LGB AFFIRMATIVE TRAINING AND CLINICAL COMPETENCY: DIFFERENCES IN COUPLE AND FAMILY THERAPY STUDENTS WHO RECEIVE TRAINING AT RELIGIOUS VS. SECULAR INSTITUTIONS

A Thesis
Submitted to the Graduate Faculty
of the
North Dakota State University
of Agriculture and Applied Science

By

Keilah Ann Thompson

In Partial Fulfillment
for the Degree of
MASTER OF SCIENCE

Major Department:
Human Development and Family Science
Option: Couple and Family Therapy

April 2013

Fargo, North Dakota

North Dakota State University
Graduate School

Title

LGB AFFIRMATIVE TRAINING AND CLINICAL COMPETENCY: DIFFERENCES IN COUPLE AND FAMILY THERAPY STUDENTS WHO RECEIVE TRAINING AT RELIGIOUS VS. SECULAR INSTITUTIONS

By

Keilah Ann Thompson

The Supervisory Committee certifies that this ***disquisition*** complies with North Dakota State University's regulations and meets the accepted standards for the degree of

MASTER OF SCIENCE

SUPERVISORY COMMITTEE:

Tom Stone Carlson
Chair

Christi McGeorge

Joel Hektner

James Korcuska

Approved:

4/17/13
Date

James Deal
Department Chair

ABSTRACT

This study determined if any differences exist in the level of affirmative training received, beliefs about sexual orientation, and perceived clinical competency with lesbian, gay, and bisexual (LGB) clients of 231 couple and family therapy (CFT) students who attend COAMFTE accredited institutions. Independent t-tests were used to compare mean scores of students who attend secular versus religiously affiliated institutions to determine if there was a difference in levels of affirmative training received, beliefs about sexual orientation, and perceived clinical competency with LGB clients. Significant differences were found in overall LGB affirmative training levels as well as therapist competency in working with LGB clients. Students did not report differences in the level of affirmative curriculum content pertaining to LGB topics that they received. Training implications are discussed such as COAMFTE providing more structured guidelines for schools to prepare students to work with LGB clients in a positive affirming manner.

TABLE OF CONTENTS

LIST OF APPENDIX TABLES

CHAPTER 1. INTRODUCTION AND LITERATURE REVIEW

In the past 20 years, the American Association for Marriage and Family Therapy (AAMFT) has become increasingly supportive of the rights of lesbian, gay, and bisexual (LGB) identified individuals (AAMFT, 2004a, 2004b, 2005a, 2005b, 2009, 2010, 2012a, 2012b, 2012c; American Psychological Association, California Psychological Association, American Psychiatric Association, and American Association for Marriage and Family Therapy, 2010). For example, the AAMFT added sexual orientation as a part of their non-discrimination clause in 1991, to the organization's code of ethics (AAMFT, 1991). As a part of this evolving commitment to non-discrimination, the AAMFT board of directors issued a statement clarifying that marriage and family therapy includes all relationships, regardless of legal standing, specifically mentioning same-sex couples as a group of people marriage and family therapists serve (2005a).

Additionally, the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) encourages programs to include course content around sexual orientation (2005a; 2005b). Furthermore, current COAMFTE accreditation standards require training programs to include educational outcomes that promote cultural diversity and understanding (2005a). Sexual orientation is included as a part of COAMFTE's definition of diversity (2005a). Furthermore, COAMFTE requires each program to admit students in a non-discriminatory manner, including lesbian, gay, and bisexual (LGB) identified students (2005a). Sexual orientation is included as a component of the educational guidelines, which provide educational content areas for accredited programs (2005b); however, COAMFTE does not require accredited programs to cover specific topics, rather providing these schools with a variety of options to choose from. Given these requirements and the AAMFT's increasingly affirmative

stance, accredited programs that are affiliated with a religious institution may need guidance in balancing religious liberty with educational and ethical requirements. COAMFTE acknowledged this need with a document entitled, *Interpretive Principles for Schools with a Religious Affiliation or Purpose* (2006). The purpose of this document is to re-enforce that religiously affiliated programs may not discriminate based on LGB identity. Additionally, it provides an explanation of how COAMFTE accreditation principles are to be interpreted given the context of religious liberty. The creation of this document is supported in the literature given the relationship between religious constructs and homophobia, as explained further below.

There is an established relationship between religiosity and homophobia both in the general population and mental health professionals (Balkin, 2009; Finlay & Walther, 2003; Newman, 2002). Furthermore, when negative attitudes toward LGB individuals exist therapists it appears that there is less competence in working with LGB clients (Rock, Carlson, & McGeorge, 2010). It is important to note that CFT's report being the most religious of all the mental health disciplines (Bergin & Jensen, 1990). Given that there is speculation that there is a large number of religious programs and that attending religiously affiliated intuitions may influence the quality of training students receive in working with LGB clients (Long & Serovich, 2003), it is important to know how students are being trained to work with LGB clients, especially given the relationship between conservative Christian religious beliefs and homophobia. Given AAMFT's increasingly supportive stance of LGB individuals and relationships, it is also important to know how well secular and religious programs are training students to work with LGB clients and if any differences exist in these training programs. It is important to note that typically literature written on the lesbian, gay, bisexual community also involves the transgender community, however for the purpose of this study I am studying sexual orientation not gender identity. The

purpose is not to further marginalize the transgender community but rather recognize that there are unique differences between the two groups.

Literature Review

As previously mentioned there is no literature exploring differences in students' preparation to work with LGB clients depending upon whether or not they are enrolled in a religious or secular academic program. Therefore, this section will provide a review of the literature on: (a) the AAMFT's history of an increasingly affirmative stance towards the LGB community, (b) the lack of training students receive on working with LGB identified clients, (c) COAMFTE's current educational requirements pertaining to the LGB population, and (d) research exhibiting the relationship between religion and homophobia.

American Association for Marriage and Family Therapy

This section will provide a brief history of the AAMFT's emerging position regarding its beliefs toward LGB individuals and relationships. As stated previously in 1991, the AAMFT incorporated sexual orientation into the non-discrimination clause of the code of ethics (AAMFT, 1991). Since adding this identity to the code of ethics, the AAMFT has further defined what it means to provide services in a non-discriminatory manner (2004a, 2005a, 2005b, 2009). For example, in 2004 the AAMFT board issued a non-pathologizing statement supporting that same-sex sexual orientation is a normal variation and does not require treatment (2004b). This nonpathological stance was reaffirmed in 2009 with a statement on reparative/conversion therapy which stated that AAMFT does not view homosexuality is a disorder that requires treatment and that there is no basis for this type of treatment (2009).

