Broaching Style and Multicultural Counseling Competence Explored in the Context of Sexual Orientation

by

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Abstract

The present study explored counselors-in-training (CITs) and their self-perceived competency in their work with lesbian, gay, and bisexual (LGB) clients along with their perception of broaching behaviors with this population. Broaching is often presented as a skill that can be used consistent with multicultural counseling competence (MCC; Day-Vines et al., 2007). This study hypothesized that individuals who endorsed having an advanced level of broaching should be able to accurately rate another therapists' MCC.

CITs who participated in this study were randomly assigned to one of three vignettes portraying a first session therapy exchange between a therapist and a gay-identified client. The three vignettes differed in the amount and level of broaching style used by the therapist from a welcoming approach to an avoidant approach, and to a shut down approach. Results indicated that CITs were able to distinguish overall quality of therapy between the welcoming portrayal of therapy (i.e., the most advanced level of broaching in this study) and the shut down portrayal of therapy (i.e., no representation of broaching). Additionally, participants were able to distinguish between the avoidant portrayal of therapy (i.e., the least advanced level of broaching) and the shut down portrayal of therapy (i.e., no representation of broaching).

The results of this study also found that participants were able to differentiate the levels of MCC of the therapist in the vignettes in that all three vignettes were rated significantly different on a measure of MCC. Participants' self-reported competence with LGB clients was

explored and the level of competence participants reported did not predict their ability to rate whether a therapist was portraying MCC. Additionally, the participants' self-reported broaching styles did not predict their ability to differentiate MCC. Overall, this study has training implications and implications for work with LGB clients. This study's results also call into question the utility of self-report measures and their ability to measure competence.

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Thank you to my family and to others who have loved and supported me through this process. When I think of my success, I think of you. Thank you with my deepest gratitude. I would not be where I am without you and I would not be who I am without you. Thank you for instilling a belief in me that I can do and be whoever and whatever I want. I love you all. Proverbs 31:25. She is clothed with strength and dignity, and she laughs without fear of the future.

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CHAPTER 1. INTRODUCTION

Multiculturalism has been coined the field of psychology's "fourth force" (Pedersen, 1991). This force in psychology has been paid heightened attention in mental health professional organizations, the field's literature, graduate training programs, in the counseling relationship, and in theoretical underpinnings of approaches to counseling. According to the broad definition of culture, each counseling relationship is multicultural because each individual is multicultural (Pedersen, 1991). Therefore, a clinician's ability to provide competent multicultural therapy has become a focus in the field.

Researchers have studied the effect of addressing culture and multicultural concerns with clients in therapy (Cardemil & Battle, 2003; Chang & Yoon, 2011; Day-Vines, Bryan, & Griffin, 2013; Day-Vines et al., 2007; Eubanks-Carter, Burckell, & Goldfried, 2005; Hays, 1996; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Mair & Izzard, 2001; Tsai, 2013; Zegley, 2007; Zhang & Burkard, 2008). This research indicates that clinicians who adapt their therapy through a multicultural framework provide more effective therapy than "bonafide" therapy (Gaztambide, 2012; Imel et al., 2011). Therefore, it is imperative for graduate programs to train students to adapt their therapy based on their clients' multicultural concerns. Graduate students who have participated in studies regarding their self-perceived levels of multicultural counseling competence (MCC) in therapy reveal a need for graduate programs to find ways to bolster students' knowledge, skills, and awareness in the area (Cartwright, Daniels, & Zhang, 2008). Although students report that they perceive themselves as able to provide multicultural-

competent therapy in a general sense, students report that they experience their largest deficit in the skills area of the delivery of multicultural-competent therapy (Cartwright, Daniels, & Zhang, 2008; D'Andrea, Daniels, & Heck, 1991; Holcomb-McCoy & Myers, 1999).

Increased attention has been paid to training in the area of MCC. For example, Ponterotto, Alexander, and Grieger (1995) have created a checklist to guide multicultural program development. Their checklist includes coursework, minority representation, counseling supervision, research, student and faculty competence evaluation, and the graduate training program environment. For the past 15 years, leaders in the field have focused increased attention on these aforementioned competencies in order to build the skills, attitudes, and knowledge base needed for trainees to conduct multicultural-competent therapy (Manese, Wu, & Nepomuceno, 2001).

The aforementioned deficit in MCC reported by students in mental health graduate programs is also found for students' work with LGB clients. That is, counselors-in-training (CITs) tend to report inadequate self-perceived competency in their work with LGB clients, and especially in the area of "skills" (Bidell, 2005; Graham et al., 2012; Grove, 2009; Kocarek & Pelling, 2003; Rock, Carlson, & McGeorge, 2010). The literature does not provide a concise suggestion for bridging this gap in competence; however, it has been found that training students on the skill and theory of broaching could be a start (Cardemil & Battle, 2003; Mair & Izzard, 2001; Zhang & Burkard, 2008). In the literature, broaching is proposed as a skill that can be used in therapy. As such, broaching can be used as a therapist's intervention in therapy and can involve explicitly "bringing up" client concerns, especially related to clients' multicultural characteristics (Day-Vines, Bryan, & Griffin, 2013). Broaching can be seen as an answer to the

call in the literature for increased behavioral intervention in the area of counseling skills related to multicultural counseling, beyond a focus on knowledge and attitudes.

The process of addressing race and others forms of culture has been coined "broaching" by Day-Vines and colleagues (2007). Broaching refers to a therapist's effort to continually invite clients into exploring issues of diversity in the therapy room (Day-Vines, 2007). The technical skill of broaching was introduced into the literature and clinical practice before it was coined "broaching" (Clarkson & Nippoda, 1997; Sue et al., 1982). Therefore, the formal definition of broaching is a therapists' actionable invite into exploring issues of diversity with clients (Day-Vines, 2007). Broaching encompasses the process of how counselors translate cultural knowledge into meaningful therapeutic practice. First, counselors must consider how sociopolitical factors influence the client's concerns and then recognize how clients relate their individual cultural to their presenting therapy concerns (Day-Vines et al., 2007). Day-Vines and colleagues identified broaching as a measurable multicultural skill. Broaching has been shown to have a positive impact on the therapy relationship, the client's perception of therapists' competency/credibility, and on the perception of the therapists' MCC (Cardemil & Battle, 2003; Chang & Yoon, 2011; Day-Vines et al., 2007; Eubanks-Carter et al., 2005; Hays, 1996; Knox et al., 2003; Tasi, 2013; Zhang & Burkard, 2008). Additionally, broaching has been shown to enhance positive counseling outcomes and the overall therapeutic alliance (Asay, 2006; Cardemil & Battle, 2003). For example, broaching and middle school counselors' self-reported level of MCC were related, and advanced attitudes toward broaching were predictive of MCC (Zegley, 2007). Additionally, Zegley (2007) found that even rudimentary attempts at broaching behavior in the therapy room might also be predictive of MCC. The majority of the studies in the

literature focus on broaching as related to race and ethnicity. Thus, other forms of cultural identity, such as sexual orientation, are relatively absent in the current literature.

Based on available studies, the broaching behaviors of CITs reflect the need for more training in graduate programs on this multicultural skill (Sue, Rivera, Capodilupo, Lin, & Torina, 2010). Specifically, studies reflect CITs' verbal avoidance behaviors with clients who identify as LGB. Studies have shown that clients have felt discouraged from discussing their sexual identity with their counselors when their sexual orientation was silenced or not explored adequately by a therapist (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993; Mair & Izzard, 2001). Furthermore, studies have found that CITs do not broach sexual orientation in therapy due to feeling self-conscious about offending their clients or appearing prejudiced against LGB (Devine, Evett, & Vasquez-Suson, 1996). Therefore, clients could mistake CITs' anxiety for apathy (Eubanks-Carter et al., 2005). Although CITs generally report that they see themselves as competent in multicultural work with LGB clients (Graham et al., 2012), there appears to be a gap in the literature between self-proclaimed competence and actual broaching behavior as a skill used in therapy.

Studies generally measure MCC, competence in work with LGB clients, and the clinician's broaching using self-report instruments. The Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), the Cross-Cultural Counseling Inventory (CCCI; LaFromboise, Coleman, & Hernandez, 1991) the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996) and the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS; D'Andrea et al., 1991) are some of the most common instruments implemented to assess MCC. The MCAS is the most widely used instrument to assess MCC currently, established by Constantine and Ladany in 2000.

Self-report measures aimed at evaluating CITs' competence in multicultural counseling, and more specifically competence to work with sexual orientation minorities, represents a first step in understanding the cultural competence of CITs (Worthington, Mobley, Franks, & Tan, 2000). However, self-report is not necessarily accurate. In cases where the subject is one's competence in a highly valued area within the profession, self-report may be subject to even more biased responding than typically present in measures (Daniels, & Zhang 2008; Hays, 2008; LaFromboise et al., 1991). The overestimation of skills and knowledge are most common in self-report measurement of MCC (Hays, 2008).

Purpose of the Study

The current study investigated CITs' self-perceived competency in work with LGB clients and their perceptions of broaching behaviors with these clients in the delivery of therapy based on a therapy vignette. Thus, the skill of broaching in work with LGB clients was a focus of this study. Because broaching is considered one part of multicultural-competent therapy, individuals who devalue broaching should not have a high level of MCC regardless of level of self-reported MCC. Thus, perceptions of the MCC of a therapist within a potential broaching behavior scenario (within vignettes) served as an approximation for CITs' skills. Again, those who are truly high in MCC should not rate a therapist who demonstrates a lack of or poor broaching behavior, defined as Avoidant and as shut down in this study, as having MCC.

Although perceptions of broaching as a skill are only an approximation for behaviors during therapy sessions, this approach provides another angle from which to explore CITs' competence in working with sexual-orientation minority clients. It is reasonable to expect that counselors who see a behavior as good therapy would be more likely to try to emulate the behavior in sessions with clients and those who perceive a behavior as reflecting poor therapy

would avoid the behavior. If perceptions of broaching as a behavior in session relate to what CITs might do in a similar situation (which when used as part of the methodology of a study by Zegley [2007] supported such an assumption), the present study may further add to our understanding of competence of CITs in working with sexual-orientation minority clients. These questions are important due to the current gaps in the literature regarding self-perceived multicultural competence and actual counseling skills related to this competency.

After conducting a literature review, it was found that research on CITs (from counseling psychology, clinical psychology, and counselor education) and their broaching behaviors with LGB clients is absent. In fact, only one dissertation has focused on MCC and broaching with school counselor students (Zegley, 2007). A qualitative dissertation by Tsai (2013) focused on LGB clients' experiences of discussing sexual orientation in therapy. A similar study conducted by Asay (2006) was completed with LGB identified clients who read one of three vignettes of therapist's approaches to discussing sexual orientation in. No studies were found using PsychInfo or PsycArticles that examined the behavior of counselors or CITs in broaching the topic of sexual orientation with clients, and no studies explored CITs' perceptions of broaching when illustrated within a therapy session or vignette of therapy (which is different from attitudes toward broaching).

Problem

Much of the current literature on the topic reflects the idea that the status-quo for training does not properly equip CITs with the MCC specific to work with LGB clients (Godfrey, Haddock, Fisher, & Lund, 2006; Graham et al., 2012: Lidderdale, 2009; O'Shaughnessy & Spokane, 2013). Additionally, the skill of broaching as a behavior does not appear to be integrated into training in graduate programs as a vital tool for use with LGB (Day-Vines et al.,

2007; Zegley, 2007). The lack of discussion of sexual orientation in the therapy process leaves a significant barrier to effective therapy (Tsai, 2013). At the same time, it is difficult to know if the use of self-report as a measurement strategy is effective for evaluating MCC specific to work with LGB clients. If self-report is inaccurate, it is possible that the field is (a) doing better than we think in training CITs or (b) even further behind than we think in training CITs.

Significance to Counseling Psychology

This dissertation examined the relationship between training and MCC. This dissertation also evaluated the utility of self-report measures in these domains because self-report may not be accurate in predicting MCC (Hays, 2008). Overall, this dissertation adds to the evidence that training programs and the mental health field may need to identify new ways to effectively evaluate MCC. The skill of broaching as applied to work with LGB clients was also a focus of the current study; therefore, this study can provide a bridge to the gap in the literature regarding self-perceived competency in work with LGB clients and the potential implementation and value (or lack) of broaching as one skill that can be used to work competently with this population.

Definition of Terms

Attitudes in therapy with LGB clients: In this study this was measured by the "Attitudes" subscale on the Sexual Orientation Counselor Competency Scale. This subscale measures the counselor's direct clinical experience with LGB clients (Bidell, 2005).

Broaching: Day-Vines and colleagues (2007) coined the term broaching as "the counselor's ability to consider how sociopolitical factors such as race influence the client's counseling concerns" (p. 401). This term is seen as paramount in the counseling process as not only an attitude or consideration, but as a behavioral skill because if the counselor does not address subjects such as race, ethnicity, and culture during the counseling process, these issues

may remain unexamined. Therefore, broaching has been conceptualized as a measureable multicultural skill (Day-Vines et al., 2007). Broaching a client's "culture" includes work with individuals who identify as LGB. In this study, a few different constructs related to broaching were included: self-perceived broaching style and broaching behavior of a counselor related to bringing up issues of sexual orientation with clients in therapy. In the latter case, broaching means that the therapist introduced the topic of sexual orientation and offered to explore the subject with the client.

Broaching Style: In this study, broaching style referred to the way in which counselors have explicit discussions about sexual orientation in therapy. The Broaching Attitudes and Behaviors Survey (Day-Vines, Bryan, & Griffin, 2013) was used in this study to identify participants' broaching styles. Counselors can assume five broaching orientations; however, because no empirical support was found for the Isolating subscale, this style was not used in this study. Participants' scores on the Avoidant, Continuing/Incongruent, Integrated/Congruent, and Infusing subscales were used to define each participants' broaching style in that participants' highest score was used to describe their main broaching style. It was observed that no participant had identical scores on two different scales, which was interpreted to mean that no participant had two broaching styles that both served as their primary style. In addition, scores on all styles were used for analyses that examined the extent to which particular broaching styles relate to other variables.

Counselors-in-training (CITs): In general refers to those graduate students who are studying to be mental health professionals. For this study, a CIT was an individual who was obtaining a doctoral or master's degree in counseling or community mental health, counseling psychology, clinical psychology, social work, or counselor education.

Culturally Competent Therapy: In this study, this was operationalized by the extent to which the therapist in the vignette actively invited the client to discuss and consider how his sexual orientation may or may not fit into his current clinical concerns (determined by broaching and the ratings on a measure of cross cultural counseling competence by the participant in the study).

Knowledge in therapy with LGB clients: In this study this was measured by the "Knowledge" subscale on the Sexual Orientation Counselor Competency Scale. This subscale measures the counselor's understanding of mental health issues specific to LGB clients.

Ratings of therapist's multicultural competence: In this study, the participants' rating of the therapist's multicultural competence in the exposure vignette measured multicultural competence. Specifically, the therapist's multicultural competence in the vignettes was assessed following the exposure vignette the participants read. The participant rated the therapists' multicultural competence using the Cross-Cultural Counseling Inventory-Revised (CCCI-R).

Self-reported LGB counseling competence: Refers to a counselor's perception of his/her own ability to effectively work with LGB clients. In this study, competency was measured as a self-reported construct as defined by Bidell's (2005) measure (the Sexual Orientation Counselor Competency Scale–SOCCS), which assesses attitudes, skills, and knowledge of counselors who work with LGB clients. Total scale scores were used to represent overall self-reported competence in CITs. The skills, attitudes, and knowledge subscales make up the full SOCCS measure.

Skills in therapy with LGB clients: In this study this was measured by the "Skills" subscale on the Sexual Orientation Counselor Competency Scale. This subscale measures the counselor's attitudes and prejudice about LGB individuals.

Vignettes: Vignette A represented the highest level broaching behavior and of culturally competent therapy, followed by Vignette B, followed by Vignette C. Vignette C represented the least culturally competent therapy. Specifically, Vignette A portrayed a blend of the integrated/congruent and continuing/incongruent style of broaching because the analogue nature of the vignettes do not align exactly to the definitions of broaching set forth by Day-Vines. In this study Vignette A was called the integrated/congruent style of broaching. Vignette B portrayed the Avoidant style of broaching. In this study Vignette B was called the Avoidant style of broaching. Vignette C portrayed a "shut down" style of therapy in which the counselor limited talking about the client's identity as a gay man. In this study Vignette C was called a "shut down" style of broaching.

Research Hypotheses (H)

Overall Therapy Quality

This hypothesis explored the participants' ratings of the overall quality of therapy portrayed in the exposure vignettes.

H 1) Ratings of the overall quality of the therapist from Vignette A will be significantly higher than that of Vignette B, and both will be significantly higher than that of Vignette C.

H1a) Ratings of the overall quality of therapy portrayed by the therapist from Vignette A will be significantly higher than that of Vignette B.

H1b) Ratings of the overall quality of therapy portrayed by the therapist from Vignette B will be significantly higher than that of the therapist in Vignette C.

H1c) Ratings of the overall quality of therapy portrayed by the therapist in Vignette A will be significantly higher than that of the therapist in Vignette C.

MCC of the Therapist

This hypothesis explored the participants' ratings of MCC portrayed by the therapist in the exposure vignette.

H 2) Ratings of the MCC, as measured by the Cross-Cultural Counseling Inventory-Revised (CCCI-R), of the therapist from Vignettes A and B will be significantly higher than that of Vignette C.

H2a) Ratings of the MCC portrayed by the therapist from Vignette A will be significantly higher than that of Vignette B.

H2b) Ratings of the MCC portrayed by the therapist from Vignette B will be significantly higher than that of the therapist in Vignette C.

H2c) Ratings of the MCC portrayed by the therapist in Vignette A will be significantly higher than that of the therapist in Vignette C.

BABS and MCC of Therapist

This hypothesis explored participants' MCC ratings of the therapist in the exposure vignette and examined the broaching styles as potential moderators of which vignette participants viewed and their MCC ratings.

H 3) CITs will rate the MCC of the therapist within the vignettes differentially based on their corresponding broaching styles, as measured by the Broaching Attitudes and Behaviors Survey (BABS).

3a) That is, CITs who receive higher scores on the Integrated/Congruent and the Infusing broaching styles (i.e., the more advanced broaching styles) will rate the therapist's MCC in Vignette A higher.

3b) CITs who receive lower scores on the Integrated/Congruent and the Infusing broaching styles will rate the therapist's MCC in Vignette B and C as higher.

3c) CITs who score higher on the Avoidant and the Continuing/Incongruent broaching styles will rate the therapist's MCC in Vignettes B and C higher.

SOCCS and MCC of Therapist

This hypothesis explored participants' self-report scores in their work with LGB clients with their ratings of MCC of the therapist in the exposure vignette. The sub hypotheses look at the subscales of the self-report measure related to MCC scores in order to further explore the literature's findings that CITs generally rate their competence higher on Knowledge and Attitudes than on Skills in work with multicultural clients (Cartwright, Daniels, & Zhang, 2008; Sue, Rivera, Capodilupo, Lin, & Torina, 2010). Additionally, the sub hypotheses are based on the therapist differences in the vignettes based on the skills used in the session and the attitudes portrayed by the therapist.

H4) CITs' Sexual Orientation Competency Scale (SOCCS) scores will be correlated with ratings of MCC (measured by the CCCI-R) of the therapist in the exposure vignette.

H4a) Higher scores on the SOCCS will relate to higher ratings of MCC for therapists in Vignette A and lower ratings of MCC for therapists in Vignettes B and C.

H4b) The relationship between SOCCS scores for competence on the "Skills" subscale and MCC ratings for Vignettes A and B will be stronger than the relationship for SOCCS scores on the "Knowledge" and "Attitudes" subscales with MCC ratings for Vignettes A and B.

H4c) The relationship between SOCCS scores for competence on the "Attitudes" subscale will be more strongly associated (in the negative direction) with competence ratings for the therapist in Vignette C than will competence on the "Skills" or "Knowledge" subscales.

BABS and SOCCS

This hypothesis explored participants' broaching style with their SOCCS scores.

H 5) CITs who have more advanced broaching styles (i.e., Infusing, Integrated/Congruent) will have higher SOCCS scores compared to those with less advanced broaching styles (i.e., Continuing/Incongruent, Avoidant).

CHAPTER 2. REVIEW OF THE LITERATURE

Background

The field of psychology has paid heightened attention to therapist competence. National conferences and numerous publications have focused on competency-based education, training, and credentialing (Kaslow, 2004; Ridley, Mollen, Kelly, 2011). Moreover, the American Psychological Association (APA) published the Ethical Principles of Psychologists and Code of Conduct standards on competence (APA, 2002). Additionally, the National Council of Schools and Programs of Professional Psychology (NCSPP) developed a competency-based core curriculum that consists of the knowledge, skills, and attitudes necessary for sound professional practice. Thus, it has become clear that the construct of competence is central to training and education in psychology (Kaslow et al., 2004).

Alongside the call for general counselor competencies, there has been demand for the adoption of multicultural counseling competencies (MCCs) and guidelines. Advocates viewed this call as vital due to the recognition that the United States is becoming increasingly diversified, multiracial, multicultural, and multilingual (Sue & Sue, 1990). The Census has projected that the U.S. will become a plurality nation between the years of 2012 and 2060, where no single majority group will exist (U.S Census, 2012).

In order to provide a standard for helping professionals, and to take a proactive stance on cultural diversity, researchers have called for competencies and standards related to

multiculturalism (Sue, Arredondo, & McDavis, 1992). The Association for Multicultural Counseling and Development (AMCD) spearheaded the task to provide the field with standards and published the "Operationalization of the Multicultural Counseling Competencies" in order to guide clinicians in counseling interactions with particular attention to culture, ethnicity, and race (Arredondo, 1996). These competencies paved the way for the American Psychological Association (APA) to later publish the "Guidelines on Multicultural Education, Training, Research, Practice, Organizational Change for Psychologists," which imparted a more expansive document on the knowledge, skills, and paradigms needed in work with multicultural clients (APA, 2002, 2008). In fact, following the National Multicultural Conference and Summit (NMCS) in 1999, APA was called to take the lead in making sure that multicultural competence became a defining feature of psychological practice, education and training, and research (Sue, Bingham, Porche-Burke, & Vasquez, 1999).

