finally, Lent, Hill, and Hoffman (2003) reported various values for the internal reliability of the entire instrument and select components of the instrument, ranging from .79 (Exploration Skills) to .94 (Session Management and Client Distress), and the CASES total scale yielding an alpha coefficient of .97. The current study computed a Cronbach's alpha value of .92 for the Helping Skills. This value seemed in line with aforementioned findings and suggested acceptable reliability for the use and subsequent analysis and interpretation of the data. Table 4 lists the Cronbach's alpha values for selected subscales of the KCAASS and CASES.

Results

Descriptive Statistics

To explore participants' awareness, skills, and knowledge in working with LGB clients, the Sexual Orientation Counselor Competency Scale (SOCCS) was administered. The overall mean score for participants (N = 204) was 4.32 (SD = .07), with scores (following log 10 transformation) ranging from 1.98 to 6.56. On the skills subscale, participants' mean score was 2.78 (SD = .15), with scores ranging from 1.98 to 3.59; mean scores on the awareness subscale were 6.20 (SD = .43), with scores ranging from 5.54 to 6.56; and, mean scores on the knowledge subscale were 4.11 (SD = .11), with scores ranging from 3.11 to 4.87.

To better understand participants' knowledge of sexuality topics as it relates to disability, the knowledge subscale of the Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale (KCAASS) was administered. The mean score on the knowledge subscale for participants was 31.29 (*SD* = 5.17), with scores ranging from 20 to 43. Additionally, to assess participants' self-efficacy in applying helping skills – in response to a clinical vignette – participants were administered the helping skill subscale of the Counselor Activity Self-Efficacy Scales. The mean score on the helping skills subscale for participants was 87.36 (*SD* = 18.51), with scores ranging from 50 to 122. Descriptive statistics for the variables of interest are presented in Table 5.

Table 5

Descriptive Statistics of Dependent Variables

Variable	Minimum	Maximum	*M*	*SD*
SOCCS Skills subscale [a]	1.98	3.59	2.78	.15
SOCCS Awareness subscale	5.54	6.56	6.20	.43
SOCCS Knowledge subscale [a]	3.11	4.87	4.11	.11
KCAASS Knowledge subscale	20.00	43.00	31.29	5.17
CASES Helping skills subscale	50.00	122.00	87.36	18.51

[a] Logarithmic transformations were conducted.

Research Questions and Hypotheses Testing

For this study, the following research questions and hypotheses were used to guide the study:

RQ1. Do rehabilitation counseling students who have completed a multicultural counseling course differ in self-perceived counseling competence in working with LGB clients, from rehabilitation counseling students who have not completed a multicultural

counseling course, as measured by the score on the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005)?

$H_0$1: The completion of a multicultural counseling course will not influence students' competence in rendering culturally appropriate services to LGB clients, as measured by scores on the SOCCS.

H_a1: Students who have completed a multicultural counseling course will have higher scores on the composite score of the SOCCS.

RQ2. For rehabilitation counseling students, to what degree does counselor competence in rendering culturally appropriate services to LGB clients, as measured by the SOCCS, predict competence in addressing the broader intersection of disability and sexuality, as measured by scores on Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale (KCAASS; Kendall, Fronek, & Geraghty, 2003)?

$H_0$2: The attainment of higher scores on the SOCCS will not influence students' scores on the KCAASS on a statistically significant level.

H_a2: Students who attain higher scores on the SOCCS will attain higher scores on the KCAASS at a statistically significant level.

RQ3: How does the number of hours completed in a graduate training program relate to outcome scores on the SOCCS?

$H_0$3: Additional hours of coursework will not influence scores on the SOCCS at a statistically significant level.

H_a3: Additional hours of coursework will influence scores on the SOCCS at a statistically significant level.

RQ4: How does the completion of additional hours in workshops, cultural immersion events, conferences, and training sessions beyond hours spent in a graduate program influence the outcome scores on the SOCCS?

$H_0$4: The completion of additional hours in workshops, cultural immersion events, conferences, and training sessions beyond hours spent in a graduate program will not influence outcome scores on the SOCCS.

H_a4: As the number of hours spent in workshops, cultural immersion events, conferences, and training sessions increases, there will be a positive correlation to higher scores on the SOCCS.

RQ5. To what extent will outcome scores on the SOCCS and KCAASS correlate to outcome scores on the CASES as a measure of self-perceived competence when presented with a clinical vignette?

$H_0$5: Higher scores on the SOCCS and KCAASS will not predict a higher degree of self-efficacy of rendering culturally appropriate services, as measured by scores on the CASES, in response to clinical vignettes describing diversity in sexual orientation and disability type.

H_a5: A positive correlation will exist between outcomes scores on the SOCCS, KCAASS, and CASES in response to clinical vignettes describing diversity in sexual orientation and disability type.

Research Question 1, Hypothesis 1

Do rehabilitation counseling students who have completed a multicultural counseling course differ in self-perceived counseling competence in working with LGB

clients, from rehabilitation counseling students who have not completed a multicultural counseling course, as measured by the score on the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005)? Research Question 1, Hypothesis 1 was explored using a factorial design 3 (knowledge, skills, awareness) × 2 (multicultural counseling course completion: yes or no), one-way analysis of variance (ANOVA) to explore the interaction between participants having completed a multicultural counseling course and their competency to work with LGB clients based on knowledge, skills, and awareness domains (i.e., total SOCCS scores).

An analysis of variance revealed the completion of a multicultural counseling course had a significant effect on the total SOCCS score, $F(1, 202) = 17.76$, $p < .001$, η2 = 0.08. Participants who completed the course obtained significantly higher mean scores ($M = 2.11$, $SD = 0.8$) than those who did not complete a multicultural counseling course ($M = 2.06$, $SD = 0.5$). Accordingly, the null hypothesis was not rejected. Please refer to Tables 6 and 7.

Table 6

Descriptive Statistics for SOCCS Scores and Multicultural Counseling Course

	M	*SD*	*N*
Yes, completed multicultural counseling course	2.11	.08	134
No, did not complete multicultural counseling course	2.06	.05	70
Total	2.09	.07	204

Table 7

One-Way Analysis of Variance of SOCCS Scores by Multicultural Counseling Course

Model	Sum of Squares	*df*	Mean Square	*F*	Eta squared

Corrected Model	.086	1	0.86	17.759*	.081
Intercept	799.784	1	799.784	165197.287	.999
Error	.978	202	0.005		.081
Total	893.939	204			.000
Corrected Total	1.064	203			

$N = 204$; * $p < .001$

Research Question 2, Hypothesis 2

For rehabilitation counseling students, to what degree does counselor competence in rendering culturally appropriate services to LGB clients, as measured by the SOCCS, predict competence in addressing the broader intersection of disability and sexuality, as measured by scores on Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale (KCAASS; Kendall, Fronek, & Geraghty, 2003)? Research Question 2, Hypothesis 2 was examined by conducting a correlation analysis by computing a Pearson's *r* to assess the relationship between knowledge, skills, and awareness domains (i.e., total SOCCS scores) and scores on the knowledge subscale of the KCAASS.

The Pearson's *r* showcased a moderate positive relationship between the two variables, $r(204) = .58$, $p < .001$. This positive correlation suggests that as students' self-efficacy in rendering services to LGB persons increases, as evidenced in higher total scores on the SOCCS, there is a corresponding, albeit moderate, increase in their application of knowledge on topics related to sexuality and disability, as measured by higher scores obtained on the KCAASS. As such, the null hypothesis for research question 2 would be accepted. A scatterplot summarizes the results in Figure 1.