As a demonstration of this commitment to non-discrimination, the AAMFT board has issued two statements to further clarify the stance on LGB partnerships and the inclusivity of the

marriage and family therapy profession for LGB couples and families (2005a, 2005b). The first statement in 2005 demonstrates the AAMFT's support for the inclusion of same-sex partners in all benefits of society, specifically, the AAMFT will support policy initiatives that strengthen and support same-sex couples and families (2005a). The AAMFT board drafted a statement called, "Marriage and Family Therapy" which includes same-sex couples in the definition of marriage and family (2005b). More specifically, this statement defining the work of marriage and family therapy explicitly invites "heterosexual, same-sex, culturally similar, intercultural/interracial, and other forms of family composition to engage with marriage and family therapists for relational development and problem solving within their cultural contexts" (para. 4).

Since making the commitment to publicly affirm policies that support and strengthen all families, including LGB families, the AAMFT board has demonstrated this increasing support of the LGB community in several ways. I will provide three such examples. First, the AAMFT board along with the American Psychological Association, California Psychological Association, and American Psychiatric Association issued an Amicus brief supporting the overturning of Proposition 8 in California (2010). This brief, based on current research, asserted that same-sex attraction is a natural variation of sexual orientation, marriage offers health benefits that are not afforded to same-sex couples, and that children will benefit from their parents being married. Second, considering the board has taken such an active position in support of affirming pubic policies, a dilemma was created when North Carolina passed a constitutional amendment, which banned same-sex marriage the summer prior to the 2012 AAMFT Annual Conference, scheduled to take place in Charlotte, North Carolina. In response to this constitutional amendment, the President of the Board issued a statement clarifying and affirming the AAMFT's stance (2012a).

As a part of this letter, the board clarified that the non-discrimination clause not only extends to the practice of therapy but the AAMFT board pledged to make intentional efforts to educate the AAMFT members and larger community about its current policies and values regarding equal rights for LGB individuals and families, which is especially important to note considering the board decided to keep the conference in North Carolina. Finally, the AAMFT publicly supported a law passed in California, which banned reparative therapy practices for minors, reminding members of the organizational stance that same-sex sexual orientation is a normal variance of sexual orientation and does not require treatment (2012b). Despite the increasingly affirming position taken by the AAMFT, and there is a still a question on whether or not students are being prepared to work with the lesbian, gay, and bisexual community (Bernstein, 2000; Doherty & Simmons, 1996; Rock et. al, 2010). Furthermore, recent literature calls for the AAMFT to take a stance supporting same-sex marriage, which is an issue that the AAMFT has been silent on, thus indicating room for affirmative growth within the organization (Bordoloi, O'Brien, Edwards, & Preli 2013).

Affirmative Training

Even though the AAMFT has included a non-discrimination clause in working with individuals who identify as lesbian, gay, or bisexual since 1991, the training and competency of couple and family therapists in this area has come into question in the literature (Bernstein, 2000; Doherty & Simmons, 1996; Rock et. al, 2010). Some researchers argue that therapists who are not trained to take into consideration the unique needs of lesbian, gay, and bisexual clients create a bias that is harmful to clients (Bernstein 2000; Long 1996). Thus it would be important to know how students are being trained to work with the LGB population including curriculum content.

There has been a marked increase in literature related to LGB topics in the family therapy journals in the past 15 years (Hartwell, Serovich, Grafsky, & Kerr, 2012). There are a number of articles that specifically pertain to affirmative training practices with therapists (Bernstein, 2000; Godfrey, Haddock, Fisher, & Lund, 2006; Long, 1996; Long & Serovich, 2003; McGeorge & Carlson, 2011). However, there are no studies that provide information on what content programs are including in their training regarding LGB related topics. Rock et al. found that slightly over 60% of students reported that they had received no training on affirmative therapy practices and a slightly higher number report not receiving training on identity development models (2010). Even more importantly this study found that education on LGB affirmative therapy appeared to be predictive of clinical competency in working with LGB identified clients.

LGB affirmative therapy is defined as an approach to therapy that embraces a positive view of LGB identity and relationships and addresses the negative influences that homophobia and heterosexism have on the lives of LGB clients (Rock et. al, 2010). Common themes within the family therapy literature include examining heterosexist and homophobic beliefs as well as increasing knowledge on content related to LGB identities. For example, McGeorge and Carlson (2011) provide a 3-step model for heterosexual therapists to examine the impact that heterosexism has had in their own life and the impact on their ability to work positively with LGB clients. Working toward eliminating heterosexist bias is a part of becoming an affirmative therapist (McGeorge & Carlson 2011), so it would make sense that programs would do the same with their own curriculum content. As another example, Long and Serovich (2003) provide suggestions on how to infuse LGB related topics into the curriculum, which they suggest is important in creating an affirmative environment. This approach to infusing LGB related into the curriculum versus only providing a diversity course requires faculty to look at the entire

curriculum of a program for heterosexist bias. Furthermore, by infusing topics into a curriculum appears to have a positive effect on developing therapists to work with diverse clients (McGeorge, Carlson, Erickson, & Guttormson, 2006).

Commission on Accreditation for Marriage and Family Therapy Education

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) provides an educational content structure for accredited programs. As a part of this content structure schools are able to utilize a variety of sources to measure their educational outcomes. These sources include the MFT Educational guidelines, AAMFT Core Competencies, AAMFT Code of Ethics, Association of American Marriage and Family Therapy Regulatory Board Guidelines, and state licensure regulations (COAMFTE, 2005a). Included within these documents are principles or guidelines that could be interpreted as including content on sexual orientation. For example, within the MFT Educational Guidelines under Area II: Clinical Knowledge, one of the sub points includes addressing "contemporary issues… including but not limited to gender, sexual functioning, sexual orientation etc." (AAMFT, 2005b). However, considering COAMFTE takes a "pick and choose approach" to developing a curriculum it would be entirely possible for a program to avoid the topic of working with LGB clients altogether and still be in line with accreditation standards. Furthermore, COAMFTE does not indicate the manner in which students should be trained to work with LGB clients and individuals, so it is possible that accredited programs could be teaching a version of reparative therapy to their students. Reparative therapy is an approach to therapy intended to change sexual orientation from homosexual to heterosexual.

Given the high number of religiously affiliated programs that are COAMFTE accredited, COAMFTE (2006) provided these programs direction on how to interpret the accreditation

standards related to sexual orientation. COAMFTE (2006) created the *Interpretive Principles for Schools with a Religious Affiliation or Purpose.* These guidelines attempt to assist in balancing the AAMFT's non-discrimination clause in the code of ethics, the accreditation standards, and the rights and values of religiously affiliated schools. COAMFTE makes it clear that religiously affiliated schools must recruit and admit students who are diverse in sexual orientation; however, these schools can require students and faculty to adhere to a code of conduct that promotes the values and mission of the institution, which could include prohibiting sexual behavior outside of marriage including same sex relationships. While not explicit, the principles imply that it would be inappropriate for programs to discriminate based on sexual orientation identity of a student or faculty member. Furthermore, this guideline requires all religiously affiliated schools to adhere to all of the accreditation standards as outlined by COAMFTE, which includes course content on cultural diversity topics. What is unknown is how and if schools that are religiously affiliated incorporate content on sexual orientation in their curriculum and whether or not this impacts clinical competence in working with LGB clients.

