Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision

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EXPLORING THE DIMENSIONS OF LESBIAN, GAY, AND BISEXUAL AFFIRMATIVE CLINICAL SUPERVISION

Lindsey N. Dollar, Ph.D.
Western Michigan University, 2023

Graduate programs have continued to improve over time regarding incorporating training on LGB issues into coursework and practicum experiences with less emphasis on supervision. Since supervision is a major training area where therapists learn about clients and themselves, it becomes an important area for also teaching supervisees how to work with minority populations. However, relatively absent from discussions of cultural influences in supervision is a focus on LGB concerns, and missing is the ‘how to’ within the supervisory relationship. This quantitative investigation sought to learn how clinical supervisors with knowledge of LGB issues and people implement LGB-affirmative supervision, and to explore the underlying dimensions of that LGB-affirmative clinical supervision through the use of multidimensional scaling. Twenty-six experienced and LGB-affirmative clinical supervisors were recruited through mental health organization listservs, APA-accredited university counseling center training directors, and professional contacts. Findings indicate four dimensions of LGB-affirmative clinical supervision for this sample: awareness, understanding LGBTQ+ identities, learning about minority identity experiences, and the relational process of supervision. Given that this investigation is the first to explore these dimensions, implications for future research are vast.
EXPLORING THE DIMENSIONS OF LESBIAN, GAY, AND BISEXUAL AFFIRMATIVE CLINICAL SUPERVISION

by

Lindsey N. Dollar

A dissertation submitted to the Graduate College in partial fulfillment of the requirements for the degree of Doctor of Philosophy Counseling Psychology Western Michigan University August 2023

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Lindsey N. Dollar
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CHAPTER I
LITERATURE REVIEW

The purpose of the current study is to explore the underlying dimensions of LGB-affirmative clinical supervision as provided to trainees by clinical supervisors with knowledge of lesbian, gay, and bisexual (LGB) issues and people. Specifically, this study looked for how clinical supervisors incorporate and implement LGB-affirmative practice informed by the American Psychological Association (APA, 2021) into the clinical supervision component of training. Having greater knowledge and understanding of how clinical supervisors practice LGB-affirmative supervision may help to promote more effective and sensitive supervision training and benefit current and future supervisors, current and future supervisees, and ultimately the clients in the care of those supervisees. Additionally, assisting trainees in effectively adopting LGB-affirmative practice may help to develop psychologists with stronger, more persistent anti-heterosexist attitudes, ultimately helping to reduce the perpetuation of sexual prejudice within the field of psychology.

The current study expands upon prior research that had begun to explore LGB-affirmative supervision. In general, previous research has primarily addressed LGB training in graduate programs and LGB-affirmative therapy, with considerably less focus on LGB issues in supervision (Alderson, 2004; Anhalt et al., 2003; Israel, Gorcheva, Burnes et al., 2008; Pachankis & Goldfried, 2004; Phillips & Fischer, 1998; Sherry et al., 2005; Wiederman & Sansone, 1999). Although the counseling field progressed in delineating a clear theory of LGB-affirmative therapy that can be enacted in practice (Bieschke et al., 2007), the same cannot be said for LGB-affirmative supervision. To help fill this gap in the research, the current study focused on exploring how experienced clinical supervisors implement LGB-affirmative practice
with their supervisees. The goal of this focus was to gain understanding of specific and concrete LGB-affirmative actions that clinical supervisors describe taking with their supervisees.

In this literature review, an overview of the research that serves as a foundation for the current study is provided. The review consists of five sections summarizing different areas of research. The first section provides an overview of LGB issues, establishing that certain aspects have been studied more than others—and the importance of this—because this knowledge is what led governing bodies in the mental health field to create guidelines for working with LGB clients. The second section provides an overview of how graduate training has evolved over time regarding LGB issue integration, both graduate training as a whole and specifically looking at coursework and practica. In the third section, LGB-affirmative therapy is explored as it is the most empirically researched affirmative practice to date. The fourth section reviews allyship and ally development, emphasizing that this work is the responsibility of every person that enters the mental health field. The fifth and final section provides a review of research on the inclusion of LGB issues in supervision and what is known about LGB-affirmative supervision. The research addressed in this section is most central to the core purpose of the current study, and thus, is reviewed in more depth compared to other sections.

**Overview of LGB Issue Literature: The Journey to Guideline Creation**

Many positive changes have occurred both socially and politically for sexual minority people in the United States in recent history. Yang (2000) reported data suggesting a gradual trend over the 25-year period from 1975-2000 toward increasingly more positive attitudes among the general population toward LGB individuals. In 2015, the Supreme Court ruled in favor of same-sex marriage, making it legal in all 50 states. There have also been positive shifts in policies regarding domestic partnership benefits, adoption, and same-sex parenting (American
Civil Liberties Union, 2015). However, it is important to keep in mind that many progressive political and social movements are met with backlash. For example, there was also a corresponding increase in highly publicized violence committed against LGB people and a mixture of outcomes in a variety of judicial and legislative legal battles over LGB civil rights issues (Anti-Violence Project, 2018; Lacayo, 1998). The National Coalition of Anti-Violence Programs (NCAVP) authored and released the Crisis of Hate report documenting the hate violence homicides in 2017. In this report, the NCAVP cited a record-breaking year of hate violence homicides in which 52 homicides were recorded, an 86% increase over 2016 and the highest number of single-incident homicides ever recorded in the 20 years of hate violence reports (Anti-Violence Project, 2018). Additionally, more than 300 anti-LGBTQ bills were proposed in state legislatures across the United States in the year 2022 alone (American Civil Liberties Union, 2022). Compared to the general population, sexual minorities face higher rates of discrimination, interpersonal harassment, and violence (Burgess et al., 2007; Federal Bureau of Investigation, 2014; Westefeld et al., 2001). The types of discrimination reported run the gamut from workplace discrimination, difficulties with the police, and trouble securing housing, to everyday experiences like being treated with less respect than others, receiving poor service, and being verbally abused (Burgess et al., 2007; Westefeld et al., 2001).

The importance of LGB issues has been established in the literature throughout the years, but certain areas have been studied more than others. Two more studied topics include help-seeking behaviors by LGB people and mental health challenges in the LGB community. It has been found that LGB individuals utilize counseling at higher rates than the general population (Burgess et al., 2007; Israel, Gorcheva, Walther et al., 2008; Pachankis & Goldfried, 2004; Palma & Stanley, 2002). In a large sample survey of college counseling center clients,
McAleavey et al. (2011) learned that sexual minority students had higher rates of counseling service utilization. Estrada and Rutter (2006) also reported that the LGB individuals in their study sought counseling services at 5 times the rate (50%) of their heterosexual counterparts and nearly all the therapists in a study by Pachankis and Goldfried (2004) reported seeing at least one LGB client in their practices.

Research clearly and consistently indicates that most sexual minority individuals are healthy and well-adjusted, and have rewarding relationships, romantic and otherwise (King et al., 2008; Mohr et al., 2013; Moradi et al., 2009). However, research also shows that LGB individuals experience elevated rates of mental health challenges relative to heterosexual people, even after controlling for variables such as age, race, educational background, and cohabitation or marital status (Burgess et al., 2007; Cochran et al., 2003; King et al., 2003; Mustanski et al., 2010). King et al. (2008) conducted a systematic review and meta-analysis of the prevalence of mental disorders, substance abuse, self-harm, suicidal ideation, and suicide on data collected from more than 200,000 heterosexual and 11,971 LGB people. The findings revealed significantly increased risk for depression, alcohol and substance dependence, and suicide attempts among LGB individuals. Westefeld et al. (2001) also found that LGB college students experienced more depression and feelings of loneliness and isolation, expressed having fewer reasons for living, and had greater suicide potential than a control group of heterosexual college students. Lastly, LGB adolescents are often found to be at higher risk for substance abuse, eating disorders, violence, depression, suicide, and sexual health problems (Ciro et al., 2005).

Although many of the determinants of elevated rates of mental disorders among LGB individuals are unknown, researchers have identified psychosocial stress caused by stigmatization and the associated exposure to prejudice, discrimination, victimization, and social
oppression as major contributors (Cochran & Cauce, 2006; King et al., 2008; Legate et al., 2012; Meyer, 2003; O’Donnell et al., 2011; Potoczniaik et al., 2007). Learning how to manage a stigmatized identity has the potential to create a great deal of confusion, anxiety, and emotional turbulence for a person. It is also critical to recognize that racial and/or ethnic minority LGB individuals are at even higher risk for mental health disorders, substance abuse, and suicidality than their White LGB counterparts (O’Donnell et al., 2011). Research has suggested that this happens because multiple minority status compounds an individual’s experience of stigma, marginalization, rejection, and discrimination (Balsam et al., 2011; Cochran et al., 2007; David & Knight, 2008; Feinstein et al., 2012). Additionally, in contrast to other socially stigmatized groups, LGB people have historically had less protection from discrimination under the law (Legate et al., 2012). Negative attitudes towards LGB persons may also be particularly harmful because many religious groups continue to condemn same-sex relationships and view them as immoral lifestyle choices (Legate et al., 2012).

Matthews (2007) wrote that “mental health professionals live in the same heterosexist society as everybody else and are subject to the biases and prejudices that permeate that culture” (p. 205). Indeed, the mental health professions have historically demonstrated the same heterocentric and homophobic beliefs, prejudices, and practices against LGB individuals that have plagued all of U.S. society (Pachankis & Goldfried, 2004). However, there has been a gradual evolution over time in the mental health fields, and at a parallel pace, to broader societal advancements. Worthington and Strathausen (2017) cited the removal of pathological conceptualizations, treatments, and interventions with respect to LGBTQ individuals as examples illustrating growth. Research has also established there is a demand for and a need to serve LGBTQ clients. The positive changes that have occurred to best serve LGBTQ clients are
important; however, a great deal of work remains and research in this area continues to contain considerable gaps and deficits (Worthington & Strathausen, 2017).

In 2000, the APA issued an initial set of Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients. These guidelines were intended to respond to the need for improved training and practice to effectively assist LGB individuals seeking psychological services. With sexual minority clients significantly overrepresented within clinical populations, this was a critical move by the APA (Pachankis & Goldfried, 2004). Israel, Gorcheva, Walther, et al. (2008) described it as illustrating the APA’s advocacy for services in response to the needs of LGB clients. In 2011, the APA guidelines were further developed and revised, and the name updated to Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients. Each of these 21 guidelines provided an expansion of the original guidelines, and an update of the psychological literature that supported them, including rationale and application. Guideline 19 in the Education and Training section was especially pertinent to graduate training, stating that psychologists must strive to include LGB issues in their professional education and training. In February 2021, the APA Guidelines for Psychological Practice with Sexual Minority Persons were published, comprising a third iteration built upon the original guidelines and revised from those before them. The new APA Guidelines for Psychological Practice with Sexual Minority Persons (APA, 2021) contain 16 guidelines with the same rationale and application format as used previously. Guideline 15 in the Professional Education and Training section is particularly relevant to the topic at hand. Guideline 15 says that psychologists should strive to educate themselves and others on psychological issues relevant to sexual minority persons, and to utilize that knowledge to improve training programs and educational systems.
Another historically and practically significant document was the Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (APA, 2009), which provided a comprehensive review of the literature and recommendations regarding sexual orientation change efforts (SOCEs), also known as reparative therapies, conversion therapies, or reorientation therapies. SOCEs have been widely discredited across various disciplines and specializations within the fields that make up the mental health professions (Worthington & Strathausen, 2017). There is no empirical evidence to suggest that enduring change in sexual orientation is likely and the potential harm to clients is too great (APA, 2009). All the various guidelines are intended to inform the practice of psychologists and to provide information for the education and training of psychologists regarding LGB issues. These guidelines are intended to be broad in nature and provide sound recommendations regarding counseling and psychotherapy that are based on substantive empirical research (Worthington & Strathausen, 2017).

The APA is not the only governing body in the mental health field to formally respond to the needs of the sexual minority client population with a written document. The American Counseling Association’s (ACA) Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC), as it was named at the time, first issued competencies in 2003. Those competencies were updated as the ALGBTIC Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals in 2013. These competencies are organized into six main sections: (1) Introduction; (2) Competencies for working with lesbian, gay, bisexual, queer, and questioning individuals; (3) Competencies for working with allies; (4) Competencies for working with intersex individuals; (5) References and additional resources; and (6) Appendix. The second section that covers competencies for working with
lesbian, gay, bisexual, queer, and questioning individuals is the largest portion of the document. The competencies found in this section are organized according to the 2009 Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards Sections: human growth and development, social and cultural foundations, helping relationships, group work, professional orientation and ethical practice, career and lifestyle development, assessment, and research and program evaluation. In April of 2020, ALGBTIC officially changed its name to the Society of Sexual, Affectional, Intersex, and Gender Expansive Identities (SAIGE) to honor inclusivity of all of the numerous identities under the sexual, affectional, intersex, and trans umbrellas and it will be referred to as such from this point onward.

