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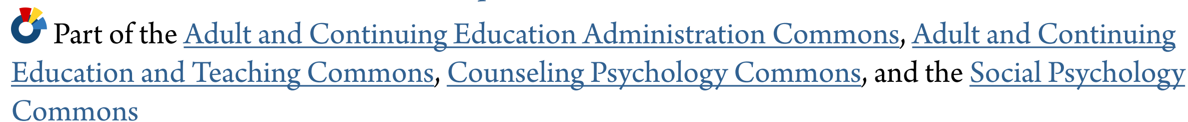

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Walden University

College of Counselor Education & Supervision

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Kimberly D. Patterson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2018

Abstract

# Measuring Self-Perceived Clinical Preparedness with Lesbian, Gay, Bisexual, and Transgender Clients

by

Kimberly D. Patterson

MA, Prairie View A&M University, 2010

MS, Prairie View A&M University, 2007

BS, Prairie View A&M University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2018

Abstract

Counselors and counselor educators must serve clients regardless of culture, race, disability, sexual orientation, and age. Counselor educators have attempted to stay abreast of new methods to enhance counselor competencies to adequately counsel lesbian, gay, bisexual, and transgender (LGBT) clients. The purpose of this quantitative study was to determine the extent of the relationship between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudinal awareness towards LGBT clients as moderated by levels of religious commitment of licensed professional counselor (LPC) using a feminist and multicultural theory framework. Statistical Package for the Social Sciences (SPSS) quantitative analysis software program was used to generate descriptive statistics such as frequencies, means, modes, correlations, and regression models for each research variable. According to study results, there was a statistically significant relationship between the criterion variable self-perceived clinical preparedness of working with LGBT clients, the predictor variable self-perceived attitudinal awareness towards LGBT clients, and the moderator religious commitment ($F(2, 123) = 4.76$, $p < .05$). The study findings promote insight for counselors to understand how their religious commitment moderates the relationship between clinical preparedness and attitudinal awareness when working with LGBT clients.

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# Dedication

I want to express my sincere thanks to my family for being patient with me throughout this journey and encouraging me to push towards the finish line. With great honor, I dedicate my dissertation to my parents, my mother and father JoAnn and John Patterson, who have supported me in all my professional development goals and who were my inspiration to achieve my doctorate. Also, I would like to acknowledge my sister, Tiffany Patterson who taught me how to strive for greatness and how to create inner strength and peace. Each of my family members have taught me faith in God and to believe that success comes after perseverance. Ultimately, I owe all praises and thanks to Jesus Christ for being my Lord and Savior. There were so many days when I just wanted to give up, but with prayer and God's grace, I was able to keep going to reach my goal.

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I was motivated by so many people in my life who expressed how proud they were of me for perusing my doctorate. As my father always said, “Pray, Focus, and Commit.”

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# Chapter 1: Introduction to the Study

Counselor supervisors, counselor education researchers, and professional counseling organizations develop skills to provide adequate services for lesbian, gay, bisexual, and transgender (LGBT) clients (Bidell, 2012, 2013; Bieschke, Blasko, & Woodhouse, 2014; Farmer, Welfare, & Burge, 2013; McGeorge, Carlson, & Toomey, 2013; Rutter, Estrada, Ferguson, & Diggs, 2008; Whitman & Bidell, 2014). In Chapter 1, I present feminist and multicultural theoretical approaches to support affirmative-LGBT counselor supervision methodology. Also, I outline prior research addressing the need to analyze current data regarding LGBT self-perceived competency among counselors. Also, I describe the significance and purpose of my study.

## Background of the Study

There are a variety of multicultural competencies, counseling ethical standards for working with LGBT clients, counselor supervision assessment tools, and religious influences associated with the development of counseling competency (Farmer et al., 2013; Graham, Carney, & Kluck, 2012; Herek & Garnets, 2007; Rutter et al., 2008; Walker & Prince, 2010; Whitman & Bidell, 2014). Various scholars within counselor education research (Bidell, 2012, 2014, 2016; Brown, 2016; Farmer et al., 2013; Graham et al., 2012; Whitman & Bidell, 2014), examined predictors associated with counseling competence development for counseling LGBT clients. Studies in LGBT counseling competency development are beneficial to support changes in academic curriculums, help determine better training methods, and to acquire knowledge of LGBT client experiences (Bidell, 2012, 2014, 2016; Brown, 2016; Farmer et al., 2013; Graham et al., 2012).

**Summary of Research Literature**

Counselor educators and mental health associations created basic standards, requirements, and training methods to address LGBT client counseling needs. Researchers (Bidell, 2014, 2016; Brown, 2016; Graham et al., 2012; Walker & Prince, 2010) improved counseling strategies and exposed limitations in LGBT client counseling. Herek and Garnets (2007) reviewed Meyer's (2003) minority stress theory to analyze social views, racial stressors, and psychological issues unique to LGBT clients. Herek and Garnets concluded that LGBT clients reported distress from internalized stigma, social heterosexism, oppression, the felt stigma, discrimination, and enacted stigma conditions, which deterred further counseling help. Herek and Garnets endorsed the assessment of heterosexism perceptions, personal bias, and counselor personality associated with LGBT counselor competence.

Furthermore, Rutter et al. (2008) used the Sexual Orientation Counselor Competency Scale (SOCCS) to measure self-perceived LGBT counseling competence among students in counselor training and found that engaging in professional development activities in the LGBT community led to an increased in LGBT counselor competency. Bidell (2014) found that students who participated in affirmative-LGBT counselor courses or had experiences in LGBT counseling training demonstrated improvements in LGBT counseling competency, compared to students who did not take part in the affirmative-LGBT counseling training.

## Gap in Literature

Prior scholars such as Bidell, 2014; Graham et al., 2012; Rutter et al., 2008; Walker and Prince, 2010; Whitman and Bidell, 2014 have addressed how personal elements of religious identity, religious values, level of experience in affirmative-LGBT counselor among students, and counseling practicums help develop skills for working with LGBT clients. However, research has failed to consider using licensed professional counselors (LPCs) as a primary sample population in this subject matter.

Also, counselor education researchers addressed factors related to self-perceived counselor competence for working with LGBT clients; however, there are few studies on the relationship between self-perceived attitudinal awareness towards LGBT clients, clinical preparedness of working with LGBT clients, and their religious activities. More specifically, Bidell (2017) created The Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS); however, there are limited studies on how this counselor assessment tool improves counselor development for working with LGBT clients.

## Study Rationale

In this study, I provided information relating to the need to continue growth in affirmative-LGBT client competency among professional counselors. The cross comparison of data between the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) and the Religious Commitment Inventory (RCI-10) has the potential to help identify associations. The measurements can be used in counselor training to help determine counselor education and training needs. By knowing

how levels of self-perceived clinical preparedness and levels of counselor's religious commitment coincide, counselor supervisors and counselors-in-training know what factors restrict, support, or increase clinical preparedness for counseling LGBT clients (Bidell, 2017).

Multiple researchers (Bidell, 2014, 2016; Brown, 2016; Graham et al., 2012; Herek & Garnets, 2007; Rutter et al., 2008; Walker & Prince, 2010; Whitman & Bidell, 2014) provided the groundwork for improvements in counseling practice and support the need to further research in clinical preparedness among LPCs working with LGBT clients. Examining levels of self-perceived assessment tools have contributed to increasing self-awareness, knowledge, and skills for working with LGBT clients among students in counseling programs and counselors-in-training (Bidell, 2005, 2014, 2016; Brown, 2016; Graham et al., 2012; Herek & Garnets, 2007; Rutter et al., 2008; Walker & Prince, 2010). The results from this study will continue social change efforts in working with LGBT clients using a different population. The purpose of this study was to discuss the correlations of clinical preparedness and religious commitment for LGBT clients in a new group.

## Research Problem Statement

Over the past decade, social change concerns for oppressed LGBT clients have increased. Some students in counselor education programs felt ill-prepared or conflicted by their values when working LGBT clients but have not addressed this among LPCs (Bidell 2014; Farmer et al., 2013; Graham et al., 2012). Although counselor educators

understand many factors related to self-perceived LGBT counselor competence, there is a gap in counselor education literature.

The focus of this research was to fill the gap in counselor education literature by discovering the extent of the relationship, if any, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudinal awareness towards LGBT clients, as moderated by levels of religious commitment of LPCs. According to Bidell (2014), Graham et al. (2012), and O'Shaughnessy and Spokane (2012), counselor supervisors and educators learned that elements such as religious identity, religious values, religious orientations, and religious beliefs are associated with the development of competence working with LGBT clients. However, the above scholars did not examine how LPCs' religious commitment influences clinical preparedness for working with LGBT clients.

**Relevant Literature Describing Research Problem and Gap**

Rainy and Trusty (2007) and Nickles (2011) explored the perception of LGBT competency among counselor education graduate students' religiosity and predictors of LGBT counseling; however, they used religiosity instruments evaluating personal values, religious discrimination, or political changes in society and the influences on individuals' attitudes, knowledge, and skills in working with lesbian, gay, and bisexual clients. Rainey and Trusty examined social issues of personal values to address how religiosity and political views influenced counseling individuals in the LGBT community. However, Rainey and Trusty did not examine how participants' levels of LGBT counselor competence influenced clients. Additional information describing predictors of self-

perceived counseling competencies is necessary due to the changes in counselor education teaching standards, training models, demographics of counselor education students, and generation social norms.

In a study reviewing personal and profession discord of religious conservatism and lesbian gay and bisexual counselor competence, Bidell (2014) evaluated various aspects of religious beliefs and expressions considered when predicting the attitudes, skills, and knowledge of masters' students (*n*=160), doctoral students (*n*=18), and counseling supervisors (*n*=50) working with lesbian, gay, and bisexual people in university counseling centers. Bidell measured variables within the SOCCS and the Religious Fundamental Scale (RFS) and found a correlation with education level, LGBT interpersonal contact, and political conservatism; Bidell found significant relationships among religious conservatism and the attitudinal awareness and skills subscales but not the knowledge subscale scores. Bidell concluded that participants who identified as having higher conservative or modernly higher religiously scores resulted in significantly lower levels of counselor competency in working with LGBT clients (SOCCS scores) compared to participants who identified as having liberal, very liberal, or atheist views. Bidell did address factors of religious beliefs, race, gender, and self-perceived LGBT counselor competence but did not examine how the level of religious commitments may influence levels of LGBT counselor competence.

The frequency of advocacy in the community, related to religious beliefs and personal political values, has shown to have negative influences in counseling relationships with gay, lesbian, and bisexual clients. O'Shaughnessy and Spokane (2012)

evaluated the development of counselor competence with the experience levels of affirmative LGBT training. O'Shaughnessy and Spokane also explained factors correlating with LGBT counselor competence by examining correlations between therapist personality, LGBT case conceptualization, and self-reported LGBT counseling competency. O’Shaughnessy and Spokane found that participants with high levels of positive attitudes of LGBT client experiences also demonstrated relatively high levels of LGBT case conceptualization. O’Shaughnessy and Spokane concluded that high levels of LGBT-case conceptualization were linked to high levels of self-reported LGBT counseling competency. The opportunity to present missing information regarding the relationship between religious commitment, experience levels in LGBT-affirmative training, and self-reported counseling competence of working with lesbian, gay, and bisexual clients will fill the gap in counselor education literature.

## Purpose of the Study

The goal of this quantitative study was to examine the correlations, in any, between self-perceived LGBT clinical preparedness and religiosity measurement levels among LPCs as measured by LGBT-DOCSS and as moderated by levels of religious commitment of LPCs as measured by RCI. The results of this study will help prepare counselor supervisors, counselor educators, and counselors-in-training to provide LGBT clients with better quality counseling services to meet their mental health needs.

## Research Questions and Hypotheses

To fill these gaps in counselor education literature, I addressed the following questions:

1. What is the extent of the relationship, if any, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as moderated by levels of religious commitment of LPCs?
2. What is the level of overall self-perceived clinical preparedness of working with LGBT clients, as measured by the LGBT-DOCSS, of LPCs?
3. What is the level of overall self-perceived attitudinal awareness of working with LGTB clients, as measured by the LGBT Attitudinal Awareness subscale within LGBT-DOCSS, of LPCs?
4. What is the level of overall religious commitment, as measured by RCI, of LPCs?

**Null Hypothesis**

$H_0$: There is no statistically significant relationship, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as measured by the LGBT-DOCSS, as moderated by levels of religious commitment measured by RCI of LPCs.

**Alternative Null Hypothesis**

$H_{a:}$ There is a statistically significant relationship, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT as measured by LGBT-DOCSS, clients as moderated by levels of religious commitment measured by RCI of LPCs.

**Language and Definitions**

Terms used to describe and express the LGBT community and identities of sexual orientation are changing and evolving. As stated by Harper et al. (2013), counselors must

recognize, adapt, and adopt new terminology with clients to develop a positive rapport. Professional counselors are obligated to be competent in descriptions and conscious of new definitions commonly used within the LGBT community. Harper et al. explained that counselors could learn proper terminology by asking their clients to clarify any unknown terms in counseling sessions. Counselors must maintain competencies related specifically for LGBT individuals and understand when to use appropriate terms, specific language, what is accepted, and what words are outdated (Harper et al., 2013).

Throughout my research, I used terminology defined by The American Counseling Association (ACA); The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC); The Council for Accreditation of Counseling and Related Educational Programs (CACREP); and The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals (ALGBTIC LGBQQIA) to identify individuals and groups within the LGBT community (ACA, 2014; CACREP, 2009; Harper et al., 2013). Self-perceived counselor competency for working with heterosexual, intersex, or other sexual orientations were not assessed using the LGBT-DOCSS assessment tool but were addressed in the literature review.

Below are definitions accepted in the counseling and psychological professions as an appropriate and commonly used language to address and identify LGBT groups, individuals, and communities.

*Advocacy:* Activities an individual or organization completes aimed to influence, support, or recommend economic, public, or institutional policies for oppressed communities or individuals (Crethar, Rivera, & Nash, 2008; Harper et al., 2013).

*Ally*: Individuals who provide therapeutic or personal support to others. In this research, the term was used to describe an individual's friends and family members who support lesbian, gay, bisexual, transgendered, queer, questioning, intersex, and ally (LGBTQQIA) individuals. The term references heterosexual allies who advocate against discrimination or oppose experiences of oppression for supporting people in the LGBTQQIA community (Harper et al., 2013).

*Affirmative training/ therapy*: An approach to therapy or counseling training to focus on lesbian and gay clients' experiences and counseling needs regarding overcoming stigma, sexuality counseling, and strategies to increase awareness for LGBT clients (Rock et al., 2010).

*Bisexual*: Individuals who share emotional and physical sexual attractions to both men and women (Harper et al., 2013).

*Counselor educator*: A person who teaches counseling therapeutic techniques and provides clinical supervision and academic training to prepare professional counselors (ACA, 2014).

*Culturally diverse*: A term that describes social, values, languages, and appearances that exist among groups in society (Bowie, 2003).

*Diversity*: A political term to describe multiculturalism. The term can be used to describe a variety of things (Bocanegra et al., 2015; Grapin, Lee, & Jaafar, 2015; Proctor & Truscott, 2013).

*Ethnic*: A term that describes people who have a physical appearance, racial, language, distinct culture, or religious characteristics and are identified by others as a member of a minority group (Bowie, 2003).

*Feminist theory:* A belief or method of teaching for advocating against systems of oppression, discrimination, and systematic injustices. In this paper, the feminist theory was the framework that drives affirmative-LGBT counseling to ensure counselors are making decisions for lesbian and gay clients (Crethar et al., 2008).

*Gay*: A term that describes a man who shares sexually driven emotional, physically, and mental attractions with another man. According to ALGBTIC, this term is also sometimes used as an umbrella term to describe individuals who identify themselves as lesbian, gay, queer, and bisexual (as cited in Harper et al., 2013). The term gay defines a person whose sexual orientation is to pursue the same-sex in an intimate relationship

*Gender*: A person's social, sexual identity, not the biological sex of an individual (Harper et al., 2013). The term often refers to male, female, or neuters. In other definitions by the American Psychological Association (APA, 2015), sex normally refers to biological aspects when gender implies the psychological, behavioral, social, and cultural aspects of being male or female.

*Heterosexism*: The idea that individuals should be heterosexual. This term is used to describe marginalized or stigmatism against individuals in the LGBTQQ community (Herek & Garnets, 2007).

*Intersectional identities*: A term identifying multiple intersecting characteristics. This term includes race, gender, sexuality, class, and ethnicity as overachieving factors in a person's character. This word was developed to address aspects of overlapping identities related to how a person may encounter discrimination, social views, decisions in lifestyle, and oppressions (Fricke, 2010; Hagen, Arcynski, Morrow, & Hawhurst, 2011).

*Intersex*: A person who is intersex is born with sex chromosomes, external genitalia, or an internal reproductive system that are not considered "standard" for either "males" or "females. This term is most commonly used to refer to developmental anomalies that result in ambiguous differentiation in of external genitalia (e.g., micropenis, clitoromegaly); it may be used to describe the lack of concordance in the chromosomal, gonadal, hormonal, or genital characteristics of an individual (Harper et al., 2013; Intersex Society of North America, 1993).

*Lesbian*: A term that describes a woman who shares an emotional, psychical, and sexual attraction with another woman (Harper et al., 2013). The term is used as a noun that refers to a female who has a same-sex attraction.

The acronym *"LGBT"* used throughout this study stands for lesbian, gay, bisexual and transgender clients.

*Multicultural*: A term that describes cultural and religious diversity (Bidell, 2012; Crethar et al., 2008).

*Queer*: A term that refers to individuals who identify with sexual orientations outside of the dominant social norms. The term in the past was used and considered a derogatory or prejudice term. The word queer has evolved into an adjective to describe individuals in the LGBT community (APA, 2015; Clarke, Ellis, Peel, & Riggs, 2010; Harper et al., 2013).

*Sexual orientation*: A person's sexual attraction to another person and the behavior and social affiliation that may result from the attraction (ACA, 2014; Bidell, 2012; Harper et al., 2013).

*Transgender*: A term used to describe individuals who socially identify themselves as gender- nonconforming. This term describes people who do not identify with their biological sex or gender assigned at birth (Harper et al., 2013).

**Theoretical and Conceptual Frameworks**

There are a variety of conceptual and theoretical frameworks used to guide counselor training for working with LGBT clients (ACA, 2014; Bidell, 2005; Harper et al., 2013; Herek & Garnets, 2007; Israel & Hackett, 2004; Nugent, 2013; Sue & Sue, 2007). Inclusive counseling practices for LGBT clients are identified in feminist theory, multicultural counseling perspectives, ACA ethical standards, self-efficacy theory, and ALGBTIC counseling competencies. In this section, I will introduce the theoretical and conceptual approaches guiding this research and discuss the phenomenon of affirmative-LGBT counselor training.

**Theoretical Framework**

To expand multicultural perspectives, counselor educators must continue to conduct research developing LGBT counseling competencies. The feminist and multicultural theoretical frameworks were the basis of this study, with the intention to improve change and sustain equal counseling services in counselor research. Goodman et al. (2004) explained that feminist theoretical perspectives take action against oppressions among minority groups to influence social and cultural norms. In both multicultural and feminist theoretical perspectives, scholars tend to emphasize social change and reorganization within unequal political philosophies (Crethar et al., 2008; Goodman et al., 2004). According to multicultural and feminist theories, counselor education training must consider students' attitudes, awareness, knowledge, and skills relating to a client's experiences of social injustice, oppression, stereotypes, and discrimination in various environments (Crethar et al., 2008; Goodman et al., 2004; Speciale, Gess, & Speedlin, 2015; Sue, 2010). A lack of sexual orientation competencies can lead to misconceptions and inappropriate counseling interventions (Bidell, 2012; Bieschke et al., 2014; Crethar et al., 2008). Multicultural and feminist approaches implement client-centered and social systems models to cover diversity, culture, and human rights perspectives in learning counseling techniques. Both multicultural and feminist approaches include components supporting my study and emphasize equality in counseling practices for LGBT clients seeking mental health services.

## Conceptual Framework

Conceptual frameworks are used to connect theoretical perceptions, assumptions, and beliefs to empirical studies and scholarship (Creswell, 2012). Similar to theoretical frameworks, the conceptual framework is used to guide research. The conceptual framework guiding this research included LGBT-affirmative counseling training, ACA advocacy, and multicultural competency standards, and counselor self-efficacy. All three ideas address counselor development for working with multicultural populations and clients with layered characteristics. In this study, I followed conceptual perspectives for guiding awareness and establishing knowledge to include clients' sexual orientation and gender identity in counselor training, case conceptualization, and client interventions.

The phenomenon of affirmative-LGBT counseling training and addressing client equality in counseling practice is exhibited throughout qualitative and quantitative research (Bidell, 2014; Crethar et al., 2008; Farmer et al., 2013; Graham et al., 2012; Goodman et al., 2004; Herek & Garnets, 2007; Meyer, 2003; Sue, 2010). In this research, I used ACA multicultural standards, social justice, and affirmative-LGBT counselor training frameworks to present concepts on counselor development for multilevel, inclusive, and intersectional knowledge of LGBT clients.

## Nature of the Study

Quantitative research is used to examine statistical comparisons between measurements (Creswell, 2012). In this study, I used numeric and statistical data to conclude patterns between self-perceived clinical preparedness and religious commitment among LPCs. According to Creswell (2012), scholars use quantitative research when

recruiting a large sample population compared to qualitative research where sample populations are small. Using a quantitative design, I analyzed self-perceived clinical preparedness for working with LGBT clients using the LGBT-DOCSS assessment tool. Also, I measured levels of religious commitment of LPCs using the RCI-10. Participants included LPCs. I provided a demographic information questionnaire to identify participants' ethnicity, age, gender, sexual orientation, religious orientation, and state of residence. Participant recruitment took place online among LPCs in the United States.

## Assumptions

I assumed that the results from this quantitative study would lead to accurate data regarding the relationships of students' self-perceived LGBT counseling competency and their demographic characteristics. In addition, I assumed that the prediction of statistical data from the quantitative process would illustrate frequencies, percentages, and empirical data to describe the relationships between the dependent variable and independent variables.

## Scope and Delimitations

Boundaries within my research included instrumentation terminology, participation demographical region, and the source of the survey.

Delimitations within my study included the following:

1. I did not address clients who were intersex, asexual, pansexual, or polyamorous or competencies developed to counsel these sexual and gender identities.