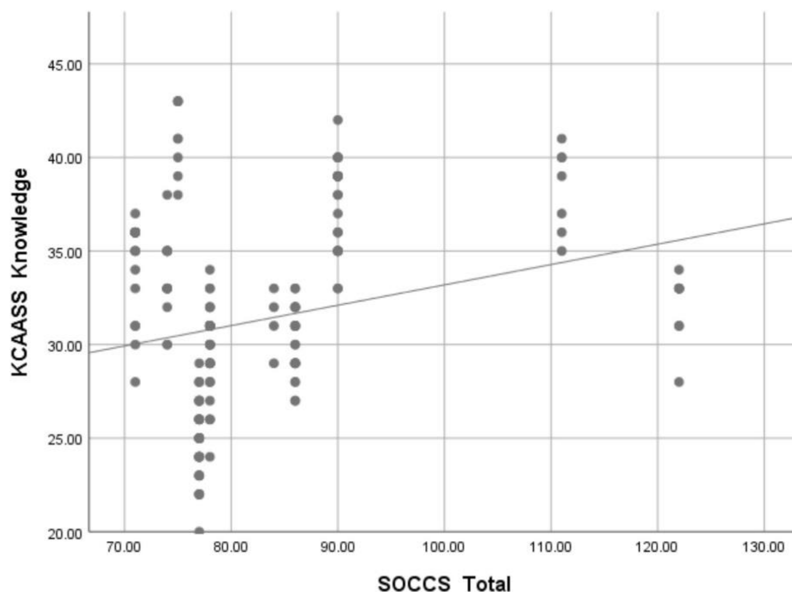

Figure 1. Scatterplot for KCAASS Knowledge Subscale and SOCCS Total Scores

To gain a better understanding of the relevance of this correlation, with respect to differences in outcomes scores on the KCAASS, a one-way ANOVA was performed to assess whether significant differences existed between participants enrolled in clinical mental health counseling, rehabilitation counseling, or "other" program. The ANOVA found a significant effect for the program type, $F(2,201) = 17.42$, $p < .001$, $\eta 2 = .15$, which suggests that there is a difference in the training models between these types of programs in preparing students to address topics of disability and sexuality. Participants enrolled in a traditional rehabilitation counseling program ($n = 122$) were found to have lower outcome scores on the KCAASS when compared to other programs ($M = 30.30$, $SD = 5.45$); participants enrolled in a clinical mental health counseling program ($n = 60$) were found to have marginally higher outcome scores ($M = 31.27$, $SD = 3.36$); and,

participants enrolled in "other" programs were found to have the highest outcome scores (M = 36.86, SD = 4.17). Please refer to Table 8.

Table 8

Descriptive Statistics for KCAASS Scores and Program Type

	M	*SD*	*N*
Clinical mental health counseling – 60 hrs	31.27	3.36	60
Rehabilitation counseling – 48 hrs	30.30	5.45	122
Other	36.86	4.17	22
Total	31.30	5.17	204

Post hoc analyses using the Bonferroni post hoc criterion for significance indicated that while outcome scores on the KCAASS were not found to be significant between participants enrolled in a clinical mental health counseling program versus participants enrolled in a traditional rehabilitation program, $F(2,2) = 17.43$, $p = .61$, there was, however, found to be significance between these scores in participants enrolled in rehabilitation counseling versus "other" programs, $F(2,2) = 17.429$, $p < .001$, and those enrolled in clinical mental health counseling versus "other" programs, $F(2,2) = 17.429$, $p < .001$. Therefore, the null hypothesis cannot be rejected (see Table 9).

Table 9

One-Way Analysis of Variance for KCAASS Scores by Program Type

Model	Sum of Squares	*df*	Mean Square	*F*	Eta squared
Corrected Model	802.250	2	401.125	17.429*	.148
Intercept	137790.881	1	137790.881	5986.890	.968
Error	4626.103	2	23.015		.148
Total	205210.000	201			
Corrected Total	1.064	203			

N = 204; * $p < .001$

Research Question 3, Hypothesis 3

How does the number of hours completed in a graduate training program relate to outcome scores on the SOCCS? A one-way ANOVA was conducted to determine if the type of program a participant was enrolled in (i.e., 48-credit, 60-credit, or "other") was different for groups in terms of their competency to work with LGB clients based on knowledge, skills, and awareness domains (i.e., total SOCCS scores). Participants were classified into three groups based upon their program type: 60-credit hour clinical mental health counseling (n = 60), 48-credit hour rehabilitation counseling (n = 122), and "other" (n = 22). The ANOVA found a significant effect for the program type, $F(2,2) = 6.61$, $p < .001$, $\eta_2 = .06$, which suggests that there is a difference in the training models between these types of programs in preparing students to address topics of sexual orientation in clinical settings. Participants enrolled in a 60-credit hour clinical mental health counseling programs (n = 60) were found to have the highest outcome scores on the SOCCS (M = 2.11, SD = .09), followed by students in 48-credit hour rehabilitation counseling programs (n = 122; M = 2.09, SD = .06), and students in "other" programs (n = 22) were found to have the lowest outcome scores (M = 2.05, SD = .08). Refer to Table 10 for the descriptive statistics.

Table 10

Descriptive Statistics for SOCCS Scores and Program Type

	M	*SD*	*N*
Clinical mental health counseling – 60 hrs	2.11	.09	60
Rehabilitation counseling – 48 hrs	2.09	.06	122
Other	2.05	.08	22
Total	2.09	.07	204

Post hoc analyses using the Bonferroni post hoc criterion for significance indicated that the mean increase from 48-credit hour rehabilitation counseling to “other” (.043, 95% CI [.003, .082]) was statistically significant, $p < .001$, as well as the increase from 60-credit hour mental health counseling to “other” (.064, 95% CI [.021, .106], $p < .001$), but no other group differences were statistically significant. Therefore, the null hypothesis would be partially accepted (see Table 11).

Table 11

One-Way Analysis of Variance of SOCCS Scores by Program Type

Model	Sum of Squares	*df*	Mean Square	*F*	Eta squared
Corrected Model	.066	2	.033	6.608*	.062
Intercept	555.517	1	555.517	111848.813	.998
Error	.998	2	.005		
Total	893.939	201			
Corrected Total	1.064	203			

$N = 204$; * $p = .002$

Research Question 4, Hypothesis 4

How does the completion of additional hours in workshops, cultural immersion events, conferences, and training sessions beyond hours spent in a graduate program influence the outcome scores on the SOCCS? A one-way ANOVA was conducted to determine if the completion of additional hours in workshops, cultural immersion events, conferences, and training hours spent beyond hours spent in a graduate training program (“additional training hours”) was different for groups in terms of their competency to work with LGB clients based on knowledge, skills, and awareness domains (i.e., total SOCCS scores). Refer to Table 12 for the descriptive statistics.

Table 12

Descriptive Statistics for Additional Training

	M	*SD*	*N*
Yes, completed additional training	2.13	.08	91
No, did not complete additional training	2.06	.05	113
Total	2.09	.07	204

Participants were classified into two groups based upon whether they had completed additional training hours or not. Of those participants who had reported having completed additional training hours (n = 91), SOCCS scores were found to increase (M = 2.13, SD = .08) when compared to those participants' (n = 113) SOCCS scores (M = 2.06, SD = .05) that had not completed additional training hours. The ANOVA found a significant effect for the completion of additional training hours, $F(1,1) = 60.65$, $p < .001$, $\eta_2 = .231$, which suggests that there is a difference in the acquisition of knowledge through additional training opportunities in preparing students to address topics of sexual orientation in clinical settings. Participants who have completed additional training hours (n = 91) were found to have higher outcome scores on the SOCCS (M = 2.13, SD = .08) compared to students who have not completed additional training hours (n = 113; M = 2.06, SD = .05). Refer to Table 13.

Table 13

One-Way Analysis of Variance of SOCCS Scores by Additional Training

Model	Sum of Squares	*df*	Mean Square	*F*	Eta squared
Corrected Model	.246	1	.246	60.654*	.231
Intercept	885.670	1	885.670	218644.819	.999
Error	.818	202	.004		

Total	893.939	204
Corrected Total		

N = 204; * $p < .001$

To further explore this effect towards gaining a better understanding of the relationship between the number of hours spent in training and the impact this has on SOCCS scores, those participants reporting having not completed additional training hours ($n = 113$) were excluded from a secondary one-way ANOVA that included only those participants having completed additional training hours ($n = 91$). Participants included were sub-categorized based upon the number of hours spent in additional training with three new sub-categories created: 1-4 hours of additional training ($n = 12$), 5-9 hours of additional training ($n = 63$), and 10 or more hours of additional training ($n = 16$). Refer to Table 14 for the descriptive statistics.

