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Walden University

College of Social and Behavioral Sciences

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Thomas J. Hegblom

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Walden University
2021

Abstract

Counselor-in-Training Self-Efficacy When Working With Transgender and Gender Non-Conforming Clients

by

Thomas J. Hegblom

MA, Hazelden Betty Ford Graduate School of Addiction Studies, 2017

BA, University of Minnesota, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

August 2021

Abstract

Researchers highlighted a significant void in existing literature surrounding the preparation of counselors working with the transgender and gender non-conforming (TGNC) population. The problem addressed is the limited understanding of self-efficacy counselors-in-training (CIT) possess while working with TGNC clients. The purpose of this quantitative study rooted in self-efficacy theory was to examine the relationship between three independent variables: (a) the cumulative time the participant spent as a CIT, (b) the amount of training the CIT received specific to transcompetent counseling practices, and (c) a CIT's competency in delivering transcompetent counseling, and the dependent variable: a CIT's self-efficacy in providing transcompetent counseling. Data collection occurred using survey research and convenience sampling. Participants completed a demographic questionnaire, the Transgender and Gender Non-Conforming Affirmative Counseling Self-Efficacy Scale – Short Form, and the Gender Identity Counselor Competency Scale – Revised. Statistical models used included analysis of variance, simple linear regression, Pearson product-moment correlation, and multiple regression. Results indicated statistically significant relationships between time spent as a CIT, amount of transcompetent training received, a CIT's competency in delivering transcompetent counseling, and the CIT's self-efficacy in providing transcompetent counseling. Implications might lead counselor educators and supervisors to expand and refine educational and training opportunities for CITs to identify additional avenues to developing competence working with TGNC clients, leading to an increase of self-efficacy while serving the TGNC population in clinical settings.

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Dedication

To the marginalized, disenfranchised, oppressed, and suffering. It gets better.

Acknowledgements

I owe an immense amount of gratitude to my chairperson, Dr. Melinda Haley. Dr. Haley, thank you for supporting and encouraging me in this program from the first day of classes as a novice doctoral student to the very end of this dissertation process. I could not have done this without your support. I sincerely appreciate it. Dr. Suzie Dukic, thank you for your sage wisdom, suggestions, and encouragement as I worked to develop and refine my ability to use a quantitative research method. I also want to acknowledge Dr. Rebecca Cowan, the university research reviewer selected to be a part of my process. Thank you for taking the time to review my work and offer thoughts and suggestions. Additionally, to the rest of the faculty in the Counselor Education and Supervision program, thank you for helping a small dream become a huge reality. You all are amazing people.

To my partner, Zac, thank you for the many, many, many sacrifices you made so I could pursue this degree. Thank you for standing by my side every step of this journey and for smiling and nodding when I would talk incessantly about coursework, research questions, theoretical frameworks, and statistical models. I know it was not always easy when I needed to adjust schedules and not partake in the things we enjoyed doing to write discussion posts and papers, work late during internship, and lock myself in my office so I could finish this work. It’s finally over!

To my parents, John and Teri, the two people in this world with the most drive and ambition to set high goals and fight their way to achieve and accomplish them, thank you. You both have always been incredible examples for me and you are the reason I am

in the place I am today. Thank you for pushing me, encouraging me, supporting me, and believing in me.

To my classmates and colleagues, past and present, thank you for encouraging me and creating space for me to celebrate victories and release stress. Finally, a very special shoutout to Ariel Hernandez, my doctoral battle buddy from day one. We did it!

Table of Contents

List of Tables v

Chapter 1: Introduction to the Study..........1

Background..........4

Problem Statement..........6

Purpose of the Study..........7

Research Questions and Hypotheses..........7

Theoretical Framework..........10

Nature of the Study..........11

Definitions..........13

Assumptions..........15

Scope and Delimitations..........17

Limitations..........18

Significance..........20

Summary..........21

Chapter 2: Literature Review..........23

Literature Search Strategy..........25

Research Databases and Scholarly Resources..........26

Search Techniques and Strategies..........26

Theoretical Framework..........27

Self-Efficacy Theory..........27

Literature Review..........33

Counseling and Multicultural Competence 34

Counseling Transgender and Gender Non-Conforming Clients.......................... 39

Counselor Self-Efficacy 50

Counselor Development.. 57

Summary and Conclusions 58

Chapter 3: Research Method...60

Research Design and Rationale 60

Methodology 63

Population 63

Sampling and Sampling Procedures 65

Procedures for Recruitment, Participation, and Data Collection 67

Instrumentation 70

Operationalization of Constructs 81

Data Analysis Plan 83

Threats to Validity 90

Ethical Procedures 92

Summary 94

Chapter 4: Results 96

Data Collection 99

Results 104

Descriptive Statistics.. 104

Time Spent as a CIT (Independent Variable 1) 104

Transcompetent Counseling Training (Independent Variable 2)........................ 105
Counselor-in-Training's Competency While Working with TGNC Clients (Independent Variable 3) 106
Self-Efficacy of a CIT Working with TGNC Clients (Dependent Variable) 107
Research Question 1 109
Research Question 2 112
Research Question 3 115
Research Question 4 117
Summary 118
Chapter 5: Discussion, Conclusions, and Recommendations 121
Interpretation of the Findings 122
Research Question 1 122
Research Question 2 123
Research Question 3 124
Research Question 4 125
Self-Efficacy Theory 127
Limitations of the Study 128
Recommendations 130
Implications 132
Conclusion 135
References 137
Appendix A: Demographic Questionnaire 156

Appendix B: Permission to Use and Alter Lesbian, Gay, and Bisexual Affirmative

Counseling Self-Efficacy Inventory – Short Form 158

Appendix C: Permission to Use and Alter Sexual Orientation Counselor

Competency Scale...160

Appendix D: Permission to Use the Gender Identity Counselor Competency Scale

-Revised 162

List of Tables

Table 1. Frequency Distribution of Respondents by Gender 102

Table 2. Frequency Distribution of Respondents by Race and Ethnicity 102

Table 3. Frequency Distribution of Respondents by Age 103

Table 4. Frequency Distribution of Respondents by Sexual Orientation 103

Table 5. Frequency Distribution of Respondents by Approximate Hours of Counseling Experience 105

Table 6. Frequency Distribution of Respondents by Approximate Hours of Transgender and Gender Non-Conforming Counseling Training Received 106

Table 7. GICCS-R Mean Score 107

Table 8. GICCS-R Distribution 107

Table 9. TGNC-CSI-SF Total Score 108

Table 10. TGNC-CSI-SF Distribution 108

Table 11. Hours of Counseling Experience and TGNC-CSI-SF One-Way ANOVA 111

Table 12. Games-Howell Multiple Comparisons Post Hoc Tests 111

Table 13. Hours of Transcompetent Training and TGNC-CSI-SF Total Score One-Way ANOVA 114

Table 14. Games-Howell Multiple Comparisons Post Hoc Tests 114

Table 15. Multiple Regression Results for TGNC-CSI-SF Total Score 118

Chapter 1: Introduction to the Study

The American Counseling Association (ACA; 2014) asserted in its *Code of Ethics* that counselors must attend to multicultural considerations and demonstrate multicultural competence when working with clients from diverse backgrounds. Similarly, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP; 2016) highlighted the importance of multicultural competence in counseling settings in its standards. Multicultural competence in a counseling setting includes possessing the awareness, knowledge, and skills that will allow a counselor to effectively work with diverse clients (Henriksen & Trusty, 2005; Sue et al., 2019). Counselor education coursework focusing on multicultural competence generally includes components involving cultural implications for working with lesbian, gay, bisexual, and transgender (LGBT) clients; however, little exploration regarding the specific needs of transgender and gender non-conforming (TGNC) clients in counseling settings and counselor competency and preparedness is available in existing literature (Gates & Sniatecki, 2016; Weir & Piquette, 2018).

Because of this study's focus on TGNC clients, it is important to note the distinction between gender identity and sexual orientation at the onset of this study. Although gender and sex are often used simultaneously in everyday language, the distinctions between the two are significant. Sexual orientation refers to the sex of a romantic, emotional, or sexual partner a person prefers (Roselli, 2018). In contrast, gender identity is a social construct and refers to a person's internal process of identifying as a male, female, or something else. A person's gender identity can be the same or

different from their physical sex (Roselli, 2018). A person who is transgender finds incongruence with their gender identity and the biological sex they were assigned at birth (Green & Maurer, 2015). A person who is gender non-conforming expresses their gender in a manner that is inconsistent with cultural norms for that gender (Green & Maurer, 2015). For this study, I focused on individuals who were transgender, gender non-conforming, or both as I measured self-efficacy of counselors in training (CITs) working with this population.

Often, clinical implications for working with TGNC individuals are associated with counseling members of the LGB community, despite much of the literature discussing implications lacking specific implications related to TGNC counseling (Watson et al., 2018). Although people who are TGNC are often associated within the LGB community, the lived experiences of TGNC individuals differ immensely from people who are LGB because of different internal and societal experiences (McCullough et al., 2017). Problematic experiences of people who are TGNC in counseling include implicit discrimination, transphobia, genderism, awareness of insufficient TGNC-specific training, and a lack of counseling strategies designed for gender diverse individuals (Campbell & Arkles, 2017; Couture, 2017; Gates & Sniatecki, 2016; Holt et al., 2019; McCullough et al., 2017; Mizock & Lundquist, 2016; O'Hara et al., 2013; Weir & Piquette, 2018).

Counseling professionals continue to work actively to improve the experiences of TGNC clients in counseling; however, much remains unfinished. TGNC clients experience in counseling: (a) lack of respect for client identity, (b) lack of counselor

competency, (c) saliency of identity, and (d) gatekeeping (Morris et al., 2020). Additionally, TGNC clients experience microaggressions such as misgendering, sexualization, exoticization, denial of identity, and minimization of problems, among others (Morris et al., 2020). However, there is a significant void in counseling literature surrounding clients who identify as TGNC in clinical settings, including counselor self-efficacy working with this population (O'Hara et al., 2013). The need for understanding current levels of counselor self-efficacy working with TGNC clients remains despite nearly two decades of work promoting an increase of competence and skills working with TGNC individuals in counseling settings (Carroll & Gilroy, 2002; Morris et al., 2020; O'Hara et al., 2013).

Results from this study, although preliminary, provide additional insight into the current levels of self-efficacy CITs have when working with TGNC clients based on time spent in clinical practice, training received, and transcompetent counseling competency. Results from this study and awareness of how these factors contribute to CIT self-efficacy can help counselor educators and supervisors promote engagement in training and for emerging counselors to improve the experiences of their future clients who identify as TGNC. Additionally, this study can serve as a catalyst for future research to better understand specific contributing factors that lead to an increase in counselor self-efficacy when working with TGNC clients.

In this chapter, I begin by describing the background that helped solidify my topic of interest. I then further extrapolate on the problem and purpose of this study while sharing my research questions and hypotheses. I discuss my chosen theoretical

framework, the nature of the study, definition of key terms, assumptions, scope and delimitations, and limitations. I conclude this chapter by highlighting the significance and possible implications for social change as a result of this study.

Background

The issue that prompted me to search the literature is the curriculum in counselor education programs that teaches the integration of multiculturally competent approaches to clinical intervention, which often focus on the needs of clients who identify as LGB (O'Hara et al., 2013). Despite the need for integrating social and cultural diversity within counselor education programs (CACREP, 2016), researchers exploring mental health clinicians' confidence in working with TGNC clients have found a significant amount of transphobia, genderism, TGNC microaggressions, and implicit biases demonstrated by clinicians in professional practice (McCullough et al., 2017). Examples of these experiences include negative attitudes, beliefs, or reactions toward TGNC individuals; small acts of hostility toward TGNC people, whether intentional or unintentional; and the cultural belief that gender is binary and that only two genders exist (Green & Maurer, 2015). In a seminal article, Carroll and Gilroy (2002) asserted the need for a more profound and proficient approach to working with TGNC clients that affirms the diversity and subjective worldview of all individuals, including those who identify as TGNC.

Despite this claim for a better TGNC client approach nearly two decades ago, there is persistent discrimination against TGNC individuals within the LGBT community, including an increased risk for violence and discrimination; an increase of depression, anxiety, suicidal ideation and attempts, and other mental health issues; and homelessness

and difficulty finding supportive housing (Weir & Piquette, 2018). The isolation of TGNC clients from family, friends, and society; the presence of transphobia in both counseling and societal settings; and limited training and support for those working with TGNC clients contribute to little confidence in a clinician's ability to provide transcompetent clinical intervention (Gates & Sniatecki, 2016).

A fair amount of research exists that identifies the connection between time spent in clinical practice, training, and counselor competence and counselor self-efficacy (Kull et al., 2018; Lent et al., 2009). Additionally, extensive research on counselor self-efficacy working with LGB clients has demonstrated the importance of clinical supervision, training, and LGB competencies related to counselor self-efficacy while working with LGB clients (Bidell, 2005; Dillon & Worthington, 2003; Dillon et al., 2015). But the exclusion of measures and training related to TGNC individuals from previous research prompted me to explore research relating to counselor and CIT self-efficacy while working with TGNC clients. However, after an extensive literature search, I could not find any relevant research on CIT self-efficacy working with TGNC clients (Couture, 2017; Gates & Sniatecki, 2016; O'Hara et al., 2013). Most literature focusing on counseling with TGNC clients surrounds counselor competency (Carroll & Gilroy, 2002; Couture, 2017; Gates & Sniatecki, 2016; Killian et al., 2019; McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020; O'Hara et al., 2013; Weir & Piquette, 2018). Although counselor competency working with TGNC clients is important, understanding the belief in a counselor's ability to implement TGNC-specific counseling strategies is equally important (Lent et al., 2009; Morris et al., 2020; O'Hara et al., 2013).

Problem Statement

Although researchers have investigated counselors' competencies when working with TGNC clients, there is a significant void in the counseling literature surrounding the preparation and self-efficacy of CITs working with TGNC clients (Couture, 2017; Gates & Sniatecki, 2016; O'Hara et al., 2013). There is a need for further understanding of additional contributors to the self-efficacy of counselors working with TGNC clients (Couture, 2017). Researchers previously explored contributing factors, such as clinical supervision, training, and cultural competence and counselor self-efficacy while working with LGB clients; however, researchers have yet to include TGNC clients in this type of research (Bidell, 2005; Bidell, 2012; Dillon & Worthington, 2003; Dillon et al., 2015). The preparedness and self-efficacy of counselors working with TGNC individuals needs to be researched and understood to promote better experiences of TGNC clients in counseling settings (Gates & Sniatecki, 2016).

The specific research problem that I addressed through this study is that CITs possess limited self-efficacy while working with TGNC clients, which contributes to increased counselor transphobia, microaggressions, and implicit biases towards TGNC clients within the counseling field (Gates & Sniatecki, 2016). These issues also contribute to TGNC clients experiencing stigmatization by counselors, having the burden of educating mental health professionals on TGNC-related issues, and an over-assertion of power by counselors (Mizock & Lundquist, 2016). Researchers' and counselor educators' further understanding of CIT's perception of their ability to provide transcompetent counseling based on training, time spent in the counseling field, and counselor

competence when working with TGNC clients is needed to reduce transphobia, TGNC microaggressions, genderism, and burden of educating counselors on TGNC issues in clinical settings.

Purpose of the Study

My purpose for this quantitative study was to examine the relationship between CITs' perceived self-efficacy in providing transcompetent counseling services, CITs' perceived competency in delivering transcompetent counseling, the cumulative time the participant spent as a CIT working with both cisgender and TGNC clients, and the amount of training CITs received specific to transcompetent counseling practices. This study could help fill the gap in the literature surrounding self-efficacy of CIT working with TGNC clients (Couture, 2017; Gates & Sniatecki, 2016; O'Hara et al., 2013). Understanding a CITs self-efficacy when working with TGNC clients could lead to a more profound knowledge base of developing and refining counselor education and training programs as those programs work to prepare counselors to assist TGNC clients (Carroll & Gilroy, 2002).

Research Questions and Hypotheses

I investigated several research questions and hypotheses in this study.

Research Question 1: Does a CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC Affirmative Counseling Self-Efficacy Inventory–Short Form (TGNC-CSI-SF; Dillon & Worthington, 2003; Dillon et al., 2015), increase with the accumulation of the participant's pre-graduation, post-graduation and

pre-licensure supervised clinical practice hours as measured by respondent self-report on the demographic questionnaire.

H_a1: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does significantly increase with the participant's accumulation of pre-graduation, post-graduation, and pre-licensure supervised clinical practice hours.

H_01: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does not significantly increase with the accumulation the participants pre-graduation, post-graduation, and pre-licensure supervised clinical practice hours.

Research Question 2: Does a CIT's self-efficacy for working with clients who identify, as TGNC as measured by the TGNC-CSI-SF, significantly increase as the amount of transcompetent counseling training received also increases, as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire?

H_a2: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, significantly increases as transcompetent counseling training received increases as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire.

H_02: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does not increase as transcompetent counseling training

received increases as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire.

Research Question 3: Does the level of CIT's perceived competence in working with TGNC clients, as measured by the Gender Identity Counselor Competency Scale-Revised (GICCS-R; Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013), significantly predict CITs' perceived self-efficacy, as measured by the TGNC-CSI-SF?

H_a3: The level of competence in working with TGNC clients, as measured by the GICCS-R does predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

H_03: The level of competence in working with TGNC clients, as measured by the GICCS-R does not predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

Research Question 4: Do the amount of time a participant spends as a CIT, as measured by the hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training as measured by participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients, as measured by the GICCS-R, predict CIT self-efficacy, as measured by the TGNC-CSI-SF?

H_a4: The amount of time a CIT spends as a trainee, as measured by hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training, as measured by participant self-reported hours of transcompetent counseling training on the demographic questionnaire, and level

of competence in working with TGNC clients, as measured by the GICCS-R, does predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

$H_0$4: The amount of time a CIT spends as a trainee, as measured by hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training, as measured by participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients, as measured by the GICCS-R, does not predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

Theoretical Framework

I used Albert Bandura's (1977, 1982) self-efficacy theory as my primary theoretical framework. Bandura (1993) posited that despite high standards, human beings tend to develop self-efficacy when faced with challenging situations. With an elevated sense of self-efficacy, human beings are likely to approach challenging tasks with the mindset that they can master the task rather than avoiding the task (Bandura, 1994). Self-efficacy theory highlights that an individual's perception of their abilities can contribute to the prediction of behavior because self-efficacy beliefs ultimately contribute to the course of action a person takes when faced with a challenge (Bandura, 1994).

Self-efficacy theory also emphasizes that an individual's beliefs about their ability to cope with situation-specific issues will lead to greater mastery and success in overcoming those issues (Lorsbach & Jinks, 1999). Self-efficacy theory relies on four pillars that lead to self-efficacy—mastery experiences, vicarious experiences provided by

social models, and social persuasion—and reduction in stress reactions to difficult situations; thus, individuals with strong efficacious tendencies will quickly take on opportunities and overcome constraints. In contrast, those with lower self-efficacy are more likely to be discouraged by institutional barriers (Bandura, 1994, 1997).

In terms of occupational self-efficacy, when newcomers to an occupational setting arrive with various competencies about a skill or task, they tend to learn more and perform at a higher level due to an elevation in self-efficacy compared to those with lower self-efficacy (Bandura, 1997). I used self-efficacy theory to inform this study as I explored how the development of competency in providing transcompetent counseling via time spent as a CIT working with clients and hours of transcompetent counseling training received predicted the self-efficacy of a CIT's ability to work with clients who identify as TGNC. Because the concept of self-efficacy is a central component in this study, self-efficacy theory is an appropriate foundation for this study.

Nature of the Study

To address the research questions in this quantitative study, I employed a correlational, cross-sectional, one-shot survey research design. Correlational, cross-sectional research designs are appropriate when using a multivariate approach and allow researchers the opportunity to understand the relationship between multiple variables (Houser, 2015). Cross-sectional survey research is suitable for this research study because data came from individual respondents at a single point in time (Rindfleisch et al., 2008). One-shot survey research is also relevant for this study because I intended to gather information about the following variables: (a) perceived self-efficacy of a CIT

working with TGNC clients, (b) perceived competence of a CIT in providing trans-affirmative counseling, (c) the amount of time a CIT spends as a trainee as measured by hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, and (d) the amount of hours the CIT spends in receiving transcompetent counseling training as measured by participant self-reported hours of transcompetent counseling training.

I recruited current students and recent graduates from any of the 50 states or United States territories who are still unlicensed from counselor education programs accredited by the CACREP or programs actively pursuing CACREP accreditation to participate in this study. Based on Ronnestad and Skovholt's (2003) model of counselor development, CITs include students who have yet to graduate and who are post-graduate, pre-licensed counseling candidates (Keller-Dupree et al., 2020; Ronnestad et al., 2018). Students from CACREP-accredited counselor education programs receive sufficient instruction focusing on the concept of multicultural competence and multicultural approaches when providing counseling services (CACREP, 2016). Although specifics of the multicultural curriculum differ between programs, ensuring that participants receive multicultural content exposure is essential for reliability and validity in my research. Thus, data came from both current students and recent graduates who are still unlicensed to ensure enough representation and variation among the independent variables: time spent in clinical practice, hours of training in transcompetent counseling practices received, and counselor competency while working with TGNC clients. I de-identified all data to ensure it remained anonymous.

I used descriptive statistics, analysis of variance (ANOVA), linear regression, and multiple regression during data analysis (Frankfort-Nachmias & Leon-Guerrero, 2018; Warner, 2013). Following data analysis, I interpreted and discussed the results and attempt to generalize the results to a larger population (Frankfort-Nachmias & Leon-Guerrero, 2018). I describe the process of using each statistical analysis in greater detail in Chapter 3.

Definitions

The following introductory operational definitions provide an initial context of this research study. I offer complete operational definitions of study variables in Chapter 3.

Counselor education: A field focusing on students' development and education preparing to serve as licensed professional counselors (CACREP, 2016). Counselor education programs provide students with academic opportunities to develop professional identity, multicultural awareness, theoretical orientation, and ethical responsibilities, among other components (CACREP, 2016).

Counselor-in-training (CIT): The definition of a CIT differs based on experience and opinion. In this study, I define a CIT as a current student enrolled in a counselor education program or a graduate of a counselor education program who is yet to be licensed in the counseling field but is practicing under the direct supervision of a licensed professional (Gibson et al., 2010; Keller-Dupree et al., 2020; Ronnestad & Skovholt, 2003).

Counselor self-efficacy: Counselor self-efficacy is a counseling professional's belief in their ability to engage effectively with clients and navigate specific clinical situations (Larson & Daniels, 1998; Lent et al., 2003).

Gender identity: An individual's perception and internal sense of who they are as a gendered being, particularly as it relates to their identity. Gender identity is a social construct and is often assumed to be congruent with biological sex, despite this not being the lived experience of all people (Green & Maurer, 2015).

Gender Identity Counselor Competency Scale-Revised (GICCS-R): A psychometric scale based on the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005) designed to measure the level of competence the respondent has when working with gender diverse clients (Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013).

Multicultural competence: Multiculturally competent counselors incorporate knowledge, skills, and awareness into their work while striving to understand their own culture and the clients' diverse cultural backgrounds (Sue et al., 2019).