2. I did not discuss participants' associations with current environment social climate.

## Limitations

There were limitations to my study. Self-reported data are limited and may have potential bias or anxiety when discussing sexual orientation. For instance, participants could answer the survey in politically or religious favorable terms, respond to questions by how they feel others would want them to answer, or fear confidentiality. Graham et al. (2012) specified that studies using self-reported data hold limitations and risks for reliability. LPC is a broad term, and participants from counseling settings (ie., marriage and family, addictions, military, community, or medical settings) were all considered in recruitment sampling. Self-perceived competence is an opinion, and this limitation was important to consider because the participants may have embellished knowledge of LGBT counseling competence. Limitations also included (a) online participants may not have had a compatible computer to complete the survey, (b) participants may have had more have more competence in sexual orientation (gay, lesbian, bisexual) than gender identity (transgender), (c) questions were considered sensitive and might have caused respondents to feel uncomfortable, and (d) unconscious bias may have arisen during participation.

This study was only offered online. The use of the Internet could have posed technical difficulties that may have hindered the participants' process in response. The distribution of the survey may have become flawed if their computer was not compatible, and some potential participants may not have had access to a private computer for

participation. Also, the LGBT-DOCSS and RCI-10 used in this study were limited to only English-speaking participants and did not accommodate students who may be international or have English as their second language. The study was limited to individuals who could comprehend the instrument online without any questions or interpretations.

## Significance

Scholars have outlined the importance of increasing attention in research of LGBT counseling competency among college students. Counselor education and social change advocacy can benefit from the results of this study in many ways. First, the information described in this study includes ideas in LGBT-affirmative training and LGBT counselor practices and reveals how religious commitment and self-perceived LGBT counseling competence are associated. Next, I validated previous conclusions and offered new trends among the LGBT- DOCSS and the RCI-10 student measurement levels. I also discussed predictors of self-perceived LGBT clinical preparedness levels and compared results to prior conclusions.

## Summary and Transition

Within Chapter 1, I identified the purpose of the study and reviewed my research procedures. I articulated the outline for using the LGBT- DOCSS and RCI-10 instrument and described possible outcomes of obtaining knowledge, recommendations, and discovering benefits for counselor education. I introduced the framework and theoretical method used to guide this study. I provided bibliographic information in Chapter 1 explaining references and previous counselor education studies to support my research. In

Chapter 1, I introduced efforts in counselor education research among educators and trainees, and I discussed the connection between increasing social change, counselor training, and advocacy for LGBT clients.

Furthermore, I offered the collaborative efforts between counselor education authors, community advocates, researchers, and counselor supervisors' efforts to increase awareness of LGBT counselor competency development. I concluded this chapter with the significance of studying LGBT counselor competencies and why support for the LGBT community is an important, ongoing, and relevant process in counselor education.

The following chapter identifies literature review which comprises critical research and articles relating to clinical preparedness for working with LGBT clients and multicultural competency evaluations. In chapter 2, I provide research descriptions of prior studies and counseling scholars ideas examining self-perceived counselor assessments for working with the LGBT community.

# Chapter 2: Literature Review

## Introduction

The purpose of this quantitative study was to assess the extent of the relationship, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudinal awareness toward LGBT clients as moderated by levels of religious commitment of LPCs. Scholars have not addressed association levels of self-perceived clinical preparedness for counselors working with LGBT clients using the LGBT-DOCSS and their religious commitment using the RCI-10. In Chapter 2, I discuss the following: (a) various research search strategies and literature resources to support the purpose of my research; (b) multicultural counseling and feminist theoretical perspectives; (c) definition and description of licensed professional counselors; (d) counselor development models related to my research topic; (e) affirmative-LGBT counseling education, competencies, and ethics; (f) religiosity in counseling practice; and (g) use of self-evaluation tools in counselor professional development for working with LGBT clients.

## Literature Review Strategy

I found information to support my study by reviewing scholarly, peer-reviewed articles and dissertations from the following databases: PsycArticles, PsycINFO, SAGE, ProQuest, SocINDEX, PsycCritique, and EBSCO. Also, I gathered information from the ACA’s website to identify codes of ethics and definitions about client diversity, cultural context, and competencies used in counseling interventions for LGBT client populations. Sources used included scholarly books, peer-reviewed articles, journals, web pages, reports, and dissertations.

The articles I selected were within the scope of subject reference by filtering using key terms and references from online resources. Information from the resources addresses advocacy and counseling clients in the LGBT community. The journal articles described clinical preparedness and counselor competencies for working with LGBT clients, and articles were peer-reviewed and limited those published between 1967 and 2017. The LGBT-DOCSS is a scale developed in 2017 and has limited resources and literature references. Therefore, studies older than ten years were important to include because the information covered a range of prior counselor education research and described the history of professional counselor development in working with LGBT clients. For related content, I identified research using the SOCCS (Bidell, 2005) and other counselor competency assessments for working with LGBT clients.

The search terms included the following: *advocacy*, *LGBT ally*, *affirmative training/therapy*, *bisexual*, *counselor educator*, *culture*, *education*, *counselor competence*, *diversity*, *feminist*, *gay*, *gender*, *gender identity*, *heterosexism*, *lesbian*, *multicultural*, *queer*, *questioning*, *religion*, *religiosity*, *spirituality*, *social justice*, *licensed professional counselor*, *sexual identity*, *multiculturalism*, *integrative*, *clinical supervisor*, *counselor supervision*, *heterosexual privilege*, *affirmative counseling*, *self-efficacy*, *minority*, *psychotherapy*, *counselor assessments*, *intersectionality*, *sexual orientation*, and *transgender.*

## Theoretical Foundation

In this section, I provide a literature review of each theoretical framework and how each theory has contributed to the growth of counselor competence when working

with diverse clients. I provide a theoretical assumption connecting the two theoretical approaches to my research hypotheses. I also explain the rationale for using multicultural and feminist counseling frameworks to support my study.

**Multicultural Theory**

Counselor educators' attention to LGBT counseling competency has expanded to support social change development in advocacy and public policies. In 2005, the ACA (2014) expanded multicultural competencies to include religion, gender, physical abilities, socioeconomic status, and sexual orientations. Multicultural theoretical frameworks have helped to expand counselor education research and improve diversity training models for counseling diverse populations. Multicultural theorists influenced counselor educators to develop training models to prepare counselors for case conceptualization considering a client's sexual orientation, gender, and sexual identity (Bidell, 2014; Israel & Hackett, 2004; Sue & Sue, 2007).

Multicultural counseling is defined as counseling methods including the clients' cultural beliefs in their treatment (Nugent, 2013). In multicultural therapy, consideration is given to a client's social class, spirituality, abilities, disabilities, sexual orientation, and cultural biases (Nugent, 2013). Counselor researchers encourage ideas of multicultural theories such as multicultural education, effects of social systems in public services, affirmative-LGBT counseling training, integration to infuse cultures in learning objectives, and including multicultural ethical standards in professional development.

Multicultural counseling competencies include acknowledging the differences in individuals and groups regarding their race, religion, spirituality, sexual orientation,

gender, age, socioeconomic class, family history, and geographic location (Minami, 2008; Sue, 2010; Sue & Sue, 2007). Multicultural counseling competencies were established to help counselors acquire skills to provide ethical and effective counseling interventions to culturally diverse clients. Sue and Sue (2007) identified components of cultural competence using a tripartite model, which they described as (a) awareness of a person's own beliefs, values, biases, and attitudes; (b) awareness and knowledge of the worldview of culturally diverse individuals and groups; and (c) use of culturally appropriate intervention skills and strategies. Sue and Sue noted self-reflection as a part of being a multiculturally competent counselor.

In a qualitative study, lesbian participants of color reported that counselor trainees imposed personal, negative beliefs during counseling experiences (Speciale et al., 2015). Speciale et al. (2015) used multicultural theory to address factors of social oppression and political influences hindering LGBT counseling competency development among counseling students. Although multicultural counseling theory (MCT) considers a person-centered approach to therapeutic intervention, this theory does not draw attention to the multiple layers of a person's characteristics within cultural groups (Crethar et al., 2008).

Baumgartner and Johnson-Bailey (2008), Minami (2008), and Sue (2010) acknowledged attitude awareness involving implicit and explicit cognitions and behaviors as factors influencing the therapeutic rapport with culturally diverse clients. Also, Sue and Sue (2007) believed self-examination of attitudes and feelings associated with cultural differences are necessary for counseling conceptualization and in counselor social conditioning. In other attributes of multicultural counselor theoretical

approaches, scholars suggested addressing bias barriers and applying culturally focused solutions during training to help counselors in training (Baumgartner & Johnson-Bailey, 2008; Minami, 2008; Sue & Sue, 2007).

Sue (2010) explained that multicultural counselor education courses inhibit generalizations defining client sexuality. LGBT counselor competencies include the knowledge to apply various sexual orientations, gender identities, sexual experiences, and social oppression in counseling. Acquiring a multicultural framework in counselor supervision to develop LGBT competencies helps counseling professionals build skills, knowledge, and awareness to adequately counsel LGBT client populations (Bidell, 2014; Bieschke et al., 2014; Farmer et al., 2013; Herek, 2007; Israel & Hackett, 2004; Speciale et al., 2015).

**Feminist Theory**

Historically, feminist theories were the foundation for many economic, social, and political advocacy policies. According to Fricke (2010), multiple sexual identities gained attention in the second wave of the feminist movement within the early 1990s. Feminist theorist expanded the realm of biological gender definitions, reproduction rights, and equality for people within the LGBT community. Feminist theorists' perspectives in counselor education involve improving ethical standards for counseling practice, public social policies, and self-awareness, and opposing heterosexist generalizations in diagnosis (Fricke, 2010; Hope & Chandra, 2015; LaMantia, Wagner, & Bohecker, 2015).

Feminist theorist campaigns originally started with efforts toward ending discrimination against women. Throughout the years, feminist theory grew to increase

social standards to improve conditions in prochoice of abortion, sexual assault, workplace equality, gender ambiguity, and equal opportunity in education, and they exposed unbalanced privileges (Clarke et al., 2010). According to feminist theory, dominant power and privileges in society hinder the growth of counselor multicultural competencies (Clarke et al., 2010; LaMantia et al., 2015; Parent, DeBlaere, & Moradi, 2013). Clarke et al. (2010) clarified that political women's rights movements stem from feminist perspectives. For example, Clarke et al. explained that the recognition of feminist approaches challenges unethical counseling standards and criticizes limited diversity competencies among professional roles and educational systems. Feminist perspectives include cross-cultural ideas and cultural-specific experiences of women and people of color, as well as LGBT individuals' experiences, to dissolve generalizations in social learning (Clarke et al., 2010). Feminist views connect advocacy with mental health practice. Feminist perspectives also paved the way for multicultural theory, queer theory, liberal-humanistic views, and LGBT-affirmative training (Clarke et al., 2010).

Four waves of liberation movements can categorize feminism. The first feminist movement was associated with women's rights in the later decades of the 1900s (LaMantia et al., 2015; Parent et al., 2013). The first wave focused on inequalities between male and female experiences of unfair voting rights, employment, positions in marriage, and rights in political positions. The second wave introduced liberation movements during the 1960s and 1970s, and it encouraged breaking down barriers of gender inequality and focusing on gender differences, homophobias, roles of women in the workplace, and attention to intersectionality in culture.

The third wave of feminism is noted for addressing viewpoints of equality in society among people of color: lesbian, gay, and transgender people and individuals who are Native Americans or of non-European descent. Parent et al. (2013) explained that the third wave of feminist theorists were concerned with not only improving conditions for women but also developing competencies regarding conditions of oppressed individuals and communities. The fourth movement of feminism includes continued attention to social justice activism and taking positions against systematic oppression to end racism, classism, body shaming, heterosexism, and ageism (Wahogo & Roberts, 2012). The fourth wave of feminism is differentiated from the others by the consideration of communication technologies connecting many women from diverse backgrounds to expand social change. Communication technologies include the use of social media platforms such as online articles, blogs, social networking, and online petitions as opportunities to discuss and express the feminist movement (Wahogo & Roberts, 2012). According to Wahogo and Roberts (2012), social media is an outlet where people can openly and quickly express their opinions and also find supporters. The fourth wave of the feminist movement addresses the breakdown of limitations in cultural boundaries, which allows individuals to be open and voice their opinions about social justice, discrimination, and heterosexist systems in a more collective realm (Wahogo & Roberts, 2012). Feminist theoretical perspectives provide models to guide counselor educators, researchers, and counselors in practice to examine clients' culture, race, religion, and sexual orientation to the development of counseling competence (Brown, 2010; Hagen et al., 2011; Parent et al., 2013; Singh et al., 2010).

Qualitative and quantitative researchers both convey feminist theoretical perspectives to address areas in counseling conceptualizations. For example, Hagen et al. (2011) used feminist, multicultural counseling (FMC) to discuss the conflict between lesbian, bisexual, and queer women clients and counselors holding conservative religious values. Hagen et al. described the relevance of integrating feminist and multicultural counseling perspectives to explore religion in counseling with LBQ women clients. The FMC model is used as a framework to address oppressive sociocultural contexts and positive religion influences in counseling LBQ women clients. Hagen et al. explained, "Little attention has been given to the struggles of LBQ women of color and understanding the lack of religious support within the community" (p. 224). Hagen et al. disputed that "spirituality is an identity or context to include with FMC in addition to race, ethnicity, gender, disability, class, and sexual identity" (p. 224).

Fricke (2010) mentioned that feminist theory challenges dominance in heterosexual counseling standards and gives recognition to minority group experiences. Counselor education research addressing the differences in sexuality and gender orientations offer alternatives to counselor education training models (Fricke, 2010). Feminist theoretical models equip counselor supervisors with frameworks to help students understand counseling techniques related to clients' sexual identities further than biological sex or expected gender roles (Fricke, 2010; Hagen et al., 2011; Speciale et al., 2015). Furthermore, feminist models help to expand affirmative training to expand diversity in counseling techniques, develop lesbian and gay client related topics within college courses, and encourage social change among counseling professionals (Bidell,

2013; Fricke, 2010; Hagen et al., 2011; Herek, 2007; Israel & Hackett, 2004; McGeorge et al., 2013; Speciale et al., 2015).

Throughout history, academic feminism, Marxist feminism, Black feminism, radical feminism, activist feminism, multicultural feminism, lesbian feminism, and socialist feminism have emerged (Singh et al., 2010). Each has goals to recognize inclusions of gender, multicultural factors, religion, and power struggles in society. According to Parent et al. (2013), feminists' approaches help counselors understand the experiences of gender and racial bias, identify class systems in society and encourage ideas of gender differences in counseling. Although the feminist approach was the core movement to help abolish inequalities, Black feminism theorists, such as LaMantia et al. (2015), explained that other feminist approaches failed to identify intersectionality among individuals. Intersectionality relates to the racism, sexism, and class oppression as separate experiences that people face in society (LaMantia et al., 2015).

Brown (2010) continued to promote the importance of understanding the dimensions of sexuality and integrating feminist-based competencies through counseling training assessments. Brown suggested using feminist therapy to integrate a person's understanding of cultural, heritage, and spiritual identity to understand a sense of self and also address details in personal dimensions used to conceptualize culture and spirituality into client counseling.

The discussion of a feminist theoretical framework identifies the need for evaluation of self-perceived LGBT counselor competency in many ways. For example, feminist theoretical information provides the basis of relating race, class, sexuality, and

gender theoretical perspectives in counselor education. Also, feminist theorists provide worldviews concerning the LGBT community and offer support to affirmative-LGBT counseling training (Clarke et al., 2010; Fricke, 2010; Speciale et al., 2015). Counselor education researchers use feminist theory models to "challenge the core assumptions of heteronormative ideology" (Speciale et al., 2015, p. 258). Feminist theoretical perspectives help to diminish heterosexist constraints in society and devalue generalizations of minority groups in practice counseling

**Rationale for Multicultural and Feminist Framework**

The developments of multicultural and feminist theoretical perspectives are continually evolving. The call for social change within the counseling profession demands counseling professionals and counseling educators to become advocates for the LGBT community as mentioned in both multicultural and feminist theories. In addition, mental health professionals and counselors are both behavioral change leaders and help to regulate public policy change for oppressed communities (Bidell, 2005; Bidell & Whitman, 2013; Graham et al., 2012; Rutter et al., 2008; Sherry, Whilde, & Patton, 2005; Sue, 2010; Walker & Prince, 2010). The feminist and multicultural theories are the ideal framework for this research because feminist theoretical perspectives describe the need for counselors to understand the social experiences of lesbian, gay, transgender, queer, and heterosexual individuals. Gathering information rooted in feminist and multicultural research benefits affirmative-LGBT counseling education training brings attention to inequality in research and improves developments of various multicultural counselor competencies (Brown, 2010; Clarke et al., 2010; Graham et al., 2012; Sherry et al., 2005;

Sue, 2010). Clinical preparedness to address a client's sexual orientations is as important as race, age, disability, and social class when developing mental health interventions (Sue, 2010).

**Theoretical Assumptions**

Researchers reported in prior research using LGBT-affirmative counselor education and training following multicultural and feminist theoretical models help students become more competent with addressing experiences common among LGBT clients (Bidell & Whitman, 2014; Halpert et al., 2007). There is an assumption this study will provide associations between the measurements of self-perceived clinical preparedness for working with LGBT clients among LPCs, as well as their religious identities. There is limited information evaluating LPCs clinical preparedness and religious commitment using the instruments I present in this study. The primary assumption is the criterion of predictors used in this research to discover the associations between self-perceived clinical preparedness working with LGBT clients and religious commitment will help fill the gap in counselor education studies using the LGBT-DOCSS data among LPCs.

## Population: Licensed Professional Counselors

In this section, the conformity of the counseling profession and development of a concise title for counseling professionals are described. Described below are the various professions and areas in professional counseling. Researchers recruit an array of counseling professionals who practice in various specialties. LPCs are the ideal population for this study because this is a sample population not primarily sampled in

prior studies evaluating clinical preparedness for working with LGBT clients and also this population is known as the gatekeepers of providing mental health counseling services.

**Definition of Counseling**

According to Kaplan, Tarvydas, and Gladding (2014), the definition of counseling developed by the 20/20 vision delegates states “Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (p. 366). Core principles outlined by the 20/20 consensus vison unify professional counseling membership, education accreditation, ethical principles, practice standards, and honor society groups within the profession of counseling (Kaplan et al., 2014). The definition was established to give a “profession-wide description of professional counseling” (Kaplan et al., 2014, p. 366). From 2005 to 2013, a group of 31 organizations representing the counseling profession, focused on promoting concise, professional standards for the entire counseling profession. This group of counseling organizations worked together to establish a core professional scope for strengthening and unifying the definition of professional counseling. Kaplan et al. (2014) explained the 20/20 vision communicated professional scholarly practices for the definition to be comprehended across the entire counseling profession.

**Licensed Professional Counselors**

In the summer of 2015, both American Counseling Association (ACA) and the American Association of State Counseling Boards (AASCB) agreed to accept the title licensed professional counselor (LPC) as the uniform name to describe the work of

professional counselors (Bethany, 2015). Bethany (2015) stated there are over 35 license titles currently in use for professional counseling. The consensus within licensure title allows the profession of counseling to be on one accord, consistent, collective and strong (Bethany, 2015). LPCs provide mental health counseling in various forms of services (ACA, 2014). LPC is a universal term describing marriage counselors, addiction counselors, counseling psychologist. The term LPC can describe any licensed counselor who offers services to individuals, couples, groups, and families. Service types include but are not limited to the following: substance abuse, behavioral, cognitive, career, trauma, or bereavement counseling (ACA, 2011; 2014). LPCs are employed within community health facilities, private practices, military, hospitals, and colleges.

To become a professional counselor and receive a counselor license to practice, individuals must obtain a master's degree and undergo supervised training by an LPC. Licensed professional counselors are required to a minimum of a master's degree from an accredited counseling program. Counseling professionals become licensed by counseling licensing boards in a state where they desire to practice counseling. ACA (2014) explained the requirements to become a licensed professional counselor vary from state to state. However, basic requirements for most of the 50 states in the United States include a master's degree, counselor supervision, and the passing of the National Counselor Examination (NCE) or the National Clinical Mental Health Counseling Examination (NCMHCE) (ACA, 2011). LPCs are responsible for upholding professional counseling ethical standards of the American Counseling Association (ACA, 2014). ACA

(2014) mentioned LPCs identify mental health conditions and conceptualize how clients can benefit from solution-focused interventions.

Counselor educators and supervisors are oriented towards helping the counselor-in-training develop knowledge, skills, personal awareness, and ethical judgment to provide cognitive, behavioral, interpersonal, and psychodynamic therapy. LPCs are required to complete 3000 hours of supervised training before they independently engage in counseling practice. During counseling supervision, counselor supervisors are to demonstrate, teach, guide, and consult with counselors-in-training and help standardize professional practice (ACA, 2011;2014).

## Counselor Developmental Models

Counselor educators use training supervision models to guide learning objectives. Stoltenberg and McNeill (2010) explained counselor supervision is beneficial when supervision objectives are structured using stages in learning development. Counselor supervisors determine supervision models based on their counseling methodology, experience, research, specializations, and ideas to provide support for supervisees (Bernard & Goodyear, 2004; Borders & Brown, 2005; Ronnestad & Skovholt 2003; Stoltenberg & McNeill, 2010). Counseling models allow counselor supervisors to take the role of teaching the supervisee counselor techniques, helping supervisees develop self-awareness, assessing their counseling competencies, and introducing them to case conceptualization and skill development using theoretical orientation.

Training and developmental supervision models are designed to help counselor supervisors apply mechanisms of counselor education to enhance supervisees' counselor

competencies. Bernard (1998) stated “we believe, the more we learn or experience in training, the better our development or ability is to complete what we are trying to accomplish” (p.26).

Supervision models such as the discrimination model of counselor supervision (Bernard, 1997; Bernard & Goodyear, 2004; Borders & Brown, 2005), the Ronnestad and Skovholt Model (Skovholt & Ronnestad, 1992; Ronnestad & Skovholt 2003), and the Integrated Developmental Model (Stoltenberg & McNeill, 2010) guide counselor supervisors in teaching supervisees multicultural competence. The three models utilize techniques such as helping counselor-in-training develop self-awareness, understand case conceptualization. In developmental supervision models, counselor supervisors clarify how bias, prejudice, and worldviews play a part in counseling conceptualization and intervention.

**Discrimination Supervision Model**

The discrimination supervision model (Bernard, 1997) is a flexible supervision approach which allows the supervisor to focus on the needs of the supervisee. The discrimination model has three different focus areas. Supervisors take the role of the teacher, act as counselors, or can act as a consultant. The discrimination model of supervision is described to be an integrative and eclectic approach to meet the supervisees needs (Bernard, 1997; Bernard & Goodyear, 2004; Borders & Brown, 2005). Each role of training is distinguished to maintain and ensure clear boundaries are set and role ambiguity is not a conflict.