Multiple historical events lead to the need for an integration of multiculturalism and diversity into the practice, research, education, and ethics of psychology. APA's 2008, "Report of the APA Task Force on the Implementation of the Multicultural Guidelines" acknowledged that their initial publication of the Multicultural Guidelines was rooted in various social, historical, and political events, alongside a number of professional developments in the field of psychology. The *Brown v. Board of Education* Supreme Court decision in 1954 and the Civil Rights Act of 1964 were two monumental events that led to increased attention and awareness of factors related to diversity (APA, 2008). Following these events, the Vail Conference was held in 1973 and the lack of attention paid to diversity in psychology was first highlighted (Korman, 1974). Following the aforementioned publications of the MCC and the Multicultural Guidelines, along with the field's new and heightened awareness for the importance of multiculturalism and

diversity, these concepts became acknowledged as "crosscutting" competencies that should be present in every counseling proficiency domain (Kaslow et al., 2004).

Multicultural Counseling Competence

MCCs are often defined by a counselor's awareness of their own cultural values and biases, awareness of the client's worldview, and culturally appropriate intervention strategies. Knowledge, skills, and attitudes/beliefs are three dimensions of these aforementioned components that theorists have used to further operationally define MCC (Sue et al., 1992). Sue et al. (1982) created the framework for the current understanding of MCC in 1982. Each of the three dimensions in Sue's theory (i.e., knowledge, skills, attitudes/beliefs) exists among the various categories in the published competencies, resulting in 31 total objectives. These competencies were originally intended for focus on oppressed minority groups of various races and ethnicities; however, increased attention to the many forms of culture that exist has proven the competencies useful in work with other oppressed groups as well.

It should be noted that inclusiveness of the term "multicultural counseling" has varied among researchers and practitioners in the field of psychology. Some theorists and practitioners define culture more broadly with a multidimensional understanding and include race, ethnicity, class, religion, sex, age, gender, place of residence, disability, and sexual orientation. Theorists with this broad definition of culture contend that no group, regardless of ethnographic variables, is unimodal (Chung & Bemark, 2002; Hays, 2009; Pedersen, 1991, 2008, 2013; Pedersen, Draguns, Lonner, & Trimble, 2008; Pope, 1995; Richardson & Molinaro, 1996). Pedersen (1991) asserted that an inclusive definition is particularly important because it prepares counselors to work with the complex individual differences among clients, even of those within the same ethnic or cultural group. Others believe that the definition of multicultural counseling

should be limited to more visible racial and ethnic minority groups (Patterson, 2004; Weinrach & Thomas, 2002). Those in this camp tend to agree that the inclusion of other definitions of culture could dilute the focus on racial and ethnic concerns in counseling. Furthermore, those who hold this point of view also debate that the addition of other forms of culture could dilute the focus of multiculturalism and that all counseling could then be seen as cross-cultural; thus, essentially eliminating the need for MCC completely.

A Debate about Multicultural Counseling Competence

The multicultural competencies published by the Association for Multicultural Counseling and Development (AMCD) were not entirely welcomed by the field and debate related to the need and utility of MCC guidelines is ongoing (Arredondo, 1996; Patterson, 2004; Weinrach & Thomas, 2002). One side of the debate relates to the question of whether the MCCs provide unique capabilities beyond the skills within general counseling competence. Therefore, some theorists and practitioners have questioned the difference between good general counseling skills and multicultural counseling skills (Coleman, 1998; Patterson, 2004; Weinrach & Thomas, 2002). Others argue that multiculturalism should complement traditional counseling theory instead of compete with it (Chung & Bemark, 2002; Pedersen, 1991, 2008, 2013; Pedersen et al., 2008).

Patterson (2004) asserted that all counseling is multicultural because everyone lives in a multicultural society. He argued that because of this, those who practice in the field do not need different counseling techniques or theories for all the possible groups in society. He acknowledged that all practitioners are not adequately prepared to work with all clients and that some extra training is necessary for some clients; but, he asserted that mental health practitioners trained within a universal system would have the bases of competency to provide treatment to a

wide variety of clients. Patterson (2004) was uncomfortable with a focus on techniques that the MCCs provide and contended that a competent mental health practitioner is one who provides an effective therapeutic relationship and possesses the inherent personal qualities needed to provide therapy. Another aspect of multicultural counseling that Patterson described as faulty is the larger focus on clients' differences rather than on their similarities. He disagreed with the utility of dividing clients into groups and requiring different counseling treatments accordingly. Instead, he called for a focus on globalization and on the blurring of differences. He saw a need for a system of counseling based on individuals' common characteristics. In Patterson's (2004) publication, he outlined a "universal system of counseling or psychotherapy" that focuses on basic counselor qualities necessary to provide therapy. Respect for the client, genuineness, empathetic understanding, the communication of empathy, and structuring are the categories that he laid out as necessary for work with all clients. This client-centered view is what he argued is needed to be a competent therapist, and that specific methods or skills for working with multicultural clients are unneeded and sometimes even harmful. He asserted that there exists no evidence that MCCs are appropriate or effective.

Other researchers have also criticized competency-based multicultural counseling. Weinrach and Thomas (2002) discussed the negative implications of adopting MCCs. They emphasized the need for more empirical data to be collected before implementation into curriculum or practice. They also alleged that there is no evidence to support the idea that those counselors who master the competencies are more effective therapists than those who do not. Their overarching concern was that only one study, which was published in 2000 by Holcomb-McCoy, found results to support the validation of the *Operationalization of the Multicultural Counseling Competencies* that were published by the Association for Multicultural Counseling

and Development (AMCD) in 1996 (Arredondo, 1996). Other studies have since been conducted to clarify the difference between general and multicultural counseling. These studies are of importance because the field lacks a clear definition of multicultural counseling. Additionally, the field lacks agreement on the specific skills needed to become a multicultural-competent clinician, if there is a need for such a list (Coleman, 1998).

Coleman (1998) focused on whether MCC provides unique and independent contributions to the perceptions of counselor's competence. Coleman's participants rated their perception of the general and MCC of two counselors in cross-cultural counseling vignettes. The results reflected Pedersen's (1991) contention that all effective counseling involves responsiveness to cultural nuances in the therapeutic relationship.

In contrast, Constantine (2002) found support for the use of multicultural counseling skills. In the study, 112 former counseling center clients of color indicated ratings of their attitudes toward counseling, their counselors' general counseling competence, their MCC, and their overall satisfaction with counseling. The student-participants' attitudes and perceptions of their counselors' general and multicultural competencies each accounted for a significant unique variance in their overall satisfaction with counseling. Another notable finding of this study was that the ratings of counselors' MCC explained significant variance in satisfaction ratings for participants who identified as a racial or ethnic minority clients, beyond the variance accounted for by their general competence. Fuertes and colleagues (2006) found similar results. Clients' ratings of therapists' MCC were significantly associated with their satisfaction in therapy, beyond ratings of empathy, expertness, attractiveness, and trustworthiness.

The importance and unique utility of MCC can be reflected in other studies with findings reflecting the clients' perceptions of therapists' competencies. Studies have compared the

difference between MCC and general counselor competence (GCC). GCC has been defined by counselor expertness, trustworthiness, attractiveness, and utility (Coleman, 1998). Fuertes and Brobst (2002) conducted their research with graduate students who had been involved in current or recent personal therapy. Similar to a previous study (Coleman, 1998), they found a significant overlap between general counseling skills (GC) and MCC skills. Although there was about a 50% overlap between GCC and MCC, the researchers found that perception of counselor's MCC accounted for a significant amount of variance in client satisfaction. Satisfaction of MCC was measured in terms of skills, attitudes, and knowledge and was significant beyond perceptions of counselor attractiveness, trustworthiness, expertness, and counselor empathy. Thus, the more the participant perceived that the counselor was competent to work within a multicultural domain, the more satisfied the client was with therapy. Lastly, the study's results also confirmed the hypothesis that MCC is important in work with minority clients (Sue & Sue, 2003). Specifically, perceived MCC explained a significant amount of satisfaction for the ethnic minority sample in the study. It was noted that because most of the minority clients had a White counselor, the results suggest that the counselors' level of MCC had a significant effect on satisfaction with therapy for the minority clients.

In another study, Fuertes et al. (2001) posited that perhaps MCC may only be attained once a certain level of general counseling skills are demonstrated. This assumption has been supported by other studies (Constantine, 2002; Coleman, 1998; Fuertes & Brobst, 2002); however, the research still remains inconclusive. Specifically, the field still is not clear about the importance of multicultural skills above and beyond general counseling skills. Some studies have found that the use of therapy informed by the multicultural competencies enhances the effectiveness of therapy (Fuertes et al., 2006; Fuertes & Brobst, 2002; Pedersen, 1991) and some

have not found that the use of these skills was remarkable (Patterson, 2004; Weinrach & Thomas, 2002).

What does remain clear is that immense attention has been given to the multicultural competence of practitioners. The APA and the American Counseling Association (ACA) both established guidelines for providing therapy to individuals of different cultural groups. APA's most recent publication of the "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" was published in 2002. Thus, multicultural counseling has become an accepted competency for practitioners by a large majority of the field. What has been left unclear is a standard definition of multicultural counseling, a clear list of competencies or necessary skills, and the clear-cut difference between general and multicultural counseling skill sets. This lack of consensus combined with a pressure to be a multicultural-competent clinician and researcher could contribute to the perceptible "lip service" that so many give to the subject. Sue and Arredondo (1992) articulated this idea well when they wrote:

> Too often, lip service is given to multicultural concerns, without the commitment to translate them into ethical standards and see that they become part of the accreditation criteria. If we truly believe that multiculturalism is central to our definition of a competent counselor then monoculturalism can be seen as a form of maladjustment in a pluralistic society. (p. 480)

A study looked at multicultural psychotherapy competencies and researched how frequent psychologists intervene in ways that are multicultural and how important they believe this practice is (Hansen et al., 2009). The research revealed that participants did not "practice what they preached;" and, 86% of the time the therapists did not indicate a multicultural

intervention when given the opportunity to do so. Also, the therapists identified their personal and professional experiences as the most influential in their development of multicultural competence. The participants indicated that guidelines and codes were the least influential contributor to their multicultural competence. These results were found despite the fact that over half of the sample reported that they were "very" or extremely" competent in multicultural practice. This lack of translation from ethics codes and multicultural guidelines to real practice is apparent in numerous studies on counselor's self-perceived level of MCC as well.

Self-Perceived Level of MCC

The major studies conducted thus far that measure MCC have used assessments such as the Multicultural Counseling Inventory (MCI), the Multicultural Awareness, Knowledge, and Skills Survey–Counselor Edition (MAKSS), the Multicultural Counseling Awareness Scale (MCAS), and the Cross-Cultural Counseling Inventory-Revised (CCCI-R). It should be noted that all of these scales except for the CCCI-R are self-report measures. The CCCI-R was originally formed for the supervisor to rate their supervisee's competence; however, modified forms for the client to rate their therapist's competence also exist. Currently, the MCAS is the most widely used inventory used to assess MCC. The studies conducted using these measures consistently noted that their results are limited by the fact that the measures are self-report and could therefore be inaccurate representations of one's true levels of MCC. Thus, critics have also noted that these self-report measures: (a) could be influenced by social desirability; (b) tend to measure anticipated rather than actual behaviors; (c) could be mismatched with the philosophy of academic training programs; and (d) lack uniformity in regards to the constructs they measure (Sue & Sundberg, 1996).

Researchers that have studied the relationship between social desirability and level of MCC have found a high positive correlation between the constructs (Constantine & Ladany, 2000; Sodowksy et al., 1998); however, Constantine (2000) used the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) and did not find that social desirability contributed significantly to the variance in self-reported MCC. Although the literature is mixed regarding the many constructs related to MCC, a pattern emerged in that clinicians believe they are competent to work with multicultural clients (Asay, 2006; Constantine, 2000; Constantine & Ladany, 2000; Holcomb-McCoy & Myers, 1999). Yet, in contrast to this research, a national survey conducted in 1999 on MCC and counselor training revealed that recently graduated therapists were unsatisfied with the adequacy of training they received in multicultural counseling while in graduate school (Holcomb-McCoy & Myers, 1999). It is important to understand that in spite of this, the graduates in the study still reported that they were competent in multicultural work. This seemingly contradictory finding might be explained by post degree experiences and training obtained immediately following graduation; however, this hypothesis was unpromising because of the recentness of graduation of the participants used.

Many models and methods for training have been developed to help ensure that CITs are component to practice within a multicultural domain. The implementation of these many approaches to training vary widely from program to program (Dickson & Jepsen, 2007; Holcomb-McCoy & Myers, 1999; Vasquez & Vasquez, 2003). Dickson and Jepsen (2007) conducted a study that highlighted the benefits of a systematic approach to the integration of multicultural training as they studied the program training experiences that were correlated with students' self-perceived MCC. After controlling for social desirability, it was found that the students' perceptions of their programs' cultural ambience were significant predictors across all

four multicultural competencies studied (i.e., skills, knowledge, awareness, and relationship). In particular, the extent to which students perceived that multicultural issues were woven throughout program curriculum, supervision, and recruitment efforts made significant contributions to participants' self-reported MCC. This finding reflected the utility of the Multidimensional Model of Cultural Competence (MDCC) created by Sue (2001). This factorial model depicted the interrelationship between individuals' social contexts (work and learning) and their multicultural competencies. The model was a 3 x 4 x 5 cube that depicted the three dimensions of MCC. Those dimensions were: (a) the three basic components of MCC (knowledge, skills, and awareness); (b) the four levels of analysis in which the individual interacts (individual, professional, organizational, and societal); and, (c) the perspectives of five cultural and racial groups. The instillation of this model into academic programs was seen as important by Sue because he believed that multicultural development must occur across all levels of the environment to be most effective. Therefore, he asserted that the attempt to develop MCC student therapists could be impeded if academic programs convey little value of multiculturalism systematically (Sue, 2001).

CITs have generally self-reported a high level multicultural competence (Cartwright et al., 2008). The literature shows CITs reporting such high levels of competence that there does not appear to be much room for growth in the area, which is counterintuitive to the idea that culturally competent counseling is an ongoing learning experience. Cartwright and colleagues (2008) conducted a study in which CITs were observed in multicultural counseling situations and rated on their level of MCC. Following a comparison of the CITs' self-report of MCC and the observer's report, significant differences were found; that is, the CITs rated their perception of their own MCC higher than the observer's perception. This study highlighted the idea that CITs

might have an inflated idea of their competence in this area. It also highlighted the possibility that CITs are likely flooded with knowledge about the importance of multicultural factors and feel pressured to report inflated levels in order to appear more competent due to their training status and pending evaluations. This would be consistent with the strong positive correlations found between social desirability and scores of MCC on self-report measures (Daniels, & Zhang 2008). These assumptions likely contribute to the "lip service" and confusion regarding training in the area of MCC.

Constantine (2001) also studied MCC in CITs through a method other than that of self-report. Participants in the study rated therapist responses to transcribed intake interviews. The study found that the trainees who had previous multicultural training were better able to conceptualize a minority client's concerns. Similarly, Neufeldt and colleagues (2006) studied the way in which CITs incorporate diversity factors in their case conceptualization, including the impacts of their own cultural factors on the relationship and treatment course. The results indicated that respondents of color in the sample were more attentive to cultural factors as they conceptualized the cases. Moreover, of the student therapists in the sample, only one participant noted the importance of the multicultural aspects of the White client. This is of concern due to the idea that "whiteness" is seen as a standard in the mental health field (Neufeldt et al., 2006). Additionally, this is an issue because it implies that the clinician did not consider individual aspects of privilege and other areas of diversity (e.g. gender, SES, sexuality, etc.), which could have been contributing to the client's concerns. Respondents in the Neufeldt et al. (2006) study also did not consider the intersectionality of cultural factors in their conceptualization of the cases. Therefore, the interplay of race, class, gender, SES, ability, sexual orientation, and age

were not considered. A lack of attention to this interplay could lead a clinician to ignore the way in which a client could have majority status in one area and minority status in another area.

Research studies have showed that CITs lack MCC in the area of "skills" most often (D'Andrea et al., 1991; Holcomb-McCoy & Myers, 1999). D'Andrea and colleagues (1991) conducted a study with three groups of student therapists and compared the effects of multicultural training on each group. They found significant increases in all three components of MCC (i.e., knowledge, skills, and awareness); however, the lowest change was in the area of skill development. This implies that training programs should investigate ways to better equip their students with specific skills to use to ensure MCC. Although many studies have found that CITs tend to report that they lack the skills to be MCC, some studies have found other gaps in competence. For instance, Boysen and Vogel (2008) found that although training increased the self-reported levels of MCC, implicit bias tends to remain consistent, which is an issue because biased attitudes can detrimentally influence treatment with diverse clients.

The literature shows that a number of variables influence multicultural competency including: social desirability attitudes, sex, ethnicity affective and cognitive empathy, biases, educational environments, therapist personality, contact with culturally different persons, therapist theoretical orientation, level of education obtained, and the amount of training in multiculturalism (Asay, 2006; Constantine, 2000; Constantine & Ladany, 2000; Dickson & Jepsen, 2007; Graham et al., 2012; Holcomb-McCoy & Myers, 1999; Steward, Wright, Jackson, & Jo, 1998). Although this list is not exhaustive, it serves to represent the current status of the literature regarding what is important in the consideration of CITs and their level of MCC. Ponterotto and colleagues (1995) published a checklist for counseling training programs to use as a pragmatic guide to increasing multicultural competency within programs. The checklist

includes 22 items organized along six major themes including minority representation, curriculum issues, counseling practice and supervision, research considerations, student and faculty competency evaluation, and physical environment. This checklist can serve as a guide to programs to assess and improve training in MCC.

The Lesbian, Gay, and Bisexual Population as a Multicultural Population

A debate in the literature existed regarding which groups to include in the definition of multiculturalism (Sue, Zane, Hall, & Berger, 2009). Some argued that racial and ethnic minorities should be the main focus of multiculturalism (Patterson, 2004; Weinrach & Thomas, 2002). Others saw a more inclusive definition as important (Lowe & Mascher, 2001; Neufeldt et al., 2006; Pedersen, 1991; Pope, 1995; Sue 2001). Pope (1995) took a firm stance on the topic and argued that gay men and lesbians must be included in any definition of multiculturalism (Pope, 1995). Pope's reasoning was based on the fact that the identity-formation tasks that racial and ethnic minorities must accomplish are similar for individuals who identify as lesbian and gay. Pope did not incorporate bisexual, queer, and transgender individuals in his theory; however, more recent research does incorporate the transgender and queer identified individuals in discussing therapy issues with these multicultural clients (Russell & Bohan, 2007). Pope (1995) also asserted that the multicultural counseling skills required for work with both populations are almost identical. Thirdly, he pointed out that there is in fact a lesbian and gay culture, and that the oppression that these individuals face from the majority culture is very real. Others have pointed to adjusting focus to what the client sees as important. For instance, Ridley, Baker, and Hill (2001) argued that other areas of focus such as religion, gender, or sexual orientation, might be more significant than race for focus during therapy.

Pedersen (1991) also advocated for the broad and inclusive definition of "multiculturalism;" he asserted that counselors must be prepared to deal with the complex differences among individual clients within or between every cultural group. He contended that individual differences and personal level constructs that are often left out of the definition of multiculturalism make the definition too exclusive. The exclusive definition of multiculturalism, he asserted, was extremely dangerous. This caution is rooted in the concept of cultural encapsulation, which was first introduced to the field in 1985 (Wrenn, 1985). Pedersen articulated the five identifying features of cultural encapsulation when warning against the exclusive use of the term multiculturalism; they are: (a) reality is falsely based on stereotypes; (b) we become insensitive to cultural variations and assume that our view is the only legitimate one; (c) individuals have unfounded assumptions which we accept without proof and protect without logic; (d) a technique-oriented job definition contributes to the encapsulation; and, (e) when there is no open-mindedness, there is no responsibility on the individual to accommodate or interpret the behavior of another except from the viewpoint of a self-reference criterion. This aforementioned way of thinking was said to be dangerous in the counseling context because it promotes "one theory, authority, and truth" (Pedersen, 1991, p. 10). A broader definition does the opposite and allows counselors to more fully comprehend the perspective and worldview of the client, without rejecting alternatives (Pedersen, 1991). The disregard for cultural complexity that cultural encapsulation promotes was reflective of the exclusive definition of multiculturalism and would not serve as best practice for clients who identify as LGB.

Various considerations are needed in work with each client depending on their diverse make up. Hansen and her colleagues (2000) suggested that multiculturalism should include the numerous aspects of a client's identity including "gender, class, sexual orientation, disability,

and age cohort" (p. 654). The authors argued that these aspects help shape a client's worldview. This idea of multidimensional cultural competence was portrayed well by Sue in the tripartite framework of personal identity (Sue, 2001). See the model for the tripartite framework of personal identity in Appendix A. This framework exemplifies the potential for the interplay of multiple multicultural identities that can exist in one individual.

The use a broad definition of multiculturalism has utility for work with clients who identify as LGB. An inclusive definition allows counselors to be more accurate in matching a client's culturally learned expectations to their behavior. Additionally, it helps counselors gain increased awareness about how their own culture influences their work with clients. Moreover, an inclusive definition highlights the complex cultural identity patterns that exist and how ever-changing cultural identities can be within a counseling interaction (Pedersen, 1991). Consequently, it is important to include LGB into the definition of multiculturalism, especially because their minority status is invisible and can be as important as other aspects of their identities. For this reason, many researchers and practitioners have been in agreement that LGB individuals should be included as a multicultural population; and, if they are not included then we are doing a disservice to, and possibly harming, these clients in therapy (Lowe & Mascher, 2001; Pedersen, 1991).

The lack of privilege held by the LGB community was another variable that added to the necessity that the community be regarded as multicultural. Neville (2001) noted that those who identify as LGB do not hold privilege due to the social environment and the political nature of the disagreement over their rights. This lack of privilege contributes to the reason why the LGB community should be included as a multicultural population. Furthermore, counselors must be

attuned to this lack of privilege that the LGB population holds because counseling occurs in a context that is influenced by institutional and societal biases and norms (Arredondo, 1999).