Transcompetent counseling: Transcompetent counseling is culturally competent counseling practice with TGNC individuals in which the counselor is aware of their own professional biases and attitudes towards a person who identifies as TGNC, has knowledge of issues present in the TGNC community, and has sensitivity needed when addressing everyday TGNC needs and challenges (Holt et al., 2019).

Transcompetent counseling training: This type of training includes professional development opportunities designed to foster the growth and development of a counselor working with TGNC clients (Kull et al., 2018).

Transgender and gender non-conforming (TGNC): This is a broad term referring to individuals who experience incongruence between their sex assigned at birth and their gender identity. The TGNC umbrella includes people who identify as agender (i.e., a person who does not have a gender identity), gender diverse (i.e., a person who deviates from their socially constructed gender based on biological sex), genderqueer (i.e., a person who does not identify as male or female, is in between genders, or is a combination of both genders), transgender (i.e., a person whose gender identity does not align with their biological sex assigned at birth), gender fluid (i.e., a person whose gender identity or expression moves between masculine and feminine and falls on a spectrum), and non-binary (i.e., a person who does not identify with the spectrum of gender identities or expressions and rejects the male and female gender binary; Green & Maurer, 2015; Knutson et al., 2019).

Transgender and Gender Non-Conforming Affirmative Counseling Self-Efficacy Inventory—Short Form (TGNC-CSI-SF): A psychometric scale based on the Lesbian, Gay, and Bisexual Affirmative CSI–SF (LGB-CSI-SF; Dillon et al., 2015) used to measure the level of self-efficacy the respondent has when working with TGNC clients.

Assumptions

One of my assumptions of this study is that CITs experience limited self-efficacy in working with TGNC based on research indicating challenges experienced by TGNC

individuals in clinical settings (Carroll & Gilroy, 2002; Couture, 2017; Dispenza & O'Hara, 2016; Gates & Sniatecki, 2016; McCullough et al., 2017; Mizock & Lundquist, 2016; O'Hara et al., 2013; Weir & Piquette, 2018). Although counselor education programs focus on developing LGBT-competence with students, research indicates ongoing challenges experienced specifically by TGNC counseling clients. Additionally, extensive research exists on the self-efficacy of counselors working with LGB clients while omitting TGNC clients from this grouping. While conceptualizing this study, I assumed that time spent in clinical practice, additional transcompetent counseling training, and elevated TGNC counseling competence scores contribute to high self-efficacy scores for counselors working with TGNC clients based on existing research exploring the effect of similar variables on counselor self-efficacy working with LGB clients (Bidell, 2005; Bidell, 2012; Dillon & Worthington, 2003; Dillon et al., 2015).

I also assumed that participants would be honest and not inflate their responses when completing the survey. This assumption is necessary as participants' honesty in a research study is a variable that I cannot control (Foerster et al., 2013). Additionally, I assumed that the scales would measure what they intend to measure based on descriptions, content, and previous use. Both scales were assumed to produce consistent results based on existing factor analysis and content validity described in earlier research studies (Bidell, 2005; Cor, 2016; Dispenza & O'Hara, 2016; Dillon & Worthington, 2003; Dillon et al., 2015; O'Hara et al., 2013). Assumptions regarding the scales are necessary because both are relatively new and altered versions of the validated scales.

Scope and Delimitations

In this study, I focused on one outcome variable and three predictor variables. The predictor variables included time spent in clinical practice before licensure as a mental health professional, hours of transcompetent counseling training received, and counselor competence in working with TGNC clients. I chose the predictor variables based on prior research that primarily involved understanding contributing factors to a CIT's competency in working with TGNC clients (Bidell, 2012; Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013). The outcome variable in this study was CITs' self-efficacy in working with TGNC clients. I chose to focus on this variable because research exploring the perception of confidence of emerging counselors working with a gender-diverse population is sparse (O'Hara et al., 2013).

The population and sample I focused on in this study were current students in practicum and internship field experience and recent graduates from CACREP-accredited counselor education programs and programs actively pursuing CACREP accreditation in the United States who were not yet licensed but were working under supervision. I excluded students and recent graduates from counselor education programs not actively pursuing accreditation or are not accredited by CACREP from this study. I chose to focus on students participating in CACREP-accredited programs because I was confident in the consistency of education received surrounding multicultural competence and approaches in counseling (CACREP, 2016). I anticipated the ability to generalize findings from this study to other CITs participating in CACREP-accredited counselor education programs.

An additional theory I considered using as a basis for my study is queer theory. Queer theory emerged in the late 20th century following the third wave of postmodern feminist approaches (Sullivan, 2003). Queer theory integrates insight and components of social constructivism and seeks to advance the understanding and acceptance of human beings' experiences, which deviate from the typically accepted norm of heterosexuality (Carr et al., 2017). Central to queer theory is the desire to challenge heteronormativity as the status quo and the evolution of social norms that promote inclusion for diverse individuals (Rumens et al., 2019). In challenging the status quo, queer theory seeks to contribute to the evolution of social norms that allow for additional inclusion for multiculturally diverse individuals (Rumens et al., 2019).

Although queer theory loosely related to my topic, I excluded the theory from my theoretical framework because it would not explain why some participants had high self-efficacy as opposed to those who have lower self-efficacy. After a thorough review of literature related to queer theory and researchers who implemented this framework, I concluded that queer theory might be more appropriate if I sought to measure acceptance of the TGNC population within a counseling setting. For these reasons, I decided to omit queer theory from my study and only use self-efficacy theory as my theoretical framework.

Limitations

A limitation in this study was the use of a scale that has been altered from its original format and not validated since its alteration (DeVellis, 2017). To address this limitation, I was mindful of how I changed vocabulary, with permission from the creator

of the scale, as I adapted the LGB-CSI-SF to shift from focusing on LGB counseling self-efficacy to TGNC counseling self-efficacy. A second challenge I planned for was the potentiality for response bias when collecting data from current counselor education students and unlicensed clinicians (Creswell & Creswell, 2018). Response bias typically occurs because data collected involves a subject that is, at times, controversial and requires a level of vulnerability on the part of the participant to be honest and truthful in their answers. Although participants' identity remained unknown and I included reminders of privacy and confidentiality throughout the survey, the possibility of societal pressures of what is expected of counseling professionals to portray from a multicultural perspective might have influenced responses.

My use of convenience sampling was another limitation of this study. Although convenience sampling affords the researcher ease during data collection, the process can significantly reduce results' reliability and trustworthiness (Houser, 2015). Despite its drawbacks, convenience sampling is often used and accepted in social sciences because of the availability of research participants and general recognition of this sampling method as a limitation within a study (Cox, 2016; Houser, 2015).

Another limitation could have been my use of a quantitative method for this study because it might not have provided sufficient information about the efficacy of how CITs prepare to work with TGNC clients. For this reason, a follow-up qualitative study may be appropriate in the future. Further, as a researcher, I entered this study with some positive bias and regard toward this topic and population. Personal viewpoints on acceptance and inclusion for diverse individuals, particularly those from sexual orientation and gender

identity minority groups, might have impeded my neutrality as a researcher. To ensure personal viewpoints did not interfere with this research, I used a quantitative approach that limited the subjectivity of data collection, analysis, and interpretation of results compared to qualitative research (Creswell & Creswell, 2018).

Another potential challenge I envisioned was the novel coronavirus (COVID-19) presence in the global society (Centers for Disease Control and Prevention, 2021). I did not expect COVID-19 to cause a significant setback in my data collection because I used technology-based data collection tools, such as SurveyMonkey. I foresaw that practicum and internship students' restrictions due to COVID-19 could have impacted the independent variable "time spent as a CIT" because some graduate programs have restricted students' abilities to participate in field experience at various points throughout the pandemic (CACREP, 2019). If I experienced this challenge, I planned to continue to collect responses until I reached my sample size and note the longer-than-expected data collection duration due to COVID-19 during the discussion of the study's limitations.

Significance

Humans can choose whether to influence change in society via positive and value-based actions (Hoff & Hickling-Hudson, 2011). Results from this study help fill the current gap in the literature and help educators understand the current level of CITs' self-efficacy in working with TGNC clients. Results demonstrated the relationship between the amount of time spent as a CIT, the number of hours a student has participated in transcompetent counseling training, and the CITs' perceived competence and self-efficacy while working with TGNC clients (Gates & Sniatecki, 2016; Weir & Piquette,

2018). These findings can demonstrate the need for additional transcompetent training in counselor education programs and during supervised practice. Increased understanding could contribute to the refinement and expansion of a curriculum that teaches the integration of multiculturally competent approaches, including work with TGNC clients, in counselor education programs (O'Hara et al., 2013). Additionally, results from this study could contribute to counselors better meeting the specific needs of TGNC clients and counselor education programs and counselor supervisors providing greater opportunity for the development of TGNC counselor competencies among CITs (O'Hara et al., 2013).

Summary

Counselors, including CITs, have an ethical obligation to employ multiculturally competent counseling strategies with their clients (ACA, 2014; Sue et al., 2019). In this study, I addressed clinical implications of working with TGNC clients more than it has been due to the heightened presence and consideration of TGNC issues in the media and overall society (McLaren, 2018). Understanding the self-efficacy that CITs possess in working with clients who identify as TGNC could better assist counselor education programs and counselor supervisors in designing coursework, learning opportunities, and supervisory experiences to help CITs prepare to provide effective and affirmative counseling to TGNC clients.

In this chapter, I provided a preview of this study. In Chapter 2, I define further my literature search strategies, discuss my chosen theoretical frameworks, and provide a complete review of current literature relevant to the topic of CIT's self-efficacy while

working with TGNC clients. I discuss my methodological approach in Chapter 3, share results and statistical analysis in Chapter 4, and discuss study findings, limitations, and recommendations in Chapter 5.

Chapter 2: Literature Review

An exhaustive search of relevant literature on counseling with TGNC clients demonstrated the often-marginalized experiences TGNC individuals have in the mental health field. Researchers identified that curriculum in counselor education programs often focuses on the needs of clients who identify as LGB while excluding specific transcompetent clinical implications (O'Hara et al., 2013). Although some TGNC individuals identify as LGB, the lived experiences of TGNC individuals primarily surrounds a gender diverse worldview and a different identity compared to someone who identifies as LGB. As such, researchers exploring mental health professionals' confidence in working with TGNC clients have discovered significant transphobia, genderism, transgender microaggressions, and implicit biases demonstrated by professional counselors due to limited resources and awareness devoted to clinical implications for this specific cultural subgroup (McCullough et al., 2017).

In a seminal article, Carroll and Gilroy (2002) highlighted the need for a more evolved way of working with TGNC clients that affirms the diversity and subjective worldview of all individuals, including those who identify as TGNC. Carroll and Gilroy highlighted the ongoing pathologization of clients who present with nontraditional gender identities. The authors suggested the field move away from the concept of gender dysphoria and toward affirming adjustment to new gender identity. Additionally, Carroll and Gilroy reflected on the need to prepare the future generation of mental health professionals to engage in a mindset shift of the needs of TGNC clients. The authors

declared the need for additional training and skills to provide transcompetent counseling based on existing literature.

Using the strengths of client-centered counseling practices can help mental health professionals move toward trans-positive counseling practices by recognizing and challenging injustice and oppression that TGNC individuals experience. The authors also focused on providing context and insight regarding appropriate needs involving medical, social, systemic, and case management concerns that CITs must develop to provide effective counseling to TGNC clients.

Despite this identified need nearly two decades ago, there is still persistent discrimination against TGNC individuals within the LGBT community in counseling settings (Weir & Piquette, 2018). Some identified issues include an increased risk of experiencing violence, discrimination, mental health concerns, challenges within the living environment, and the need for ongoing support (Weir & Piquette, 2018). TGNC clients' isolation, presence of transphobia, and limited counselor training contribute to a limited sense of preparedness in a clinician's ability to provide transcompetent clinical intervention (Gates & Sniatecki, 2016).

Although research continues on working with TGNC clients in counseling settings, there is a lack of counseling literature involving the specific needs of clients who identify as TGNC in clinical settings (O'Hara et al., 2013). Research surrounding counselor preparedness while working with TGNC exists, but limited understanding of a counselor's perception of their readiness to provide transcompetent counseling intervention is available. In this study, I addressed the limited self-efficacy that CITs

possess while working with TGNC clients, leading to increased transphobia, microaggressions, and implicit biases toward TGNC clients (O'Hara et al., 2013).

With a greater understanding of CITs' self-efficacy in providing transcompetent counseling services, I hope to help fill the gap in the literature surrounding best practices for preparing counselors to work with TGNC clients (Gates & Sniatecki, 2016; Weir & Piquette, 2018). Understanding a CIT's self-efficacy when working with TGNC clients could eventually contribute to refining counselor education and training programs as they work to prepare counselors to assist TGNC clients (Carroll & Gilroy, 2002). In this literature review section, I share my literature search strategy and discuss the theoretical foundations that I will build on throughout my study. Then, I highlight existing research surrounding multicultural and LGBT-competent counseling, professional counselors' preparedness in working with TGNC clients, self-efficacy of CITs, and the counselor development process.

Literature Search Strategy

A dissertation is deeply rooted in the existing literature that serves as a basis for the research study conducted by a doctoral candidate (Rudestam & Newton, 2015). As the doctoral candidate reviews literature, they strive to engage with a critical approach that evaluates the merits and liabilities of that work (Rudestam & Newton, 2015). In this section, I describe the research databases, scholarly resources used, and literature search strategy.

Research Databases and Scholarly Resources

While engaging in the literature review process, I chose pieces from respected journals, books related to the topic, and published dissertations (Creswell & Creswell, 2018). During the information-gathering stage, I accessed various research databases and other resources to explore the experiences of TGNC in counseling settings, along with the preparedness of CITs to work with clients who identify as TGNC. Using databases and sources that include scholarship grounded in empirical evidence is a crucial backbone of my study (Walden University, 2019a). The research databases I used were PsycARTICLES, SAGE Journals, LGBT Life with Full Text, ProQuest Central, SocINDEX, and Google Scholar. Additionally, I used ProQuest Central to encounter published dissertations similar to my topic to identify how other doctoral candidates used existing literature and research methodologies to explore their respective topics.

Search Techniques and Strategies

To complete the exhaustive literature search, I broke my overall topic into smaller keywords to gather as many results related to the subject as possible (Walden University, 2019b). I used varied keywords, intending to access a more comprehensive range of results to construct my study (Creswell & Creswell, 2018). With this in mind, I used the following keywords during my literature search: *transgender, gender identity, non-binary, competence, cultural competence, transcompetent, counselor trainee, counselor supervisee, self-efficacy, counselor development, and counselor education*. I also used combinations of these keywords, specifically: *cultural competence, counseling, and counselor trainee; transgender, competence, and self-efficacy; transgender and*

counseling; transgender, counselor, and self-efficacy; transgender counseling; transgender counseling and competence; transgender counseling and counselor education; transgender counseling and counselor trainee; transgender counseling and self-efficacy; and *transgender counseling and supervisee.* I attempted to collect literature from 2016 to 2020, the 5 years leading up to my literature search. Because this topic's scope remains somewhat limited, I remained open to using existing literature outside of the 5-year range that appeared relevant and valuable to the development of my topic.

Theoretical Framework

Theoretical frameworks offer support for the various components of a research study (Creswell & Creswell, 2018; Grant & Osanloo, 2014). While serving as a blueprint for the foundational elements of a research study, these frameworks also allow readers to understand the conceptualization, formation, and summarization of research studies (Grant & Osanloo, 2014; Ravitch & Carl, 2016). In this section, I describe how I used self-efficacy theory (Bandura, 1977, 1982, 1993, 1994, 1997) as the framework for my study.

Self-Efficacy Theory

Bandura proposed that an individual's belief in their abilities can predict behavior and coined this concept "self-efficacy" (Bandura, 1977, 1982, 1993, 1994, 1997). As part of self-efficacy theory, self-efficacious beliefs contribute to how a person approaches challenges based on the perception of their ability to overcome a challenge (Maier & Curtin, 2005). Additionally, self-efficacy theory asserts that an individual's beliefs in

their ability to cope with challenges promote mastery and future success in overcoming similar issues (Lorsbach & Jinks, 1999).

With mastery of skills and abilities in mind, a primary component of self-efficacy theory is that individuals with strong efficacious tendencies will quickly take on opportunities and overcome constraints. In contrast, lower self-efficacy leads to an individual's discouragement due to institutional barriers, weak commitment to goals, focus on personal deficiencies, and an often-times slow recovery from setbacks (Bandura, 1994; 1997). Bandura (1993) was adamant that humans are poised to develop self-efficacy when faced with difficult situations. Critical to this theory is the belief that an increased level of self-efficacy encourages an individual to meet challenging tasks with a mindset rooted in potential accomplishment rather than avoidance. This is due to the idea that overcoming the challenge is possible (Bandura, 1994).

Constructs of Self-Efficacy Theory

Bandura (1994) highlighted that self-efficacy development is not uniform and can develop via different means. Self-efficacy theory relies on four pillars that define self-efficacy: mastery experiences, vicarious experiences provided by social models, social persuasion, and reduction in stress reactions to difficult situations (Bandura, 1994). Though each of these methods of self-efficacy is unique, each contributes to the belief in a person's ability to accomplish a task. In the following sections, I briefly describe each of the four components of self-efficacy theory and discuss which apply to this study.

Mastery Experiences. Mastery experiences occur after someone attempts a task and realizes they can achieve success (Bandura, 1994). Bandura indicated that mastery

experiences are the quickest method to develop self-efficacy as they provide individuals with an opportunity to grow through experiences such as degree programs, training, seminars, internships, and other field experience activities (Bandura, 1994). It is important to note that self-efficacy development via mastery experience requires challenging situations to overcome rather than simple tasks. If one focuses on previously mastered challenges, stagnation can occur. Instead, a strong sense of self-efficacy develops when an individual attempts increasingly complicated tasks and overcomes new challenges (Bandura, 1994).

Vicarious Experiences. The development of self-efficacy via vicarious experiences differs from mastery experiences because the individual building self-efficacy is not personally overcoming a challenge (Bandura, 1994). Instead, a person observes someone else's successes or struggles attempting a task. An example of vicarious experience self-efficacy is a role-play in a counseling theories class. The success of a classmate practicing and effectively demonstrating specific therapy techniques can help other classmates feel greater confidence in their ability to practice a similar type of counseling. Conversely, a student who struggles in a similar role-play activity might deter the development of self-efficacy in the observer (Bandura, 1994).

Social Persuasion. Social persuasion, also known as verbal persuasion, promotes self-efficacy in an individual following encouragement by a support person (Bandura, 1994). Bandura (1994) highlighted that social persuasion is useful because it includes the instillation of hope and optimism, even before the full development of skills. Social

persuasion can also be detrimental to a person's self-efficacy if the communication focuses on a lack of ability and limited prospect for future success (Bandura, 1994).

Somatic and Emotional States. Social and emotional states are central to both the development and abatement of self-efficacy (Bandura, 1994). Bandura (1994) described unpleasant emotional conditions such as stress, anxiety, and worry as detriments to self-efficacy as they can lead to an expectation that failure will occur followed by reinforcement of that belief when a person is not successful at the desired task. However, emotional states can produce self-efficacy as well. Following an achievement or success, a person might feel pleased, proud, and hopeful. These pleasant emotions can bolster future confidence in one's ability to overcome a similar task (Bandura, 1994).

Use of Self-Efficacy Theory in Previous Research

Self-efficacy theory is present in much counseling-related literature. Lent et al. (2006) conducted a quantitative study exploring client-specific counselor self-efficacy among 110 novice counselors at a mid-Atlantic university. Lent et al. used the Counselor Activity Self-Efficacy Scales (CASES; Lent et al., 2003) to collect general data (labeled CASES-G) and client-specific data (marked CASES-S) for the correlational components of this study. Additionally, the researchers used the Session Evaluation Scale from the Helping Skills Measure (Hill & Kellems, 2002) to gauge both the client's and counselor's perception of session quality. Results showed a substantial covariance between general counselor self-efficacy and client-specific counselor self-efficacy, highlighting a 29% to 58% shared variance. Additionally, client-specific counselor self-efficacy provided

unique predictability related to general counselor self-efficacy during each session. Results also showed that CASES-S scores changed significantly over time, with statistical analysis demonstrating linear growth for sessions two through five, $F(1, 81) = 96.50$, $p < .001$, partial $\eta 2 = .54$. The counselor's pre-session CASES-S ratings also significantly predicted possession evaluations, accounting for 12% of the variance in ratings following the session. The authors also found moderate support for CASES-S scores before the counselor's previous session evaluations significantly predicting a session. However, as sessions progressed, the CASES-S scores began to stabilize, minimizing the change in predictability. Finally, they found statistical significance in the path coefficients between counselor and client session evaluations, $p < .05$. Based on these results Lent et al. asserted that the amount of time spent counseling predicted an increase in the counselor self-efficacy.

In another study using self-efficacy theory, Mehr et al. (2015) sought to understand contributing factors to a CIT's willingness to disclose in clinical supervision. Mehr et al. found that higher counseling self-efficacy contributed to lower CIT anxiety, a stronger supervisor working alliance, and higher willingness of the CIT to disclose during supervision. Similarly, Reese et al. (2009) explored whether client feedback in psychotherapy training impacted supervision and counselor self-efficacy. Using a theoretical approach based on self-efficacy, Reese et al. assigned CITs to a continuous feedback condition or no-feedback condition for a 1-year period. The authors found the relationship between counselor self-efficacy and client outcome was greater for CITs in

the feedback condition, asserting that client feedback helps bolster skills and self-efficacy.

Other researchers used the theory to explore the relationship between multicultural counseling competence, multicultural self-efficacy, and the ethnic identity development of practicing counselors (Matthews et al., 2018). In this study, the researchers demonstrated a positive correlation between ethnic identity and multicultural self-efficacy. Additionally, Matthews et al. found a large positive correlation between cultural competency and multicultural self-efficacy. This supports my focus on a narrower component of cultural competence and self-efficacy rather than overall multicultural competence and multicultural self-efficacy.

Applicability of Self-Efficacy Theory to this Research Study

Self-efficacy theory is central to this research study because of the core component that mastery experiences, vicarious learning, social persuasion, and somatic and emotional states can contribute to the belief in one's ability to overcome challenges. Mastery experiences and vicarious experiences are the primary pillars of self-efficacy theory that contributed to my decision to use this theory. Existing research demonstrates that classroom instruction, training, and repeated experience predict greater self-efficacy (Schunk & Pajares, 2009). I predicted that CITs experience an increase in self-efficacy in working with clients who identify as TGNC following practical training and while accumulating hours in clinical practice under the supervision of a licensed professional.

Further, though self-efficacy is present in many parts of life, Bandura (1997) described the importance of occupational self-efficacy as the opportunity for newcomers

in a profession to arrive with various competencies surrounding skill or task. With these competencies, a person tends to learn more and perform at a higher level due to an elevation in self-efficacy than their counterparts with lower self-efficacy. Thus, I used self-efficacy theory to inform this study as I explored how the time spent in clinical practice while working towards licensure, training received in transcompetent counseling, and competence in working with TGNC clients predicts the self-efficacy of a CIT's ability to work with clients who identify as TGNC.