Bernard and Goodyear (2004) explained skill development in the discrimination model includes focusing on the following: (a) processing issues, (b) conceptualizing issues, (c) personalization issues, and (d) professional behavior development (Bernard, 1997; Bernard & Goodyear, 2004; Borders & Brown, 2005). With processing issues, the supervisor focuses on how the supervisee is accurately attending to the client's needs and providing the appropriate interventions during the therapy process. The supervisee focuses on how the supervisee is using a theoretical framework to formulate cases and how they develop a clear understanding of what the client's needs are based on clinical theory. In the last focus area, personalization issues involve the supervisee incorporating personal feelings, thoughts, and experiences to present in the therapy training process to help the supervisee understand how personal values have an impact on clients. In this area of skill building, the supervisor also helps the supervisee understand how to use their personal feelings and experiences to support clients in the therapy session. Counselor supervisors show supervisees how to become more self-conscious and become aware of how their demeanors affect the therapeutic relationship. Also, the role of the supervisor in the discrimination model is to make sure the supervisee is following legal guidelines and is reacting professionally and respectfully during training and therapy with clients (Bernard, 1997; Bernard & Goodyear, 2004).

**Ronnestad and Skovholt Model**

The Ronnestad and Skovholt Model (Ronnestad & Skovholt 2003; Skovholt & Ronnestad, 1992) explained counselors continue learning counseling techniques throughout their career and initial counselor supervision training is just the foundation.

The Skovholt and Ronnestad supervision model has six focus areas of development and is considered a phase development model. Ronnestad and Skovholt conducted a cross-sectional qualitative study and discovered 14 common themes of counselor development among 100 counselors and therapist.

The 14 themes of counselor development found include:

1. Professional development consistently involves the higher-order integration of the professional self and the personal self
2. The focus of functioning shifts dramatically over time from internal to external to internal.
3. Continuous reflection is a prerequisite for primary learning and professional development at various levels of experience.
4. A commitment to learning helps to extend the developmental process.
5. The cognitive map changes; beginning professionals rely on external expertise, and senior practitioners rely on internal expertise.
6. Professional development is a long, slow, continuous process.
7. Professional development is a lifelong process.
8. In the beginning, practitioners experience anxiety, which reduces overtime.
9. Clientele serves as a source of teachers and is primary sources of learning influences.
10. Personal life influences professional performance and development throughout life.

11. Interpersonal sources of influence professional development more than impersonal sources of influence.
12. New practitioners view professional has been in the field longer with strong affective reactions.
13. Extensive experience with suffering contributes to heightened recognition acceptance and appreciation of human variability.
14. For the practitioner, there is a realignment from the self as a hero to the client as a hero.

The 14 themes of counselor development resulted were categorized in six specific stages of learning development counselors experience. The stages are (a) lay helper (b) the beginning student (c) the advanced student (d) the novice professional (e) the experienced professional (f) the senior professional. During each phase, Skovholt and Ronnestad, (1992) described areas of continued learning throughout a counselor's life within each stage such as professional growth, shifts in attentional focus, emotional functioning, and continuous self-reflection. The authors point out how a counselor conceptualizes and resolve their challenges are similar to how they will professionally conceptualize what their client's intervention needs are. Ronnestad and Skovholt (2003) explained interpersonal experiences in a counselor's personal life, and experiences in their professional life are both significant sources for counselor competency development. Ronnestad and Skovholt (2003) explored how counselor development is consistent and has many different areas of learning.

### Integrated Developmental Model

The integrated developmental model (IDM) introduced by Stoltenberg (1981) is the last developmental supervision model supporting my research study. In this supervision model Stoltenberg (1981), Stoltenberg and Delworth (1987), and Stoltenberg, McNeill, and Delworth (1998) classify three levels of counselor development.

In level one, the supervisee is described to have high motivation but is fearful of evaluation and has the high anxiety of their expectations (Stoltenberg, 1981; Stoltenberg & Delworth, 1987; Stoltenberg et al., 1998). The second level is midlevel for supervisees where they experience changes in confidence and motivation. According to Stoltenberg, (1981); Stoltenberg and Delworth, (1987); Stoltenberg et al. (1998) in the second level the supervisee feels their perception of confidence influences therapeutic success with clients. The third level the supervisee is more secure and motivated to help clients by using accurate empathy and conceptualization of interventions. During each stage, the supervisor supports the supervisee by addressing the supervisees' need for development. Stoltenberg and Delworth (1987) explained the supervisee master each challenge in every level the supervisor presents in training to become more self-reflection and to allow autonomy.

## Affirmative-LGBT Counseling Education

This section describes how counselor education includes efforts of social change by addressing experiences of LGBT individuals in counselor conceptualization methods and developing adequate counselor interventions for LGBT clients. Brown (2010) explained institutions of higher education and counselor education programs must adhere

to worldviews, social interaction, and diversity in clientele population. Attention to social change efforts in counselor development involves multicultural academic curriculums and institutional policies attending to social fairness in counseling methodologies for LGBT clients (Bidell, 2012; 2014; Bidell & Whitman, 2013; Farmer et al., 2013; Herek & Garnets, 2007; Israel & Hackett, 2004).

Miller, Miller, and Stull (2007) conducted quantitative research among 83 counselor education programs using the Survey of Cultural Attitudes and Behaviors (SCAB) (22% response rate) to measure 154-counselor education faculty members' perceptions of institutional social-fair policies and procedures. Miller et al. (2007) examined the relationship between counselor educators' attitudes, behaviors, and perceptions of institutional support regarding race, sexual orientation, social class, and gender. Miller found counselor educators' perceptions of institutional cultural-fair policy and practices are predictors of students developing counselor competencies and affirming behaviors with LGBT clients. Participants in Miller et al.'s study reported higher levels of biases towards sexuality and social class compared levels of bias towards race and gender.

In result, Miller et al. (2007) concluded there was a statistically difference between subscales and discovered domains $F(3, 439) = 86.81$, $p < .000$, $\eta_p{}^2=.36$, and the main effect for dimensions indicated, $F(1, 153) = 229.71$, $p<.000$, $\eta_p{}^2=.60$ (Miller et al., (2007). Researchers reported statistically significant correlations between race and sexual orientation, race and social class scores, gender and sexual orientation subscales scores. Miller et al. concluded the cultural attitudes of faculty members were predictors of

institutional and student cultural behaviors. Miller et al. reported student opinions of obtaining multicultural learning is strongly influenced by institutional, cultural policies or social norms. Their study also clarified correlations existing between institutional climate and students' competency development associated with instructional support.

In conclusion, Miller et al. (2007) suggested counselor-affirming behaviors have a correlation with counselor educator's perceptions of institutional cultural-support. Counselor education studies have exhibited the importance of uncovering institutional policies or practices to ensure personal or institutionalized beliefs do not interfere with the ability to train cultural-competent professionals (Bidell, 2005; Bidell, 2014; Bidell, 2016; Farmer et al., 2013; Graham et al., 2012; Rutter et al., 2008; Walker & Prince, 2010).

Innumerable debates proposed concerns in counselor education research and the development of counselor training models to prepare professional counselors to efficiently develop competence in LGBT client mental health conceptualization (Bidell, 2014; Case & Meier 2014; Farmer et al., 2013; Graham et al., 2012; Rutter et al. 2008). For example, Case and Meier (2014) criticized the lack of multiple factors excluded in affirmative-LGBT counseling training enables counselors' ability to acknowledge how various sexual identities are important in mental health diagnosis and intervention strategies. Using the Gender Infinity Practitioner training model, Case and Meier (2014) found customizing LGBT client counseling workshops with feminist pedagogy helps to facilitate ally interaction between teachers, school counselors, and LGBT client populations. During the Gay, Lesbian, and Straight Education Network (GLSEN)

workshop, 93% of the participants reported developing knowledge and skills after attending (Case & Meier, 2014). Their study concluded engaging in the GSLSEN workshop, or affirmative-LGBT counseling training is essential to increase support for counselors and educators' LGBT students or clients.

In a mixed method study, Grove (2009) evaluated counselor education students to discover how years in counselor education training and LGBT counseling learning experiences were associated with self-perceived LGBT counselor competence. Fifty-eight counselor education students participated in the quantitative section of the study with an additional 15 counselor education student completing a questionnaire to gather qualitative data. Grove (2009) used a one-way analysis (ANOVA) to interpret the research data regarding the associations between self-perceived LGBT counselor competence and up to 4 years of counselor training.

Grove (2009) distinguished significant higher levels among counselors-in-training in SOCCS knowledge and skills subscales as the years of training increased. On the other hand, Grove found there were no significant changes in the SOCCS awareness subscale when students reported an increase of years in counselor training. Empirical data indicated $p$ values for skills, knowledge, and attitudes being below a significance level of 0.05. The data indicated there are associations between years of training and the impact of students' skills, knowledge, and attitude competency development. Within the qualitative description, Grove determined two themes related to high levels of self-perceived LGBT counselor competence among counselor education students. One theme indicated personal beliefs of sexual orientation were factors of self-perceived counselor

competence growth and the other theme revealed participants felt counselor competence growth was related to participating in various activities within the LGBT community.

According to Grove (2009), students mentioned learning the differences in heterosexist perspectives, along with discussing personal sexuality, their position of stereotypes, and sexuality assumptions among LGBT clients increased their confidence in LGBT counselor competence growth. In results, Gove explained participants with more experiences with LGBT clients, and training opportunities increased their attitudes and knowledge in counseling LGBT clients. Groves promoted the SOCCS instrument as a valuable training method to include in affirmative-LGBT counseling training along with applying affirmative counselor techniques help students effectively counsel LGBT clients.

Logan and Barret (2005) discussed how professionals' identity, social-cultural diversity, human growth, and career environments all contribute to LGBT counselor competency level. Most importantly, the authors provided an overview of organizations such as the ACA, and The Association of Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGTBIC) are working towards developing quality counseling practice and social advocacy programs for LGBT clients

**CACREP Competencies**

CACREP is recognized for accrediting counseling programs by providing and reviewing quality standards set for professional counseling practice. CACREP is the primary counseling program review board in 1981 by the Council on Postsecondary Accreditation (COPA) and created by ACA (Smith & Okech, 2016; Troutman & Packer-

Williams, 2014). CACREP ensures students are attaining the appropriate skills and knowledge to become a professional in counseling practice. The learning content in CACREP programs is structured to help students with professional training to obtain counseling licensure in most states (CACREP, 2016).

According to Troutman and Packer-Williams (2014), CACREP in the past faced scrutiny for heterosexist counseling practice standards and criticized for not establishing standards for religious and sexual orientation diversity in counseling training. Troutman and Packer-Williams (2014) criticized CACREP for not offering specific standards regarding the LGBT population and the lack of specifying gender identity and sexual orientation competencies in counseling training. Although CACREP standards offered multicultural counseling considerations, many of their past standards were vague about counseling services for LGBT clients (Troutman & Packer-Williams, 2014). CACREP counselor education program standards grew to include counselor education standards to identify institutional bias, social discrimination among LGBT individuals, reserved counselor training experiences, and heterosexist norms associated with LGBT counselor competence (CACREP, 2016).

Specifically, Section 2.F.2. of CACREP (2016) standards titled Professional Counseling Identity identifies counseling curriculum standards related to social and cultural diversity. In this section of CACREP accreditation standards, the following eight requirements are listed to ensure students learn relevant counseling strategies to serve diverse client populations: (a) multicultural and pluralistic characteristics within and among diverse groups nationally and internationally; (b) theories and models

of multicultural counseling, cultural identity development, and social justice and advocacy; (c) multicultural counseling competencies; (d) the impact of heritage, attitudes, beliefs, understandings, and acculturative experiences on an individual's views of others; (e) the effects of power and privilege for counselors and clients; (f) help-seeking behaviors of diverse clients; (g) the impact of spiritual beliefs on clients' and counselors' worldviews; (h) strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination.

**Multicultural Competencies**

Several researchers examined efforts of LGBT advocacy by examining how institutions address sexual orientation diversity and provide curriculums addressing sexuality within counselor training programs (Bidell & Whitman, 2013; Dunn et al., 2006; Rutter et al. 2008; Walker & Prince, 2010). This section describes multicultural competency research including the need to include sexual orientation in counselor development research.

In a cross-sectional research study, McCarty-Caplan (2015) found differences between the levels of LGBT client competencies among social work faculty members compared to those of students in the social work education program. Using a Multidimensional Cultural Competence (MDCC) model, the researchers examined participant's perceptions of culture attention in the social work programs about their self-perceived LGBT counselor competence. McCarty-Caplan's research population consisted of 34 masters of social work (MSW) programs, 34 directors, 242 faculty members, and 1,109 students. McCarty-Caplan evaluated the academic criteria of 1,109 social work

programs and determined high levels of self-perceived organizational LGBT-competence among the social work programs. The evaluation also yielded measurements correlating to higher levels of self-perceived LGBT-competence among the students in the social work programs ($b$ =.04, $p$ <.001) (McCarty-Caplan, 2015). Students who reported feeling more competent to counsel LGBT clients rated their institutional program's overall cultural attention higher than those students who reported feeling less competent to meet LGBT clients counseling needs (McCarty-Caplan, 2015).

McCarty-Caplan (2015) reported students' perceptions of multicultural agendas within the social work program was associated with their level of self-perceived LGBT counseling competence. McCarty-Caplan indicated the lower the level of self-perceived LGBT counselor competence among respondents was a predictor of low perceptions of multicultural attention within the social work program.

Israel, Ketz, Detrie, Burke, and Shulman (2003) empirically categorized specific areas of competence necessary for counseling LGBT clients. Israel et al. found multicultural frameworks required modifications to address specific competencies to meet LGBT client needs effectively. Israel et al. conducted research to identify the important aspects of multicultural counseling training using LGBT counselor competency assessments. Their study highlighted specific attributes of LGBT competence and expanded the idea to evaluate LGBT counselor competency among graduate students to ensure counselor professional development. Israel et al. discussed when developing LGBT counselor competencies, counselor training must focus on knowledge, attitudes, behaviors, and applied skills. While earlier studies tried to identify components of

counselor competency with LGBT clients, empirically and comprehensively, they did not break down the complexity of how a counselors' religious commitment and counselor competency with LGBT clients into knowledge, awareness, and skills is related (Bidell, 2012,2014, 2015; Herek & Garnets, 2007; Israel et al., 2003; McCarty-Caplan, 2015; Nickles, 2011).

**LGBT Competencies from ALGBTIC**

The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals (ALGBTIC LGBQQIA) outlined counselor competencies to promote adequate and quality counseling services to LGBT clients (Harper et al., 2013). This section provides literature reviews to explain why the ALGBTIC organization established counselor competency standards for working with LGBT clients. Also, the section also identifies standard areas ALGBTIC deemed necessary to address in counseling training.

Harper et al. (2013) explained the ALGBTIC LGBQQIA Competencies Taskforce created standards in several areas of counseling competencies for working with LGBT clients. The counseling competencies established include religious values, politics, public policies, personal self-reflection, social attitudes, behavior, and politics associated with LGBT client experiences. ALGBTIC LGBQQIA emphasized the need for counselors working with LGBT clients to acknowledge diversity within the LGBT population by understanding intersecting identities and multiple layers of individual's characteristics (Harper et al., 2013). Harper et al. explained ALGBTIC LGBQQIA developed a

framework to help create social, emotional, personal and relational development in counselor training. ALGBTIC LGBQQIA's primary focus is to reduce marginalized or heterosexist perspectives in counseling practice (Harper et al., 2013).

ALGBTIC LGBQQIA outlined six main areas for competency development (Harper et al., 2013). ALGBTIC LGBQQIA competencies are divided into six sections. LGBT competencies are listed in the following sections: (a) competencies for working with lesbian, gay, bisexual, queer, and questioning individuals; (b) competencies for working with allies; and (c) competencies for working with intersex individuals. ALGBTIC referenced the 2009 CACREP standards to structure the core areas of competency development within each competency section (Harper et al., 2013).

ALGBTIC enforced competencies to address common experiences and challenges LGBT individuals to face when entering the workforce, in public policies, family relationships, and when making decisions about identity disclosure to bring about new changes in the counseling practice (Harper et al., 2013). For example, ethical guidelines C.3 state counselors must be aware of misconceptions and myths regarding affectional orientations and gender identity expressions. Ginicola, Filmore, and Smith (2017) clarified myths generalizing all transgender individuals' life experiences is unethical. Counselors must address every lesbian, gay man, bisexual individuals, and transgender client as an individual and acknowledge his or her journey (Ginicola et al., 2017). ALGBTIC ethical competencies indicated professional counselors must understand how to include terms, experiences, and behavior tailored to the needs of the LGBT community.

Section III titled Allies lists guidelines for counselors who are allies of the LGBT community. The Allies section recommends counselors take part in attending seminars, workshops, and meeting supporting the LGBT community (Harper et al., 2013). ALGBTIC describes the benefits of counselors gaining knowledge and personal awareness to support individuals' decisions about coming out and facilitating supportive counseling environments for LGBT clients (Harper et al., 2013). Also, competencies developed ALGBTIC describes competencies for counseling Allies of the LGBT community. ALGBTIC identified information to ensure counselors seek knowledge to help clients who may not fit into majority or norm culture group and to include competencies for those who "hold identity that has traditionally been marginalized in the LGBT community" (Harper et al., 2013, p. 25).

Harper et al. (2013) identified how competencies developed by ALGBTIC not only help counselors to understand what to be aware of a professional counselor working with Intersex clients but the need to be able to define behavior specific to this population to apply in case conceptualization to provide quality counseling. ALGBTIC used a holistic framework for developing competencies for counseling LGBT individuals. Therefore, counselor education programs are recommended to train counselors to understand behavior, social factors, medical conditions, experiences, and advocacy efforts to support the LGBT community (Harper et al., 2013).

**Spiritual Competencies from ASERVIC.** Organizations such as the Association of Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) promoted growth and development of counseling techniques to include holistic, spiritual, and religious

values in counseling practice and counselor preparation. ASERVIC encouraged counselor educators to recognize diversity in human development and social engagement further than knowing about religion but understanding religious and spiritual influences, practices, rituals, attire, traditions, and holidays (ASERVIC, 2017).

According to Robertson (2008), "ASERVIC is the only division of the ACA that is exclusively committed to infusing the spiritual, religious, and values aspects of diversity into counseling" (p.87). Nickles (2011) discussed integrating a client's spirituality and own belief system in counseling helps to maintain their mental health, behavior, and encourages a positive rapport in the therapeutic relationship. ASERVIC (2017) explained this is also important to consider in counselor development because religious and spiritual beliefs can affect the choices individuals make. Therefore, counselor education should encourage counselors to take steps in learning and understanding how their belief system influences their relationship with clients, conceptualizing client's cases, and their role in counselor supervision training (ASERVIC, 2017; Nickles, 2011; Robertson, 2008). Counselor training involving self-perceived religion and spirituality assessments are crucial tools used to uncover self-awareness for counseling practice. ASERVIC (2017) encouraged counselor knowledge to include evaluating religious beliefs systems and recognizing the importance of connecting the psychological impact of religious beliefs and religious commitments.

The ASERVIC competencies are in line with the eight areas of counselor training established by CACREP (Robertson, 2008). These competencies are used as ethical guidelines for best practices in counseling (ASERVIC, 2017). ASERVIC developed five

sections of counselor competencies, (a) culture and worldview; (b) counselor self-awareness; (c) counselor self-awareness; (d) human and spiritual development, (e) communication; (f) assessment; (g) diagnosis and treatment. Appendix A illustrates the 14 competencies developed by ASERVIC.

## Affirmative LGBT Counselor Supervision

Ultimately, counselor competence development begins with the role of competent supervisors and counselor educators (Aducci & Baptist, 2010; Halpert et al., 2007; Miller et al., 2007; Rutter et al., 2008). Counselor training programs have the responsibility to support counselor trainee's progress in developing adequate competencies to counsel LGBT client populations. This section describes effective counselor supervision and counseling training efforts for counseling individuals with diverse sexual orientations and multicultural backgrounds.

Prior researchers reported LGBT clients experienced discrimination experiences, lack of self-awareness such as body language, and noticed little to no knowledge of issues affecting LGBT communities (Falender et al., 2014; Halpert et al., 2007; Miller et al., 2007; Rutter et al., 2008). Miller et al. (2007) explained these conditions result in negative perceptions of mental health services and caused an adverse outlook in counseling services. Affirmative-LGBT counseling research data proved the need for counselor supervisors to prepare counselors-in-training in various ways to safeguard proper counseling methods with LGBT clients (Rutter et al., 2008; Walker & Prince, 2010). Halpert et al. (2007) contested LGBT-affirmative training model is appropriate and reliable and works with the supervisor's existing theoretical models and frameworks.

Bruss, Brack, Glickauf-Hughes, and O'Leary (1997) developed an earlier affirmative supervision model associated with LGBT client-counseling competence. This model introduced self-evaluation assessments of skills such as motivation, awareness of self, and autonomy to educate counselor supervisors before LGBT-affirmative training begins. The Affirmative-Developmental Model of counselor supervision allows the counselor supervisor the opportunity to confront the lack of knowledge with LGBT-client counseling (Bruss et al., 1997). The Affirmative Developmental Model supervision brought attention to creating collaborative learning environments including competency assessments for identifying developmental levels of the counselor supervisor and the counselor trainee. Bruss et al.'s (1997) model describing collaborative supervisory tasks opened the door for attention in assessments in affirmative training but lacked evaluation of heterosexism and bias attitudes experienced by the LGBT population.

Several aspects surrounding the competence development of sexual orientations, gender identities, and diversity in sexuality are important to address in affirmative-LGBT counseling training and counselor professional development. Affirmative-LGBT supervision models are frameworks used to supplement a counseling supervisor's existing theoretical models. According to Halpert et al. (2007), the Gay-Affirmative Model developed in 2000, provides a training framework where respect for sexuality, personal choices, and religious beliefs helped to establish the supervisory relationship despite differences between the counselor supervisor and supervisee's lifestyle or cultural background. Following many feminist theorist models, the basis of the affirmative-LGBT counseling training approach is the belief all human sexualities are equally acknowledged

in mental health diagnosis. According to Halpert et al. (2007), during counselor training counselor supervisors must encourage counselors-in-training to identify how their sexuality plays a role in their decision-making process and lifestyle.

Mutual respect in counseling training occurs when the counselor supervisors openly discuss their sexual orientation, has clear boundaries regarding various sexual orientations and addresses social change for LGBT human rights (Halpert et al., 2007; Miller et al., 2007; Rutter et al., 2008). For instance, the Gay-affirmative model is used as a method for counseling supervisors to assess their supervisees and uncover any bias feelings, attitudes, and perceptions of LGBT individuals (Halpert et al., 2007).