Research showed that the LGB population is one of the largest minority groups receiving therapy services (Dorland & Fisher, 2001; Fassinger, 1991). Dating back to the 1940s, Alfred Kinsey conducted groundbreaking studies that estimated the lesbian and gay population to range from 10–15% of the population (Kinsey, 1948). Although Kinsey's findings have been questioned, more recent studies generally indicate that the percentage of the United States population that identifies as LGB ranges from four to seventeen percent (Fassinger, 1991; Gates, 2006). This large range was likely due to the invisibility of this population's minority status. Furthermore, the large range could also be attributed to the fluidity and continuum of sexuality that exists. Because the LGB population faces many of the same concerns that other minority populations face, it is important for counselors to focus on specific multicultural considerations in work with these individuals.

Therapists and researchers also must be equipped to focus on the aspects of this population that are unique. For instance, members of the LGB population are the only people who share the experience of the coming out process related to sexual orientation (Pope, 1995). As defined by Altman (1971), coming out is the process by which an individual comes to identify as gay and recognizes their position as part of a stigmatized and partially hidden minority group. Unlike most ethnic minority individuals, many individuals who identity as LGB are raised in families, and even in communities, that do not share their minority status (Israel & Selvidge, 2003). Furthermore, many religions and major political parties do not agree with providing those who identify as LGB with rights such as marriage (Chamie & Mirkin, 2011). Furthermore, these individuals sometimes face the loss of relationships from family, friends, and

others if they come out as a LGB (Fassinger & Galor, 2006). Other areas of life that the majority has privilege to and the LGB still lacks privilege in are: housing rights, healthcare rights, joint tax returns, career planning, parenting and adoption rights, social security benefits, next-of-kin rights when a partner is hospitalized, and academic institution policies (Bradford, Ryan, & Rothblum, 1994; Cocrhan, Sullivan, & Mays, 2003; Fassinger & Galor, 2006; Herek, 2009). It should be noted that these rights and sanctions vary by state law and academic institution in the United States; however, the stereotypes, prejudice, and discrimination against this group has been an ongoing issue (Herek, 2009).

The first National Multicultural Conference and Summit (NMCS) occurred in 1999, which was held to examine multicultural concerns in the field. In Sue, Bingham, Porché-Burke, and Vasquez's publication about the conference (1999), they noted that a "multicultural revolution" was occurring. Thus, one of the major themes they saw emerge from NMCS were the "difficult dialogues" on race, gender, and sexual orientation. Specifically, it was apparent that the term 'multiculturalism' needed to change and include the broad range of significant differences that hindered communication and understanding among individuals; and, sexual orientation was among others in this list. They explained that by leaving groups such as LGB out of the definition, they were left to feel excluded and minority groups might therefore put themselves in opposition to one other, eventually leaving the groups in a "who's more oppressed" game (p. 1063).

The separate development of multicultural counseling and LGB counseling has seemingly caused the populations to be "pitted" against one another (Israel & Selvidge, 2003). The authors pointed out the need for the fields to collaborate and build a more comprehensive vision of counselor competence with diverse clients. Because multiculturalism emerged out of

the civil rights movement, and LGB psychology primarily emerged following the Stonewall riots, the former has had more time to develop and contribute to the field. Therefore, it has been found that therapists use MCC models and principles and apply these to their work with LGB clients (Israel & Selvidge, 2003). Thus, as before mentioned many scholars have found it necessary for the two fields to collaborate and learn from one another in order to increase communication, understanding, and sensitivity to multicultural clients.

The aforementioned authors and others who have agreed with the inclusive definition of multiculturalism are in company with APA's 2008 report of the task force on the implementation of the Multicultural Guidelines (MCGs). They stated that the guidelines were written to address "the different needs for particular individuals and groups historically marginalized or disenfranchised within and by psychology based on their ethnic/racial heritage and social group identity or membership" (APA, 2008, p. 4). Thus, it has been clear that the LGB population fits within the purview of the MCGs.

View of the LGB Community

Competent practice with those who identify as LGB is of utmost importance in the practice of psychology, especially because the history of professional practice with this community does not portray a picture of multicultural sensitivity or best practice. In 1952, "homosexuality" was classified as a mental illness in the first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Following the publication of results of several studies that dispelled the beliefs that gay men were less mentally healthy than heterosexual men, "homosexuality" was removed as a disorder. Although both the American Psychiatric Association and the APA released a statement in 1974 regarding this change in press, it was not until 1987 that the new *DSM-III-R* reflected this change (Jordan &

Deluty, 1995). APA has since published the *APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation* and concluded that efforts to change sexual orientation are basically unsuccessful and involve a chance of harm to clients (APA, 2009). In APA's *Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients* they explained that following their statement in 1973, they have "taken the lead in promoting the mental health and well-being of lesbian, gay, and bisexual people" (APA, 2012, p. 10).

Jordan and Deluty (1995) studied the clinical interventions used by psychologists with gay and lesbian clients. Although their results are limited to the time and to the specific individuals involved in their research, their results are still alarming. Eleven percent of the therapists surveyed agreed that they used methods to change the sexual orientation of their clients. Additionally, the use of aversion therapy was supported by 5.8% of the sample (n=139). It was also found that a view that "homosexuality was unacceptable" predicted use of these approaches to change sexual orientation. Tozer and McClanahan (1999) published an article that outlined a number of reasons why sexual orientation conversion therapy stands in opposition to the APA ethics code. They also reiterated that no empirical evidence existed that showed conversion therapy to be useful or effective for LGB clients (Tozer & McClanahan, 1999). Members from the American Counseling Association (ACA) made it clear that in their review of psychological peer-reviewed literature they were unable to find scientific evidence concluding that conversion therapy was effective. Additionally, they concluded that extant published research indicates that conversion therapy might harm clients (Whitman, Glasoff, Kocet, & Tarvydas, 2006). APA's *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (2012) include a similar sentiment. Guideline three stated that "Psychologists understand that same-sex attractions, feelings, and behavior are normal variants of human sexuality and that

efforts to change sexual orientation have not been shown to be effective or safe" (APA, 2012, p. 14).

Another area where some counselors have been shown to hold negative attitudes and stereotypic thinking is toward individuals who identify as bisexual. This orientation is sometimes even less accepted socially than the lesbian or gay sexual identity because not only do they tap into individuals' intolerance for same-sex relations, they also do not fit into the dichotomous category of being either gay or straight. Mohr, Israel, and Sedlacek (2001) studied this hypothesis and concluded that the counselors who held the highest level of negative attitudes toward bisexuality were more likely than others to have negative reactions to the fictional bisexual client. These clinicians also anticipated responding in a biased and judgmental manner to the bisexual client. Lastly, it was found that these clinicians believed the client had problems in areas related to bisexual stereotypes and rated the client as having low levels of psychosocial functioning overall. On the other hand, the counselors in the study who viewed bisexuality as a stable and legitimate sexual orientation were less likely than others to rate the client as having problems in areas related to bisexual stereotypes, such as problems with intimacy.

Although some clinicians still hold negative attitudes toward the LGB population, research shows that trend is declining. Yet, one does not have to search far back in the literature to find reviews and large-scale studies that portray incompetent practice in work with LGB clients. For instance, Fassinger (1991) published a review of the literature that reflected the negative attitudes, stereotypes, misinformation, and heterosexist assumptions that many mental health professionals held before 1991. In this same year, Garnets and colleagues (1991) conducted a large-scale qualitative study (n=2,544) consisting of a diverse sample of psychologists' work with LGB clients. The authors charted the frequency of different

approaches to work with gay clients in order to identify beneficial or harmful practices. Of the 31 themes identified, 17 (~55%) consisted of "biased, inadequate, or inappropriate practice" (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991, p. 966). However, four years later, a study was published that found no significant results related to a sexual orientation effect on countertransference reactions to lesbian and heterosexual client actresses (Gelso et al., 1995). These newer findings were similar to those of Hayes and Gelso's (1993) in their study of counselor reactions to gay male clients in that no significant differences were found. This literature reveals that mental health professionals' attitudes toward the LGB population appear to be making positive changes in that homophobia scores in these studies were lower than what was expected based on previous literature. The aforementioned authors hypothesized that majority of these results might be accounted for by the fact that most (i.e., 90%) of the participants in the studies completed a demographic questionnaire indicating that they had friends who identify as gay. This is notable because past research has found that having at least one gay or lesbian friend is negatively associated with homophobia (Herek, 1988).

Recent literature also reflects clinicians' more positive attitudes toward the LGB community. In a study of counselors from school and community practice, participants reported high LBG-affirmative attitudes (Farmer, 2013). Many other studies produced similar results regarding high self-perceived attitudes and awareness in work with LGB clients (Graham et al., 2012; Grove, 2009; Pelling, 2006). Although these results could be attributed to social desirability, they do highlight an increase in awareness of competence regarding clinicians' work with the LGB community.

Another aspect of competence that is important beyond positive attitudes is an awareness of personal ideas and biases. APA asserted that psychologists must be held responsible to

explore their biases and stereotypes of LGB individuals (APA, 2012); without this, therapists are unable to attend to countertransference concerns in their work (Buhrke & Douce, 1991). Thus, it is suggested that CITs and professional practitioners should endure the burden of working to remove the stigmas associated with the LGB community that the fields of psychology and psychiatry helped to create (Schneider, Brown, & Glassgold, 2002). Internalized homophobia and discriminatory attitudes hinder a clinician's ability to competently serve this population (Estensen, 2005). Thus, it is the therapist's responsibility to hold positive, non-judgmental views of this population, especially in the therapy room.

Although more positive attitudes toward individuals who identify as LGB are also emerging in the general population (Baunach, 2011), there still exists an abundance of stereotypes, prejudice, discrimination, and oppression toward these individuals (Herek, 2009). The history of treatment toward this population has likely contributed to the lingering negative attitudes and the high rate of mental health concerns in the community as well (Mustanski, Garofalo, & Emerson, 2010). In Fassinger's (1991) review, she highlighted the fact that the LGB population is not mentioned or studied in U.S. history and that the knowledge of the population was largely derived from religious and legal sanctions against same-sex behavior. There does exist evidence of tolerant attitudes toward same-sex behavior in classical Greek history and in cross-cultural research as well (Ford & Beach, 1951); however, the current Western attitudes of LGB relations were shaped most by intolerant religious views (Bullough, 1979). The seminal book, *Patterns of Sexual Behavior,* integrated information from 191 countries regarding sexual behavior and attitudes. The authors concluded that there is a "basic mammalian capacity" for same-sex behavior. This was surmised based on the finding that in 64% of the cultures they studied there was no absolute norm for sexual behavior and that same-

sex behavior was "normal" for portions of the population (Ford & Beach, 1951). Although this publication made same-sex behavior more visible, it did not overturn the conservative, religiously influenced attitude that influenced the majority opinion and legal codes in the United States at the time (Isay, 2010).

In 2016 the social, legal, political, and religious discrimination of the LGB community still exists and interacts with other forms of oppression (Butler, 2010). This marginalized status in society may help explain why these individuals experience mental health concerns at higher rates (Mustanski et al., 2010). In fact, LGB individuals seek mental health treatment at a higher rate than the majority population (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Estensen, 2005; Liddle, 1997). They also participate in a greater number of counseling sessions than clients who identify as heterosexual (Biescke et al., 2000; Liddle 1997). Liddle's research results found that gay and lesbian clients had a mean of 82 sessions of therapy and matched heterosexual clients had a mean of 29 sessions. Problems such as internalized homophobia, self-acceptance, coming out, relational concerns, depression, and anxiety are common in this population due to the environment in which they live (APA, 2012; Estensen, 2005). A nationally representative survey of mid-life adults who identified as LGB revealed that gay and bisexual men had a higher prevalence of depression, panic attacks, and psychological distress than their heterosexual counterparts. Additionally, lesbian and bisexual women showed higher prevalence rates of anxiety than their heterosexual counterparts (Cochran, 2003). A similar study found that their respondents who had same-sex sexual partners had higher prevalence of mental health concerns including anxiety, mood, substance use disorders, suicidal thoughts, and suicidal plans than those who had opposite-sex partners only (Gilman et al., 2001).

Living in a heterosexist society also creates concerns of violence and overt acts of stigma and discrimination to this population (APA, 2012). For example, in a study conducted by Herek (2009) on hate crimes and other stigma-related experiences, the sample of LGB individuals reported their experiences at alarming rates. One in five LGB individuals reported experiencing personal violence or property crime due to their sexual orientation. Additionally, almost half of the sample reported that they had experienced verbal abuse due to their sexual orientation. More than one respondent in ten reported having experienced housing or employment discrimination because of their LGB status. Men who identified as gay reported the highest levels in each category surveyed. More than a third of gay men reported experiencing one or both types of crimes (i.e., property crimes or personal violence), compared to one-eighth of lesbians. This victimization and discrimination based on antigay acts have been associated with mental health problems and psychological distress (Cochran, 2001; Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; Rostosky, Riggle, Horne, & Miller, 2009). Therefore, it is of utmost importance for the therapist to acknowledge this stress and create a safe therapeutic environment (APA, 2012).

In a national health care survey of young adults who identified as lesbian, over half the sample reported that they had thought about attempting suicide at some point and 18% had attempted suicide (Bradford et al., 1997). About 75% of the sample reported that they had received counseling at some point; and, 50% reported that they had sought counseling due to sadness and/or depression. These results were found even though the participants reported having social connections and supports. Because the majority of participants lived in a metropolitan area, were well-educated, and were professionally employed individuals, the sample was "privileged" in some respects and lesbians who are more likely to be cut off from a supportive community could be at an even higher risk for distress and mental health concerns

(Bradford et al.,1997). Although this study was conducted quite some time ago, a more recent study found 37.4% of their sample endorsed current suicidal ideation (Liu & Mustanski, 2012) suggesting that serious mental health concerns are still found within this population.

Though individuals who identify as LGB have a higher prevalence of mental health concerns and seek treatment at a higher rate than those in the majority population, they also have had higher rates of early termination from therapy (Bieschhke, McClanahan, Tozer, Grzegorek, & Park, 2000; Dorland & Fischer, 2001). There is scant literature covering what contributed to early termination. Garnets and colleagues (1991) found that counselors who held heterosexist attitudes were as much as five times more likely to have clients who terminated therapy prematurely. These attitudes included negative and/or biased attitudes toward LGB individuals' identities and the therapists' assumption that the client was heterosexual. Thus, it can be assumed that these practices were seen as unhelpful by LGB clients and contributed to their decision to end therapy early. Another study that gave insight into what causes these clients to terminate therapy early had participants evaluate their therapy experiences and indicate "unhelpful" practices that were most influential to their decision to terminate: (a) the therapist supported the position that identifying as LGB is "bad, sick, or inferior;" (b) the therapist "discounted, argued against, or pushed you to renounce your self-identification as a lesbian or gay man;" (c) the therapist "blamed your problems on your sexual orientation or insisted on focusing on sexual orientation without evidence that your sexual orientation was relevant to your problems; (d) the therapist "lacked the basic knowledge of gay and lesbian issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues;" (e) the therapist "suddenly refused to see you any more after you disclosed your sexual orientation" (Liddle, 1997; p. 397). The clients who endorsed these items responded by saying

their therapists' inappropriate behaviors were either "not at all helpful" or even "destructive" to their treatment (Liddle, 1997).

Mental health practitioners and student therapists must employ current best practices in their treatment of the LGB population (Biaggio, Orchard, Larson, Petrino, & Mihara, 2003). Therapists have consistently reported that they have treated individuals who openly identify as LGB (Garnets et al., 1991). In fact, Garnets' (1991) study found that 99% of their sample reported working with a LGB. At the time of this study, the affirmative orientation to therapy with LGB clients was already credited as being of high importance; however, research revealed that out of the two thousand psychologists studied, only five percent indicated that they used a gay-affirmative orientation in their work. The authors concluded that psychologists varied widely in their adherence to a standard of practice in work with LGB clients and that in order to bring practitioners into accord with the APA policy at the time, more efforts were needed to educate the field (Garnets et al., 1991).

Other research suggested that due to the recent attitudinal changes occurring in society, therapists will be given even more opportunities to work with this population in the future (Eubanks-Carter, 2005). Thus, because mental health clinicians will likely work with multiple clients who identify as LGB, or with those who are questioning their sexual orientation, it is paramount that clinicians know how to best serve this population.

APA pronounced that they have taken the lead in "providing psychologists with affirmative tools for practice, education, and research with [the LGB] population" (APA, 2012, p. 10). The literature overwhelmingly agreed that an affirmative approach is highly beneficial in work with LGB clients (APA, 2009; Eubanks-Carter, 2005; Fassinger, 1991; Hancock, 2003;

Israel et al., 2003; Logan & Barrett, 2005; Pachankis & Goldfried, 2004; Ritter & Terndrup, 2002; Tozer & McClanahan, 1999).

Numerous professional associations for mental health providers (i.e., APA, the American Counseling Association [ACA], the Counsel for Accreditation of Counseling and Related Educational Programs [CACREP], the National Association of Social Workers [NASW], and the American Association for Marriage and Family Therapy [AAMFT]) have standards for practice with LGB clients. Despite the development of guidelines, standards, and ethics codes, a coherent and agreed upon model of competency for work with LGB clients is still absent from the literature (Israel et al., 2003). As Israel and colleagues (2003) argued, many authors have published ideas about the components that compose LGB counseling competency, some of which included exploring countertransference, helping clients develop self-esteem, assisting in the coming out process, understanding lesbian and gay parenting issues, being non-heterosexist, increasing resilience from discrimination, and understanding the interaction of varying identities. In fact, in a review of the literature, the authors identified 47 areas of knowledge, 17 attitudes, and 56 skills that were recommended for counseling LGB clients (Israel et al., 2003). Other authors recommended that therapists be skilled in working with legal and workplace issues, assessment, religious concerns, identity formation, relationships, and unique stressors faced by individuals who are underrepresented in the LGB research (Fassinger, 1991; Logan & Barret, 2005; Pachankis & Goldfried, 2004; Ritter & Terndrup, 2002). Given the stigma faced by LGB individuals and the potential interplay of identities at work in each individual, it behooves psychologists to "understand the effects of stigma and its various contextual manifestations in the lives of lesbian, gay, and bisexual people" (APA, 2012, p. 12). In fact, multiple other guidelines for practice with this population exist that highlight this important factor (see the

following guideline numbers in *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients:* 5, 6, 11, 12, 13, 15, 16, 17).

It is apparent that LGB counseling competency is a complex issue; and, as a result of this complex issue, Israel and colleagues (2003) conducted a two-phase Delphi study with professional experts and LGB-identified experts in order to better articulate the components of competency with LGB clients. The authors cited 33 knowledge components, 23 attitude components, and 32 skill components of competency that make up a comprehensive model for work with LGB clients. The three lists of competencies that Israel and colleagues (2003) demonstrated well the extensive amount of literature surrounding the topic of how to best counsel LGB individuals. The skills list specifically highlighted the need for counselors to broach topics related to work with LGB identified clients. The competencies listed that specifically noted the need for broaching included: talking about and listening to all aspects of LGB clients' lives, helping clients with the coming out process, using affirming techniques, facilitating the exploration of the impact of oppression, and helping clients with exploring options for facing discrimination.

In addition to Israel and colleagues' study, many other authors who have contributed to the literature on how to best serve LGB clients have focused on the importance of first engaging in self-reflection regarding personal attitudes, feelings, and behaviors toward LGB clients (APA, 2009; Butler, 2010; Eubanks-Carter, 2005; Fassinger, 1991; Godfrey et al., 2006; Logan & Barret, 2005; Tozer & McClanahan, 1999). Although it has been shown that this self-reflection is vital in all clinical work, it is of critical importance in work with LGB clients because of the lingering bias against this population that exists (Eubanks-Carter, 2005). For instance, in an analogue study involving psychologists reading case descriptions of a depressed client, the

therapists rated the client who identified as a LGB as more in need of medication than the client who identified as heterosexual. This result was found even though the clients presented with identical depressive features (Biaggio, Roades, Staffelbach, Cardinali, & Duffy, 2000). Therefore, it can be surmised that therapists' beliefs might subtly impact their behaviors in their work with LGB clients, even if therapists consciously reject stereotypes about this population (Eubanks-Carter, 2005). In an analogue study of student therapists, results showed that even among those who scored very low on levels of homophobia, negative views of homosexuality were correlated with behaviors that discouraged clients from exploring important themes in therapy related to sexual orientation (Gelso et al., 1995).

Counselors'-In-Training (CITs') Self-Efficacy Working with LGB Clients

The literature was inconclusive regarding how competent CITs feel they are in work with LGB clients. While some studies have found that CITs report a moderate level of competence (Bidell, 2005; Graham et al., 2012; Grove, 2009; Rock et al., 2010), others have found that CITs tend to report an inadequate level of self-perceived competency in work with LGB clients (Biaggio et al., 2003; Murphy et al., 2002; Phillips & Fischer, 1998; Sherry, Whilde, & Patton, 2005). Additionally, discrepancy existed between which areas of counseling trainees feel more or less competent; however, of the three broad areas of MCC (i.e., attitude, knowledge, and skills), the literature showed that CITs tended to report the lowest levels of competence in the area of skills in work with LGB clients (Bidell, 2005; Graham et al., 2012; Grove, 2009; Kocarek & Pelling, 2003; Rock et al., 2010).

Grove (2009) studied the difference in CITs' self-reported competence in work with LGB clients over four years of graduate school. Findings revealed that the overall mean of competence in the skills area did not correlate with years of training. This finding replicated that

of Bidell (2005) who found that the measurement of skills were half those of the measurement of attitudes on the SOCCS (Sexual Orientation Counselor Competency Scale). As with Bidell's results, Grove's research found that the scores measuring CITs' attitudes toward LGB clients were almost double those of knowledge and skills, even in the first year of graduate school. Authors attributed this finding to a lack of training in that the students may believe that they have a high level of comfort with LGB issues, but do not receive training that attends to the awareness of biases (Pelling, 2006). This finding reflected Mohr's (2002) "democratic working model of heterosexual identity," where individuals using this model view people of all sexual orientations as essentially the same (pp. 540–541). Dillon and Worthington (2003) also reported high scores on the awareness scale and attributed these scores to trainees giving inflated answers in order to appear socially desirable. Perhaps these inflated scores could be an attempt to fit in with a gay affirmative training program, therefore pleasing supervisors and fitting with expected norms (Mohr, 2002).