Literature Review

The ACA (2014) highlighted in its *Code of Ethics* that counselors must attend to multicultural considerations and demonstrate multicultural competence when working with clients from diverse backgrounds. Multicultural competence includes possessing the knowledge, skills, and awareness that allow a counselor to provide effective therapeutic intervention with culturally diverse clients (Henriksen & Trusty, 2005). Counselor education coursework focusing on multicultural competence generally includes cultural implications for working with LGBT clients. Unfortunately, little exploration regarding the specific needs of TGNC clients in counseling settings is available in existing literature (Gates & Sniatecki, 2016; Weir & Piquette, 2018).

Studies exploring the confidence of mental health clinicians' in working with TGNC clients found a significant amount of transphobia, genderism, TGNC microaggressions, and implicit biases demonstrated by mental health clinicians in clinical practice (McCullough et al., 2017; Weir & Piquette, 2018). Long before the awareness of an increase in multicultural competence in working with TGNC clients, Carroll and

Gilroy (2002) asserted the need for a more profound and proficient approach to working with TGNC clients that affirms diversity and subjective worldview. Weir and Piquette (2018) explored the concept of discrimination against transgender individuals within the LGBT community. They found that individuals who identify as TGNC experienced more significant issues and challenges because they deviate from the socially constructed gender binary.

A significant void exists in the counseling literature surrounding clients' specific needs who identify as TGNC in clinical settings (O'Hara et al., 2013). Research surrounding the problem of limited self-efficacy that CITs possess while working with TGNC clients might reduce transphobia, microaggressions, and implicit biases towards TGNC clients within the counseling field. In this literature review section, I explore existing research highlighting the importance of specific competencies for counselors working with TGNC as it relates to, and deviates from, multiculturally-competent counseling. I also discuss literature surrounding CIT self-efficacy and the process of counselor development.

Counseling and Multicultural Competence

Counselors who engage with multicultural competence incorporate knowledge, skills, and awareness into their work, intending to understand their culture and their clients' diverse cultural backgrounds (Sue et al., 2019). Vital to the development of multiculturally competent and ethically based counselors is an understanding why a clinician must continue to develop and refine their multicultural competence (Henriksen & Trusty, 2005). Additionally, counselors must engage in critical thinking surrounding

implicit biases, power, and oppression as they consider the intersectionality between their own cultural identity and the cultural identities of their clients (Collins et al., 2015).

Trends in Multiculturally-Competent Counseling

The concept of multicultural competence in counseling and development of multicultural counseling competencies continues to evolve (Sue et al., 2019). The ACA (2014) discussed multicultural competence in many sections of its *Code of Ethics,* while the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) highlighted multicultural competence as a foundation for counselor education programs accredited by the body. Standards such as the multicultural counseling competencies (Arredondo, 1999; Sue et al., 1992) and assessments like the SOCCS (Bidell, 2005) allow counselors, educators, and supervisors insight into a clinician's strengths and development areas surrounding culturally relevant counseling strategies.

Additionally, multicultural competence in counseling is evolving from client-specific counseling strategies to the expansion of roles in social justice and advocacy work (Vera & Speight, 2003). Lee and Kelley-Petersen (2018) asserted that a professional counselor who integrates social justice into his or her practice adjusts counseling approaches to ensure strategies in a clinical setting are culturally appropriate and meet individual client needs and attempts to impact systemic issues that hinder the success of oppressed individuals. Ratts et al. (2016) reflected that multiculturally competent counselors could balance office-based counseling practice with community-based advocacy that challenges marginalized groups' social norms and oppression.

Ultimately, participating in social justice activities coupled with multiculturally-competent counseling practices is an ethical responsibility that can contribute to the betterment of clients, families, communities, and society (ACA, 2014).

Multiculturally-Competent Counseling and Counselors-in-Training

Sue et al. (2019) highlighted that to become multiculturally competent, CITs must openly discuss race, culture, gender, and other differences that they will encounter in clinical practice. This conversation helps the CIT understand that their development includes understanding necessary counseling skills and engaging in the knowledge that the demographics with which they will work will be diverse and have varying needs (Henriksen & Trusty, 2005). CITs can understand the importance of multicultural competence by gaining awareness of their experiences with privilege and oppression. Hays et al. (2007) discussed the awareness of privilege and oppression as integral to ethically-sound counseling. Ultimately, CITs benefit from both training and opportunities to reflect in this area due to a common lack of self-awareness at the onset of their careers (Hays et al., 2007).

Watson et al. (2006) explored how the connection between multicultural competence and ethical behavior has been historically slow to form in the development of counselors and counselor education. Integrating the association between multicultural competence and ethical practice into the classroom or training setting is critical to counselor development (Sheely-Moore & Kooyman, 2011). Torino (2015) discussed the importance of the growth of cognitive awareness of the student or supervisee and the use of racial identity models in the development of cultural self-awareness. Validating the

feelings that students have and processing emotional reactions can help students accept their cultural competence level, leading to the further development of self-awareness (Torino, 2015).

Fundamental to multicultural competence in counselor education curriculum is the exploration of implicit biases. Gonzalez et al. (2018) described implicit bias as unintentional assumptions that we hold towards other individuals, particularly involving cultural differences. When students gain an understanding of implicit bias they have, reflecting on that implicit bias, and exploring ways to mitigate risk associated with that implicit bias in a clinical setting is a useful approach as a novice counselor continues to develop skills and abilities (Gonzalez et al., 2018). Similar to the discussion of privilege, allowing students to explore feelings relating to implicit bias they hold can lead to a more significant debate and understanding of ways to alleviate risks associated with bias in a counseling relationship.

LGBTQ+ Counseling Competencies

The umbrella acronym LGBTQ+ encompasses affectional orientation, sexuality, and gender identity and expression (Goodrich & Luke, 2015). Goodrich and Luke (2015) highlighted that LGBTQ+ identities on this spectrum often experience marginalization regarding subgroup-specific approaches. Goodrich and Luke discussed a historically low amount of training provided to counselors working in the mental health field, despite research indicating elevated mental health issues and a greater need for mental health resources among members of the LGBTQ+ community. Challenges often reported by members of the LGBTQ+ community include heterosexism, genderism, oppression,

microaggressions, violence, rejection, and discrimination (Bostwick et al., 2014; Goodrich & Luke, 2015; Peters, 2018).

The Society for Sexual, Affectional, Intersex, and Gender Expansive Identities (SAIGE), formerly the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, published counseling competencies for work with lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals (ALGBTIC LGBQQIA Competencies Taskforce, 2013) and a separate set of competencies for counselors working with TGNC clients (SAIGE, 2010). Within both groups of competencies is encouragement for counselors to approach counseling members of the LGBTQ+ community with an affirmative method and cultivate a resiliency and wellness culture. Additionally, each set of competencies discusses the appropriate knowledge, skills, and awareness counselors should embody when working with members of the LGBTQ+ community.

Queer Counseling Competencies Article Review. Killian et al. (2019) reflected that many counselors report feeling a lack of preparedness to effectively work with queer clients in this qualitative, hermeneutic article. Using a literature review strategy, Killian et al. focused on a research question seeking to understand the benefit of using experiential learning as an opportunity to enhance CIT’s competence and preparedness to work with LGBTQ+ clients. The authors found that experiential learning approaches helped increase CIT’s competency as they learned methods for working with queer clients. Additionally, the authors asserted that experiential learning helped expand the CIT’s cognitive complexity by contributing new competencies to the CIT’s existing knowledge base.

A strength of this article is the authors' use of a specific technique to help promote cultural competence for working with queer clients. Killian et al. (2019) highlighted many different approaches appropriate for working with CITs as they develop skills for working with this specific cultural subgroup. A limitation of this research study is that the authors did not separate particular interventions for particular subgroups within the LGBTGQ+ community. Although members of this community share similarities, many differences exist between the lived experiences of a lesbian versus a transgender individual. This limitation leads to my intention in this study to measure the self-efficacy of CITs as it relates explicitly to working with clients who identify as transgender.

Killian et al. (2019) suggested many opportunities to improve counselor education programs to evolve and enhance the training provided to CITs as they prepare to work with LGBTQ+ clients. Additionally, the authors highlighted many implications for future research, including awareness of the intersectional and multi-faceted concept of identity within the LGBTQ+ community, a departure from lumping a plethora of identities into the concept of sexual orientation. My research study addressed this by separating TGNC clients from the overarching LGBTQ+ moniker.

Counseling Transgender and Gender Non-Conforming Clients

Transgender and gender-nonconforming clients often experience a lack of representation in research and literature discussing effective counseling and mental health strategies (Watson et al., 2018). Watson et al. (2018) cited literature that found a majority of articles focused on the LGBTQ+ community minimally, if at all, discussed

implications specific to the TGNC population. Weir and Piquette (2018) discovered that TGNC individuals experience more significant issues and challenges because they deviate from the socially constructed gender binary. Additionally, TGNC individuals are prone to experience heightened discrimination, transphobia, and microaggressions from LGBTQ+ community members and mental health professionals (Weir & Piquette, 2018). In this section of the literature review, I expand on TGNC clients' experiences in counseling, discuss barriers to effective TGNC counseling services, strategies for TGNC counseling, and ethical considerations.

Experiences of Gender Diverse Clients in Counseling

Transcompetent counseling services can range from therapy during which process challenges associated with everyday life stressors are explored to conceptualizing and further understanding gender identity issues (dickey & Singh, 2020). Laoch and Holmes (2018) posited that TGNC individuals often seek counseling services with unique social, familial, and systemic discrimination and rejection challenges. Laoch and Holmes also discussed a general lack of trust TGNC individuals have in health care settings due to feeling targeted for violence, financial and housing insecurity, health care challenges, and continuous requests to discuss gender-identity related topics and issues. Brown et al. (2019) highlighted a high amount of TGNC individuals that engage in mental health therapy with professionals who are often under-prepared to engage supportively with members of the gender diverse population. As members of the TGNC community continue to live more public lives, the counseling field needs a greater understanding of

disparities and challenges faced by TGNC individuals in mental health settings (dickey & Budge, 2020; Kanamori & Cornelius-White, 2017).

Gender Diverse Counseling Article Critique. Mizock and Lundquist (2016) explored the negative experiences often reported by TGNC clients in medical and mental health services. In this qualitative research study, Mizock and Lundquist used a grounded theory approach to identify counselors and therapists' specific missed opportunities when working with TGNC clients. The authors recruited 45 participants to engage in semistructured interviews at a northeast United States conference for transgender individuals. The authors created the semistructured interviews that focused on various topics, including internalized and external stigma, coping strategies that help combat stigma, bolstering vocational functioning, and service recommendations for improved mental health care. Findings indicated consistent errors made by mental health clinicians, including stigmatizing TGNC clients, placing the burden of education on the clients, and over-asserting power. The authors also highlighted the need for additional trans-affirmative counseling services.

A strength of Mizock and Lundquist's (2016) research study is the effort the authors took to ensure trustworthiness and validity. Mizock and Lundquist discussed using a data auditor, the presence of a multi-member research team, and an additional content expert. The authors also indicated many growth areas for counselors that will contribute to more effective and useful counseling services for TGNC clients. The authors reflected a limitation of this study included the lack of a quantitative follow-up from this preliminary research with a larger sample size. Additionally, the authors

revealed the unique differences between transfeminine and transmasculine clients. The authors suggested that future research ungroup the various TGNC populations for more effective and inclusive data collection.

Mizock and Lundquist (2016) highlighted several implications for counseling and psychological practice from their research. The authors indicated that data demonstrated the importance of individual clients in expressing their unique narratives of gender and not being categorized by the mental health professional. Additionally, the authors reflected on the significance that all mental health providers receive training that focuses on the unique needs of TGNC clients. This implication leads to my study's importance as I sought to identify primary factors that contribute to, and predict, a CIT's self-efficacy in working with TGNC clients.

Barriers to Effective Counseling with Gender Diverse Clients

Campbell and Arkles (2017) discussed various deficits in transcompetent counseling practices by mental health professionals, including limited recognition of specific needs in treatment, lack of understanding and expertise in transaffirmative care, ongoing stigma and discrimination experienced by TGNC individuals, and compounding mental health challenges due to these and other issues. Contributing to barriers TGNC individuals face in counseling is the historical marginalization the mental health community placed on TGNC by labeling as disordered individuals with differing gender identities than those assigned at birth (Holt et al., 2019).

Holt et al. (2019) described additional liabilities hindering effective counseling and care for TGNC individuals, including an absence of qualified professionals,

particularly in rural and small communities. Additionally, Holt et al. reflected on the difficulties TGNC clients experienced due to a counselor’s limited training and misunderstanding of terminology and vocabulary related to effective TGNC care.

Discriminatory Experiences. McCullough et al. (2017) used an interpretive phenomenological analysis framework and ethnographic approach to explore a research question seeking to understand the counseling experiences of TGNC individuals. Central to the foundation of this study was existing literature alluding to barriers to efficient mental health care TGNC clients reported experiencing. McCullough et al. discussed the presence of transphobia, genderism, TGNC microaggressions, and other misunderstandings in counseling settings. Additionally, other barriers to transcompetent counseling include fear and stigma associated with receiving mental health services, lack of knowledge and sensitivity to TGNC clients’ needs, and blatant refusal on the part of the mental health professional to acknowledge preferred pronouns and demonstrate a willingness to discuss gender altogether.

McCullough et al. (2017) engaged a sample of 13 individuals during the data collection process. The authors identified four significant themes: the mental health professional selection process, the use of a transaffirmative approach, a transnegative approach, and the existence of a support network outside of the counseling environment. Participants ranged in age from 21 to 54 years old and identified as Black or African American, White, multiethnic or multiracial, and Latinx The participants reported using many different formats of mental health services, including marriage and family therapists, social workers, and professional counselors. The authors discussed that

attention to each of the identified four themes can contribute to more effective counseling services for transgender clients.

McCullough et al. (2017) reflected a limitation of this research study is the small sample size and the limited representation of diversity within the transgender community. Additionally, the authors highlighted that most participants identified on the masculine spectrum (male or female-to-male), limiting the representation from the feminine spectrum. The sample was self-selected, and all respondents reported attending at least some college, narrowing the results' transferability. The research article's benefits include the identification that TGNC individuals have significantly different life experiences compared to those who identify as lesbian, gay, and bisexual. This awareness leads to the ability to expand transcompetent counseling practices. Additionally, the authors identified many positive experiences of TGNC clients in counseling settings.

Findings from the research study by McCullough et al. (2017) could contribute significantly to future research. McCullough et al. identified a wealth of unintended microaggressions towards TGNC individuals, particularly when comparing the experiences of TGNC individuals to the experiences of those who are lesbian, gay, or bisexual. Additionally, the authors identified future opportunities for a greater understanding of the social ramifications of the transition process and additional outcome research on transcompetent counseling interventions. Overall, this study's implications apply to my research because greater knowledge, skills, awareness of barriers to effective counseling for TGNC, and transcompetent counseling strategies can increase self-efficacy for a CIT working with TGNC individuals.

Insufficient Training. Couture (2017) sought to understand mental health clinicians' preparedness in a collegiate setting as they set forth to work with TGNC clients. The author used a quantitative, cross-sectional approach to measure two research questions. The first research question involved the perceived level of preparedness of college mental health clinicians providing counseling to TGNC college students based on years of experience and participation in a counselor education program. The second question was an inquiry if college mental health professionals believed they needed to know gender identity issues.

Couture (2017) used a sample of 84 college mental health counselors who completed a survey questionnaire that used a Likert Scale range from zero (not prepared) to three (better prepared than average) to assess the preparedness of working with TGNC clients. The survey consisted of four subscales: clinical interviewing and assessment skills, counseling ethics, personal and community awareness, and education on TGNC issues that, when combined, produced a "total preparedness" score (Couture, 2017, p. 468). Couture used a one-way ANOVA, between-subjects design to discover the differing scores based on years of experience for the first part of the first research question. There was no statistical significance when measuring counselor preparedness based on years of experience, $F(4, 79) = .96$, $p > .05$. For the second part of the first research question, Couture used an independent samples *t*-test. Again, no statistical significance in preparedness for counselors who graduated from a CACREP-accredited program versus a non-CACREP accredited program with $t(82) = .77$, $p > .05$. The second research question asked counselors if they thought it was their responsibility to know

clients' gender identity issues. Of the 84 respondents, 83 (98.90%) responded "yes" to this question (Couture, 2017).

Couture (2017) highlighted the primary limitation of this research study was the relatively small sample size. Overall, the author emphasized that 84 respondents for a quantitative research study did not allow for the results to be generalizable to the college mental health clinician population. A benefit from this study included the understanding that a majority of college mental health clinicians feel they need additional training and growth opportunities before counseling TGNC clients. This understanding will allow counselors to receive this training before engaging in a therapeutic relationship with a client that identifies as TGNC. The identification that counselors believe additional training is needed supports my decision to use hours of training to determine if training predicts a CIT's self-efficacy in working with TGNC clients.

Couture's (2017) study allowed for the understanding that counselor educators possess a greater responsibility to teach best practices for providing appropriate counseling services to TGNC clients. Additionally, the author identified greater awareness of the specific needs of TGNC clients, including more prevalent mental health issues for TGNC individuals compared to members of the cisgender community. Other implications included the heightened likelihood of discrimination, substance abuse, violence, self-injury, and suicide. Couture suggested further research might explore how training in transcompetent counseling strategies can potentially increase counselors' self-efficacy, contributing to the purpose of my research study.

Gender Diverse Counseling Strategies

Primary to the provision of appropriate and effective counseling to TGNC clients is the mental health professional's ability to engage with the multicultural competencies of knowledge, skills, and awareness (Holt et al., 2019; Sue et al., 1992). This awareness includes an understanding of the professional's own biases and attitudes towards TGNC individuals, knowledge of issues present in TGNC communities, and sensitivity when addressing everyday TGNC needs and challenges such as gender dysphoria, gender history, and the impact of the client's gender identity on mental health (Holt et al., 2019). Along with the counselor's self-awareness, knowledge of barriers to care, the ability to use a diverse toolkit, information about community resources, and medical and legal policies affecting TGNC individuals are crucial components of TGNC counseling (Holt et al., 2019). Holt et al. (2019) suggested developing these skills via networking opportunities with community-based, culturally sensitive, and responsive providers.

Krieger (2017) discussed opportunities for counselors to help TGNC individuals focus on their gender identity using narrative techniques. Included in this oratorical approach, TGNC individuals were encouraged to explore and challenge three fundamental roadblocks: (a) that their birth-assigned sex feels incongruent, (b) that aspects of their gender and body feel wrong, and (c) that they desire congruence between the gender they feel and the gender demonstrated outwardly. Additionally, Krieger suggested exploring authenticity, allowing the TGNC client to be true to themselves while allowing support people to encourage authentic gender identity expression. A

simple way to do this is to use chosen pronouns and names and demonstrate humility when uncertain about how to refer to a client.

The Society for Sexual, Affectional, Intersex, and Gender Expansive Identities published its set of competencies for counseling with TGNC clients, approved by the ACA in 2010 (SAIGE, 2010). Within the competencies, authors discuss the importance of using a transaffirmative approach to counseling that demonstrates the belief that all individuals can live a "fully functioning and emotionally healthy [life] through the life span along the full spectrum of gender identity and gender expression" (SAIGE, 2010, p. 136). Included in the competencies is a focus on the use of TGNC-affirmative language while demonstrating knowledge and awareness of the following while working with TGNC clients: (a) human growth and development, (b) social and cultural foundations, (c) helping relationships, (d) group work, (e) professional orientation, (f) career and lifestyle development competencies, (g) appraisal, and (h) research.

Ethical Concerns

Despite the insistence that counselors provide ethically grounded, multiculturally-competent clinician intervention, research demonstrates significant ethical dilemmas present in counseling provided to TGNC clients (Campbell & Arkles, 2017; Morris et al., 2020). Campbell and Arkles (2017) reflected that ethical considerations when working with TGNC clients become exponentially more challenging due to intersecting standards of care and laws that are generally not applicable in similar ways with other populations. These ethical problems include understanding complexities related to gender identity transition, social transition, medical transition, and the differences between each.

Campbell and Arkles (2017) discussed the American Psychological Association's (APA; 2015) guidelines for practice with TGNC clients. These guidelines include adequate competence, avoiding harm, advocacy, informed consent, and record keeping. Additionally, Campbell and Arkles highlighted the expansive legal challenges TGNC individuals experience. They suggested counseling professionals become educated in this domain to help clients navigate the legal system and protect themselves from potential liability. Following the conversation of various ethical and legal challenges, Campbell and Arkles asserted that mental health professionals, including counselors, working with the TGNC population require added layers of competence, willingness to engage with and apply unique ethical and legal considerations to the work, and the ability to integrate these components into their practice. In their conclusion, Campbell and Arkles stated that mental health professionals more-often-than-not claim to be less competent working with this demographic. A lack of confidence generally leads to lower self-efficacy, contributing to this study's importance as I sought to understand components that might increase a counselor's self-efficacy working with TGNC clients.

Morris et al. (2020) conducted a study with TGNC clients in a mental health setting to further understand microaggressions, described as ethical violations, directed towards those individuals by mental health providers. The premise for this research study was derived from existing research indicating minimal competencies of mental health providers working with TGNC clients and limited awareness of specific counseling techniques and strategies due to a lack of training provided to mental health professionals

in their preparation to work with TGNC clients, creating significant barriers for the clients (Morris et al., 2020).

Using a microaggressions model, Morris et al. (2020) discovered four themes from interviews with TGNC counseling clients: (a) lack of respect for client identity, (b) lack of counselor competency, (c) saliency of identity, and (d) gatekeeping. Within these themes, the researchers reported microaggressions such as misgendering, sexualization, exoticization, denial of identity, minimization of problems, use of outdated diagnostic criteria, and conflation of sexual orientation and gender identity (Morris et al., 2020). Following their study's culmination, Morris et al. suggested counselors and CITs receive additional formal and informal education surrounding best practices for TGNC clients which can contribute to elevated levels of self-efficacy.

Counselor Self-Efficacy

Members of the counseling profession continue to assess the use of self-efficacy in ongoing counselor development (Lent et al., 2003). Counselor self-efficacy refers to counseling professionals' belief in their ability to engage effectively with clients and navigate particular clinical situations (Larson & Daniels, 1998; Lent et al., 2003). Professionals, including counselors and others in the mental health field, often experience what is known as "impostor syndrome" or the "impostor phenomenon" (Sakulku & Alexander, 2011; Tigranyan et al., 2020). Central to the impostor phenomenon is low self-efficacy or a person's belief that they are intellectually fraudulent or ill-prepared for a task or duty (Sakulku & Alexander, 2011; Tigranyan et al., 2020). Unaddressed low self-efficacy and impostorism can lead to burnout, poor achievement, and limited

motivation; ultimately affecting both the professional and client in clinical practice (Lent et al., 2009; Sakulku & Alexander, 2011; Tigranyan et al., 2020)

Counselor Self-Efficacy with Gender Diverse Clients

O'Hara et al. (2013) used a mixed methods study and sought to understand the strengths and opportunities for improvement in counselors' preparation to work with TGNC clients. In their literature review, O'Hara et al. cited much of the existing literature, including TGNC individuals in research but focusing predominantly on the experiences of lesbian, gay, and bisexual individuals, consequently marginalization an entire subgroup of people. As such, the authors sought to understand better a counselor's perception of their preparedness to work with TGNC clients.