To continue the discussion of Affirmative-Developmental Supervision model (ADS), Aducci and Baptist (2010) discussed the importance of supervisors balancing competence in applying affirmative training practices when working with supervisees. Aducci and Baptist indicated the following:

> Supervisees may have little to no awareness of larger contextual issues facing LGBT clients. Likewise, supervisees may have little to no awareness of their attitudes, beliefs, and biases toward LGBTs (p. 89).

Aducci and Baptist (2010) brought light to the collaborative approach in supervision and how merging collaborative and affirmative practices in counselor training can build a positive relationship between the supervisor and supervisee. When both counselor supervisors and supervisees have respectful working alliances, this creates a parallel training process, and various aspects of sexual orientation are exchanged between both parties in the supervisory relationship. Aducci and Baptist noted

satisfaction among supervisees increased in counselor training when counselor supervisors addressed personal learning experiences and also when supervisors were open to mutually exchange ideas, power, knowledge, and beliefs of LGBT clients Positive correlations resulted between using the ACS and supervisee's level of LGBT counselor competence. Also, Aducci and Baptist reported positive correlations between training alliances and discussing satisfaction, understanding, and safety in the supervisory learning process.

Falender et al. (2014) conducted an experimental study and found activities, assignments, and professional speakers helped to facilitate LGBT counselor training, improved the relationship between counselor supervisors and trainees, and also increased competency among counselors-in-training with effectively counseling LGBT clients. The use of such affirmative training techniques gives counselor supervisors the opportunity to apply various techniques, models, and approaches in training to help trainees develop LGBT counseling skills. Falender et al. studied couple and family therapists counseling experiences with lesbian and gay couples seeking assistance and found participants did not feel clinically competent to provide treatment for LGBT clients.

Falender et al. (2014) criticized training programs for failing to provide adequate preparation and failing to incorporate affirmative-LGBT counseling training practices. The authors discussed counselor supervision failing to train students jeopardizes therapeutic relationships with individuals in the LGBT community and can harm LGBT clients if prejudice and biased treatments are not pre-assessed in counselor training. Falender et al. concluded counselors' supervisors in couple and family therapy

specializations, benefit from learning affirmative approaches necessary to develop clinical skills, knowledge, and awareness to theorize LGBT client mental health needs.

**Affirmative-LGBT Ethics**

In this section, I review the literature concerning ethical counseling practices for LGBT clients. Also, this section details counseling multicultural ethical standards established by ACA about counseling LGBT client.

Counseling methods based on a counselor's personal religious and spiritual belief towards sexual orientation are considered unethical and can do more harm than help during the intervention (Bidell, 2014; Graham et al., 2012). Several counselor education studies have evaluated factors such as religion, spirituality, heterosexism, and limited program resources affecting counselor competence development among students in counselor education (Herek & Garnets, 2007; Rutter et al. 2008; Walker & Prince, 2010; Whitman & Bidell, 2014). Israel et al. (2003) characterized specific areas of development in LGBT counselor competencies such as the counselor's values, religion, and spirituality, sexual orientations, race, and institution policy standards.

According to the *ACA Code of Ethical Standards* (2014), counselors are required to gain knowledge of religious viewpoints and develop ways to explore how religion affects counseling practice and training. Assessing personal and client religious views reveal the scope of therapy barriers, boundaries, ideas surrounding sexuality, adoption, death, marriage, birth.  Knowledge of how to incorporate religious assessments in counselor training provides trainees with the ability to learn how to correctly

conceptualize intervention strategies and create positive rapport in the therapeutic relationship (ACA, 2014).

Counselors must understand counselor ethical standards and apply the ethical standards to ensure best counseling practices are in place (ACA, 2014). The *ACA Code of Ethics* outlines various areas of ethical standards covering the following: (a) the counseling relationship, (b) confidentiality and privacy, (c) professional responsibility, (d) relationship with other professionals; (e) evaluation, assessment, and interpretation, (f) supervision, (g) research and publication, (h) distance counseling, technology and social media, and (i) resolving ethical issues. Each Section provides standards to ensure counselors are making choices to provide adequate counseling services.

Numerous sections in the ACA Code of Ethics specifically address multicultural standards and diversity awareness in the counseling profession. For example, under section B1 Respecting Clients Rights is part B.1.a. Multicultural/Diversity Consideration. In this section, ACA (2014) explained counselors are required to maintain awareness of cultural meaning. Counselors respect different views and discuss whom the information is shared with. ACA (2014) ethical code C.5 Nondiscrimination Professional Responsibility states:

> counselors do not discriminate or condone discrimination against clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion, spirituality, gender, gender identity, sexual orientation, marital partnership status, language preference, socioeconomic status, language preference, or immigration status (p.9).

ACA Codes of Ethics (2014) explain the essential need for counselors to be aware of normed assessment tools or heterosexist assessment techniques administered to populations other than of the clients. These standards further explained the counselor's responsibility to recognize "the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation" (ACA, 2014, p.12).

Also, in ACA Code of Ethics (2014), counselor supervision and counselor ensure counselors-in-training are prepared to work with and "serve a range of diverse clients" (ACA, 2014, p.12). More specifically section F.2.b clarified counselor supervisors must be aware of the multicultural difference between themselves and their supervisees and also teach their supervisees to address cultural differences they may have with their clients (ACA, 2014).

## Affirmative-LGBT Counselor Training

In several literature reviews and studies, researchers discussed concerns about counselors being ill-prepared to address the needs of the LGBT clientele (Bidell 2005, 2014; Farmer et al., 2013; Graham et al., 2012). This section will cover research studies explaining how assessment tools are beneficial to utilize in counselor training to evaluate factors affecting the development of competencies for working with LGBT clients.

Bieschke, Perez, and DeBord's (2014) handbook help professional counselors and counselor supervisors by explaining a range of complex cultural issues lesbian, gay, bisexual, and transgender individuals experience in psychotherapy. Bieschke et al. (2014) provided solutions such as the Integrative Affirmative Supervision model (IAS) as the

most practical approach to ensure affirmative-LGBT counseling training is adequate. Bieschke et al. (2014) addressed challenges in clinical training such as training environment, personal fear, and lack of experiences with LGBT clientele. According to Bieschke et al. (2014), the process of self-reflection among counselor supervisors expands self-awareness for counselors-in-training and discloses beliefs, attitudes, and knowledge they may have with counseling LGBT clients. The information provided in the handbook is critical for the development of counselors-in-training and brings value to gaining awareness to resolve personal issues hindering LGBT counselor competence before engaging in counseling practice with clients.

In 2004, Israel and Hackett specifically examined 274 areas of knowledge, 120 attitudes, and 146 skills using the Delphi technique. Israel and Hackett (2004) recruited a panel consisting mental health professionals and LGBT-identified experts who reported 31 knowledge areas, 23 attitudes, and 31 skills as competencies required to meet the counseling needs of LGBT clients adequately. Israel and Hackett suggested offering general counseling training along with specific affirmative-LGBT counseling training, as the best approach for increasing effective techniques and competence for counseling LGBT client populations. Israel and Hackett explained panelist reported having difficulties in conceptualizing lesbian and gay client's mental health concerns due to the lack of knowing specific experiences among LGBT clients. Israel and Hackett indicated participants reported the lack of knowledge and bias treatment are due to limited literature, restrained heterosexual counselor training models, and insufficient LGBT counseling training techniques. Concerns regarding these limitations of counselor training

have sparked an increase in research necessary to examine affirmative-LGBT counseling training.

Past counselor education studies revealed classroom training alone is not sufficient and does not guarantee LGBT counselor competency development (Robinson-Wood, 2009; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). Incorporating experiences for counselors-in-training to apply training techniques support the development of skills, awareness, and knowledge needed to counsel clients within the LGBT population effectively. Robinson-Wood (2009) along with Israel et al. (2008) argued counselors are incompetent to make profound clinical judgments with gay and lesbian clients because training models in the past have not included knowledge and skills to categorize various sexual and gender identities. Both authors highlighted the significance of exploring multiple sexual or gender identities in counselor training (Robinson-Wood, 2009; Israel et al., 2008).

Robinson-Wood (2009) advised professional counselors to consider the complexity of the intersectionality in clientele characteristics such as culture, gender, sexuality, education level, age, income status, and social environments help to develop counseling conceptualizations and interventions adequately. Skills in recognizing clients layered identities increase professional development for counselors in training. Training students to acknowledge unique individual experiences reduces biased case conceptualization to accurately provide intervention strategies for lesbian and gay clients seeking support (Israel et al., 2008; Robinson-Wood, 2009). Feminist models specify the

need to use each client's unique background to articulate appropriate counseling interventions and avoid imposing personal values.

Rutter et al. (2008) also found using the SOCCS concluded LGBT competencies grew after affirmative-LGBT counseling training programs. The authors identified positive aspects of LGBT training and ways specialized training methods help to develop knowledge, awareness, and skills among counselor education students. Rutter et al. studied participants in a control group receiving training and compared them to students not receiving training. Their research found students who participated in affirmative-LGBT counseling training had relevantly higher scores on the SOCCS than the students who did not take part in affirmative-LGBT counseling training. In results, the researchers concluded the SOCCS suggests affirmative-LGBT counseling training increased LGBT counselor competencies and trainee evaluation is also needed to ensure LGBT clients are getting effective counseling services (Rutter et al., 2008). Rutter et al.'s study supported prior studies showing counselors-in-training who participate in affirmative LGBT counseling training improved in LGBT counseling competencies compared to those who did not participate in the affirmative-LGBT counseling training.

Graham et al. (2012) used the SOCCS to define additional areas of affirmative-training benefits for LGBT counseling competency growth. Using 234 participants (n=9 Masters level and 138 doctoral students) in the Council of Counseling Psychology Training Programs (CCPTP) and CACREP programs, Graham identified differences in self-perceived LGBT counseling competencies. Similar to prior studies Graham et al. discovered how certain students feel to counsel LGBT clients (Bidell, 2017; Graham et

al., 2012; Rutter et al., 2008). Graham et al. (2012) identified counselors felt inadequate in their ability to conceptualize LGBT client intervention strategies. Addressing how counselors in training perceived attitudinal awareness, skills, and knowledge demonstrated the need for self-perceived measurements prior counseling practice with LGBT clients. Graham et al. examined the relationship between differences in various students' demographics and their level of self-perceived LGBT counseling competence.

Among skills, knowledge, and attitudes, Graham et al. (2012) found participants attending affirmative-LGBT counseling workshops and affirmative-LGBT counseling training scored the lowest in the skills subscale. Moreover, Graham et al. found doctoral counselor education students reported higher levels of awareness on the SOCCS compared to master level participants. Graham et al. found a mean score of 6.52 in awareness, a 3.88 in skills, and 4.67 in the knowledge subscale. The researchers identified on average participants had a high range of LGBT awareness and also fell within average scores within the skills and knowledge subscales. Among program type, gender, workshop attendance, counselor experience, and degree level, the SOCCS scores in awareness were significantly higher followed by knowledge scores, and the skill scores resulted in the lowest competency levels overall. Graham et al. supported the value of the SOCCS and measuring self-perceived LGBT competency to identify an association between an individual's characteristics and increased professional counselor growth.

Although Graham et al. (2012) recognized useful information regarding gender, classification, and other characteristics associated to self-perceived LGBT competency levels, their study did not identify how personal values such as religious commitments

may affect engaging in LGBT counseling development experience. Graham et al.'s (2012) hypothesis were proven correct. The conclusions of their study clarified benefits of counselor affirmative-training experiences, degree level, and clinical experience significantly increased self-perceived LGBT counseling competency among students compared to those without experiences, fear years in training and fewer clinical experiences with LGBT clients.

## Variables

Variables in this study include Affirmative-LGBT training, counselor competency in working with LGBT clients, social justice and advocacy for LGBT clients, multicultural assessment tools, and involvement in religious commitment. These variables each give a clear understanding of how clinical preparedness for working with LGBT clients develop and evolve. The following sections will recognize counselor responsibility, describe counselor supervision models for working with LGBT clients, address institutional, cultural climate, and provide LGBT community experiences in counseling.

### Counselor Competency for LGBT Clients

In counselor education and counseling supervision, professional counselors learn best practices and counseling models to serve clients of different races, sexual orientations, genders, socioeconomic status, and other intersectional characteristics. Counselor competence for working with LGBT clients involves not just learning but knowing how to apply knowledge, clinical skills, and research correctly. Counselors' competence improves when counselors show non-bias social engagement, experience

activities within the LGBT community, or have family members or friends who identify as LGBT (Bidell, 2012; 2014; 2017; Farmer et al.,2013; Graham et al., 2012; Rutter et al., 2008).

Counselor education researchers suggest counselor-training models go beyond minimally standards to avoid marginalization of LGBT clients (Bidell, 2014; Fricke, 2010; Israel et al., 2008; Robinson-Wood, 2009). For example, Herek and Garnets (2007) discovered counselors-in-training who were active advocates and allies within the gay community reported favorable attitudes towards LGBT clients, compared to counselors-in-training with fewer involvements. Herek and Garnets indicated heterosexual counselors in LGBT-affirmative training are more likely to react in three ways such as the following: (a) detach the pre-existing stereotypes, (b) have positive attitudes towards the person but view them as a typical case, or (c) maintain positive feeling and then correctly categorize the case conceptualization.

Past researchers discovered among professional counselors, 86% report meeting with at least one lesbian or gay client in practice (Ward et al., 2013). The National Health Interview Survey (NHIS) examined 34,557 adults representing the U.S population (Ward et al., 2013). NHIS reported 96% individuals identified as heterosexual, 1.6% identified as lesbian or gay, and 0.7% identified themselves as bisexuals. NHIS found lesbian, gay, and bisexual persons have significant differences in health status, health care access, and health behaviors to be considered when developing counseling interventions (Ward et al., 2013). LGBT counselor competency studies help to reveal specific topics for counselors to address in affirmative-LGBT counseling training to establish skills, knowledge, and

awareness for specific LGBT clients' experiences (Bidell, 2005; 2014; 2016; Bieschke et al., 2014; Farmer et al., 2013; Graham et al., 2012; Rutter et al., 2008; Walker & Prince, 2010; Whitman & Bidell, 2014).

Several researchers discussed LGBT students' perceptions of social support, evaluations of campus policies supporting LGBT college students, LGBT client counseling assessment tools, and addressed sexual identity attention in education curriculums helps to increase self-perceived counselor competence when working with LGBT clients (Bidell, 2012; Graves & Wright, 2009; Miller et al., 2007). Prior studies report counselors misdiagnosing experiences of LGBT clients' behaviors as a mental illness, along with aversive behavioral and cognitive interventions aimed to change the behaviors, which can result in added stress on gay and lesbian clients (Bidell, 2015; Herek & Garnets, 2007; Whitman & Bidell, 2014).

In an exploratory study, Israel, Gorcheva, Walther, Sulzner, and Cohen (2008) interviewed 14 therapists who reported counseling a range of 5 to 25 LGBT clients per week. Using semi-structured interviews five counseling psychology researchers asked each participant to describe specific situations including the client's demographic information, aspects of the therapeutic relationship, the counseling experience, impact of the client's lifestyle in therapeutic approach, and the environment setting where services took place. From the interviews, researchers categorized the counselor's response as helpful or unhelpful therapeutic experiences. In results, 21.4% therapist reported unhelpful situations were caused by inactive therapeutic connections with their LGBT clients, compared to other reports which indicated 14.3% of the helpful situations resulted

from establishing healthy therapeutic relationships with LGBT clients (Israel et al., 2008). On the other hand, participants reported unsupportive therapeutic alliance and characteristic marginalization were factors in unhelpful therapeutic situations.

According to Israel et al. (2008), training students how to build a positive rapport with LGBT clients creates helpful therapeutic situations and ultimately helps to provide a better counseling intervention for their LGBT clients. Israel et al. found quality therapeutic relationships come from those counselors who are competent in affirming services for lesbian and gay clients. Also, Israel et al. established counselors who are knowledgeable in creating a welcoming environment for the LGBT clients are reported to have more helpful counseling strategies and better rapport with their clients.

In a similar study by Fuertes and Brobst (2002), participants reported high measures of counseling therapy satisfaction (80%) in association with acknowledging their counselors having strong multicultural competencies. Overall, Fuertes and Brobst (2002), revealed using various competencies contribute to client confidence and satisfaction during counseling practice. Their study analysis significantly confirmed trustworthiness, empathy, and counselor attractiveness were direct correlations of clients' perceptions of their counselor's competence. Developments of the multicultural competencies continue to expand beyond racial identities and require broader competence training with counseling training models to include techniques based on human sexuality (Speciale et al., 2015; Sue & Sue, 2007). Counselor education programs are increasing standards, accreditations, and experiences for students in mental health training to

implement LGBT-affirmative and multicultural curriculums for LGBT counseling interventions.

**Bias and Social Influence**

Professional counselor competence development includes human right advocacy social change experiences and self-reflection knowledge and understanding of how various experiences influence professional counseling development. The American College Health Association (ACHA) reported LGBT students in college are considered a high-risk group for mental health issues and contribute to college dropout rates higher than their heterosexual colleagues (Stozer, 2009). Counseling professionals find oppression and discrimination experiences contribute the most to mental health conditions among clients in the LGBT community. Researchers found, specifically among people in the LGBT community, heterosexual bias and discrimination of sexual orientation were the main contributing factors of mental health issues (Bidell, 2014; Graham et al., 2012; Herek & Garnets, 2007; Rutter et al. 2008; Walker & Prince, 2010; Whitman & Bidell, 2014).

Researchers explored how personality, unconscious bias, and personal values affect the ability of trainees to prepare for counseling practice with LGBT clients (Bidell, 2005; 2014; 2016; Farmer et al., 2013; Graham et al., 2012; Herek & Garnets, 2007; Rutter et al., 2008). Farmer et al. (2013) noted politically conservative, and perceptions of religious minority groups may hold a different perspective in LGBT counselor training than compared to their counterparts.  Using The Attitudes Toward Lesbians and Gay Men Scale (ATLG), Herek and Garnets (2007) found many sexual prejudices cause

mistreatment and incompetent diagnosis for clients in the LGBT community. Also, in a mixed method study, Stotzer (2009) interviewed 50 female and 18 male heterosexual undergraduate psychology students at a Midwestern University, to gain further perspective of what attitudes and how attitudes are developed towards people in the LGBT community. Participants in this study reported family influence, LGBT peer classmate relationships, and empathy for human rights among LGBT peer were features related to forming positive attitudes for people in the LGBT community.

Stotzer 's article argued the need for more efforts in understanding how individuals increase positive attitudes towards LGBT people, how social behavior contributes to the formation of attitudes of human rights, and advocacy efforts from heterosexual allies. Using the ATLG, Stotzer (2009) screened participants to select students who were considered to have open or accepting attitudes to participate in the research interview process. During the interview process, Stozer asked students to elaborate on their ATLG results and views towards the LGBT community, what influenced the development of their views, and what exact experiences have impacted their views towards LGBT individuals. Several participants mentioned social justice reasons for holding positive attitudes. Ten participants (25.2%) mentioned their positive attitudes stemmed from pro-choice beliefs, another six participants (9.0%) said their beliefs were developed from human right advocacy, and another nine participants (13.6%) supported both in freedom of choice and human rights for individuals in same-sex relationships. More than half of the participants contributed their positive attitudes by

the openly supportive attitudes from their parent's influence and the way their parents raised them to respect everyone.

Furthermore, O'Shaughnessy and Spokane (2012) expanded counselor education knowledge by finding the significance of positive attitudes among counselors-in-training with LGBT clients LGBT-affirmative training. Assessing 212 counselors-in-training, women, gay men, and bisexual individuals tend to demonstrate relatively higher levels of competence than those counselors-in-training who have negative attitudes towards these clientele populations. Also, the trainees with positive attitude levels also showed more accurate responses of case conceptualization for individuals in the LGBT community. In their results, data showed associations between high levels of LGBT counselor competence to high levels of self-reported LGBT counseling competency. With this information, counselor supervisors can keep in mind the more LGBT counselor competencies are obtained, the more confident counselors-in-training feel to counsel various LGBT client populations. As diversity among sexual orientations and gender increases, counselor educators must stay cognizant of assessment tools and recognize training factors to meet the counseling needs of LGBT clients.

Rock, Carlson, and McGeorge (2010) found clients in the LGBT community seek counseling services regarding discrimination more frequently than other minority groups. According to Rock et al. (2010), lesbian, gay, and bisexual clients make up between 4-17% of the entire United States population seeking counseling services. Research findings report discrimination, stigma, and societal bias against same-sex preferences lead to depression, substance abuse, thoughts of suicide, isolation, and emotional distress

among individuals in the LGB community (Rock et al., 2010; Ward, Dahlhamer, Galinsky, & Josestl, 2013). According to Case and Meier (2014), LGB students in grades, K-12 reported higher levels of being sexually harassed and physically abused compared to heterosexual students resulting in psychological and emotional problems. Therefore, research in affirmative-LGB counseling training and LGB counselor competency for counselor educators in school counseling, community counseling, and private practice is necessary.

LGBT clients reported being more reluctant to engage in counseling and felt isolated when they received inappropriate conceptualization for their mental health concerns (Case & Meier, 2014). Also, Stotzer (2009) discussed how abuse, unsafe environments, and no support in school increases school dropout among LGBT college students and doubles the risk of depression. The researcher took an alternative focus on how heterosexual students develop positive attitudes as LGBT allies and reinforcing supportive attitudes to reduce homophobia. The need for LGBT allies among counseling professionals is imperative. Studies show supportive, accepting attitudes towards the LGBT community among counselors are predictors of higher LGBT counseling competence (Bidell, 2014; Bieschke et al., 2014; Farmer et al., 2013; Herek & Garnets 2007; Graham et al., 2012; Israel & Hackett, 2004; Speciale et al. 2015). Stozer supported multicultural and feminist counseling perceptive by acknowledging struggles of social inequality. This study also addressed what experiences are necessary to create positive attitudes among heterosexual allies and continue positive social change for LGBT individuals.

Additionally, opinions against same-sex relationships are ongoing political, religious, and public policy debates. In the past, lawmakers debated sexual activity among gay men and considered same-sex relations between men sodomy. Political laws such as same-sex marriages, adoption with lesbian or gay parents, and gender discretion in public restrooms are an ongoing debate in human rights advocacy for the LGBT community (Stozer, 2009). Counselor educators have become involved in addressing public policies about human rights for the LGBT community due to the overwhelming reports of mental health disparities. Counselor education research addressing the challenges of conservative beliefs help establish counselor practice standards.

Bidell (2005) explained to develop proper training assessments and agendas for trainees to acquire LGBT counseling competencies; counselor supervisors must know and understand what specific bias, personal values, barriers, and other factors affect the growth process. Since 1975, the Association for Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC), formally known as the Gaby Caucus, has played a pivotal role in advocacy for establishing affirmative treatment for LGBT clients (Logan & Barret, 2005).