Table 14

Descriptive Statistics for SOCCS Scores and Additional Training Hours

	M	*SD*	*N*
1-4 Training hours	2.04	.06	12
5-9 Training hours	2.12	.06	63
10+ Training hours	2.25	.03	16
Total	2.13	.08	91

SOCCS scores were found to increase amongst participants that completed 1-4 hours of additional training ($M = 2.05$, $SD = .06$), compared to those that completed 5-9 hours of additional training ($M = 2.12$, $SD = .06$), compared to those that completed 10 or more hours of additional training ($M = 2.25$, $SD = .03$). Significance between groups was found, $F(2,2) = 52.29$, $p < .001$.

Post hoc analyses using the Bonferroni post hoc criterion for significance indicated that the mean increase from 1-4 hours of additional training to 5-9 hours of additional training (-.073, 95% CI [-.12, -.03]) was statistically significant (p < .001), as well as the increase from 5-9 hours of additional training to 10 or more hours of additional training (-.13, 95% CI [-.17, -.09]) was statistically significant (p < .001). Therefore, the null hypothesis could not be rejected (see Table 15).

Table 15

One-Way Analysis of Variance of SOCCS Scores by Additional Training Hours

Model	Sum of Squares	*df*	Mean Square	*F*	Eta squared
Corrected Model	.319	2	.159	52.293*	.543
Intercept	254.081	1	254.081	83307.617	.999
Error	.268	88	.003		
Total	413.741	91			
Corrected Total	.587	90			

$N = 91$; * $p < .001$

Research Question 5, Hypothesis 5

To what extent will outcome scores on the SOCCS and KCAASS correlate to outcome scores on the CASES as a measure of self-perceived competence when presented with a clinical vignette? A one-way ANOVA was conducted to determine whether the type of clinical vignette, where sexual orientation and type of disability were manipulated, influenced outcome scores on the SOCCS. There were no significant differences between vignette versions and participants' mean SOCC scores, $F(7,196) = .424$, $p = .887$, $\eta 2 = .015$. Mean scores ranged from 2.08 to 2.11, with a total mean score of 2.09 ($SD = .07$). Refer to Table 16.

Table 16

One-Way Analysis of Variance of SOCCS Scores by Clinical Vignette

Model	Sum of Squares	*df*	Mean Square	*F*	Eta squared
Corrected Model	.016	7	.002	.424	.015
Intercept	892.170	1	892.170	166845.147	.999
Error	1.048	7	.005		
Total	893.939	204			
Corrected Total	1.064	203			

N = 204

An additional one-way ANOVA was conducted to determine whether the type of clinical vignette, where sexual orientation and type of disability were manipulated, influenced outcome scores on the KCAASS. There were no significant differences between vignette versions and participants' mean KCAASS scores, $F(7,196) = .549$, $p = .797$, $\eta_2 = .019$. Mean scores ranged from 30.28 to 32.40, with a total mean score of 31.29 (*SD* = 5.17). Refer to Table 17.

Table 17

One-Way Analysis of Variance of KCAASS Scores by Clinical Vignette

Model	Sum of Squares	*df*	Mean Square	*F*	Eta squared
Corrected Model	104.299	7	14.900	.549	.019
Intercept	199739.128	1	199739.128	.000	.974
Error	5324.054	196	27.164		
Total	205210.000	204			
Corrected Total	5428.353	203			

N = 204

A final one-way ANOVA was conducted to determine whether the type of clinical vignette, where sexual orientation and type of disability were manipulated, influenced

outcome scores on the CASES. There were no significant differences between vignette versions and participants' mean CASES scores, $F(7,196) = 1.32$, $p = .243$, $\eta^2 = .045$. Mean scores ranged from 83.23 to 95.76, with a total mean score of 87.36 ($SD = 18.51$). Refer to Table 18.

Table 18

One-Way Analysis of Variance of CASES Scores by Clinical Vignette

Model	Sum of Squares	*df*	Mean Square	*F*	Eta squared
Corrected Model	3128.069	7	446.867	1.319	.045
Intercept	1556711.599	1	1556711.599	4593.811	.959
Error	66418.808	196	338.871		
Total	1626351.000	204			
Corrected Total	69546.877	203			

N = 204

Summary

For this study, five research questions and five hypotheses were developed to explore how well-prepared rehabilitation counseling students believe themselves to be to render culturally appropriate services to LGB clients with disabilities. Statistical analyses employed included the Pearson's *r*, one-way Analysis of Variance (ANOVA), and multivariate analysis of variance (MANOVA). Based upon these analyses, there was a significant interaction found between participants' outcome scores on the SOCCS and their having completed a course in multicultural counseling. There was a significant, moderate positive relationship between participants' knowledge and clinical application of topics related to sexuality and disability, as measured by the KCAASS, and their competency to work with LGB clients based on knowledge, skills, and awareness

domains, as measured by the SOCCS. While there was no significant difference between participants' SOCCS scores when factoring for the type of program (i.e., 48- or 60-credit hour program), there was statistical significance found in the SOCCS scores of participants enrolled in a 48- or 60-credit hour program compared to participants who identified themselves as being enrolled in an "other" program. There was a significant positive relationship between participants' self-perceived competence in working with LGB clients, as measured by the SOCCS, and having completed *any* amount of additional training hours. Finally, there was no significance between outcome scores on the SOCCS, KCAASS, or CASES in relation to the version of clinical vignette participants were presented with during the survey.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This study was developed to further explore rehabilitation counseling students' level of preparedness in providing culturally appropriate clinical services to clients who identify as sexual minorities with a disability (i.e., physical or psychiatric). While previous studies have sought to examine multicultural competence in relation to working with LGB persons, these studies have almost entirely focused on students enrolled in traditional clinical mental health counseling programs or in applied psychology fields. Few studies, if any, have examined perceived multicultural competence of rehabilitation counseling students, and even fewer have seemingly examined the intersection of sexual identity and disability status.

In Chapters 1, 2, and 3, this researcher presented the research problem, a comprehensive review of the relevant literature, and the research proposal. In Chapter 4, this researcher outlined the sampling procedure, the data analyses that were used to examine the guiding research hypotheses, and the results of the study.

After examining the data, it became apparent that, similar to previous studies, there was, indeed, significance in the role that multicultural counseling coursework plays in moderating students' self-perceived competence in providing services to LGB clients. Further, the data suggested that, in addition to formal coursework in a graduate program, completion of additional hours in workshops, cultural immersion events, conferences, and training sessions also leads to higher levels of self-perceived multicultural competence. Additionally, a significant correlation was found between the outcomes

scores obtained on the SOCCS and KCAASS instruments. This suggests that as multicultural competence in working with LGB persons increases, there is a corresponding increase in the knowledge of clinical application of topics related to sexuality and disability. Therefore, the null hypotheses for these research questions were accepted.

In Chapter 5, this researcher provides an analysis of the results and limitations of the study. The results gained from this study are applicable in both academic settings, in terms of counselor preparation, and in applied clinical settings; when combined, they represent a significant contribution to positive social change. This study yields valuable data which may improve multicultural counseling curricula to better prepare rehabilitation counseling students to work with LGB clients with disabilities.