In summary, the rationale for having guidelines in place is straightforward. Despite the rising emphasis on diversity training during graduate education and internship, studies have shown that graduate students in psychology and early career psychologists report inadequate education and training in LGB issues (Matthews et al., 2005; Pilkington & Cantor, 1996) and feel unprepared to work with sexual minority clients (Allison et al., 1994; Phillips & Fischer, 1998). Students are also likely to describe their attitudes toward LGB individuals as more affirmative than if they are examined more deeply (Israel & Hackett, 2004), and training in LGB issues has been shown to be effective in clarifying and reducing heterosexist attitudes (Boysen & Vogel, 2008; Rudolf, 1989). Thus, having clear professional statements that recommend specific professional behaviors and conduct can help to facilitate the growth and development of those still in training or early in their careers and ultimately help to ensure a higher level of professional practice by all psychologists.
Graduate Training

Considering the rate that counseling services are utilized by the LGB population and the likelihood that counselors will work with sexual minority clients, one wonders about the graduate training taking place regarding LGB issues. The debate in the literature is no longer whether to include training on LGB issues, but how to include it—the format and comprehensiveness (Pearson, 2003). Some argue that LGB people should be included in any definition of multiculturalism and that training in LGB issues needs to be incorporated into curricula, while others argue that these approaches are inadequate (Buhrke & Douce, 1991; Carroll & Gilroy, 2001; Pope, 1995). Phillips (2000) suggested that a separate elective course or training seminar would be an ideal setting for providing in-depth knowledge of LGB issues and opportunities for experiential activities, but stressed that this would be an adjunct to, not a substitution for, integrating these issues throughout the training curriculum. Biaggio et al. (2003) suggested that relegating coverage to a specific course could run the risk of marginalizing the content, while infusing LGB issues across the curriculum sends a message about the importance of such issues. In general, Phillips and Fischer (1998) suggested striking a balance between two broad approaches: dissemination of knowledge about LGB people and experiential learning. Although the APA issued LGB guidelines explicitly encouraging faculty and supervisors to integrate and include LGB content into program curricula, training, and supervision, there has been a great deal of discussion within the psychotherapy literature about the importance of complying with these guidelines and the form that graduate training should take (Sherry et al., 2005). Dworkin and Gutierrez (1989) noted that, “therapists typically receive the most intensive part of their training in graduate school, and if graduate programs do not address gay, lesbian, and bisexual issues, most therapists will probably be inadequate in this area” (p.7). For the
profession of psychology to provide effective services to the LGB population, graduate programs are one of the most promising agents of change.

The current section is divided into this main section and two subsections. Each section is organized in the same way—anchored in the past and moving more current—providing a historical overview and illustrating how training in that area has evolved. This main section provides a review of studies involving training on LGB issues in graduate programs (Anhalt et al., 2003; Biaggio et al., 2003; Lark & Croteau, 1998; O'Shaughnessy & Spokane, 2013; Phillips & Fischer, 1998; Sherry et al., 2005; Wiederman & Sansone, 1999). The primary purpose for including this main section is to demonstrate that while there is a good picture of the state of graduate training regarding LGB issues and how it has improved over time, inconsistencies remain, and many graduate students continue to report feeling ill-equipped to work with LGB clients. The first subsection provides a review of studies that examine overall coursework integration in graduate programs, elective courses, and supplemental trainings concerning LGB issues (Anhalt et al., 2003; Bidell, 2013; Finkel et al., 2003; Pearson, 2003; Phillips & Fischer, 1998; Sherry et al., 2005; Wiederman & Sansone, 1999). The primary purpose of this subsection is to show the field’s evolution and progression from a time of no integration of LGB issues into coursework, as well as to enhance understanding of the impact that learning about LGB issues has on students and competency development. In the second subsection, a review is provided of studies regarding LGB issue integration into counseling practica (Anhalt et al., 2003; Dillon & Worthington, 2003; Emert & Milburn, 1997; O'Shaughnessy & Spokane, 2013; Phillips & Fischer, 1998; Sherry et al., 2005; Wiederman & Sansone, 1999). The purpose of this subsection is two-fold: to illustrate the improvement in LGB integration over time and to emphasize that
while knowledge and awareness are important, it is practice with direct skills and intervention that are critical in building counselor competency.

In 1998, Phillips and Fischer conducted the first relatively comprehensive study of graduate training regarding LGB issues and as such, their study serves as a point of comparison for the current state of training. Of primary interest for this study was that, although there had been multiple calls for the integration of LGB issues into the curricula of psychology graduate programs, little empirical data on the quantity and quality of training existed. Particularly scarce was data on training after the presentation of substantial training recommendations set forth in the counseling literature (e.g., special issues of *The Counseling Psychologist* in 1991 and the *Journal of Counseling and Development* in 1989) (Phillips & Fischer, 1998). The doctoral training experiences of 107 graduate students—69 from counseling psychology programs and 38 from clinical psychology programs—prior to internship were examined in the Phillips and Fischer (1998) study. Their surveys inquired about graduate program coursework, comprehensive examinations, practicum experiences, whether any faculty members had expertise in LGB issues or were “out” as LGB, other sources of information on LGB issues in therapy, and how well students felt prepared to work competently with LGB people in comparison to heterosexual people (Phillips & Fischer, 1998). The researchers concluded that training in LGB issues continued to be inadequate based on the majority of respondents reporting that coursework had not prepared them to work as well with LGB clients compared to heterosexual clients (Phillips & Fischer, 1998).

Around the same time, Lark and Croteau (1998) raised interesting points pertaining to departmental environments that should also be considered regarding training. Participants in that study communicated perceptions about the degree of safety felt in their programs using terms
that fell into roughly three categories: an overtly affirmative environment, a null environment, or an overtly negative environment. Now, one must keep in mind that perception is reality (Jussim, 1991). Therefore, academic departments should put time and effort into understanding how they are being perceived by people and adjust accordingly. Are there LGB faculty members present? Is the department making efforts around professional development on LGB issues? The term ‘null’ was used by several participants who explained that LGB issues were not discussed or were considered a nonissue in their departments (Lark & Croteau, 1998). Hitchings (1999) elaborated on this further by saying that having an ‘orientation-blind’ attitude, while possibly meant as a way of avoiding prejudice, carries the almost inevitable risk of perpetuating it. When participants described their training environments as positive, the researchers reported that there was a tone of pride present and a gratefulness at having found an LGB-affirmative program (Lark & Croteau, 1998). The researchers also reported learning that when students felt safe and affirmed in their identities, they had the energy and freedom required to work on becoming counseling psychologists instead of being consumed with survival (Lark & Croteau, 1998).

Imagine how some of these same feelings and experiences might transfer into the therapeutic environment. LGB clients that are not being provided with an LGB-affirming environment are likely being robbed of that safety and of the opportunity to fully immerse themselves in therapy sessions.

In 1999, Wiederman and Sansone surveyed training directors at both clinical and counseling psychology doctoral programs, as well as at predoctoral internship sites, about the extent of sexuality training being offered to students and interns. This study was born out of prior research that found that many clinical psychology training directors believed that training focused on sexuality was most appropriately offered on internship rather than during graduate
school (Nathan, 1986), as well as the fact that the most recent literature on predoctoral internships had not included an investigation of sexuality curriculum (Stedman, 1997). The Sexuality Training Survey was mailed to 689 training directors of APA-accredited doctoral programs in clinical, professional, and counseling psychology, as well as to all APA-accredited predoctoral psychology internship sites at that time. Of those, 347 surveys (47%) were returned, with a higher response rate for predoctoral internships (53%) than for doctoral programs (37%) (Wiederman & Sansone, 1999). The researchers inquired about program size, number of full-time faculty with identified expertise (e.g., certifications, publishing, research, and extensive professional experience) in each of six content areas, and whether those content areas were covered in each of four different ways—entire course, topic in a course, seminar, or practicum (Wiederman & Sansone, 1999). The content area asked about and relevant to the present study was therapy with gay clients. The researchers learned that, although about half of the doctoral programs covered at least some sexuality topics within courses, though 19% of programs did not offer any training regarding therapy with gay clients at all (Wiederman & Sansone, 1999). Sexuality training was even less likely to occur during predoctoral internships per survey findings. Results appeared to be less about the size of the program and more a function of the number of faculty with relevant expertise (Wiederman & Sansone, 1999).

A few years later, Anhalt et al. (2003) surveyed behavioral clinical psychology programs to gain doctoral student perspectives on training in LGB issues. The researchers reported that 10 programs agreed to participate and that 200 students returned the survey. The researchers asked for information regarding coursework, clinical work, research, personal contacts with LGB issues, and attitudes toward those who identify as LGB. The results of the study indicated that participants had received minimal overall training in LGB issues and thus felt inadequate in
working with LGB clients. Additionally, it was reported that the greatest feelings of inadequacy trainees described were related to low levels of helpfulness in supervision regarding LGB issues relative to therapy—a key finding that further supports the importance of the current study (Anhalt et al., 2003). However, despite feeling inadequately trained, the comfort level in addressing sexuality and LGB issues in therapy appeared to be quite high. The researchers posited that students were obtaining information and assistance outside of their formal training programs, which was partially supported by the data (Anhalt et al., 2003). The most common methods of exposure to LGB issues, aside from formal training, that students reported included contact with LGB individuals, exposure through the media, and independent readings (Anhalt et al., 2003).

Biaggio et al. (2003) also found a relationship between institutional climate and the quality of education around LGB issues—much like the previously discussed Lark and Croteau (1998) study. According to the researchers, institutions and programs that actively embrace LGB-affirmative strategies will be rewarded with more stimulating, accepting, and LGB-affirming environments for all members of their community (Biaggio et al., 2003). In more recent years, many institutions have revised their diversity policies to prohibit discrimination against people of minority status (Biaggio et al., 2003). The extent to which institutions realize an LGB-affirming environment is a function of their commitment to fostering one—by explicitly publicizing their position, providing LGB-affirmative education and training, and addressing policy violations (Biaggio et al., 2003). Institutions that are LGB-affirmative in their policies are more likely to attract and retain LGB faculty and heterosexual allies who are knowledgeable about LGB issues (Biaggio et al., 2003). These are the faculty that can address LGB issues in programs and provide mentoring to LGB students. Additionally, sexual minority students may look to the campus environment as a safe haven. Every member of an educational community
has a responsibility toward those who seek safety on campus. The very presence of LGB faculty and students can prompt a kind of openness to discussions around sexual orientation that fosters a safe and LGB-affirming atmosphere for sexual minority faculty, staff, and students (Biaggio et al., 2003). This is because openness about being LGB is crucial to education and a critical part of inclusiveness. Graduate psychology programs can signal that they are LGB-affirmative by including LGB issues in the curriculum, fostering LGB-related research, displaying symbols of affirmation, and offering mentor programs for LGB students (Biaggio et al., 2003).

In 2005, Sherry et al. conducted a study examining the extent to which APA-accredited clinical and counseling psychology doctoral programs were incorporating training on issues relevant to LGB clients. One hundred and four (104) training directors in total–43 from counseling psychology programs and 61 from clinical psychology–completed surveys. The survey was a modification of the Multicultural Competency Checklist (MCC) (Ponterotto et al., 1995) and was intended to evaluate programs on the following categories: representation, curriculum, practice and supervision, research, student and faculty competency, and physical environment (Sherry et al., 2005). The researchers edited the original MCC so that words related to the concept of “multiculturalism” referred specifically to LGB issues and added seven items in order to address these topics specifically: whether LGB issues were covered in a multicultural course, whether LGB issues were covered in a sexuality course and if this was a required course, if there was exposure to LGB issues in practicum and supervision, if a faculty member had a secondary interest in LGB research, if an LGB organization existed on campus, and if there was an LGB support group on campus (Sherry et al., 2005). The survey consisted of 27 self-report items intended to generally assess graduate program inclusion of LGB issues (Sherry et al., 2005). The researchers found that, according to training director self-reports, APA-accredited
doctoral programs did appear to be integrating LGB issues into their curricula with counseling psychology programs demonstrating greater levels of attention in some areas than clinical psychology programs (Sherry et al., 2005). For example, counseling psychology programs were more likely to require students to take multicultural courses as part of the curriculum, where LGB issues are more likely to be addressed (Sherry et al., 2005). The researchers posited that this finding may reflect a difference in training emphasis as clinical psychology programs often focus on psychopathology while counseling psychology programs tend to emphasize contextual etiologies (Sherry et al., 2005).