Religiosity and Homophobia

The relationship between homophobia and religiosity has been well documented in the literature (Altemeyer, 2003; Balkin, 2009; Finlay & Walther, 2003; Malcomnson, Christopher, Franzen & Keyes, 2006; Rowatt et al., 2006; Tsang & Rowatt, 2007; Veenvliet, 2008). In a 61 study meta-analysis religious fundamentalism, religious service attendance, endorsement of Christian orthodoxy, and self-reported religiosity were all associated to varying degrees with negative attitudes toward gay men and lesbian women (Whitley, 2009). More specifically, this relationship has been established in both the general population and university students (Altemeyer, 2003; Balkin, 2009; Finlay & Walther, 2003; Malcomnson et al., 2006; Rowatt et

al., 2006; Tsang & Rowatt, 2007; Veenvliet, 2008). This relationship has been established utilizing both self-report methods and implicit attitude testing (Altemeyer, 2003; Balkin, 2009; Finlay & Walther, 2003; Malcomnson et. al, 2006; Rowatt et. al, 2006; Tsang & Rowatt, 2007; Veenvliet, 2008). For example, one study found that the more conservative the religious beliefs the higher level of homophobia (Malcomnson et al., 2006). Finlay and Walther's (2003) study used religious affiliation as one of the measures and created six categories ranging from conservative Christian to non-Christian. This study found that conservative protestants had the highest homophobia scores, followed by moderate protestants, and Catholics; non-Christians had the lowest scores on the same scale. All of the studies focused on Christian religions and in particular conservative Christian religions and beliefs.

While the link between homophobia and religious constructs is clear, few studies explore the relationship between homophobia and religiosity in mental health professionals (Balkin, 2009; Newman, 2002). Balkin found in a sample of counselors, including some graduate students, that those counselors who were more rigid and authoritarian in their beliefs held more homophobic attitudes (2009). Religious affiliation played the strongest role in explaining the differences in attitudes towards lesbian and gay individuals in a sample of approximately 2,300 graduate students in social work and counseling (Newman, 2002). Like Finley and Walther, Newman (2002) found that conservative Protestants held the most negative attitudes toward LGB individuals. The most positive attitudes were held by atheist, agnostic, Jewish, or those who claimed no religion. It is important to note that almost all of the religiously affiliated schools that are accredited by COAMFTE are associated with Christian religions. No studies have measured the relationship between CFT's religious beliefs and homophobia; however, CFT's report being the most religious of all mental health disciplines (Bergin & Jensen, 1990). Given the link

between conservative religious constructs and homophobia it would be important to know how teachings, values, and philosophy of religiously affiliated academic institutions are impacting the learning outcomes of CFT's in training.

Research Questions

Given the previous literature review, the following research questions remain regarding students who receive training related to working with LGB clients at religious and secular institutions: 1) How many programs have historical roots or current affiliations with religious organizations and how many of these programs have a statement within their code of conduct that restricts same-sex sexual behavior? 2) Is there a difference in student's reported levels of LGB affirmative training based on the type of institution (secular or religious) that students attend? 3) Is there a difference in student's reported levels of beliefs and competence based on the type of institution (secular or religious) that students attend?

CHAPTER 2. METHOD

For this study I utilized a secondary data set. The original data set explored affirmative training and clinical competency in masters and doctoral students in COAMFTE accredited couple and family therapy programs.

Sample Description for the Current Study

The participants (N = 231) in this study were master's and doctoral students in COAMFTE accredited programs. There were more students enrolled in secular programs (n = 172) than those enrolled in a religiously affiliated program (n=59). It should be noted that two participants were removed from the original data set due to unusually high reported hours working with LGB clients.

Secular Programs

The students enrolled in a secular program (n = 172) ranged in age from 21 to 61 years old (M = 29.20, SD = 7.92). Almost 80% (n = 137) students identified as female and 35 identified as male. Of these students, 117 were master's degree students and 55 were enrolled in Ph.D. programs. Just over half (n = 88) of the participants reported having worked with at least one LGB client and 85 reported that they had no experience; 10 participants did not respond to the question. In their current training program participants reported experience working from 0 to 200 hours of therapy with LGB clients (M=9.79, SD=24.79). See Table C1 for additional information about the sample of students enrolled in secular institutions.

Religious Program

The participants enrolled in a religiously affiliated program (n = 59) ranged in age from 22 to 54 years old (M = 30.00, SD = 7.23). Nearly 70% (n = 40) of students identified as female and 19 as male. 47 were master's degree students and 12 were enrolled in Ph.D. programs.

Twenty-eight participants reported having worked with LGB clients and 27 reported that they had no experience; 6 did not report on their experience with LGB clients. In their current training program participants reported experience working from 0 to 100 hours of therapy with LGB clients (M=11.08, SD=21.92). See Table C1 for additional information about the sample of students enrolled in religiously affiliated institutions.

Participant Recruitment

For the original data set, program directors of COAMFTE accredited programs were identified through the AAMFT program directory. An e-mail was sent to the program directors asking them to forward it on to students who met the study requirements. Additional participants were recruited at an annual conference of the AAMFT.

Procedure

For the original data set, potential participants received an e-mail inviting them to participate in the study. An informed consent and a link to the survey were included in the e-mail. The Group Decision Center at North Dakota State University managed the website. Three reminder e-mails were sent at 1-week increments. This same survey was given in a paper copy form to attendees who were recruited at an annual conference of the AAMFT.

Instruments

Revised Sexual Orientation Counselor Competency Scale

For the current study, a revised version of the Sexual Orientation Counselor Competency Scale (R-SOCCS) was used to measure CFT student's self-reported competency in working with LGB clients (Bidell, 2005; Carlson, McGeorge, & Toomey, 2013). This scale is a 28-item measure utilizing a 6-point Likert scale ranging from 1 (*strongly disagre*e) to 6 (*strongly agree*). The scale is split into two subscales, Awareness (12-items) and Knowledge-Skills (16-items).

Higher scores on each of the scales mean more supportive beliefs of LGB clients and more knowledge and skills in working with LGB clients respectively. An example of a question in the awareness subscale is "I believe being highly discreet about their sexual orientation is a trait that LGB clients should work towards." This item is reverse scored. An example of a question from the knowledge/skill subscale is "I know where to find resources to enhance my therapy skills by monitoring my functioning/competency-via consultation, supervision, and continuing education." The R-SOCCS, through confirmatory factor analysis, demonstrated that it is a valid measure of sexual orientation counselor competency (Carlson et al., 2013). The alpha coefficient for the R-SOCCS is .90, while the Awareness subscale had an alpha of .96 and the Knowledge-Skills subscale had an alpha of .82.