Rainey and Trusty (2007) used the ATLG and the Balanced Inventory of Desirable Responding (BIDR) to evaluate variables correlating with attitudes towards gay men and lesbians. Rainey and Trusty (2007) measured variables such as gender, environment, political conservatism, religiosity, academic training, and counselors experience with gay men and lesbian clients. Herek and Garnets (2007) discussed how personal bias could impede affirmative LGBT perspectives. In a quantitative study, Rainy

and Trusty also analyzed how personal bias towards lesbians and gay men had a significant emphasis in the counselor's desirability to engage in LGBT counseling, participation in advocacy for the LGBT community, and LGBT counseling competence level.

Rainey and Trusty (2007) found positive connections with gay and lesbian individuals among the 132 master-level counseling students also indicated higher levels of LGBT counselor competency. After assessing levels of participant's religiosity and political views and the researchers found participants with higher scores in religiosity indicated more positive experiences with gay men ($M$ = 5.22) compared to their experiences with lesbians ($M$ = 4.85) (Rainey & Trusty, 2007) The research data revealed negative attitudes lead to unethical counseling treatment towards gay and lesbian clients. Rainey and Trusty explained the participants who reported higher political values also reported fewer positive experiences with the LGBT community. On the other hand, the participants with higher religiosity scores reported more positive experiences with individuals in the LGBT community (Rainey & Trusty, 2007). Moreover, measures also concluded students who scored lower levels of religiosity were found to have higher levels of positive experiences among gay and lesbian individuals.

Rainey and Trusty (2007) concluded counselors in training could advance in counseling practice with LGBT clientele by examining their levels of positive experiences with gay and lesbian clients and also knowing how their conservative beliefs could pose a threat to professional counselor growth. Research in affirmative -LGBT training encourages researchers to continue to evaluate how assessing counselors-in-

training increase counselor competencies and help to build social change to improve counselor-client positive relationships before counseling gay and lesbian clients.

## Awareness, Skills, and Knowledge in LGBT Counselor Competence

As mentioned, counselors are required to possess specific skills, awareness, and knowledge to conceptualize mental health needs for LGBT client populations comprehensively. The three factors are assessed in courses and training to help counselor educators and supervisors further educate students to develop LGBT counselor competence. This section breaks down each element important to establishing counselor competencies for working with LGBT clients.

**Awarenes**s. The association between personal values and LGBT counseling competence are necessary to understand (Bidell, 2005; Hope & Chandra, 2015; Israel et al., 2008). Herek and Garnets (2007) found implicit biases negatively affected counselor's processing information regarding LGBT clients and resulted in counselors minimizing the importance of sexual orientation in treatment goals. According to Bidell (2013) heterosexual privilege, personal sexuality, fear, and discriminations toward same-sex relationships are discovered in self-awareness assessments and associated to lower levels of self-perceived LGBT counselor competence among counseling professionals and counselors-in-training. Counselor professionals use modification techniques such as psychodynamic models, aversive behavior, and feminist therapeutic techniques to discover undisclosed discriminatory behaviors hindering counseling practice (Bidell, 2012; 2015; Herek, 2007; Whitman & Bidell, 2014).

In counselor supervision utilizing pre-assessment tools help promote self-awareness, safety, and ethical standards for trainees developing LGBT counselor competence (Bidell, 2005; Herek, 2009; Hope & Chandra, 2015; Israel et al., 2008). Continued research developments in affirmative-LGBT counseling training methods are necessary not only to identify best training practices for students in counselor education but to also support counselor supervisors with the best training models needed to assist their students with developing LGBT counselor competence.

**Knowledge**. In a study by Rainy and Trust (2007), positive experiences with gay men, and lesbians were found to be predictors of high self-perceived LGBT competence. Bidell (2014) suggested counselors-in-training who engage in experiences such as workshops, personal engagement, multicultural courses, and applied affirmative LGBT counseling training techniques were associated with higher levels of knowledge measurements on the SOCCS. For instance, Bidell (2014) found LGBT course attendance was a significant predictor of scores on the SOCCS ($B$ =.27. p <.001) and education level ($B$ =.21, p <.001). Bidell (2014) indicated sexual orientation competencies have a significant relationship to the number of years or amount of affirmative training and multicultural courses students have completed.

The concept of knowledge in LGBT client counseling competency relates to a counselors' ability to conceptualize aspects about experiences distinctively amongst the LGBT community. In affirmative-LGBT counseling training, the discussion of LGBT community political history, public policies, lifestyles, research data, and clinical models are essential along with evaluating self-perceived LGBT counselor competence (Bidell,

2005; Hope & Chandra, 2015; Rainy & Trust, 2007). Counselors recognize the different experiences among heterosexual individuals, lesbians, gay men, and people who identify as bisexual and stay abreast of current issues, laws and providing advocacy efforts for the LGBT community help (ACA, 2014; Hope & Chandra, 2015). Herek and Garnets (2007) explained LGBT counselor competence involves distinguishing differences in definitions, terms, and multiple sexual identities and understanding how race, religion and socioeconomic status intersects among sexual orientations to adequately address mental health concerns.

**Skills.** Counseling skills is another essential element in LGBT counselor competency development. In affirmative-LGBT counseling training, counselor supervisors help trainees develop strategic planning, insight, and techniques to consider when counseling LGBT client population. Farmer et al. (2013) explained lesbian and gay clients are prone to have a more positive and confident response to counseling when their counselor had created a gay-friendly environment. For example, items such as gender or alternative gender responses on intake applications, LGBT ally posters, or stickers representing human rights in the counseling facility create a positive rapport with LGBT clients (Farmer et al., 2013). Counselor supervisors guide trainees to create welcoming environments and are mindful of proper terms to use when addressing LGBT clients.

Graham et al. (2012) explained counselor supervisors could teach trainees how to create LGBT-friendly, safe, and open treatment environments to help build a relaxed connection with their clients before counseling even begins. Graham et al. (2012) found the SOCCS indicated counselor trainees reported to perceive a lack of competency skills

compared to their confidence levels in the awareness and knowledge subscales. Counselor supervisors teach students how to be skilled, competent counselors by providing appropriate resources, several references, and explaining the importance reliable referral networks for LGBT client populations (ACA, 2014; Bidell, 2014). Skills in LGBT counselor competence also include the counselors' ability to network with various professionals in the community to safeguard and expand intervention support (Hope & Chandra, 2015).

During affirmative training counselor supervisors provide advocacy ideas, create practicum experiences with LGBT clients, and offer resources such as workshops to improve LGBT counselor competency (Bidell, 2014; Bieschke et al., 2014; Case & Meier, 2014; Farmer et al., 2013; Graham et al., 2012; Grove, 2009). Researchers in earlier studies concluded experiences in workshops and conferences regarding sexual orientations increased levels of LGBT counselor competence among counselors-in-training (Case & Meier, 2014; Graham et al., 2012; Grove, 2009). Israel et al. (2008) argued networking experiences and activities are valuable assets in affirmative-LGBT counseling training to increase competency for counseling lesbian, gay, and bisexual clients.

## LGBT Competency Scales

Counselor education programs and training programs reference research of assessment tools for gathering information to improve counseling techniques and knowledge to treat LGBT clientele but also a counselor’s willingness to create a welcoming environment for diverse clients. Researchers in counselor education have

found assessing self-perceived LGBT, counselor competencies necessary in counselor training to measure self-awareness, unconscious biases, and other behaviors students may have towards LGBT clients before counseling practice begins (Bidell, 2005; Herek, 2007; Sue & Sue 2007).

Bidell (2005) introduced the first instrument to evaluate a counselor's perceptions of confident in LGB counselor competence. The assessment was developed to ensure affirmative-LGB counseling training supported the growth of trainees and also as a tool to improve mental health services for LGBT clients. Research literature concluded The Sexual Orientations Counselor Competency Scale (SOCCS) is a reliable assessment tool to measure levels of skills, knowledge, and awareness LGB counselor competence (Bidell, 2005; 2013; Farmer et al., 2013; Graham et al., 2012; Rutter et al., 2008). Nevertheless, current research studies have limitations when assessing counselor-in-training perceptions in clinical preparedness due to the constant changes in diversity among counselor education curriculums, characteristics of students in counselor education programs, and changes within the LGBT community.

Although there are several assessment instruments for LGBT clients counseling techniques, Bidell (2005) was among the first pioneers to develop a training tool to particularly measure mental health professionals' self-perceptions counselor competency in LGBT knowledge, skills, and awareness before engaging in professional counseling practice. Using the LGBT-affirmative tripartite matrix model, Bidell researched to find a reliable instrument to enhance and promote LGBT counselor competence. Following ideas of Sue and Sue's (2007) tripartite model of cultural diversity, Bidell enhanced evaluation

methods in counselor education to address institutional cultural-climate strategies, awareness in LGB discrimination barriers and the implementation of affirmative counseling practices for the LGBT community. Bidell discussed the importance of addressing diverse characteristics among counselor trainees and implementing multicultural training instruments with objectives to develop comprehensive strategies for all client populations. Affirmative-LGBT counseling training research contributes to bridging awareness of proper counselor training methods and developing competencies to distinguish what misconceptions, discriminations, and stereotypes affect counselor training.

The SOCCS (Bidell, 2005) was used to evaluate the skills, knowledge, and attitudes among doctoral and masters' students in counselor programs. According to Bidell (2005), among graduate counselor education students, the SOCCS indicated a positive correlation between levels of self-perceived LGBT counseling competence and their ability to counsel LGBT clientele successfully. Counselor supervisors are agents of social change and gatekeepers of counseling education and benefit from self-assessing instruments to ensure the best intentions to provide their supervisees and clients with appropriate services. As a primary goal in counselor education, Bidell argued counselors in training must conduct self-perceived evaluations and analyze data to determine competence in LGBT-affirmative training is providing adequate models for professional counselor development. Bidell surveyed 101 counselor education students using the SOCCS, along with the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) to discover factors of LGBT counselor competence among students

specializing in school counseling compared to students studying to become community counselors. His study found school counseling students had a significantly lower level of multicultural competencies and sexual orientation competencies compared to community agency students. Results from his study indicated school counselor education programs needed more affirmative-LGBT counseling training.

Further studies by Bidell continued to bring attention to the benefits of the assessment tool used in determining self-perceived competence among various counselor specializations (Bidell, 2014; 2015; 2016; Bidell & Stepleman, 2017). Bidell (2014) examined experiences in counselor education associated with increasing students' counselor competence working with lesbian, gay, and bisexual (LGB) clients. His research discovered graduate students did have an increase in LGB counselor competency when given the opportunity of professional LGB-affirmative counseling experiences in counselor training. Also, Bidell found significant differences between the levels of self-perceived LGB counseling competence among students who only had occasional experiences with LGB clients compared to those students who reported attending several workshops and advocacy programs. In results, the researcher concluded students who experienced more counseling practice and LGB community advocacy had higher levels of self-perceived LGB counselor competence. In recent literature, Bidell (2015) added questions to the SOCCS to evaluate counselors' self-perceived competence to include transgender clients.

Instruments measuring the development of LGBT counselor competence have various objectives. Bidell and Whitman (2014) reviewed the LGBT Affirmative

Counseling Self-Efficacy Inventory (LGBT-CSI) and found this instrument had threats to validity and showed venerability to skewed results. The authors explained limitations within the LGBT-CSI scale identifies lesbian, gay, and bisexual clients within one question, and only allows the researcher to address self-efficacy with individuals in the LGBT community as only one of the subgroups instead of separating each sexual orientation (Bidell & Whitman, 2014). Another instrument I omitted to use in my study is the LGBT Working Alliance Self-Efficacy Scale (LGBT-WASES). The LGBT-WASES assesses the working alliance's theory and counselor self-efficacy to focus on treatment environment. The LGBT-WASES specifically evaluates the therapeutic relationship, tasks, and goals of counselors providing therapy for LGBT clients. Bidell and Whitman noted the LGBT-WASES instrument also has limitations in the measurement criteria and generalizes sexual orientations, which make distinctions of counselor competence between lesbian, gay, and bisexual clients challenging. Since many graduate students have not counseled or had training in counseling LGBT clients, the LGBT-WASES scale will not present information needed relevant to my purpose of research.

Feminist ethical standards introduced new perspectives in addressing human rights in business and educational programs. Counseling associations and organizations continued to address the importance of counselor education research incorporating self-assessment for cultural competency development in counselor education training (ACA, 2014). For instance, quantitative research conducted by Swank, Woodford, and Lim (2013) using the Counselor Competencies Scale (CCS) compared self-perceived LGBT counseling competency levels of counselor supervisees and supervisors. Swank et al.

described the benefits of self-perceive evaluation methods in multicultural counseling training. In the results, the researchers found supervisees reported significantly lower levels of counseling self-perceived competence compared to counselor supervisors. The comparison study also revealed self-perceived competency measurements among supervisees grew throughout their experience in counselor training. The study evaluated the supervisee's competence growth mid-semester and then again at the end of the semester to ensure development (Swank et al., 2013). The researchers in this study illustrated the necessity to use assessment instruments to evaluate students' progress in experiencing counseling training to gain better understandings of competency growth.

Though there are studies showing assessment tools to evaluate counselor competencies for working with LGBT clients, many have not specifically evaluated counselor-clinical preparedness for working with LGBT clients. For this reason, Bidell (2017) identified an assessment tool similar to the SOCCS (Bidell, 2005). Bidell (2017) explained LGBT respondents reported they noticed counselors lacked clinical competencies to conceptualize their needs as LGBT individuals which discouraged them from further seeking assistance. Bidell (2017) introduced The Lesbian, Gay, Bisexual, Transgender Development of Clinical Skills Scale (LGBT-DOCSS) to establish a new interdisciplinary self-assessment for health providers. Since this is a new assessment tool developed there are limited studies to reference the benefits of its use. However, to test reliability and validity Bidell (2017) conducted three studies amongst many samples, variables, and demographics. The first research tested factor analysis, the second test

examined reliability estimates of internal consistency, and the third research examined the construct validity of the LGBT-DOCSS.

Bidell and Stepleman (2017) provided an article reviewing various studies, theories, and research of effectual LGBT health and mental health services and suggested the LGBT-DOCSS as a reliable new assessment to help the growth counselor competency in working with LGBT clients. The authors described how healthcare professionals could use assessment tools such as the LGBT-DOCSS to support the ongoing growing relationship with the LGBT community (Bidell & Stepleman, 2017). According to Bidell (2017), the LGBT-DOCSS was developed to facilitate self-exploration among healthcare providers and is intended to be used as an outcome variable to explore specific clinician characteristics. Further description and design details of this instrument are in chapter 3.

In conclusion, assessing self-perceived LGBT counselor competence within counselor education and training helps to determine levels of skills, preparation experiences, awareness, and counselor competency development. Results from various research studies contribute to the self-awareness of counselor growth, applied learning standards in counselor education programs, supervision competence, and help to prove the necessity of assessment evaluations in counselor education and training. Several prior studies have presented the value of using the SOCCS (Bidell, 2005; 2014; Bidell & Whitman, 2014; Farmer et al., 2013; Graham et al., 2012; Rutter et al., 2008) and the LGBT-DOCSS (Bidell, 2017) to discover self-perceived LGB client competence. However, ongoing research is essential with additional characteristics among counselors-

in-training and LGBT client populations. Prior research results found counselor educators and their trainees benefit tremendously from evaluating their personal biases, sexuality, and religiosity to determine what particular predictors are associated with LGBT counselor competence development (Bidell, 2014; Logan, 2013; Whitman & Bidell, 2014).

## Religiosity

Religiosity is an ongoing topic of discussion in mental health because of diversity among counselor and clientele characteristics. The term religiosity refers to people's experience, behavior, knowledge, and attitudes as they pertain to belief in a higher power (Nickles, 2011). On the other hand, religion is defined as the rituals or theology of an individual's spiritual experience (Nickles, 2011). This section describes religiosity in counselor education, counselor training, and counselor practice.

Contemporary researchers identified specific attitudes which directly interfere with the counselor’s ability to address LGBT client’s mental health needs (Bidell, 2012; 2014; 2015; Herek, 2009; McIntosh, 2011). Bidell (2013) and Borgman (2009) discussed how religious values, religious identity, and religious beliefs are reliable predictors of how counselors and students in counselor education effectively help LGBT clients. According to Allport and Ross (1967), psychology and mental health researchers place religion in two categories: intrinsic or extrinsic religious orientation. Intrinsic religious orientation is an idea of having deeply personal religious values and living by religious beliefs (Allport & Ross, 1967; Bidell, 2014; Borgman, 2009). Extrinsic religious orientation is the idea of individuals using religion for social status, social gain or a

means of protection (Allport & Ross, 1967; Bidell, 2014; Borgman, 2009). Both terms are used in counselor education research to examine individuals' religious behaviors and attitudes as they relate to mental health diversity development in practice and training.

**Religious Assessments**

Harper et al. (2013) reviewed ALGBTIC's standards for including religion assessments in affirmative-LGBT counseling training. For instance, counselors have ethical obligations to know their limitations of LGBT counselor competency and have an awareness of providing recommendations or alternative options necessary to avoid imposing personal convictions in counseling interventions (Harper et al., 2013). Whitman and Bidell (2014) also discussed the evolution of religious inclusiveness in counselor education and LGBT-affirmative training. In a literature review article, several studies were presented by Whitman and Bidell regarding the potential conflicts between conservative religious beliefs and LGBT client case conceptualization. Whitman and Bidell addressed research identifying religious viewpoints, and sexual orientations are factors in the development of LGBT counseling competence.

Researchers argued the counseling profession has advanced in advocating for LGBT-affirmative training and education, however, using assessment tools to understand how of counselors' religious values and LGBT counseling competence are associated improve counselor training experiences (Borgman, 2009; Rainey & Trust, 2007; Whitman & Bidell, 2014). Borgman (2009) emphasized the importance of counselor supervisors assessing supervisees' religious characteristics in affirmative-LGBT counseling training. He found counselors who report frequently attending church have

lower participation with the LGBT community compared to their colleagues with limited attendance in church and more involvement in the LGBT community. Borgman's research indicated counselors with unconscious conservative, religious beliefs were less efficient when counseling LGBT clients. Whitman and Bidell (2014) noted when counselors-in-training uncover religious barriers they then can address values or lifestyle differences in training with guided supervision and decide whether they will avoid or refer LGBT client populations to alternative counseling practices.

On the other hand, Nickles (2011) discussed counselors and clients participating in religious activities integrated religious interventions and initiated discussion of religiosity in counseling sessions. Many authors addressed the use of religious activities as a strategy to promote counseling intervention. Nickles reviewed prior research literature and indicated clients opposed discussing their counselor's religion and feared having different beliefs would challenge their lifestyles and counseling interventions. In his study, several clients were open to counseling when their counselors disclose their religious beliefs and felt similar religious beliefs with their counselor would help to create positive viewpoints and contribute to a better client-counselor relationship.

According to Nickles (2011), various studies have found counselors who reported higher religiosity also reported higher contributions in helping others also in community service, human rights efforts, and advocacy projects. Logan (2013), Nickles (2011), Whitman and Bidell (2014), along with Worthington et al. (2003) mentioned religious support as an intervention tool encouraged clients to participate in positive social relations. Although past studies have concluded religion motivation and religion

conservatism in counselor education (Nickles, 2011), there is little research examining religion commitment and LGBT counselor competence.

The Religious Commitment Inventory-10 (RCI-10) is an assessment used to evaluate an individual's level of commitment. In prior studies in counselor education, this scale has provided researchers with significant statistical information to describe how religious commitments are important to examine in counseling education. Factors such as activities in religious organizations, religious values, beliefs, and practices are valid to understand in counseling practice concerning counselor supervision, counselors, counselor trainees, and clients (Nickles, 2011; Worthington et al. 2003). The RCI-10 is the ideal assessment for this study to examine self-perceived religious commitment because the survey tool is convenient for online administration, can be easily interpreted, reliable, and no other studies have shown associations with this survey instrument and the LGBT-DOCSS. Further description and design details of this instrument are located in chapter 3.

**Religious Values**

Counselor education includes exploring the associations between religion and counselor education and how the two factors coincide to influence training models, counseling techniques, and counselor competency growth. Political and religious viewpoints have traditionally directed the view of counseling practice and standards (ACA, 2014; Nickles, 2011; Whitman & Bidell, 2014; Worthington et al., 2003). Counselor educators, psychologists, and social science researchers continue to establish useful qualitative and quantitative data to use as resources for developing LGBT

counselor competency. These studies have contributed to helping counselors understand how to include religion in counselor intervention, techniques, and in counseling theoretical frameworks (Nickles, 2011; Robertson, 2008; Whitman & Bidell, 2014; Worthington et al., 2003). Logan (2013), Whitman and Bidell (2014), and Worthington et al. (2003) argued research in LGBT counselor competence, and counselor religiosity is needed to uncover sources of conflict, social support, and coping mechanism in counseling practice.

Researchers evaluated the following: (a) the impact of religion on therapeutic relationships; (b) religious influence in behavior; (c) religion as a coping mechanism for loss, grievance, or in suicide cases (Allport & Ross, 1967; Nickles, 2011; McIntosh, 2011; Whitman & Bidell, 2014). Counseling organizations such as ACA, CACREP, ASERVIC, and ALGBITC set ethical standards in place for addressing personal diversity in counseling practice and training. Counselors may not necessarily agree with a client's religious or sexual orientation viewpoints but are required to be open and accepting of various cultural views for treatment purposes (ACA, 2014; ASERVIC, 2017; Harper et al., 2004; Smith & Okech, 2016). In the role of a counselor, it is important to have an understanding of personal religious values, religion competencies, and how countertransference or imposing religion in practice can affect clients (ACA, 2014; ASERVIC, 2017; Bidell, 2014; Whitman & Bidell, 2014).

## Self-Efficacy: Bandura

As mentioned by Bandura (1986), perceived self-efficacy has a direct influence on one's choice of activities and setting when providing services to other individuals.

Perceived self-efficacy affects the outcome of performance, an individual's expectation of experience, and also can determine how some individual copes with initiated processes (Bandura, 1977). "Self-efficacy is the belief in one's own ability to accomplish something" (Hayden, 2013, p.15). This theory, in general, explains people who are confident in completing a task will continue to work and complete the task. In other words, self-efficacy is a positive perception or beliefs which eventually help a person achieve what they are set out to do.