Interpretation of the Findings

In considering the existing literature on the topic of multicultural counseling with sexual minority clients, it was hypothesized that despite having completed similar multicultural counseling coursework as students enrolled in traditional clinical mental health counseling programs students enrolled in a rehabilitation counseling program may showcase a lesser degree of multicultural competence in working with LGB clients. This hypothesis was based on the disparity that exists with respect to the number of credit hours required in these programs, where clinical mental health counseling programs often require 60-credit hours and rehabilitation counseling programs often require 48-credit hours of coursework towards conferral of a degree. Whereas students enrolled in a clinical mental health counseling program might demonstrate greater multicultural

competence in working with LGB clients, given the great emphasis on working primarily with persons with disabilities, it was believed that students would demonstrate greater competence in topics related to disability. Thus, one of the overarching hypotheses was that rehabilitation counseling students would demonstrate lower levels of competence in working with LGB clients, higher levels of competence in working with persons with disabilities, but comparable levels of competence in working with LGB clients with disabilities.

To accomplish this study, several measures were employed to assess students' (a) self-perceived competence in working with LGB clients, measuring responses across the knowledge, skills, and awareness domains; (b) knowledge in relation to the clinical application of topics related to sexuality and disability; and (c) perceived self-efficacy in applying helping skills when presented with a version of a clinical vignette.

Multicultural Competence

Previous research has stressed the importance of multicultural counseling coursework in preparing students to work with diverse populations (see Bidell, 2003; Bidell, 2005; Graham, 2009; Graham, Carney, & Kluck, 2012; Jennings, 2014; Patterson, 2018; Troutman & Packer-Williams, 2014) and shown that professional training or specialized coursework, such as participating in workshops, cultural immersion events, or LGB-centric classes, positively influences self-efficacy in working with LGB persons (see Bidell, 2013; Shi & Doud, 2017; Whitman & Bidell, 2014). Consistent with these findings, the present study found a significant interaction between the self-perceived competency of students in working with LGB clients, as measured by outcome scores on

the SOCCS, and having completed a course in multicultural counseling. Additionally, when examining the interaction between outcome scores on the SOCCS and having participated in a form of training beyond multicultural counseling coursework, there was found to be significance, suggestive that participation in as few as one to four hours may positively influence competence in working with LGB clients. Combined, it is plausible that based upon previous research and the current findings, that while there may be areas of improvement warranted in multicultural counseling curricula, in terms of the content and delivery with respect to LGB-affirmative practices, these courses nevertheless do appear to positively effect student competence in working with LGB persons, and that additional training gained outside of the program, further improves students' competency.

Sexuality and Disability

Unique to this study was the combination of measures employed to explore the intersection of sexual minority and disability statuses; the SOCCS was administered to explore clinical work with LGB persons and the KCAASS was administered to explore clinical work with topics on human sexuality and disabilities. A key limitation, which will be discussed in greater detail below, was the absence of a measure specifically designed to examine students' competence with intersectionality as it relates to sexual orientation and disability status. As such, the examination of competence in addressing intersectionality relied upon examining for correlation between a students' overall performance on the SOCCS, where higher scores are suggestive of higher competence in working with LGB clients, and overall performance on the KCAASS, where higher

scores on the subscale adopted are suggestive of higher knowledge of clinical application on topics relating to disability and, more broadly, sexuality.

The Pearson's *r* that was performed to examine whether there was truly a correlation between SOCCS and KCAASS scores found that there was certainly a positive, albeit moderate correlation in scores; that is, as outcome scores on the SOCCS increased, so did outcome scores on the KCAASS. While it is difficult to definitively draw conclusions based upon a simple correlation analysis, it is plausible that completion of a multicultural counseling course, which was previously found to correspond to higher overall SOCCS scores, may impart students with sufficient multicultural competence (i.e., knowledge, skills, awareness) to address topics related to the convergence of sexuality and disability.

An underlying hypothesis to this research study was that students enrolled in a rehabilitation counseling program may demonstrate greater competency in addressing topics involving disability compared to other participants. Kelsey and Smart (2012) suggested that compared to other applied social sciences fields, rehabilitation counseling often focuses on disability as a marginalized status; therefore, it appeared only natural that whilst rehabilitation counseling students may have demonstrated limitations in addressing sexual orientation, they might have demonstrated strength in addressing the broader topics of sexuality and disability. Unfortunately, based upon the findings of this study, rehabilitation counseling students appear to have less knowledge of clinical application on topics relating to disability and, more broadly, sexuality. It is worth

mentioning that several limitations exist that may have influenced the findings of students' performance on the KCAASS, which will be reviewed in greater depth below.

Limitations of the Study

As with any research, several limitations were identified and discussed in the proposal prior to conducting the present study. Additionally, several limitations were discovered at the conclusion of the study, ranging from limitations in the research design to opportunities for improvement noted during the data analyses. Below, this researcher will present opportunities noted throughout all facets of the study to aide future researchers attempting to replicate this study or expand upon the data collected from this study.

Sample Population

Chief amongst the limitations of the current study are the inherent challenges associated with conducting research with student populations. The present study was limited to solicit participants currently enrolled in a graduate training program leading to a master's degree in rehabilitation counseling or another master's degree in counseling with a specialization in rehabilitation counseling. Given the narrow scope of this study, in terms of inclusion criteria prospective participants were required to meet in order to participate, response rates were considerably lower than one might find in a study analyzing the same constructs across a general counseling or psychology graduate student population. While perhaps adding to the professionalism of the study, though likely impacting receptiveness to participate, this researcher was limited in their ability to incentivize participation (e.g., extra credit, gift cards, etc.). Furthermore, it is worth

mentioning that the participants that did participate in the present study were likely inclined to participate in part, due to their interest in the topic being explored, potentially introducing confounding variables not evaluated in the present study; unfortunately, this is likely a limitation for many if not all voluntary research studies.

Research Design

While many of the limitations of this study centers on the population being sampled, it is believed that there were significant limitations in the design and execution of the current study. The average response completion time for the survey was 37 minutes, likely resulting in the early departure and incomplete surveys, resulting in the exclusion of 28 surveys. Unfortunately, given the complexity of the topic being examined in the current study, and the lack of measures specifically designed to assess the intersection of sexuality and disability, an effort to employ partial measures (i.e., subscales) was taken to explore counselor competency and self-efficacy in working with sexual minority clients *and* their knowledge, comfort, approach and attitudes towards sexuality (generally speaking) and disability. The inclusion of several tools undoubtedly resulted in a lengthier overall survey, dissuading some individuals from participating and likely contributing to some of those incomplete surveys that were ultimately excluded. Admittedly, this approach, while not ideal, was the only option short of developing a new measure aimed at specifically assessing competency and self-efficacy in working with sexual minorities with disabilities.

The current study was a concerted effort at gaining a better understanding of intersectionality as it relates to sexual minority and disability statuses; however, there

exists the fundamental limitation of having used inclusive grouping. Whereas this researcher took steps to minimize this limitation by purposefully excluding transgender individuals in the overall design, certain variables – multiple jeopardies – could not be sufficiently examined in the scope of a doctoral dissertation, such as racial and ethnic identity or religious background. For example, Vaughn, McEntee, Schoen, and McGrady (2015) pointed to prior research suggesting that unique disparities exist in the acceptance of lesbians with disabilities from both the disability and lesbian communities; these disparities, which are believed to be more profound compared to gay men or bisexual men or women, certainly influences social support – a key component in moderating behavioral health, potentially exacerbating the symptoms of numerous psychiatric disabilities. Further, multicultural perspectives have consistently showcased disparities that exist in not only the acceptance of sexual orientation across different racial and ethnic groups (e.g., Holley, Oh, & Thomas, 2019), but also across different religious groups (e.g., Haldeman & Rasbury, 2014).

In addition to the aforementioned structural limitations of this study, it is worth addressing one of the core components of the current study – the clinical vignettes. In the present study, participants were asked to read an exchange between a rehabilitation counselor and a client that identified as heterosexual, gay, or lesbian, and absent disability, or possessed a psychiatric or physical disability. Thereafter, participants were to respond to questions based upon what they had read in the clinical vignette. Given the technological constraints of administering a study through the survey tool Qualtrics, it is plausible that participants, unable to return to a previous screen, were unable to

completely recall or fully understand the context of the exchange between counselor and client in the clinical vignette, despite the emphasis in the instructions to “carefully read” the exchange. Additionally, it is believed that the use of a clinical vignette itself, as discovered in similar studies, may not have been as effective as an animated depiction with dialogue or video presentation of an exchange between a client and counselor.