In 2013, O'Shaughnessy and Spokane (2013) took a different approach to learning about therapists-in-training and competency working with the LGB population. The researchers were interested in exploring the relationship between therapist personality, self-reported LGB-affirmative therapy competency, and demonstrated LGB-affirmative therapy competency utilizing an analogue method, ultimately recruiting 212 therapists-in-training as study participants. One of their more interesting findings was that the extent of relationship a participant reported having with LGB individuals was positively correlated with nearly all outcome variables, which supports findings from prior studies that relationships with LGB individuals tend to influence perceptions in a positive direction (Barrett & McWhirter, 2002; Cullen et al., 2002). The researchers suggested that findings such as these provide support for the importance of increasing experiential processes in training programs–otherness experiences and community immersion projects–that expose trainees to a broad range of individuals and help expand trainee worldviews. However, it is essential to keep in mind that as students step outside of their comfort zones, they will be entering the safe zones of communities that are often the targets of discrimination (O'Shaughnessy & Spokane, 2013). Therefore, it becomes imperative
for training programs to think critically about how to prepare trainees to engage in these environments in a respectful way. Roleplaying and visualization exercises to help build trainee empathy before engaging in community work can help maintain safety (O'Shaughnessy & Spokane, 2013). Additionally, it might benefit programs to develop partnerships with community organizations so that communities have a voice in determining how counseling students gain access to them.

In summary, there is evidence of increasing inclusion of LGB issues into graduate training curricula through the years. Graduate programs appear to be answering the call and responding to the need for competency regarding LGB issues, particularly due to high sexual minority counseling utilization (Alderson, 2004; Burgess et al., 2007; Pachankis & Goldfried, 2004; Palma & Stanley, 2002; Sherry et al., 2005). However, the integration that has occurred over time continues to be both inadequate and inconsistent as indicated by the number of graduate trainees that report feeling ill-prepared to work competently with LGB people in comparison to heterosexual clients. This lack of coverage of LGB issues in graduate programs could result in, at the least, limited knowledge about sexual orientation and the needs of LGB individuals and at worst, misconceptions about sexual minorities (Biaggio et al., 2003). Practitioners with inaccurate information could not only be insensitive but could also be harmful. This is why quality and comprehensive graduate training is so critical.

It is important to further emphasize how graduate training occurs across multiple settings, including in coursework (e.g., integration in required classes, elective courses, and supplemental trainings), counseling practica, and supervision. Leaders in the field of multicultural counseling have long highlighted the importance of specialized training and knowledge to enable practitioners to provide competent services to minority populations (Sue et al., 1982). To be
deemed multiculturally competent in psychology requires knowledge (e.g., culture-specific knowledge about various cultural groups), skills (e.g., ability to respond verbally and nonverbally in manners appropriate to the cultures of one’s clients), and attitudes (e.g., awareness of one’s own cultural identities, values, beliefs, and biases) (Sue et al., 1982). If LGB issues are only covered in one facet of training—for example, as part of a required multicultural course as opposed to across the various training environments, including in practicum and supervision—competence and subsequently specialization cannot hope to be achieved. This sort of inconsistency across training programs, based on previously discussed research, is likely contributing to students feeling ill-prepared regarding LGB issues and clients. Professional guidelines highlight the need for training programs in psychology to incorporate knowledge, skills, and attitudes relevant to LGB issues into their curricula and training experiences in order to train multiculturally competent and ethical psychologists (Miles & Fassinger, 2014). The various guidelines are important resources for educators providing training on sexual minority issues in counseling, of course, but a reading of those documents should not be mistaken as all one needs for quality training (Phillips & Fitts, 2017). Gauging the follow-through of LGB issue inclusion across the various graduate training settings necessitates taking a closer look into each. In the following subsections, reviews are provided of coursework, electives, supplemental trainings, and counseling practica regarding LGB issue integration and how each has evolved over time.

Coursework Integration, Electives, and Supplemental Trainings

Surveys conducted in the 1980s consistently showed that a minority of doctoral programs offered a course exclusively devoted to human sexuality (Nathan, 1986). As of 1987, only 25% of doctoral programs offered any information on human sexuality, and when such training was
offered, it typically consisted of an isolated lecture, colloquium, or workshop (Nathan, 1986). This means that, at that time, information was not being integrated into programs. Students had to take the initiative to seek out additional training opportunities. Supplemental training is a nice option for those interested in learning more or developing expertise in certain topic areas, but these trainings do not have the impact of required coursework that reaches every student in a program.

Phillips and Fischer (1998) inquired about coursework in their extensive survey examining doctoral training experiences of counseling psychology and clinical psychology graduate students about LGB issues prior to internship. The researchers asked whether lesbian, gay, and bisexual issues (separately by type) had been integrated into each of 19 typical courses, whether LGB issues had been integrated into any other course at the doctoral level, whether a doctoral course devoted solely to LGB issues was offered, whether students were encouraged to explore their heterosexist biases in coursework, and the number of articles or book chapters on LGB issues that were read. In terms of formal training experiences, students reported that gay and lesbian issues were integrated into some courses (median for each = 3 courses; mode for each = 2), but this was less true for bisexual issues (median = 1; mode = 0). Few participants’ programs (15%) had available courses specifically focused on LGB issues, but about half of the students had a multicultural counseling course that included LGB issues as part of the multicultural emphasis (Phillips & Fischer, 1998). Students were also unlikely to be required to read many articles or book chapters on LGB issues. In fact, most students indicated that they obtained information on LGB issues from sources other than their respective doctoral program (Phillips & Fischer, 1998).
Wiederman and Sansone (1999) learned that it was relatively rare for an entire course to be devoted to sexuality topics, such as therapy with gay clients. In their study, they found that only 10.5% of APA-accredited counseling psychology and clinical psychology doctoral programs and 2.2% of predoctoral internship sites offered such a course. However, half of the doctoral programs (50.5%) reported covering sexuality topics—including clinical work with sexual minority clients—in the context of other courses (Wiederman & Sansone, 1999). Only 24.6% of predoctoral internships reported integrating sexuality topics.

Recall the Anhalt et al. (2003) study that surveyed behavioral clinical psychology programs to gain doctoral student perspectives on training in LGB issues. Information regarding coursework was also gathered at that time, with researchers specifically inquiring about the total number of courses taken in the program, the number of courses that addressed LGB issues, and the percentage of class time that addressed LGB issues. On average, doctoral students reported that only 10% of courses taken had addressed LGB issues at all, with little time spent discussing LGB issues (Anhalt et al., 2003). Researchers also reported that 90% of respondents conveyed that they would benefit from training in LGB issues, some recommending that LGB issues be included in all existing required courses (Anhalt et al., 2003). Additionally, sources of informal training were assessed, meaning exposure that students had to LGB issues outside of their respective programs. Independent readings were endorsed by 72% of participants and 29% reported attending workshops or symposia on LGB issues (Anhalt et al., 2003).

Sherry et al. (2005) also examined the extent to which APA-accredited clinical psychology and counseling psychology doctoral programs were incorporating training on issues relevant to LGB clients into coursework. The researchers inquired about formal program curricula, specifically asking program training directors if LGB issues were covered in a
multicultural course, if LGB issues were covered in a sexuality course, and if these were required courses. The response data were examined, in aggregate and separately by program type, clinical psychology or counseling psychology. The researchers provided all data but chose to focus on the collective data when reporting. Of the 67.7% of overall programs, both clinical and counseling, that required a multicultural course and the 61% of programs that had an additional advanced multicultural course, 71% of them reported covering LGB issues in the course. Only 21% of overall programs reported integrating LGB issues into courses that were not specifically multicultural (Sherry et al., 2005).

The counseling classroom seems the ideal place to begin addressing and reducing gaps in training. The classroom is, after all, the first gateway through which all students must enter and pass in a graduate program. The deficiency in, and necessity for, effective clinical practice with ethnic minority client groups resulted in the development of multicultural counseling coursework (Malott, 2010). For this reason, nearly all mental health programs now offer and typically require students to complete a multicultural course as part of their professional training. Malott (2010) reported, “researchers have demonstrated that a single multicultural counseling course can positively affect variables related to multicultural competency” (p. 58). However, multicultural coursework has its limitations. Priester et al. (2008) reviewed syllabi for multicultural courses offered across counseling programs in the United States and discovered that content, minority groups addressed, and teaching styles varied widely. For example, LGB issues may not be addressed at all in a multicultural counseling course. This lack of consistency likely contributes to the frequent reports made by students and professionals alike that they feel unprepared, poorly trained, and only marginally competent to work with LGB clients (Graham et al., 2012; Grove,
2009) and makes a case for substantively developed courses that are specifically designed to address LGB mental health and counselor education disparities (Bidell, 2013).

As a result, there have been efforts to supplement information in various ways while waiting for programs to implement guidelines pertaining to training in LGB issues (Finkel et al., 2003; Pearson, 2003). In fact, a good deal of training in LGB issues appears to come from either elective courses or various supplemental efforts that individual students take responsibility to seek out and choose to pursue as opposed to being part of training program core curricula. Bidell (2013) sought to evaluate the impact of an elective LGB-affirmative graduate counseling course that was offered across a summer session. After completing the LGB course, enrolled students demonstrated significant improvements regarding their sexual orientation counselor competency and self-efficacy (Bidell, 2013). Results from this study show the positive impact that a full-credit course dedicated solely to LGB issues could have on graduate counseling student’s sexual orientation counselor competency and self-efficacy (Bidell, 2013). This supports Constantine’s (2001) finding that coursework in multicultural counseling results in changes in counselors’ self-reported competence in working with diverse clients.

Lastly, while supplemental trainings are not ideal because they do not reach all students in a program and only those actively seeking them out, that does not lesson their value or contributions to the field or the positive impacts that they have on developing mental health professionals. Supplemental efforts, such as attending a seminar or Safe Zone programs—a predominantly university-based diversity training program designed to increase awareness and knowledge of, and sensitivity to, important issues affecting LGB students, faculty, and staff—are helping to fill existing training gaps with invaluable information (Finkel et al., 2003). The ideal scenario, however, would be that LGB issues are integrated throughout training curricula, a
separate course is offered providing in-depth knowledge of LGB issues, and that students are encouraged to continue building their knowledge base through supplemental pursuits of their choice. Phillips and Fitts (2017) also emphasized the importance of developing an attitude of self-reflectiveness and lifelong learning, framing this as a competence for one’s professional career well beyond graduate training and recognizing that everything cannot be expected to be taught and learned in graduate school despite best intentions and efforts.

Counseling Practicum Experiences

Seeing clients, the actual practice of therapy, likely stands out as the main role of a counselor. Kocarek and Pelling (2003) ascertained that knowledge and awareness are important, but that practice with direct skills and intervention are critical and often overlooked in building counselor competency. In their in-depth examination of graduate student training experiences with LGB issues, Phillips and Fischer (1998) collected information about practicum experiences as well. There were items inquiring about the number of hours spent in didactic training in LGB issues, whether students were encouraged to explore personal heterosexist biases, and the number of LGB clients seen. First, the researchers learned that students were unlikely to have received more than an hour or two of didactic training on LGB issues in practicum, if that (mode = 0 hours). Second, regarding experiential training experiences, only about half of the participants reported being encouraged to explore personal heterosexist biases in practicum. The exploration of internal beliefs and values is crucial, even for LGB-identified students, because all students are influenced by social forces such as heterosexism (Lidderdale, 2002). Additionally, students seemed to have had little exposure to LGB clients. Phillips and Fischer (1998) found that the modal number of LGB clients students reported seeing was zero. Participants who reported knowingly working with LGB clients described seeing more gay males than lesbian or
bisexual clients. Although some participants may have had a supervisor whose expertise in LGB issues was unknown to them, almost three-fourths reported that they had not had a supervisor whose expertise included LGB issues (Phillips & Fischer, 1998). Thus, training in LGB issues was determined to be less than adequate across practicum experiences.

Wiederman and Sansone (1999) inquired about sexuality training regarding practicum as well. Training directors at APA-accredited doctoral programs in counseling psychology and clinical psychology and at predoctoral internship sites affiliated with those programs provided information about the curricular content areas of practica at their respective locations. Training regarding therapy with gay clients was offered by 42.1% of doctoral programs that responded, while only 28.1% of predoctoral internship locations had such training. Despite those numbers, respondents from more than 80% of doctoral programs and more than 70% of predoctoral internships surveyed indicated at least some training opportunities regarding intervention with gay and lesbian clients, including two-thirds of doctoral program respondents who indicated didactic coverage of these issues (Wiederman & Sansone, 1999). This is important because psychologists that have adequate knowledge and comfort regarding sexuality will be better able to serve sexual minority clients and avoid ethical predicaments (Wiederman & Sansone, 1999).

Additionally, Anhalt et al. (2003) asked behavioral clinical psychology doctoral students about their clinical work. The data from this study included information about the total number of clients seen, number of known LGB clients, and whether participants found sexual orientation issues to be relevant to the therapy provided. The researchers learned that few clients seen were known to be LGB and that LGB issues were rarely perceived as relevant to therapy (Anhalt et al., 2003). The researchers cautioned that these findings reflected graduate student knowledge of client sexual orientation and that sexual orientation and related issues may not have been
assessed. Given what is known about the LGB population and counseling utilization, as already discussed, the most likely scenario is that many of these graduate students have worked with LGB clients and were simply unaware as opposed to LGB clients not being present.