O'Hara et al. (2013) recruited a sample of 87 counseling students in CACREP-accredited or APA-accredited masters and doctoral counseling and psychology programs for this two-phase study. O'Hara et al. (2013) created the GICCS, an adaptation of the SOCCS to explore transcompetent counseling practices for the quantitative portion of the study. For the quantitative approach, O'Hara et al. proposed three hypotheses. The first hypothesis asserted that advanced counseling students would produce higher TGNC counseling competence scores than beginning counseling students. The second hypothesis proposed that completing a counseling practicum or internship would lead to higher TGNC counseling competence scores. Finally, the third hypothesis predicted that personal connection with someone who identified as TGNC would produce higher TGNC counseling competence scores versus students with no personal connection.

After participants completed both a demographic questionnaire and the GICCS, O'Hara et al. (2013) reported quantitative results. For the initial two hypotheses, O'Hara et al. performed a 2 (program) x 2 (practicum experience) between-subjects factorial analysis of covariance (ANCOVA). The authors calculated a bivariate correlation and discovered a medium-sized positive correlation between the number of courses taken (beginning student versus advanced student) and the GICCS score ($r = .242$, $p = .03$). However, the main effects for beginning or advanced students nor participation in practicum, or not nor interaction effect were significant. O'Hara et al. performed a one-way between-subjects ANCOVA to measure a difference in GICCS final scores for participants who knew someone who identified as TGNC. The main effect for the third hypothesis was significant, $F(1, 75) = 20.855$, $p < .001$, partial eta squared = .218.

For the qualitative component, O'Hara et al. (2013) recruited seven participants from a single university and employed a basic qualitative research design using focus groups during data collection. The authors maintained process notes and memos throughout the data collection process and reached a consensus among each other during the data analysis and conceptual and thematic identification process. Five themes emerged from the focus group interviews: confusion regarding terminology, sources of information and knowledge, approaches to transcompetent counseling, characteristics that contribute to the counselor's development in training, and future training recommendations.

O'Hara et al. (2013) noted a limitation of this study is using a self-report method and potentiality for response bias. Additionally, the authors reflected that using a

qualitative approach with a small sample might not generalize to the overall CIT population. The authors identified a benefit of this study: ongoing exposure to transcompetent counseling practices promotes effective and appropriate counseling practices with TGNC clients.

Overall, both the quantitative and qualitative portions of this research study identified future implications for developing the components of counselor education programs that focus on transcompetent counseling practices (O’Hara et al., 2013). From the quantitative portion, O’Hara et al. (2013) ascertained that counselor education programs might not adequately prepare CITs to work with TGNC clients effectively. I will attempt to confirm or refute this implication for future research based on the CIT’s self-assessment of their confidence in my study. Additionally, the use of time spent in counseling practice and training received supports my decision to use both as independent variables for my study. I elected to deviate from using comprehensive counselor training and focus solely on transcompetent counseling training to determine if focused training programs promote self-efficacy in working with TGNC clients.

Counselor-in-Training Self-Efficacy

Counselor self-efficacy is understood as the counseling professional’s belief in their ability to provide effective therapeutic intervention when working with clients (Flasch et al., 2016). Flasch et al. (2016) described anxiety as a contributing factor to a CIT’s challenges developing self-efficacy and reflected that helping a CIT develop self-efficacy can significantly impact the experience of future clients. In this section I will

discuss self-efficacy as it relates to two of my constructs: time spent in clinical practice and training experiences.

Self-Efficacy and Time. Lent et al. (2009) conducted a semiqualitative research study using questionnaires to understand the sources impacting a change in CIT self-efficacy. Lent et al. described CIT self-efficacy as the ability to perform specific tasks, engage with helping and attending skills, manage sessions, and navigate crises and other challenging client situations. In their literature review, Lent et al. highlighted antecedents to the development of CIT self-efficacy including developmental levels, amount of training received, therapy hours accrued, and coursework completed. Despite the understanding of contributors to CIT self-efficacy from previous research, Lent et al. focused on limited trustworthiness of results due to much of the data-focused around findings deciphered following mock counseling sessions. Additionally, Lent et al. highlighted that previous research focused on global CIT self-efficacy beliefs rather than client-specific needs, subgroups, situations, or demographics.

In their study, Lent et al. (2009) sought to answer the following research questions using a qualitative method: (a) if the counselor experienced a change in self-efficacy during the first session with a client, (b) if self-efficacy grows between sessions, (c) the general direction of change, and (d) what factors CITs believe contributes to change in self-efficacy. Data collection occurred with 98 Master's-level CITs in their first practicum experience at a mid-Atlantic university. Participants answered a series of four questions exploring their perception of their confidence following each session.

Upon completion of data collection, Lent et al. (2009) evaluated responses. The authors emerged with an understanding that ongoing time spent practicing contributed to greater self-efficacy in counseling sessions, confirming the first two research questions were accurate in their predictions. Overall, the results for the third research question indicated positive growth of self-efficacy over time. Finally, the researchers engaged in a coding process for the fourth research question. Lent et al. emerged with the following themes that contributed to the development of CIT self-efficacy: (a) trainee performance, (b) observations about the client's behavior, cognitions, or feelings, (c) observations about the therapeutic relationship, (d) trainees' psychological or affective states, (e) direct feedback from the client, (f) perceptions about the session process or outcome, and (g) effects of supervision.

The understanding of the development of CIT self-efficacy is fundamental to my study. The authors demonstrate that time is a real contributor to the development of CIT self-efficacy (Lent et al., 2009). Despite the overwhelming confirmation of this finding by Lent et al. (2009), a limitation of this study is that the authors based the measurement of self-efficacy on overall counseling competence and abilities, not population- or individual-specific issues. Exploring CIT's self-efficacy, specifically with TGNC clients, can contribute to results posited by Lent et al. and further confirm the benefit of time spent in the development of clinical skills and abilities for CITs.

Self-Efficacy and Training Experience. Kull et al. (2018) conducted a quantitative research study examining whether school counselors' graduate coursework and professional development focusing on LGBT issues in counseling predicted self-

efficacy in working with LGBT students. Research indicating that mental health professionals felt unprepared to work with LGBT individuals, and a shortage of training for school counselors in working with LGBT youth, prompted this study. The researchers' questions sought to identify if: (a) exposure to graduate education and professional development predicted higher self-efficacy with LGBT students; and (b) if graduate education and ongoing professional development are indirectly related to LGBT-related practice through self-efficacy, such that more exposure to education and training would predict higher self-efficacy, leading to more work with LGBT students (Kull et al., 2018).

Using a sample of 466 school counselors from around the United States, Kull et al. (2018) collected demographic information and had respondents complete a survey using survey research methods assessing exposure to graduate education and professional development for working with LGBT students, beliefs in their abilities to provide LGBT-competent counseling, and the frequency the counselors worked with LGBT students. During data analysis, Kull et al. used an ordinary least squares regression model to predict self-efficacy in working with LGBT students. Results indicated statistical significance ($p < .001$) that more exposure to LGBT-related graduate training and professional development predicted self-efficacy and more frequent practice with LGBT students. The models accounted for more than one-third (35.6%) of the variance in self-efficacy and four-tenths (42.5%) of the variance in LGBT-related practice.

Results from the study by Kull et al. (2018) confirmed that graduate training and ongoing professional development were instrumental to an increase in self-efficacy for

school counselors working with LGBT students. While one could assume these results are generalizable to other counseling settings and demographics, I found that generalizing a research study involving school counselors working with LGBT students to mental health counselors working with LGBT clients in the greater community lacks credibility. While this study was useful, the literature indicates the inappropriateness of clumping TGNC individuals with LGB counseling competencies (Kull et al., 2018). For this reason, exploring TGNC-specific counselor self-efficacy was an appropriate next step for my study.

Counselor Development

Active development for CITs leads to increased counselor self-efficacy, professional identity, cognitive complexity, reflection, and self-awareness while the CIT focuses on clinical knowledge, skills, and competence (Mullen et al., 2015; Wagner & Hill, 2015). In a seminal article, Ronnestad and Skovholt (2003) highlighted six phases of development for a counselor: lay helper, beginning student, advanced student, novice professional, experienced professional, and senior professional. Each phase of counselor development involves both experiences gained via time spent working with clients, and ongoing education and training received (Ronnestad et al., 2018; Ronnestad & Skovholt, 2003). For this research study, I explored two factors of counselor development: time spent in clinical practice and hours of transcompetent training received.

Factors of Counselors-in-Training

There are varying definitions of what constitutes a CIT. For example, Gibson et al. (2010) conducted a study exploring the evolution of professional identity for emerging

counselors. Gibson et al. assessed CITs at different points of their counselor education program: before coursework, during coursework, before practicum, before internship, and at graduation. Alternatively, individuals who graduated from counselor education programs but were not independently licensed by their state's licensure body are CITs as well (Keller-Dupree et al., 2020).

Keller-Dupree et al. (2020) reflected that CITs rely on educational experiences and validation via demonstration of knowledge acquisition and ongoing direct professional experiences for their development. Both time and training results include a more internalized locus of professional identity (Keller-Dupree et al., 2020; Wagner & Hill, 2015). Because there is no single definition of a CIT, I combined approaches from studies by Gibson et al. (2010), Keller-Dupree et al. (2020), and Ronnestad and Skovholt (2003) and defined a CIT for this study as an individual who was still participating in a counselor education graduate program or had graduated from a counselor education program but continued to accrue supervised hours towards state licensure.

Summary and Conclusions

Counselors, including CITs, have an ethical obligation to employ multiculturally competent counseling strategies with their clients (ACA, 2014; Sue et al., 2019). Clinical implications of working with transgender clients have been discussed and considered more readily in the past half-decade due to the heightened presence and consideration of transgender issues in the media and overall society (McLaren, 2018). Despite advancements in understanding the experiences of TGNC in counseling settings and barriers to effective care and useful counseling strategies with TGNC clients, uncertainty

about CITs' belief in their ability to provide transcompetent clinical intervention still exists. In this study, I met this need by collecting data to help fill the gap in the literature in this field. Understanding the self-efficacy that CITs possess in working with clients that identify as TGNC will better assist counselor education programs in designing coursework and learning strategies to help students in counselor education programs be better prepared to work directly with TGNC clients.

In this chapter, I provided an exhaustive review of existing literature surrounding multicultural competence in counseling, counseling TGNC clients, CITs and self-efficacy, and counselor development. In Chapter 3, I describe the research method to measure the relationships between time spent in clinical practice, transcompetent training received, counseling competence while working with TGNC clients, and CIT's self-efficacy working with TGNC clients. I discuss the population, sample frames and sampling procedures, research design and rationale, instrumentation and operationalization of variables, analytical strategy, threats to validity, and ethical considerations.

Chapter 3: Research Method

Counselors recognize the importance of providing multiculturally competent counseling services to clients of diverse backgrounds (Sue et al., 2019). But TGNC often experience marginalization when associated directly with LGB individuals because sexual identity and orientation clinical implications differ significantly from gender identity clinical implications (McCullough et al., 2017; O'Hara et al., 2013). Further, competency alone does not produce sufficient and effective clinical intervention by every counselor (Tormala et al., 2018). The purpose of this study was to examine the relationship between CIT's perceived self-efficacy in providing transcompetent counseling services, the CIT's perceived competency in delivering transcompetent counseling, the cumulative time the participant spent as a CIT working with both cisgender and TGNC clients, and the amount of training CITs received specific to transcompetent counseling practices. Further understanding of CIT's perception of their ability to provide transcompetent counseling can improve TGNC individuals' experiences in counseling. In this chapter, I provide details regarding my methodology in the following sections: research design and rationale; methodology; population; sampling and sampling procedures; procedures for recruitment, participation, and data collection; instrumentation and operationalization of constructs; threats to validity; and ethical procedures.

Research Design and Rationale

Quantitative researchers use statistical analysis to understand the relationships and differences among variables (Frankfort-Nachmias & Leon-Guerrero, 2018). Statistical

procedures that use both independent and dependent variables provide researchers insight into diverse societal problems and challenges and allow for the encountering of answers to questions, examining ideas, and exploring theories (Frankfort-Nachmias & Leon-Guerrero, 2018). Although the inference of cause and effect is challenging to achieve in social science, researchers use variables to attempt to reach conclusions regarding research questions (Bleske-Rechek et al., 2015; Frankfort-Nachmias & Leon-Guerrero, 2018).

In this study, the predictor variables were the number of hours of transcompetent counseling training CITs received as measured by self-reported training hours, the amount of time a participant spends as a CIT, as measured by the hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, and competence when working with TGNC clients as measured by the GICCS-R (Cor, 2016; Dispenza & O'Hara, 2016; Cor, 2016). The outcome variable was CIT's self-efficacy working with clients who identify as transgender as measured by the TGNC-CSI-SF, adapted from the LGB-CSI-SF (Dillon et al., 2015).

I used a quantitative, non-experimental design for this research study. A non-experimental research design was most appropriate as I did not manipulate variables. Instead, I measured the relationships and differences between existing variables (Frankfort-Nachmias & Leon-Guerrero, 2018). Specifically, I used correlational, cross-sectional design during data collection and analysis, which are appropriate when using a multivariate approach and allow a researcher the opportunity to understand the

relationships and differences among variables (Houser, 2015). This design was also suitable because data came from individual respondents at a single point in time (Frankfort-Nachmias & Leon-Guerrero, 2018).

Further, survey research methods allow a researcher to gather numerical data by using closed-ended questions that focus the respondent on explicitly answering a question and reducing variance within the coding process, leading to ease during analysis (Bradburn et al., 2004). Survey research using closed questions also provides a researcher the opportunity to standardize data collection processes and ultimate generalization of results (Friborg & Rosenvinge, 2013). Survey research was appropriate for my study as I used two different psychometric scales and a demographics questionnaire that I administered at a single point in time during the data collection process (Krosnick, 1999).

A correlational, cross-sectional, one-shot survey research design was an applicable method of data collection for my research questions. Essential to my research questions was measuring the effect of both CIT transcompetent counseling training received, pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, and their perceived competence in providing effective TGNC counseling services on CIT's self-efficacy working with clients who identify as TGNC. Collecting data via questionnaires and employing a statistical analysis process to arrive at results was consistent with quantitative research (Frankfort-Nachmias & Leon-Guerrero, 2018).

I perceived minimal time restraints regarding this research design, particularly due my use of convenience sampling and conducting a non-experimental research study

(Houser, 2015). It is possible that COVID-19 and ramifications on practicum, internship, and supervision sites could have impacted my data collection. But I accepted the possibility of needing to prolong my data collection until I satisfied the required sample size. However, the pandemic did not hinder my ability to sufficiently collect data.

During data analysis, I used ANOVA to measure the differences between subgroups of variables, and linear regression and multiple regression models to measure the relationship among variables (Frankfort-Nachmias & Leon-Guerrero, 2018; Warner, 2013). Although a qualitative approach could have been appropriate for similar research questions, the ability to collect aggregate data from a sample indicative of a larger population can contribute to a greater opportunity to generalize results about self-efficacy and perceived competence of CITs working with TGNC clients (Groves et al., 2009; Onwuegbuzie & Collins, 2017).

Methodology

Before conducting a study, researchers outline their methodological plan (Creswell & Creswell, 2018). A detailed review of the methodological approach allows readers to replicate a study based on the researcher's descriptions. In this section, I outline the overall population, sample, instrumentation, operationalization of constructs, and analytical strategy.

Population

I recruited current students and recent graduates who were still unlicensed from counselor education programs accredited by CACREP and programs actively pursuing CACREP accreditation to participate in this study. I collected data from both current

students and recent graduates who are still unlicensed to ensure enough representation and variation among the independent variables. Based on the Minnesota Study of Therapist and Counselor Development (Ronnestad et al., 2018; Ronnestad & Skovholt, 2003), CITs include students who have yet to graduate and post-graduate, pre-licensed counseling candidates (Keller-Dupree et al., 2020). I chose to focus on students from CACREP-accredited counselor education programs and programs actively pursuing CACREP accreditation because of the chances of those students receiving instruction focusing on multicultural competence and approaches when providing counseling services (CACREP, 2016).

Although multicultural curriculum differs between programs, it was important to ensure that participants received multicultural content exposure. I recruited students in counselor education programs and recent graduates from counselor education programs from any of the 50 states or United States territories. The sample population came from CACREP-accredited counselor education programs and programs actively pursuing CACREP accreditation, members of the ACA, and members of the Counselor Education and Supervisor Network (CESNET) and their students or supervisees.

At the time of this writing, in July 2021, there were over 780 CACREP-accredited master's degree programs across the United States (CACREP, 2021). The ACA reported roughly 55,000 members, although the number of student members was unknown. Kent State Archives (2014) listed 5,601 subscribers of CESNET-L. Additionally, I sought current students or recent graduates of two higher learning institutions. I used a large, American-based, online university with over 800 students in a counselor education

program offering a participant pool for data collection within research studies and a small, American-based, non-profit graduate-level counselor education program with over 250 students. Finally, I recruited participants on a social media page of the Minnesota Counseling Association, which has over 1,200 members.

Sampling and Sampling Procedures

The initial sampling strategy I used was a nonprobability, purposeful convenience sampling. This sampling method is common among researchers due to limitations and challenges associated with accessing possible sample frames using random and probability sampling methods (Cox, 2016; Houser, 2015). Convenience sampling afforded me a limited representative sample of the larger population while acknowledging that exact representation using this method was impossible (Cox, 2016). A strength of convenience sampling was that the sample was easily accessible to me, and the approach minimized costs and the amount of time conducting the study (Houser, 2015).

The purposive component of my sampling strategy was the method by which I recruited participants. The sampling frames I used included the following: (a) the Calls for Study Participants discussion forum on the ACA Connect website (ACA, 2021); (b) the CESNET-L listserv (Kent State Archives, 2014); the Minnesota Counseling Association social media page; (d) the participant pool at a large, American-based, online university; and (e) students and recent graduates from a small, American-based, non-profit graduate-level counselor education program. I posted a call to participate on the ACA Connect community discussion forum website and posted a similar message on the

CESNET-L listserv while asking recipients to forward my call for study participants to students and supervisees. I posted my call to participate on the participant pool page within a large, American-based, online university with a counselor education program. I requested a staff member at the small, American-based, non-profit graduate-level counselor education program to forward my survey to current students and recent graduates. Finally, I posted my call for study participants on a social media page of the Minnesota Counseling Association with permission from the site administrator.

Students currently participating in, or who had recently graduated from, a CACREP-accredited counselor education program or programs actively pursuing CACREP accreditation from all 50 states were eligible to participate in my study. Excluded from participating were students enrolled in, or are recent graduates from, non-CACREP accredited universities, programs not actively pursuing CACREP accreditation, and counseling professionals who were fully licensed mental health professionals.

I recruited an appropriate number of respondents to participate in the research study. The number of respondents needed to meet the required sample size was 82 respondents. I used version 3.1 of G*Power (Faul et al., 2009) to calculate the required sample. The α level of my study, or probability of making a Type I error, was .05 (5%). This indicated there was a 5% chance of detecting an effect when there was none (Frankfort-Nachmias & Leon-Guerrero, 2018). The β level, the likelihood of making a Type II error, or determining there was no effect when one did exist, was set at .20 (20%), which is common for social sciences (Frankfort-Nachmias & Leon-Guerrero, 2018). As such, the power level (1-β), or likelihood of detecting an effect, was .80 (80%).

These alpha, beta, and power levels are typical for social science research (Frankfort-Nachmias & Leon-Guerrero, 2018). I chose an effect size of .3, which was based on prior studies using the LGB-CSI-SF (Dillon & Worthington, 2003; Dillon et al., 2015). As such, I used the following parameters to calculate my sample size: a power level of .80, a 5% margin of error, and an effect size of .3. Considering a possible response rate of approximately 20% (Sauermann & Roach, 2013), I estimated sending at least 410 surveys to reach my desired sample.

Procedures for Recruitment, Participation, and Data Collection

Because a single method of connecting with students in counselor education programs and CITs did not exist, I used creative approaches to access potential participants. I recruited my target demographic, CITs, using various methods, including sending emails to counselor educators who are members of the CESNET-L listserv asking those individuals to pass my survey recruitment to their students via snowball sampling (Houser, 2015). I also recruited potential participants by posting on the ACA Connect online discussion forum, social media, and sharing my study with counselor education students at two different American-based higher learning institutions to which I had access.

During the recruitment process, I described the study's purpose, discussed participant qualifications, and provided a link to the survey. I obtained the link to the survey after constructing the study using the web-based SurveyMonkey platform. Upon arrival to the SurveyMonkey platform, the potential participant identified whether they were a current student or recent graduate who was still unlicensed from a counselor

education program accredited by CACREP or actively pursuing accreditation from CACREP. If the potential participant answered “yes” to this question, they moved forward in the study. All respondents who indicated “no’’ to the initial question were informed they did not meet inclusion criteria and were thanked for their time. I sent reminders after two weeks until I reached the minimum sample size.

Before starting the survey, I informed potential participants that engagement in the research study was optional, and they could discontinue their participation at any time. Before beginning the survey, participants navigated the informed consent form, which was located on the second page of the survey. Participants read the prepared informed consent and indicated whether they agreed to move forward with the study or disagreed and elected to not participate in the study. If the participant indicated agreement to informed consent, they continued to the demographic questionnaire. Included in the informed consent section of the survey was information about the background of the study, the study procedures, the voluntary nature of the study, the risks and benefits of participating, information related to privacy and confidentiality, a statement of no compensation for participation, the contact information of the primary researcher, and contact information for the research participant advocate at my university (Walden University, n.d.).

Following informed consent, participants completed a basic demographic survey (see Appendix A). I collected information such as age, race, ethnicity, gender identity, sexual orientation, hours of counseling experience as a CIT, and hours of transcompetent training received in this portion of the survey. Also included in the survey was the 15-

item TGNC-CSI-SF, based on the LGB-CSI-SF (Dillon et al., 2015) and the 29-item GICCS-R (Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013). Upon completing all the necessary components of the survey, participants then clicked "done" to submit the survey. They were taken to an exit page where I offered a note of gratitude for the individual's participation and my contact information in the event of follow-up questions or concerns (Creswell & Creswell, 2018). I did not schedule any formal follow-up with participants as I used a cross-sectional, one-shot survey research design.

I used SurveyMonkey to administer the surveys for this research study. SurveyMonkey is a web-based survey application that allows for the administration, data collection, and review of surveys for multiple purposes, including survey research (SurveyMonkey, 2021). SurveyMonkey hosts their systems and technical infrastructure in SOC 2 accredited data centers with physical security controls, including constant monitoring, cameras, visitor logs, and entry requirements (SurveyMonkey, 2021). SurveyMonkey uses anonymous survey administration, anonymous data and responses, secure email communication, and survey embedding (SurveyMonkey, 2021).

In compliance with my university's IRB guidelines, I downloaded all data from SurveyMonkey and stored it on a password protected desktop computer and password protected file to ensure confidentiality and security (Walden University, 2020). I was the only person with direct access to the data file and saved data for the sole purpose of analyzing results and determining research study conclusions. My university's guidelines indicate the requirement of saving data for a minimum of 5 years following the culmination of a study. At the culmination of those five years, I will destroy all data by

using my computer's function allowing me to permanently delete data and rewrite the disk space to which it was saved.