Finally, in the context of limitations identified in the design of this study, it must be mentioned that given the expansive nature of this phenomena, several factors related to the measures employed had to be either abbreviated, opting to administer a single subscale, or modified to generalized applicability, potentially jeopardizing the study’s findings, in the interest of reducing the amount of time participants spent completing the survey, and in aligning the measures for applicability to the population under investigation (i.e., graduate students). As previously discussed, no singular measure existed at the time of this study to examine counselor competence in working with LGB clients with disabilities; however, existing measures were available to measure counselor self-efficacy in working with LGB clients (SOCCS) and competency and comfort on topics of disability and sexuality (KCAASS), presenting as a significant challenge in further exploring the premise of this study.

Whereas the SOCCS was able to be administered in its entirety, this researcher opted to administer only the helping skills subscale of the CASES and the knowledge subscale of the KCAASS; unfortunately, this limited the study in that all domains – contributing to counselor competence – were unable to be fully-explored during data analysis. Furthermore, without having the ability during a doctoral dissertation study to

reevaluate psychometric properties, such as validities or internal consistencies that could result from minor modifications to the verbiage introduced to normed instruments, it is uncertain as to how a minor modification may have influenced the reliability of the KCAASS. For example, "Changes in people's perception of their sexual identity following *spinal cord injury*" was changed to "Changes in people's perception of their sexual identity following *acquired disability*"). Whilst this slight modification undoubtedly influenced the properties of the measure, it is plausible that a threat to reliability may be minimal given spinal cord injuries are often classified more broadly as "acquired disabilities."

Scope of Data Collected

The present research study was unquestionably a time-consuming effort for participants, as evidence in the average response time, and every effort was made to ensure that as much data could be collected as possible, while attempting to control for the time investment of the participants completing the survey. In retrospect, several pieces of data, that were not collected, likely could have been collected, as this information would have been beneficial in enhancing the overall quality of this study. In the context of working with diverse populations, for example, several studies have showcased a disparity in counselor training in rural versus urban settings (see Eliason & Hughes, 2004), unique ethical implications when working with clients in rural versus urban settings (see Coduti & Luse, 2015), and limited exposure to LGB clients in rural versus urban settings (see Lee & Quam, 2013). As such, in the present study regional differences amongst participants was not collected in the demographic questionnaire and

could have benefited this study in potentially further exploring how regional settings might influence competency in working with LGB clients with disabilities.

In terms of the scope of information gathered pertaining to participants' graduate training programs, several pieces of information were not collected that would have likely contributed to gaining a better understanding of how students are being prepared to work with diverse populations, and certainly enhanced the data analyses performed. For example, few research studies have examined the differences in pedagogy and, more importantly, outcomes of students receiving multicultural counseling training in traditional face-to-face, virtual, or hybrid course delivery. Whereas Alvarez and Rodriguez (2020) found no significance in multicultural competence between students participating in multicultural counseling course in face-to-face versus virtual course delivery, there remains a dearth of research specifically analyzing this effect to draw definitive conclusions as to whether the mode of delivery influences multicultural competence. In the present study, participants were not asked whether they were completing their program face-to-face, virtually, or in a hybrid environment, and they were not asked to disclose the mode of delivery for multicultural counseling coursework.

In the present study, participants were asked to provide whether they were enrolled in a 60-credit hour clinical mental health counseling or 48-credit hour rehabilitation counseling program or permitted to endorse a broad "other" category. Occurring during the planning and implementation of this study, CORE had merged with CACREP, allowing many 48-credit hour rehabilitation programs to remain "grandfathered" for a period of time, continuing to confer degrees to students only having

completed 48-credit hours of coursework, or permitted to seek eventual CACREP accreditation by transitioning to a 60-credit hour program. (CACREP, 2016; 2017). Without having explicitly inquired what an "other" program was, beyond having a rehabilitation counseling focus, it is uncertain as to whether these participants were enrolled in a comparable applied social sciences program with an emphasis in rehabilitation, or enrolled in a rehabilitation program requiring 60-credit hours. Thus, certain conjectures put forth through this study may not be as reflective of rehabilitation counseling students' competence in, for example, addressing topics of disability and sexuality, as measured by the KCAASS, had this information been sought.

While every effort was made to recruit a population of students enrolled in programs with similar training standards, hence the recruitment of students enrolled in CORE- or CACREP-accredited programs, there nevertheless likely exists some differences in terms of the course content covered in multicultural counseling coursework and program requirements for, as either part of the program or elective coursework, successful completion of courses in human sexuality and courses focusing on LGB- and disability-centric topics. Notably, a content analysis of coursework completed by participants was unable to be completed in the present study to better understand the phenomena being researched and inform future research on this topic.

Previous research has shown that differences exist in the levels of inclusion of disability topics (see Feather & Carlson, 2018) and human sexuality topics (see McCray, 2018) in counselor training programs, and that despite many programs subscribing to accreditation standards, such as American Psychological Association or CACREP, many

programs omit or place little emphasis on LGB topics in relevant coursework (see Castro, 2017). Additionally, and while admittedly antiquated, Stebnicki and Cubero (2008) found that 55% of sampled graduate-level rehabilitation counseling programs' syllabi failed to meet CORE accreditation standards in addressing all standard multicultural counseling content, to include topics of sexual orientation. It is certainly plausible, when considering the results of studies, such as that performed by McCray, that similar findings to that of Stebnicki and Cubero may persist today.

In line with the guiding theoretical framework of this study, Bandura's (1986) social cognitive theory, research on counselors' attitudes in working with LGB clients (e.g., Alessi, Dillon, & Kim, 2015; Dillon, Worthington, Soth-McNett, & Schwartz, 2008, etc.), and perhaps to a degree several other constructs derived through social psychology, the research has consistently demonstrated a correlation between the level of exposure to a marginalized population and the formation of biases or attitudes towards that particular population. Amongst other variables, Alessi and colleagues even suggested that affirmative practices in working with LGB clients are often mediated by positive beliefs and hours spent, partly derived through exposure, training for such engagements with this population. In academia, this exposure and reflection of biases and attitudes is often explored through not only participation in formal multicultural counseling coursework, but also through cultural immersion events or activities; in real life, consistent with social cognitive theory, these factors are often influenced by familiarity or exposure to marginalized populations – social determinants – such as in the context of the

present study, by knowing a family member or friend who identifies as LGB or who has a disability.

A limitation of the present study, with respect to exposure and social determinants, could be having not collected a sufficient amount of data from participants in the demographic questionnaire. Whereas this researcher was able to capture data relevant to participation in elective courses, professional development opportunities, non-program training, conferences, and whether the participant has a family member or friend who either identifies as lesbian, gay, or bisexual, or has a disability, participation in cultural immersion events or activities was not collected, nor was the level of familiarity or other perceptions with a family member or friend able to be explored in greater detail to ascertain how these variables influence participants' ability to work with LGB clients with disabilities.

Despite the aforementioned noted limitations, it is nevertheless believed that this study was a concerted effort in further exploring and contributing to the available research on the topic of counselor competency in working with topics of intersectionality, as it applies to the convergence of sexual minority and disability statuses, warranting future exploration through a follow-up study. Future research studies are encouraged to evaluate the limitations discussed and consider techniques or approaches for overcoming such challenges.

Considerations for Future Research

First and foremost, for future studies it is recommended that further research and exploration be devoted to developing an appropriate measure to gain a better

understanding of how well-prepared counselors are to render culturally appropriate services to sexual minorities with disabilities. It is likely that with a singular measure, many of the limitations in the current study could be mitigated or negated completely (e.g., length of time of the survey, applicability of tools used, etc.).