Likewise, Sherry et al. (2005) inquired about practice in their study examining how APA-accredited clinical psychology and counseling psychology doctoral programs were incorporating training relevant to LGB issues, specifically asking program training directors if their graduate students were being exposed to LGB topics in practicum. The researchers learned that 89.5% of overall programs surveyed, so both clinical and counseling psychology, indicated that graduate students were exposed to LGB clientele during practicum and that LGB issues were addressed in 94.3% of those practicum experiences. However, several limitations should be noted about this study. First, training directors were asked to evaluate parts of programs of which they may not have had full knowledge. Second, self-report measures are vulnerable to biased responding. Third, not all programs responded (e.g., only a 51% response rate) and it is impossible to know how responses from non-participating programs might have influenced the results. Specific information was also not collected, like a breakdown of LGB exposure in practicum, which would have been useful additional information (Sherry et al., 2005). Lastly, it would have been interesting to gather this same information from the perspectives of faculty and students to be able to draw comparisons.

Still further, Burkard, Pruitt, et al. (2006) found that trainees with lower levels of heterosexism had greater self-efficacy for establishing rapport and emotional connections with LGB clients, but trainees were less confident overall in their ability to establish appropriate goals and tasks for therapy. Graham et al. (2012) reported that trainees rated themselves as more competent in terms of knowledge and attitudes for working with LGB clients, but less so in
terms of skills. Later, O'Shaughnessy and Spokane (2013) gave voice to how trainee openness to experience was found to be significantly related to LGB-affirmative therapy competency, further describing both openness, and having an LGB-affirmative stance, as ideal trainee characteristics. These researchers suggested perhaps pairing students with lower levels of openness with students who naturally have higher levels in group work as this may be a useful scaffolding strategy to help challenge students to whom this does not come as readily. Additionally, Bidell (2014) found that political conservatism was associated with significantly lower levels of self-reported competencies to work with LGB clients. These findings are consistent with earlier research indicating that it is critical for all counselors-in-training to confront personal heterosexist biases and to reflect on and evaluate their own attitudes, assumptions, and biases before working with LGB clients (Dillon et al., 2004). The development of an awareness of heterosexual privilege and an active commitment for continued self-exploration is important for all trainees. It is also important for training programs to think about how to provide clinical opportunities for students to work with sexual minority clients while also ensuring that students have an adequate level of background knowledge to protect LGB clients (O'Shaughnessy & Spokane, 2013).

There are clinics and counseling centers all over the country teaching and preparing graduate students to enter the mental health field and training sites such as these are increasingly adopting LGB-affirmative stances. Dillon and Worthington (2003) developed and validated a measure to assess LGB-affirmative counseling self-efficacy that could be adapted into a useful training tool. According to the inventory developers, the Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI) could enable practicum instructors, for example, to implement and assess a social-cognitive model of LGB-affirmative counselor training aimed at developing appropriate levels of self-efficacy among counseling trainees, stimulating interest
in LGB-affirmative interventions, and promoting LGB-affirmative counseling competency (Dillon & Worthington, 2003). Additionally, the LGB-CSI could be used to assess the strengths and needs in training programs and as a self-assessment tool in multicultural courses and practica (Dillon & Worthington, 2003).

Another useful training technique mentioned frequently in articles discussing counseling practica is that of roleplaying. Emert and Milburn (1997) developed a training model for beginning counselors that culminates in illustrating scenarios that may arise in therapy with LGB clients. The overarching goal is educating trainees in ways that increase their confidence in working with LGB clients and their knowledge about LGB subculture (Emert & Milburn, 1997). After practicum students “begin to assimilate the information we have offered them about counseling with queer clients, we often employ roleplaying techniques as a method of allowing them to practice the skills they are acquiring and to evaluate the progress they are making toward becoming non-heterosexist practitioners” (p. 282). Roleplaying often invokes performance anxiety in students. Emert and Milburn (1997) stated that their interest in roleplaying exercises is grounded in the belief that it is a highly effective tool for exploring and practicing new techniques and rehearsing familiar ones, emphasizing that exercises are about skill-building and not critical evaluation. This could be an important consideration for practicum instructors.

**LGB-Affirmative Therapy**

The following section provides an overview of LGB-affirmative therapy, including a brief history, what it is and what LGB-affirmative therapists do, a review of key terms and issues, and a description of LGB-affirming and LGB non-affirming therapy experiences. This is important to understand because LGB-affirmative therapy was the beginning, the foundation, of
the affirmative shift in clinical work. Without LGB-affirmative therapy, there would be no LGB-affirmative supervision.

As LGB individuals have become more visible in the mainstream of United States culture, heterosexuals’ knowledge of LGB history, symbols, and community have exhibited corresponding increases (Worthington et al., 2005). As a result, scholars in counseling psychology and other fields have made efforts to understand how heterosexual individuals, and especially counselors, develop positive and LGB-affirmative attitudes toward LGB people (Bieschke et al., 1998; Gelberg & Chojnacki, 1995). There has been a shift in recent years toward an LGB-affirmative paradigm and particularly regarding clinical work with the LGB population, but what is LGB-affirmative therapy and what does LGB-affirmative support of clients look like?

LGB-affirmative therapy has been defined as “therapy that celebrates and advocates the authenticity and integrity of lesbian, gay, and bisexual persons and their relationships” (Bieschke et al., 2000, p. 328). ‘Gay-affirmative therapy’ was first noted in the literature by Leslie (1995) as a new approach to gay and lesbian issues. This therapy style was described as requiring the therapist to understand the anti-homosexual biases that can operate in both obvious and subtle ways in society, including externalized homophobia (people acting upon their negative assumptions about LGB people), internalized homophobia (an LGB person turning the hatred and fear they feel from the outside inward on themselves), and heterosexism (beliefs and attitudes that favor opposite sex over same sex partnerships) (Leslie, 1995). Having a solid understanding of these biases is important because they can influence not only therapist conceptualizations of LGB clients but also how LGB clients see themselves. LGB-affirmative
therapy attempts to repair the damage caused by a heterosexist society while enhancing the identities and lives of LGB clients (Morrow, 2000).

An LGB-affirmative therapist has been described as one who views sexual minorities and LGB issues as central and identity-defining as opposed to marginal and perceived in terms of the heterosexual norms society holds (Morrow, 2000). LGB-affirmative therapists utilize the body of knowledge that addresses issues specific to LGB individuals with the purpose of bridging gaps left by the heterocentric (societal assumptions that the experiences of heterosexual people generalize to all individuals) biases of predominant therapy models (Davies & Neal, 1996). Thus, LGB-affirmative therapy could be conceptualized as an adaptation of prevailing models of therapy to specific issues related to LGB individuals (Pachankis & Goldfried, 2004). For instance, some clinicians argue that because basic cognitive-behavioral principles apply to working with LGB clients, the addition of LGB considerations to the framework of cognitive-behavioral therapy is sufficient for LGB-affirmative therapists (Purcell et al., 1996; Safren & Rogers, 2001). However, others believe that because no school of therapeutic thought is completely neutral due to societal heterocentrism and heterosexism, it is necessary for LGB-affirmative therapists to challenge the heterocentric assumptions that underlie the principal practices of the major schools, such as the psychoanalytic emphasis on arrested psychosocial development as a cause of homosexuality and bisexuality (Clark, 1987; Davies, 1996; Isay, 1989). Some professionals have suggested that a variety of theoretical orientations can be effective with LGB clients if the therapist operates from an LGB-affirmative stance (Cornett, 1993; Dworkin, 2000; Falco, 1991, 1996; Fassinger, 1991, 2000).

A number of clinicians have shared advice or offered guidelines for implementing LGB-affirmative therapy. Among them, Clark (1987) proposed specific tasks that each therapist-client
dyad should address. These tasks include encouraging LGB clients to establish a support system of other LGB individuals; helping clients become aware of how oppression has affected them; desensitizing the shame and guilt surrounding same-sex thoughts, behaviors, and feelings; and allowing clients’ expression of anger in response to being oppressed. To be able to successfully engage clients in these tasks, therapists first need to examine their own feelings and attitudes toward LGB individuals and behavior and, as a result, feel competent to work with sexual minority clients. Davies (1996) discusses the need for therapists to amplify Rogers’ (1951) fundamental provision of unconditional positive regard when working with LGB clients, which means explicitly showing respect for the client’s sexual orientation, personal integrity, lifestyle, attitudes, and beliefs. Matthews (2007) also emphasizes the importance of using an LGB-affirmative stance in every interaction because client sexual orientation is not readily apparent. Until a client discloses in some way, a therapist may be unaware that they are working with an LGB client. It is due to this quality that Fassinger (1991) refers to LGB clients as a “hidden minority.” This observation alone highlights the importance of all counselors being trained to take an LGB-affirmative stance with all clients from the onset of therapy.

Shannon and Woods (1991) also suggest that being an LGB-affirmative therapist means acting as an advocate for LGB clients by helping them face challenges that are inherent in possessing a sexual minority status. This entails helping clients identify societal issues that they may feel compelled to challenge, supporting clients in those actions, and teaching coping skills for issues that might not be able to be successfully challenged at that time. It is also important for LGB-affirmative therapists to be aware of support resources that are available for LGB clients. Examples of such resources may include gay-straight alliances in junior and senior high schools and on college campuses, inclusive religious groups, groups that offer contact and networking
opportunities within professions, LGB reading groups, and a wide variety of organizations for ethnic and racial minority LGB individuals (Pachankis & Goldfried, 2004). Additionally, LGB-affirmative therapists must be able to discern the mental health struggles of LGB people that are not the result of sexuality, but rather a reaction to the societal response to LGB individuals (Pachankis & Goldfried, 2004). When working with LGB clients, it is important for therapists to determine whether the focus should be on the presenting disorder or issues concerning the client’s sexuality (Liddle, 1996). Considering such fundamental issues when conceptualizing approaches to LGB clients allows for LGB-affirmative paths to intervention to be created.

An increase in knowledge about sexual minority clients is crucial when it comes to providing LGB-affirmative therapy. Long (1996) reported on interviews with LGB couples who were asked what they would like a therapist to know about identifying as a sexual minority. Their responses included knowledge about the invisibility of LGB relationships; the coming out process with friends, family, co-workers, and employers; history of the gay rights movement; the major social battles facing sexual minority people; and the effects of heterosexism (Biaggio et al., 2003). Pachankis and Goldfried (2004) also stressed some key issues that therapists need to understand to work effectively with LGB clients, including identity development, couple relationships and parenting, family issues (e.g., families of origin and families of choice), the unique experiences of underrepresented sexual minority populations (e.g., older, ethnic minority, religious, bisexual), and legal and workplace issues. Pachankis and Goldfried (2004) also emphasized the importance of understanding heterocentrism, the implicit and at times explicit, bias against LGB individuals. The term heterosexism is typically, and has been historically, used in the literature to describe such bias, but these researchers expressed that the term ‘heterocentrism’ better captures the notion that this bias is often not intentional, but is rather due
to oversights on the part of mainstream society in considering the existence of diverse sexual orientations (Pachankis & Goldfried, 2004). Herek (1996) describes these beliefs as manifesting at both cultural and individual levels. At the cultural level, heterocentrism is evident in laws, bans, and the lack of recognition of LGB individuals that serve to restrict the rights and opportunities of LGB people (Pachankis & Goldfried, 2004). Heterocentrism is demonstrated at an individual level when a person internalizes the hostility and disdain that society exhibits toward LGB people and their behaviors (Pachankis & Goldfried, 2004).

LGB-affirmative clinical practice must begin with an acknowledgment of the powerful presence of heterosexism—in oneself, in clients, and in the culture—and a proactive commitment by the clinician to overcome, or at least minimize, heterosexist assumptions and behaviors (Matthews, 2007). Therapists need to have a working knowledge of internalized heterosexism, the phenomenon whereby LGB individuals absorb the negative messages they receive from others and from the larger society causing them to feel shame and a desire to hide (Pachankis & Goldfried, 2004). Individuals rarely present to counseling reporting a struggle with internalized heterosexism. Instead, it can present in other ways, such as anxiety, depression, relationship difficulties, substance abuse, suicidality, and the devaluation of LGB activities (Green & Mitchell, 2002; Hughes & Eliason, 2002; Matthews et al., 2002; Safren & Heimberg, 1999; Stein & Cabaj, 1996). Psychological adjustment in the face of heterocentrism and internalized heterosexism is likely mediated by the degree to which an LGB individual is committed to their LGB identity, their level of contact with other LGB individuals, the amount of family support received, and the extent to which an LGB individual is open about their sexual identity (Pachankis & Goldfried, 2004). As mentioned earlier, it is vital for therapists to recognize that an LGB client’s problems are not necessarily intrinsic to sexual orientation. Instead, it needs to be
understood that LGB clients’ problems may arise as the result of society’s negative reaction to non-heterosexual orientations (Pachankis & Goldfried, 2004). Awareness of the effects that societal factors can have on LGB individuals’ psychological well-being and identity development is a critical part of being an LGB-affirmative therapist.