Kocarek and Pelling (2003) discussed a model to facilitate the development of CITs' skills for work with LGB clients. The authors noted that as of 2003, they had conducted multiple literature searches and were unable to find results that directly related to skill building in the areas of LGB and general multicultural work. As a result, they looked at literature related to skill building in educational literature and found that role-playing and experiential exercises could facilitate skill development. Although this model could positively promote skill building, it appeared as though training programs have not overwhelmingly incorporated this model. After completion of the current literature review, it was found that Buhrke (1989) also published a resource guide for the incorporation of lesbian and gay issues into training and suggested that role-plays with lesbian and gay clients should be included in microskills class in graduate school.

This literature highlighted the need for training programs to implement these specific suggestions.

Although CITs reported general MCC, the literature showed that the lack of self-reported competence in the skills area of work with LGB clients tends to affect the self-efficacy of CITs (Dillon & Worthington, 2003). Dillon and Worthington found that more experience in counseling this population led to an increase in efficacy. Other aspects the researchers found that positively correlated with CITs confidence in work with LGB clients were performance accomplishments, hours of training in supervision and instruction, and years of clinical experience. Graham and colleagues (2012) found similar results; increased level of training (master's vs. doctoral), number of LGB clients seen, and attendance at LGB-focused workshops and conferences were associated with increased competence in their study. In summary, exposure and experience were shown to be vital in forming LGB counseling competence.

Another important factor in LGB counseling self-efficacy were the personal characteristics of the CIT. For instance, counselor identification as a LGB was predictive of LGB counseling self-efficacy (Dillon, Worthington, Soth-McNett, & Schwartz, 2008). Although this finding was unsurprising, the underlying factors that lead to the result might transfer to heterosexual identifying CITs. Specifically, Dillon and colleagues explained that LGB therapists are more likely to (a) possess needed knowledge regarding LGB issues; (b) engage in LGB-affirmative counseling and related professional activities; and (c) learn from LGB-affirmative colleagues who share knowledge and encourage best practices for LGB. Therefore, CITs who do not identify as LGB might be able to transfer these aforementioned skills to gain competence in their work.

An additional personal factor that accounted for variance in LGB counseling self-efficacy in prior research was having friends and family who identify as LGB (Carlson et al., 2013). Studies have shown that these personal contacts are associated with gay-affirmative attitudes and self-perceived competence in work with the population as a result (Carlson et al., 2013; Dillon & Worthington, 2003; Phillips & Fischer, 1998). Along this line, it has been found that student therapists generally believe that their personal experiences provided them with more knowledge about LGB issues than their education program (Lynch et al., 2013). Although it is not possible to assign friends and family to CITs in order to increase competency, it is possible to encourage students to increase personal contact with the population in order to increase knowledge and awareness. In fact, it has been found that the most effective way of altering negative stereotypes about LGB individuals is through increased personal contact with the population (Green, 1996).

A study conducted by O'Heron (2011) examined what factors most influence trainees' self-efficacy with LGB clients. The researchers found that trainees with more positive attitudes toward LGB individuals cited that their attitudes were most affected by their training experiences in their work with LGB clients. The author therefore suggested that training activities may also serve as a crucial influence on increasing LGB counseling self-efficacy beliefs. Thus, it can be surmised that CITs vary in their self-perceived level of competency in work with the LGB population. The literature summarized that graduate school training, clinical experiences, and personal characteristics of the counselor were key factors in determining self-efficacy with LGB clients.

Status of Training

As aforementioned, the literature revealed that some variation in perceived competence with the LGB population existed, which may be partially related to differential levels of training

received in graduate school (Carlson, et al., 2013; Sherry et al., 2005). Although there has been an increase in training on LGB issues over time, the literature reveals an overwhelming agreement that there is still not enough (Godfrey et al., 2006; Grove, 2009; Lynch, Bruhn, & Henriksen, 2013; Martino-Harms, 2013; O'Heron, 2011). Following is a review of the status of training for CITs on LGB issues.

Concern regarding training with LGB clients has been discussed thoroughly in the literature. In 1989, Buhrke found that 29% of women counseling psychology doctoral students reported no training on LG concerns; and if they were addressed, it was in specialty didactics or in practicum scenarios. The students in this study also reported that they perceived themselves to be more accepting of LGB than their faculty and supervisors. Therefore, these students had limited exposure to LGB role models and reported that they felt more comfortable counseling clients that were not LGB. These results were similar to those of another study almost 10 years later (Phillips & Fischer, 1998) in which the authors concluded that training was inadequate and students reported feeling ill prepared to work with LGB clients from their coursework and training alone. In the latter study, results showed a mode of zero for the following: LGB articles required to read, LGB identified clients, and number of hours of didactic training in practicum on LGB issues. Moreover, the results suggested that the students received even less training on bisexual issues than on gay and lesbian concerns. Lastly, differences between programs were also found in that counseling psychology students reported more training on LGB concerns than clinical psychology students. The finding of increased tendencies to incorporate LBG issues in counseling psychology relative to clinical psychology graduate programs was replicated a few years later (Sherry, Whiled, & Patton 2005). This 2005 study also reviewed LGB training competencies in APA accredited graduate programs by surveying training directors (TDs). This

study was a positive reflection of the apparent infusion of LGB concerns in multicultural classes, practicum, and supervision. And although these findings were encouraging, only 21% of TDs reported that their programs infused LGB issues into training courses that were not specifically multicultural in nature. When considering these results, it is important to consider that the study's participant pool was TDs and the potential for over reporting positive training in order to reflect social desirability might have been high.

A more recent study published in 2012 replicated results of former studies and found that CITs felt that they most lacked competence in the skills domain in work with LGB clients (Graham et al., 2012). Therefore, the authors suggested that because both ACA and APA have suggested frameworks for work with LGB clients in the area of skill development (i.e., interventions, research methods, and assessments), that a unique skill set should be defined in the literature to guide training. In general, many publications in the literature have made suggestions for the improvement of training regarding work with LGB concerns; however, uniformity does not exist and this lack of clarity may contribute to the lack of competence felt by student therapists in general. The following list contains items most often cited in the literature as necessary for work with the LGB population that training programs could take into account: (a) the need for CITs to gain clinical experience with LGB identified clients in order to increase skill level; (b) CITs need to gain self-awareness and examine their own biases regarding the LGB community; (c) didactic trainings and classes on MCC and LGB concerns in order to increase knowledge; (d) increase personal exposure to the LGB community; (e) hold LGB-affirmative beliefs and counseling skills including advocacy outside of therapy; (f) explore internalized homophobia in clients; and, (g) feel comfortable broaching sexual orientation and related

concerns in therapy with LGB clients (Godfrey et al., 2006; Lidderdale, 2009; O'Shaughnessy & Spokane, 2013).

Beyond the aforementioned things training programs might consider, the institutional support for a LGB affirmative training environment was also cited in the literature as an important factor for CITs' competence. In fact, studies discussed their finding that there exists a relationship between institutional climate and the quality of education and training about LGB issues (Biaggio et al., 2003; Carlson et al., 2013; Lidderdale, 2009; Miller, Miller, & Stull, 2007). Carlson and colleagues (2013) conducted a study that found that LGB affirmative training in the classroom was positively associated with the experience of an overall LGB affirmative stance in the environment of graduate programs. These authors also concluded that programs who adopted a LGB-affirmative stance were positively associated with students' beliefs, knowledge, and skills associated with competent therapy with clients who identify as LGB.

Ways to create an organizational climate that is gay-affirmative was discussed by Bieschke and Matthews (1996); they explained that hiring an openly diverse staff, advertising to target a LGB staff, and providing training and professional development related to LGB issues were important. The authors found that the participants who reported involvement in a non-heterosexist organizational climate were more affirming with all clients, not just LGB clients. The literature on CITs' work with LGB clients was filled with suggestions for the improvement of training; however, it appears that little change has been made in the area (Green, Callands, Radcliffe, Luebbe, & Klonoff, 2009). After reviewing the literature it became clear that

individuals in the field were endorsing a strong need for specialized training on LGB issues and graduate programs appear to be largely behind in providing students with the necessary competencies (Sherry et al., 2005).

What LGB Clients Reported as Helpful

To bridge the gap in knowledge of LGB needs in therapy, studies have explored LGB-identified clients' needs and perceptions of therapist competence. Consistent with general research on effective therapy (Norcross, 2011), the working alliance has been shown to be a unique contributor to LGB client satisfaction with therapy (Stracuzzi, Mohr, & Fuertes, 2011). Other factors that clients have reported to be helpful are the depth of sessions, session smoothness, mastery of general counseling skills, counselor characteristics, therapist attitude toward LGB concerns, and the communication of a non-pathological perspective on gayness (Israel, Gorcheva, Burnes, & Walther, 2008; Pixton, 2003; Stracuzzi et al., 2011). It should be noted that these studies were conducted with clients who were seeing counselors who identified "gay-affirmative."

Research has shown that clients often prescreen their prospective therapists for gay-affirmative signs; and, this method of prescreening has been found to produce higher therapist ratings (Liddle, 1997). In fact, Liddle found that 63% of their sample prescreened their therapists. Some of the most common methods for prescreening she found included: seeking a referral, consulting with friends in the LG community, asking a LGB organization, and speaking directly with the therapist about sexual orientation.

Another factor that has been shown to contribute to client satisfaction is whether heterosexist language is used in therapy (Dorland & Fischer, 2001). In one analogue study involving LGB identified participants, the vignette that was free of heterosexist language bias

was correlated with participants' reports that they would: "(a) perceive and rate the counselor more positively, (b) express a higher likelihood of returning to therapy, (c) express more willingness to disclose personal information in therapy; and, (d) express more comfort in disclosing sexual orientation in therapy than the participants who read the vignette containing heterosexist bias" (Dorland & Fischer, 2001, p. 532). Burckell and Goldfried (2006) researched other factors that clients who identify as LGB deem important in therapy. They found that a LGB affirming therapist, along with the alliance and knowledge of LGB specific issues were rated as "essential" therapist characteristics.

Liddle (1999) conducted a study with LGB clients who had previously been in therapy with a counselor who identified as heterosexual in order to study client satisfaction based on sexual orientation of the therapist. Results showed that 75% of the participants rated their therapist as "very helpful" and 19% rated their therapist as "fairly helpful," the participants who identified as heterosexual rated their therapists at 62% and 24% respectively. Another study found similar client satisfaction results. In a survey of 600 LGB clients, Jones and Gabriel (1999) found high therapist ratings; specifically, 86% of respondents reported that therapy had positively influenced their lives. Therefore, the authors discussed that the increase in LG client satisfaction in therapy might be the result of increased attention to multicultural aspects and sensitivity to gay and lesbian issues in the field. These findings could have implications in regards to the hope that training on LGB concerns could increase client satisfaction in therapy.

Broaching

Day-Vines and colleagues (2007) define broaching as the counselor's ability to consider in an actionable way the influence of sociopolitical factors on the client's counseling concerns. Although not a new concept, Day-Vines and colleagues coined the term "broaching." These

authors point out that cultural concerns often remain unexamined during the counseling process, which can be detrimental to positive change in therapy. The literature has reflected that the acknowledgement of cultural factors during the counseling process enhances counselor credibility, client satisfaction with counseling, the depth of clients' disclosures, and clients' willingness to remain in therapy (Sue & Sundberg, 1996). Therefore, it has shown to be of paramount importance that the therapists not only consider clients' diversity, but also broach, or bring up (i.e., introduce), these cultural concerns with clients in therapy (Day-Vines et al., 2007).

Day-Vines et al. (2007) argued that counselor behaviors regarding broaching should be included as one of the many multicultural competencies needed to provide competent therapy. Specifically, the MCC call for counselors to acknowledge cultural factors present in the counseling relationship, and Day-Vines and colleagues conceptualized the broaching process as an actionable way to implement this guideline. They asserted that although broaching is not the only skill needed for MCC, it was a tool that can be used to comply with MCC.

The Types and Impact of Broaching

The authors discussed five broaching styles in their seminal paper on the topic (Day-Vines et al., 2007), which also highlighted the important aspect of broaching in the counseling relationship. The continuum of broaching styles they described consists of: (a) Avoidant, (b) Isolating, (c) Continuing/Incongruent, (d) Integrated/Congruent, and (e) Infusing.

The avoidant style of broaching is seen in a counselor who minimizes minority status differences and sees individuals as united by their humanity. In fact, they "make no attempt to broach cultural factors during the counseling process" (Day-Vines et al., 2007, p. 404). The isolating counselor broaches cultural issues, but in a "simplistic and superficial manner." This style is explained as a single statement or question from the counselor. The continuing/

incongruent therapist invites the client to explore the relationship between cultural considerations and the clients' presenting concern. Furthermore, they continue to ask about cultural factors several times in therapy; however, this clinician may not be equipped with the skill set to fully explore the issues in a manner that empowers the client. The integrated/congruent therapist not only broaches diversity throughout therapy, but they also have integrated this practice into their worldview in their professional identities. These counselors do not see broaching as a technique, but more of a routine practice. The infusing style of broaching is similar to that of the integrated style. The main difference is that a counselor who holds an infusing style sees broaching as a lifestyle outside of the professional realm and holds a high commitment to social justice and equality that lies outside of their identity as a mental health practitioner. After an exploratory assessment of the dimensionality of the Broaching Attitudes and Behaviors Survey (BABS) was completed, authors found support for a four-factor measure. No empirical support was found for the Isolating subscale in that the Avoidant subscale accounted for the items intended to load onto the Isolating subscale (Day-Vines et al., 2013).

Day-Vines and colleagues (2007) asserted that broaching helps the clinician and client attach meaning to phenomena in order to translate cultural knowledge to practices that facilitate client empowerment. Many authors noted that this process enhances counseling outcomes and enhances the therapeutic alliance overall (Asay, 2006; Cardemil & Battle; 2003). The literature continuously reflected on the idea that many therapists did not know how to incorporate their cultural competence into the therapy session; and, many discussed that broaching was a tool to do so. That is, authors asserted that by engaging in open conversation about culture, clinicians promoted an environment of trust and understanding that is crucial for forming the therapeutic alliance (Cardemil & Battle, 2003). Although both APA and ACA have developed guidelines

for work with LGB clients, a specific skill set still appears to be missing from the literature on training CITs to work competently with these clients (Graham et al., 2012). Thus, broaching could be introduced as a skill set that could provide CITs with the means to engage in cultural exploration in therapy.

CITs' Broaching Behavior

As of 2016, a small portion of the literature exists that has explored CITs and their ability to broach sexual orientation concerns in therapy. When the topic is included in the literature, broaching is usually a secondary finding or the conceptual theory goes unnamed. In two studies conducted on countertransference reactions in work with clients who identified as lesbian or gay, low levels of homophobia were still correlated with verbal avoidance behaviors on behalf of the CIT (Gelso et al., 1995; Hayes & Gelso, 1993). From these studies it can be inferred that clients who work with therapists who engage in the Avoidant style of broaching might feel discouraged from exploring their same-sex relations and are also be diverted from discussing related themes in therapy; and, this process could interfere with the development of the ever-important therapeutic alliance. Another set of studies found similar results and were also able to expand upon the reasoning that CITs with reportedly low levels of homophobia would engage in Avoidant broaching. Devine and colleagues (1996) found that heterosexually-identified counselors predicted that they would feel self-conscious and anxious in therapy with an LGB client because they feared that they might offend their client (Devine et al., 1996). The authors discussed that the counselors were afraid to appear prejudice and therefore avoided broaching, which could thus mirror the interactions of those who actually are prejudice against the LGB community. This miscommunication due to the lack of broaching by the counselor could lead the client to perceive anxiety as antipathy (Eubanks-Carter et al., 2005).

Neufeldt and colleagues (2006) explored CITs' conceptualizations of clients in an analogue study that assessed MCC from responses after watching a videotape of an initial psychotherapy session. The authors noted that none of the respondents mentioned that they would ask follow up questions to their client regarding sexual orientation. It was discussed that this lack of follow up could have been a result of the vignettes presented to participants in that none of the vignettes had clients explicitly state concerns of sexual orientation. However, other studies have found that individuals who identify as LGB find it difficult to establish rapport without the disclosure of sexual orientation, even if these issues do not directly relate to the presenting concern (Platzer, 1998). Mair and Izzard (2001) conducted a qualitative study with gay men who had been in therapy and found that while the participants reported that therapy was "quite" or "very" helpful, they also reported that the discussion of sexual orientation issues was not perceived to be helpful. In particular, the clients expressed that their experience of exploring their sexuality was either silenced or not explored adequately by their therapist. This contrast in helpfulness could be explained by the fact that the men had not entered therapy to work specifically on sexual identity; however, the therapeutic process was likely affected by the clinicians' inability to broach sexual orientation because the participants reported that they saw this as a drawback of their therapeutic experiences.

These aforementioned findings reflected the need for CITs to be trained to broach sexual orientation concerns because clients may not disclose their sexual orientation issues on their own accord. Additionally, the assumption that clients are heterosexual unless otherwise told reflects heterosexual privilege, and a lack of MCC on the part of the therapist (Simoni & Walters, 2001). Because identifying as heterosexual is the current "norm" in society, counselors who are heterosexual and work with LGB identifying clients must attend to the differences that occur

between them and their clients in order to avoid imputing negative characteristics and engaging in cultural oppression (Sue et al., 1992). As Sue and colleagues (1992) discussed, a counselor who is culturally skilled is "comfortable with the differences that exist between them and their clients in terms of background and worldview" (p. 482). Therefore, a discussion of these differences, or the broaching of culture, is a tool that clinicians should use in order to remain culturally aware and competent (Day-Vines et al., 2007).

The Client's Perspective of Broaching

Asay (2006) explored the importance of addressing issues of culture in therapy in an analogue study. The study explored the perceptions of potential LGB client reactions to three different therapist approaches to addressing sexual orientation in counseling. Findings revealed that addressing a client's sexual orientation was correlated with higher ratings of general therapy competence and MCC.

It was also found that perceived general competence, MCC, and working alliance were all predictive of how willing participants would be to discuss general concerns and sexual orientation issues in therapy. This research made it clear that broaching of sexual orientation is important, even in the first session of therapy. A qualitative study by Grove and Blasby (2009) looked at the client's perspective of broaching behaviors of sexual orientation as well. This study revealed notable findings regarding the former therapy clients' experiences in therapy; that is, when clients were unsure of their counselors' attitudes and knowledge regarding same-sex relationships, the clients noticed barriers to change in therapy. Also, clients reported ideas about their counselors' comfort or lack of comfort regarding issues in same-sex relationships; specifically, the participants noted that "deep counseling work" was prevented when therapists were perceptibly uncomfortable. Furthermore, "deep counseling work" was also prevented when

the therapist was perceptibly "too comfortable" with gay culture and perceived as "overcompensating" for discomfort. In all, the clients reported that they wanted their sexuality to be a component of their presentation in counseling, but they did not want it to be overly defining. This research pointed to the balance that counselors must acknowledge in broaching with some clients who identify as LGB.

Liddle (1996) discussed a similar issue to the one before mentioned in a study regarding what clients report as helpful in therapy. Liddle noted that therapists must not avoid discussion around sexual orientation when the client brings it up; and, a therapist should also not insist on broaching and focusing on sexual orientation when the client does not report it to be most relevant or helpful. Other authors have discussed the clients' report that a discussion of sexual orientation is important, no matter what the leading presenting concern (Israel et al., 2008; Pixton, 2003). In fact, it was found by Mair (2001) that clients feel frustrated when their therapists do not assist them in exploring sexual orientation identities, even among clients who did not report sexual orientation as a main issue. Generally, many authors asserted that counselors and CITs must be able to initiate and talk comfortably about sexual orientation issues with their clients who identify as LGB (Grove, 2009). These aforementioned studies represent the idea that the literature appeared to be mixed regarding the amount of broaching the therapist should do on the topic of sexual orientation.

CHAPTER 3. METHODS

Design Overview

This study examined CITs' broaching styles, confidence in work with LGB clients, and their ability to recognize MCC. Specifically, the study focused on CITs' competence in working with clients who identify as LGB through a mechanism other than self-report where competence was measured having participants rate the competence of a therapist in a vignette.

An experimental design was used in this study. Specifically, written vignettes containing counselor-client scenarios were used as stimuli to test the hypotheses. Participants were randomly assigned to one of three analogue broaching vignettes (see vignettes in Appendix B). The vignettes, or scenarios, portrayed a simulated interaction between a client and therapist in the first session of therapy. Across all vignettes, the statements of the client were identical. The vignettes varied in the therapists' broaching style regarding their response to the clients' conversation about their presenting concern and their sexual orientation identification. Day-Vines (2007) originally identified five broaching styles: (a) Avoidant, (b) Isolating, (c) Continuing/Incongruent, (d) Integrated/Congruent, and (e) Infusing. This study builds on research that demonstrated psychometric similarity of the avoidant and isolating styles (Day-Vines et al., 2013). Additionally, this study was built on research that demonstrated psychometric similarity of the integrated/congruent and continuing/incongruent styles when used in another analogue vignette study (Asay, 2006). Therefore, only the integrated/congruent and avoidant vignettes were used in this study, which replicated those used in Asay's study (2006).

In addition, this study added a scenario that reflected a shut down style of counseling. This style is not discussed by Day-Vines, but attempted to reflect a scenario where the therapist repeatedly redirects the client away from discussing sexual orientation, thereby sending the message that it is not acceptable to discuss sexual orientation in therapy. Although this is less extreme than a therapist suggesting work to alter sexual orientation (which would be expected to produce poor outcomes for LGB clients based on prior research; e.g., APA, 1998; Haldeman, 2002; Haldeman, 1999), it is thought that some CITs and practicing counselors may be uncomfortable enough with diversity in sexual orientation that they redirect any discussion involving sexual orientation out of their own countertransference issues (Asay, 2006; Gelso et al., 1995; Liddle, 1997). This shut down scenario was not validated in prior research and was established for this study's purpose in order to further investigate the way in which CITs rate MCC in the context of broaching and sexual orientation. Lastly, an infusing vignette was not used in this study because this broaching style is practiced outside the therapy interaction and represents a counselor who incorporates sociopolitical issues and acts as change agents in his/her personal and professional life (Day-Vines et al., 2007). In summation, the integrative/congruent (i.e., Vignette A), the Avoidant (i.e., Vignette B), and the shut down (i.e., Vignette C) approaches were used in this study. This research determined that the two vignettes that were used in Asay's (2006) study were appropriate to use in order to explore CIT differences instead of client differences. Furthermore, the shut down approach was created for the purpose of this study in order to expand the literature.