Affirmative Training Inventory

The second scale used in this study is the Affirmative Training Inventory (Carlson et al. 2013; Rock et. al, 2010). The purpose of this inventory is to measure to what extent CFT programs incorporate LGB affirmative training practices into their educational processes. This nine-item inventory uses a 6-point Likert scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Higher scores on the ATI are associated with higher levels of affirmative training. The alpha coefficient for the ATI is .86. The ATI is divided into two subscales: Classroom and Program. The Classroom subscale measures the type and level of affirmative training content based on participant report. An example of the Classroom subscale is, "Content related to the experiences of LGB individuals is specifically addressed in each of my family therapy courses." The Classroom subscale had an alpha of .87, and is comprised of 6-items. The Program subscale measures to what extent the program takes an affirmative stance and engages with the LGB community. An example of the Program subscale is, "my program provides students with the

opportunity to work with LGB clients." The Program subscale had an alpha of .67 and is comprised of 3-items. Confirmatory factory analysis was used to establish the validity and factor structure of the ATI (Carlson et al., 2013).

Analysis Plan

Research Question One

In an effort to understand how many programs are religiously affiliated both currently and historically, I visited each accredited program's website to determine if the college/university is/was affiliated with a religious group. This information was readily available on admissions pages, mission statement pages, quick facts pages, as well as pages devoted to explaining the history of the educational institution. The next step was to determine which of these schools had anything in their code of conduct that would prohibit same-sex sexual behavior. I visited the website for each of the religiously affiliated schools to determine if their student code of conduct either discouraged or prohibited same-sex sexual behavior.

Research Question Two

An independent samples t-test was conducted to determine if any differences in mean scores exist in affirmative training levels between students who attend secular or religiously affiliated educational institutions. Considering the group sizes are different, a Levene's test for equality of variances was used to determine if the variance within each sample is the same. The score on the Classroom subscale was used as the dependent variable to determine to what extent students report programs are incorporating affirmative topics into the classroom. The score on the program subscale was used as the dependent variable to determine to what extent students report programs are taking an overall affirmative stance with their approach to training couple and family therapists. The total score on the ATI was used as the dependent variable to

determine the overall levels of affirmative training. In the event that a significant difference was discovered, a Cohen's *d* was computed to determine the magnitude of the difference.

Research Question Three

An independent samples t-test was used to compare the total R-SOCCS score to determine if there's a difference in the students' overall clinical competency based on educational institution type. The total score of the R-SOCCS was used as the dependent variable. In the event that a significant difference was discovered, a Cohen's *d* would be computed to determine the magnitude of the difference. Considering the group sizes are different, a Levene's test for equality of variances will be used to determine if the variance within each sample is the same.

An independent samples t-test to compare differences in mean scores was conducted to determine if any differences existed in beliefs between students who attend secular or religiously affiliated educational institutions. The awareness score on the R-SOCCS was used as the dependent variable. The awareness subscale measures therapists' attitudes toward LGB individuals and relationships. In the event that a significant difference is discovered, a Cohen's *d* will be computed to determine the magnitude of the difference.

An independent samples t-test was conducted to determine if any differences in mean scores exist in knowledge/skills subscale between students who attend secular or religiously affiliated educational institutions. The score on the knowledge/skills subscale was used as the dependent variable. Additionally, In the event that a significant difference was discovered, a Cohen's *d* would be computed to determine the magnitude of the difference.

CHAPTER 3. RESULTS

Research Question One

In an effort to understand how many programs are religiously affiliated both currently and historically, each accredited program's website was visited and searched to determine if the college/university is/was affiliated with a religious group. This information was readily available on admissions pages, mission statement pages, quick facts pages, as well as pages devoted to explaining the history of the educational institution. Through this process it was determined that almost 25% of accredited programs (n = 33) are religiously affiliated or have historical roots in religion. Some schools that have more than one program and thus are counted multiple times. Thus, if a school has a master's and doctoral program, the school's affiliation was counted twice; this was done for both secular and religiously affiliated institutions. The purpose of doing this was to make sure that all programs admitting and graduating students were accounted for equally. After all of the proportion of religiously affiliated programs was determined, the next step was to determine if these schools had anything in their code of conduct that would prohibit same-sex sexual behavior. An example of this is a statement directly from a university's code of conduct, "We believe that sexual intercourse and other forms of intensely interpersonal sexual activity are reserved for monogamous, heterosexual marriage (Bethel University, n.d., para. 13)." One-third (n = 11) of the religiously affiliated schools had a policy in their student code of conduct prohibiting or discouraging same-sex sexual behavior this could come in the form of direct opposition to same-sex sexual behavior or it could say that no sex outside of marriage is permissible.

Research Question Two

To explore the difference between the levels affirmative training for students in religious and secular institutions, an independent samples t-test was calculated comparing the mean scores of each group on total score on the ATI. A significant difference between the two groups was found, $t(227) = 2.25$, $p<.05$. In particular, students trained in secular institutions had a higher mean score ($M = 4.50$, $SD = 0.84$) than students training in religiously affiliated institutions ($M = 4.22$, $SD = 0.80$). Thus, students receiving their training in secular institutions reported higher levels of affirmative training. To increase confidence in this significant finding, a Cohen's *d* was calculated. According to Howell (2010), Cohen's *d's* of .20, .50, and .80 are small, medium, and large respectively. The Cohen's *d* value was .34, thus indicating a small difference between the two groups. Given there was a significant difference in the levels of affirmative training, an independent samples t-test was conducted on each of the ATI subscales. (See Table C2 for a summary of the results for the total ATI and corresponding subscales).

To explore the difference in the amount of classroom related content associated with LGB affirmative therapy an independent sample t test was calculated comparing the mean scores of each group using the score on the Classroom subscale of the ATI. A significant difference between the two groups was not found, $t(225) = .42$, $p>.05$. Students at religious institutions had a slightly lower mean score ($M = 4.04$, $SD = 0.96$) than students who studied at secular institutions ($M = 4.11$, $SD = 1.16$) but the results were not statistically significant. (See Table C2 for a summary of the results for the total ATI and corresponding subscales).

To explore the difference of the extent to which CFT programs adopt an affirmative stance at the program level, an independent samples t-test was calculated comparing the mean scores of each group on the Program subscale of the ATI. A significant difference between the

two groups was found, $t(225) = 3.74$, $p<.05$. The students trained in secular institutions had a higher mean score ($M = 5.17$, $SD = 0.74$) than students training in religiously affiliated institutions ($M = 4.73$, $SD = 0.86$). Thus, students receiving their training in secular institutions reported higher levels of the overall affirmative program environment. To increase confidence in this significant finding, a Cohen's *d* was calculated. The Cohen's *d* value was .55, indicating a medium difference between the two groups. (See Table C2 for a summary of the results for the total ATI and corresponding subscales).