On the other hand, self-efficacy theory reveals individuals who doubt their ability in accomplishing a task do not engage in a task or see the task as a challenge or threat (Bandura, 1977, 1982, 1986). Self-efficacy theory stems from Albert Bandura's social cognitive theory which empathizes social learning, observational learning, and social experience in developing a personality. According to Bandura (1982), our self-system or our attitudes, abilities, and our cognitive skills all play a major role in the way a person perceives various situations and respond to situations. Bandura's self-efficacy theory clarifies how individuals' perception of competence stems from four major sources; mastery experiences, social modeling, social persuasion, and psychological responses.

## Chapter Summary

In all, in chapter 2, prior research studies discussed the significance of increasing LGBT competency among various counselor education programs (Bidell, 2005; 2012; 2014; 2016; 2017; Bieschke et al., 2014; Farmer et al., 2013; Graham et al., 2012; Herek & Garnets, 2007; Rutter et al., 2008; Whitman & Bidell, 2014). Literature reviews in this section describe support for affirmative- LGBT counseling training and contributions in

research to enhance counselor education social change efforts. As prior literature has shown counselor education training includes the understanding of relationships between personal biases and cultural values to determine new models and strategic planning in affirmative-LGBT counseling training (Whitman & Bidell, 2014). As provided by the ACA (2014) Code of Ethics, counselor supervisors are gatekeepers of social change and professional counselor development and have a duty to conduct training facility evaluations, student evaluations and self-evaluations of their values as well as their trainees.

Studies outlined in this chapter provide implications to continue filling the gaps in for counselor education and continuing evaluations among counselors-in-training to find other predictors associated with self-perceived LGBT counselor competency growth (Bidell, 2005; 2012; 2014; 2016; 2017; Farmer et al., 2013; Graham et al., 2012; Rutter et al., 2008; Whitman & Bidell, 2014). Therefore, my study is in line with ongoing efforts to strengthen the relationship between LPCs and the LGBT community studies using the LGBT-DOCSS and counselor personal religious values and commitment.

In summation, I presented literature in chapter 2 to described efforts to support affirmative- LGBT counselor training and contributions to continued research towards the scholarship in counselor education social change. More specifically the review of literature in this chapter presented information supporting the evaluation of religiosity, culture discrimination, heterosexist counseling, and institutional multicultural policies within this section to describe barriers preventing the development of LGBT counseling competency. Finally, the information in chapter 2 acknowledged research using LGBT

competency scales and addressed additional assessment tools to identify further clinical preparedness among counselors working with LGBT clients.

# Chapter 3: Research Methodology

In this chapter, I present the research questions and relevance of the research questions, a method for data collection, description of my participant population and sampling procedure, description of the survey instruments used to collect data, and data analysis procedures planned to address research questions. The purpose of this quantitative study was to assess the extent of the relationship, if any, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudinal awareness towards LGBT clients as moderated by levels of religious commitment of LPCs.

## Purpose and Significance of the Study

Prior researchers did not consider if there are relationships between LPCs' self-perceived clinical preparedness in working with LGBT clients and their self-perceived attitudinal awareness towards LGBT clients while using religious commitment as a moderator. Implicit bias, conservative values, and strong religious beliefs can negatively affect the development of LGBT counselor competency and the quality of counseling services for LGBT clients (Bidell, 2005, 2013; Bieschke et al., 2014; Farmer et al., 2013; Graham et al., 2012; Herek, 2009; Rainey & Trusty, 2007; Rutter et al., 2008). To make changes in counselor education training, it is important to understand at what level attitudinal awareness and personal religious commitment correlate with counselors' self-perceived clinical preparedness. Research addressing counselor self-awareness contributes to not only helping counselors' development as professionals but also ensures quality counseling services are provided to the public.

## Research Questions

To fill the gap in counselor education literature, I addressed the following questions:

RQ1: What is the extent of the relationship, if any, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudinal awareness towards LGBT clients as measured by the LGBT-DOCSS, as moderated by levels of religious commitment of LPCs measured by the RCI?

RQ2: What is the level of overall self-perceived clinical preparedness of working with LGBT clients, as measured by the LGBT Clinical Preparedness subscale within the LGBT-DOCSS of LPCs?

RQ3: What is the level of overall self-perceived attitudinal awareness of working with LGBT clients, as measured by the LGBT Attitudinal Awareness subscale within the LGBT-DOCSS of LPCs?

RQ4: What is the level of overall religious commitment, as measured by the RCI) of LLPCs?

## Null Hypothesis

$H_0$: There is no statistically significant relationship between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as measured by the LGBT-DOCSS, as moderated by levels of religious commitment measured by RCI of LPCs.

## Alternative Null Hypothesis

$H_{1:}$ There is a statistically significant relationship between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as measured by the LGBT-DOCSS as moderated by levels of religious commitment measured by the RCI of LPCs.

## Research Design

My primary goal was to assess the extent of the relationship, if any, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudinal awareness towards LGBT clients as moderated by levels of religious commitment of LPCs. I used a multiple regression design to assess the effects of each moderating variable. The LPC participants completed online, self-reporting survey instruments for the study data collection. The assessment instruments were the LGBT-DOCSS and the RCI. After the participants completed the surveys, data collection and multiple regression analysis of the statistical information was used to describe the correlation between the three variables.

## Participants

LPCs were the target population of participants in this research. Participants from various ages, genders, and demographical backgrounds were targeted. The individuals recruited to participate in the surveys were asked to hold a state LPC license or the equivalent state licensure for professional counseling. The ACA is the only official professional association of LPCs. Using a criteria-based sampling method, I was able to reach a large number of diverse individuals who identified as LPCs in the United States.

ACA and Psychology Today are both directories for LPCs. I provided the survey link and invitation for LPCs to participate in my research on ACA connect and Psychology Today PeerCast. ACA and Psychology Today online websites allow LPCs to contribute their thoughts, share ideas, and network to discuss mental health. Both ACA and Psychology Today have message forums for LPCs to blog, market counseling tools, advertise mental health conferences and workshops, and recruit professionals to participate in research surveys to improve the quality of counseling services (Psychology Today, 2017).

To assess moderating effects of the dependent variable (clinical preparedness) and the two independent variables (attitudes and religious commitment), I used Statistical Package for the Social Sciences (SPSS) software to conduct interval multiple regression analyses. Using the G* power 3.19.2 prior power (Raosoft, 2004) analysis calculation, I determined that with three variables, using a medium effect size at an alpha of .05 and beta of 0.95, a sample size of 134 was appropriate for my study.

## Data Collection Procedures

The primary purpose of this research was to evaluate the relationship between LPCs' level of self-perception of developmental, clinical preparedness working with LGBT clients and their self-reported measurements of attitudinal awareness towards LGBT clients as moderated by their religious commitment. The research invitation e-mail provided a link for LPC participants to complete the LGBT-DOCSS and the RCI. A copy of the initial invitation e-mail is located in Appendix B. Also, participants identified their demographic background (see Appendix D).

Researchers use SurveyMonkey as an online survey tool to offer data collection using multiple choice, true/false, and open-ended questions from respondents (SurveyMonkey, n.d.). For my research, SurveyMonkey was the online survey platform used for participants to access the demographic questionnaire, the consent form, LGBT DOCSS, and the RCI-10. Each survey instrument took approximately 5-10 minutes to complete (Bidell, 2017; Worthington et al., 2003). The overall research assessment took participants approximately 20 minutes to complete. To ensure anonymity, personal names, e-mails, and other contact information were not collected. In the consent form, I also notified the participants of the right to terminate the survey at any time without fear of penalty. Once the participant clicked on the link offered by the announcement, the surveys opened, and participants read the consent form and participated. Follow-up communication e-mails were out sent two weeks after the initial online invitation to help increase online responses from volunteer LPCs (see Appendix C). Once the survey was completed, the participants received a completion confirmation and a thank you message.

## Instrumentation

Self-awareness evaluations, such as the LGBT-DOCSS and the RCI-10, are key instruments used during counselor training. These tools allow counselors the opportunity to gain perspectives of what their clinical perceptions, knowledge, and skill levels are when working with clients. Self-evaluation surveys also help counselors know what areas need improvement to better their counseling techniques.

**Demographic Information Questionnaire**

To describe the participants' backgrounds, each participant completed a questionnaire to identify their demographic identities. The demographic information questionnaire helped to identify participants' characteristics. In the demographic information questionnaire, I asked participants to report their ethnicity, age, gender, sexual orientation, religious orientation, and state of residence.

**LGBT-DOCSS**

Based on the research questions, the LGBT-DOCSS was the best instrument to address counselor-clinical preparedness development. It was also the only scale that evaluates questions about transgender clients, unlike other self-evaluation counselor competency scales. The LGBT-DOCSS was an assessment used to facilitate self-exploration of counselors' clinical preparedness, attitudinal awareness, and knowledge of working with LGBT clients (Bidell, 2017). Similar to other self-reporting assessments, the LGBT-DOCSS is administered to health professionals to help providers strengthen learning objectives and training methods for providing LGBT clients with quality healthcare. Permission from Dr. Markus Bidell to use the instrument in this study is located in Appendix E.

The LGBT-DOCSS questionnaire uses a 7-point Likert scale (number 7 representing *strongly agree* and number 1 representing *strongly disagree*). The scale consists of 18 items inquiring about sexual orientation or gender identity; two questions address both sexual orientation and gender identity. The instrument includes seven items addressing clinical preparedness (Items 4, 10, 11, 13, 14, 15, and 16), seven items

examining attitudes (Items 3, 5,7,9,12, 17), and four items measuring knowledge (Items 1, 2, 6, and 8). For my research, I only calculated the sum of the clinical preparedness subscale and the attitudinal awareness subscale.

When scoring the LGBT-DOCSS, all 18 items are added to give the total raw score, with the respective numbers revised, then divided by 18 to equal the total mean score. Also, the sum of each subscale is added for the subscale total raw score and then divided by the number of items in each subscale to get the subscale mean score (Bidell, 2017). Scores range from 18 to 126. Participants who score higher scores on the LGBT-DOCSS in the total of all subscales show higher levels of clinical, developmental skills. The mean scores can range from 1 to 7 (M. Bidell, personal communication, October 26, 2017). The LGBT-DOCSS includes mean scores from different subscales, and the researcher determines the mean with participants (M. Bidell, personal communication, October 26, 2017).

Also, high scores in each subscale indicate the participants show less attitudinal awareness and higher knowledge and skills of working with LGBT clients (Bidell, 2017). Bidell (2017) stated that the lower LGBT-DOCSS scores highlight the need for educators to focus on developing educative methods that facilitate the acquisition of practical tools and skills for health professionals working with LGBT clients and patients (p. 31). In this study, I only provided the sum of the attitudinal awareness subscales and also the skills subscale. This scale is useful in training programs, completed by clinical supervisors, and used as a self-exploration tool.

Bidell (2017) determined that the LGBT-DOCSS was a reliable and valid assessment to be used for research purposes with clinical development, testing LGBT training programs, and exploring clinician characteristics. Establishing internal consistency, reliability, and validity in prior studies helped to determine how reliable the LGBT-DOCSS is regarding assessing health care professionals and students in counseling programs (Bidell, 2017). Without determining the reliability of the assessment tool by research, the LGBT-DOCSS cannot be valued as a credible tool. Reliability is tested to ensure that the instrument tool can be used in studies. Bidell determined the instrument to be reliable using a full analytic sample (*N=602)*. In Study 2, Bidell concluded the LGBT-DOCSS instrument to have a strong an internal consistency ($\alpha$ = .86). Each internal subscale consistency resulted in clinical preparedness (*r* =.88), attitudinal awareness (*r*=.80), and basic knowledge subscale (*r* = .83; Bidell, 2017). Overall, the instrument demonstrated good internal consistency and for each subscale. Although the majority of the sample participants were Caucasian, female, undergraduate students in counseling programs the test re-test reliability were strong (*r*=.87). Bidell mentioned future studies will benefit by establishing retest reliability across “broader demographic, educational, and professional parameters” (p. 25).

In the third study, Bidell (2017) found convergent and discriminant validity established by evaluating participant criteria by measuring LGBT prejudice, assessment skills, and social desirability. Correlations were calculated from the LGBT-DOCSS subscales and overall total in a relationship with the RWS-S scale, GTS-R-SF, LGBT-CSI, and the MCSD-SF-A Scale. Overall correlations, the LGBT-DOCCS Clinical

Preparedness subscale and the LGBT-CSI correlated the strangest (r=.69, $p$<.001). The LGBT-DOCSS Attitudinal Awareness subscale and the GTS-R-SF showed the stronger correlating relationship scores ($r$=-.84, $p$ <.001). The weak correlations scores between the LGBT-DOCSS and the MCSD-SF-A scale demonstrated strong discriminant validity. As in prior studies (Bidell & Whitman, 2013; Farmer et al., 2013; Graham et al., 2012), the LGBT-DOCSS proved to demonstrate participants who scored higher scores were also in advanced professional health care positions and reported advanced education.

The LGBT-DOCSS was tested across various disciplines in healthcare and also internationally to determine validity and reliability across a broader scope of research demographics. When considering the diversity of the research, participants ranged in age, gender, professional/ educational level, ethnicity, and sexual orientation. Analyses from five levels of education concluded that LGBT-DOCSS scores were significantly higher at each level of education increased (undergraduate to doctoral level; *ps*<.001 to.05). Participants from the United States ($n$=261) and United Kingdom ($n$=303) were recruited to participate. Additional identifying information included (a) psychologist ($n$ = 30), (b) medicals doctors ($n$ = 97), (c) medical students ($n$ = 29), and (d) counselors ($n$ = 52).

**The Religious Commitment Inventory**

The RCI-10 is a 10-item scale based on Worthington's (1988) religious values in counseling. The assessment of religious commitment was developed to evaluate how an individual's religious behavior influences his or her lifestyle values. Religiosity is measured by respondents' assessing their religious beliefs, values, and practices within their daily living (Worthington et al., 2003). The RCI-10 is a revised version. Prior RCI

scales included 62 items, 20 items, and 17 items (Worthington et al., 2003). The RCI-10 scale is a 10 question, a 5-point Likert scale that allows responders to rate self-perceived religious commitment level (1= *not at all true of me* to 5= *totally true of me*). The RCI-10 has one full total score and also two subscale scores: Intrapersonal Religious Commitment (1, 3, 4, 5, 7, and 8) and Interpersonal Religious Commitment (2, 6, 9, and 10). Permission from Dr. Everett L. Worthington to use the instrument in this study is located in Appendix F.

To find the total sum for the RCI-10, each item is added. According to Worthington (2003), the lowest total score is 10, and the highest is 50. Respondents with a score higher than the normative mean of 26 are reverently considered moderately religious. The normative mean indicates that, on average, participants reported they sometimes (middle) considered religion when developing personal values and worldviews (Worthington et al., 2003). Those participants who score an overall score of 38 or higher are considered highly religious; the assessment measurements conclude that individuals who score high on the RCI-10 significantly consider religion when developing personal values or worldviews, and those participants who score below (>26) rarely consider religion when developing personal values and worldviews (Logan, 2003; Worthington et al., 2003). Individuals scoring high (< 38) on the RCI-10 feel that religion plays a part in the perception of counseling methods and also in their perception of their clients (Worthington et al., 2003).

Researchers and counselor educators commended the RCI instrument for reliability, convenience, and valid scores (Worthington et al., 2003). In several studies,

the RCI-10 was deemed reliable by testing the internal consistency of measurement and stability in study scoring (Wade et al., 2005; Worthington et al. 1996; Worthington et al., 2003). To test the reliability of scores, the RCI-10 was correlated with other religiosity measurement instruments.

The RCI scale was presented in many psychology, mental health, and quantitative counseling studies. Over 2,000 people were evaluated to understand RCI-10 means and standard deviations for groups. In prior research, the RCI-10 scores were resourceful for assessing the religious commitment of Christians, Buddhists, Jewish, Muslims, Hindus, and people who respond as non-denominational (Worthington et al., 2003). Other identifying demographic information included (a) age; (b) ethnicity; and (c) gender. Studies using the RCI indicate participants came from various areas of study and also various educational levels (Worthington et al., 1996; Worthington et al., 2003). The RCI was considered valid and reliable by considering the following populations and criteria: (a) secular university students, (b) university student from explicitly Christian colleges, (c) adults from the community, (d) single and married people, and (e) therapists and clients at secular and explicitly Christian counseling agencies.

Worthington et al. (2003) along with other researchers have presented evidence of the reliability and validity of the RCI-10. According to Wade, Worthington, and Vogel (2006), the RCI-10 "exhibited strong estimated reliability" Cronbach's coefficient *x*s >.92) (p.5). In a 3-week test-retest reliability, the RCI-10 scores were calculated by Pearson correlation coefficients and respectfully resulted in $r$=.87 (Worthington et al., 2003). Internal consistency for the RCI-10 was .93.

After six studies, the RCI-10 is valid and reliable using several research settings and relatively consistent using many types of scores and participant samples (Worthington et al., 2003). Worthington et al. (2003) mentioned the RCI- 10 a key instrument when identifying how “religious people see the world” (p.95). These instruments are considered useful when determining to what extent therapists, students, or clients’ religious commitments should be considered when developing therapeutic intervention strategies or developing counselor supervision methodology.

## Research Procedures

After the successful defense of the dissertation proposal and committee approval, I gained approval from the Institutional Review Board (IRB). Then uploaded the research invitation to the ACA connect and Psychology Today PeerCast forums for prospective participants. Once the initial invite post to recruit participants for the study was sent out for the research collection begin. Data collection only occurred once.

The initial recruitment e-mail was being sent out on Day 1 of Week 1. The follow-up invite post was uploaded out on Day 1 of Week 3. Participants were allowed four weeks for participation and were anticipated to close on Day 7 of Week 4. However, the timeframe was extended due to the slow response.

The data collection was intended to generate a sample size of 134 participants. After acquiring the minimum sample within the 4-week window of the data collection timeline, the online survey will close, and the start of data screening and cleaning process will begin. The next step is to conduct the appropriate statistical analyses. To answer the purposed research questions, descriptive information detailing the levels of clinical

preparedness, levels of attitudinal awareness, and levels of religious commitment. From each measurement, I assessed for model assumptions, review any patterns and interpret if any correlated relationships found between the dependent variable and independent variables. I utilized the Statistical Package for The SPSS software version 23 to analyze the data (Cronk, 2016). Multiple regression analyses helped to determine correlations and provide statistics to identify if the hypotheses are true and accepted or if the measures do not support the hypotheses. Practical significance was also assessed.

## Chapter Summary

The primary purpose of this research was to evaluate the relationship between LPCs level of self-perception of developmental, clinical skills working with Lesbian, Gay, Bisexual, and Transgender clients, and their self-reported measurements of attitudes towards Lesbian, Gay, Bisexual, and Transgender clients, as moderated by their religious commitment. In this chapter, the research design, population, sample, and sampling technique, instrumentation, data collection, and analyses were described. In this study, empirical data collected for LPCs throughout the United States help determine the levels of self-perceived clinical, developmental skills working with LGBT clients and self-perceived attitudinal awareness working with LGBT clients as measured by the LGBT-DOCSS. Also, religious commitment levels as measured by the RCI-10. From the research data, I provide quantitative descriptive information to describe the results, patterns, relationships, and statistic frequencies. The data collection and results are described in Chapter 4.

# Chapter 4: Results

Ensuring adequate mental health care for working with LGBT clients has been an ongoing topic amongst counseling professionals and researchers. The purpose of this study was to assess how counselors perceived their clinical preparedness for working with LGBT clients and to evaluate how their attitudinal awareness and religious commitment are associated with clinical preparedness perception. It is important for counseling educators to address how a counselor's level of attitudinal awareness and personal religious commitment correlate with his or her self-perceived clinical preparedness to effectively counsel LGBT clients. Research addressing counselor self-awareness contributes to not only helping counselors develop as professionals but also ensures social change actions are initiated within counselor education and training.

The research was conducted to determine the extent of the relationship, if any, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudinal awareness towards LGBT clients as measured by the LGBT-DOCSS, as moderated by levels of religious commitment of LPCs measured by RCI. The null hypothesis was there is no statistically significant relationship between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as measured by LGBT-DOCSS, as moderated by levels of religious commitment measured by RCI-10 of LPCs. The alternative hypothesis was there is a statistically significant relationship between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT

clients as measured by LGBT-DOCSS, as moderated by levels of religious commitment measured by RCI of LPCs.

This chapter includes descriptions and illustrations of statistical information collected and provides a summary of the exact data collection process. The descriptive data in Chapter 4 are presented in the following order: (a) demographic characteristics of the participating sample, (b) measures of central tendency for each variable, and (c) correlations between the variables. The moderated multiple regression will address model assumptions, statistical significance, the influence of the moderator, and practical significance.

## Data Collection

The data collection took six weeks. Initially, the estimated timeframe was four weeks; however, due to a slower response rate of participants, the timeframe was extended, which was within the 1-year, IRB-approved timeline. The first invitation went out on March 6, 2018, the second request went out March 28, 2018, and the final request was sent April 4, 2018. The data collection ended time 12:00 AM central standard on April 16, 2018. As discussed in Chapter 3, the sampling resources included ACA Connect forums and Psychology today. The final count of respondents was 136; however, only 126 submitted the survey, for a total completion 92.6% rate. Nonprobability sampling was ideal for this research because sampling the entire population of LPCs was impossible to accomplish within the time constraints and limited resources available for conducting this research.

The process of selecting a portion of the population is outlined in Chapter 3. Prior research using the LGBT-DOCSS targeted individuals who were in counseling training, graduate students in counselor education, and who lived in the United Kingdom (Bidell, 2017). Criterion sampling allowed only LPCs to be targeted for this research based on their availability to participate. The ACA (2016) reported that within the five ACA regions representing LPCs, the state of Texas accounted for 18,753 professional counselors out of the entire recorded population of 162,130 professional counselors (ACA, 2016). Regarding external validity, I found that the highest percentage of respondents were from Texas.

## Participant Demographics

Each of the participants was asked to take part in the research voluntarily. LPCs of all ethnic backgrounds and ages were encouraged to participate. Anonymous demographic information was obtained from participants to identify their state of residence, age, sexual orientation, gender, and race/ethnicity. Upon agreement and approval of consent, each participant completed the demographic questionnaire to identify background information.

Professional counselors in all four ACA regions of the United States (including the Midwest Region, North Atlantic Region, Southern Region, and Western Region) were represented in this sample (ACA, 2018). When reporting the state of residence, most of the participants responded from the Southern Region with Texas accounting for 31 (24.6%). Table 1 illustrates the frequency of respondents by the state of residence.