In future studies, it would be recommended to consider separate studies assessing counselor competency and self-efficacy with lesbian, gay, and bisexual clients with disabilities, rather than pursuing a study utilizing inclusive grouping, as there are undoubtedly unique factors that warrant further exploration for lesbian women with disabilities, gay men with disabilities, and bisexual men with disabilities, and bisexual women with disabilities. For example, whereas the research has shown that sustained exposure to minority stress effects the mental health of LGB person, collectively (see Meyer, 2003), Volpp (2010) pointed to research suggesting that bisexual men and women often disclose their sexuality later, when compared to gay men or lesbian women, suggestive that these individuals may be exposed to a lesser degree of minority stress from heteronormative societies. However, Volpp argued that bisexual individuals often face internal stigma within the broader LGB community, citing assumptions that bisexual men and women are often perceived as being incapable of monogamy or promiscuous, to name a few. When considering such factors, not to mention cultural, ethnic, and disability status – multiple minority characteristics – all of which likely influences, to an unknown degree, receptiveness to participating in psychotherapy or the rehabilitation process, rehabilitation counseling students and professionals working in the field likely have disproportionate exposure and opportunities to hone their skills when working with the

broad spectrum of diversity within the LGB community, ultimately influencing their competency. Unfortunately, in the present study these variables were unable to be fully examined.

Finally, it may be beneficial for future researchers to consider utilizing different approaches to presenting participants with a clinical rendering of a psychosocial intake session, such as exploring animated or mock, recorded sessions, as opposed to the text-based clinical vignette utilized in the present study. Drawing upon a lengthy exploration of the use of vignettes and similar stimulus materials within the realm of social sciences research (e.g., Crilly et al., 2006; Merton & Kendall, 1946, Törrönen, 2002; Stacey and Vincent, 2011, etc.), Sampson and Johannessen (2020) asserted that the use of graphical depictions of information have been found to be far more effective in such research. Further, Visser and colleagues (2016), as part of a study aimed at validating the Video Engagement Scale (VES), which purports to assess participant engagement while viewing graphical vignettes, found that video vignettes were capable of eliciting empathic and emotional responses in participants correlating to greater engagement and retention of information being relayed.

Recommendations

The findings of this study yielded invaluable data that may be used and applied in both academia and in professional practice. Below are specific recommendations, guided by both the existing literature and data gleaned from this study, on methods for not only improving counselor trainee outcomes, but also opportunities for improving upon the clinical practice with LGB clients with disabilities.

Academic Applicability

The current study yielded data suggestive that despite improvements in multicultural curricula – and other subject areas relevant to this study – there remains opportunities for improving on delivery to effect positive change in student outcomes; specifically, their preparedness to address intersectionality. Whereas many of the results found in this study align with similar studies that have been previously explored (see Bidell, 2011, Bidell, 2012, Bidell, 2013, Brodwin & Orange, 2002, and Easton, 2015), several opportunities exist which might improve student counselor outcomes.

Particularly concerning in the present study was the fact that compared to clinical mental health counseling students and students enrolled in a comparable program (i.e., "other" program), rehabilitation counseling students scored significantly lower on their knowledge of clinical application on topics relating to disability and, more broadly, sexuality, as measured by the KCAASS. As this measure blended topics of disability and sexuality, it nevertheless showcased a limitation in the knowledge students believe they possess in addressing such topics, suggestive that compared to programs in clinical mental health counseling, which often require completion of a course in human sexuality, students not required to take such a course may demonstrate lower levels of competence in addressing this topic. Of note, many 48-credit hour rehabilitation programs do not require a dedicated course with a focus on human sexuality. As such, it may be beneficial to consider infusing, where appropriate, coursework on disability and sexuality, and even considering requiring students to have completed a course in human sexuality prior to degree conferral.

Differing from traditional, academic coursework, Evans, Forney, Guido, Patton, and Renn (2010) described experiential coursework or training as an approach that promotes a student's ownership of learning through reflection, idea development, assimilation, and promotion through engagement. Such training is believed to merge self-awareness through learning, allowing students to hone their acquisition of knowledge, and provides for the occasion for students to reflect on the attainment of such knowledge in practical application (Kolb, 1984). Killian, Farago, and Peters (2019) argued that while there has been an increased focus on improving LGB competence training and practice, much of the current research continues to showcase a failure in addressing intersectionality, multiplicity of identity, and socioecological perspective, in part due to emphasis on didactic learning in counselor education programs.

In the present study, 44% ($n = 91$) participants endorsed having completed elective courses, professional development, non-program training, or conferences, all forms of experiential work aimed at bolstering skills and competency, as part of their professional growth in working with diverse populations. Given the complexity of acquisition and harnessing skills towards effectively working with LGB clients with disabilities, both in terms of multiplicity and intersectionality with this population, it goes without saying that a single, predominately didactic approach to teaching such multicultural competencies could result in students reporting lower degrees of comfort, skills, and abilities in working with more than one minority status.

Based upon the findings of this study, it is plausible that in addition to the need for greater emphasis towards experiential training opportunities in counselor education

programs, that the scope of counselor supervision may need to be reevaluated, as the breadth and depth of clinical supervision may moderate student outcomes. Falender, Shafranske, and Ofek (2014) perhaps so eloquently summarized the importance of clinical supervision by describing it as not only being a means of protecting client receiving services from students and unlicensed clinicians, but also an essential function in enhancing the professional development of the supervisee.

Similar to the challenges associated with providing sufficient supervision to student counselors, the availability and quality of consultation opportunities may warrant some further exploration in future studies. Moe, Perea-Diltz, and Sparkman-Key (2019) described consultations, in the context of multicultural counseling with LGB clients, as being a form of intervention used to share or impart expertise in LGB issues. In their study, Moe and colleagues explored whether the capability to provide consultations correlated to competency in knowledge, awareness, and skills in working with LGB clients, finding a significant predictive relationship between counseling competence and the availability and quality of consultation opportunities.

It is also worth exploring the role of personal attributes of student counselors, such as level of religiosity and their spiritual beliefs, as mediating or moderating factors contributing to challenges in preparing students to effectively work with sexual minority clients. For example, expanding upon his initial exploration in understanding general factors influencing LGB competence in student counselors, Bidell (2014) honed his exploration on this topic to focus on how the religious views and conservative political beliefs of student counselors influence LGB competence. Bidell's findings suggested that

conservative religious views and political beliefs were indeed inversely related to LGB competence.

Applied Clinical Implications

Given the disproportionate rate of disability amongst LGB persons, the likelihood of encountering a client that identifies as both LGB and as a person with a disability is almost certain over the course of a counseling career. The present study found limitations in rehabilitation counseling students' competence in addressing topics of intersectionality, when evaluated collectively, and when applied to professionals in the field, are suggestive that clinicians in practice may possess limitations in preparation to provide culturally appropriate services to LGB persons with disabilities.

As a profession devoted almost exclusively to working with persons with disabilities in achieving greater inclusiveness in society, it is incumbent upon rehabilitation counseling professionals to possess certain competencies in achieving the goals of their clients. Research has emphasized the importance of the therapeutic alliance in meeting not only short-term treatment goals, but also long-term goals in improving a client's functioning (e.g., Bordin, 1994; Gonzalez, Barden, Sharp, 2018; Matrone & Leahy, 2005). While the therapeutic alliance has been found to be a complex relationship established between client and counselor, involving client- and clinician-related variables, Anderson, Bautista, and Hope (2019) outlined clinician-related variables that are within the clinicians' locus of control that may contribute to the development of a working alliance: experience, training level, and multicultural competence.

Drawing upon the results of the current study, a mere 12.3% of students and 15.7% of students acknowledged having worked with a gay or lesbian client, respectively; significance was found in competence levels of students whom had completed a multicultural counseling course; and, significance was found in competence levels of students whom had received additional training hours. When evaluated collectively, these data are not only suggestive of areas likely warranting some improvement – primarily in terms of exposure leading to experience in working with LGB clients with disabilities – but also highlight the importance of multicultural counseling coursework and additional training on topics related to LGB- or disability-centric issues; all of these factors potentially moderating the therapeutic alliance.