Instrumentation

Survey research relies on psychometric scales during the data collection process (Groves et al., 2009). Additionally, as a quantitative method, survey research allows for the investigation of relationships and differences between independent and dependent variables. In this section, I describe the psychometric scales I used in my study and provide additional detail about the constructs I used as a I collected data.

Transgender and Gender Non-Conforming Affirmative Counseling Self-Efficacy Scale-Short Form

The TGNC-CSI-SF is an adapted version of the LGB-CSI-SF (Dillon et al., 2015), which is an updated version of the LGB-CSI (Dillon & Worthington, 2003). With permission from the primary creator of the LGB-CSI-SF, I adjusted the language in the original scale to reflect self-efficacy related to counseling and TGNC issues rather than LGB issues (see Appendix B).

Dillon and Worthington (2003) developed the LGB-CSI to assess a mental health professional's perception of their confidence to provide LGB-affirmative counseling services in the realms of research, training, and clinical practice. Dillon and Worthington envisioned the LGB-CSI as affirmative counseling for lesbian women and gay men emerged while the counseling field focused more efforts on the concept of self-efficacy. Still, due to ongoing stigma related to negative attitudes in society, LGB-counseling competence was slow to develop into the repertoire of mental health professionals (Dillon

& Worthington, 2003). At the time of the LGB-CSI development, researchers indicated that counseling students and trainees reported limited confidence in the training they received preparing them to work with lesbian and gay clients. As such, the creators of this scale focused on LGB-affirmative counseling, defined as a therapeutic intervention that celebrates diverse sexual orientations and promotes the authenticity and integrity of LGB individuals (Bieschke et al., 2000).

The LGB-CSI consists of five core construct areas related to the self-efficacy of a counselor providing LGB-affirmative counseling. The dimensions include: (a) application of knowledge of LGB issues (Application of Knowledge), (b) engaging with advocacy skills (Advocacy Skills), (c) self-awareness of the development of sexual identity for the counselor and others (Self-Awareness), (d) development of a working relationship with LGB clients (Relationship), and (e) discovery of underlying issues and problems experienced by LGB clients (Assessment; Dillon & Worthington, 2003). I used both total and subscale scores from this instrument during the data analysis process. The original LGB-CSI consisted of 32-items, while the evolved LGB-CSI-SF reduced the overall items in the scale to 15 within the initial five core constructs (Dillon et al., 2015). Dillon et al. (2015) used the strongest loading items from the original LGB-CSI when creating the updated version of the inventory. While completing the instrument, respondents use a five-point Likert scale ranging from 1 (not confident) to 5 (extremely confident) to rate their ability to perform a total of 15 counseling-related tasks and behaviors with LGB clients.

The LGB-CSI-SF takes approximately 10 minutes to complete (Dillon et al., 2015). The primary creator of the scale, Frank R. Dillon, PhD, provided me with written consent to use this scale and amend LGB-specific vocabulary reflect working with clients who are TGNC. Total scores on the instrument range from no confidence, or no self-efficacy (15 total points) to extremely confident, or high self-efficacy (75 total points). Two sample questions from the measure include: (a) rate your ability to assist TGNC clients to develop effective strategies to deal with cisgenderism and transphobia and (b) rate your ability to examine your own gender identity development process.

Dillon et al. (2015) performed a confirmatory factor analysis (CFA) and a procedure related to validity estimates when creating the updated LGB-CSI-SF. The final analytical sample consisted of 543 participants after the authors applied eligibility criteria and removed responses that did not fit within the needed sample. Participants ranged from 27 to 83 years old with the average age of respondent as 50.07 years. Approximately 76% of respondents were female and 80% of respondents identified as White/Latino while less than 7% identified as African American or Black and non-Latinx and less than 5% identified as Asian or Pacific Islander. The remainder of participants identified as Black and Latinx, American Indian or Alaskan Native, or another race or ethnicity. Approximately 45% of respondents were licensed psychologists, 24% were licensed clinical social workers, 20% were social work graduate students, and 11% were licensed marriage and family therapists.

The LGB-CSI-SF is present in additional existing research studies. Pepping et al. (2018) conducted a study exploring the effectiveness of LGBT-affirmative therapist

training with 96 mental health professionals. Participants ranged in age from 22 to 70 years, with the average age 36.21 years. Eighty of the participants identified as female with the remaining 16 identifying as male. Most participants (*n* =70) identified as heterosexual, with the remaining (*n* = 21) identifying as LGBTQ. Twenty-one respondents reported current religious beliefs, 36 reported previous religious background but not currently practicing, and 39 reported no previous or current beliefs. Participants' therapeutic experience ranged from less than one year to 37 years in the field. Sixty-five of the respondents were licensed psychologists, 14 were social workers, two were medical professionals, and the remaining 15 were mental health practitioners.

Acevedo et al. (2020) adapted the instrument to measure social workers' confidence in working with LGBTQ migrants. Acevedo et al. provided limited demographics for this study but did indicate 43% of participants had an undergraduate degree and 40% had a graduate degree. Within this study, 59% denied previous training on working with migrants and 49% reported this was their first training working with LGBTQ people.

Dillon et al. (2015) performed a CFA using structural equation modeling (SEM), which assessed the original LGB-CSI model's fit derived from the original development study. Using a confirmatory fit index (CFI) and the root mean square error of approximation (RMSEA), the authors reported the items selected significantly loaded, and the measurement model provided an adequate fit to the data, CFI = .90; RMSEA = .07 (90% CI = .07 to .08). Following this step, the authors began removing the weakest loading items until three items remained for each of the five domains. Upon arrival at a

new short-form version of the LGB-CSI, the authors estimated the instrument with a new CFA. The newly created LGB-CSI-SF provided an adequate fit to the data, CFI = .96; RMSEA = .07 (90% CI = .07 to .08). Dillon et al. then correlated the factors in the new short-form model to corresponding factors in the original LGB-CSI at $r \geq .95$ (Application of Knowledge = .96; Advocacy = .95; Self-Awareness = .95; and Assessment = .98).

Dillon et al. (2015) explored convergent validity for the LGB-CSI-SF. Using information gathered within the demographics section of their survey, Dillon et al. highlighted that amount of instruction in LGB issues, number of family or friends who are LGB, and number of LGB clients correlated with Application of Knowledge, Advocacy Skills, Assessment, and Relationship subscales and total scale scores, $r = .10$ to $.47$, $p < .05$. The Self-Awareness subscale did not relate to LGB instruction and weakly related with number of LGB clients and number for family or friends who were gay males. Dillon et al. estimated a reliability index of each latent construct of the LGB-CSI-SF. Estimates for the latent constructs were as follows: Application of Knowledge = .87, Advocacy = .92, Self-Awareness = .87, Assessment = .87, and Relationship = .81). One-week test-retest reliability estimates of the LGB-CSI-SF total and subscales demonstrated a majority significant relationships: $r = .80$, $p < .01$ (Total), $r = .69$, $p < .01$ (Application of Knowledge), $r = .76$, $p < .01$ (Advocacy Skill), $r = .34$, $p = .06$ (Self-Awareness), $r = .68$, $p < .01$ (Relationship), $r = .61$, $p < .01$ (Assessment).

GICCS

The GICCS (Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013) is an evolution of the SOCCS (Bidell, 2005) that explores a counselor's competency level in working with TGNC clients. After O'Hara et al. (2013) recognized a gap in existing competency-based, quantitative measurement opportunities for working with TGNC clients, they adapted the SOCCS, an existing scale to explore the competency of counselors working with LGB clients, with the original author's permission. Although I used an updated version of the GICCS, I describe the original evolution of this scale as it contributed to the revised version. I review the GICCS and SOCCS in greater detail than what might be normal because the version of the GICCS I used had not been replicated in additional studies following its initial validation.

Bidell (2005) defined sexual orientation counselor competency as a counselor's preparedness to engage with the appropriate knowledge, skills, and attitude competencies to provide ethical and affirmative clinical interventions to LGB clients. Bidell described his process of creating the SOCCS by using existing LGB literature to identify 100 items that measured either LGB attitude, skill, or knowledge counseling competencies. By using a rational-empirical approach (Dawis, 1987; Ponterotto et al., 2002), Bidell reduced the initial pool of 100 items to 42 questions, which then became the first draft of the SOCCS. Twelve questions measure attitude competencies, 18 measure knowledge competencies, and 12 measure skill competencies (Bidell, 2005).

This version of the SOCCS requests the respondent to rate the truth of each question as it applies to them using a Likert scale ranging from 1 (not true at all) to 7

(totally true, Bidell, 2005). Bidell (2005) reflected that higher overall SOCCS and subscale scores indicate elevated counselor competency levels related to working with LGB clients. Bidell used a factor analysis, criterion, convergent, and divergent validity assessment, and internal consistency alphas to measure reliability while establishing the SOCCS with an overall sample of 312 undergraduate, graduate, and doctoral-level students.

While exploring convergent validity, Bidell (2005) used three existing measures expected to correlate with the SOCCS's subscales: The Attitudes Toward Lesbians and Gay Men Scale (Herek, 1998), the Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002), and the Counselor Self-Efficacy Scale (Melchert et al., 1996). The attitudes subscale of the SOCCS significantly correlated with the Attitudes Toward Lesbians and Gay Men Scale, $r = -.78$, $p < .01$. The skill subscale of the SOCCS significantly correlated with the Counselor Self-Efficacy Scale, $r = .65$, $p < .01$. The knowledge subscale of the SOCCS significantly correlated with the Multicultural Counseling Knowledge and Awareness Scale, $r = .63$, $p < .01$. Bidell ran a regression analysis using the scores from the Multicultural Counseling Knowledge and Awareness Scale, the Attitudes Toward Lesbians and Gay Men Scale, and the Counselor Self-Efficacy Scale as predictor variables for the total SOCCS score and accounted for approximately 65% ($R = .81$) of the variance, demonstrating statistical significance, $F(3, 311) = 192.13$, $p < .001$. The Multicultural Counseling Knowledge and Awareness Scale, the Attitudes Toward Lesbians and Gay Men Scale, and the Counselor Self-Efficacy

Scale were significant predictors of SOCCS scores ($\beta = .41, -.32, .28, p < .001$, respectively) (Bidell, 2005).

Bidell (2005) conducted an exploratory factor analysis on the 42 SOCCS items using principal-axis factoring procedures and oblique rotation with the assumption that the three factors within the SOCCS were likely correlated. Bidell reported that the three-factor solution accounted for 40% of the total variance with a total of 29 questions. Bidell highlighted that the Skills factor accounted for 24.91% of the variance and consisted of 11 items. The Attitudes factor accounted for 9.66% of the variance and consisted of 10 items. The Knowledge factor accounted for 5.41% of the variance and consisted of eight items. These remaining 29 questions became the final version of the SOCCS.

Bidell (2005) reported the coefficient alpha for the overall SOCCS was .90. Coefficient alphas for the subscales were .88 (Attitudes), .91 (Skills), and .76 (Knowledge). Following a one-week test-retest, correlation coefficients were .84 for the overall SOCCS. Correlation coefficients for the subscales were .85 (Attitudes), .83 (Skills), and .84 (Knowledge). Bidell explored criterion validity through the use of education level and sexual orientation of participants in relation to SOCCS scores. Regarding sexual orientation, participants who identified as LGB scored significantly higher on the overall SOCCS $F(1, 301) = 30.14$, $p < .001$; on the Attitudes subscale, $F(1, 301) = 8.27$, $p < .001$; on the Skills subscale, $F(1, 301) = 29.12$, $p < .001$; and on the Knowledge subscale, $F(1, 301) = 8.80$, $p < .005$, compared with heterosexual respondents. Additionally, respondents with higher education levels scored significantly higher on the overall SOCCS, $F(3, 308) = 75.10$, $p < .001$; on the Attitudes subscale, $F(3,$

308) = 5.33, $p < .001$; on the Skills subscale, $F(3, 308) = 107.82$, $p < .001$; on the Knowledge subscale, $F(3, 308) = 25.62$, $p < .001$.

Dispenza and O’Hara (2016) used the GICCS in a study exploring TGNC counselor competencies. The authors sampled a total of 113 psychologists and mental health professionals. Half of the respondents (49.5%) reported doctoral level education, while the other half (50.5%) identified as master’s level clinicians. Sixty-seven percent of respondents identified with full licensure at the time of the study. The authors reported approximately 18% of respondents were between the ages of 18 and 27 years, 50% were between the ages of 28 and 37, 18% between the ages 38 and 47, and the remaining respondents were over 48 years. Nearly 48% of respondents identified as White, 31% identified as Black or African American, 5.3% identified as Asian, 7% Latinx, and 7% as multiracial. Seventy-eight percent identified as cisgender women with the remaining 22% identifying as cisgender men. Seventy-five percent identified as heterosexual, 5.3% as gay men, 5.3% as lesbian women, 12.4% as bisexual, and 2% as queer.

GICCS-R

Researchers in two previous studies used the GICCS to explore the competency of counselors working with TGNC clients without validation (Cor, 2016; Dispenza & O’Hara, 2016; O’Hara et al., 2013). Cor (2016) completed a dissertation aimed at validating the GICCS. Cor engaged with a sample of 187 participants and administered a demographics questionnaire along with GICCS, the Multicultural Counseling Inventory (Sodowsky et al., 1994), and Marlowe-Crowne Social Desirability Scale Form-C (Crowne & Marlowe, 1960; Reynolds, 1982). Participants ranged in age from 21-68, with

the majority of participants within the age range of 21-30 (59.8%). Approximately 70% of respondents identified as heterosexual, 8% as bisexual, and nearly 10% as gay or lesbian. A majority of respondents, 78%, identified as White with the remaining participants identifying as Asian or Asian American (2.7%, Black or African American (4.3%), Hispanic or Latinx (4.8%), multiracial (4.3%), Native Hawaiian or Pacific Islander (.5%), and mixed race (4.8%).

Similar to the GICCS, the GICCS-R requests respondents to self-report their knowledge, skills, and awareness surrounding various tasks when working with TGNC clients. Responses range from 1 (not true at all) to 7 (totally true) on this 27-item instrument. Respondents can expect to spend approximately 10 minutes completing this survey. Examples of statements in this measure include the following: (a) I have received adequate clinical training to counsel transgender clients and (b) Transgender clients receive “less preferred” forms of counseling treatment than non-transgender clients. To score this instrument, the researcher calculates mean scores for the subscales and overall instrument. Eleven of the total items are reverse scored, since for those items a high number equates to lower competence. Higher scores indicate higher levels of perceived competency (Cor, 2016; Dispenza & O’Hara, 2016).

Cor (2016) used exploratory factor analysis (EFA) to examine the GIS factor structure. After determining two of the original GICCS questions had extraction communalities below .20, Cor dropped those two items from the scale. Following this decision, Cor referred to the new instrument as the GICCS-R. Cor then determined that the scale supported the tripartite model for multicultural counseling competency

assessment of knowledge, skills, and awareness (Sue et al., 1992). The Cronbach's alpha for the overall scale was .78. Cronbach's alphas for the subscales here .76 (Knowledge), .84 (Awareness), and .79 (Skills) (Cor, 2016). I will use both total and subscale scores from this instrument during the data analysis process. Subscales include: (a) Attitude competences, (b) Knowledge competencies, and (c) Skill competencies (Cor, 2016).

Cor (2016) demonstrated convergent validity using the GICCS-R and the Multicultural Counseling Inventory. Cor observed a statistically significant, moderately positive correlation between the two instruments ($r = .574$, $p = .001$), highlighting convergent validity for the overall scale. Cor also explored convergent validity for the subscales. The Knowledge subscale had a moderate, positive correlation with the Multicultural Counseling Inventory Knowledge subscale ($r = .429$, $p = .001$). The GICCS-R Awareness subscale had a weak, positive relationship with the Multicultural Counseling Inventory Awareness subscale ($r = .192$, $p = .008$). Finally, the GICCS-R Skills subscale demonstrated a moderate, positive correlation with the Multicultural Counseling Inventory skills subscale ($r = .446$, $p = .001$). Cor used bivariate correlation matrices to discover discriminant validity between the Marlowe-Crowne Social Desirability Scale Form-C and the GICCS-R, with findings demonstrating a statistically significant, weak negative correlation between the instruments ($r = -.184$, $p = .012$). Among the subscales, Cor was unable to find evidence of a statistically significant relationship between the Knowledge and Awareness subscales scores on the Marlowe-Crowne Social Desirability Scale Form-C and the GICCS-R. Cor did discover evidence

of a weak, negative relationship between the Marlowe-Crowne Social Desirability Scale Form-C and the GICCS-R Skills subscale (r = -.162, p = .027).

Operationalization of Constructs

I used variables based on existing research exploring the concept of CITs, self-efficacy, and counselor competence working with TGNC clients (Bidell, 2012; O'Hara et al., 2013). I individually coded each variable, as outlined in the following descriptions. Each variable applied to all participants.

Time Spent as a CIT

I gathered information about the time the respondent has spent as a CIT as part of the demographic questionnaire. I asked the respondent to indicate how much time they had spent as either a graduate student in a counselor education program or a recent graduate from a counselor education program who was still accruing supervision hours for licensure. Using Ronnestad and Skovholt's (2003) phases of counselor development in conjunction with previous studies that focused on the level of development as a CIT (Cor, 2016; Dillon et al., 2015), I had respondents self-identify with how much time they had spent as a CIT (including time participating in pre-graduation practicum and internship field experience and post-graduation/pre-licensure supervised practice). I coded this question as follows: 1 = less than 400 hours, 2 = 401 to 800 hours, 3 = 801 to 1,200 hours, 4 = 1,201 to 1,600 hours, 5 = 1,601 to 2,000 hours, 6 = 2,001-2,400 hours, 7 = 2,401 to 2,800 hours, and 8 = over 2801 hours. I based the subgroupings of hours on Ronnestad and Skovholt's (2003) phases of counselor development, particularly the novice student, advanced student, and novice professional phases. I also used data from a

study by Page et al. (2017) that indicated the average amount of supervised hours before licensure for a CIT is 2,800 within the United States. I measured time spent as a CIT as a categorical variable as it allows me to perform ANOVA models to observe differences between CITs early in their training versus CITs who are further along in their development.

Transcompetent Counseling Training

I gathered information about the estimated hours of transcompetent counseling training the respondent has received as part of the demographic questionnaire. Following the example of Dillon et al. (2015), I asked the respondent to indicate how many hours of transcompetent training they had received based on the breakdown of hours. I coded the responses to this question as follows: 1 = less than 5 hours, 2 = 6 to 10 hours, 3 = 11 to 15 hours, 4 = 16 to 20 hours, 5 = 21 to 25 hours, 6 = 26 to 30 hours, 7 = more than 30 hours. I based this subgrouping of training hours on the study used as a foundational element for my study. Dillon et al. classified training as a categorical and used nonparametric Spearman's rho correlation coefficients to examine this variable. I used transcompetent counseling training as a categorical variable to perform ANOVA models to observe differences between subgroups, such as CITs with minimal hours of transcompetent counseling training versus CITs with many hours of transcompetent counseling training.

Counselor-in-Training's Competency While Working with TGNC Clients

A CIT's competence working with TGNC clients serves as the third predictor variable for this study. I gathered data about a CIT's competency working with TGNC

clients using the GICCS-R, an instrument based on the SOCCS (Bidell, 2005; Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013). I used results from this instrument to determine if TGNC competence predicted a CIT's self-efficacy working with clients who are TGNC. I received permission from the creator of the SOCCS to use the version adapted for TGNC-competency in my study (see Appendix C). I also received permission from the creator of the GICCS-R to use this scale in my study (see Appendix D).

Self-Efficacy of a CIT Working With TGNC Clients

The self-efficacy of a CIT working with TGNC clients serves as the first outcome variable for this study. I used the TGNC-CSI-SF, an adapted version of the LGB-CSI-SF (Dillon et al., 2015).

Data Analysis Plan

I used the International Business Machines (IBM) Statistical Package for the Social Sciences 27. The Statistical Package for the Social Sciences (SPSS) tools for statistical analysis, modeling, predicting, and completing survey research. Researchers engaging in quantitative studies use SPSS for data organization and analysis via data output, tables, and graphs (Ward, 2013).

I conducted appropriate data screening and cleaning methods that correspond with the statistical models I used following the culmination of data collection to determine that the data was valid, accounted for, and if the data contained extreme outliers (Frankfort-Nachmias & Leon-Guerrero, 2018). I assessed the data to determine if all necessary data was present and methods by which I could eliminate or replace missing data. I used frequency tables to observe and summarize independent and dependent variables, along

with responses from the demographic questionnaire. I then inspected data plots, skew, kurtosis, and histograms. Reviewing this information allowed me to determine if my data met various assumptions for the statistical models I used (Frankfort-Nachmias & Leon-Guerrero, 2018). I observed questions not answered in the frequency data tables. I marked questions requiring a response with an asterisk (*) in SurveyMonkey to encourage respondents to answer all necessary questions. I did not end the data collection process until each question met my required sample size. Upon culminating the data collection process, I reviewed the surveys to determine if any with missing data were usable and removed those that were.

I investigated several research questions and hypotheses in this study:

Research Question 1: Does a CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, increase with the accumulation of the participant's pre-graduation, post-graduation and pre-licensure supervised clinical practice hours as measured by respondent self-report on the demographic questionnaire.

H_a1: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does significantly increase with the participant's accumulation of pre-graduation, post-graduation, and pre-licensure supervised clinical practice hours.

H_01: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does not significantly increase with the accumulation the participants pre-graduation, post-graduation, and pre-licensure supervised clinical practice hours.

Research Question 2: Does a CIT's self-efficacy for working with clients who identify, as TGNC as measured by the TGNC-CSI-SF, significantly increase as the amount of transcompetent counseling training received also increases, as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire?

H_a2: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, significantly increases as transcompetent counseling training received increases as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire.

H_02: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does not increase as transcompetent counseling training received increases as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire.

Research Question 3: Does the level of CIT's perceived competence in working with TGNC clients, as measured by the GICCS-R, significantly predict CITs' perceived self-efficacy, as measured by the TGNC-CSI-SF?

H_a3: The level of competence in working with TGNC clients, as measured by the GICCS-R does predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

H_03: The level of competence in working with TGNC clients, as measured by the GICCS-R does not predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

Research Question 4: Do the amount of time a participant spends as a CIT, as measured by the hours of pre-graduation practicum and internship hours accumulated and

post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training as measured by participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients, as measured by the GICCS-R, predict CIT self-efficacy, as measured by the TGNC-CSI-SF?

H_a4: The amount of time a CIT spends as a trainee, as measured by hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training, as measured by participant self-reported hours of transcompetent counseling training on the demographic questionnaire, and level of competence in working with TGNC clients, as measured by the GICCS-R, does predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

H_04: The amount of time a CIT spends as a trainee, as measured by hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training, as measured by participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients, as measured by the GICCS-R, does not predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

I used descriptive statistics, ANOVA, simple linear regression, Pearson product-moment correlation, and multiple regression during this study's data analysis component.