Table 1

*Frequency of Respondents by State of Residence*

| State of Residence | *n* | % |
|---|---|---|
| Alabama | 2 | 1.6 |
| Arizona | 2 | 1.6 |
| Arkansas | 1 | .8 |
| California | 8 | 6.3 |
| Colorado | 11 | 8.7 |
| Florida | 6 | 4.8 |
| Georgia | 14 | 11.1 |
| Hawaii | 1 | .8 |
| Illinois | 2 | 1.6 |
| Kansas | 1 | .8 |
| Kentucky | 1 | .8 |
| Louisiana | 7 | 5.6 |
| Maine | 1 | .8 |
| Maryland | 4 | 3.2 |
| Massachusetts | 1 | .8 |

*Table 1 Continued*

| State of Residence | n | % |
|---|---|---|
| Michigan | 3 | 2.4 |
| Minnesota | 1 | .8 |
| Mississippi | 2 | 1.6 |
| Missouri | 1 | .8 |
| Nebraska | 2 | 1.6 |
| New Jersey | 3 | 2.4 |
| New York | 6 | 4.8 |
| North Carolina | 2 | 1.6 |
| Oklahoma | 1 | .8 |
| Oregon | 3 | 2.4 |
| South Carolina | 2 | 1.6 |
| Tennessee | 2 | 1.6 |
| Texas | 31 | 24.6 |
| Virginia | 2 | 1.6 |
| Washington | 2 | 1.6 |
| West Virginia | 1 | .8 |

Of the 126 participants, the majority were female (*n* = 84 or 66.7%). Thirty-two participants responded as male (25.4%), five answered prefer not to say, two responded as nonbinary, one responded as pangender, one participant responded as transgender, and one responded as nonconforming (see Table 2).

Table 2

*Frequency of Respondents by Gender*

| Gender | *n* | % |
|---|---|---|
| Male | 32 | 25.4 |
| Female | 84 | 66.7 |
| Nonbinary | 2 | 1.6 |
| Nonconforming | 1 | 0.8 |
| Prefer Not to say | 5 | 4 |
| Pangender | 1 | 0.8 |
| Transgender | 1 | 0.8 |

Among the 126 participants, 58 identified as Caucasian, 31 reported their race or ethnicity as African American/Black, 13 reported Mixed race, 11 responded as Latino or Hispanic American, three reported Indian American, two reported as Pacific Islander, three reported Afro-Caribbean, two responded Asian (East, South, Asian American), two responded as Arab American, and one respondent identified as Middle Eastern (see Table 3).

Table 3

*Frequency of Respondents by Race/Ethnicity*

| Race/Ethnicity | *n* | % |
|---|---|---|
| African American/Black | 31 | 24.6 |
| Afro-Caribbean | 3 | 2.4 |
| Asian (East, South, Asian American) | 2 | 1.6 |
| Caucasian/White | 58 | 46.0 |
| Indian American | 3 | 2.4 |
| Latino/Hispanic American | 11 | 8.7 |
| Middle Eastern | 1 | .8 |
| Mixed Race | 13 | 10.3 |
| Pacific Islander | 2 | 1.6 |
| Arab American | 2 | 1.6 |

The participants were also asked to report their sexual orientation. Out of the 126 participants, 77 or 61.1% reported being heterosexual, 21 or 16.7% responded as bisexual, seven reported gay, seven reported lesbian, six participants responded, "preferred not to report," three reported queer, two reported pansexual, one reported poly, one reported nonbinary, and one reported asexual. The majority of the participants responded as heterosexual with a report of 77 at 61.1%. Table 4 further illustrates the frequency of respondents by sexual orientation.

Table 4

*Frequency of Respondents by Sexual Orientation*

| Sexual Orientation | *n* | % |
|---|---|---|
| Asexual | 1 | 0.8 |
| Bisexual | 21 | 16.7 |
| Gay | 7 | 5.6 |
| Heterosexual | 77 | 61.1 |
| Lesbian | 7 | 5.6 |
| Nonbinary | 1 | 0.8 |
| Pansexual | 2 | 1.6 |
| Poly | 1 | 0.8 |
| Prefer to Not Report | 6 | 4.8 |
| Queer | 3 | 2.4 |

Participants' ages ranged from 23 to 71. Age 31 (9.5%) was listed as the most frequent age. The median age was recorded as 39, and the mean age was mean was 39 (see Table 5).

Table 5

*Frequency of Respondents by Age*

| Age | n | % |
|---|---|---|
| 23 | 1 | .8 |
| 25 | 1 | .8 |
| 26 | 1 | .8 |
| 27 | 2 | 1.6 |
| 28 | 4 | 3.2 |
| 29 | 3 | 2.4 |
| 30 | 2 | 1.6 |
| 31 | 12 | 9.5 |
| 32 | 8 | 6.3 |
| 33 | 8 | 6.3 |
| 34 | 4 | 3.2 |
| 35 | 1 | .8 |
| 36 | 6 | 4.8 |
| 37 | 4 | 3.2 |
| 38 | 3 | 2.4 |
| 39 | 5 | 4.0 |

*Table 5 continued*

| Age | *n* | % |
|---|---|---|
| 45 | 7 | 5.6 |
| 46 | 8 | 6.3 |
| 47 | 5 | 4.0 |
| 49 | 1 | .8 |
| 51 | 2 | 1.6 |
| 52 | 2 | 1.6 |
| 53 | 1 | .8 |
| 56 | 2 | 1.6 |
| 60 | 1 | .8 |
| 62 | 2 | 1.6 |
| 65 | 1 | .8 |
| 66 | 1 | .8 |
| 71 | 1 | .8 |

When asked the question "What religion are you?" 22 participants reported being Christian, 21 reported being Baptist, 13 reported being Christian, non-denominational, 11 responded as "I am Spiritual but do not have religion," and 11 reported being atheist. Additional information can be found in Table 6. Of the 126 participants, the majority responded as Christian with a total of 22 at 16.7%. The analysis also revealed only one participant responded for each of Jehovah's Witness, Muslim-Suni, Muslim-other, Pagan, and Scientologist religions.

Table 6

*Frequency of Respondents by Religion*

| Religion | *N* | % |
|---|---|---|
| Agnostic | 4 | 3.2 |
| Atheist | 11 | 8.7 |
| Baptist | 21 | 16.7 |
| Believe in God but no Religion | 5 | 4 |
| Catholic | 9 | 7.1 |
| Christian | 22 | 17.5 |
| Christian, Non-Denominational | 13 | 10.3 |
| Do not Believe in God and No Religion | 3 | 2.4 |
| Episcopalian | 2 | 1.6 |
| Hindu | 2 | 1.6 |
| Humanist | 9 | 7.1 |
| Jehovah's Witness | 1 | 0.8 |
| Jewish | 2 | 1.6 |
| Lutheran | 1 | 0.8 |
| Methodist | 3 | 2.4 |

*Table 6 Continued*

| Religion | *n* | % |
|---|---|---|
| Muslim-Other | 1 | 0.8 |
| Pagan | 1 | 0.8 |
| Prefer Not to Say | 2 | 1.6 |
| Scientologist | 1 | 0.8 |
| Spiritual but No Religion | 11 | 8.7 |
| Unitarian Universalist | 1 | 0.8 |

## Results

The purpose of this dissertation was to discover if there is a significant relationship between clinical preparedness levels of LPCs and their attitudinal awareness as moderated by their religious commitment. The information in this section includes variable descriptions, correlation, model assumptions, multiple regression with and without the moderator, and the practical significance. This section begins with descriptions for the frequency of distributions for the three items.

### Descriptive of Each Variable

Clinical preparedness. The criterion variable is clinical preparedness of LPCs. Clinical preparedness is measured by the Clinical Preparedness subscale within the LGBT-DOCSS assessment. Scores can range from 1 to 7. Clinical preparedness scores higher than ($M > 5$) indicates a high score (Bidell, 2017). A high score implies the participant felt more clinically prepared to provide counseling to LGBT clients (Bidell, 2017). A low score indicates the participant believed they were less clinically prepared to

work with LGBT clients (Bidell, 2017). Participants scored an average of (*M* = 5.321, *SD* = .856). Of the 126 participants, 14 or 11.1% of the responses frequently scored 5.8 for an overall total clinical preparedness score. The range of scores indicated most LPCs overall clinical preparedness levels were between 5.8 and 6.9 which indicated high levels of self-perceived clinical preparedness for working with LGBT clients (see Table 7).

Attitudinal awareness. The Attitudinal Awareness subscale represented the predictor variable. The Attitudinal Awareness predictor is identified by questions on the Attitudinal Awareness subscale of the LGBT-DOCSS. The questions within this subscale measures counselor's attitudes, biases, and stereotypes towards counseling LGBT clients. A low score (*M* > 5) on the Attitudinal Awareness subscale indicates the respondent is more prejudicial regarding working with LGBT clients. A high score implies the participant felt less bias towards providing counseling to LGBT clients (Bidell, 2017). Attitudinal Awareness predicator variable means scores resulted in (*M* = 6.4, *SD* =. 802). Median for the attitudinal awareness predictor was recorded as 6.4. The most frequent score was 7. The attitudinal awareness scores ranged between 7.0 being the maximum score and the lowest score was 3.3.

Religious commitment. The RCI-10 was given to the respondents to determine their levels of religious commitment. The RCI-10 was used as a moderator. Respondents with a higher standard deviation higher than the mean would be considered highly religious. High religious commitment is considered in the range of 26 to 50, and low religious commitment is considered in the range of 10 to 25. The mean score of religious commitment was recorded as 28.90. The most frequent score was 10, and the median

score was recorded as 29.0. The standard deviation of the religious commitment was 13.21. When reviewing the participant's total score on the RCI-10 72 or 57.1% participants scored between 26 to 50 thus indicating higher religious commitment compared to 54 or 42.9% participants scoring religious commitment levels between 10 to 25 indicating lower religious commitment.

**Correlations between Variables**

Through statistical analysis, the relationships between each research variable were determined. The below section describes the correlations between the criterion variable and the predictor variables and correlations between the two predictor variables. The correlations are illustrated in table 7.

The correlation between the clinical preparedness and attitudinal awareness is $r$ = .23, which is a small, positive non-statistically significant relationship. Meaning clinical preparedness and attitudinal awareness have a small impact on each other. Specifically, when an LPC’s self-perception of being clinically prepared to work with LGBT clients goes up, then their perceived attitudinal awareness to work with LGBT clients goes up. Conversely, when an LPC’s self-perception of being clinically prepared to work with LGBT clients goes down, then their perceived attitudinal awareness to work with LGBT clients goes down.

The correlation between the clinical preparedness and religious commitment is $r$ = -.18, which is a small, negative or inverse statistically significant relationship. Meaning when LPC's self-perception of being clinically prepared to work with LGBT clients goes up, then LPC's religious commitment goes down. Alternatively, when LPC's self-

perception of being clinically prepared to work with LGBT clients goes down, then LPC's religious commitment goes up.

The correlation between the attitudinal awareness and religious commitment is $r$ = -.10, which is a small, negative or inverse non-statistically significant relationship. Meaning when LPC's attitudinal awareness of being clinically prepared to work with LGBT clients goes up, then LPC's religious commitment goes down. Alternatively, when LPC's attitudinal awareness of being clinically prepared to work with LGBT clients goes down, then LPC's religious commitment goes up.

Table 7

*Descriptive Statistics and Variable Correlations*

| Predictor | *M* | *SD* | *N* | Attitudinal Awareness | Religious commitment |
|---|---|---|---|---|---|
| Clinical Preparedness | 5.32 | .86 | 126 | .23* | -.18* |
| Attitudinal Awareness | 6.41 | .80 | 126 | - | -.10 |
| Religious commitment | 28.9 | 13.21 | 126 | -.10 | - |

*Note*. The asterisk* indicates statistical significant correlation at p = .05*Note*. Clinical preparedness high-level score would be considered 7 and low scores considered 1. Attitudinal awareness the high score would be considered 7 and low scores considered 1. Religious commitment high score would be considered between 26-50 and low scores considered between 10-25

## Model Assumptions

Before conducting the multiple regression assessing the extent of the relationship, if any, between clinical preparedness based on attitudinal awareness and with religious commitment as the moderator, model assumptions were assessed. No significant evidence was provided ($p > .05$) and skewness and kurtosis values were close to zero. Normal distribution was represented by the criterion variable scores, SW (126) = 0.14, $p < 0.05$ and normality were found among the criterion variable using the box plot as well. Normal distribution with standardized residuals were found, SW (126) = .93, $p < 0.05$. No curvilinear relationship was found between the criterion variable and the predictor variable after the scatterplots were analyzed for linearity.

## Multiple Regression and Comparative Moderated Multiple Regression for Statistical and Practical Significance

To test the null hypothesis, there is no statistically significant relationship, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as moderated by levels of religious commitment measured, two multiple regressions were conducted. According to Dietz and Kalof (2009), the first regression contains the following: interval level data criterion variable, interval level predictor variable, and the nominal level moderating variable. This initial regression obtains a baseline of the regression model to then compare with the moderating regression.

The second analysis was the moderated multiple regression containing the following: interval level data criterion variable, interval level predictor variable, the nominal level moderating variable, and interaction variable that consists of a re-coded predictor variable-by-dichotomous moderating interaction variable. The addition of the interaction variable would capture the influence, if any, of the moderating variable (religious commitment) on the model (Dietz & Kalof, 2009).

## Preparing the Moderated Variable for Comparative Moderated Multiple Regression

The moderating variable, religious commitment, was transformed to prepare it for inclusion in the multiple regression and moderated multiple regression. The first step was to turn religious commitment from an interval variable to a dichotomous, nominal variable for the initial multiple regression (Dietz & Kalof, 2009). Per Worthington et al.

(2003), religious commitment has a natural division between high religious commitment, which is considered between 26-50, and low religious commitment, which is considered between 10-25. The variable was dummy coded into these two categories based on each participant's interval scores. This coding of the religious commitment was used in the initial multiple regression only to assess the general model.

The second step in the transformation process was to create the interaction moderator variable. This consists of combining the predictor variable (self-perceived attitudinal awareness towards LGBT clients) and the moderating dichotomous variable (high/low religious commitment), which creates attitudinal awareness-by-dichotomous religious commitment (Dietz & Kalof, 2009). This coding of the moderating interaction variable was used only in the moderated multiple regression. The comparison of the initial multiple regression to the moderated regression is what captures the extent of the impact, if any, of the moderator on the model.

Initial multiple regression**.** I ran the initial multiple regression with the criterion variable of self-perceived clinical preparedness of working with LGBT clients, the predictor variable as self-perceived attitudes towards LGBT clients, and the nominal level moderator (behaving like a baseline predictor variable) as high/low religious commitment. The alpha level to determine statistical significance was set at .05. There was a statistically significant relationship between self-perceived clinical preparedness of working with LGBT clients, self-perceived attitudes towards LGBT clients, and high/low religious commitment, $F(2, 123) = 4.76$, $p < .05$ (see Table 8). Conservatively, a small

effect size was noted with 6% of the model was accounted for ($R2 = .07$, adjusted $R2= .06$).

Comparative moderated multiple regression. I ran the moderated multiple regression with the criterion variable of self-perceived clinical preparedness of working with LGBT clients, the predictor variable of self-perceived attitudes towards LGBT clients, and the created attitudinal awareness-by-dichotomous (high/low) religious commitment as the moderated interaction variable. The alpha level to determine statistical significance was set at .05. There was a statistically significant relationship when the interaction variable (attitudinal awareness-by-dichotomous religious commitment) was added to the model, $F(3, 122) = 3.43$, $p >.05$ (see Table 9). Conservatively, a small effect size was noted with 6% of the model was accounted for ($R2 =.08$, adjusted $R2=. 06$). Due to no statistically significant interaction effect, no further investigation into the impact of the moderating variable was needed.

Table 8

*Initial Multiple Regression Results for Clinical Preparedness*

| Predictor | B | SE | β | *T* | *P* | *sr*$^2$ | *rs*$^2$ |
|---|---|---|---|---|---|---|---|
| Clinical Preparedness | 3.978 | .613 | - | 6.479 | .000 | .072 | .057 |
| Attitudinal Awareness | .232 | .093 | .217 | 2.492 | .014 | - | - |
| | | | - | - | | | |
| Religious Commitment | -.243 | 1.50 | .141 | 1.617 | .108 | - | - |

Table 9

*Moderated Multiple Regression Results for Clinical Preparedness*

| Predictor | B | SE | β | *T* | *P* | *sr*$^2$ | *rs*$^2$ |
|---|---|---|---|---|---|---|---|
| Clinical Preparedness | 3.38 | .90 | - | 3.74 | .00 | - | - |
| Attitudinal Awareness | .32 | .14 | .30 | 2.34 | .021 | - | - |
| Religious Commitment | .84 | 1.21 | .49 | .69 | .492 | - | - |
| Attitudinal awareness-by- | | | | | | | |
| Dichotomous Religious | - | | | | | | |
| Commitment | .168 | .187 | -.63 | -.89 | .372 | .08 | .06 |

** Note: Dependent Variable: Clinical Preparedness Subscale

## Chapter Summary

A sample of 126 LPCs was surveyed to examine the relationship between clinical preparedness and attitudinal awareness as moderated by their religious commitment. An initial multiple regression analysis revealed a statistically significant relationship, with a small effect of 6% of the variance accounted for in the model, between clinical preparedness, attitudinal awareness, and high/low religious commitment. I conducted moderated multiple regression to account for the interaction effect of attitudinal awareness-by-high/low religious commitment, which revealed no statistically significant moderated relationship of the model. Therefore, the null hypothesis of there is no statistically significant relationship, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as moderated by levels of religious commitment, is not rejected.

The statistical descriptions explained the types of associations between clinical preparedness and attitudinal awareness when moderated by religious commitment. In chapter 5, I provide further interpretations of the statistical outcomes and results presented in chapter 4. I discuss the limitations and implications of counseling education and provide recommendations for counseling training and future research.

# Chapter 5: Discussion, Conclusions, Recommendation

## Introduction

In this section, I reiterate the significance of the study and discuss what methods were used to conduct the research. This section provides information on the findings from the data analysis, and I also describe the limitation, threats to validity, and reliability that arose from the study.

Prior researchers did not consider if there are relationships between LPCs' self-perceived clinical preparedness in working with LGBT clients and their self-perceived attitudinal awareness towards LGBT clients while using religious commitment as a moderator. Implicit bias, conservative values, and strong religious beliefs can negatively affect the development of LGBT counselor competency and the quality of counseling services for LGBT clients (Bidell, 2005, 2013; Bieschke et al., 2014; Farmer et al., 2013; Graham et al., 2012; Herek, 2009; Rainey & Trusty, 2007; Rutter et al., 2008). To address this concern, it is important to understand at what level attitudinal awareness and personal religious commitment correlate with counselors' self-perceived clinical preparedness to make changes in counselor education training. This study can solidify the integrity of the counseling field by showing counselors how assessing their clinical preparedness of working with LGBT clients and their religious commitment can better help counselors provide adequate health care for the LGBT community. Research addressing counselor self-awareness contributes to not only helping counselors' development as professionals but also ensures quality counseling services are provided to the public.

## Interpretation of the Findings

Convenience sampling was used to recruit diverse professional counselors in all four ACA regions of the United States (including the Midwest Region, North Atlantic Region, Southern Region, and Western Region; ACA, 2018). One hundred and thirty-six participants submitted the survey within a total of 6 weeks. Of the 136, only 126 or 92.6% of the individuals who provided consent were used for a total completion in the study. Participants who did not complete every question or responded as in Canada were not accounted for. Although the research consisted of many diverse demographic backgrounds, variables revealed that the majority of the LPC respondents were Caucasian (58 or 46%), age 31 (12 or 10%), heterosexual (77 or 61%), females (84 or 67%), and Christian (22 or 18%).

### Clinical Preparedness

The LGBT-DOCSS allowed participants to measure their clinical preparedness and attitudinal awareness (Bidell, 2017). Scores on the LGBT-DOCSS range from 1 to 7. Participants who score higher than 5 are considered more clinically prepared to work with LGBT clients. Those who score under 5 have low levels of clinical preparedness to work with LGBT clients. From the data results, I determined that out of 126 participants, 93 had a score over 5 and 33 had a score under 5 on the Clinical Preparedness subscale. More than 73% of the participants felt that they were clinically prepared to work with LGBT clients.

**Attitudinal Awareness**

The Attitudinal Awareness subscale measured the bias LPCs felt towards working with LGBT clients. A low score is less than a score of 5 on the Attitudinal Awareness subscale. A score lower than 5 indicates that the respondent is more prejudicial regarding working with LGBT clients. A high score implies that the participant felt less bias towards providing counseling to LGBT clients (Bidell, 2017). Among the 126 participants, 116 respondents scored higher than a 5, and 10 participants had a score under 5 on the Attitudinal Awareness subscale. The results from this self-assessment indicated that more than 92% of the participants felt that they were not biased or had prejudicial feelings toward working with LGBT clients.

**Religious Commitment**

I found that most of the participants considered themselves to have a high religious commitment. More than 57% considered their religious values when making life decisions. The RCI-10 is a 10-item self-assessment of religious commitment and was used to evaluate how LPCs' religious behavior influences their level of clinical preparedness (Worthington, 1988; Worthington et al., 2003). High religious commitment is considered in the range of 26 to 50, and low religious commitment is considered in the range of 10 to 25. Out of 126 participants, 72 or 57% scored between 26 to 50 and 54 or 43% scored between 10 to 25.

**Correlations**

I determined that there was a small, positive correlation between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards

LGBT clients. For example, as a participant's score of clinical preparedness increased, his or her associated score of attitudinal awareness was higher. Although the data revealed a small impact between the criterion variable and the predictor variable, I concluded that participants with more perception of being clinically prepared to work with LGBT clients also had a greater level of attitudinal awareness towards working with LGBT clients.

When discovering the correlation between self-perception of being clinically prepared to work with LGBT clients and religious commitment as a moderator, I found a small, negative inverse statistically significant relationship. As LPCs' self-perception of being clinically prepared to work with LGBT went up, their religious commitment went down. Also, the correlation between the attitudinal awareness and religious commitment resulted in a small, negative, or inverse non-statistically significant relationship. As LPCs' attitudinal awareness of being clinically prepared to work with LGBT clients went up, then LPCs' religious commitment went down.

**Multiple Regression**

Significance levels were found by running two multiple regressions. The initial multiple regression was conducted to distinguish the relationship between the criterion variable self-perceived clinical preparedness and the predictor variable attitudinal awareness. Significance levels were found by running two multiple regressions. The initial multiple regression was conducted to distinguish the relationship between the criterion variable, self-perceived clinical preparedness, and the predictor variable, attitudinal awareness. I found that the more LPCs felt clinically prepared and had a high

attitudinal awareness to work with LGBT clients, the lower their religious commitment. Alternatively, if the religious commitment score was higher than their perception of being clinically prepared and attitudinal awareness to work with LGBT clients was lower. I also determined that religious commitment had a moderating effect between the criterion variable, clinical preparedness, and the predictor variable, attitudinal awareness. The more LPCs were influenced by religious values, and religious commitment, the more impact religious values, and religious commitment had on their perception of being clinically prepared to work with LGBT clients.