The dependent variable for experimental analysis was the participants' ratings of the scenario therapist's MCC. Specifically, it was conceptualized that CITs who rate therapists demonstrating a lack of MCC as high in MCC are themselves lacking MCC. As such, the ratings

of the therapist were an approximation for MCC competence of CIT participants. In order to better understand what variables might affect how CITs perceive the vignettes, CITs' self-perceived competency with LGB clients and CITs' self-reported broaching attitudes were examined. Finally, the utility of self-reported MCC was examined by comparing a measure of MCC (i.e., the CCCI-R) with participants' ratings of therapist's competence.

Participants

Vignette A contained 79 participants, Vignette B contained 68 participants, and Vignette C contained 77 participants. Due to deleted data, 50 participants were missing from Vignette A, 52 were missing from Vignette B, and 51 were missing from Vignette C. The number of participants varied across the three vignette assignments due the random assignment of the vignettes to the participants in Qualtrics. Data were analyzed from 224 participants unless otherwise specified throughout the analyses. The pattern of missing data was such that those who had missing data were generally missing entire questionnaires and appeared to have stopped responding to the survey. Of the 377 participants who completed the questionnaires, 153 of this kind, with entire questionnaires missing, were deleted. For those retained in analyses but who still had some missing data, no more than five items from the entire survey were missing. For these few missing values, the average responses to non-missing items of the same scale were imputed in place of the missing values.

Participants in the study consisted of CITs obtaining either their master's or doctoral degrees. CITs from the following doctoral and master's programs were included: counseling psychology, clinical psychology, counselor education (to include clinical mental health counseling, and school counseling), and social work. Additionally, it was required that participants had at least one semester of practicum completed or had completed a course in

diversity in graduate school. These requirements were implemented in order to ensure that participants had been exposed to clients or the issues being studied in this dissertation. Exclusion criteria included those who were not enrolled in a graduate program in the mental health field, had not taken a course on diversity, or had not completed at least one semester of practicum.

Because of participants who had missing demographic data, some of the following descriptive information may not sum to 100%. The sample consisted of 76% White identified participants, 7% Asian, 6% as Biracial, 5% Latino, 4% African American, and 1% Native Americans. This sample is not representative of the last Census data collected in the United States. The last Census showed that 63% of the population is White, 17% Hispanic, 12.3% African American, 5% Asian, and 2.4% multi-racial (U.S. Census Bureau, 2012). In regards to participants' sexual orientation identification, 79% of the sample self-identified as heterosexual. 4% self-identified as gay or lesbian, 10% as bisexual, and 5% as queer. With regard to degree level, 66% of the sample reported that they were doctoral students and 33% of the sample reported that they were Master's level students. Participants' accrediting bodies included 61% accredited by APA and 31% accredited by CACREP. The "other" category was coded as missing data because three participants responded to this item; therefore, this did not warrant an "other" category. Participants were from various education programs; 35% of the sample were counseling psychology students, 29% were clinical psychology students, 19% were mental health counseling students, 8% were counselor education students, and 5% were school counseling students. The original sample included seven program categories; however, two categories were eliminated and recoded into missing data for this item due to the size and qualitative responses of these participants. It was determined that these groups were not large

enough and were not coherent enough to be included in analyses. The sample ranged from 22 to 55 years of age. For gender identity, 18% of the sample self-identified as male, 79% self-identified as female, and 4% self-identified as gender queer.

Procedure

Vignette Exposure Conditions

Participants were randomly assigned to one of three analogue counseling vignettes. Appendix B contains the vignettes. Vignette A portrayed the highest level of broaching and cultural competence (i.e., integrated/congruent), followed by Vignette B (i.e., avoidant) followed by Vignette C (i.e., shut down). Vignette C reflected the lowest level of competence and an attempt to limit the discussion of the client's sexual orientation in a shut down style. This vignette was created for the purpose of this study.

Order Effects

The order of measures given to each participant was varied to control for order effects. Each participant received the SOCCS or the BABS in different orders. A one-way multiple analysis of variance (MANOVA), with order of administration as the independent variable and predictor variables as the dependent variables, revealed that order effects were not present between the dependent and predictor variables and the test was not significant (p = .101). Every participant first read a randomly assigned vignette and answered follow-up questions regarding their perception of the therapist's interventions in the scenario (See Appendix E). Each participant then rated the therapist's MCC using the CCCI-R, a measure used to assess therapists' cross-cultural counseling competence. The surveys were set up to prevent individuals from going back to alter their responses to the vignette once they have started responding to other surveys (participants were instructed to carefully read the vignette when it was presented).

In addition, the survey was set up so individuals could not participate in the study more than once.

Accessing and Completing the Study

"Qualtrics" was used to gather data for the current study. Following approval from the Auburn University Institutional Review Board (IRB), the participants were recruited using listservs and email correspondence to training directors (TDs) and directors of internship sites. Listservs from the following professional organizations were used: COUNSGRADS (an American Counseling Association listserv), Diversegrad-L (an American Counseling Association listserv), the Council of Counseling Psychology Training Programs (CCPTP), the Association of Counseling Center Training Agencies, the Counselor Educators and Supervisors Network (CES-NET), the American Psychological Association of Graduate Students (APAGS), APA Division 44-Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues in Counseling, the ACA Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling. Recruitment through correspondence with the TDs involved a recruitment message sent to TDs requesting that they forward the study to their graduate students or trainees.

The email and listserv posts contained a hyperlink that took participants to the online study. Once participants clicked the link, they were directed to a page containing an information letter that described the voluntary nature of the study, how to contact the PI and advisor, confidentiality, anonymity, IRB information, and fact that completing the study constitutes consent. After reading the information letter, those participants who agreed to participate clicked a link that took them to questions used to determine eligibility for participation. To ensure that individuals met the criteria to be included in the study, the inclusion and exclusion criteria were

asked prior to starting the study (i.e., before the experimental exposure to one of the three vignettes). Those potential participants who did not meet criteria were directed to the end of the study and thanked for their time. Those participants who met the inclusion criteria were exposed to one of three vignettes through random assignment. After responding to questions about the vignettes, participants responded to the following questionnaires: therapist competency ratings, the Cross Cultural Counseling Inventory-Revised (CCCI-R), the Sexual Orientation Counselor Competency Scale (SOCCS), and the Broaching Attitudes and Behaviors Survey (BABS). Participants also provided additional information about their doctoral or master's programs and training experiences related to working with clients who identify as LGB.

Participants were offered the option to win one of four Amazon gift cards in the amounts of $75.00, $50.00, and two at $25.00. After submitting their survey responses, participants were routed to another separate survey within Qualtrics where they entered their email address if they wanted to be included in the random drawing. This process was implemented in order to ensure that Emails and survey responses were not connected.

Missing Data

Participants' data was deleted if they did not respond to a number of items and the measure was invalid as a result. Participants' missing data under the cut off for invalidation were included in analyses. These participants' items were pro-rated; the average score for non-missing items was determined and used for the missing items.

Instruments

The instruments used in this study that use Likert scales were kept in their original scaling format in order to preserve the use of each measure in its original form. Therefore, the following scales vary across measures; however, the means of the measures were not compared

and instead, linear relationships were examined. Therefore, the variables did not need to be on the same scale for the purpose of this study.

Demographic Questionnaire

The demographics section was split into two parts and elicited the following information about the participants: age, ethnicity, gender identification, sexual orientation, graduate program type, graduate program accreditation status, year in graduate school, number of years and/or months of clinical training, number of LGB clients seen, and amount of training associated with LGB concerns. Only questions used for determining eligibility to participate appeared in the section immediately following the information letter. All additional demographic questions appeared after all study measures at the end of the study. Appendix D contains the demographics questionnaire parts 1 and 2.

Additional Questions

Items developed for this study were used to evaluate the participants' rating of the therapist's MCC and to assess participants' views of the overall quality of therapy portrayed in the vignettes. These were single-item questions. It should be noted that some single-item measures fail to achieve acceptable reliability due to their heterogeneous nature (Postmes, Haslam, & Jans, 2013). Prior evidence for the validity of the interpretation and use of these scores for therapist competence was not established in that these items were constructed for this study's use. One additional question was also asked of the participants in order to disguise the purpose of the study. The question used to disguise the purpose of the study asked about the likelihood of referring the client in the vignette for a medical evaluation. The items were individually rated on a 6-point Likert scale, ranging from "1" (strongly disagree) to a "6"

(strongly agree). Total scores were not used on these questions. Appendix E contains these questions.

Cross-Cultural Counseling Inventory-Revised (CCCI-R)

This instrument is a measure used to assess cross-cultural counseling competence, better known as MCC in current literature (LaFromboise, Coleman, & Hernandez, 1991). The measure is based on APA's Division 17 Education and Training Committee's tridimensional characteristics of cross-cultural counseling and therefore assesses the beliefs/attitudes, knowledge, and skills necessary for cross-cultural competence. As previously mentioned, the CCCI-R was originally formed for the supervisor to rate their supervisee's competence; and, modified forms for the client to rate their therapist's competence also exist. Thus, this measure was deemed appropriate for use in the current study due to its usefulness for rating third-party counselor competence (Asay, 2006; Owen, Leach, Wampold, & Rodolfa, 2011; Ridley & Shaw-Ridley, 2011). Participants completed the CCCI-R in reference to the therapist in the exposure vignette to which they were assigned. Therefore, participants answered the items on this measure based off the therapists' competence in the vignette they read, not their own.

The CCCI-R consists of 20 items. The items were individually rated on a 6-point Likert scale, ranging from "1" (strongly disagree) to a "6" (strongly agree). Items in the measure contain prompts such as "the therapist is aware of his own cultural heritage" and "the therapist values and respects cultural differences." Scores were obtained by adding the participant responses to each item in order to obtain a total score ranging from 20–120. Higher scores on the CCCI-R reflect higher ratings of cross-cultural counseling competence. Exploratory studies of the CCCI-R were completed in order to develop the measure and study the factor structure. The content analysis determined whether the measure represented cross-cultural counseling

competencies as defined in APA's Division 17 report. The study generated acceptable content validity (interrater reliability kappa of .58) and determined that the measure was representative of the Division 17 competencies. The reliability of the average rating across the three raters used in the initial study was .78 (LaFromboise, Coleman, & Hernandez, 1991). See the prompt for the measure in Appendix F.

Sexual Orientation Counselor Competency Scale (SOCCS)

This instrument was developed in order to extend multicultural counselor competency theory to work with LGB clients. Therefore, this measure assesses the attitudes, knowledge, and skills necessary to provide affirmative and competent services to LGB clients. As a result, the *SOCCS* is comprised of three subscales including CITs' awareness, knowledge, and skills. The measure does not focus on work with transgender individuals because of the variation between sexual orientation and gender (Bidell, 2005).

The final version of the measure contains 29 items and has three subscales including Skills (11 items focused on LGB affirmative clinical work), Attitudes (10 items which assess self-awareness of LGB biases and stigmatization), and Knowledge (8 items assessing knowledge of LGB psychosocial issues). The SOCCS has 11 items that are reverse scored and the items are randomly ordered. The measure uses a 7-point Likert scale ranging from "1" (not at all true) to "7" (totally true), where higher scores indicate greater levels of self-perceived competency (Bidell & Whitman, 2013). Examples of prompts included on the measure are "I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients" and "the lifestyle of a LGB client is unnatural or immoral." Participants complete the items based off their self-reported perceptions. The scores on the measure represent competency in participant responses ranging from one to seven. The higher the total score on the measure and

subscales, the higher the competency reported by the participant completing the measure. The overall score for the SOCCS is obtained by totaling the participants' responses on each subscale. The individual subscale scores are obtained by totaling the participants' scores on the items that load onto the appropriate subscale.

Research on the psychometric properties of the SOCCS reveals that the measure has acceptable levels of validity, reliability, and consistency for use with counseling graduate trainees (Bidell, 2005). Bidell (2005) reported alpha coefficient of .90 for the full-scale SOCCS and the subscale coefficients of .88 (Awareness), .91 (Skills), and .76 (Knowledge). The test-retest reliability coefficient was .84 (Bidell, 2005). Another study that implemented the SOCCS showed similar psychometric results with overall alpha coefficients of .87 and .91, .86, and .71 for the Total, Awareness, Skills, and Knowledge subscales respectively (Graham et al., 2012). See the prompt for the measure in Appendix G.

Broaching Attitudes and Behaviors Scale (BABS)

The BABS is an assessment of counselors' attitudes and behaviors toward broaching. The scale was developed to measure the continuum of broaching behaviors that might be exhibited by clinicians. An examination of 117 trial, self-report items designed to assess the five broaching styles (i.e., Avoidant, Isolating, Continuing/Incongruent, Integrated/Congruent, and Infusing) were reduced through content analysis and factor analysis. The content analysis involved review of the trial items by 8 doctoral students, 17 Master's-level students, and three counselor educators with expertise in MCC. A criterion of at least 80% agreement on the broaching category was required to retain the item for the next phase of development. Each item was also evaluated for clarity on a one- to three-point Likert scale and if items were denoted

"unclear" then the item was reviewed and was either deleted or reworded to enhance clarity (Day-Vines et al., 2013).

A factor analysis using responses from members of ACA was conducted and a four-factor structure was retained; it was found that the items included in the Isolating subscale accounted for those in the Avoidant subscale. The Avoidant subscale, characterized by a counselor's unwillingness to discuss issues related to race, ethnicity, and culture, contains 14 items and was internally consistent with an alpha of .88. The Continuing/Incongruent subscale, comprised of 10 items, was internally consistent with an alpha of .88. This scale measures the counselor's difficulty applying the broaching skill to their work with clients. The Integrated/Congruent subscale contains 10 items and was found internally consistent with an alpha of .80. This scale reflects a counselor's ability to initiate or respond to a client's racial, ethnic, and cultural concerns. Lastly, the Infusing subscale contains nine items and was found internally consistent with an alpha of .78. This scale captures a counselor's self-reported "ability to recognize the importance of using institutional supports with clients" (Day-Vines et al., 2013, p. 215). Following the aforementioned factor analysis and content analysis, the final version was established and contains 42 items. After examining the inter-factor correlations between the four aforementioned subscales, it was found that the categories on the continuum of broaching used in the BABS are independent subscales and the positive or negative correlations between the subscales are theoretically sound, suggesting support for construct validity (Day-Vines et al., 2013).

Respondents used a 5-point Likert scale ranging from "1" (strongly agree) to "5" (strongly disagree) to indicate their agreement with measure items with some items reversed scored. Example items (which have been modified for the purpose of this study) are, "a sexual

orientation-neutral perspective is the most appropriate stance for counseling" and "I typically broach one or two times over the course of the counseling relationship." The items on each subscale are averaged. The subscale with the highest score represented greater endorsement of a particular broaching style; however, respondents obtained a separate score for each subscale. Each subscale score was calculated in order to represent the possibility that counselors could operate in more than one broaching style within the counseling process. Additionally, the subscale with the highest score represented the respondent's most predominant mode of functioning in terms of broaching style (Day-Vines et al., 2013). The entire measure was administered in the current study. Participants' scores on the Avoidant, Continuing/Incongruent, Integrated, and Infusing subscales were used. The participants' scores on the Isolating subscale were not used because this scale loaded onto the Avoidant subscale in an exploratory assessment of the measure's dimensionality. Although the vignettes in this study represented two broaching styles and a shut down approach, the entirety of the BABS measure was used including the subscales in order to investigate the participants' self-reported broaching styles.

For the current study, many of the BABS items were modified in order to pertain to counselors' work with clients who identify as LGB. The items that specifically mention race, ethnicity, and clients of color were modified to language that pertains to sexual orientation and work with LGB. Other items in the measure remained unchanged in order to maintain the psychometric properties of the original measure created by Day-Vines (2007). See the prompt for the measure in Appendix H and permission email in Appendix I.

CHAPTER 4. RESULTS

Overview and Data Screening

The results of the data analyses are presented in this chapter. Various analyses were used to test the hypotheses based on the most appropriate statistical test. Additionally, simple correlations between variables of interest are presented along with reliability statistics of the measures used in this study.

Analyses were run using a total of 224 participants unless otherwise specified. Analyses of Variance (ANOVA) and *t*-tests were run in order to examine whether group differences existed, which would suggest a failure of randomization. Gender, ethnicity, program (i.e. counseling psychology, clinical psychology, school counseling, and counselor education), BABS scores, SOCCS scores, sexual orientation, and degree level were run and none of the results were statistically significant. Participant characteristics appeared to be randomized across vignette types. Tests of normality for all continuous variables suggested variables were adequately normal and no transformations were required.

Reliability Statistics

The reliability of the scores of the measures used in this study were examined in order to determine internal consistency of each measure within the study sample. Reliability levels were compared to those suggested by Kline (2013). The CCCI-R was found to have excellent internal consistency ($\alpha = .96$), similar to the authors' findings in their development of the scale

(LaFromboise, Coleman, & Hernandez, 1991). The internal consistency of the SOCCS was acceptable (α = .76). This finding was lower than the internal consistency found by the author of the measure (Bidell, 2005). The scores within each of the subscales of the SOCCS were also analyzed for reliability. Scores within the Skills subscale evidenced acceptable internal consistency (α = .77). The scores within the Attitudes subscale evidenced excellent reliability (α = 0.93). Lastly, the scores within the Knowledge subscale evidenced questionable reliability (α = .67). These findings were similar to those found in the author's research on the development of the scale (Bidell, 2005); however, the Knowledge subscale in the development sample evidenced acceptable reliability (α = .76). Because of the questionable reliability on the Knowledge subscale, the overall reliability was decreased on this measure.

In regards to the BABS, analyses were conducted based on the authors' recommendations and subscales determined its internal consistency (Day-Vines, Bryan, & Griffin, 2013). The Avoidant, Continuing Incongruent, Integrated/Congruent, and Infusing subscales ranged from .80 to .82 and were determined to have good reliability. These findings were similar to that of the authors' of the scale (Day-Vines, Bryan, & Griffin, 2013).

Descriptive Statistics

Descriptive statistics were computed for the measures used in this study. Refer to Table 1 for results. Pearson product-moment correlations were run in order to explore the relationship between the variables used in the current study. Refer to the correlation matrix in Table 2 for results. Inspection of bivariate correlations revealed expected patterns in that measures that assessed similar constructs were related. The Integrated/Congruent and Infusing broaching styles reflect more advanced broaching, where therapists engage in an approach-style behavior of inviting conversation. The Avoidant and Continuing/Incongruent are less advanced broaching

styles where therapists engage in a more avoidant style conversation. As expected, the more advanced broaching styles positively correlated with one another and negatively correlated with endorsement of less advanced broaching styles. In addition, the less advanced broaching styles were positively correlated with one another, as expected. The Infusing broaching style did not correlate significantly with the SOCCS total, which is a measure of self-reported competence in work with LGB clients. This aforementioned finding was unexpected given the self-report nature of both of the measures. The number of LGB-identified clients the participants self-reported seeing and their self-ratings on SOCCS was moderately, positively correlated. This aforementioned relationship was also expected given that experiences will likely increase one's self-report of ability with LGB clients in particular.

An ANOVA was conducted followed by post-hoc *t*-tests to determine which programs differed from one another significantly on the BABS. Overall program differences were found [$F(6,220) = 3.40$, $p = .003$]. Specifically, it was found that CITs in clinical psychology ($M = 2.73$, $SD = .23$) differed significantly from CITs in mental health counseling ($M = 2.88$, $SD = .21$) on the BABS in that mental health counseling students endorsed higher broaching styles than clinical psychology students. Differences between programs were also discovered for SOCCS scores [$F(6,220) = 3.79$, $p = .001$]. Specifically, it was found that counseling psychology students ($M = 3.40$, $SD = .50$) differed significantly from both mental health ($M = 3.08$, $SD = .52$) and school counseling ($M = 2.82$, $SD = .50$) programs. Lastly, counselor education ($M = 3.48$, $SD = .56$) and school counseling ($M = 2.82$, $SD = .50$) CITs significantly differed on SOCCS scores. Additional analyses were run in order to examine the categorical variables. Specifically, differences in ethnicity and gender were explored on the key study measures (i.e., BABS and SOCCS scores). It was found that there were not significant

differences in the mean values of in key study variables (i.e., BABS and SOCCS scores) as a function of ethnicity and gender.

Next, master's students and doctoral students' differences were examined in key study variables (i.e., BABS and SOCCS scores). It was found that master's students and doctoral students' scores on the Avoidant subscale of the BABS were significantly different in that master's students endorsed higher scores on this subscale. SOCCS scores were also significantly different among master's and doctoral students in that doctoral students produced higher scores on this scale. See results in Table 3. In contrast, whether participants were in master's or doctoral schooling was not found to be significant among Vignettes and ratings of MCC. See Table 4 for results. A MANOVA was run in order to further explore any differences that might exist among master's and doctoral students across the three vignettes; this test was not significant (F (2,220) = .22, p = .803).

Tests of Hypotheses

Overall Quality of Therapy

The hypotheses that examined the overall quality of therapy ratings by participants were tested using an ANOVA. Post-hoc analyses (i.e., t-tests with Bonferroni corrections for Type I error) were employed in order to determine which groups significantly differed from the others. This hypothesis was confirmed in that participants rated the overall quality of therapy in the vignettes significantly different [F (2,221) = 13.90, $p < .001$, $\omega^2 = .10$]. Post-hoc analyses using the Bonferroni correction indicated that quality ratings for Vignette A were higher than those for Vignette C. Further, Vignette B was rated more highly than C. Vignette A was not rated significantly different from B. See Table 5 for a further explanation of results.

MCC of the Therapist in the Vignette

The hypotheses regarding the multicultural counseling competence of the therapist in the vignettes were also used tested using an Analysis of Variance (ANOVA). The ANOVA revealed that the vignette exposure effect was significant [F (2, 221) = 55.36, $p < .001$, $\omega^2 = .13$]. Post-hoc analyses using the Bonferroni correction were employed in order to determine which groups significantly differed from the others. Post-hoc analyses revealed that participants rated the therapists' MCC significantly different across all three vignettes. That is, participants rated the therapists' MCC in Vignette A higher than that of Vignette B. Participants also rated the therapists' MCC in Vignettes A and B higher than that of Vignette C. See Table 5 for results.