Descriptive Statistics

Before running descriptive statistics, I observed frequencies to see the distribution of my data. Then, I reviewed descriptive statistics and observed data for central tendency and variability measures (Frankfort-Nachmias & Leon-Guerrero, 2018). Measures of central tendency highlight averages of distribution using mean, median, and mode. Measures of variability describe the level of diversity within the data set using the range, variance, and standard deviation. I completed a visual inspection of data plots, skew, kurtosis, and histograms to ensure I met the statistical tests' assumptions.

Analysis of Variance (ANOVA)

I used an ANOVA statistical analysis to observe the between subgroups of one independent variable and the dependent variable (Grove, 2009; Warner, 2013). The inclusion of multiple outcome measures in a study can provide greater detail and more rich information about the impact of a predictor variable (Grove, 2009; Warner, 2013). During my research study, I performed two different ANOVAs and created subgroups of my first two independent variables to observe differences between the created subgroups (Grove, 2009; Warner, 2013). I completed the ANOVA after creating subgroups within each independent variable as that made a categorical variable, a required assumption for an ANOVA test to be run. Additional assumptions necessary for the ANOVA tests include the following: (a) observations are randomly and independently sampled from the population, (b) each dependent variable is continuous and is measured at either the interval or ratio level, (c) each outcome variable is normally distributed, and (d) homogeneity of variances is achieved among covariance matrices (Warner, 2013). I could

ensure observations were randomly and independently sampled from the population because I used a cross-sectional design, meaning respondents participated only once. I tested for normality of distribution for the outcome variable using a Shapiro-Wilk test of normality in SPSS (Frankfort-Nachmias & Leon-Guerrero, 2018; Grove, 2009; Warner, 2013). Finally, I tested for homogeneity of variances using a Levene's test.

Linear Regression

A simple linear regression allows a researcher to observe the relationship between two continuous variables. Additionally, a simple linear regression provides the opportunity to identify how much of the variation in the dependent variable is a result of the independent variable and use the independent variable to predict values of the dependent variable (Frankfort-Nachmias & Leon-Guerrero, 2018; Warner, 2013). I performed a simple linear regression to determine the relationship between the TGNC-CSI-SF total score and GICCS-R mean score for each respondent. The following assumptions were necessary to run a simple linear regression: (a) both variables were measured at the continuous level, (b) a linear relationship between the two variables exists, (c) independence of observations is present, (d) there is homoscedasticity, (e) there are no significant outliers, and (f) the residuals of the regression are normally distributed (Frankfort-Nachmias & Leon-Guerrero, 2018; Warner, 2013).

Pearson Product-Moment Correlation

A Pearson product-moment correlation model provides a researcher with the strength of a linear association between two variables (Frankfort-Nachmias & Leon-Guerrero, 2018; Jaafar et al., 2009; Warner, 2013). I performed a Pearson product-

moment correlation model to determine linearity between each of the three independent variables and the dependent variable. The following assumptions were necessary to run a Pearson product-moment correlation: (a) variables are continuous and measured at either the interval or ratio level and (b) there is a linear relationship between the two variables, (c) absence of outliers, and (d) each observation has a pair of values (Frankfort-Nachmias & Leon-Guerrero, 2018; Jaafar et al., 2009; Warner, 2013). In the event my data violated the assumptions required for a Pearson correlation, I was prepared to perform the nonparametric version of this statistical model, the Spearman rank-order correlation (Jaafar et al., 2009; Warner, 2013).

Multiple Regression

A multiple regression model provides a researcher with information about the relationship between multiple predictor variables and one outcome variable. (Frankfort-Nachmias & Leon-Guerrero, 2018; Johnson & Williams, 2014; Warner, 2013). I performed a multiple regression to explore how the amount of time a CIT spent as a trainee as measured by hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spent in receiving transcompetent counseling training as measured by participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients as measured by the GICCS-R (Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013) effects the CIT's self-efficacy in working with TGNC clients as measured by the TGNC-CSI-SF.

Before running the multiple regression statistical model, I verified the data met assumptions for a multiple regression. The following assumptions were necessary to run a multiple regression: (a) observations are randomly and independently sampled from the population, (b) the outcome variable is continuous and is measured at either the interval or ratio level, (c) each variable is normally distributed, (d) there is a linear relationship between the predictor and outcome variables as determined by the Pearson correlation, (e) the variables contain homoscedasticity, (f) there is little to no multicollinearity, and (g) there is no autocorrelation (Frankfort-Nachmias & Leon-Guerrero, 2018; Johnson & Williams, 2014; Warner, 2013).

I verified assumptions were met by performing various tests before running the multiple regression (Frankfort-Nachmias & Leon-Guerrero, 2018; Johnson & Williams, 2014; Warner, 2013). I used skewness and kurtosis to determine normal distribution. I determined there was little or no multicollinearity by performing a collinearity diagnostic while running the multiple regression model. If the VIF was less than 10 and the tolerance was above 0.1 during this test, I was able to be confident there was likely no multicollinearity. To demonstrate homoscedasticity, I observed scatterplots for each variable. Finally, to determine there is no autocorrelation, I performed a Durbin Watson test.

Threats to Validity

Validity in quantitative research involves whether the study measures what it sets out to measure. Researchers must assess their study's validity when evaluating the efficacy of their method (Houser, 2015; Warner, 2013). Threats to internal validity using

a non-experimental, cross-sectional survey research design are important to highlight (Creswell & Creswell, 2018). The potential threats to internal validity in a quantitative study include: (a) history, (b) maturation, (c) regression, (d) selection, (e) mortality, (f) diffusion of treatment, (g) compensatory or resentful demoralization, (h) compensatory rivalry, (i) testing, and (j) instrumentation (Creswell & Creswell, 2018). Because I used a non-experimental, one-shot survey research design with no lapse of time between participation and no augmentation of variables by me, these threats to internal validity surrounding: (a) history, (b) maturation, (c) mortality, (d) diffusion of treatment, (e) compensatory or resentful demoralization, (f) compensatory rivalry, and (g) testing are not of concern. Participants self-selected for this study, meaning no information about potential responses could be gleaned before the data collection process, limiting threats related to regression and selection.

Content validity refers to the content of the instrument items used, and convergent validity ensures scores on a new test correlate positively with scores on existing tests believed to be valid measures of a characteristic (Warner, 2013). I used two scales in my research study, both of which are derivatives from empirically-based and validated psychometric scales. I adapted the TGNC-CSI-SF from the LGB-CSI-SF (Dillon et al., 2015). The LGB-CSI-SF was tested rigorously and validated against its predecessor, the LGB-CSI, during its creation (Dillon et al., 2015). Rewording vocabulary within the scale poses some threat to the validity of the TGNC-CSI-SF, which I highlight in my discussion of limitations. The GICCS-R is based on the SOCCS, and was previously validated by researchers (Bidell, 2005; Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et

al., 2013). Additionally, I used the same instruments and written instructions for all participants at the study's onset, reducing the threat to internal validity (Creswell & Creswell, 2018).

Potential threats to external validity include the following: (a) interaction of selection and treatment, (b) interaction of setting and treatment, and (c) interaction of history and treatment (Creswell & Creswell, 2018). Recruitment for this study involves current students and recent graduates of CACREP-accredited counseling programs and programs actively pursuing CACREP accreditation. I am unable to generalize findings to a larger population outside of CACREP-accredited counseling programs and recent graduate students of CACREP programs within the United States. Additionally, I intended to explore CIT's self-efficacy, hindering my ability to generalize results to the overall counseling profession.

Ethical Procedures

Adherence to appropriate behavior before, during, and after the research process helps promote trust in findings; along with respect, beneficence, and justice towards the research subjects and data collected (Robinson III & Curry, 2008). Before recruiting participants and collecting data, I had my research study approved by my university's IRB. The IRB focused on ensuring research at a university complies with university ethical standards and U.S. federal regulations (Walden University, 2020).

I began by completing IRB Form A, which provided background information about my proposal and intentions for sample characteristics and the recruitment process. Approval of Form A was a requirement before obtaining IRB approval and moving

forward with my study. I received final approval from the IRB on May 21, 2021 under approval number 05-21-21-0980179. I needed various approvals and permissions to conduct this study as well. I obtained permission to use and adapt the LGB-CSI-SF (Dillon et al., 2015) and the SOCCS (Bidell, 2005). Additionally, I obtained permission to post on the CESNET-L listserv, ACA Connect digital forum, my university's participant pool, and the ability to access the student body at a small graduate school at which I had affiliation.

Participation was voluntary and subject to the respondent's decision to participate in the research study. During my study's informed consent process, I was explicit that participation was entirely voluntary, and respondents could discontinue their participation at any time during the process, including after I had collected the data. Although social science research generally involves minimal risk (Groves et al., 2009), I ensured appropriate treatment of participants during recruitment, data collection, and post-survey periods. This included highlighting any potential psychological, relationship, legal, economic, and professional risks the participant could experience and my work to minimize risks as much as possible.

There was a possibility of challenges during the data collection process. I intended to recruit students at a small, American-based counselor education graduate program where I was an adjunct instructor. To address this issue, I obtained IRB approval from this institution. I reiterated during the recruitment and informed consent at this site that participation was voluntary. I also recruited participants via the CESNET-L listserv, the ACA Connect bulletin board, and the participant pool at a large, American-based,

online university. Due to the absence of dual relationships with these entities, I did not foresee participant recruitment concerns.

I included informed consent relating to the purpose, conditions, parameters, and implications of this research study, inviting respondents to contact me directly if they had any questions or concerns (ACA, 2014; Groves et al., 2009). I ensured respondents were aware of privacy and confidentiality stipulations during informed consent. I used SurveyMonkey, a web-based platform for data collection. SurveyMonkey hosts their systems and technical infrastructure in SOC 2 accredited data centers with physical security controls, including constant monitoring, cameras, visitor logs, and entry requirements and uses anonymous survey administration, anonymous data and responses, secure email communication, and survey embedding (SurveyMonkey, 2021). I downloaded data for the sole purpose of analyzing results and determining research study conclusions and only I, my committee members, and a possible statistical expert from my university had access to this data. My university requires data to be retained for five years following the culmination of a study and to delete all data following the five-year data retention parameter by using my computer's function allowing me to permanently delete data and rewrite the disk space to which it was saved

Summary

I used a correlational, cross-sectional, one-shot survey research design for this study. I employed ANOVAs, linear regression, and multiple regression as I analyzed the relationships, differences, and predictive nature of participants' time spent as a CIT, hours of transcompetent counseling training, and counselor competence in working with

TGNC clients has on the self-efficacy and competence of CITs working with TGNC clients. I needed a sample size of 82 with a margin of error of 5% and the desired power level of .80 for statistical significance. I recruited participants in many settings, including via the CESNET-L listserv, the ACA Connect online bulletin board, social media, and two universities with counselor education programs. Following the data collection, I discuss the data collection process and provide results and summaries of each hypothesis in Chapter 4.

Chapter 4: Results

Despite a recent emphasis on the growth of TGNC counseling competencies, limited understanding of a counselor or CIT's confidence, or self-efficacy, in their ability to provide effective counseling services to TGNC exists in current literature. The purpose of this study was to examine the relationship between CITs' perceived self-efficacy in providing transcompetent counseling services, the CIT's perceived competency in delivering transcompetent counseling, the cumulative time the participant spent as a CIT working with both cisgender and TGNC clients, and the amount of transcompetent counseling training received. Additionally, the purpose of this study was to explore whether independent variables such as participants' time spent in clinical practice, training surrounding transcompetent counseling approaches, and competency working with TGNC clients predict the dependent variable of CIT self-efficacy in working with TGNC clients. Further understanding of CIT's perception of their ability to provide transcompetent counseling can help to reduce the issues mentioned above, which TGNC individuals experience.

I explored four research questions in this study. Each research question and related hypotheses follow:

Research Question 1: Does a CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, increase with the accumulation of the participant's pre-graduation, post-graduation and pre-licensure supervised clinical practice hours as measured by respondent self-report on the demographic questionnaire.

H_a1: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does significantly increase with the participant's accumulation of pre-graduation, post-graduation, and pre-licensure supervised clinical practice hours.

H_01: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does not significantly increase with the accumulation the participants pre-graduation, post-graduation, and pre-licensure supervised clinical practice hours.

Research Question 2: Does a CIT's self-efficacy for working with clients who identify, as TGNC as measured by the TGNC-CSI-SF, significantly increase as the amount of transcompetent counseling training received also increases, as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire?

H_a2: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, significantly increases as transcompetent counseling training received increases as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire.

H_02: A CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, does not increase as transcompetent counseling training received increases as measured by self-reported hours of transcompetent counseling training received on the demographic questionnaire.

Research Question 3: Does the level of CIT's perceived competence in working with TGNC clients, as measured by the GICCS-R, significantly predict CITs' perceived self-efficacy, as measured by the TGNC-CSI-SF?

H_a3: The level of competence in working with TGNC clients, as measured by the GICCS-R does predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

H_03: The level of competence in working with TGNC clients, as measured by the GICCS-R does not predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

Research Question 4: Do the amount of time a participant spends as a CIT, as measured by the hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training as measured by participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients, as measured by the GICCS-R, predict CIT self-efficacy, as measured by the TGNC-CSI-SF?

H_a4: The amount of time a CIT spends as a trainee, as measured by hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training, as measured by participant self-reported hours of transcompetent counseling training on the demographic questionnaire, and level of competence in working with TGNC clients, as measured by the GICCS-R, does predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

$H_0$4: The amount of time a CIT spends as a trainee, as measured by hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training, as measured by participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients, as measured by the GICCS-R, does not predict CIT self-efficacy, as measured by the TGNC-CSI-SF.

In this chapter, I describe the data collection process, the general demographics of the sample, the approach I took during data analysis, descriptive statistics, ANOVAs, correlation analysis, and simple linear and multiple linear regressions. I also provide data interpretation for each research question.

Data Collection

I received my university's IRB approval on May 21, 2021 (approval # 05-21-21-0980179). I began disseminating my survey using the approved methods on that day. I shared a call for study participants to three different online platforms on May 21, 2021. I began by posting a call for participants to the CESNET-L listserv, reaching 5,705 recipients (an increase of approximately 100 recipients since I initially identified CESNET-L as a tool to share the call for study participants in February 2021). This initial participant request included a brief overview of the problem and purpose of the study, a summary of inclusion criteria, and a link to the survey hosted on the SurveyMonkey online data collection platform.

I also posted a brief call for participants on the ACA connect online discussion forum in the Call for Study Participants section, accessible to over 55,000 ACA members. I included a summary of the study and a discussion of inclusion criteria, along with a link to the survey hosted on the SurveyMonkey website. I also posted a call for participants on the Minnesota Counseling Association social media page. On May 24, 2021, a link to my study was posted to the participant pool page at a large, American-based, online university with a counselor education program. Results arrived at a moderate pace during the first 2 weeks of data collection, and I reached about one-third of my desired sample size through these recruitment strategies alone.

As initial postings to the CESNET-L listserv, ACA blog, social media, and the participant pool website at a large university drew some responses, I made strides at gaining final approval to recruit students and graduates from a small, American-based, non-profit graduate-level counselor education program. I received final approval from both my university's IRB and this partner organization to recruit students at this institution on June 1, 2021. An employee of the partner organization emailed the call for study participants directly to approximately 120 recipients. I received many responses following this email, helping me almost reach my desired sample size. Additionally, the social Minnesota Counseling Association social media page administrator shared a link to my study from the association's official social media account on June 5, 2021. Finally, I submitted a second call for study participants to the CESNET-L listserv on June 7, 2021. This helped me achieve my necessary sample size. I closed the survey on June 12, 2021,

with 107 total responses and 85 completed responses, a 79.4% completion rate. There were no discrepancies to the data collection process identified in the previous chapter.

In total, I estimate I disseminated the call for participants to approximately 8,000 individuals between the CESNET-L listserv, ACA Connect blog, Minnesota Counseling Association social media page, the participant pool at a large, American-based, online institution with a counselor education program, and small, American-based, non-profit graduate-level counselor education program. Based on the estimate of potential viewers, I achieved a response rate of 1.33% and a completion rate of 1.06%. Despite a low response and completion rate, the completed response rate exceeded my identified sample size of 82 needed for an alpha of .05 and desired power level (.8) for statistical significance obtained through G*Power (See Chapter 3 for an explanation of power analysis).

Of the 85 participants in this study, most were female (n = 68, 80%). In alignment with the topic of this study, I attempted to include diverse gender identity options. Most respondents identifying as female in this study were likely attributed to females' large population in the counseling field compared to other genders (U.S. Census Bureau, 2019; see Table 1 for descriptive data on participant gender).

I collected data about the race and ethnicity of respondents as well. Most respondents identified as White or Caucasian (n = 72, 84.71%) and one respondent (1.18%) identified as Multiracial. Like gender, most of the sample identifying as White or Caucasian was consistent with demographic information for mental health counselors

(U.S. Census Bureau, 2019; See Table 2 for descriptive data on participant race and ethnicity).

Table 1

Frequency Distribution of Respondents by Gender

Gender	*n*	%
Female	68	80.0
Male	14	16.47
Transgender	0	0.0
Non-Binary	1	1.18
Gender Non-Conforming	2	2.35
None of the above	0	0.0
Total	85	100.0

Table 2

Frequency Distribution of Respondents by Race and Ethnicity

Race/Ethnicity	*n*	%
White or Caucasian	72	84.71
Black or African American	6	7.06
Hispanic or Latino	3	3.53
Asian or Asian American	3	3.53
American Indian or Alaska Native	0	0.0
Native Hawaiian or other Pacific Islander	0	0.0
Middle Eastern	0	0.0
Multiracial	1	1.18
Total	85	100.0

I also collected data about age ranges. I created subgroups of ages for ease of data analysis and reporting. Most respondents answered as members of the 25–34 age subgroup (n = 46, 54.12%). It appears respondents skewed lower than the national average age for mental health counselors, which is approximately 42 years (U.S. Census Bureau, 2019). However, it is essential to note that this study observed CITs, including

students, and I expected the average age to be lower. (See Table 3 for descriptive data on participant age.)

Table 3

Frequency Distribution of Respondents by Age

Age	*n*	%
18–24	3	3.53
25–34	46	54.12
35–44	15	17.65
45–54	18	21.18
55–64	3	3.53
65+	0	0.0
Total	85	100.0

I also collected data on sexual orientation. Of the total respondents, 61 (71.76%) identified as heterosexual. The remaining respondents identified as asexual, bisexual, gay, lesbian, queer, and pansexual. (See Table 4 for descriptive data on participant sexual orientation.)

Table 4

Frequency Distribution of Respondents by Sexual Orientation

Sexual Orientation	*n*	%
Asexual	3	3.53
Bisexual	6	7.06
Gay	5	5.88
Heterosexual	61	71.76
Lesbian	5	5.88
Queer	4	4.71
Pansexual	1	1.18
Total	85	100.0

Results

The primary focus of this study was on the self-efficacy of CITs when working with clients who identify as a TGNC as measured by the TGNC-CSI-SF, an adapted version of the LGB-CSI-SF (Dillon et al., 2015) based on three different independent variables: time spent as a CIT, approximate hours of TGNC counseling training received, and TGNC counseling competence as measured by the GICCS-R, an instrument based on the SOCCS (Bidell, 2005; Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013).

Descriptive Statistics

I calculated descriptive statistics to observe data from each variable in the study. I analyzed data based on the primary research question of how time spent as a CIT (Independent Variable 1), amount of transcompetent counseling training received (Independent Variable 2), TGNC counseling competence (Independent Variable 3), and self-efficacy of CITs working with clients who identify as TGNC (dependent variable). Data for Independent Variable 1 and Independent Variable 2 were collected directly from respondents within the demographic questionnaire. I calculated the total self-efficacy score for each respondent for the TGNC-CSI-SF and the mean score for each respondent for the GICCS-R. In the following sections, I provide descriptive statistics for each variable.

Time Spent as a CIT (Independent Variable 1)

I asked respondents to report the approximate hours of counseling experience as a counselor trainee when completing the demographic questionnaire. I used Ronnestad and Skovholt's (2003) phases of counselor development and previous studies that focused on

the level of development of CITs to determine appropriate time brackets (Cor, 2016; Dillon et al., 2015). I coded the responses as follows: 1 = less than 400 hours, 2 = 401 to 800 hours, 3 = 801 to 1,200 hours, 4 = 1201 to 1,600 hours, 5 = 1,601 to 2,000 hours, 6 = 2,001–2,400 hours, 7 = 2,401 to 2,800 hours, and 8 = over 2801 hours. Responses varied greatly for this question. (See Table 5 for descriptive data on approximate hours of counseling experience.)

Table 5

Frequency Distribution of Respondents by Approximate Hours of Counseling Experience

Approximate Hours of Counseling Experience	*n*	%
Less than 400 hours	22	25.88
401 to 800 hours	12	14.12
801 to 1,200 hours	14	16.47
1,201 to 1,600 hours	10	11.76
1,601 to 2,000 hours	8	9.41
2,001 to 2,400 hours	5	5.88
2,401 to 2,800 hours	3	3.53
Over 2,801 hours	11	12.94
Total	85	100.0

Transcompetent Counseling Training (Independent Variable 2)

I collected information regarding the approximate hours of transcompetent counseling training the respondent had received so far in their career. I asked about this information in the demographic section as it was my second independent variable. Following the example of Dillon et al. (2015), I asked respondents to indicate the hours of transcompetent counseling training they had received based on subgroupings of hours. Most respondents (42 or 49.41%) indicated receiving less than 5 hours of transcompetent counseling training. (See Table 6 for descriptive data on the approximate hours of transcompetent counseling training received.)

Table 6

Frequency Distribution of Respondents by Approximate Hours of Transgender and Gender Non-Conforming Counseling Training Received

Approximate Hours of Transgender and Gender Non-Conforming Counseling Training Received	*n*	%
Less than 5 hours	42	49.41
6 to 10 hours	20	23.53
11 to 15 hours	10	11.76
16 to 20 hours	4	4.71
21 to 25 hours	3	3.53
26 to 30 hours	0	0.0
Over 30 hours	6	7.06
Total	85	100.0

Counselor-in-Training's Competency While Working with TGNC Clients (Independent Variable 3)

The third independent variable I observed in this study was the CIT's competence while working with TGNC clients, as measured by the GICCS-R (Cor, 2016). The GICCS-R is a psychometric scale consisting of 27 items that allow the respondent to rate the truth of various statements using a Likert scale. Responses range from 1 (*not true at all*) to 7 (*totally true*). Following the collection of this data, 10 questions required reverse scoring. After completing the reverse scoring process, I calculated the mean score for each response as suggested by the creator of the scale. The mean score for the 85 respondents was 5.05, with a standard deviation of .601. The median score for this scale was 5.04 with a mode score of 4.93, and the total scores ranging from a low of 3.41 with a frequency of 1 to a high of 6.37 with a frequency of 1 (see Table 7). The distribution scores were not kurtotic (-.143) or skewed (-.226), indicating the normal distribution of

data (See Table 8). Additionally, the scale had a high level of internal consistency, as determined by a Cronbach's alpha of .820.