In applied clinical settings, these data are not only suggestive of the importance of quality education in rehabilitation counseling, but also suggestive that newer or more seasoned clinicians, who perhaps have not received formal or informal training preparing them to work with diverse clients, may not be as prepared to not only work with LGB clients with disabilities, but also may be at a disadvantage in their ability to build a strong therapeutic alliance with their clients. This is particularly concerning in that certain settings that rehabilitation counselors may be employed do not require a degree (undergraduate or graduate) in rehabilitation counseling as a requirement for employment, such as is the case in many state agencies. Compared to those professionals working in rehabilitation counseling settings not possessing education in rehabilitation counseling, Mackay and colleagues (2020) found that counselors possessing education in rehabilitation counseling demonstrated higher positive case outcomes for their clients, in

relation to the quality of job placement and salary, to include clients with more-severe qualifying disabilities.

The implications of poor preparation and likelihood that professionals are currently working in the field of rehabilitation counseling without sufficient education or continuing education, likely warrants further exploration by not only clinicians in the field, but employers and certification boards, such as the Commission on Rehabilitation Counselor Certification (CRCC), in terms of reevaluating the educational requirements for employment in public settings (i.e., federal and state rehabilitation agencies) to the standards required for professional certification. In the interim, based upon the findings of the present study, for those currently working in the field, it may be beneficial not only for the clinician but also in the best interest of the client those clinicians not possessing degrees in rehabilitation counseling or specialized training, pursue such education or training, or at the very minimum, consider completing core coursework leading to greater knowledge.

Additionally, it may be beneficial for currently practicing professionals to consider these findings in tailoring their field supervision of counselor trainees participating in practicum or internship experiences at their site and under their supervision. As previously discussed, the data revealed limitations noted in the exposure to this population that students receive while completing experiential coursework and emphasizing encouraging the importance of additional training opportunities and encouraging participations towards honing students' competence in working with LGB clients with disabilities.

Social Change

In recognizing that rehabilitation counselors, by the very nature of having a professional focus on working with persons with disabilities, have served in a profession that is already on the "front line" of navigating topics of intersectionality, whether it be ethnicity and disability or sexual orientation and disability as forms of presenting multiple jeopardies, studies such as the present offer opportunities to further hone the skills necessary to not only work with LGB clients with disabilities, but also opportunities to help their clients achieve what McAllan and Ditillo (1994) so eloquently summarized as, "personal empowerment, and full and equal participation in society…" (p. 26).

The findings of this study contributes not only towards bolstering the dearth of scholarly contributions on the broader topic of multicultural counseling competence, specific to the field of rehabilitation counseling, but also presents findings that are relevant to both academia and the professional practice, aimed at ensuring that both students enrolled in rehabilitation counseling programs and professionals in the field are sufficiently prepared to address multicultural topics as it relates to sexual orientation and disability status. Chief amongst the findings of this study are the importance of multicultural counseling coursework and professional engagement of students, in terms of seeking and acquiring knowledge through additional training opportunities outside of the program requirements, in preparing students to become practicing professionals with sufficient competencies to work with topics involving the intersection of two minority statues.

Conclusions

It is the sincere hope of this researcher that the field of rehabilitation counseling continues to evolve and strive towards helping all persons with disabilities achieve personal empowerment and full and equal participation in society, by ensuring students possess the skills, knowledge, and awareness necessary to form rapport with clients and effect positive social change by challenging self-imposed professional boundaries, reducing stigma, and advocating for minorities and marginalized groups.

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Appendix A: Recruitment E-mail

Dear Program Director:

My name is Sean Meyer, and I am a doctoral candidate in psychology at Walden University. I am soliciting your assistance for participants for my dissertation study, by asking that you consider forwarding this email to your students:

I am conducting a study which seeks to understand how multicultural counseling curricula influences self-efficacy and competency. This is an important issue which has received very little attention in the empirical literature. It is my hope that your participation will contribute to the development of quality multicultural counseling coursework to enhance rehabilitation counseling students' training. Please share this e-mail with others who may be interested in participating.

Should you decide to participate in this study, you will be asked to complete a set of questionnaires online. It is estimated that participation requires 15-25 minutes.

Participation is completely confidential and voluntary. Participants are considered eligible if they (a) are currently enrolled in a graduate training program leading to a degree or emphasis in rehabilitation counseling, (b) have completed either a practicum or internship experience, (c) are able to read English, and (d) have access to a computer and internet access.

Students who wish to participate can click on the link below (or cut and paste into a web browser) and proceed to the informed consent page. This study has been approved by the Institutional Review Board at Walden University.

INSERT LINK HERE

Remember, participation is voluntary. It is anticipated that this study will be completed by December 2019 and published shortly thereafter. All are encouraged to search for this author in the ProQuest Dissertation and Theses database to review the results of this study. If you would like a copy of this summary, more information, or have any questions about the study, please feel free to contact me through electronic mail.

Professionally,

Sean P. Meyer, MS, BHA, LMHC
Doctoral Candidate, Psychology
Walden University

Appendix B: Demographics and Experience Questionnaire

1. What is your gender?

○ Male ○ Female ○ Gender Non-Binary

2. What is your age? _____

3. What is your ethnicity?

○ African American ○ Asian American ○ European American / European American ○ Hispanic / Latino ○ Native American ○ Other _____

4. What is your religious affiliation?

○ Agnostic ○ Atheist ○ Baptist ○ Buddhist ○ Catholic ○ Christian Non-Denominational ○ Jehovah's Witness ○ Jewish ○ Mormon ○ Muslim ○ Protestant ○ Other _____

5. How do you define your sexual orientation?

○ Heterosexual ○ Gay ○ Lesbian ○ Bisexual ○ Other _____

6. Do you have a friend or family member who identifies as lesbian, gay, or bisexual?

○ Yes ○ No

7. Do you have a friend or family member who has a disability?

○ Yes ○ No

8. What is your graduate program specialty?

○ Clinical Mental Health Counseling ○ Rehabilitation Counseling ○ Other _____

9. At what stage in your program would you consider yourself?

○ First year ○ Second year ○ Third year ○ Other _____

10. Have you completed:

○ A single practicum experience ○ A single internship experience ○ Both of the above

○ None of the above

11. Have you completed at least a single course in multicultural/cross-cultural counseling?

○ Yes ○ No

12. Have you participated in any elective courses, professional development, non-program training, or conferences that have discussed the intersectionality of sexuality and disability status?

○ Yes ○ No

13. If you answered “yes” to question 11, approximately how many contact hours: _____

Appendix C: Clinical Vignette Script

Directions:

Imagine yourself working as a rehabilitation counselor at your local division of vocational rehabilitation. Carefully read and examine the following case illustration, so that you can provide adequate services to this client. Take your time, as a good understanding of your client's presentation is important to the delivery of your services.

Scenario:

Shortly before meeting with a new client that has been added to your case load, you reviewed the client's preliminary intake paperwork, and noted that the client identified as LESBIAN, GAY MALE, HETEROSEXUAL FEMALE, or HETEROSEXUAL MALE. She/He comes to the session and advises that she/he has brought along her/his wife/husband of three-years for support. During the intake session, she/he tells you that she/he had a strong partnership with her/his wife/husband, though it has been challenging since the onset of her/his disability. She/he described a once vibrant and diverse sex life, but since the onset of her/his disability, intercourse with her/his wife/husband has been unsatisfying, further contributing to the strained relationship.

She/he completed high school and has no desire to ever return to school. Prior to the onset of her/his PHYSICAL or PSYCHIATRIC disability, she/he stated that she/he was employed by a construction company where she/he was an electrician. Her/his doctor has told her/him that she will never be able to return to her/his former work, and that she/he would have to find work that was considerably lighter. She/he described her/his favorite leisure activity, prior to acquiring a disability, as spending time with her/his wife/husband

at the local gay bar/bar. Towards the end of the session, her/his wife/husband added that not being able to go back into the field of construction, and the potential loss of household income from this skilled trade, is “very disappointing.”