Research Question Three

The third research question sought to explore if any differences exist in the beliefs and competence of students who attend secular or religiously affiliated educational institutions related to working with LGB clients. An independent samples t-test was calculated comparing the mean scores of each group on the total R-SOCCS score. A significant difference between the two groups was found, $t(194) = 2.96$, $p<.05$. The students in secular programs had a higher mean score ($M = 4.38$, $SD = 0.68$) than students in religiously affiliated programs ($M = 4.04$, $SD = 0.74$). Thus, students trained in secular institutions reported a significantly higher overall level of clinical competency working with LGB clients. To increase confidence in this significant finding an effect size (Cohen's *d*) was calculated. The Cohen's *d* value for the total R-SOCCS score was .48, indicating a medium difference between the two groups. Given there was a significant difference in the R-SOCCS scores, an independent samples t-test was run on each of the R-SOCCS subscales. (See Table C2 for a summary of the results for the total R-SOCCS and corresponding subscales).

To explore if any differences exist in students' attitudes toward LGB people, based on attendance at a secular or religiously affiliated educational institution, an independent sample t

test was calculated comparing the mean scores of each group on the total awareness subscale of the R-SOCCS. The Levene's test for equality of variances was significant, thus a modified degrees of freedom and t-score were used for this independent samples t-test. A significant difference between the two groups was found, $t(88.85) = 3.79$, $p<.05$. The students in secular programs had a higher mean score ($M = 5.27$, $SD = 1.12$) than students in religiously affiliated programs ($M = 4.56$, $SD = 1.27$). Thus, students trained in secular institutions reported significantly higher positive attitudes toward LGB people. To increase confidence in this significant finding an effect size (Cohen's *d*) was calculated. The Cohen's *d* value for the R-SOCCS awareness subscale was .80, indicating a large difference between the two groups.

To explore if any differences exist in skills and knowledge of students who attend secular or religiously affiliated educational institutions, an independent samples t-test was calculated comparing the mean scores of each group on the R-SOCCS skills/knowledge subscale. A significant difference between the two groups was found, $t(244) = 2.00$, $p<.05$. The students in secular programs had a higher mean score ($M = 3.76$, $SD = 0.90$) than students in religiously affiliated programs ($M = 3.48$, $SD = 0.94$). Thus, students trained in secular institutions reported a significantly higher level of knowledge and skills in working with LGB clients. To increase confidence in this significant finding an effect size (Cohen's *d*) was calculated. The Cohen's *d* value for the skills/knowledge subscale was .30, indicating a small difference between the two groups.

CHAPTER 4. DISCUSSION

Research Question One

It is not surprising that 25% of all COAMFTE accredited programs have historical or current connections to religious organizations. Long and Serovich (2003) theorize that training programs housed in conservative religious organizations may have an impact on the type of training students receive in working with LGB clients. The results form this study affirms that there is a difference in training, with programs being less supportive of LGB identities and therapists reporting that they are less prepared. Based on the large number of religiously affiliated programs it might be important to think about how many students may not be prepared to work in a non-discriminatory manner with LGB clients. Furthermore, in 11 of these programs students are either discouraged or prohibited from having same-sex sexual relationships themselves. It would be interesting to know how institutions and programs will change policies as same-sex marriage is passed in each of the states, considering some of the policies discourage same-sex sexual behavior outside of marriage. Furthermore, these results provide important information to COAMFTE and AAMFT about the number of programs that do not fully accept LGB identities.

Research Question Two

Although there was a difference between students from secular and religiously affiliated institutions in the overall ATI it seems most important to expand on the differences within the subscales. As previously mentioned the ATI contains a program subscale and a classroom subscale. Although there was an overall difference, there was no statistically significant difference in the classroom content sub-scale of the ATI. The fact that there was no difference in LGB affirmative topics is not surprising given the results of Rock et. al, (2010) which indicated

that more than half of all students from accredited CFT programs had received no affirmative training at all. Thus, it appears that faculty from both religious and secular programs only somewhat include LGB affirmative content. Given the differences in programmatic stance toward LGB individuals and levels of overall competency, one would expect a difference in the level of content at religious versus secular institutions. Whereas there could be many reasons why faculty are only somewhat include classroom content on LGB related issues, it appears that it could be more of a priority in the curriculum. This finding has implications for COAMFTE as the current accreditation guidelines provide little direction regarding what is required as it related to LGB topics.

Perhaps the most important finding regarding the level of affirmative training was related to the extent to which programs take a positive affirming stance toward LGB individuals and relationships, support research related to LGB topics, and give students opportunities to work with LGB clients. This finding of a difference in affirmative training at the program level seems particularly important given the documented relationship between self-reported clinical competency and the overall affirmative stance of a training program (Carlson et. al, 2013). It is also possible that the lower scores from religiously affiliated institutions are a direct impact of explicitly non-affirming policies on the part of those institutions as well as the programs. Again, given the relationship between affirmative stance at the program level and overall competency it seems particularly important that COAMFTE consider including requirements related to the overall affirmative nature of training programs at the program level (Carlson et. al, 2013; Rock et. al, 2010).

Research Question Three

Students attending religiously affiliated programs report being less prepared to work with LGB clients than their secular counterparts as measured by the R-SOCCS. In particular, there was a large difference in the beliefs and attitudes towards LGB individuals and families. This is not surprising given the previously discussed relationship between certain specific religious beliefs (in particular conservative Christian religions) and homophobia. It should be noted that Cohen's *d* revealed large effect which further highlights the magnitude of the difference. It makes sense that students who hold less affirming beliefs would be attracted to programs that share similar beliefs about LGB individuals and relationships. Given that on average students at religious programs hold less positive beliefs, and that relationship between positive beliefs are positively related to clinical competency, this seems particularity important. It is possible that the differences in gender composition within the study might explain some of the difference in beliefs students at religiously affiliated institutions had ten percent more men than the secular sample. Rock et. al (2010), found that men had more negative beliefs toward LGB individuals. Exploring heterosexism and homophobia is a key component to providing affirming therapy to LGB individuals and families (Bernstein, 2000; McGeorge & Carlson, 2011).

Another important finding is that there is a difference in the level of knowledge and skill about LGB topics. This result makes sense given the possible intersection of religious beliefs, program stance towards LGB individuals and families, and classroom content. Given that there was not a difference in the level of content, one might expect a similar level of knowledge and skills. However, research has shown that less affirming beliefs is associated with lower levels of LGB clinical competence (Carlson et al., 2013; Rock et al., 2010). Therefore, the difference in clinical competence could be attributed to a difference in beliefs. Heterosexism and homophobia

impact an LGB client's experience of the problems they are experiencing, thus just developing therapeutic skills without developing a positive set of beliefs toward LGB individuals and relationships does not allow therapists to fully embrace LGB identities and encourage clients to do the same (McGeorge & Carlson, 2011).