I then examined vignette differences in multicultural counseling competence of the therapist while controlling for overall quality ratings. Multicollinearity between MCC and overall quality was tested. Tolerance was greater than .10 and variance inflation was less than 10. This suggests that data met the assumption of collinearity. In the ANCOVA analysis, Vignette A was significantly different from Vignettes B and C (F (2,220) = 40.93, $p < .001$, $\omega^2 = .81$). Vignettes B and C were not significantly different when I controlled for overall quality ratings. See Table 6 for results.

Broaching Style, Vignette, and MCC

In these hypotheses, I made specific predictions regarding the relationships between specific broaching styles and MCC among those who read particular vignettes. Supplemental analyses were used in order to examine broaching style as a potential moderator of the relationship between vignette read and MCC ratings. In examining moderation, I tested interactions between broaching styles and vignettes in the prediction of MCC.

To organize the presentation of findings I first present tests of the regression models testing broaching style and MCC among those who read particular vignettes. Following, I

present regression analyses testing broaching styles as potential moderators of vignette differences and MCC ratings.

Within Vignette Regression Analyses

I first examined the Integrated/Congruent and Infusing broaching styles as predictors of MCC among participants who read Vignette A. Multicolinearity was tested and the distribution was determined normal. In this regression model, neither broaching style was statistically significant (for Integrated/Congruent: B = .54, SE = .33, β = .20, t = 1.67, p = .10; for Infusing: B = 1.06, SE = .55, β = .23, t = 1.92, p = .06). In a regression model examining the same model for those who read Vignettes B or C, neither predictor was statistically significant (for Integrated/Congruent: B = .29, SE = .34, β = .09, t = .85, p = .40; for Infusing: B = -.25, SE = .44, β = -.05, t = -.56, p = .58). Finally, I examined Avoidant and Continuing/Incongruent broaching styles as predictors of MCC among those participants who read Vignettes B or C. In this model, neither predictor was statistically significant (for Avoidant: B = .21, SE = .27, β = .08, t = .79, p = .43; for Continuing/Incongruent: B = -.01, SE = .27, β = .00, t = -.03, p = .98). Thus, in no instance were any of the predicted broaching styles associated with MCC among specific subgroups of participants based on the vignette they read.

Broaching Style as a Potential Moderator of the Impact of Vignette on MCC

To further explore this hypothesis, I used linear regression models to test my prediction that broaching styles could serve as a potential moderator of the impact of vignette on CCCI-R scores. Multicollinearity between was tested and tolerance was greater than .10 and variance inflation was less than 10. This suggests that data met the assumption of collinearity. The testing of vignette in these models utilized a variable that reflected whether participants were assigned to Vignette A, or one of the other two vignettes (i.e., B or C). In each of these models, CCCI-R

scores served as the dependent variable. The predictor variables were: the vignette (i.e., Vignette A vs. Vignettes B and C) and broaching style. An interaction term was computed in order to examine the interaction between vignette type and broaching style. In these models, the interaction of vignette and BABS subscale one (i.e., the Avoidant subscale) was significant as was the interaction of vignette and BABS subscale four (i.e., the Infusing subscale). The interaction of vignette with BABS subscales two and three were not significant. Results of these models are provided in Table 7.

As the table shows, only BABS subscales one and four were found to significantly moderate the impact of vignette on MCC ratings. To understand what was driving these interactions, an online utility was used (Preacher, Curran, & Bauer, 2006). To clarify the nature of the moderating role of the BABS subscale one (i.e., Avoidant), I tested the simple slopes of the effect of vignette among those who were low (-1 SD) and high (+1 SD) in the Avoidant broaching style. The simple slopes report the relationship of the predictor at different values of the moderator; the slopes of the current test were one standard deviation below the mean and one standard deviation above the mean. Another online utility was used in order to test the specific simple slopes in this study (Dawson & Richter, 2006). The Avoidant broaching style slopes test revealed that both slopes were significant at [$t(3) = 18.99$, $p < .001$] and [$t(3) = 16.44$, $p < .001$]. Among those low in this broaching style (-1 SD), those who responded to vignette A gave significantly higher CCCI-R ratings than those who responded to vignette B or C ($\beta = 31.46$ (3.11), $t = 10.1$, $p < .001$). Among those high in this broaching style (+1 SD), those who responded to vignette A also gave significantly higher CCCI-R ratings than those who responded to vignette B or C ($\beta = 16.55$ (3.24), $t = 5.12$, $p < .001$). However, as the values show, the difference between vignettes was greater for those who reported a lower Avoidant broaching

style. The interaction is depicted visually in Figure 1. As the figure shows (and the significance test for vignette in model one of the previous Table 7 corroborates), overall the therapist in Vignette A was rated higher on the MCC by participants; however, this main effect was moderated by BABS subscale one (i.e., the Avoidant subscale).

To clarify the nature of the moderating role of the BABS subscale four (i.e., Infusing), I examined the effect of vignette among those who were low (-1 SD) and high (+1 SD) in the Infusing broaching style. Again, the online utility created by Dawson and Richeter (2006) was used in order to test the specific simple slopes. For the infusing style of broaching, the testing of the slopes revealed that both slopes were significant at [$t(3) = 14.61$, $p < .001$] and [$t(3) = 15.44$, $p < .001$]. Among those low in this broaching style (-1 SD), those who responded to vignette A gave significantly lower CCCI-R ratings than those who responded to vignette B or C ($\beta = 17.37$ (3.60), $t = 4.82$, $p < .001$). Among those high in this broaching style (+1 SD), those who responded to vignette A also gave significantly higher CCCI-R ratings than those who responded to vignette B or C ($\beta = 29.14$ (3.28), $t = 8.89$, $p < .001$). However, as the values show (see significance test in Table 7), the difference between vignettes was greater for those who reported a higher Infusing broaching style. The interaction is depicted visually in Figure 2. As Figure 2 shows (and the significance test for vignette in model four of the previous table X corroborates), overall the therapist in Vignette A was rated higher on the CCCI-R by participants; however, this main effect was moderated by BABS subscale four (i.e., the Infusing subscale).

Following the aforementioned analyses, the hypothesis was tested while controlling for overall quality ratings. When overall quality of therapy rating were included as a covariate in the models, results were not statistically significant.

MCC, Vignette, and SOCCS Scores

The hypothesis that examined SOCCS scores and participants' ratings of the MCC of the therapist in the vignettes were examined. Participants' total SOCCS scores were examined as a potential predictor of MCC and exposure vignette. The interaction did not achieve statistical significance in that the participants' SOCCS scores did not predict CCCI-R ratings. Refer to Table 8 for results.

The next hypotheses explored the subscales of the SOCCS and predicted that the relationship between SOCCS scores for competence on the "Skills" subscale and MCC ratings for Vignettes A and B would be stronger than the relationship for SOCCS scores on the "Knowledge" and "Attitudes" subscales with MCC ratings for Vignettes A and B. Additionally, it was predicted that the relationship between SOCCS scores for competence on the "Attitudes" subscale would be more strongly associated (in the negative direction) with competence ratings for the therapist in Vignette C than will competence on the "Skills" or "Knowledge" subscales.

To test these hypotheses, subscales of the SOCCS were examined using correlations in order to determine the relationship between participants' subscale scores and their ratings of MCC. Only the correlation involving Knowledge was statistically significant ($p < 0.05$). Results indicated that Vignettes B and C were not significantly correlated with the SOCCS. Refer to Table 9 for results.

To further test the hypotheses, the magnitude of correlations in the SOCCS subscales were examined in order to see whether differences in the size of the relationship between the variables of interest were statistically significant, assuming the differences across relationships (correlations) were consistent with the predicted direction (i.e., larger for Skills than for Knowledge and Attitudes).

Among the 147 participants who responded to vignettes A or B, the correlation of the SOCCS Skills subscale and CCCI-R was .07 (p = .42). The correlation of the SOCCS Knowledge subscale and CCCI-R was .04 (p = .61). The correlation of SOCCS Attitude subscale and CCCI-R was .12 (p = .16). To test whether correlations differed significantly, I used an online utility for testing such differences in correlation coefficients within the same sample (Lee & Preacher, 2013) and, because I had directional hypotheses, a one-tailed test was employed. This test showed that the correlation of the SOCCS Skills subscale and CCCI-R (r = .07) was not significantly greater than the correlation of the SOCCS Knowledge subscale and CCCIR (r = .04; z = .25, n = 147, p = .40). In addition, the correlation of the SOCCS Skills subscale and CCCI-R (r = .07) was not significantly greater than the correlation between SOCCS Attitudes subscale and CCCI-R (r = .12; z = 1.496, n = 147, p = .07).

Among the 77 participants who responded to Vignette C, the correlation of the SOCCS Attitudes subscale and CCCI-R was not significant (r = -.17, p = .13). The correlation of the SOCCS Skills subscale and CCCI-R was also not significant (r = -.01, p = .90). Lastly, the correlation of the SOCCS Knowledge subscale and CCCI-R was not significant (r = -.15, p = .19).

As previously stated, I used the same online utility for testing the magnitude differences in correlation coefficients, again using a one-tailed test because I was testing a directional hypothesis. This test showed that the correlation of the SOCCS Attitudes subscale and CCCI-R (r = -.17) was not significantly greater than the correlation between SOCCS Skills and CCCI-R (r = -.01; z = 1.017, n = 77, p = .15). When comparing the correlation of the SOCCS Attitudes subscale and CCCI-R (r = -.17) with the correlation of the SOCCS Knowledge subscale and CCCI-R, this difference was not statistically significant (r = -.15; z = 1.773, n = 77, p = .08).

Broaching Style and SOCCS Scores

It was hypothesized that those who had their highest broaching score as one of the two more advanced broaching styles (i.e., the Integrated/Congruent and Infusing styles), would have higher SOCCS scores than those who had a less advanced broaching style as their highest score (i.e.,, the Avoidant and Continuing/Incongruent). To analyze this hypothesis the broaching styles were categorized and a comparison of means was employed.

For reference, refer to Table 10 for the broaching styles participants endorsed. Participants who endorsed a more advanced broaching style endorsed significantly higher SOCCS total scores (M = 95.80, SD = 15.16) as compared with those who endorsed less advanced broaching styles (M = 89.22, SD = 16.70; $t(218) = -2.20$, $p = .03$, $d = -0.43$).

CHAPTER 5. DISCUSSION

This chapter focuses on a discussion of the results presented in Chapter 4. The purpose of this study was to examine CITs and their ability to rate the level of cultural competence observed in a vignette. This procedure was used in order to examine CITs' level of insight around MCC and beliefs about their own broaching style and work with LGB clients. The design of the study was experimental in that participants were randomly assigned to one of three counseling scenarios and were asked to rate the MCC of the therapist in the vignette. The participants also completed two self-report measures, the Broaching Attitudes and Behaviors Survey (BABS) and the Sexual Orientation Counselor Competence Scale (SOCCS). This method was used in order to expand the literature in three different areas: further our knowledge in work with clients who self-identify as LGB, broaching and its use as a specific skill in order to provide therapy that is based in multicultural sensitivity, and further the exploration of self-report and its ability to accurately measure clinicians' MCC. This study also focused on training implications.

Implications of Findings

Discussion of Correlations and Variable Relationships Examined

The number of LGB-identified clients that participants reported having experience with was correlated with participants' self-report on a measure that assesses attitudes, skills, and knowledge in work with LGB clients; the more LGB identified clients participants reported seeing, the higher the participants' belief that they were competent in their work with LGB

clients. This positive correlation shows a relationship between CITs' experience with counseling LGB clients and their confidence in this work. Additionally, because LGB identified individuals seek therapy more often than the general population, attend therapy for more severe mental health concerns, are at a higher risk for suicide, use more therapy sessions than the general population, and are more likely to terminate their therapy due to negative experiences, it is of vital importance that counselors be competent in their work with these clients (Cochran, 2001; Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; Liu & Mustanski, 2012; Rostosky, Riggle, Horne, & Miller, 2009).

The comparison of master's versus doctoral level students' results was interesting in that master's students were more likely to endorse the less developed broaching styles (the Avoidant and Continuing/Incongruent). This result was likely due to the experience difference between these levels of education. Furthermore, it was found that doctoral students had higher scores on the self-report measure that assessed confidence in work with LGB clients (i.e., the SOCCS); again, likely due to an experience difference among these groups.

Further comparisons revealed an interesting finding that does not align with the theory that more training produces more competence and confidence. Master's mental health counseling students endorsed more advanced broaching styles than clinical psychology students. Other program differences revealed that doctoral counseling psychology students self-report higher competence in their work with LGB clients than that of master's CITs from both clinical mental health counseling and school counseling. Lastly, counselor education doctoral students rated their competence with LGB clients higher than did master's school counseling students.

Hypotheses Discussion

First, I predicted that participants would differentially rate the overall quality of the therapy portrayed in the three vignettes. When participants' results were analyzed, it was found that participants were able to distinguish generally "good" versus generally "bad" ways to work with a gay client in terms of creating an environment where a client was invited to talk about his sexual orientation. Following the identification of these aforementioned results, I looked at the differences between each vignette in order to determine the magnitude of participants' ability to distinguish "good" versus "bad" therapy. Because a between groups design was used to examine perceptions of the vignettes, each participant rated only one vignette. With this it was possible to compare the ratings across vignettes (which reflect ratings across groups of participants). Vignettes A and C and B and C were evaluated differently. In contrast, there was not a difference in the ratings for level of quality of the therapy between Vignettes A and B across the participants who viewed Vignette A or Vignette B based on random assignment. This finding was counterintuitive. Specifically, Vignette A depicted a therapist asking about (or broaching) the client's sexual orientation in a welcoming way and represented the integrative/congruent broaching style. However, Vignette B, which was previously found to be seen as less helpful by individuals who identified as LGB (Asay, 2006), depicted a therapist who was only speaking about culture in a very general way and not asking about sexual orientation (i.e., the avoidant broaching style). The failure of participants who read Vignette B to rate the quality of therapy as significantly lower than the rating assigned to Vignette A by the participants who read Vignette A indicates that there may be a difference in how CITs in this study conceptualized what constituted quality therapy and how LGB individuals think about helpful therapy. The fact that both Vignettes A and B were rated higher in terms of quality therapy than Vignette C suggests

that CITs did recognize that a shut down approach to the discussion of sexual orientation reflects lower quality of therapy. Although these aforementioned results were found, the vignette approach to this study limits these findings and CITs actual practice in the therapy room cannot be determined.

These aforementioned results portray the trainees' abilities in this particular study to read another's work and rate the quality of therapy. One could theorize that these particular findings could imply that if trainees are able to rate quality therapy, they might be able to mirror this quality in their individual work with clients. Although this current study did not explore the supervisor process, it could be theorized that trainees in this study might be able to better provide feedback about quality of therapy in a supervisory relationship as well.

Second, this study examined participants' ability to rate the MCC of therapists in the three exposure vignettes. It was found that participants exposed to Vignette A rated the MCC of the therapist in the Vignette the highest. Next, those exposed to Vignette B rated the MCC of the therapist within their vignette higher than did those individuals exposed to Vignette C. Looking at the pattern across groups, participants rated Vignette A the highest, followed by Vignette B, followed by Vignette C. These results were all statistically significant. Therefore, it can be theorized that some CITs are able to observe another's work and determine ability to provide culturally competent therapy to LGB clients in specific. Moreover, if CITs are able to translate this observation into their own clinical practice, they may be able to provide MCC therapy. Unfortunately, confirming the specifics of knowing what to do in order to provide therapy that is sensitive to LGB clients' needs is beyond the scope of this study.

Another hypothesis in this study explored participants' self-endorsed broaching styles and the way in which endorsed broaching style relates to MCC ratings of a therapist in an

exposure vignette. When the relationships among the variables was tested, no significant results were found; however, when supplemental analyses were conducted and the interactions of broaching style, vignette, and MCC ratings were tested, partial support for the relationships was found. The least advanced broaching style (i.e., the Avoidant) and the most advanced broaching style (i.e., the Infusing) reached significance in the model tested and were found to moderate the impact of vignette (A vs. B and C) exposure on MCC ratings. The mid-level broaching styles failed to reach significance in the current study and there seemed to be more of a difference in how the vignettes were rated when respondents endorsed extreme broaching styles. Therefore, broaching style moderated participants' ratings of MCC in the vignettes only in participants who endorsed the most and least advanced broaching styles (i.e., the Avoidant and Infusing broaching styles).

Because it was found that the highest and lowest broaching styles were the only significant findings, this could have implications for training programs in that curriculum could incorporate training on the various broaching styles and the impact of broaching style on ability to determine MCC. For instance, programs might consider screening to identify students who endorse the Avoidant broaching style at a certain level of training. The literature reflects the idea that clients who work with therapists who engage in the Avoidant style of broaching potentially feel discouraged from exploring their sexuality and feel diverted from discussing these relevant themes in therapy, thereby negatively impacting the therapeutic alliance (Israel et al., 2003). It may be that those CITs who endorse the Avoidant style of broaching will need more training before they can effectively work with LGB clients. Because LGB clients gave higher ratings of general therapy and perceived MCC to counselors who directly explore sexual orientation (Asay, 2006), programs might encourage behaviors in and out of the therapy room that correspond with

the Infusing broaching style. For example, programs might encourage students to further advocate for their clients outside of the therapy room and provide support to do so. Day-Vines and colleagues (2007) call for broaching to be included as a domain within multicultural competency and assert that broaching is not only a skill, but should be viewed as a tool used to comply with MCC. This study found that only those who endorse the Avoidant and Infusing broaching styles had differing ability to recognize MCC. Therefore, the results of this study have implications regarding the nature of the broaching styles and the concept that these two ideas (i.e., broaching style and MCC) are truly intertwined.

To further investigate trainees' self-report validity, I examined their scores on a measure that assesses skills, attitudes, and knowledge (i.e., the SOCCS) in work with LGB clients and the interaction of these scores with which vignette they were exposed and their ratings of the therapists' MCC in the vignette. Participants' total SOCCS scores were examined as a potential predictor of MCC based on the assigned vignette. It was found that participants' SOCCS scores did not predict CCCI-R ratings, even within the different types of vignettes. Following, subscales of the SOCCS were explored using correlations in order to determine the relationship between participants' subscale scores and their ratings of MCC. Only the correlation involving the Knowledge subscale of the SOCCS and the MCC ratings of the therapist in Vignette A reached statistical significance. The meaning of this finding is limited by the low reliability on this SOCCS subscale. This finding calls into question whether the SOCCS can really measure competence or if it is problematic as a self-report measure. As other literature has found, the SOCCS and MCC measures in general are subject to self-report concerns and might actually be measuring self-efficacy instead of competence (Daniels, & Zhang 2008; Hays, 2008). This finding, along with the lack of correlation between the SOCCS and the BABS subscales one and

four (which related significantly to MCC, the outcome measure), calls the self-report nature of the measure into further question. Therefore, training programs and the mental health field may need to identify new ways of evaluating CITs' work with LGB clients and MCC in general. Although confidence and self-reported competence to work with LGB clients could be important, the nature of these self-report measures may not be an adequate way to ensure that trainees are able to provide MCC to LGB identified clients. Additionally, these results reflect the idea that there is a difference between self-report measures and actual behavioral skills implemented in the therapy room.

The last prediction examined in this study was that CITs who endorsed more advanced broaching styles would have higher scores on the self-report measure of their skills, attitudes, and knowledge in their work with LGB clients (i.e., the SOCCS). This hypothesis was confirmed in this study in that participants who endorsed more advanced broaching styles had higher SOCCS scores and participants who endorsed the least advanced broaching styles had lower SOCCS scores. Interestingly, the Integrated/Congruent style of broaching was most commonly endorsed suggesting that CITs see themselves as not only able to broach the subject of sexual orientation effectively in the therapy process, but they have integrated this behavior into their professional identity. Additionally, those who endorse this broaching style encourage their clients to make culture-specific interpretations of their counseling concerns and can distinguish between culture-specific behaviors and unhealthy human functioning. Overall, these individuals do not see broaching as just a technique but as a routine practice (Day-Vines et al., 2007). CITs most endorsed this style of broaching despite the finding that there were not differences in ratings of MCC for the therapists in the vignettes between individuals who endorsed lower and higher levels of this broaching style. Therefore, it can be theorized that self-

perceived ability to work with diverse clients (in this case, LGB clients) differs depending on the broaching style of the student.

Limitations

There are several important limitations of this study. First, the generalizability of the results might not apply to the larger population. The majority of the participants in this study consisted of White, heterosexual, women. Although this generally reflects the population of CITs, the current study had a disproportionately higher amount of White, heterosexual, women (HRSA, 2013). Therefore, it cannot be determined how these results might generalize to the larger population of CITs.

Another limitation that exists is a threat to internal validity due to the differential dropout rate among the three vignettes in the study. More participants dropped out of the Vignette B condition than the other two Vignette cases. It can be hypothesized that this was a random drop out and that the Vignette type did not determine, or drive, the dropout rate; however, this was not tested in the current study. Additionally, the participants answered a single-item question related to the therapists' overall quality of therapy in the exposure vignette; this study's results would be stronger if an entire measure for overall therapy quality were implemented due to the inability to determine reliability of this construct (Postmes, Haslam, & Jans, 2013). Additionally, the nature of the use of the vignettes in order to determine therapist competence is a major limitation. Participants did not directly observe the therapeutic context and this likely influenced their response to the quality of the therapist in the vignettes. This is a limitation because therapy is not simply words on a page in a vignette. The tone of voice, the therapists' non-verbal actions, the timing of interventions, the client's reactions, and eye contact are all important aspects of the therapeutic process that are not included in this vignette style approach. Instead, they were

essentially left to the participants' imaginations or assumptions based on their experiences as clients or therapists. These aspects of therapy were not controlled for in this study and could have influenced the results. Additionally, because the vignettes portray a small clip of an entire therapy session, it is hard to determine how responses would differ if an entire therapy session were transcribed and read by participants. Therefore, the use of vignettes creates a major limitation in this study.