The term LGB-affirmative, literally meaning positive, affirmative attitudes toward LGB individuals, is often assumed to be the absence of heterosexism (Worthington et al., 2005). However, it is not that simple. Everyone raised in this society grows up with heterosexuality being normative. There is no way to escape those messages as they are pervasive in our culture and subsequently in the training of those in the helping professions as well. In fact, Clark (1987) believed that neutrality on this point is not possible as everyone has been exposed to negative attitudes and beliefs about same-sex relations. Thus, it is important for therapists to learn to challenge the biases that portray sexual minorities as being different or deviant when they are working with LGB clients, and with all clients, as you do not always know when a client identifies as LGB. Worthington et al. (2002) found that a significant proportion of the variance in heterosexual knowledge and attitudes regarding LGB individuals is related to sexual identity development. In particular, heterosexual individuals who have explored their own sexual identities in terms of perceived sexual needs, sexual values, sexual orientation identity, and preferences for modes of sexual expression and sexual activities are more likely to express comfort with internal experiences of attraction to and affiliation with members of their same sex (i.e., internalized LGB-affirmativeness) and more strongly endorse pro-gay civil rights attitudes (Worthington et al., 2002).

Israel, Gorcheva, Walther, et al. (2008) carried out an exploratory study to identify variables that characterize psychotherapists’ perceptions of helpful and unhelpful therapy
experiences of LGB individuals. Prior to introducing their research study, Israel, Gorcheva, Walther, et al. (2008) referenced several other studies that had identified factors associated with more positive outcomes for gay and lesbian clients. Garnets et al. (1991) found that central factors that made therapy for gay and lesbian clients helpful were therapists exhibiting gay-affirmative attitudes, understanding the effects of heterosexism, helping clients to overcome internalized heterosexism, not focusing therapy on the client’s sexual orientation unless the client wanted to, and being aware of gay-affirmative community resources. Other researchers identified additional factors that were associated with more positive therapy outcomes for gay and lesbian clients, including prescreening the therapist for gay-affirming attitudes, type of therapist professional training, and therapist disclosure of sexual orientation (Atkinson et al., 1981; Liddle 1999). Alternatively, factors that have been associated with unhelpful therapy experiences for gay and lesbian clients included viewing same-sex attraction as a disorder, attributing all presenting concerns to sexual orientation, lacking knowledge and awareness about the possible consequences of coming out, using a heterosexual frame of reference for same-sex relationships, and expressing demeaning beliefs about same-sex relationships (Bartlett et al., 2001; Garnets et al., 1991; Hayes & Gelso, 1993). Liddle (1996) surveyed 392 gay men and lesbians about personal encounters with these practices and demonstrated the relationship between inappropriate practices and early termination of counseling, as well as client perception that therapy was unhelpful.

Therapists interviewed in Israel, Gorcheva, Walther, et al. (2008) defined most of the helpful situations with LGB clients as those in which the therapist was knowledgeable, helpful, appropriate, or LGB-affirming in dealing with the client’s sexual orientation (e.g., exploring options related to identity or coming out, exploring internalized heterosexism, and providing
resources or validation). This finding was consistent with prior studies that had demonstrated the importance of using LGB-affirming approaches when counseling lesbian and gay clients (Garnets et al., 1991; Liddle, 1996). This finding also suggests that even if the client’s primary concern is not sexual orientation, it is important that the therapist display an LGB-affirming attitude toward LGB issues. The therapeutic relationship also emerged as a critical variable that characterized both helpful and unhelpful situations, as well as their consequences (Israel, Gorcheva, Walther et al., 2008). Indeed, interviews revealed that helpful situations were characterized by positive relationships, which aided in working successfully with clients toward resolution of their concerns. Worthington and Strathausen (2017) also discussed the pivotal role that the therapeutic relationship had regarding counselor efficacy and effectiveness when working with LGB clients. Unhelpful situations included a number of different negative therapy outcomes, challenges to the therapeutic alliance, client mistrust of the therapist (e.g., experiencing therapist as judgmental, indifferent, cold, or LGB non-affirming), a lack of preparation or competency to work with LGB clients, and an agency setting that was not LGB affirming (Israel, Gorcheva, Walther et al., 2008).

These findings about helpful and unhelpful therapy experiences of LGB clients were corroborated in another study by Israel, Gorcheva, Burnes, et al. (2008), this time interviewing LGB individuals instead of therapists. An additional takeaway emphasized by the researchers was that the most commonly described helpful and unhelpful situations were defined by the presence or absence of basic counseling skills, as well as a positive therapeutic relationship. Israel, Gorcheva, Burnes, et al. (2008) found that warmth, listening, appropriateness of interventions, focus of therapy, and therapist congruence with client values and decisions were particularly relevant to creating helpful situations and avoiding unhelpful ones. A few other
studies discussed this in terms of counselor-client rapport. Main factors influencing counselor-client rapport included the counselor’s interpersonal characteristics (e.g., personal relationships with LGB individuals), focused training about LGB issues, and clinical experience working with LGB clients (Bidell, 2013; Dillon & Worthington, 2003; Grove, 2009). Israel, Gorcheva, Burnes, et al. (2008) went on to say that beyond basic counseling skills, therapists may require specific training in working with LGB clients. The results of a study by Israel et al. (2003) surveying professional, LGB-identified experts about the components of counselor competence with LGB clients also suggested that specialized training in LGB-specific information is needed to prepare counselors to competently work with LGB clients. Thus, the consensus seems to be that general counselor training, in addition to specific training for working with LGB clients, is the most effective preparation. Israel, Gorcheva, Burnes, et al. (2008) concluded their article by saying that not only does possessing knowledge of LGB issues help therapists select appropriate interventions to use when working with LGB clients, but counselors may not necessarily know they are working with an LGB client if that information is not disclosed. Thus, another reminder that all therapists should be prepared to work with sexual minority clients.

Dillon and Worthington (2003) found that counselors reporting contact with LGB friends and relatives hold more LGB-affirmative attitudes and are more efficacious concerning LGB-affirmative counseling behaviors, which is consistent with existing literature (Flores et al., 1995; Herek, 1994; Mohr & Rochlen, 1999). The findings by Graham et al. (2012) also appear to be consistent with the contact hypothesis (Miller & Brewer, 2013) in that the number of LGB clients seen in therapy by participants was significantly related to the overall level of participants’ self-perceived competency. Specifically, those with more contact reported higher levels of competency. Results such as this suggest that there is tangible benefit to counseling
trainees receiving clinical experience working with LGB clients. Dillon et al. (2008) also found self-identified LGB individuals to be more effective in providing LGB-affirmative counseling than heterosexual individuals. Additionally, it appears that many LGB clients prefer to see LGB therapists. In one study, gay men and lesbians selected an LGB therapist 41% of the time (Liddle, 1997). Another study by Liddle (1996) offered qualified support and positive outcomes for therapist-client matching on sexual orientation for LGB clients. However, Liddle (1996) also found heterosexual female therapists to be no less helpful. Thus, Liddle (1996) concluded that while matching on sexual orientation may increase the probability of a satisfactory therapy experience, such a match is clearly not necessary for success. If a client prefers an LGB therapist, though, and there is availability in the community, it would be helpful for therapists to accommodate those referrals.

It is also important to note that while there are a growing number of articles on therapy with LGB clients, a fair amount of this literature focuses on working with gay and lesbian individuals and does not specifically address working with bisexual clients (Malley & McCann, 2002; Miller, 2008; Negy & McKinney, 2006). Even articles that include LGB in the title or abstract do not always include bisexual-specific information or there can be the intention of capturing the bisexual experience that ultimately ends up not being reflected by those who participate. This lack of focus on bisexuality is problematic as research suggests that bisexual individuals experience unique challenges when seeking mental health services due to societal beliefs about bisexuality (e.g., assumptions of promiscuity and polyamory; bisexual males seen as sexual disease carriers; bisexual females seen as objects of sexual objectification by heterosexual men) (Dworkin, 2001; Nova et al., 2013; Page, 2004). Research studies have also documented the lack of acceptance of bisexual individuals as a group (Herek, 2002; Mulick &
Wright, 2002). For example, Herek (2002) found that heterosexual individuals held fewer positive beliefs about bisexual-identified individuals than other minority groups, including racial and ethnic minorities, gay men, lesbians, and people living with AIDS. Additionally, Mulick and Wright (2002) found that although heterosexual individuals scored highly on both homophobia and biphobia scales, gay and lesbian participants scored highly only on the biphobia scale. In another qualitative study of 60 bisexual individuals, McLean (2008) found that almost all the participants reported experiencing invisibility and discrimination within the gay and lesbian community. Respondents reported that most of the lesbians and gay men that they knew believed them to be in a phase or an immature stage as far as the development of their sexual orientation.

There is no clear definition that exists in the literature distinguishing LGB-affirmative therapy with bisexual clients. However, the general thought around it appears to involve embracing a positive view of bisexuality as a legitimate sexual orientation, supporting bisexual clients in their relationships and lives, and understanding the influence that heterosexism and biphobia (people acting upon their negative assumptions about bisexual people) have on all people, including therapists (Bradford, 2004; McGeorge & Carlson, 2011; Mohr et al., 2001). Scholars also suggest that therapists make themselves aware of bisexual-specific topics in order to work more effectively with clients who identify as bisexual (Dodge & Sandfort, 2007). Furthermore, while experiences of biphobia may influence a client’s presenting problem, it is critical that therapists not make assumptions that a client’s sexual identity is the primary focus of therapy (McGeorge & Carlson, 2011; Scott, 2006). Lastly, as is the nature of being an LGB-affirmative therapist, it is necessary for one to spend time reflecting on any personal biases and beliefs around bisexuality, bisexual individuals, and their relationships (Dworkin, 2001; McGeorge & Carlson, 2011).
Psychologists’ overall attitudes and therapeutic approaches toward LGB clients have continued to change and evolve for the better. Kilgore et al. (2005) conducted a survey of doctoral-level licensed psychologists and members of the APA, inquiring about their attitudes and therapeutic approaches toward LGB issues. The goal of the study was to capture the present climate of the field regarding LGB issues and compare findings to past climate studies to see what changes had occurred over time. Kilgore et al. (2005) found that there was an increase in the number of psychologists that viewed an active LGB lifestyle and identity as acceptable and nonpathological. Psychologists were also more likely to provide LGB-affirmative therapy and much less likely to support changing sexual orientation through conversion therapies (Kilgore et al., 2005). The researchers postulated several factors that may account for these findings, including the APA’s developing professional guidelines for treating LGB clients, psychology programs implementing training on LGB issues, society at large having become generally more tolerant and accepting of LGB people, and greater exposure to LGB people compared to 10 years ago (Kilgore et al., 2005).

In sum, the gains that LGB individuals have made in recent decades is remarkable. In the face of colossal challenges, this group has persevered. Undeniably, LGB individuals are continually making admirable attempts to gain equality with their heterosexual peers (Pachankis & Goldfried, 2004). Therapists must not forget, however, that the mental health profession has historically mistreated—and some professionals continue to mistreat—sexual minorities. For this reason, therapists need to demonstrate possessing the competence required to treat LGB individuals appropriately and affirmatively. This ability is gained by becoming familiar with current guidelines and recommendations, as well as the existing literature on specific issues that are relevant to LGB clients. When therapists incorporate an understanding of these issues into
therapeutic work, the likelihood that the work will lighten the impact that societal heterocentrism and discrimination has had on LGB clients increases (Pachankis & Goldfried, 2004).

**Allies**

This section is divided into a main section and one subsection. The main section introduces terminology, looks at the important role allies serve, reminds of the harm that can be done with a lack of training in LGB issues, and provides examples of ally and non-ally behavior (DiStefano et al., 2000). The primary purpose for including this main section is to emphasize how LGB-affirmative work is for everyone that enters the mental health field. It is specialized work and requires specialized knowledge and training, but that does not mean it is exclusive. LGB does not mean it is for those who identify as LGB or only those with an interest in LGB issues. Every person, the majority identifying as heterosexual, that enters a mental health profession will see LGB clients and has a responsibility to be competent and do no harm to sexual minority clients. The following subsection provides a review of studies concerning ally development (Broido, 2000; Dillon et al., 2004; Duhigg et al., 2010; Gelberg & Chojnacki, 1995; Ji, 2007). The primary purpose for including this subsection is to elaborate on an experience that is relevant and relatable to both supervisors and supervisees alike because it happens in the room with clients, and subsequently in supervision. Therefore, all parties need to be familiar.