Implications for Training

Based on the findings of this study, there are a few suggestions for training programs that should be addressed. Given that the students from both types of schools are only somewhat including affirmative training topics, COAMFTE could encourage programs to include more LGB affirmative training content is to specifically include affirmative training content in the curriculum requirements for accredited programs. For example, COAMFTE could include a requirement that programs include training on LGB affirmative therapy practices.

Given that AAMFT has included sexual orientation in its non-discrimination clause of the code of ethics, it seems important that COAMFTE also adjust its requirements of training programs to prepare clinicians to provide this non-discriminatory service. For example, COAMFTE could require schools to provide their students with opportunities to examine their own heterosexist biases and assumptions, as examining these beliefs is associated with higher levels of LGB clinical competence (Carlson et al., unpublished; Phillips & Fisher, 1998). In an effort to provide non-discriminatory service, taking a positive view of LGB identity and relationships appears to coincide with the AAMFT's current stance. This positive view in addition to challenging homophobia and heterosexism is considered affirmative therapy. Thus, it would make sense that COAMFTE would endorse, promote, and require that all programs include LGB affirmative therapy content within their program. Furthermore, this type of training is associated with clinical competence and positive beliefs about LGB clients and relationships

(Carlson et al., 2013). There are resources available that could assist not only COAMFTE in identifying content requirements but also assist programs in including LGB topics and content into all courses in the curriculum (Godfrey et. al, 2006; Green et. al, 2009; Long & Serovich, 2003; and McGeorge & Carlson, 2011). For example, Godfrey (2006) includes key theoretical orientation pieces as well as content that affirming therapists should know to work competently with LGB clients. Green et. al (2009), encourages therapists to increase their level of contact with LGB community. Most importantly, all of the resources mentioned above encourage therapists to examine their own beliefs about LGB identities.

Perhaps the most important and concerning finding was the difference in beliefs toward LGB individuals and relationships. Not only was this a significant difference, it was a large difference as measured by Cohen's *d.* This seems particularly important as researchers have found that negative beliefs toward LGB individuals is associated with lower levels of LGB clinical competence (Henke, Carlson, McGeorge 2009; Rock et al. 2010). What is concerning about this finding is that a large number of students are leaving accredited training programs with beliefs that compromise their ability to provide competent and affirming services. Additionally, it appears that these students leave the training programs with beliefs that are not in alignment with the AAMFT. COAMFTE should require that programs teach students about the AAMFT stances on not pathologizing sexual orientation, reparative therapy, and AAMFT's inclusion of sexual orientation in their non-discrimination clause. While this finding is concerning in and of itself it is compounded by the fact that conservativeness of religious schools was not taken into consideration for this study, meaning that there may be schools affiliated with religious institutions that take a positive and embracing and embracing view on LGB identities and relationships and this is not accounted for in the results of this study. If this were accounted

for, differences may be even larger than they were. Furthermore, this large difference in beliefs toward LGB individuals demonstrates that this may be an area that needs to be addressed not only at the programmatic level of each institution but also within COAMFTE's expectations of programs and students.

Strengths of the Study

There are several strengths of this study that should be addressed. This study is the first of its kind to compare differences in LGB affirmative training at religious and secular couple and family therapy training programs. Secondly, this study is the first to compare students' perceived competency in working with LGB clients based on whether or not they attend a religious or secular couple and family therapy training program. Third, the proportion of the students attending secular and religious institutions is similar to the breakdown of actual accredited programs, so it does not appear that religious or secular programs are over or under represented. The scales used in this study demonstrated good internal reliability. A final strength of this study is the large sample size.

Limitations

There are several possible limitations for this study. First, all of this information is self-report, thus the information students reported might not accurately reflect the content of their training program or the position the program takes toward LGB individuals and families. Furthermore, the self-reported clinical competency may not translate into actual clinical skills with LGB clients. Given that it is not known which programs are represented, it may be hard to determine if this sample provides accurate view of the differences between religious and secular institutions; students self-select to take this survey after program directors have forwarded on the

invitation. It is possible that not all students at accredited programs had the opportunity to participate in the survey.

Suggestions for Future Research

Given this study found that there was no difference in affirmative training content, it would be important to know what specific content CFT programs are including regarding working with LGB individuals and families. Furthermore, it also would be interesting to interview LGB identified students about their experiences in religious versus secular programs. It also would be interesting to determine if differences exist in affirmative therapy with transgender individuals and families based on institutional type. Given, that this study identifies differences between institutional types it would be interesting to know how these differences translate into actual practice with clients versus perceived practice.

Conclusion

The purpose of this study was to examine if any differences exist in affirmative training and competency of student therapists based on institutional affiliation (religious vs. secular). What this study found was that differences exist in affirmative training levels, the programmatic stance toward LGB individuals, overall self-reported competency in working with LGB individuals and families, attitudes toward LGB individuals and families, and the skills and knowledge student therapists report having working with LGB clients. It was the difference in attitudes toward LGB individuals and families that demonstrated the largest difference between the two groups followed by the level of affirmative stance student report that their program takes toward LGB individuals and families. This study also found that there was no significant difference in classroom content included on LGB related topics. The results support the existing

literature that more training is needed on LGB related topics. Furthermore, these results begin to demonstrate where the differences in training exist.

REFERENCES

Altemeyer, B. (2003). Why do religious fundamentalists tend to be prejudiced? *International Journal for the Psychology of Religion*, *13*(1), 17-28. doi:10.1207/S15327582IJPR1301_03

American Association for Marriage and Family Therapy (1991). *Code of Ethics*. Alexandria, VA: The American Association for Marriage and Family Therapy.