Beyond concerns related to the nuances within the vignette approach, the leap from a vignette approach to what therapists can actually do during the therapy encounter is not clear and cannot be assumed. As such, caution is required in making assumptions that those CITs who indicated the therapist in Vignette A has a high level of MCC would actually engage in the same actions as the therapist in Vignette A. Although ability to detect MCC seems like a relevant requirement for intentional therapy that reflects multicultural competence, the ability to detect MCC does not guarantee that the therapist can intentionally engage in MCC. Furthermore, I did not use a vignette that captured the therapist who engages in the Infusing broaching style (i.e., BABS subscale four) and advocates for clients outside of the therapy room, making it difficult to draw any conclusions about how CITs would perceive the MCC of a therapist with this style of broaching. Additionally, the lack of performance of the two major BABS subscales (i.e., the Continuing/Incongruent and Congruent/Integrated) that directly deal with the interventions in the therapy room raise questions about the utility of the measure used in general. Furthermore, the use of the self-report measures in this study (i.e., the BABS and the SOCCS) and their inability to predict competence in this study could mean that students have learned they should be competent in work with LGB clients and in MCC rather than that they actually are competent, limiting our ability to use the findings for those measures to inform what to do with CITs.

Therefore, the lack of use of another form of evaluation of CITs and MCC would have been beneficial, such as supervisor evaluations or client reports.

Lastly, a limitation exists related to the number of analyses used to determine the results of this study. Specifically, the large number of analyses used can result in inadvertent Type I errors. This study used corrections in order to limit Type I error; however, this still exists as a limitation of the current study.

Summary and Applications

This study called into question the utility of self-report measures and CITs' ability to distinguish overall therapy quality from MCC. This study reflected the idea that there is some issue for CITs regarding the way in which competence gets translated into quality of therapy.

The results of this study provide evidence that CITs rated the overall quality of therapy highest when the therapist broached sexual orientation throughout the therapy session; however, participants were not able to distinguish between the most advanced level of broaching in this study (i.e., the integrative/congruent style) and an avoidant style of broaching (i.e., the least advanced level of broaching in this study). This finding calls into question the interconnectedness of MCC and overall quality of therapy. The results also beg the question of whether or not broaching should be incorporated as a multicultural skill in therapy as authors request (Day-Vines, 2007; Sue 2006).

Additionally, when MCC ratings were specifically analyzed, this study found that participants rated the vignettes they were exposed to statistically different. Therefore, this study provides evidence that the CITs rated the MCC of the therapist higher when the therapist broached sexual orientation in therapy. Because all levels of broaching (i.e., the three vignettes)

were significantly different in this finding, it further calls into question CITs' association between MCC and the necessity of it for overall quality of therapy.

CITs report that they lack skills needed in order to provide MCC (Sue et el., 2010). Broaching can be taught to mental health clinicians during graduate school in order to provide students with a concrete tool to use in order to increase their MCC; however, findings from this study raise the possibility that this statement is limited to the teaching of the infusing broaching style only. Specifically, only the most extreme broaching styles were related to the ability to correctly label the cultural competence of the therapist in Vignette A as high. The fact that the extreme styles of broaching related to levels of MCC assigned for the therapist in Vignette A suggests that those styles of broaching may be relevant for the ability of trainees to identify the presence culturally competent therapy. Yet, no broaching style was related to ability to correctly label the cultural competence of the therapist in Vignettes B and C as lower. At the same time, there were differences in the cultural competence ratings of the therapists across the vignettes that reflect that CITs could detect differences. Future research is needed to identify what actually accounts for this pattern. It is possible that all CITs just recognized the MCC of the therapists in Vignettes B and C as poor, but the scores were well above the minimum for the measure of MCC. This raises the question of what CITs would expect to see before they would describe a therapist as incompetent in terms of multicultural competence. For example, one might wonder if CITs would only rate therapists who are directly discriminatory or engaging in micro-assaults (a form of micro-aggression that involves making hostile comments) as being very low in MCC. If that is the case, it raises the question of whether that is where the field hopes to be in terms of conceptualizing MCC. If so, it suggests that being avoidant and

uncomfortable is really just in the middle. Alternatively, it may be that we wish to hold counselors and CITs to a higher standard.

Lastly, there is a debate in the field regarding the utility of framing multicultural counseling differently than general counseling competence (Coleman, 1998; Patterson, 2004; Weinrach & Thomas, 2002). This study provides mixed evidence for broaching as a multicultural skill that increases the way in which therapists view the overall quality of therapy because participants rated the overall quality of therapy higher when the therapist was using broaching, rather than avoidance, in the vignettes. This study found that participants did not think that the highest level of broaching was needed; and instead, just the avoidance of dismissing the client's desire to talk about sexual orientation was enough.

Directions for Future Research

This study was built on findings from another study that used similar methodology; however, their participants were clients reading and rating the therapists in the vignettes instead of CITs (Asay, 2006). That study found that it was important to clients that therapists address sexual orientation through broaching in the therapy process. The current study found less differentiation in that overall quality of therapy was not differentiated between the welcoming or integrated/congruent and avoidant vignettes (note, the avoidant vignette in this study was the "poorest" vignette in the study by Assay, 2006). Therefore, this means that within these two studies, it was found that broaching was viewed as more essential to clients than CITs. It would be important for more studies to explore this question in order to further the literature. Moreover, future studies should explore the question of whether broaching is something we can reliably and validly make judgments about regarding the amount needed, the timing, and what kinds of clients it is most important to broach with during the actual therapy session. This

question is important because the simple implementation of broaching is likely not the key to the behavioral skill; there is likely finesse to the skill and an appropriate way to implement it into the therapy process.

Future research should explore broaching related to other client multicultural characteristics (i.e., ethnicity, race, gender, disability, socioeconomic status, etc.) in order to determine whether broaching is an overarching skill that should be implemented in the therapeutic process. Related to the therapeutic process, this study explored an interaction between two men within the first session of therapy. Although an obvious limitation in this study, future studies should determine if the gender of the therapist and client changes or influences the findings. Also, because the therapist that used a shut down approach (Vignette C) received mid-range ratings in terms of MCC, it seems important to empirically explore what CITs would consider to be incompetent therapy in terms of multicultural competence (i.e., how bad does it have to be?). Lastly, a qualitative component would be recommended for future research related to this study. A qualitative component might add information to the results and provide detail related to the participants' opinions of the therapy they observe during exposure to the vignette.

Direct observation of clinical work by a supervisor and/or researcher would further the research on broaching and work with LGB clients. Directly observing the therapeutic exchange, while also measuring client's experiences, could more directly answer the question of whether broaching is viewed as a skill that positively influences the client's experience in therapy.

Conclusion

This study adds to the literature related to the lack of utility of self-report measures, CITs ability to evaluate overall therapy quality and MCC, the CITs' perceptions of the utility (or lack

of) broaching in therapy, and work with clients who identify as LGB. The study's findings also revealed that CITs rated the overall quality of therapy higher when the therapist in an exposure vignette was using a more advanced broaching style in their work with the client in the exchange. This study did not find support for differentiation of avoidant and welcoming or integrated/congruent broaching, however. The findings of this study also revealed that CITs rated the MCC of the therapist in the exchange higher when the therapist in an exposure vignette was using a more advanced broaching style. This study also found that self-report measures were related to one another but they did not translate as well into CITs' ability to rate therapist competence overall when some other criterion (other than self-report) was used.

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Table 1

Means and Standard Deviations for Key Study Measures

	M	*SD*
BABS, Avoidant	25.36	20.35
BABS, Continuing/Incongruent	26.27	6.00
BABS, Integrated/Congruent	38.67	6.32
BABS, Infusing	30.14	5.54
CCCIR	72.23	3.92
SOCCS	15.51	15.51

Note. $N = 224$.

Table 2

Correlation Matrix for the Intercorrelations Between Study Variables for All Participants

	Overall Quality	BAB SS 1	BABS SS 2	BABS SS 3	BABS SS 4	CCIR Total	SOCCS Total	Vignette Items	Age	LGB Clients
Overall Quality	--									
BABS SS 1	-.01	--								
BABS SS 2	.00	.40**	--							
BABS SS 3	.17*	-.42**	-.45**	--						
BABS SS 4	.14*	-.46**	-.30**	.56**	--					
CCCI-R Total	.68**	-.01	-.05	.14	.10	--				
SOCCS Total	-.02	-.17*	-.38**	.35*	.15	.01	--			
Vignette Items	.95**	-.02	-.02	.18*	.14**	.78	.00	--		
Age	.05	-.06	-.07	.09	.06	.02	.09	.04	--	
LGB Clients	-.12	-.15*	-.32**	.23**	.11	-.09	.51**	-.11	.10	--
Year in Program	-.06	-.19*	-.18*	.07	0	-.03	.21*	-.04	.17	.39**

Note. BABS SS 1 = Broaching Attitudes and Behaviors Survey Subscale One (The Avoidant broaching style); BABS SS 2 = Broaching Attitudes and Behaviors Survey Subscale Two (The Continuing/Incongruent broaching style); BABS SS 3 = Broaching Attitudes and Behaviors Survey Subscale Three (The Integrated/Congruent broaching style); BABS SS 4 = Broaching Attitudes and Behaviors Survey Subscale Four (The Infusing broaching style); CCCI-R = Cross Cultural Competence Inventory-Revised; SOCCS = Sexual Orientation Counselor Competence Scale; Vignette items = items related to therapist's multicultural counseling and the therapist's overall quality of therapy; LGB Clients = number of lesbian, gay, and bisexual clients seen in therapy; n = 224; $p < 0.05$* $p < 0.001$**

Table 3

Mean Differences Between Doctoral and Master's CITs on the BABS and SOCCS

	Doctoral CITs			Master's CITs				
	n	*M*	*SD*	*n*	*M*	*SD*	*t*	*d*
Broaching Attitudes and Behaviors Scale: Subscales								
Avoidant	147	24.14	5.98	74	27.68	5.46	-4.28*	-0.61
Continuing/Incongruent	147	25.54	6.38	74	27.62	6.12	-2.32	-0.33
Integrated/Congruent	147	39.07	5.76	74	37.85	5.02	1.55	0.22
Infusing	147	30.00	4.21	74	30.46	3.37	-0.86	-0.11
Sexual Orientation Counselor Competence Scale								
Total score	147	95.10	13.02	74	85.86	13.92	3.66*	0.69

Note. For each *t*-test, the *t* value reported is the test statistics for pooled variances when variances between groups did not differ significantly. When variances were unequal, the Satterthwaite approximation of the standard errors was used.

In the table, *d* indicates Cohen's *d*, the mean difference between the groups in standard deviation units.

* indicates $p < .0102$, reflecting the Sidak correction for tests.

Table 4

Mean Differences Between Doctoral and Master's CITs on Ratings of MCC by Vignette

	Doctoral CITs			Master's CITs				
	n	*M*	*SD*	*n*	*M*	*SD*	*t*	*d*
Vignette A								
CCCI-R	52	85.88	15.59	24	91.89	13.69	-1.64	-.40
Vignette B								
CCCI-R	44	64.75	19.07	22	73.71	14.37	-2.01	-.51
Vignette C								
CCCI-R	51	58.51	16.71	26	63.81	16.72	-1.31	-.32

Note. CCCI-R = Cross-Cultural Counseling Inventory-Revised.

For each *t*-test, the *t* value reported is the test statistics for pooled variances when variances between groups did not differ significantly. When variances were unequal, the Satterthwaite approximation of the standard errors was used.

In the table, *d* indicates Cohen's *d*, the mean difference between the groups in standard deviation units.

The Sidak correction for tests was used and no value was $p < .017$.

Table 5

Means and Standard Deviations in Overall Quality and Cross-Cultural Counselor Competence by Vignette Type

Overall Quality	*n*	*M*	*SD*
Vignette A	76	4.30[a]	1.10
Vignette B	68	3.87[a]	1.05
Vignette C	77	3.38[b]	1.14
Cross-Cultural Counselor Competence	***n***	***M***	***SD***
Vignette A	76	87.58[a]	15.38
Vignette B	68	67.91[b]	17.97
Vignette C	77	60.30[c]	16.81

Note. Superscript letters indicate instances in which groups differed in Bonferroni adjusted comparisons. Where letters are the same, the difference between groups was not significant. Where letters differ, the difference between the group achieved significance.
Overall quality refers to participants' ratings of the overall quality of therapy portrayed by the therapist in the vignette.
* $p < .0001$

Table 6

Means and Standard Deviations in Cross-Cultural Counselor Competence by Vignette Type, Controlling for Overall Quality

Cross-Cultural Counselor Competence	*n*	*M*	*SD*
Vignette A	76	83.19[a]	12.99
Vignette B	68	67.77[b]	12.86
Vignette C	77	64.92[b]	13.77

Note. Means provided are least squared means (i.e., adjusted for overall quality).
Superscript letters indicate instances in which groups differed in Bonferroni adjusted comparisons. Where letters are the same, the difference between groups was not significant. Where letters differ, the difference between the groups achieved significance.
Overall quality refers to participants' ratings of the overall quality of therapy portrayed by the therapist in the vignette.
* $p < .0001$

Table 7

The Four Broaching Styles as Potential Moderators of the Influence of Vignette on MCC Ratings

Model 1. Avoidant Style	*b*	*SE*	β
Vignette (A vs. B and C)	55.48	11.00	1.31*
Avoidant Style	.21	0.22	.06
Interaction	-1.24	0.42	-.77*
Model 2. Continuing/Incongruent Style	***b***	***SE***	**β**
Vignette (A vs. B and C)	41.36	10.12	.97*
Continuing/Incongruent Style	0.10	0.22	.03
Interaction	-0.68	0.38	-.43
Model 3. Integrated/Congruent Style	***b***	***SE***	**β**
Vignette (A vs. B and C)	-2.01	16.52	-.05
Integrated/Congruent Style	0.17	0.25	.05
Interaction	0.66	0.42	.61

Table 7 (Continued)

Model 4. Infusing Style	*b*	*SE*	β
Vignette (A vs. B and C)	-22.00	20.11	-.52
Infusing Style	-0.02	0.33	.00
Interaction	1.50	.66	1.08*

Note. * $p < .05$.

Table 8

Sexual Orientation Counselor Competence Scale (SOCCS) as a Potential Moderator of the Influence of Vignette on MCC

Parameter	*b*	*SE*
Vignette (A vs. B and C)	2.02	(14.90)*
Sexual Orientation Counselor Competence Scale	-0.09	(0.09)
Vignette (A vs. B and C) * Sexual Orientation Counselor Competence Scale	0.23	(0.15)

Note. *$p < .05$.

Table 9

Correlations of SOCCS subscales and CCCI-R across Vignettes

	Vignette A (n = 79)	Vignette B (n = 68)	Vignette C (n = 77)
SOCCS: Knowledge	.27*	-.11	-.15
SOCCS: Attitudes	.17	-.04	-.17
SOCCS: Skills	.13	-.13	-.01

Note. * $p < .05$.

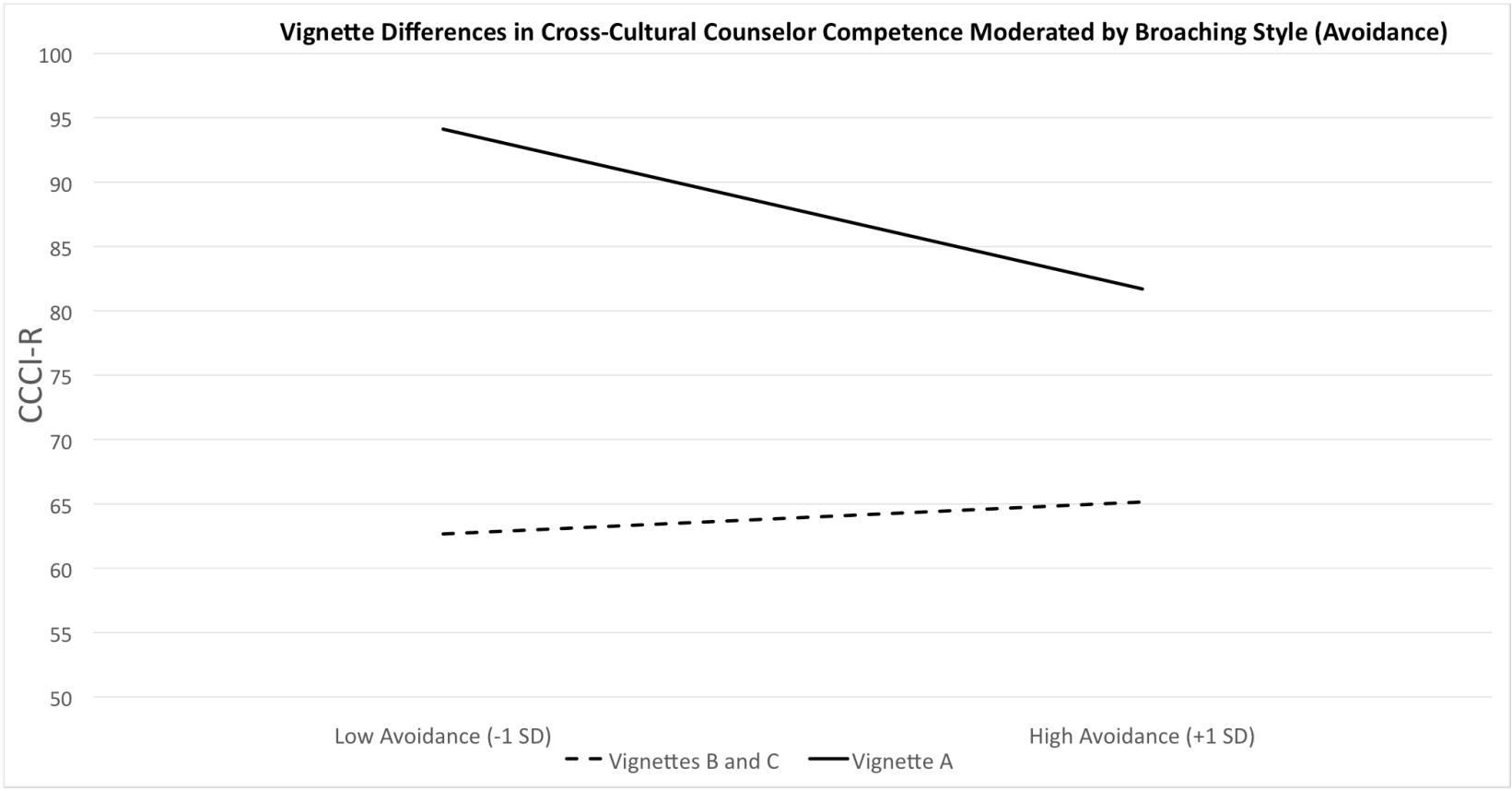
SOCCS: Sexual Orientation Counselor Competence Scale;

CCCI-R: Cross-Cultural Counseling Inventory- Revised.

Table 10

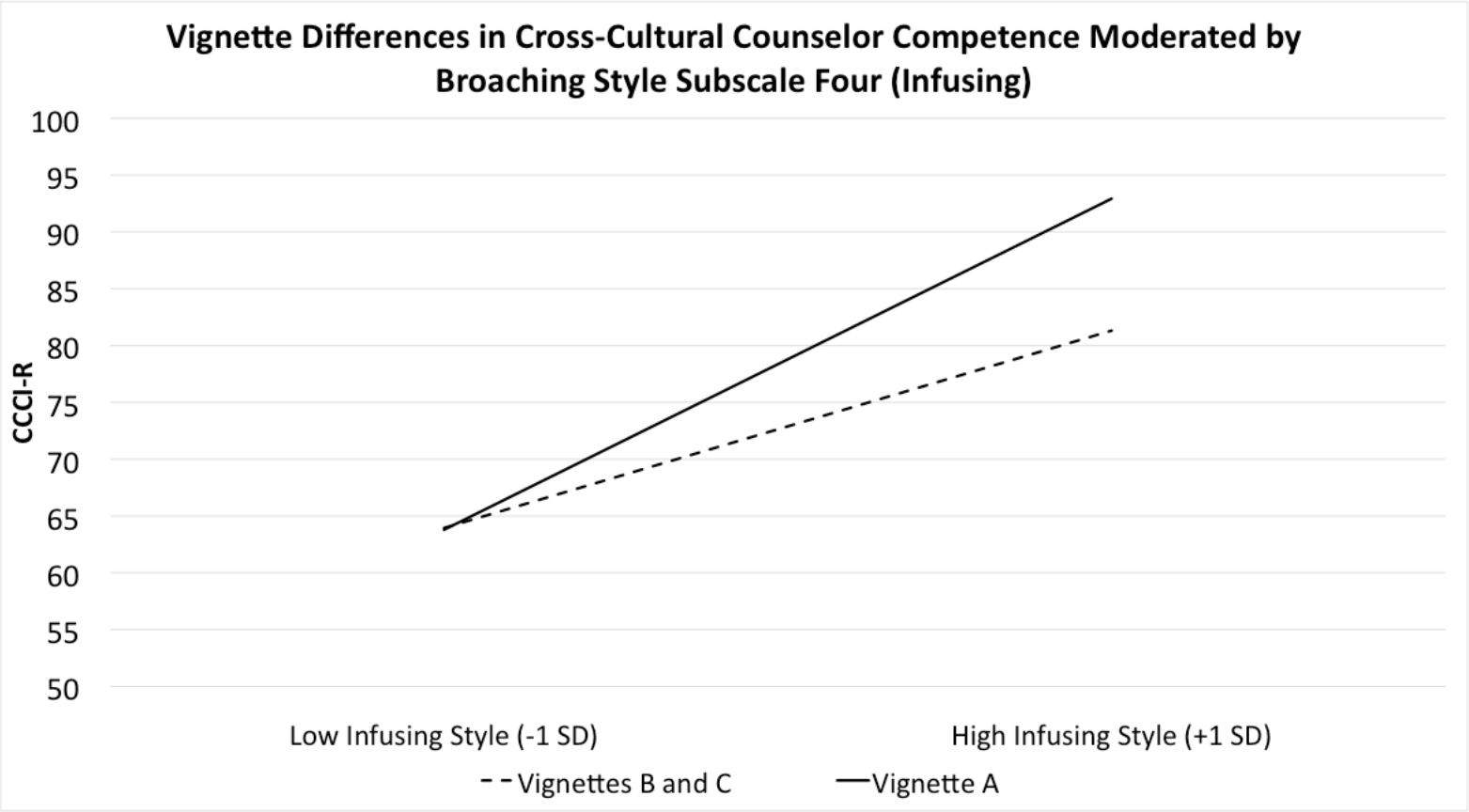
Frequency and Percentage of Participants with each Broaching Style

Broaching Style	*n*	Percent of Total
Avoidant	14	6.36
Continuing/Incongruent	17	7.73
Integrated/Congruent	188	85.45
Infusing	1	.45



Note. Model predicted values for CCCI-R scores are shown for participants responding to Vignette A compared to those who read Vignettes B or C, as well as those scoring ± 1 SD from the mean of the Avoidant broaching style.
One standard deviation above and below the mean was used as convention in this figure's analyses because there was no theoretical underpinning to use another cut off point for plotting the data.
CCCI-R = Cross-Cultural Counseling Inventory, Revised.