My research findings are similar to Worthington et al. (2003) who claimed that evaluating the religious commitment of professionals in mental health can help uncover barriers with developing counselor competency. Evaluating religious commitment contributes to improving counselor education strategies, counselor supervision support, counseling theoretical frameworks, and teaching methodology to counseling LGBT clients (Borgman, 2009; Nickles, 2011; Worthington et al., 2003). From the data analysis, I determined that there was a statistically significant relationship between the criterion variable, the predictor variable, and the moderator religious commitment. The more religious values an LPC has, the more training and education they may need to feel clinical prepared to work with LGBT clients. I stopped reviewing here. Please go through the rest of your chapter and look for the patterns I pointed out to you. I will now look at your references.

In summary, the predictor variables showed a small significant relationship with the criterion variable. The analysis of this study provided evidence that out of 126 LPCs

more participants have a higher perception of being clinically prepared to counsel LGBT clients than those who have a lower perception of clinical preparedness of working with LGBT clients. Also, the results of the study determined out of the 126 LPCs there was a greater number of LPC participants who considered themselves to have high religious commitment. My research data revealed there is a statistically significant relationship between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as measured by the LGBT-DOCSS, as moderated by levels of religious commitment measured by RCI of LPCs. Therefore the null hypothesis of there is no statistically significant relationship, between self-perceived clinical preparedness of working with LGBT clients and self-perceived attitudes towards LGBT clients as moderated by levels of religious commitment, is not rejected and the alternative null hypothesis is rejected.

## Relationship of Findings in Prior Studies

In this section, I provided information from my literature review search that relates prior relevant study findings. I searched online under various key terms and combinations. The search terms included the following: *advocacy*, *LGBT ally*, *affirmative training/therapy*, *bisexual*, *counselor educator*, *culture*, *education*, *counselor competence*, *diversity*, *feminist*, *gay*, *gender*, *gender identity*, *heterosexism*, *lesbian*, *multicultural*, *queer*, *questioning*, *religion*, *religiosity*, *spirituality*, *social justice*, *licensed professional counselor*, *sexual identity*, *multi-culturalism*, *integrative*, *clinical supervisor*, *counselor supervision*, *heterosexual privilege*, *affirmative counseling*, *self-efficacy*, *minority*, *psychotherapy*, *counselor assessments*, *intersectionality*, *sexual orientation*, and

*transgender.* Surprisingly there was a gap in the literature concerning the influence of LPCs religious commitment to their perception of self-perceived clinical preparedness in working with LGBT clients. Below I describe various areas of counselor education research similar to my study.

While earlier studies tried to identify components of counselor competency with LGBT clients, empirically and comprehensively, they did not break down the complexity of how a counselors' religious commitment and counselor competency with LGBT clients. Sue and Sue (2007) brought forth the need for using multicultural counselor theoretic frameworks for self-exanimating attitudes and feelings associated with cultural differences for counseling training. In my research attention was given to LPC's multi-level identity traits such as skills, attitudinal awareness, and religious commitment to see how these characteristics associate self-perceived confidence in working with LGBT clients. As in prior studies, counselor training models were developed based from research by multicultural theorists (Bidell, 2014; Israel & Hackett, 2004; Sue & Sue, 2007) to discover effective counseling conceptualization strategies, training models, and counselor education curriculum.

The closest study found is Bidell (2017) which established consistent reliability and validity of the instrument LGBT-DOCSS. Bidell explored correlations of the LGBT-DOCSS subscales with the RWS-S scale, GTS-R-SF, LGBT-CSI, and the MCSD-SF-A Scale to test convergent and discriminant validity. Alternatively, I determined correlations between the LGBT-DOCSS Clinical Preparedness subscale, Attitudinal Awareness subscale, and the RCI-10. My sample population demographic characteristics

were similar to Bidell's study with the majority of my participants reporting they were Caucasian and female. However, Bidell recruited healthcare professionals and undergraduate students in counseling programs in the United States and the United Kingdom, while I, on the other hand, used LPCs in the United States. Unlike my study, Bidell examined the association of self-perceived clinical preparedness in working with LGBT among advanced professional health care positions and advance education and determined those participants with higher scores were in more advanced education levels and professional positions. Similar to my study I found high levels of self-perceived clinical preparedness in working with LGBT clients among LPCs.

Also, using the SOCCS, Bidell (2014) found LGBT course attendance was a significant predictor of students self-perceived counselor competence in working with LGBT clients. Bidell indicated sexual orientation competencies have a significant relationship with the number of years or amount of affirmative training and multicultural courses students have completed. This study is related to my study assumptions and also concludes more affirmative training and advancement in counselor credentialing leads individuals to feel more prepared to work with LGBT clients.

In a mixed method study by Grove (2009) evaluated counselor education students to discover how years in counselor education training and LGBT counseling learning experiences were associated with self-perceived LGBT counselor competence. Fifty-eight counselor education students participated in the quantitative section of the study with an additional 15 counselor education student completing a questionnaire to gather qualitative data. Grove (2009) distinguished significant higher levels among counselors-

in-training in SOCCS knowledge and skills subscales as the years of training increased. Comparable to Gove's study my study also sampled a population with higher levels of counseling training than prior studies and overall the LPCs felt they were clinically prepared to work with LGBT clients.

On the other hand, Grove (2009) found there were no significant changes in the SOCCS awareness subscale when students reported an increase of years in counselor training. Grove concluded participants reported personal beliefs of sexual orientation were factors of self-perceived counselor competence growth. Grove revealed participants felt counselor competence growth was related to participating in various activities within the LGBT community. Grove found similar results found in my study. My study data reinforced the need to evaluate personal beliefs to predict self-perceived clinical preparedness for working with LGBT clients.

Also, contrary to my study results finding higher RCI-10 scores were associated with lower attitudinal awareness, Nickles (2011) found counselors who reported higher religiosity also reported higher contributions in helping others in community service, human rights efforts, and advocacy projects. In comparison, the findings in my study indicated although counselors with high religious values may want to make efforts towards advocating for human rights, they still reported to have some unconscious biases that may impede on counseling individuals in the LGBT community.

Ultimately, my study differs from the studies mentioned above because the LGBTDOCSS includes questions regarding self-perceived clinical preparedness and additional awareness for counseling transgender clients. Most interests in counselor

education research about working with LGBT clients focused on evaluating counselor competence preparation instead of bringing attention to how a counselor's personal bias, belief, or values affect counselor professional practice. In summary, it is noted from my study as LPCs report having a high commitment towards religious values they tend to lack confidence in clinical preparedness and attitudinal awareness in working with LGBT clients.

## Limitations of the Study

The limitations of this study are outlined in chapter 1 and this section; I further discussed information related to limitations regarding the sampling method, convenience sampling, generalizability, and research design. My study was considered a non-experimental survey research design. Therefore maturation, instrumentation, mortality, and diffusion of treatment did not pose any internal or external validly threats. Re-testing did not occur; the directions instructed the participants to complete the research survey only once. Therefore regression may have posed a threat to internal validity. Further limitations and validity information is discussed below.

Graham, Carney, and Kluck (2012) specified studies using self-reported data always hold limitations and risks for reliability. Using quantitative data did provide statistically descriptive information. However, it is important to note using qualitative data could help expand details and reveal information regarding LPCs individual experiences with religious commitment, attitudinal awareness, and self-preparedness in working with LGBT clients. As Graham et al. noted self-perceived evaluations are opinions, therefore there are limits in knowing if the participants may embellish

knowledge or answer in a favorable light. To reduce this internal threat, confidentiality and boundaries of disclosure information were given in the consent form at the beginning of the research survey. All participants were given 24 hours of access to complete the survey, and all participants were allowed the same timeframe to complete the survey from March 28, 2018, to April 16, 2018.

The recruitment sampling resources were limited to only ACA Connect forums and Psychology today message boards. Due to specific recruitment sampling criteria, generalizability was limited to LPCs. LPC is a broad term, and participants from counseling settings such as marriage and family, addictions, military, community, or medical settings are all considered in recruitment sampling (Kaplan et al., 2014). The study did not include a psychiatrist, neurologist, or psychologist. More specifically, counselor specialties were not documented; therefore, some participants may have other credentials geared toward working with mental health client populations compare to others. All participants were recruited anonymously and were not able to reveal details of their job description, years of practice, or if they were currently in counseling practicing. Future research using mental health professionals as the target population can be clarified for further data analysis.

## Implications for Social Change

Few studies address the relationship between LPCs' religion and their perception of being prepared to work with LGBT clients. It is important to address the gap in literature to promote positive change and ensure counselors are equipped with the knowledge to continue as agents of change. Counselor's competence in diverse and oppresses

populations is an important area to address these social change efforts. Whitman and Bidell (2014) noted when counselors-in-training uncover religious barriers they then can address values or lifestyle differences in training with guided supervision and decide whether they will avoid or refer LGBT client populations to alternative counseling practices. In the below section I provide additional information linking this study to the implications of social change.

When comparing prior studies, I found a few had similar results as my data concluded. For example, authors, O'Shaughnessy and Spokane (2012) found positive attitude levels among 212 counselors-in-training, showed more accurate responses of case conceptualization for LGBT clients. I also concluded from my research data among LPCs higher self-perceived attitudinal awareness in working with LGBT clients a predictor of higher clinical preparedness for working with LPC clients. In their results, data showed associations between high levels of LGBT counselor competence to high levels of self-reported LGBT counseling competency. Also, with this information, counselor supervisors can keep in mind the more LGBT counselor competencies are obtained, the more confident counselors-in-training feel to counsel various LGBT client populations. Though this finding help expands knowledge and direct standards about counselor education curriculum requirements in training, future research should not be limited to master's- level graduate students or counselors-in-training. For this reason, future studies should focus on recruiting LPCs as my research did to ensure focus is on self-evaluation of clinical preparedness among professionals who are already providing counseling services.

The results in this study provide the opportunity for counselor educators to facilitate self-perceived assessment tools in training, obtain the proper skills to counsel after self-reflection and build teaching curriculums to identify the need to educate counselor about religious values and self-perceived clinical preparedness for counseling practice with LGBT clients. Parent et al. (2013), noted feminists' approaches help counselors understand experiences of gender and racial bias, identify class systems in society and encourage ideas of gender differences in counseling. My research used multicultural counseling competency and feminism theoretical frameworks to connect how a counselor's diverse characteristics and multi-layers of demographic backgrounds impact counselor education and supervision

The statistical data from my research is evidence there is an inverse relation between self-perceived clinical preparedness and religious commitment. Although prior research addressed counselor competence with lesbian, gay and bisexual clients, this study brought attention to counselors perceived clinical preparedness in working with clients that are in the transgender population. The study findings promoted insight into the need for counselors to understand how their social experiences, personal values, and lifestyle are related to how prepared they feel with working with LGBT clients. I conducted this research to bridge the gap in the literature by providing important statistical information to add to social change efforts in the counseling profession.

## Recommendations for Professional Practice

Counselor education and counselor in training must meet the increasing demand for mental health services among oppressed groups and marginalized populations.

Graham et al. (2012) identified counselors felt inadequate in their ability to conceptualize LGBT client intervention strategies. Israel and Hackett (2004) indicated participants reported the lack of knowledge and bias treatment are due to limited literature, restrained heterosexual counselor training models, and insufficient LGBT counseling training techniques. Concerns regarding these limitations of counselor training have sparked an increase in research necessary to examine affirmative-LGBT counseling training. The LGBT population is constantly expanding characteristics. Future research may benefit from including the LGBT-DOCSS survey tool because this assessment has questions about clinical preparedness in counseling transgender clients. Furthermore, adding counselor religious values as a component to identify counselor training needs would be helpful.

Counselor education studies have exhibited the importance of uncovering institutional policies or practices to ensure personal or institutionalized beliefs do not interfere with the ability to train cultural-competent professionals (Bidell, 2005; Bidell, 2014; Bidell, 2016; Farmer et al., 2013; Graham et al., 2012; Rutter et al., 2008; Walker & Prince, 2010). Training students to acknowledge unique individual experiences reduces biased case conceptualization to accurately provide intervention strategies for LGBT clients seeking support (Israel et al., 2008; Robinson-Wood, 2009). Bidell (2014) indicated sexual orientation competencies have a significant relationship with the number of years or amount of affirmative training and multicultural courses students have completed. Falender et al. (2014) conducted an experimental study and found activities, assignments, and professional speakers helped to facilitate LGBT counselor training and

increased competency among counselors-in-training. Adding religious assessment and self-perceived evaluations for working with LGBT clients at the beginning of counselor education master's programs will help counselors-in-training fully develop the skills, knowledge, and experiences needed to counsel LGBT clients adequately.

Prior research using LGBT-affirmative counselor education and training concluded multicultural and feminist theoretical models help students become more competent with addressing experiences common among LGBT clients (Bidell & Whitman, 2014; Halpert et al., 2007). Counselor educators could provide counselors-in-training with more opportunities to explore their unconscious bias before they begin counseling LGBT clients. By initiating this process in class or during counselor practicums, results may help modify the desire and uncover confidence levels in working with LGBT clients. Nickles (2011) discussed integrating spirituality and own belief system in counseling helps to maintain and encourages a positive rapport in the therapeutic relationship. As mentioned by Stoltenberg and Delworth, (1987), using the IDM during each stage the supervisor supports the supervisee by addressing the supervisees' need for development. It is important for counselor supervisors to continue to facilitate more self-reflection among counselors-in-training.

## Summary

Overall, the findings from my study concluded LPCs believe they are clinically prepared to provide counseling to LGBT clients and feel they are not biased towards working with LGBT clients. Based on my sample population, LPCs are not only confident in clinical preparedness for working with LGBT clients but feel they have more

attitudinal awareness towards working with LGBT clients. Although my study findings show assertion in working with LGBT clients among LPCs, the findings suggest adverse interaction when introducing religious commitment as a moderator. More specifically, measures of high religious values among LPCs were associated with low levels of confidence in self-perceived clinical preparedness and attitudinal awareness in working with LGBT clients. With understanding the associations between clinical preparedness and religious commitment we can infer religious values and beliefs may pose a conflict with proper case conceptualization for LGBT clients. Results suggest there is a need for LPCs who plan to provide counseling to LGBT clients to consider measuring their religious commitment and determine if their level of religious commitment may influence their levels of clinical preparedness in working with LGBT clients. In all, my research findings promote social change among LPCs by bringing attention to uncovering personal barriers that may be hindering counseling for individuals in the LGBT community.

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# Appendix A: ASERVIC Competencies

ASERVIC Competencies

Culture and Worldview

1. The professional counselor can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.

2. The professional counselor recognizes that the client's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning.

Counselor Self-Awareness

3. The professional counselor actively explores his or her own attitudes, beliefs, and values about spirituality and/or religion.

4. The professional counselor continuously evaluates the influence of his or her own spiritual and/or religious beliefs and values on the client and the counseling process.

5. The professional counselor can identify the limits of his or her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and spiritual resources, including leaders, who can be avenues for consultation and to whom the counselor can refer.

Human and Spiritual Development

6. The professional counselor can describe and apply various models of spiritual and/or religious development and their relationship to human development.

Communication

7. The professional counselor responds to client communications about spirituality and/or religion with acceptance and sensitivity.

8. The professional counselor uses spiritual and/or religious concepts that are consistent with the client's spiritual and/or religious perspectives and that are acceptable to the client.

9. The professional counselor can recognize spiritual and/or religious themes in client communication and is able to address these with the client when they are therapeutically relevant.

Assessment

10. During the intake and assessment processes, the professional counselor strives to understand a client's spiritual and/or religious perspective by gathering information from the client and/or other sources.

Diagnosis and Treatment

11. When making a diagnosis, the professional counselor recognizes that the client's spiritual and/or religious perspectives can a) enhance well-being; b) contribute to client problems; and/or c) exacerbate symptoms.

12. The professional counselor sets goals with the client that are consistent with the client's spiritual and/or religious perspectives.

13. The professional counselor is able to a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint.

14. The professional counselor can therapeutically apply theory and current research supporting the inclusion of a client's spiritual and/or religious perspectives and practices.

# Appendix B: Participation Invitation

My name is Kimberly Patterson, and I am a doctoral student at Walden University. I am interested in discovering the relationship if any between self-perceived clinical preparedness of working with lesbian, gay, bisexual, and transgender clients and self-perceived attitudinal awareness towards lesbian, gay, bisexual, and transgender (LGBT) clients as moderated by levels of religious commitment of Licensed Professional Counselors. Counselors feeling inadequately prepared to serve the LGBT clients remains a major problem. Because this is the case, evaluating licensed counselors in clinical preparedness of working with LGBT clients can be invaluable resources in confronting this critical social problem.

Please take a few minutes to complete the following demographic questionnaire and assessments. The questionnaire and assessment should take about 15-30 minutes. The demographic questionnaire will solicit information such as personal identification. The assessment tools used in this survey are called the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) and the Religious Commitment Inventory (RCI). The LGBT-DOCSS was developed to measure licensed professional counselor's perceptions of clinical preparedness, and attitudinal awareness, and knowledge for working with LGBT clients. The RCI-10 was developed to evaluate how an individual religious behavior influences their lifestyle values.

All information gathered will remain confidential, and all participants will remain anonymous. Participation in the study is completely voluntary, and you may discontinue participation at any time. My research information and participants results will be shared from the link below.
https://kimberlypatterspn.wixsite.com/professionalsite

Questions or concerns may be directed to Kimberly Patterson. You can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu.

Thanks in advance,
Kimberly Patterson, MS LPC-S NCC
Doctoral Student AT Walden University

Appendix C: Follow up Participation Invitation

My name is Kimberly Patterson, and I am a doctoral student at Walden University. I am interested in discovering the relationship if any between self-perceived clinical preparedness of working with lesbian, gay, bisexual, and transgender clients and self-perceived attitudinal awareness towards lesbian, gay, bisexual, and transgender clients as moderated by levels of religious commitment of Licensed Professional Counselors. Counselors feeling inadequately prepared to serve the LGBT clients remains a major problem. Because this is the case, evaluating licensed counselors in clinical preparedness of working with LGBT clients can be invaluable resources in confronting this critical social problem.

Just as a reminder, I am asking you to take a few minutes to complete the following demographic questionnaire and assessments. **If you have already completed this questionnaire, I extend my gratitude. Please do not complete the research survey a second time, though you may extend the invitation to other participants you believe may qualify.** The questionnaire and assessment should take about 15-30 minutes. The demographic questionnaire will solicit information such as personal identification. The assessment tools used in this survey are called the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) and the Religious Commitment Inventory (RCI). The LGBT-DOCSS was developed to measure licensed professional counselor's perceptions of clinical preparedness, and attitudinal awareness, and knowledge for working with LGBT clients. The RCI-10 was developed to evaluate how an individual religious behavior influences their lifestyle values.

All information gathered will remain confidential, and all participants will remain anonymous. Participation in the study is completely voluntary, and you may discontinue participation at any time. All information gathered will remain confidential, and all participants will remain anonymous. Participation in the study is completely voluntary, and you may discontinue participation at any time. My research information and participants results will be shared from the link below.
https://kimberlypatterspn.wixsite.com/professionalsite

Questions or concerns you can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu.

Thanks in advance,
Kimberly Patterson, MS LPC-S NCC
Walden University Doctoral Student

Appendix D: Demographic Questionnaire

The demographic information questionnaire will ask participants to report their ethnicity, age, gender, sexual orientation, religious orientation, and state of residence.

1. Gender:

   Male

   Female

   Transgender

   Prefer not to say

2. What is your sexual orientation?

   Gay

   Lesbian

   Bisexual

   Heterosexual

   Other/Not listed above

   Prefer not to report

3. What is your age range? __________________

4. Please identify your Race/ethnicity:

   Asian (East, South, Asian American)

   Indian American

   Middle Eastern

   Arab American

Pacific Islander

African American/Black

Afro-Caribbean

Caucasian/White

Latino or Hispanic American

Mixed race (please describe) _________

Other: ______________________

5. When someone asks, “What religion are you?” How do you reply?

Orthodox

Christian

Jehovah's Witness

Christian, Non-Denominational

Mormon/Latter-day Saints

Muslim-Sunni

Muslim-Shi’a

Muslim-Other

Hindu

Sikh

Taoist/Confucian

Buddhist

Jewish

Jain

Baha'i

Scientologist

Pagan

Catholic

Anglican

Protestant

Baptist

Methodist

Lutheran

Presbyterian

Pentecostal

Episcopalian

Pantheist

Wiccan

I believe in something I call "God" but do not have a religion.

I am Spiritual but do not have religion.

Unitarian Universalist

Humanist

Agnostic

Atheist

I do not have a religion, and I do not believe in "God."

Other Label, Religious (please specify) _______

Other Label, Non-Religious (please specify) _______

Other (please specify) ___________

6. Please list the state of residence:

Alabama

Alaska

Arizona

Arkansas

California

Colorado

Connecticut

Delaware

Florida

Georgia

Hawaii

Idaho

Illinois

Indiana

Iowa

Kansas

Kentucky

Louisiana

Maine

Maryland

Massachusetts

Michigan

Minnesota

Mississippi

Missouri

Montana

Nebraska

Nevada

New Hampshire

New Jersey

New Mexico

New York

North Carolina

North Dakota

Ohio

Oklahoma

Oregon

Pennsylvania

Rhode Island

South Carolina

South Dakota

Tennessee

Texas

Utah

Vermont

Virginia

Washington

West Virginia

Wisconsin

Wyoming

Other please specify: _____

Appendix E: Permission Email to Use The LGBT-DOCSS

Markus P Bidell <mbidell@hunter.cuny.edu>

Sat 7/22, 6:26 AM

Kimberly Patterson

Inbox

Kimberly – You have my permission to use the LGBT-DOCSS in a research study.

Good Luck, Dr. Bidell

---

Markus P. Bidell, Ph.D.

Associate Professor

Educational Foundations & Counseling

Hunter College - 695 Park Avenue, NY, NY 10065

And

Associate Professor of Clinical Psychology

Clinical Psychology at Queens College

CUNY Graduate Center

mpbidell@hunter.cuny.edu

...

Appendix F: Permission to use the RCI

College of Humanities and Sciences
Department of Psychology

White House
806 West Franklin Street
P.O. Box 842018
Richmond, Virginia 23284-2018

804 828-1193 • Fax: 804 828-2237
TDD: 1-800-828-1120
www.psychology.vcu.edu

You have my permission to use the RCI-10. I included information you need to administer, score, interpret, and reference it. I wish you well with your research.

Everett L. Worthington, Jr.

Ev