American Association for Marriage and Family Therapy (2004a). *Marriage and Family Therapy Core Competencies.* Retrieved from http://www.aamft.org/imis15/Documents/MFT_Core_Competencie.pdf

American Association for Marriage and Family Therapy (2004b). *Statement on nonpathologizing sexual orientation.* Retrieved from http://www.aamft.org/iMIS15/AAMFT/MFT_Resources/MFT_Resources/Content/Resources/Position_On_Couples.aspx

American Association for Marriage and Family Therapy (2005a). *AAMFT position on couples and families*. Retrieved from http://www.aamft.org/iMIS15/AAMFT/MFT_Resources/MFT_Resources/Content/Resources/Position_On_Couples.aspx

American Association for Marriage and Family Therapy (2005b). *What is marriage and family therapy?* Retrieved from http://www.aamft.org/iMIS15/AAMFT/MFT_Resources/MFT_Resources/Content/Resources/Position_On_Couples.aspx

American Association for Marriage and Family Therapy (2009). *Statement on reparative/conversion therapy*. Retrieved from

http://www.aamft.org/iMIS15/AAMFT/MFT_Resources/MFT_Resources/Content/Resources/Position_On_Couples.aspx

American Association for Marriage and Family Therapy (2012a). A statement about Charlotte, North Carolina. Retrieved from http://newsmanager.commpartners.com/aamft/issues/2012-05-31/1.html

American Association for Marriage and Family Therapy (2012b). California bans reparative therapy for minors. Retrieved from http://newsmanager.commpartners.com/aamft/issues/2012-10-11/index.html

American Association for Marriage and Family Therapy (2012c). *Code of Ethics*. Alexandria, VA: The American Association for Marriage and Family Therapy. Retrieved from http://www.aamft.org/imis15/Content/Legal_Ethics/Code_of_Ethics.aspx

American Psychological Association, California Psychological Association, American Psychiatric Association, and American Association for Marriage and Family Therapy (2010). Brief as amici curiae American Psychological Association, California Psychological Association, American Psychiatric Association, and American Association for Marriage and Family Therapy in support of plantif-appellees. Retrieved from http://www.ca9.uscourts.gov/datastore/general/2010/10/27/amicus29.pdf

Balkin, R. S., Schlosser, L. Z., & Levitt, D. H. (2009). Religious identity and cultural diversity: Exploring the relationships between religious identity, sexism, homophobia, and multicultural competence. *Journal of Counseling & Development*, *87*(4), 420-427. doi:10.1002/j.1556-6678.2009.tb00126.x

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy: Theory, Research, Practice, Training*, *27*(1), 3-7. doi:10.1037/0033-

3204.27.1.3

Bernstein, A. C. (2000). Straight therapists working with lesbians and gays in family therapy. *Journal of Marital and Family Therapy*, *26*(4), 443-454. doi:10.1111/j.1752-0606.2000.tb00315.x

Bethel University (n.d.). *Covenent for life together*. Retrieved from http://www.bethel.edu/about/covenant.

Bidell, M. P. (2005). The sexual orientation counselor competency scale: Assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education and Supervision*, *44*(4), 267-279. doi:10.1002/j.1556-6978.2005.tb01755.x

Bordoloi, S., O'Brien, N., Edwards, L. L., & Preli, R. (2013). Creating an inclusive and thriving profession: Why the American Association of Marriage and Family Therapy (AAMFT) needs to advocate for same-sex marriage. Journal of Feminist Family Therapy, 25(1), 41-55. http://dx.doi.org/10.1080/08952833.2013.755082

Carlson, T. S., McGeorge, C. M., & Toomey, R. B. (2013). Establishing the validity of the affirmative training inventory: Assessing the relationship between lesbian, gay, and bisexual affirmative training and students' clinical competence. *Journal of Martial and Family Therapy*, *39(2)*, 209-222. doi:101111/j.1752-0606.2012.00286.x

Commission on Accreditation for Marriage and Family Therapy Education (2005a). *Accreditation Standards 11.0*. Alexandria, VA: The American Association for Marriage and Family Therapy. Retrieved from http://www.aamft.org/imis15/Documents/Accreditation_Standards_Version_11.pdf

Commission on Accreditation for Marriage and Family Therapy Education (2005b). *MFT Educational Guidelines.* Alexandria, VA: The American Association for Marriage and Family Therapy. Retrieved from http://www.aamft.org/imis15/Documents/COAMFTE_MFT_Educational_Guidelines.pdf

Commission on Accreditation for Marriage and Family Therapy Education (2006). *Interpretative principles for schools with a religious affiliation or purpose: As related to compliance with Standard I, key elements I-B, I-F, and I-G.* Alexandria, VA: The American Association for Marriage and Family Therapy.

Doherty, W. J. & Simmons, D. S. (1996). Clinical practice patterns on marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital and Family Therapy, 22(1)*, 9-25. doi:10.1111/j.1752-0606.1996.tb00183.x

Finlay, B., & Walther, C. S. (2003). The relation of religious affiliation, service attendance, and other factors to homophobic attitudes among university students. *Review of Religious Research*, *44*(4), 370-393. doi:10.2307/3512216

Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay, and bisexual clients: A delphi study. *Journal of Marital & Family Therapy*, 32(4), 491-504. doi:10.1111/j.1752-0606.2006.tb01623.x

Green, M. S., Murphy, M. J., Blumer, M., & Palmanteer, D. (2009). Marriage and Family Therapists' Comfort Level Working With Gay and Lesbian Individuals, Couples, and Families. American Journal Of Family Therapy, 37(2), 159-168. doi:10.1080/01926180701441429

Hartwell, E. E., Serovich, J. M., Grafsky, E. L., & Kerr, Z. Y. (2012). Coming out of the dark:

Content analysis of articles pertaining to gay, lesbian, and bisexual issues in couple and family therapy journals. *Journal of Marital & Family Therapy, 38 (Supp S1)*, 227-243. doi:10.1111/j.1752-0606.2011.00274.x

Henke, T., Carlson, T. S., & McGeorge, C. R. (2009). Homophobia and clinical competency: An exploration of couple and family therapists' beliefs. *Journal of Couple and Relationship Therapy, 8*(4), 325-342. doi: http://dx.doi.org/10.1080/15332690903246101

Howell, D. (2010). *Statistical methods for psychology* (7 ed.). Belmont, CA: Wadswort, Cengage Learning.

Long, J. K. (1996). Working with lesbians, gays, and bisexuals: Addressing heterosexism in supervision. *Family Process*, 35(3), 377-388. doi:10.1111/j.1545-5300.1996.00377.x

Long J. K., & Serovich, J. M. (2003). Incorporating sexual orientation into MFT training programs: infusion and inclusion. *Journal of Marital and Family Therapy*, 29(1), 59-67. doi:10.1111/j.1752-0606.2003.tb00383.x

Malcomnson, K. M. , Christopher, A. N., Franzen, T., & Keyes, B. J. (2006). The protestant work ethic, religious beliefs, and homonegative attitudes. *Mental Health, Religion & Culture*, *9*(5), 435-447. doi:10.1080/13694670500264068

McGeorge, C., & Carlson, T. S. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital & Family Therapy, 37(1)*, 14-26. doi:10.1111/j.1752-0606.2009.00149.x

McGeorge, C., Carlson, T., Erickson, M., & Guttormson, H. (2006*).* Creating and evaluating a feminist informed social justice couple & family therapy training model. *Journal of Feminist Family Therapy, 18(3),* 1-38. doi:10.1300/J086v18n03_01