Appendix D: Helping Skills Self-Efficacy Scale of the Counselor Activity Self-Efficacy Scales

Part I Instructions: Please indicate how confident you are in your ability to use each of the following helping skills effectively, in counseling <u>this</u> client.

No Confidence At All			Some Confidence				Complete Confidence		
0	1	2	3	4	5	6	7	8	9

How confident ae you that you could use these general skills effectively with this client?

1. Attending (orient yourself physically toward the client).

2. Listening (capture and understand the messages that the client communicates).

3. Restatements (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear).

4. Open Questions (ask questions that help clients to clarify or explore their thoughts or feelings).

5. Reflection of Feelings (repeat or rephrase the client's statements with an emphasis on his or her feelings).

6. Self-Disclosure for Exploration (reveal personal information about your history, credentials, or feelings).

7. Intentional Silence (use silence to allow clients to get in touch with their thoughts or feelings).

8. Challenges (point out discrepancies, contradictions, defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change).

9. Interpretations (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behavior, thoughts, or feelings).

10. Self-Disclosure for Insight (disclose past experiences in which you gained some personal insight).

11. Immediacy (disclose immediate feelings you have about the client, the therapeutic relationship, or yourself in relation to the client).

12. Information-Giving (teach or provide the client with data, opinions, facts, resources, or answers to questions).

13. Direct Guidance (give the client suggestions, directives, or advice that imply actions for the client to take).

14. Role Play and Behavioral Rehearsal (assist the client to role-play or rehearse behaviors in-session).

15. Homework (develop and prescribe therapeutic assignments for clients to try out between sessions).

Appendix E: Approval to Use/Modify Counselor Activity Self-Efficacy Scales

From: Robert W. Lent
Sent: Thursday, May 4, 2017 12:18 PM
To: Sean Meyer
Subject: Re: Request Access to CASES

Here you go.

Best wishes,

Bob Lent, Ph.D.
Professor, Counseling Psychology
Department of Counseling, Higher Education, & Special Education

On Thu, May 4, 2017 at 10:45 AM, Sean Meyer wrote:

Good afternoon, Dr. Lent:

I am a doctoral student at Walden University, and am currently working on my dissertation which seeks to explore counselor competence in rendering culturally appropriate services to sexual minority clients with disabilities (intersectionality). I stumbled across an abbreviated version of the CASES, and was wondering if you could share the full measure with me, as I am interested in possibly using this in my study?

Respectfully,
Sean

Sean P. Meyer, MS, BHA
Doctoral Student, Psychology
Walden University

Appendix F: Sexual Orientation Counselor Competency Scale

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

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

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

2. The lifestyle of a LGB client is unnatural or immoral. (*R*)

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

4. I have experienced counseling gay male clients.

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

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

7. I have experience counseling lesbian or gay couples.

8. I have experience counseling lesbian clients.

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

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

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

12. I have been to in-services, conference sessions, or workshops, which focused on LGB issues in psychology.

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

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

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

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

17. It would be best if my clients viewed a heterosexual lifestyle as ideal. (*R*)

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

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

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

21. I think that my clients should accept some degree of conformity to traditional sexual roles. (*R*)

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

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

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

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

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

27. Personally, I think homosexuality is a mental disorder or a sine and can be treated through counseling or spiritual help. (*R*)

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

29. When it comes to homosexuality, I agree with the statement: "You should love the sinner but hate or condemn the sin". (*R*)

Note: *R* = Item reverse scored.

Appendix G: Approval to Use Sexual Orientation Counselor Competency Scale

Hi Sean,

Thanks for checking with me about using the SOCCS for your dissertation. The scale is published so you are free to use it as long, of course, as you appropriately reference Dr. McGeorge and I as well as Dr. Bidell who developed the original version of the scale.

Best of luck with your study.

Tom

Tom Stone Carlson, Ph.D.
Professor, Human Development & Family Science

From: Sean Meyer
Date: Wednesday, October 10, 2018 at 9:37 AM
To: "Carlson, Thomas"
Subject: Request: Permission to use modified SOCCS in Doctoral Dissertation

Good afternoon, Dr. Carlson:

My name is Sean Meyer, and I am a doctoral student at Walden University preparing to complete my doctoral dissertation. My study aims to explore the role multicultural counseling curricula has on the self-efficacy/competency of rehabilitation counseling students in rendering culturally appropriate services to lesbian, gay, and bisexual individuals with physical or psychiatric disabilities. To accomplish this feat, I was hoping to gain your approval to use your modified version of the Sexual Orientation Counselor Competency Scale (SOCCS). Should you be interested in reviewing my results, I would be glad to furnish you with a copy. Your approval would be greatly appreciated.

Cordially,

Sean

Sean P. Meyer, MS, BHA
Doctoral Student, Psychology
Walden University

Appendix H: Knowledge Subscale of the Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale

On a scale of 1-4, please indicate your current level of knowledge in dealing with the following topics as they relate to people with disability.

	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
Sexual anatomy and physiology	1	2	3	4
Sexual positioning	1	2	3	4
Care of bladder and bowel during sexual activity	1	2	3	4
Assistive devices and medications for achieving erections	1	2	3	4
Fertility procedures	1	2	3	4
Male and female contraception	1	2	3	4
Teenage sexuality issues	1	2	3	4
Dealing with people of another sexual preference different from your own	1	2	3	4
Changes in people's perception of their sexual identity following *acquired disability* (self-esteem, body image, and sexuality)	1	2	3	4
Courtship and dating	1	2	3	4
Communication in relationships	1	2	3	4
Managing inappropriate behaviours	1	2	3	4
Methods of sexuality counselling	1	2	3	4
Professional issues in dealing with sexuality rehabilitation	1	2	3	4

Appendix I: Approval to Use/Modify Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale

From: Melissa Kendall
Sent: Sunday, May 21, 2017 10:20 PM
To: Sean Meyer
Subject: RE: Permission to Use/Modify KCAASS

Dear Sean

I apologise for my delay in responding. I have been on extended leave. I am happy for you to use/modify the KCAASS for your own purposes. We just request that you appropriately reference the original source in your dissertation. Good luck with your doctorate and we would be interested to hear the results.

Regards

Melissa

From: Sean Meyer
Sent: Saturday, 15 April 2017 4:04 AM
To: Melissa Kendall
Subject: Permission to Use/Modify KCAASS

Good afternoon, Ms. Kendall:

My name is Sean Meyer, and I am a doctoral-level psychology student currently working on completing my dissertation on intersectionality, as it relates to sexuality and disability statuses. My research objective is to gain a better understanding of how prepared rehabilitation counselors are to render competent services to lesbian, gay, and bisexual clients with disabilities.

I was hoping to gain your permission to use the Knowledge, Comfort, Approach, and Attitudes Towards Sexuality Scale in my study, and if granted permission, was hoping that you would permit me to modify the scale to omit references to spinal cord injury?

Your consideration would be greatly appreciated.

Respectfully,

Sean P. Meyer, MS, BHA
Doctoral Student, Psychology
Walden University

Appendix J: Social Desirability Scale

Note:

Copyrighted instrument; omitted from this publication.

Please contact copyright owner to obtain a copy.

Appendix K: Approval to Use Social Desirability Scale

Approved.

Sent from my mobile phone

On 9 Oct 2018 5:49 p.m., Sean Meyer wrote:

Good afternoon, Dr. Stöber:

My name is Sean Meyer, and I am a doctoral student at Walden University preparing to complete my doctoral dissertation. My study aims to explore the role multicultural counseling curricula has on the self-efficacy/competency of rehabilitation counseling students in rendering culturally appropriate services to lesbian, gay, and bisexual individuals with physical or psychiatric disabilities. To accomplish this feat, I was hoping to gain your approval to use the SDS-17 as part of my study. Should you be interested in reviewing my results, I would be glad to furnish you with a copy. Your approval would be greatly appreciated.

Cordially,

Sean

Sean P. Meyer, MS, BHA
Doctoral Student, Psychology
Walden University