Heterosexual identified individuals can serve a critical role as allies in eliminating sexual prejudice and the resulting policies that discriminate against LGB people (Duhigg et al., 2010). It is the combined effects of heterosexism and lack of formal training in LGB issues that are hypothesized to manifest inappropriate mental health practitioner behaviors (Lidderdale, 2002). Therapists may exhibit inadvertent heterosexist bias, at best, or blatant homonegative attitudes, at worst, in their clinical work with LGB clients (Pearson, 2003). Examples of these biases might
include automatically assuming that a client is heterosexual before the client indicates their sexual orientation, not recognizing the problems of social prejudice against LGB people or lacking the basic knowledge of LGB issues necessary to be an effective counselor to sexual minority clients (Garnets et al., 1991; Liddle, 1996). Research has shown training in LGB issues to be effective in reducing mental health practitioners’ heterosexist attitudes and increasing their skills in working effectively with LGB clients (Rudolf, 1989). In their 1998 study, Lark and Croteau indicated that there was a critical need to increase the number of heterosexual allies and mentors in the counseling field. Heterosexual allies or allies have been defined in the literature as heterosexual professionals who are members of the dominant group and who work to end oppression in their professional and personal lives through support and advocacy for LGB people (Washington & Evans, 1991). So, how are LGB-affirmative allies created and trained? How do heterosexual counselor allies develop LGB-affirmative attitudes and behaviors?

With similar questions in mind, Dillon et al. (2004) conducted a qualitative analysis of a process by which a research team of counselors-in-training explored their own heterosexist biases through their work investigating sexual identity and heterosexual attitudes toward sexual minorities. The research team met weekly for two hours during an academic year–meetings varying from seminar format to group discussions–regarding personal beliefs, attitudes, and experiences between and within sessions (Dillion et al., 2004). Participants described a primary participation motivation of acquiring further knowledge and insight regarding the LGB population that would complement their counseling curriculum. Participants also expressed concerns about their own ignorance, insensitivity, and doubts regarding working with LGB clients and a desire to increase their awareness, knowledge, and skills as a means of professional development (Dillon et al., 2004).
The findings of this personal-level self-study by Dillon et al. (2004) provide an encouraging glimpse into the process of developing LGB-affirmative attitudes among heterosexual counselors-in-training, or allies. Dillon et al. (2004) reported that growth was evident, with participants moving from maintaining socialized heterosexist beliefs, assumptions, and behaviors toward becoming professional and personal heterosexual allies of the LGB community. When expressing the overarching themes of their experience in the study, participants emphasized the importance of self-reflection in their journeys and particularly in relation to their personal sexual identity development, related beliefs, and attitudes about LGB individuals (Dillon et al., 2004). Participants also contemplated questions regarding their present attitudes and actions in both their professional and personal lives and how those could impact LGB clients and colleagues alike (Dillon et al., 2004). Some participants even described future plans to engage in further exploration and LGB-affirmative behaviors in their professional and personal lives. The general themes that emerged from the analysis corresponded with existing empirical findings and theoretical discussions, including increased sensitivity to heterosexism in society, challenging one’s own and others’ heterosexist responses, and increased advocacy for LGB individuals (Dillon et al., 2004; Gelberg & Chojnacki, 1995).

Such themes can be used to inform efforts to improve the training of mental health professionals and trainees in overcoming heterosexist attitudes and adopting LGB-affirming attitudes and behaviors. The Dillon et al. (2004) findings suggest that an understanding of one’s own and others’ sexual identity development can reduce the tendency of trainees to accept only heterosexuality as normal and as the default sexual identity in their own and others’ lives (Dillon et al., 2004). Training experiences such as this could also foster increased understanding and comfort with sexuality-related issues that clients bring to counseling. This type of examination
may be an important step toward preparation for working with LGB clients. Lastly, these findings provide a framework for educators to understand potential training needs of heterosexual trainees in the development of LGB counseling competencies.

DiStefano et al. (2000) surveyed heterosexual student affairs professionals with an interest in LGB issues about their ally work with LGB people. A wide range of information was collected from participants. Participants described how they acted as allies, reactions to their ally activities, times they did not act as allies and reasons for not doing so, their personal reactions to not acting as allies, and influential events to becoming allies. The goal of this qualitative study was to help inform the heterosexual ally work of both counselors and other student affairs professionals. Participating in or providing LGB-affirmative training was the most frequently cited ally activity (DiStefano et al., 2000). Visibly displaying LGB symbols to show affirmation, confronting heterosexism, and advocating for LGB-affirmative institutional policy changes were also commonly cited (DiStefano et al., 2000). Not responding to or confronting heterosexism in social and professional situations was the most frequently reported example of not behaving as an ally (DiStefano et al., 2000). DiStefano et al. (2000) reported that the most commonly stated reasons for not acting as an ally were feeling that effort put forth at that time would not have been effective, personal ignorance or struggles, or lack of energy. Self-critical reactions were most often described by participants when asked about the times they did not act as allies. Lastly, regarding influential events in participants becoming allies, relationships with LGB people was most frequently mentioned (DiStefano et al., 2000). So, knowing LGB people appears to not only increase positive attitudes, but awareness and knowledge of LGB issues and acts as motivation to work as an ally as well (DiStefano et al., 2000; Gelberg & Chojnacki, 1995; Herek, 2002; Sullivan, 1998). Educational and professional development was also commonly cited as
influential in becoming more LGB-affirming (DiStefano et al., 2000). DiStefano et al. (2000) concluded with the message that while being an LGB-affirmative ally can be a challenging experience at times, it is an overall positive and rewarding one worthy of perseverance.

**Ally Development**

Gelberg and Chojnacki (1995), both identifying as heterosexual career counselors, shared their personal perspectives about becoming LGB-affirmative allies. The researchers attempted to illustrate a few of the ways that their LGB-affirmative ally growth journeys paralleled the stages of coming out as experienced by LGB individuals (Cass, 1979). Gelberg and Chojnacki (1995) stated that it was their hope that their experiences would enable other helping professionals to become more effective at recognizing and addressing heterosexism in current counseling services, materials, interventions, and theories (Gelberg & Chojnacki, 1995). As with any stage model, progression should be viewed as a lifelong and cyclical process, which means that each new professional goal might send you cycling through the stages all over again, for example. For Gelberg and Chojnacki (1995), integration was the end goal. The researchers stated that at this point—integration—they felt better able to perceive subtle interconnections between heterosexism and their thoughts, feelings, behaviors, and relationships and they described greater congruence between their values and behaviors as career counselors who were affirmative to sexual orientation. The way the researchers discussed their journey was reminiscent of one of the earliest LGB-ally development models in the literature. Sullivan (1998) presented a general model of heterosexual ally development, which starts from a place of being naïve about sexual orientation, proceeds to acceptance of the heterosexist status quo, moves to conflict or resistance when first observing the realities of heterosexism, and finally progresses to a redefinition and internalization of oneself as a heterosexual ally.
Broido (2000) conducted qualitative interviews with college students who identified as “heterosexual social justice allies.” These students collectively recognized three areas as being significant to their development as allies: (1) acquisition of information and particularly information addressing the impact of oppression on others; (2) development of meaning making, including discussion, perspective taking, and self-reflection; and (3) identification of an inner sense of self-confidence and the ability to stand up for their beliefs (Broido, 2000). Once again, participants indicated that contact with LGB individuals was extremely influential in their decision to protest sexual minority oppression, a common theme in ally studies. Broido (2000) concluded that “their development as allies was predominantly a learning process” (p. 13). The findings from this study emphasize the significant role that both interpersonal contact and learning about oppression can play in the development of heterosexual allies (Broido, 2000).

Furthermore, Duhigg et al. (2010) conducted individual interviews with a community sample of heterosexual identified participants who demonstrated ally commitment through some form of LGB activism. Participants described early role models, close relationships with LGB individuals, and the evolution of their understanding of sexual prejudice and heterosexual privilege. They also discussed the conflict between this evolving understanding and the core values of justice, equality, and appreciation of diversity (Duhigg et al., 2010). According to the researchers, participants ultimately resolved this conflict by using their privilege to promote social justice for sexual minorities. Consensual qualitative research methods were used to analyze the collected data. Findings revealed six domains that best described the development of these heterosexual allies: (1) Early family modeling, (2) Recognition of oppression and privilege, (3) Response to recognition, (4) Impact of values and attitudes, (5) Others’ reactions to ally work, and (6) Rewards from ally work (Duhigg et al., 2010). Understanding the factors and
processes that facilitate the development of heterosexual allies will contribute to the larger goal of ending discrimination against LGB people (Duhigg et al., 2010).

Lastly, Ji (2007) provides readers with a narrative of his own development as a heterosexual ally in the context of existing ally identity development models. He identifies key factors that helped him to advance through the stages of ally development and went on to formulate ideas for the training of others seeking to become allies to the LGB community. The researcher stated that the models that fit his experience best were ones that described the affective experience of being an ally versus those based on an ally’s awareness of the oppression of the LGB community (Ji, 2007). Thus, while Ji (2007) presented numerous ally development models, he chose to focus on the few that he felt truly captured his growth best and most authentically (DiStefano et al., 2000; Gelberg & Chojnacki, 1995; Getz & Kelty, 2003).

Ji (2007) also talked a good deal about his initial anxiety due to the incongruency between his internal LGB-affirmative beliefs and his external behaviors, such as remaining silent in situations where people were talking negatively about the LGB community. He described some early anxiety around not knowing what was expected of him and about whether he would be a “credible” ally. Additionally, Ji (2007) took care to emphasize how the models that helped his ally development (DiStefano et al., 2000; Gelberg & Chojnacki, 1995; Getz & Kelty, 2003) encourage trainees to explore fears, self-doubts, and anxiety as they learn and progress. Ji (2007) discussed how he engaged with his internship supervisors about his need to be credible and discovered that he had fears about openly proclaiming that he was an ally and he had to process and accept that those feelings were rooted in heterosexism and oppression. Dillon et al. (2004) also found this phenomenon among their sample of heterosexual LGB-affirmative counselors and called it homophobic self-consciousness, or the fear of being gay by association. Engaging in
ally work requires addressing the fear of being viewed as LGB if that is a barrier to activism (Duhigg et al., 2010).

All ally models have some sort of action as a final stage, which involves open advocacy for the LGB community. Based on the models and his experience, Ji (2007) determined that he had two roles as an ally: support and advocacy. Ji (2007) constructed an ally outreach during his internship which aimed to demonstrate that allies do more than voice support for the LGB community but can also support those who are coming out and support family and friends of LGB persons, as well as non-LGB persons who struggle with heterosexism and oppression. Ji (2007) wrote, “By accessing supportive resources and interacting with the LGB community, one can develop pro-LGB skills and form an ally identity” (p. 179). Ji (2007) concluded with the key factors that helped him move from one stage to another on his LGB ally development journey: (1) access to supportive relationships, (2) contact, and (3) practice opportunities. Potential allies need supportive relationships to explore questions, concerns, and anxieties about the process, as well as to explore the difficult subjects of heterosexism and oppression (Duhigg et al., 2010; Ji, 2007). Ji (2007) encouraged potential allies to choose which model best fits their development and then to enlist the support of other allies as guides. Allies are not born—they are trained. As with all training, this is an active and ongoing pursuit and there is always more to learn and do.

**Supervision**

Graduate programs continue to improve over time when it comes to incorporating training on LGB issues. This holds particularly true regarding integration of LGB issues into coursework and practicum experiences. However, while these areas and the larger field have improved, growth edges remain. After reviewing graduate training literature concerning LGB issues, it is clear that integration has been more focused in certain training settings over others.
Beyond the classroom, clinical supervision is another avenue through which students could receive pertinent LGB training. In fact, a survey of practicing psychologists suggests that supervision is a predominant way that clinicians receive training as students (Murphy et al., 2002). For being such a large and critical component of graduate training, supervision has received the least attention when it comes to integrating LGB issues. The influence of cultural and gender differences on supervision has been of interest to researchers and practitioners for some time (e.g., effect of ethnicity, race, and gender on clinical supervision) (Bernard & Goodyear, 2004). However, relatively absent from the discussion of cultural influences in supervision is a focus on LGB concerns (Bernard & Goodyear, 2004). This section is divided into a main section and one subsection. The main section provides a review of research illustrating how LGB issues have been incorporated into supervision. The primary purpose for including this section is to provide historical context for supervision regarding multicultural inclusion, LGB-specific inclusion, and/or the lack thereof. The following subsection provides an overview of the literature concerning LGB-affirmative supervision (Bieschke et al., 2014; Bruss et al., 1997; Burkard et al., 2009; Halpert et al., 2007; Pett, 2000). The primary purpose of this subsection is to demonstrate the existing research in this area and highlight how it has been primarily conceptual in nature.