Newman, B. S. (2002). Lesbians, gays and religion: Strategies for challenging belief systems. *Journal of Lesbian Studies*, *6*(3-4), 87-98. doi:10.1300/J155v06n03_08

Phillips, J. C., & Fisher, A. R. (1998). Graduating students' training experiences with lesbian, gay, and bisexual issues. *The Counseling Psychologist, 26*(5), 712-734. doi:10.1177/001100098265002

Rock, M., Carlson, T. S., & McGeorge, C. R. (2010). Does affirmative training matter? Assessing CFT students' beliefs about sexual orientation and their level of affirmative training. *Journal of Marital & Family Therapy, 36(2),* 171-184. doi:10.1111/j.1752-0606.2009.00172.x

Rowatt, W. C., Tsang, J., Kelly, J., LaMartina, B., McCullers, M., & McKinley, A. (2006). Associations between religious personality dimensions and implicit homosexual prejudice. *Journal for the Scientific Study of Religion*, *45*(3), 397-406. doi:10.1111/j.1468-5906.2006.00314.x

Tsang, J., & Rowatt, W. C. (2007). The relationship between religious orientation, right-wing authoritarianism, and implicit sexual prejudice. *International Journal for the Psychology of Religion*, *17*(2), 99-120. doi:10.1080/10508610701244122

Veenvliet, S. G. (2008). Intrinsic religious orientation and religious teaching: Differential judgments toward same-gender sexual behavior and gay men and lesbians. *International Journal for the Psychology of Religion*, *18*(1), 53-65. doi:10.1080/10508610701719348

Whitley, J. E. (2009). Religiosity and attitudes toward lesbians and gay men: A meta-analysis. *International Journal for the Psychology of Religion*, *19*(1), 21-38. doi:10.1080/10508610802471104

APPENDIX A. REVISED SOCCS

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

2. The lifestyle of a LGB client is unnatural or immoral

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

3. I know where to find resources to enhance my therapy skills when working with LGB clients by monitoring my functioning/competency—via consultation, supervision, and continuing education.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

4. I have had the opportunity to work with gay male clients in therapy.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

5. LGB clients receive less competent treatment than heterosexual clients.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

7. I have had the opportunity to work with lesbian or gay couples in therapy.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

8. I have had the opportunity to work with lesbian clients in therapy.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

12. I have received course work that focused on LGB issues in family therapy.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

15. I am knowledgeable about LGB identity development models.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

17. It would be best if my clients viewed a heterosexual lifestyle as ideal.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

18. I have had the opportunity to work with bisexual (male or female) clients in therapy.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

21. I think that my clients should accept some degree of conformity to traditional sexual values.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

22. Currently, I do not have the skills or training to do a case presentation if my client was LGB.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

23. I believe that LGB clients will benefit most from therapy with a heterosexual therapist who endorses values and norms that promote a heterosexual lifestyle.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

25. I feel that sexual orientation differences between therapist and client may serve as an initial barrier to effectively working with LGB individuals.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

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

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

27. Personally, I think homosexuality (gay male and lesbian relationships) is a mental disorder and/or a sin and can be treated through therapy or spiritual help.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

28. Personally, I think bisexuality (both female and male bisexuality) is a mental disorder and/or a sin and can be treated through therapy or spiritual help.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

29. I believe that all LGB clients should be discreet about their sexual orientation around children.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

30. When it comes to homosexuality (gay male and lesbian relationships), I agree with the statement: “You should love the sinner but hate or condemn the sin”.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

31. When it comes to bisexuality (both female and male bisexuality), I agree with the statement: “You should love the sinner but hate or condemn the sin”.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

APPENDIX B. AFFIRMATIVE TRAINING INVENTORY

1. Content related to the experiences of LGB individuals is specifically addressed in each of my family therapy courses.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

2. I learned about the presence of heterosexual bias (i.e., the act of conceptualizing human experiences in heterosexual terms, thereby discounting LGB experiences and relationships) in my family therapy training program.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

3. I learned about the concept of heterosexism (i.e., a belief system supported by laws and societal customs that legitimizes heterosexuality as the only acceptable way of being which leads to the unequal treatment of LGB individuals) in my family therapy training program.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

4. I learned about the concept of heterosexual privilege (i.e., the unearned advantages given to heterosexual individuals based solely on their sexual orientation) in my family therapy training program.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

5. The faculty in my family therapy program encourages students to explore their own heterosexual biases (i.e., the act of conceptualizing human experience in heterosexual terms, thereby discounting lesbian, gay, and bisexual lifestyles and relationships).

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

6. The faculty in my family therapy program would be supportive of students pursuing research on topics related to LGB individuals, couples, and/or families.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

---

7. My program provides students with the opportunity to work with LGB clients.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

8. My program takes an affirmative (i.e., a positive view of LGB identity and relationships) stance toward LGB individuals and relationships.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

9. My program provides students with information on LGB affirmative therapy (i.e., an approach to therapy that embraces a positive view of LGB identity and relationships and addresses the negative influences that homophobia and heterosexism have on the lives of LGB clients) through readings, lectures, supervision, etc.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

APPENDIX C. TABLES

Table C1. Characteristics of Participants

	Secular		Religious	
Characteristic	*n*	%	*n*	%
Gender				
Female	137	79.7	40	67.8
Male	35	20.3	19	32.2
Race				
African American	9	5.2	7	11.9
Asian American/Asian	7	4.1	2	3.4
Biracial/Multiracial	9	5.2	2	3.4
European American/Caucasian/White	138	80.2	45	76.3
Latino(a)/Hispanic	6	3.5	1	1.7
Middle Eastern/Arabic	1	0.6	0	0.0
Pacific Islander	0	0.0	1	1.7
Other	2	1.2	1	1.7
Sexual Orientation				
Heterosexual	151	87.8	53	89.8
Lesbian, Gay, or Bisexual	21	12.2	6	10.2
Level of Program				
Master's	117	87.8	47	78.7
Doctoral	55	32.0	12	21.3

Note. N=231.

Table C2. Independent Samples T-Test Values and Effect Sizes (d) for ATI and R-SOCCS

	t	*df*	*p*	Secular		Religious		*d*
				M	SD	*M*	SD	
ATI	2.25	227	.03	4.50	0.84	4.22	0.80	.34
Classroom	0.42	225	.68	4.11	1.16	4.04	0.96	
Program	3.74	241	.00	5.17	0.74	4.73	0.86	.55
R-SOCCS	2.96	194	.00	4.38	0.68	4.04	0.74	.48
Awareness	3.79	88.85	.00	5.27	1.12	4.56	1.27	.80
Knowledge/Skill	2.00	228	.05	3.76	0.90	3.48	0.94	.30

Note. $N = 172$ students attending secular institutions and $N = 59$ students attending religious. institutions. ATI = Affirmative Training Inventory. R-SOCCS = Revised Sexual Orientation Counselor Competency Scale.