Table 7

GICCS-R Mean Score

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3.41 to 3.78	3	3.6	3.6	3.6
	4.04 to 4.44	1 3	15.5	15.5	18.8
	4.52 to 4.96	22	26.1	26.1	44.7
	5.00 to 5.48	27	32.1	32.1	76.5
	5.52 to 5.96	16	19.1	19.1	95.3
	6.00 to 6.37	4	4.8	4.8	100

Note. MDN = 5.04

Table 8

GICCS-R Distribution

N	Valid	85
	Missing	0
Mean		5.05
Median		5.04
Mode		4.93
Std. Deviation		.601
Skewness		-.226
Kurtosis		-.143
Range		2.96
Minimum		3.41
Maximum		6.37

Self-Efficacy of a CIT Working with TGNC Clients (Dependent Variable)

I asked participants to complete the TGNC-CSI-SF. Within this scale, respondents rated their confidence for each of the 15 statements on a scale of 1 (*not confident*) to 5 (*extremely confident*). Total scores on this instrument range from no confidence, or no self-efficacy (15 total points) to extremely confident, or high self-efficacy (75 total

points). The mean score for the 85 respondents was 51.69, with a standard deviation of 12.01. The median score for this scale was 54 with a mode score of 61, and total scores ranging from a low of 26 with a frequency of 1 to a high of 71 with a frequency of 1 (see Table 9). The distribution scores were not kurtotic (-.930) or skewed (-.397), indicating the normal distribution of data (see Table 10). Additionally, the scale had a high level of internal consistency, as determined by a Cronbach's alpha of .931.

Table 9

TGNC-CSI-SF Total Score

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	26 to 29	4	4.8	4.8	4.8
	30 to 39	14	16.5	16.5	21.2
	40 to 49	18	20.2	20.2	42.4
	50 to 59	19	22.6	22.6	64.7
	60 to 69	27	31.8	31.8	96.5
	70 to 71	3	3.6	3.6	100.0

Note. MDN = 54

Table 10

TGNC-CSI-SF Distribution

N	Valid	85
	Missing	0
Mean		51.69
Median		54.00
Mode		61
Std. Deviation		12.014
Skewness		-.397
Kurtosis		-.930
Range		45
Minimum		26
Maximum		71

Research Question 1

The first research question measured if a CIT's self-efficacy in working with clients who identify increased with the accumulation of the hours spent in clinical practice. I used a one-way ANOVA statistical model to explore this research question as the independent variable consisted of various eight subgroups of time ranges. Before analyzing this research question, I ensured the necessary assumptions for a one-way ANOVA statistical model were met. Initial assumptions for a one-way ANOVA include having a continuous dependent variable, a categorical independent variable with at least two or more independent groups, and independence of observations. Each of these assumptions was satisfied, allowing me to review the remaining required assumptions.

The next assumption was determining the absence of outliers in the groups of independent variables in terms of the dependent variables. There were no outliers in the data, which I determined by inspecting a boxplot of each group within the variable. Although outliers are commonly present in social science research, it is possible to gather data that is homogeneous and does not contain outliers (Frankfort-Nachmias & Leon-Guerrero, 2018; Steinbuss & Bohm, 2021; Warner, 2013). I discuss my hypothesis regarding the absence of outliers in the limitations section located in Chapter 5. Following this, I sought to determine if my data for this research question was normally distributed. I consulted the Shapiro-Wilk test of normality which was violated as one of the eight *p*-values was statistically significant ($p < .05$). After consulting with a contributing statistician, I elected to observe skewness and kurtosis, as outlined in the descriptive statistics section, and Q-Q plots to determine the normal distribution of data

and elected to carry on regardless. The final assumption I tested for was homogeneity of variances. The assumption of homogeneity of variances was violated, as assessed by Levene's test for equality of variances (p = .033). Because this final assumption was violated, I used Welch's one-way ANOVA and results from the Games-Howell post hoc test for data analysis.

I conducted a Welch's one-way ANOVA to compare the amount of time a CIT spent in supervised clinical practice on the CIT's self-efficacy when working with clients who identify as TGNC. I observed means and standard deviations for each subgroup (See Table 11). The self-efficacy of a CIT when working with clients who identify as TGNC was statistically significantly different for different amounts of time spent in supervised clinical practice as a CIT, Welch's $F(7, 17.675) = 4.434$, $p < .005$, η2 = .187. Because I used a Welch's one-way ANOVA, I also performed a Games-Howell post hoc to compare combinations of group differences since the assumption of homogeneity of variances was violated (See Table 12). There was an increase of self-efficacy scores from the lowest time accumulation group (less than 400 hours) (M = 47.86, SD = 10.4) to the group reporting the highest number of hours (more than 2,800) (M = 62, SD = 5), which was statistically significant (-14.14, 95% CI [-23.36, -4.92], p = .001). There was an increase of self-efficacy scores from the second-lowest hours accumulation group (401 to 800 hours) (M = 47.43, SD = 13.8) to the group reporting the highest number of hours (more than 2,800) (M = 62, SD = 5), which was statistically significant (-14.571, 95% CI [-28.41, -.73], p = .035). Finally, there was an increase of self-efficacy scores from the third hours accumulation group (801 to 1,200 hours) (M = 48.07, SD = 12.2) to the group

reporting the highest number of hours (more than 2,800) (M = 62, SD = 5), which was statistically significant (-13.93, 95% CI [-25.94, -1.92], p = .016). No other subgroup differences were statistically significant. The group means were statistically significantly different ($p < .05$) and, therefore, I can reject the null hypothesis and accept the alternative hypothesis.

Table 11

Hours of Counseling Experience and TGNC-CSI-SF One-Way ANOVA

TGNC-CSI-SF total score	N	Mean	SD	95% CI for Mean		Minimum	Maximum
				LL	UL		
Less than 400 hours	21	47.86	10.39	43.13	52.59	27	65
401 to 800 hours	14	47.43	13.81	39.46	55.40	26	71
801 to 1,200 hours	15	48.07	12.21	41.31	54.83	28	64
1,201 to 1,600 hours	10	57.5	8.46	51.45	63.55	43	69
1,601 to 2,000 hours	9	52.33	14.19	41.43	63.24	29	67
2,001 to 2,400 hours	4	56.25	11.93	37.21	75.23	45	68
2,401 to 2,800 hours	3	58.33	11.06	30.86	85.81	48	70
More than 2,801 hours	9	62.00	5.00	58.16	65.84	55	70
Total	85	51.69	12.01	49.10	54.29	26	71

Note. Full model: Welch's $F(7, 17.675) = 4.434$, $p < .005$, $\eta^2 = .187$

Table 12

Games-Howell Multiple Comparisons Post Hoc Tests

Approximate hours of counseling experience	Approximate hours of counseling experience	Mean Difference	Std. Error	Sig.	95% CI for Mean	
					LL	UL
Less than 400	More than 2,801	-14.14	2.82	.001	-23.36	-4.92
401 to 800	More than 2,801	-14.57	4.05	.035	-28.41	-.73
801 to 1,200	More than 2,801	-13.93	3.57	.016	-25.94	-1.92

Research Question 2

The second research question measured if a CIT's self-efficacy in working with clients who identify as TGNC increased with the accumulation of transcompetent counseling training. I used a one-way ANOVA statistical model to explore this research question as the independent variable consisted of eight subgroups of time ranges. Before analyzing this research question, I ensured the necessary assumptions for a one-way ANOVA statistical model were met. Initial assumptions for a one-way ANOVA include having a continuous dependent variable, categorical independent variable with at least two or more independent groups, and independence of observations. Each of these assumptions was satisfied, allowing me to move review the remaining required assumptions.

The next assumption was to determine the absence of outliers in the groups of independent variables in terms of the dependent variables. There were no outliers in the data, which I determined by inspecting a boxplot of each group within the variable. Although outliers are commonly present in social science research, it is possible to gather data that is homogeneous and does not contain outliers (Frankfort-Nachmias & Leon-Guerrero, 2018; Steinbuss & Bohm, 2021; Warner, 2013). I discuss my hypothesis regarding the absence of outliers in the limitations section located in Chapter 5. Following this, I sought to determine if my data for this research question was normally distributed. I consulted the Shapiro-Wilk test of normality which was violated as one of the eight *p*-values was statistically significant ($p < .05$). Consequently, I observed skewness and kurtosis, as outlined in the descriptive statistics section, and Q-Q plots to

determine the normal distribution of data and elected to carry on regardless. The final assumption I tested for was homogeneity of variances. The assumption of homogeneity of variances was violated, as assessed by Levene's test for equality of variances (p = .036). Because this final assumption was violated, I used Welch's one-way ANOVA and results from the Games-Howell post hoc test for data analysis.

I conducted a Welch's one-way ANOVA to determine if a CIT's self-efficacy when working with clients who identify as TGNC increases based on the amount of transcompetent counseling training received. The self-efficacy of a CIT when working with clients who identify as TGNC was statistically significantly different for the number of hours of transcompetent counseling training received, Welch's $F(5, 14.598) = 6.788$, $p = .002$, $\eta 2 = .144$ (See Table 13). Because I used a Welch's one-way ANOVA, I performed a Games-Howell post hoc to compare combinations of group differences since the assumption of homogeneity of variances was violated (See Table 14).

There was an increase of self-efficacy scores from the group with the lowest number of hours of training received (less than 5 hours; $M = 48.56$, $SD = 12.034$) to the group reporting the highest amount of transcompetent counseling training received (more than 30 hours; $M = 65.4$, $SD = 4.561$), which was statistically significant (-16.842, 95% CI [-26.02, -7.67], $p < .005$). There was an increase of self-efficacy scores from the group with the second-lowest number of hours of training received (6 to 10 hours; M = 53.4, $SD = 11.376$) to the group reporting the highest amount of transcompetent counseling training received (more than 30 hours; $M = 65.4$, $SD = 4.561$), which was statistically significant (-12.000, 95% CI [-22.41, -1.59], $p = .019$). Finally, there was an

increase of self-efficacy scores from the third to last group reporting the number of hours of training received (21 to 25 hours; *M* = 55.33, *SD* = 2.082) to the group reporting the highest amount of transcompetent counseling training received (more than 30 hours; *M* = 65.4, *SD* = 4.561), which was statistically significant (-10.067, 95% CI [-19.57, -.56], *p* = .039). No other subgroup differences were statistically significant. The group means were statistically significantly different ($p < .05$), and therefore, I can reject the null hypothesis and accept the alternative hypothesis.

Table 13

Hours of Transcompetent Training and TGNC-CSI-SF Total Score One-Way ANOVA

TGNC-CSI-SF total score	N	Mean	SD	95% CI for Mean		Minimum	Maximum
				LL	UL		
Less than 5 hours	43	48.56	12.03	44.85	52.26	26	67
6 to 10 hours	20	53.40	11.38	48.08	58.72	32	70
11 to 15 hours	10	55.90	11.26	47.85	63.95	36	70
16 to 20 hours	4	46.50	14.20	23.90	69.10	28	62
21 to 25 hours	3	55.33	2.08	50.16	60.50	53	57
More than 30 hours	5	65.40	4.56	59.74	71.06	61	71
Total	85	51.69	12.01	49.10	54.29	26	71

Note. Full model: Welch's $F(5, 14.598) = 6.788$, $p = .002$, $\eta^2 = .144$

Table 14

Games-Howell Multiple Comparisons Post Hoc Tests

Approximate hours training	Approximate hours of training	Mean Difference	Std. Error	Sig.	95% CI for Mean	
					LL	UL
Less than 5	More than 30	-16.84	2.74	.000	-26.02	.7.67
6 to 10	More than 30	-12.00	3.26	.019	-22.41	-1.59
21 to 25	More than 30	-10.07	2.37	.039	-19.57	-.56

Research Question 3

The third research question measured a CIT's competence in providing counseling to clients who identify as TGNC predicted CIT self-efficacy while working with clients who identify as TGNC. I used a simple linear regression statistical model to explore this research question as both the independent and dependent variables were at a continuous level of measurement. Before analyzing this research question, I ensured the necessary assumptions for a simple linear regression were met. The initial assumption for a simple linear regression is that the dependent and independent variables are measured at a continuous level. After accepting this assumption, I proceeded to verify additional assumptions.

To assess linearity, I plotted a scatterplot of TGNC counseling competence against TGNC counseling self-efficacy. Visual inspection of this scatterplot indicated a linear relationship between the variables. There was homoscedasticity and normality of the residuals, as determined by visual inspection and reviewing the Durbin-Watson statistic of 2.015, respectively. I determined there to be an absence of outliers via visual inspection of the scatterplot and the absence of casewise diagnostics results in the data output. Although outliers are commonly present in social science research, it is possible to gather data that is homogeneous and does not contain outliers (Frankfort-Nachmias & Leon-Guerrero, 2018; Steinbuss & Bohm, 2021; Warner, 2013). I discuss my hypothesis regarding the absence of outliers in the limitations section located in Chapter 5. Finally, I identified a normal distribution of data by inspecting the normal probability plot.

I ran a simple linear regression to understand if TGNC counseling competence predicted self-efficacy of CITs working with clients who identify as TGNC. The predicted equation was: TGNC-CSI-SF total score = -18.74 + 13.96*GICCS-R mean score. The GICCS-R mean score statistically significantly predicted TGNC-CSI-SF, $F(1, 83) = 79.244$, $p < .0005$, accounting for 48.8% of the variation in TGNC-CSI-SF total score with adjusted $R^2 = 48.2\%$, a large effect size (Cohen, 1988). An elevation of one point on the GICCS-R mean score leads to a 13.959, 95% CI[10.840, 17.078] increase in TGNC-CSI-SF total score. I made predictions to determine the TGNC-CSI-SF total score for people with a GICCS-R mean score of 2, 3, 4, and 5. For a GICCS-R mean score of 2, TGNC-CSI-SF total score was predicted as 23.138, 95% CI[16.491, 29.785]; for a GICCS-R mean score of 3, TGNC-CSI-SF total score was predicted as 37.097, 95% CI[33.340, 40.854]; for a GICCS-R mean score of 4, TGNC-CSI-SF total score was predicted as 51.055, 95% CI[49.185, 52.926]; and for a GICCS-R mean score of 5, TGNC-CSI-SF total score was predicted as 65.014, 95% CI[61.502, 68.526].

I then performed a Pearson product-moment correlation to determine the strength and direction of the relationship between the two continuous variables. Assumptions for the Pearson product-moment correlation were met while performing the simple linear regression, allowing me to carry on with the statistical model. I performed a Pearson's product-moment correlation to assess the relationship between TGNC-CSI-SF total score and GICCS-R mean score. The preliminary analyses showed the relationship to be linear with both variables normally distributed, as evaluated by visual inspection of the normal

probability plot. A statistically significant, strong positive correlation between TGNC-CSI-SF total score and GICCS-R mean score, $r(83) = .70$, $p < .001$.

Research Question 4

The fourth research question measured if time spent as a CIT, the number of hours spent receiving transcompetent counseling training, the CIT's competence in providing counseling to TGNC clients, predicted CIT self-efficacy while working with clients who identify as TGNC. I used a multiple regression statistical model to explore this research question. Before proceeding with analyzing data for this research question, I ensured the necessary assumptions for a multiple regression statistical model were met, including using a continuous dependent variable and at least two independent variables measured at either the categorical or continuous level.

I assessed linearity by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.002. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals great than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption for normality was met, as assessed by a Q-Q Plot.

I performed a multiple regression to predict TGNC-CSI-SF total score from time spent as a CIT, hours of transcompetent counseling training received, and GICCS-R mean score. The multiple regression model statistically significantly predicted TGNC-

CSI-SF total score, $F(3, 81) = 27.51, p < .0005$, adj. $R^2 = .49$. Only GICCS-R mean score added statistically significantly to the prediction, $p < .05$. The two additional independent variables: time spent as a CIT and hours of transcompetent counseling training received did not statistically significantly predict TGNC-CSI-SF total score within this model. As a result, I rejected the alternative hypothesis and accepted the null hypothesis that time spent as a CIT, hours of transcompetent counseling training, and the GICCS-R mean score did not predict the TGNC-CSI-SF total score. (See Table 15 for regression coefficients and standard errors.)

Table 15

Multiple Regression Results for TGNC-CSI-SF Total Score

TGNC-CSI-SF total score	*B*	95% CI for *B*		*SE B*	β	R^2	ΔR^2
		LL	UL				
Model						.51	.49***
Constant	-15.16	-31.56	1.23	8.24			
GICCS-R mean score	12.67***	9.16	16.15	1.76	.63***		
Hours of counseling experience as a CIT	.52	-.41	1.46	.47	.10		
Hours of transcompetent counseling training received	.56	-.70	1.82	.63	.08		

Note. $F(3, 81) = 27.51, p < .0005$, adj. $R^2 = .49$. *** $p < .001$.

Summary

In this chapter, I provided statistical analysis for each research question and interpreted those results. Of the four research questions I examined in this study, three returned results that partially supported the hypothesis and one returned with results that

were highly significant. In summary, Research Question 1: Does a CIT's self-efficacy in working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, increase with the accumulation of the participant's pre-graduation, post-graduation and pre-licensure supervised clinical practice hours as measured by respondent self-report? There was an effect found for accumulation of clinical practice hours on CIT's self-efficacy in working with clients who identify as TGNC in some subgroups of hours. Overall, the alternative hypothesis for Research Question 1 was moderately supported.

Research Question 2: Does a CIT's self-efficacy for working with clients who identify as TGNC, as measured by the TGNC-CSI-SF, significantly increase as the amount of transcompetent counseling training received also increases, as measured by self-reported hours of transcompetent counseling training received? There was statistical significance found for the accumulation of transcompetent counseling training received on CIT's self-efficacy in working with clients who identify as TGNC in some subgroupings of hours of training. Overall, the alternative hypothesis for Research Question 2 was moderately supported.

Research Question 3: Does the level of CIT's perceived competence in working with TGNC clients, as measured by the GICCS-R, significantly predict CIT's perceived self-efficacy as measured by the TGNC-CSI-SF? A medium effect was found for GICCS-R mean score predicting TGNC-CSI-SF total score. Overall, the alternative hypothesis for Research Question 3 was supported.

Research Question 4: Does the amount of time a participant spends as a CIT, as measured by the hours of pre-graduation practicum and internship hours accumulated and

post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training as measured by participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients as measured by the GICCS-R predict CIT self-efficacy as measured by the TGNC-CSI-SF? Although the overall model demonstrated statistical significance, the multiple regression model could not explain how much of the variation in GICCS-R mean score, hours of clinical practice, and hours of transcompetent counseling training received together explained TGNC-CSI-SF total scores. Overall, the alternative hypothesis for Research Question 4 was rejected, and the null hypothesis was accepted.

In Chapter 5, I interpret the findings, discuss the limitations of the study, and highlight recommendations for future research. Additionally, I share implications for positive social change because of this study. Finally, I present recommendations for professional practice.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to examine the relationship between a CIT's perceived self-efficacy in providing transcompetent counseling services, the CIT's perceived competency in delivering transcompetent counseling, the cumulative time the participant spent as a CIT working with both cisgender and TGNC clients, and the amount of training CITs received specific to transcompetent counseling practices. I explored whether the independent variables participants' time spent in clinical practice, training surrounding transcompetent counseling approaches, and competency working with TGNC clients predicted the dependent variable of CIT self-efficacy in working with TGNC clients. Further understanding of CIT's perception of their ability to provide transcompetent counseling can help to reduce the issues TGNC individuals experience.

Of the four research questions examined in this study, three returned results that partially supported the hypothesis, and one returned with results that were highly significant. Findings indicated that time spent as a CIT and the number of hours of transcompetent training received was moderately related to the CIT's self-efficacy while working with clients who identify as TGNC. Results indicated that a CIT's ability to provide transcompetent counseling services overwhelmingly predicted a CIT's self-efficacy while working with clients who identify as TGNC. In the following sections, I describe results in greater detail, discuss limitations of the study, highlight recommendations for future work, and share implications from this study.

Interpretation of the Findings

Eighty-five CITs participated in this study, answering demographic questions and completing both the TGNC-CSI-SF and GICCS-R. All respondents indicated they participated in a counselor education program either already accredited by CACREP or were in a program actively pursuing CACREP-accreditation. Additionally, all respondents highlighted they met the operational definition of a CIT as outlined in Chapter 3. Demographic information revealed a predominately female response (80%), and the majority reported as part of the 25 to 34 age range (54.12%). Most respondents identified as White or Caucasian (84.71%) and heterosexual or straight (71.76%). Most respondents indicated less than 400 hours of counseling experience (25.88%) and less than 5 hours of transcompetent counseling training (49.41%).

Research Question 1

Research Question 1: Does a CIT's self-efficacy in working with clients who identify as TGNC as measured by the TGNC-CSI-SF increase with the accumulation of the participant's pre-graduation, post-graduation and pre-licensure supervised clinical practice hours as measured by respondent self-report.

Previous research on the effect of time spent in clinical practice and self-efficacy when working with clients who identify as LGB prompted me to explore the effect of the same independent variable on CIT self-efficacy when working with clients who identify as TGNC. Relying on this previous research (Dillon & Worthington, 2003; Dillon et al., 2015), I hypothesized that similar results would occur as I measured CIT self-efficacy when working with clients who identified as TGNC. Findings from the analysis for this

research question confirmed results from previous studies exploring competency of counseling students working with TGNC clients in that advanced student are better prepared to provide transcompetent counseling compared to novice students (O’Hara et al., 2013). Additionally, results from this research question confirm the importance of time on the growth of a CIT’s self-efficacy in clinical situations (Lent et al., 2009).

Results from this study also indicated an opportunity for counselor educators and supervisors to promote ongoing opportunities over time for a CIT to develop skills in providing counseling to diverse clients to bolster CIT self-efficacy, particularly as it relates to clients who identify as TGNC. Time spent in clinical practice often contributes to increased counselor self-efficacy, professional identity, cognitive complexity, reflection, and self-awareness (Mullen et al., 2015; Wagner & Hill, 2015). As a CIT progresses through the early phases of counselor development via the accrual of supervised clinical hours, they experience growth not only in their counseling competencies but also in their self-efficacy in providing appropriate clinical services (Ronnestad et al., 2018; Ronnestad & Skovholt, 2003).

Research Question 2

Research Question 2: Does a CIT’s self-efficacy for working with clients who identify as TGNC as measured by the TGNC-CSI-SF significantly increase as the amount of transcompetent counseling training received also increases, as measured by self-reported hours of transcompetent counseling training received?

Relying on the literature surrounding the importance of clinical training on a counselor’s perception of their preparedness to work with TGNC clients (Bidell, 2012;

Couture, 2017), I hypothesized that additional training would increase self-efficacy for CITs working with clients who identify as TGNC. Findings from the analysis for this research question confirmed this assumption. Similarly, literature highlighted in Chapter 2 showed that additional training helped prepare emerging school counselors to work with LGBT students (Kull et al., 2018). Further, the literature indicated that graduate training and ongoing professional development are instrumental in the development of self-efficacy for school counselors to provide effective services to LGBT students (Kull et al., 2018; Lent et al., 2009). Counselor educators and supervisors might use results from this research question to consider how training in counselor education programs and continuing education opportunities focused on TGNC-specific issues that a client might explore in a counseling session, leading to increased self-efficacy while serving this population.

Research Question 3

Research Question 3: Does the level of CIT's perceived competence in working with TGNC clients, as measured by the GICCS-R, significantly predict CIT's perceived self-efficacy as measured by the TGNC-CSI-SF?