The amount of research covering LGB training in graduate programs and LGB-affirmative therapy (Alderson, 2004; Anhalt et al., 2003; Israel, Gorcheva, Burnes et al., 2008; Pachankis & Goldfried, 2004; Phillips & Fischer, 1998; Sherry et al., 2005; Wiederman & Sansone, 1999) has provided us with a knowledge base for each of those areas. There has been less research done in the supervision realm on this topic, however, as will be evident by what is able to be shared in this section compared to those prior. With the high likelihood of LGB clients
presenting to therapy, clinical supervisors need to be knowledgeable and able to provide supervision regarding LGB issues. This knowledge and sensitivity to LGB issues will also prove to be valuable when supervising LGB-identified trainees (Burkard et al., 2009). Supervisors need to be LGB-affirmative regardless because, again, sexual orientation status can only be determined when the topic is openly shared or discussed. Recall that LGB people have been referred to as a “hidden minority” and just as LGB individuals may be ‘hidden’ in counseling, they may be in supervision as well (Bieschke et al., 2007; Hitchings, 1999). Furthermore, LGB individuals are often reluctant to offer this key piece of identifying information due to the prejudice and discrimination that accompanies a non-heterosexual orientation (Bieschke et al., 2007). This is why LGB-affirmative practice is so imperative in the mental health field.

Phillips and Fischer (1998) learned that almost three-fourths of the graduate psychology students in their survey had not had a supervisor whose expertise included LGB issues. Perhaps more alarming, Pilkington and Cantor’s (1996) research found that some trainees were directly exposed to heterosexual bias during supervision. A reported 50% of their participants indicated that supervisors had pathologized LGB people, made derogatory comments about LGB clients, inappropriately stressed a client’s sexual orientation, or discussed “curing” sexual minorities (Pilkington & Canton, 1996). In addition, Gatmon et al. (2001) reported learning that sexual orientation rarely came up during supervision, and if it did, it was typically the student that brought up the topic (e.g., 55% of supervisees reported initiating discussions). These collective results suggest that supervision regarding LGB concerns is inconsistent at best, may not be particularly well-informed, and is quite possibly unhelpful or even harmful toward those who identify as LGB–both supervisees and clients alike.
Biaggio et al. (2003) posited that perhaps many supervisors themselves are not trained to work with the LGB population. Indeed, it may be that current supervisees are better trained overall to address cultural issues because of more recent awareness and subsequent improvements in training requirements regarding cultural competence in graduate programs (Burkard, Johnson et al., 2006; Constantine, 1997; Gatmon et al., 2001). Regardless of the reason, the low frequency of initiation of discussions by supervisors suggests that further training is needed to increase supervisor competence in addressing cultural variables in the supervisory relationship (Gatmon et al., 2001). Discussions of cultural variables, such as sexual orientation, in the supervisory relationship will most likely enhance the supervisory working alliance and increase supervisee satisfaction with supervision (Burkard, Johnson et al., 2006; Gatmon et al., 2001). In fact, Gatmon et al. (2001) asserted that “providing an atmosphere of safety, depth of dialogue, and frequent opportunities to discuss cultural variables in the supervisory relationship significantly contributes to building alliances and increasing satisfaction” (p. 110). On the contrary, Gray et al. (2001), as well as Burkard, Johnson, et al. (2006), carried out separate studies whereby supervisees experiencing counterproductive or culturally unresponsive events had clear negative consequences for the supervisory relationship. To cope, supervisees reported emotionally withdrawing from supervision to protect themselves from further abuses of power by clinical supervisors and/or their clients from further harm (Burkard, Johnson et al., 2006; Gray et al., 2001). Any action that significantly limits trainee use of supervision and impedes their professional skill development is hugely problematic and needs to be addressed and remedied immediately.

The current discussion is being expanded from ‘LGB issues’ in supervision to ‘multicultural issues’ as well, which allows for more research to be included. Previously
reviewed literature has shown that the term multicultural oftentimes includes sexual identity (Buhrke & Douce, 1991; Carroll & Gilroy, 2001; Pope, 1995). Past research has examined the role that prior multicultural training plays in predicting self-reported multicultural counseling competence; however, comparably fewer studies have explored the extent to which multiculturally focused supervision is related to trainees’ perceived multicultural counseling competence (Constantine, 2001). Pope-Davis and Coleman (1997) posited that perhaps one of the most significant factors to learning and integrating multicultural competencies into practice was having supervision experiences that promoted growth as a culturally competent practitioner. In two separate investigations, Pope-Davis and colleagues—examining in part the extent that multicultural issues were discussed in supervision—reported that receiving multicultural supervision was predictive of higher levels of self-perceived multicultural counseling competence (Pope-Davis et al., 1994, 1995). Constantine (2001) later sought to examine the impact that time spent focusing on multicultural issues in supervision was predictive of counseling graduate students’ multicultural counseling self-efficacy. In Constantine’s (2001) study, after accounting for both social desirability attitudes and prior multicultural training, multicultural supervision contributed a significant amount of the variance to Multicultural Awareness/Knowledge/Skills Survey (MAKSS) full-scale scores, the primary measure being used (D’Andrea et al., 1991). Thus, Constantine (2001) concluded that receiving multicultural supervision appeared to be a critical factor in increasing trainee self-efficacy in working with culturally diverse populations beyond the contributions associated with multicultural training.

In another study, Constantine (1997) learned that predoctoral interns and their supervisors only spent an average of 15% of their supervision time addressing multicultural issues and that some participants felt that their supervisory relationship would have been further enhanced if
they had spent more time discussing multicultural issues. Additionally, Ladany et al. (1999) found that 7% of supervisees believed their supervisors to be multiculturally insensitive regarding both clients and supervisees (i.e., negative stereotyping, ignoring and/or dismissing cultural concerns, questioning supervisees’ clinical abilities and/or challenging the use of specific interventions with culturally diverse clients, and conflictive situations involving negative communication or lack of intervention by the supervisor) (Burkard, Johnson et al., 2006; Gray et al., 2001). The researchers noted that supervisor insensitivity toward multicultural clients was potentially detrimental to their supervisees’ work with culturally diverse clients (Ladany et al., 1999). Clinical supervisors are in a unique position to be critical catalysts in influencing the extent to which cultural issues are addressed in trainees’ counseling and supervision relationships (Constantine, 2001). Because providing multicultural supervision to trainees has been associated with higher levels of multicultural counseling self-efficacy, it is plausible that these self-efficacious feelings translate directly into trainees’ actual work with clients (Constantine, 2001).

Kadushin and Harkness (2002) described supervision as a significant component of the helping relationship between clients and therapists. Undeniably, a supervisor’s teachings and guidance enter the therapy room every time a trainee has a session with a client. Realizing the full gravity and impact of the clinical supervisor role reinforces the importance of providing LGB-affirmative supervision.

The most recent ethical standards of the profession mandate that “psychologists seek training, experience, consultation, or supervision when necessary to ensure competent practice” (APA, 2017, p. 7). Since supervision is a major training arena where therapists have the potential to learn about clients and themselves, it becomes an important area for also teaching supervisees how to work with minority populations (Bruss et al., 1997). There is literature that addresses
supervision issues with the LGB population, but not nearly the amount as other areas of training. In the meantime, use of the guidelines, competencies, and standard of care documents is highly recommended as a starting point for increasing knowledge for working with sexual minority clients as these documents offer a wealth of resources to educators and students for increasing knowledge (Phillips & Fitts, 2017). Bieschke et al. (2014) also describe how comfort with ambiguity and an ability to sit with and think deeply about dilemmas that emerge are likely to enhance development for both clinical supervisors and their supervisees.

In sum, supervision has the potential to be a major catalyst for development and change (Bruss et al., 1997). It is one of the most intimate and vulnerable of all training environments, illustrated by the nature of the supervisory relationship and the influence that a supervisor can have on a supervisee. Additionally, the benefits of LGB-affirmative therapy have been established. Could the same or similar benefits apply in supervision? There can certainly be parallels drawn between the close working relationship of counselor and client and that of supervisor and supervisee (Hartley-Pfohl, 2004). If having an LGB-affirmative stance in one training area is seen as ideal, then having an LGB-affirmative stance in other training areas should be also.

**LGB-Affirmative Supervision**

Scholars and mental health organizations have made it clear that providing LGB-affirming therapy as a practice is necessary (APA, 2021), but how are clinical supervisors incorporating LGB-affirmative practice into the supervision they provide and subsequently imparting that practice on to trainees? Since the APA first issued LGB guidelines in 2000, there has been a good amount of focus in the literature regarding LGB issues. Over time, LGB-affirmative training and therapy have grown and become more commonplace. 'LGB-affirmative
supervision’ yields much fewer results as a search term, however, even though supervision is such a large component of training in the mental health professions. This appears to be a gap, not only in the literature, but also in training—particularly in the context of the field’s efforts to be inclusive and LGB-affirming. Since there is existing empirical research regarding LGB-affirmative therapy, is it possible that this knowledge could also be applied to LGB-affirmative supervision or perhaps makes a case for the potential benefits of adopting LGB-affirmative practice in supervision?

Given the rather discouraging findings regarding LGB issues in supervision, as discussed in the prior section, some theorists became interested in conceptualizing LGB-affirming and LGB non-affirming supervision and what those experiences might be like for trainees. Historically, supervision in the United States has generally been seen in the context of training. One of the most popular supervision models, for example, has been the Developmental Model of Stoltenberg and Delworth (1987), which provides a sequence of developmental stages for supervisees to move through as they gain clinical experience. To the contrary, Pett (2000) describes how British approaches develop more from the theoretical schools of therapy to provide supervision more theoretically appropriate to the working of the therapist. The few LGB-affirmative supervision models or approaches that have been published fall into one of those categories. It should be noted that these affirmative models of LGB supervision, because of their atheoretical nature, were designed to be “add-ons” and intended to be used in tandem with more traditional supervision models that are more theoretically based (Singh & Chun, 2010). There have also been additional critiques about what current approaches are missing, from a lack of developmental focus to being not straightforward in application (Singh & Chun, 2010).
In 1997, Bruss et al. published an article whereby the researchers applied the comprehensive Stoltenberg and Delworth (1987) developmental model of supervision to clinicians working with LGB clients, successfully addressing the developmental tasks within the supervision process. This adapted LGB-affirmative developmental model of supervision is discussed in terms of three levels, indicating that the supervision of trainees working with LGB clients should be targeted at the specific developmental level of the supervisee. At each level there are specific supervisory roles, functions, and interventions to fulfill. In Level 1, it is the supervisor’s role to educate the trainee about LGB clients and the primary supervisory intervention is to provide enough structure, openness, and safety to keep supervisee anxiety at a manageable level (Bruss et al., 1997). If the supervisor does this effectively, the supervisee will not only have the room to grow clinically but will be encouraged to share and explore reactions, biases, assumptions, misconceptions, and/or any uncomfortable feelings about sexual orientation issues (Bruss et al., 1997). Supervisors can assist supervisees in their early exploration by assuring them that lack of knowledge, biases, and anxiety are common for new trainees. Supervisors must be aware of their own reactions, biases, and misconceptions regarding LGB clients as well. A major goal is to facilitate knowledge and skill acquisition. In Level 2, the supervisor’s role is no longer only to support, but to confront and challenge the trainee to incorporate new information and to modify existing beliefs, feelings, attitudes, and behaviors (Bruss et al., 1997). It is also at this level that the supervisee may begin to struggle with their own issues of heterosexism. An important task of supervision is to assist in the supervisee’s examination of heterosexism to protect clients (Bruss et al., 1997). There should be more encouragement of independence at this level and a major supervisory intervention is to facilitate process comments. The role of the supervisor in Level 3 is to assess strengths and weaknesses,
confront discrepancies, and to encourage exploration and integration (Bruss et al., 1997). The supervisor should encourage the processing of the use of the self as an instrument of change (i.e., being aware of their feelings in session and using them as a powerful therapeutic tool with LGB clients) (Bruss et al., 1997). Bruss et al. (1997) believed that the goal of supervision of trainees with LGB clients was to facilitate understanding and acceptance of individual differences.

In 2000, Pett published an article about LGB therapy and supervision. In it, he made some suggestions towards a model of ‘gay affirmative supervision,’ only a notion at that time. Pett’s (2000) biggest contribution that is often cited in the literature are his five characteristics that supervisors must exhibit to be considered gay affirmative: (1) Supervisor acceptance of LGB identification and the belief that heterosexism is pathological; (2) Supervisor awareness of their own attitudes, beliefs, and feelings regarding LGB identification; (3) Supervisors respect LGB supervisees; (4) Supervisors possess knowledge about heterosexism, coming out, and related aspects of LGB people’s lives; and (5) Supervisors use supervision to educate trainees about LGB issues and challenge supervisees’ negative stereotypes. Pett (2000) strongly believed that these characteristics should be the criteria all supervisors and therapists exemplify, and be given a grounding in, as part of their basic training.