Figure 1. Vignette Differences in Cross-Cultural Counselor Competence Moderated by Broaching Style (Avoidance)

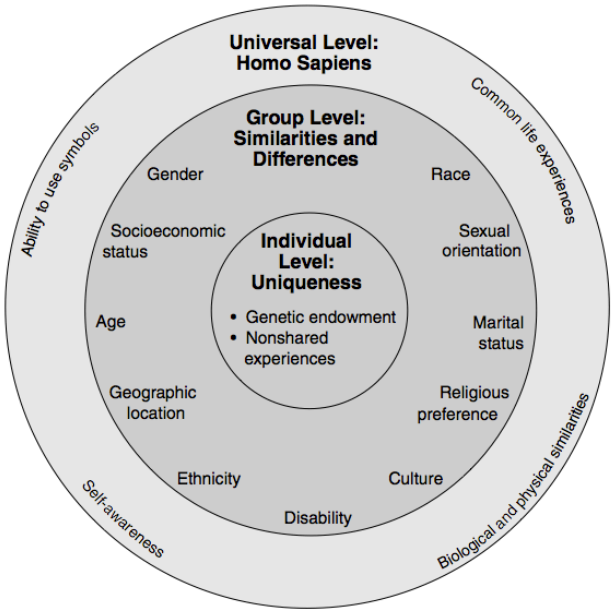


Note. Model predicted values for CCCI-R scores are shown for participants responding to Vignette A compared to those who read Vignettes B or C, as well as those scoring ± 1 SD from the mean of the Infusing broaching style.
One standard deviation above and below the mean was used as convention in this figure's analyses because there was no theoretical underpinning to use another cut off point for plotting the data.
CCCI-R: Cross-Cultural Counseling Inventory, Revised

Figure 2. Vignette Differences in Cross-Cultural Counselor Competence Moderated by Broaching Style Subscale Four (Infusing)

Appendix A

Tripartite Framework of Personal Identity (Sue, 2001)



Appendix B

Vignettes

Modified from Asay (2006)

Introduction to all versions of the vignettes:

The following is a fictional exchange between a counselor and a client in their first session together. The counselor is a White, heterosexual male. The client is White, gay, male. They have spoken briefly on the phone prior to this meeting, during which the client disclosed his sexual orientation. After you read the dialogue, please answer the survey questions that follow. Please be advised that once you read this vignette and move onto the next screen, you will not be able to go back.

VERSION A
Integrated/Congruent style of broaching used by the counselor

Counselor: Michael, I know we spoke briefly on the phone, but why don't you tell me a little about what brings you into counseling.

Client: Yeah,, well, I've never had a lot of friends—I'm kinda shy with people, and when I was growing up it was hard enough feeling different...I didn't realize until later that being gay explained a lot. The few people I have been friendly with at work, I've just sort of stopped accepting their invitations. I don't know why, but lately I've just withdrawn from people even more.

Counselor: So this has gotten worse lately

Client: I think so. Especially since I started working with this new company. I just don't feel like I fit in there at all. People have all been friendly, I guess, but I just feel less and less interested to keep putting myself out there to be with people.

Counselor: What do you think is making it even more difficult at your new job?

Client: I don't really know. I've been trying to figure that out. At my old job I was at least used to the place and the people, even if I still didn't feel totally comfortable. It seems it's hard to find people I "click" with, you know? So I guess with this new job, I tried at first because I thought this time it might be different. But, pretty soon it seemed like everyone was the same, and I just gave up. I don't know. I hope people will be different, but I guess people don't get me.

Counselor: People don't get you? Could you tell me a little more about what you mean when you say that?

Client: Well, I've always felt like a bit of an outsider, even in school. I always feel really awkward and shy around people. I really do like to open up with the right people, but it's just so hard for me to find them. It just seems so hard for me and so easy for everyone else.

Counselor: A lot of the feelings you're having are actually pretty universal, but that certainly doesn't make them any less painful. How do you think being a gay man may contribute to some of the feelings you're having?

Client: Uh….I'm not quite sure I follow you

Counselor: Well, I'm wondering if you see any link between your feelings and any negative reactions you've gotten from people about being gay—prejudice or even outright discrimination?

Client: Hmm. (Client pauses to think) Well, being gay certainly doesn't help. Not only is it tough to find people who are like me, there aren't that many, especially around here.

Counselor: It does sound tough.

Client: Yeah, as if it weren't hard enough for me to connect with people, it's like I make it worse.

Counselor: You make it worse?

Client: Well, maybe I don't make it worse, but it doesn't help that I'm gay and of course most of the people at work are straight

Counselor: How do you think being gay might affect your relationships at work?

Client: Hmmm…I guess you could say I'm "out" at work, although it certainly wasn't planned. After a month or two at my new job, a guy who works in another division asked me out. It didn't go anywhere, but it ended up he told a lot of people. I guess it's hard to have people I barely speak to know something so personal about me. I think it makes me even more reluctant to open up to people.

Counselor: Sounds like it makes you feel a little exposed.

Client: Yeah, like they barely know anything about me, and the one thing they do know is something I don't exactly share with strangers.

Counselor: What about the climate for gay people at work? How might that come into play with your difficulty in feeling connected?

Client: Actually, it could be worse. There seems to be an active Minority Matters group, with brown-bag lunches every two weeks for racial minorities, lesbians and gays, you name it. I went once when I first started the job, and it was a nice group, but I haven't been back because…well, I don't really know why. I guess I just gave up.
Counselor: Maybe that's part of withdrawing from people. You just don't feel up to trying.

Client: Yeah, I guess so.

Counselor: Michael, for some people I work with, it matters whether or not I'm different from them or like them in various ways. I think it's important for you to know that I'm straight. It occurs to me it might be really tough to talk about being gay with a counselor who's straight. I was wondering about your reaction to me and what it's been like to talk about these issues today.

Client: I'm actually feeling okay. I know there are things you probably can't understand about being me, but it feels good to talk about them, anyway. I'd like to give counseling a try, I think.

VERSION B
Avoidant style of broaching used by the counselor

Counselor: Michael, I know we spoke briefly on the phone, but why don't you tell me a little about what brings you into counseling.

Client: Yeah,, well, I've never had a lot of friends—I'm kinda shy with people, and when I was growing up it was hard enough feeling different...I didn't realize until later that being gay explained a lot. The few people I have been friendly with at work, I've just sort of stopped accepting their invitations. I don't know why, but lately I've just withdrawn from people even more.

Counselor: So this has gotten worse lately?

Client: I think so. Especially since I started working with this new company. I just don't feel like I fit in there at all. People have all been friendly, I guess, but I just feel less and less interested to keep putting myself out there to be with people.

Counselor: What do you think is making it even more difficult at your new job?

Client: I don't really know. I've been trying to figure that out. At my old job I was at least used to the place and the people, even if I still didn't feel totally comfortable. It seems it's hard to find people I "click" with, you know? So I guess with this new job, I tried at first because I thought this time it might be different. But, pretty soon it seemed like everyone was the same, and I just gave up. I don't know. I hope people will be different, but I guess people don't get me.

Counselor: People don't get you? Could you tell me a little more about what you mean when you say that?

Client: Well, I've always felt like a bit of an outsider, even in school. I always feel really awkward and shy around people. I really do like to open up with the right people, but it's just so hard for me to find them. It just seems so hard for me and so easy for everyone else.

Counselor: A lot of the feelings you're having are actually pretty universal, but that certainly doesn't make them any less painful. How do you think who you are might be contributing to some of the feelings you're having?

Client: Uh….I'm not quite sure I follow you

Counselor: Well, I'm wondering if you see any link between your feelings and aspects of who you are.

Client: Hmm. (Client pauses to think) Well, being gay certainly doesn't help. Not only is it tough to find people who are like me, there aren't that many, especially around here.

Counselor: It does sound tough.

Client: Yeah, as if it weren't hard enough for me to connect with people, it's like I make it worse.

Counselor: You make it worse?

Client: Well, maybe I don't make it worse, but it doesn't help that I'm gay and of course most of the people at work are straight

Counselor: How might aspects of who you are impact your relationships at work?

Client: Hmmm…I guess you could say I'm "out" at work, although it certainly wasn't planned. After a month or two at my new job, a guy who works in another division asked me out. It didn't go anywhere, but it ended up he told a lot of people. I guess it's hard to have people I barely speak to know something so personal about me. I think it makes me even more reluctant to open up to people.

Counselor: Sounds like it makes you feel a little exposed.

Client: Yeah, like they barely know anything about me, and the one thing they do know is something I don't exactly share with strangers.

Counselor: What about the atmosphere at work? How might that come into play with your difficulty in feeling connected?

Client: Actually, it could be worse. There seems to be an active Minority Matters group, with brown-bag lunches every two weeks for racial minorities, lesbians and gays, you name it. I went once when I first started the job, and it was a nice group, but I haven't been back because…well, I don't really know why. I guess I just gave up.

Counselor: Maybe that's part of withdrawing from people. You just don't feel up to trying.

Client: Yeah, I guess so.
Counselor: Michael, for some people I work with, it is really tough to talk about very personal things with someone. I was wondering about your reaction to me and what it's been like to talk about these issues today.

Client: I'm actually feeling okay. I know there are things you probably can't understand about being me, but it feels good to talk about them, anyway. I'd like to give counseling a try, I think.

VERSION C
Shut down Counselor (this is not a specific broaching style and items that have been modified from the original vignette are bolded, italicized, and underlined)

Counselor: Michael, I know we spoke briefly on the phone, but why don't you tell me a little about what brings you into counseling.

Client: Yeah, well, I've never had a lot of friends—I'm kinda shy with people, and when I was growing up it was hard enough feeling different...I didn't realize until later that being gay explained a lot. The few people I have been friendly with at work, I've just sort of stopped accepting their invitations. I don't know why, but lately I've just withdrawn from people even more.

Counselor: So this has gotten worse lately? ***It sounds like connecting with friends might help you.***

Client: I think so. Especially since I started working with this new company. I just don't feel like I fit in there at all. People have all been friendly, I guess, but I just feel less and less interested to keep putting myself out there to be with people.

Counselor: What do you think is making it even more difficult at your new job?

Client: I don't really know. I've been trying to figure that out. At my old job I was at least used to the place and the people, even if I still didn't feel totally comfortable. It seems it's hard to find people I "click" with, you know? So I guess with this new job, I tried at first because I thought this time it might be different. But, pretty soon it seemed like everyone was the same, and I just gave up. I don't know. I hope people will be different, but I guess people don't get me.

Counselor: ***Maybe people do get you, but you just assume that they don't?***

Client: Well, I've always felt like a bit of an outsider, even in school. I always feel really awkward and shy around people. I really do like to open up with the right people, but it's just so hard for me to find them. It just seems so hard for me and so easy for everyone else.

Counselor: A lot of the feelings you're having are actually pretty universal, but that certainly doesn't make them any less painful. How do you think ***who you are*** might be contributing to some of the feelings you're having?

Client: Uh....I'm not quite sure I follow you.

Counselor: Well, I'm wondering if you see any link between your feelings ***and aspects of who you are.***

Client: Hmm. (Client pauses to think) Well, being gay certainly doesn't help. Not only is it tough to find people who are like me, there aren't that many, especially around here.

Counselor: ***Besides being gay…it sounds like there's something else that makes it hard for you to connect with people.***

Client: Yeah, as if it weren't hard enough for me to connect with people, it's like I make it worse.

Counselor: You make it worse?

Client: Well, maybe I don't make it worse, but it doesn't help that I'm gay and of course most of the people at work are straight.

Counselor: How might ***any other aspects of who you*** are impact your relationships at work?

Client: Hmmm...I guess you could say I'm "out" at work, although it certainly wasn't planned. After a month or two at my new job, a guy who works in another division asked me out. It didn't go anywhere, but it ended up he told a lot of people. I guess it's hard to have people I barely speak to know something so personal about me. I think it makes me even more reluctant to open up to people.

Counselor: Sounds like it makes you feel a little exposed.

Client: Yeah, like they barely know anything about me, and the one thing they do know is something I don't exactly share with strangers.

Counselor: ***What about the atmosphere at work? How might that come into play with your difficulty in feeling connected?***

Client: Actually, it could be worse. There seems to be an active Minority Matters group, with brown-bag lunches every two weeks for racial minorities, lesbians and gays, you name it.. I went once when I first started the job, and it was a nice group, but I haven't been back because...well, I don't really know why. I guess I just gave up.

Counselor: Maybe that's part of withdrawing from people. ***It's not that you feel so different;*** you just don't feel up to trying.

Client: Yeah, I guess so.

Counselor: Michael, for some people I work with, ***it is really tough to talk about very personal things with someone.***

Client: I'm actually feeling okay. I know there are things you probably can't understand about being me, but it feels good to talk about them, anyway. I'd like to give counseling a try, I think.

Appendix C

Email Invitation for Online Survey
Modified from Auburn University Research Compliance Forms

E-MAIL INVITATION FOR ON-LINE SURVEY
Recruitment Message and Listserv Post

Email Post:

Subject line: Participants for study about training, enter drawing to win gift card

Dear Training Director,

My name is Sadi Fox, a doctoral student in the Department of Special Education, Rehabilitation and Counseling at Auburn University. For my dissertation, I am examining training experiences of students and how those relate to perceptions of a therapy vignette. I am asking that you please forward the email below to all of your current students who have complete a course on diversity or a semester of practicum.

Thank you,
Sadi Fox

Graduate Students,

I would like to invite you to participate in my research study that will help to inform the field's understanding of training in graduate school.

You may participate if you are at least 19 years of age, are enrolled in a master's or doctoral program in counseling psychology, clinical psychology, or counselor education (to include clinical mental health counseling, school counseling, rehabilitation counseling, etc), and have completed a course on diversity *or* a semester of practicum.

If you decide to participate in this study, you will be asked to read a vignette of a first session interaction of a therapist and client. You will then be asked to answer a variety of questions about the vignette. Following, you will be asked to complete some questions about yourself and your training. The entire study should take about 25 minutes to complete. To thank you for participating, you can choose to enroll in a drawing at the end of the study where you could win one of four Amazon gift cards. The gift cards will be in the amounts of $75, $50, $25, and $25.

Click on the link below to take part in the study:
Link to the study was pasted here

If you have any questions please contact me at Sjf0006@auburn.edu. You can also contact my advisor, Dr. Annette Kluck, at Ask0002@auburn.edu.

Listserv Post

Greetings fellow graduate student!

My name is Sadi Fox, a doctoral student in the Department of Special Education, Rehabilitation and Counseling at Auburn University. I would like to invite you to participate in my research study that will help to inform the field's understanding of training in graduate school.

You may participate if you are at least 19 years of age, are enrolled in a master's or doctoral program in counseling psychology, clinical psychology, or counselor education (to include clinical mental health counseling, school counseling, rehabilitation counseling, etc), and have completed a course on diversity or a semester of practicum.

Your participation is voluntary, and you are free to discontinue your participation at any time without penalty. If you decide to participate in this study, you will be asked to read a vignette of a first session interaction of a therapist and client. You will then be asked to answer a variety of questions about the vignette. Following, you will be asked to complete some questions about yourself and your training. The entire study should take about 25 minutes to complete. To thank you for participating, you can choose to enroll in a drawing at the end of the study where you could win one of four Amazon gift cards. The gift cards will be in the amounts of $75, $50, $25, and $25.

Click on the link below to take part in the study:
(INSERT LINK HERE)

If you have any questions please contact me at Sjf0006@auburn.edu. You can also contact my advisor, Dr. Annette Kluck, at Ask0002@auburn.edu.

Consent Form

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT.)

STUDY INFORMATION LETTER

You are invited to participate in a research study to *better understand training in doctoral and master's programs in the mental health field.* The study is being conducted by *Sadi Fox, a doctoral candidate* under the direction of her academic advisor, Annette S. Kluck, Ph.D., Associate Professor and Training Director in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You are invited to participate in a research study because you are in a doctoral or master's program in clinical psychology, counseling psychology, or counselor education or counseling. You must also have completed a diversity course or at least one semester of practicum and be 19 years of age or older.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to read a vignette of a first session interaction of a therapist and client. You will then be asked to answer a variety of questions about the vignette. Following, you will be asked to complete some questions about yourself and your training. Your total time commitment will be approximately 25 minutes; please know that this time can vary.

Are there any risks or discomforts? The risks associated with participating in this study are are minimal. You may experience slight discomfort as you answer personal questions. To minimize these risks, we will take into account your desire to terminate the study at any time.

Are there any benefits to yourself or others? If you participate in this study, you can expect to reflect on your training experiences and potentially impact graduate level training in the field of mental health. We/I cannot promise you that you will receive any or all of the benefits described. Benefits to others may include enhanced training in graduate school on important aspects of working with diverse clients.

Will you receive compensation for participating? To thank you for your time you will be offered the opportunity to participate in a raffle to win one of four Amazon gift cards in the amounts of $25, $25, $50, and $75, which will be delivered to you electronically if you win. If you choose to enter the raffle, you will provide your e-mail address in a separate survey. Once you have reached the end of the survey, you will see the link to the survey where you can enter your email address. Your contact information will not be linked to your responses.

Are there any costs? If you decide to participate, you will be contributing your time and information about your experiences in graduate school.

If you change your mind about participating, you can withdraw at any time by *(example: closing your browser window).* If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Once you've submitted anonymous data, it cannot be withdrawn since it will be unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University or the Department of Special Education, Rehabilitation, and Counseling.

Any data obtained in connection with this study will remain anonymous. We will protect your privacy and the data you provide by password. Your name will not be connected to your responses. You will not be asked to provide your name or other potentially identifying information.
Information collected through your participation may be used to fill an educational requirement, presented at a professional meeting and/or published in a scholarly journal.
The investigators on this study have the right to terminate subject participation.
If you have questions about this study, please contact Sadi Fox, at sjf0006@auburn.edu or Dr. Annette Kluck at ask0002@auburn.edu.
If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334) 844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.
HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE CLICK ON THE LINK BELOW.
YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

_____
Investigator Date

_____
Co-Investigator Date

The Auburn University Institutional Review Board has approved this document for use from _____ to _____. Protocol #_____
Thank you for your time and assistance with this research. By clicking the link below, you acknowledge that you have read the information above. Please be reminded that you may discontinue the study at any point without penalty.

Appendix D

Demographics Questionnaire

DEMOGRAPHICS QUESTIONS PART ONE
(Immediately following the information letter in order to ensure participants meet criteria)

1. Are you 19 years of age or older?
   Yes _____
   No _____

2. Are you currently enrolled in a doctoral or master's program in one of the following fields: counseling or community mental health, counseling psychology, clinical psychology, or counselor education?
   Yes _____
   No _____

3. Have you completed AT LEAST two semesters of practicum OR have you taken a course on diversity?
   Yes _____
   No _____

4. Is your academic program accredited by EITHER APA or CACREP?
   Yes _____
   No _____

DEMOGRAPHIC QUESTIONS PART TWO
(Will appear at the end of the study)

1. What is your gender? _____

2. What is your age? _____

3. What is your ethnicity? _____

4. How do you identify your sexual orientation?_____

6. Degree Level that you are currently working towards:
   Master's degree _____
   Doctoral degree _____

7. Choose your degree program from the options below:

8. What year are you in your graduate program?

1 _____
2_____
3_____
4_____
5_____
6_____
7+_____

8. How many clients have you worked with, either in practica or other clinical work, that self-identify as lesbian, gay, or bisexual?

1-5 _____
6-10 _____
11-15 _____
15 or more _____

ADDITIONAL TRAINING EXPERIENCES

1. Have you attended a WORKSHOP related to COUNSELING LGB-identified clients?

Yes ___
No ___

2. Have you attended a GENERAL TRAINING SEMINAR on LGB-related issues (e.g., Safe Zone, Safe Place)?

Yes ___
No ___

3. Have you attended a CONFERENCE PRESENTATION or SPEAKER SERIES that discussed COUNSELING LGB-identified clients?

Yes ___
No ___

Appendix E
Additional Questions

Please use the scale below to rate how much you agree or disagree with the statements below. Please rate the statements based off the therapist's work in the vignette.

1 2 3 4 5 6
Strongly Disagree Strongly Agree

1) The therapist's overall quality of therapy was superior.
2) The therapist would be a good referral source to use to refer clients.
3) The therapist portrayed multicultural counseling competence.
4) The client would benefit from a referral to a medication consultation.

APPENDIX F

The Cross-Cultural Counseling Inventory-Revised (CCCI-R)
LaFromboise, Coleman, & Hernandez (1991)

Please use the scale below to rate the therapist's cross-cultural counseling competence in the vignette.

1	2	3	4	5	6
Strongly Disagree					Strongly Agree

This measure has been removed for Copyright purposes.

APPENDIX G

Sexual Orientation Counselor Competency Scale (SOCCS)
Bidell (2005)

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

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

This measure has been removed for Copyright purposes.

APPENDIX H

Broaching Attitudes and Behaviors Survey (BABS)
Modified from Day-Vines (2010)

Broaching refers to the counselor's effort to determine the extent to which culture may be related to the client's presenting problem. Using the response scale below, please click on the response that best describes your behavior in therapy with a client who identifies as lesbian, gay, or bisexual.

Strongly Disagree-1
Disagree-2
Neither Agree Nor Disagree-3
Agree-4
Strongly Agree-5

This measure has been removed for Copyright purposes.

APPENDIX I

Permission Email

From: Norma Day-Vines <Norma.Dayvines@jhu.edu>
Sent: Thursday, July 31, 2014 7:56 PM
To: Sadi Fox; Norma Day-Vines
Subject: Re: BABS Access- Thanks!

Sadi,
I hope all is well with you. Thank you for your interest in using the Broaching Attitudes and Behavior Survey (BABS). I am willing to let you use the instrument for your dissertation, but please let me know a little more about your research project. What are your research questions? What type of research design will you use? What other instruments do you plan to use? Take care.
N. Day-Vines