Due to a need to develop a method of working with TGNC clients that affirms diversity and the unique worldview of individuals who do not identify within the gender binary (Carroll & Gilroy, 2002), counselors, counselor educators, and supervisors have focused on developing TGNC-specific counseling strategies and competencies (Cor, 2016; Dispenza & O'Hara, 2016; O'Hara et al., 2013). Through this focus, in the past 5 years, methods of measuring counselor competency when working with clients who

identify as TGNC emerged, including the GICCS-R (Cor, 2016). Using this scale, I sought to understand the relationship between a CIT's competency working with clients who identify as TGNC and self-efficacy serving this population.

Results indicated a large effect size, highlighting that CITs' TGNC counseling competency was a strong predictor of self-efficacy of CITs working with clients who identify as TGNC. The overall findings of the statistical models I ran for this research question overwhelmingly supported the assumption that TGNC-specific counseling competency predicted CIT self-efficacy when working with clients who identified as TGNC. Results from this research question confirm the correlation between competency and self-efficacy for CITs, as supported by the literature in Chapter 2 (see Mizock & Lundquist, 2016). Additionally, previous research highlighted the positive relationship between multicultural counseling competence and multicultural counseling self-efficacy (Matthews et al., 2018), which I confirmed with my results highlighting a strong positive correlation between transcompetent counseling and CIT self-efficacy when working with clients who identify as TGNC. The results of this research question suggest that counselor educators and supervisors strive to strengthen opportunities for CITs to develop additional competency working with the TGNC population.

Research Question 4

Research Question 4: Do the amount of time a participant spends as a CIT, as measured by the hours of pre-graduation practicum and internship hours accumulated and post-graduation and pre-licensure supervised practice hours accumulated, the amount of hours the CIT spends in receiving transcompetent counseling training as measured by

participant self-reported hours of transcompetent counseling training, and level of competence in working with TGNC clients as measured by the GICCS-R predict CIT self-efficacy as measured by the TGNC-CSI-SF?

Similar to the intentions outlined for the third research question, through the final research question of this study, I sought to determine if the three independent variables in this study: (a) time spent as a CIT, (b) amount of transcompetent counseling training received, and (c) competency working with clients who identified as TGNC predicated self-efficacy of the CIT when working with clients who identify as TGNC. I intended to expand research observing trends that contributed to developing a counselor's self-efficacy working with clients who identified as LGB (Dillon & Worthington, 2003; Dillon et al., 2015). Although the third research question identified the importance of CITs developing competency when working with TGNC individuals, I intended to determine the relative contribution of each of the predictor variables on the dependent variable.

The multiple regression model significantly statistically predicted TGNC-CSI-SF total scores. However, only the GICCS-R mean score added statistically significantly to the prediction equation. Although CIT time spent in clinical practice and CIT transcompetent counseling training received did not significantly statistically contribute to the prediction of TGNC-CSI-SF total scores in this model, GICCS-R mean scores did. As such, it is important to continue bolstering counselor education and supervision efforts to determine factors that lead to the development of additional TGNC-specific counseling competency. Results from this research question confirm implications from past research

that focusing on the development of transcompetent counseling practices can contribute to the development of a CIT's self-efficacy when working with clients who identified as TGNC (Matthews et al., 2018; Mizock & Lundquist, 2016). Future research might consider identifying contributing factors to the development of competency while working with TGNC clients.

Self-Efficacy Theory

Using Bandura's (1977, 1982) seminal research on self-efficacy as my primary theoretical framework allowed me to predict various components of a CIT's development that might lead to increased self-efficacy when working with clients who identify as TGNC. I used self-efficacy theory to inform this study as I explored how the development of competency in providing transcompetent counseling via time spent as a CIT working with clients, and hours of transcompetent counseling training received, predicted the self-efficacy of a CIT's ability to work with clients who identify as TGNC. Results confirmed that time spent in clinical practice involved both mastery and vicarious experiences working with a gender-diverse population, leading to an increase of CIT self-efficacy. Additionally, results indicated that ongoing training contributed to an increase in self-efficacy via learning opportunities that created the ability to engage in both mastery and vicarious experiences. The highly significant correlation between transcompetent counseling and self-efficacy when working with clients who identify as TGNC highlighted the importance of various learning experiences, such as additional time spent in clinical practice and training opportunities, to the development of self-efficacy when working with this cultural subgroup (Bandura, 1977, 1994; Killian et al.,

2019, Kull et al., 2018; Lent et al., 2009; Matthews et al., 2018; Mizock & Lundquist, 2016; O'Hara et al., 2013).

Limitations of the Study

In the preliminary stage of this study, I envisioned possible limitations I might experience. Of primary interest during the discussion of limitations was using a scale that I altered from its original format and was not validated since its alteration (DeVellis, 2017). I was cautious of the vocabulary change and only adjusted language describing sexual orientation, such as lesbian, gay, and bisexual, in the original scale. As such, I changed any reference to orientation in the original scale to language reflecting gender identity to create this new scale. No other language was altered.

The second limitation I predicted involved potential response bias due to collecting data that pertains to a topic that is, at times, controversial (Creswell & Creswell, 2018). I requested a significant level of vulnerability of the respondents to be honest and truthful in their answers. To quell concerns about response bias and promote truthfulness in responses, I reiterated the anonymity and privacy of all responses. I included statements about confidentiality and the voluntary nature of this study in each call for participants posted and the consent form respondents acknowledged before participating. Visual inspection of data normality, central tendency, and outliers provided me confidence that response bias did not occur during the data collection process. I also entered this study with some positive bias and regard towards the topic and population discussed. I was aware that my viewpoints on acceptance and inclusion for a diverse

group might have impeded my neutrality. I was aware of this as I recruited participants, collected data, analyzed results, and completed the writing of the final study.

I envisioned the use of convenience sampling would be a limitation of this study. Convenience sampling allows a researcher ease during data collection by soliciting participants the researcher has access to through various networks and removes the opportunity for random selection of respondents (Houser, 2015). I found accessing CITs challenging, mainly due to the rigorous review process institutions require before data collection can commence. Although probability sampling would have strengthened the validity and reliability of my results, the process of random sampling was not feasible for this study. Additionally, convenience sampling is often used and accepted in social sciences due to the limited availability of, and access to, research participants.

I was able to recruit participants using a variety of methods. However, I suspect the bulk of my responses came from individuals recruited at the small partner organization that disseminated my survey on my behalf. Although I cannot confirm this due to the anonymity of study participants, the students at this organization received a direct link, creating a more accessible opportunity to complete the survey. Having a majority sample from the same institution causes me to consider that most respondents received similar training and had a similar experience working in the field as a CIT. Despite this limitation, I am confident my sample is a fair reflection of the overall mental health counselor population. The results are generalizable after comparing demographic information obtained during data collection to available information about demographics of mental health counselors in the United States (U.S. Census Bureau, 2019).

Additionally, the use of a quantitative method for this study was a limitation. Although using a quantitative method provided me with valuable data about competencies and self-efficacy related to working with clients who identify as TGNC, it does not allow me to explore what specifically helped the CIT develop the identified competencies and self-efficacy. Using a quantitative approach did, however, help me ensure that my own bias and assumptions were not evident and prevalent during data collection. As the researcher, I was removed from direct involvement in data collection as respondents completed the survey in private. Future research might use a qualitative approach to expand on this study. I discuss recommendations for future research in greater detail in the next section.

Finally, I acknowledged the presence of the novel coronavirus (COVID-19) as a possible limitation for this study. Although I did not anticipate challenges related to COVID-19 due to using a quantitative method, I prepared to extend data collection if I experienced difficulties reaching potential respondents. Fortunately, the global pandemic was subsiding as I approached the data collection period, and I achieved my required sample size in a matter of weeks.

Recommendations

A fundamental result of this study was the identification that transcompetent counseling training predicted CIT self-efficacy when working with clients who identify as TGNC. This study intended to determine if time spent as a CIT and transcompetent counseling training received contributed to developing competence and self-efficacy working with the TGNC population. Results involving the amount of time spent in

clinical practice and transcompetent counseling training indicated that CITs in the novice and advanced student phase of development and those with little (less than 15 hours) of transcompetent counseling training experienced a limited amount of self-efficacy working with clients who identified as TGNC whereas individuals reporting over 2801 hours of clinical experience and over 30 hours of transcompetent training reported strong self-efficacy.

An opportunity for expanding this study is to create an experimental research design using a pre-test, post-test, or control group function along with training opportunities explicitly focused on working with clients who identify as TGNC. Future research might consider using a qualitative method or mixed-methods approach, including focus groups and ethnographic interviews, to identify specific strategies CITs used to develop proficiency working with the TGNC population. Further understanding of what has assisted CITs in this area could strengthen counselor education programs and continuing education opportunities.

Additionally, further research might involve exploring the experiences of clients who identify as TGNC as they participate in counseling services, potentially comparing feedback informed outcomes with both self-efficacy and competence of the counselor the client is working with to determine possible relationships among those variables and the impact the CIT’s competence and self-efficacy have on the client’s outcome in counseling. Finally, future research might explore validating the TGNC-CSI-SF for use as a replicated psychometric scale, like the evolution of the GICCS-R (Cor, 2016), which was initially based on the SOCCS (Bidell, 2005).

Implications

This study is significant to positive social change because human beings can choose whether to influence change in society via positive and value-based actions (Hoff & Hickling-Hudson, 2011). With the existing gap in the literature surrounding a CIT's self-efficacy while working with clients who identify as TGNC (Couture, 2017; Gates & Sniatecki, 2016; O'Hara et al., 2013), findings from this study can contribute to social change and help programs that focus on the development of counseling students or pre-licensed supervisees implement more robust training protocol to help develop transcompetent counseling skills in clinical settings that can ultimately strengthen a CIT's perception of their ability to provide effective counseling to clients who identify as TGNC. During this study's structuring process, the intention was to determine if current counselor education and training programs adequately prepared CITs to serve this often disenfranchised and marginalized population. Results indicated that CITs with minimal counseling experience and training possess limited self-efficacy in this domain. As highlighted in Chapter 2, many counselor education programs focus a wealth of attention on the LGBTQ+ population but often discredit the specific needs of TGNC individuals within this population (Mizock & Lundquist, 2016).

Results from this study might also contribute to positive social change by helping to expand knowledge and understanding of how to help counseling students provide more appropriate services to clients who identify as TGNC (Weir & Piquette, 2018; Gates & Sniatecki, 2016). Although results from this study were mixed, those in line with the alternative hypotheses provide context for better training CITs to serve this population.

Expanding educational opportunities and allowing CITs the chance to become better prepared to serve this population can help reduce counselor transphobia, microaggressions, and implicit biases towards TGNC clients (Gates & Sniatecki, 2016, O'Hara et al., 2013).

Additionally, greater awareness of the developmental needs of CITs regarding the TGNC cultural subgroup might help remove the burden of clients educating mental health professionals on TGNC-related issues. This evolution knowledge, skills, and awareness on the part of the CIT could contribute to the counseling space serving as a place of safety and growth for the client rather than the counselor. Ultimately, results move the counseling field towards preparing emerging counselors to better serve the TGNC population, a call to action originally identified nearly two decades ago (Carroll & Gilroy, 2002).

Results also highlighted a need to focus on the specific issues and challenges clients who identify as TGNC bring to the counseling setting within counselor education programs and continuing education training sessions. As I discussed in Chapter 2, individuals who identify as TGNC are often subjected to counselor microaggressions, discrimination, and implicit biases and serve as a hindrance to their successful response to therapeutic intervention (Campbell & Arkles, 2017; Couture, 2017; Gates & Sniatecki, 2016; Holt et al., 2019; McCullough et al., 2017; Mizock & Lundquist, 2016; O'Hara et al., 2013; Weir & Piquette, 2018). Actively preparing CITs to be better stewards of the needs of individuals who identify as TGNC can contribute to positive social change in the form of improved therapeutic outcomes (Carroll & Gilroy, 2002).

Laoch and Holmes (2018) asserted the presence of unique social, familial, and systemic discrimination and rejection challenges often discussed in counseling by clients who identify as TGNC. Opportunities for CITs to learn more about challenges including violence experienced among TGNC individuals, financial and housing insecurity, health care challenges, and frequent requests to discuss gender identity-related topics and issues within counselor education programs and counselor training opportunities could lead to an increase of self-efficacy serving this population. Creating space for CITs to learn how to appropriately address these types of situations and feel confident doing so can contribute to positive social change for individuals who identify as TGNC (dickey & Budge, 2020; Brown, 2019; Kanamori & Cornelius-White, 2017; Laoch & Holmes, 2018).

Counselor educators might also consider providing additional options for experiential learning activities to help CITs develop self-efficacy working with the TGNC population. As discussed in Chapter 2, Killian et al. (2019) found that experiential learning approaches helped increase CIT competencies as they explored methods for working with queer clients. Results from this study highlighted a strong correlation between competence and self-efficacy, allowing the conclusion that experiential learning and training opportunities would benefit emerging counselors, leading to positive social change (Hoff & Hickling-Hudson, 2011; Killian et al., 2019).

An additional training opportunity that might contribute to an increase in self-efficacy helping CITs prepare to work with clients who identify as TGNC includes assisting clients in focusing on gender identity challenges using narrative techniques

(Krieger, 2017). A narrative therapy approach might help a CIT feel more prepared to engage with challenging aspects of a counseling session. Narrative therapy allows a counselor a structured opportunity to direct and guide a client as they discuss and re-story challenges (Ivey et al., 2012; Krieger, 2017).

It is possible that results from this study are transferable to the counseling field overall. Although the specific sample chosen for this research study was CITs, I assume that a similar study conducted with counselors at any point of time in professional practice would highlight that additional training and time spent in the counseling field contributes to great TGNC-counseling competence and self-efficacy while working with clients who identify as TGNC. Counselors might consider participating in additional training focused on TGNC-counseling competencies because of this study. Additionally, counselors might consider how they provide opportunities for CITs to foster growth in this area as emerging members of the counseling profession. The opportunity for licensed, practicing counselors to consider their self-efficacy when working with clients who identify as TGNC can lead to better outcomes for clients within this cultural subgroup in counseling settings (Couture, 2017; Holt et al., 2019; Krieger, 2017; McCullough et al., 2013; Mizock & Lundquist, 2016).

Conclusion

Transgender and gender non-conforming clients often experience a limited recognition of their needs in counseling, minimal transaffirmative care, stigma and discrimination purported by cisgender individuals, and compounding mental health challenges (Campbell & Arkles, 2017). As a result of these lived experiences, mental

health counselors must receive adequate training to serve TGNC individuals in compassionate, empathetic, and affirmative ways (Carrol & Gilroy, 2002, Gates & Sniatecki, 2016, McCullough et al., 2017; O'Hara et al., 2013; Weir & Piquette, 2018). Researchers who have studied the experiences of counseling and TGNC individuals focus heavily on the counselor's competencies or the lived experiences of the client. While both avenues for existing research were necessary, a limited understanding of the preparedness of counselors to provide adequate counseling to TGNC individuals existed in the existing literature. As such, I sought to measure the relationships between the time spent as a CIT, transcompetent counseling training received, competence working with TGNC clients, and self-efficacy of CITs working with clients who identify as TGNC.

As demonstrated by the findings of the study, the factors of time spent as a CIT and hours of transcompetent training received moderately predicted a CIT's self-efficacy while working with clients who identified as TGNC. CITs with the most time spent in the field (more than 2,800 hours) and most hours of transcompetent training received (more than 30 hours) reported the highest average competency scores and highest total self-efficacy scores. Additionally, results demonstrated a strong relationship between transcompetent counseling scores and self-efficacy when working with clients who identify as TGNC. Further understanding that competency working with TGNC clients predicts self-efficacy working with TGNC clients can help counselor educators and supervisors create adequate and appropriate training opportunities to allow CITs to develop strengths and skills working with this cultural subgroup.

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Appendix A: Demographic Questionnaire

Please respond to the following questions in the space provided.

1) Age: ______ years old

2) Race/Ethnicity:
    a) African American/Black
    b) Asian American/Pacific Islander
    c) European American/White
    d) Hispanic/Latino
    e) Middle Eastern
    f) Native American/American Indian
    g) Other ______________

3) Sexual Identity:
    a) Heterosexual
    b) Homosexual (Gay Male, Lesbian Woman)
    a) Bisexual
    b) Pansexual
    c) Asexual
    d) Other _______________

4) Gender Identity
    a) Cisgender
    b) Transgender
    c) Gender Non-Conforming
    d) Other _______________

5) Approximate hours of counseling experience as a counselor trainee (for the purpose of this question, a counselor trainee is defined as either a current student in a counselor education program or a recent graduate from a counselor education program that is not yet fully licensed/remains under supervision prior to licensure):
    a) Less than 400 hours
    b) 401 to 800 hours
    c) 801 to 1,200 hours
    d) 1,201 to 1,600 hours
    e) 1,601 to 2,000 hours
    f) 2,001 to 2,400 hours
    g) 2,401 to 2,800 hours
    h) Over 2,801 hours

6) Approximate hours of transgender and gender non-conforming specific counseling training received during your career:

a) None
b) Less than 5 hours
c) 5.01 to 10 hours
d) 10.01 to 15 hours
e) 15.01 to 20 hours
f) 20.01 to 25 hours
g) 25.01 to 30 hours
h) More than 30.01 hours

Appendix B: Permission to Use and Alter Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory – Short Form

From: Thomas Hegblom <redacted>
Sent: Tuesday, February 2, 2021 5:35 PM
To: Frank Dillon <redacted>
Subject: Request to use LGB-CSI-SF

Greetings, Dr. Dillon:

My name is Tom Hegblom, and I am a doctoral candidate in the counselor education and supervision program at Walden University. Additionally, I am a licensed counselor and work in an intensive outpatient substance use disorder treatment program with the Hazelden Betty Ford Foundation and am an adjunct faculty member at the Hazelden Betty Ford Graduate School of Addiction Studies.

I am currently constructing my dissertation proposal and will complete a quantitative study surrounding the self-efficacy of counselor trainees who work with clients who identify as transgender and gender non-conforming. There is quite a bit of existing literature surrounding competency in this area. Unfortunately, there is a shortage of research revolving around counselor trainees' confidence and perception of their ability to provide effective trans-affirmative counseling services. While competency is important, I am a firm believer that a counselor's belief in their ability to engage effectively with clients is equally important. This is what led me to exploring this topic.

With that, there is very little in the form of existing scales involving my topic. I am intrigued by your Lesbian, Gay, and Bisexual Affirmative Counseling Self-Inventory - Short Form (LGB-CSI-SF) and wonder if you might be amenable to me using this scale adapting it to focus on transgender and gender non-conforming (TGNC) affirmative counseling self-efficacy for my dissertation? After discussion with my committee, I believe your scale's premise is consistent with the nature of providing TGNC affirmative counseling and could fit this need with minimal changes to vocabulary while maintaining the scale's overall integrity.

Thank you for your consideration as I work towards achieving this goal. I am more than happy to answer any further questions you might have.

Best regards,

Tom Hegblom, MA, LADC
CES Doctoral Candidate - Walden University
Minneapolis, MN
<redacted>

From: Frank Dillon <redacted>
Sent: Tuesday, February 2, 2021 6:38 PM
To: Thomas Hegblom <redacted>
Subject: RE: Request to use LGB-CSI-SF

Yes, that would be a great study! Yes of course you are welcome to use the measure. Best of luck, Frank

Frank R. Dillon, PhD
(he, him, his)
Associate Professor
Director of Doctoral Training
Counseling & Counseling Psychology
Arizona State University
Mail Code: <redacted>
p: <redacted> **c:** <redacted>
email: <redacted>
web: <redacted>

Appendix C: Permission to Use and Alter Sexual Orientation Counselor Competency Scale

From: Thomas Hegblom <redacted>
Date: Sunday, February 28, 2021 at 4:12 PM
To: Markus Bidell <redacted>
Subject: Request to use SOCCS/GICCS in Dissertation

Greetings, Dr. Bidell:

My name is Tom Hegblom and I am a doctoral candidate in the Counselor Education and Supervision program at Walden University. I am currently in the proposal stage of my dissertation and am researching the self-efficacy of counselors-in-training while working with transgender and gender nonconforming (TGNC) clients. A component of my study is looking at whether competency in providing effective TGNC counseling intervention with clients predicts counselor-in-training self-efficacy while working with clients who identify as TGNC.

I'm writing to request permission to use adapted version of your Sexual Orientation Counselor Competency Scale, the Gender Identity Counselor Competency Scale, as used by O'Hara et al. (2013), Dispenza and O'Hara (2016), and Cor (2016).

If you have further questions about my study or intentions with this scale, please let me know.

Thank you in advance for your consideration.

Regards,

Tom Hegblom
Doctoral Candidate – Counselor Education and Supervision
Walden University
Minneapolis, MN

From: Markus P Bidell <redacted>
Sent: Monday, March 1, 2021 4:28 PM
To: Thomas Hegblom <redacted>
Subject: Re: Request to use SOCCS/GICCS in Dissertation

Tom- You have my permission, good luck with your research.

Markus P. Bidell, Ph.D., LMHC

xe, xem, xyrs/they, them, theirs – what's this?
NYS-LMHC & School Counselor (Permanent Certificate)
Associate Professor
Counseling & Psychology
Hunter College & CUNY Graduate Center

Appendix D: Permission to Use the Gender Identity Counselor Competency Scale - Revised

From: Thomas Hegblom <redacted>
Date Sent: Wed 4/7/2021 1:43 PM
To: Deanna Cor <redacted>
Re: Request to use GICCS-R in dissertation

Greetings, Dr. Cor:

My name is Tom Hegblom and I am a doctoral student in the Counselor Education and Supervision program at Walden University. I am currently in the proposal stage of my dissertation and am researching the self-efficacy of counselors-in-training while working with transgender and gender non-conforming (TGNC) clients. A component of my study is looking at whether competency in providing effective TGNC counseling intervention with clients predicts counselor-in-training self-efficacy while working with clients who identify as TGNC.

I'm writing to request permission to use the Gender Identity Counselor Competency Scale - Revised that you adapted in your dissertation. I have sent a request to Dr. Markus Bidell as well as he is the originator of the Sexual Orientation Counselor Competency Scale, which he granted.

If you have further questions about my study or intentions with this scale, please let me know.

Thank you in advance for your consideration.

Regards,

Tom Hegblom
Doctoral Student – Counselor Education and Supervision
Walden University
Minneapolis, MN

On Apr 6, 2021, at 10:37 PM, Deanna Cor <redacted> wrote:

Hi Tom,

Congratulations on making it to this point in your degree! You're nearly there...hang on tight!

Yes, you are welcome to use this for your dissertation. My colleagues and I are actually running a version of my dissertation study again to further validate the scale. If you could, it would help us tremendously to have access to your data in that process. Is it possible to see that?

Let me know!
Deanna

Deanna N. Cor, Ph.D., LPC
Assistant Professor of Counseling
Program Coordinator | Clinical Mental Health Counseling
LPC Approved Supervisor | OBLPCT
Past President, Oregon Association for LGBT Issues in Counseling
<redacted>
<redacted>
Google Voice: <redacted>
Pronouns: she, her, hers
"You have to join every other movement for freedom of people." -Bayard Rustin