In 2007, Halpert et al. proposed a model of supervision that they called the Integrative Affirmative Supervision (IAS) Model. According to the researchers, four supervision models (Bruss et al., 1997; Buhrke, 1989; House & Holloway, 1992; Pett, 2000) were selected to provide the essential elements required for a comprehensive and inclusive affirmative supervision model that could be applied to any supervision style or theoretical orientation (Halpert et al., 2007). The IAS Model was developed to provide for sensitive, supportive, and substantive supervision for LGB and non-LGB supervisees alike that would in turn help to provide the best possible
informed, ethical, and therapeutic care to LGB and non-LGB clients (Halpert et al., 2007). The foundation of the IAS model is that all gender and sexual orientations are equally valid and respected. Three core conditions help to solidify the success and usefulness of the IAS model: safety, respect, and empowerment (Halpert et al., 2007). The researchers believe that to effectively take risks and grow through clinical supervision experiences, supervisees must feel professionally and emotionally safe in both individual and group supervision settings. Once the foundation of safety and respect is established, supervisees can begin to feel empowered to work effectively with a broad range of clients who may or may not be LGB-identifying (Halpert et al., 2007). The IAS model rests on the assumption that the supervisor is competent regarding supervisory tasks, such as building and maintaining a supervisory working alliance, attending to relevant legal and ethical issues, and providing both formative and summative feedback. The model also clearly identifies the clinical supervisor as the individual most responsible for providing a productive learning environment (i.e., bringing up issues of sexual orientation, even if they do not appear to be central as opposed to that burden being on the supervisee to initiate) (Halpert et al., 2007). Lastly, Halpert et al. (2007) describes three separate phases of IAS: presupervision, supervision, and advanced/continuing tasks. What is required of the clinical supervisor is dependent on the phase of supervision.

In addition to there being less research, another barrier that exists is that a universal operational definition of LGB-affirmative supervision has yet to be recognized in the literature. For their 2009 study, Burkard et al. borrowed from Tozer and McClanahan (1999) who defined LGB-affirmative counseling. The researchers substituted the word ‘therapist’ with ‘supervisor’ in order for the definition to be applicable to supervisees. Therefore, for the purposes of their study, the researchers defined LGB-affirmative supervision as an approach that “celebrates and
advocates the validity of LGB persons and their relationships” and further stated that, “such a supervisor goes beyond a neutral or null environment to counteract the life-long messages of heterosexism that LGB individuals have experienced and often internalized” (p. 177).

Alternatively, LGB non-affirmative supervision may be neutral where the supervisor does not respond to or incorporate LGB concerns during supervision or presentation of client cases and/or it may involve intentional or unintentional bias (i.e., heterosexism) that pathologizes or invalidates supervisees or their clients’ identification as LGB (Burkard et al., 2009). The combination of Pett’s (2000) characteristics, the Burkard et al. (2009) definition, and the two model adaptations above (Bruss et al., 1997; Halpert et al., 2007) help piece together a conceptual foundation of LGB-affirmative supervision.

There are infinite ways that clinical supervisors can assist students in developing clinical competence to work with LGB clients, some of which may vary based on supervisee and/or client needs. These are some examples of general LGB-affirmative supervision behaviors as the models presented above were discussed in more of a theoretical as opposed to practical nature. For instance, supervisors could be consistently asking supervisees how binary understandings of sexual orientation influence their assumptions and clinical work with clients (e.g., the existence of sexual orientation along a continuum). In fact, supervisors should be consistently asking supervisees how their beliefs about sexual orientation influence their understanding of their clients’ presenting problems and their clinical judgments about a case (Nova et al., 2013). There is some preliminary evidence suggesting that trainees are hesitant to approach the topic of sexuality and to initiate or engage in discussions about sexuality with clients (Rutter et al., 2010). Having sexuality topics be an open and ongoing part of supervision will increase the comfort and ease with which supervisees are able to dialogue about them. Clinical supervisors can ensure that
Trainees assess for sexuality and sexual orientation issues in their work with clients; however, as stated a number of times previously, it is of critical importance to avoid attributing the problems of LGB clients to sexual orientation (Anhalt et al., 2003). Being LGB-affirmative does not mean that issues around sexual orientation have to be the focus of therapy (Bieschke et al., 2014). In fact, most LGB individuals present to therapy for the same reasons that heterosexual clients do, but the informed psychologist recognizes that there can be concerns specific to LGB clients and LGB persons operate in a different social context. LGB persons must often navigate two different cultures: a heterosexist society and their own minority culture (Biaggio et al., 2003). Additionally, LGB people can be victims of prejudice, discrimination, and even violence. Supervisors need to be aware of these forms of oppression and should be knowledgeable about community resources and support systems for LGB persons (Biaggio et al., 2003). This knowledge and sensitivity to LGB issues will prove to be valuable when providing supervision to students in training and to LGB-identified supervisees who may be more attuned to the inclusion or exclusion of LGB issues in their training (Burkard et al., 2009).

Supervisees need the support of their clinical supervisors in gaining awareness about their personal values and working to resolve any conflicts between those values and an LGB-affirmative treatment stance. It is also important for clinical supervisors to consider the knowledge and skills that supervisees need to develop regarding competency in working with LGB clients (Bieschke et al., 2014). Supervisors must carefully balance attention to the development of clinical skills while also facilitating examination of personal views relevant to this area (Bieschke et al., 2014). The Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale for Heterosexuals (LGB-KASH) could be a useful training tool in this endeavor (Worthington et al., 2005). The LGB-KASH is a psychometrically sound, multidimensional measure with a broad
range of heterosexuality knowledge and attitudes regarding LGB individuals and offers a number of important improvements in measurement over existing instruments available to counseling psychologists (Worthington et al., 2005). A critical use of this scale could be in training counselors to identify and develop levels of LGB-affirmativeness, especially in terms of working with LGB clients. This scale could also enable supervisors to assess supervisees’ levels of LGB-affirmativeness and develop supervision interventions promoting LGB-affirmative counseling competencies (Fassinger & Sperber Ritchie, 1997). Supervisors could then provide supervisees with specific suggestions regarding further training relative to LGB concerns as part of their evaluation process (Bieschke et al., 2014).

Research has shown that just as a positive, productive relationship is critical to successful and effective counseling—so too is a positive, productive relationship critical to successful and effective supervision (Efstation et al., 1990). This is especially true regarding withstanding sensitive, and oftentimes vulnerable, discussions in supervision (Efstation et al., 1990). Existing empirical data also supports the central role of the supervisory relationship, particularly for sexual minority supervisees (Bieschke et al., 2014). So, how is the supervisory relationship—a crucial element of meaningful supervision—impacted by receiving either LGB-affirmative or non-affirmative supervision? Burkard et al. (2009) found that supervisees that experienced LGB-affirmative supervision felt supported, validated, and respected by their supervisors and felt subsequently more confident in their clinical work. Additionally, students that received LGB-affirmative supervision reported having a higher quality training experience, a stronger working alliance with their supervisor, and more positive client outcomes (Burkard et al., 2009). Alternatively, supervisees that experienced LGB non-affirmative supervision felt less trustful, withdrew from supervision, and reported experiencing negative effects on their clinical work and
client care (e.g., distrusted supervisors’ clinical recommendations regarding LGB issues; stopped addressing important clinical and supervision issues with supervisor) (Burkard et al., 2009). These supervisees not only reported experiencing negative emotions such as anger, fear, and distress because of LGB non-affirming supervision events, but there were negative effects on their supervisory relationships as well (Burkard et al., 2009). Having read the available research in this area, it seems reasonable to argue that LGB non-affirmative supervision has the potential to undermine supervisee growth and development as therapists. Such a connection raises an important ethical question: Is LGB non-affirmative supervision unethical if it impedes supervisee professional development and results in diminished client care? With stakes such as these, supervisors simply cannot be passive regarding LGB concerns in supervision.

Supervisees should initially, at a minimum, get familiar with the APA’s sexual minority persons guidelines (APA, 2021), as well as their resolution outlining empirical evidence that conversion therapy is ineffective and harmful (APA, 2009). Knowledge about models of sexual identity development could also clarify questions supervisees might have and aid in avoiding common mistakes, as could knowledge about research on intersecting identities (Bieschke et al., 2014). Other important clinical skills that could be imparted include learning how to educate oneself so as not to burden clients, how to conceptualize cases and formulate treatment plans that neither overemphasize nor ignore sexual minority status, how to think about and locate community resources that could be helpful, and how to decide whether or not to come out to clients (Bieschke et al., 2014). Supervisors should also be prepared to challenge superficial affirmations (i.e., “it’s okay to be gay”) due to shallowness and oversimplification and instead incorporate such topics as the social construction of sexual orientation and identity and advocacy into supervision, which are more effective in promoting genuine equity (Bieschke et al., 2005). It
can also be helpful for supervisors to avoid comments that support stereotypes, positive or negative, about any LGB group, as well as to model using gender-neutral pronouns when asking about romantic partners (Bieschke et al., 2014).

In the training of supervisors to work with LGB clients, trainee supervisors need to develop and maintain an awareness that one tends to look at the world through our given cultural filter which contains heterosexist assumptions (Hitchings, 1999). Trainee supervisors also need to know what to do with such developed awareness. On this point, Hitchings (1999) stressed that there is general agreement about many of the issues involved in working with LGB clients, but what is essentially missing is the ‘how to’ within the supervisory relationship. That same argument could be applied to prior attempts at adapting models of LGB-affirmative supervision. Supervisor training needs to combine the development of awareness and the building of knowledge together with practiced supervisory skills. How is theory put into action? This is where the current study comes in. There is a desire to hear from experienced LGB-affirmative clinical supervisors, in their own words, about practical supervisory skills—the literal and specific actions they perform with supervisees in their LGB-affirmative supervision. By this point, there appears to be enough evidence to argue that the most effective supervision is that which is affirmative. Burkard et al. (2009) clearly illustrate that LGB non-affirmative supervisory practice pushes supervisees away, undermines supervisee training, and subsequently compromises client care. Training needs to be better. What better way than going directly to the source and learning how theory is being turned into action?

**Conclusion**

From this review, it appears that the state of the literature is divided, wavering between continued inadequate training to how far the field has come. To minimize or overlook ignorance
and prejudice within the mental health professions regarding LGB clients, however, would be detrimental to counselors and clients alike. Training is essential for owning and addressing these challenges and ultimately a comprehensive approach is needed. Promoting the development of therapists with an understanding of affirmative treatment for LGB clients has been an important goal in applied psychology in general and in counseling psychology specifically in more recent years. Given the high likelihood of seeing LGB clients in clinical settings for both student trainees and practitioners, efforts to understand and promote the development of LGB-affirmative counseling knowledge and skills has been increasingly prioritized—and LGB-affirmative clinical supervisors have a critical role to play in this training. For the profession of psychology to provide effective and unbiased services to the LGB population, graduate programs in psychology and counseling must continue to be agents of change. As the training grounds for future clinicians, graduate programs have possibly the greatest influence to make a positive impact.

Phillips and Fischer (1998) stated unequivocally that “both counseling and clinical psychology need to ensure that graduate programs make more concerted efforts to integrate LGB issues into their curricula if they are to produce psychologists who are competent to work with LGB clients” (p. 728). Just as generalist training does not automatically result in multiculturally competent or sensitive therapists because it is traditionally grounded in White, middle-class, male worldviews, generalist training will not automatically result in LGB-affirmative therapists as it is traditionally provided from a heterosexual and heterosexist worldview (LaFromboise et al., 1996). Without specialized training, therapists will be more likely to be harmful to LGB clients due to their own unchallenged conscious and/or unconscious heterosexist biases, the heterosexual biases of the traditional psychological therapies in which they have been trained,
and/or their lack of familiarity with LGB issues, lifestyles, and resources (McHenry & Johnson, 1993). Explicit, specific, and specialized training in LGB issues is imperative in empowering clinicians-in-training to work with sexual minority clients successfully and confidently. Phillips and Fischer (1998) made several suggestions for improving training in LGB issues following their extensive survey of graduate students, including integrating LGB issues throughout formal training (i.e., faculty learning how to include LGB issues into each course taught) and continuing education in this area. Another way to improve training would be for graduate programs to target the next open faculty position for a person with expertise in LGB issues (Phillips & Fischer, 1998). Finally, programs need to make sure that graduate students are receiving competently supervised practicum experience with LGB clients. Phillips and Fischer (1998) found that having a greater amount of formal training in LGB issues was at least moderately related to having a supervisor with LGB expertise.

Given previous theoretical and conceptual work, there is not a clear understanding about how experienced clinical supervisors conduct LGB-affirmative clinical supervision with supervisees. Describing a phenomenon being studied is one thing but hearing directly from those working in the field about the actions they perform is another. Having access to research that illustrates how practicing clinical supervisors provide LGB-affirmative supervision, especially multiple perspectives, fills a gap in the training literature. What do you do to promote an accepting and safe supervision atmosphere? There are special concerns with the LGB population. How do you promote this learning with supervisees? Do you provide a reading list or resources? Things are no longer hypothetical. The current study is aimed at identifying how experienced clinical supervisors implement the concepts of LGB-affirmative supervision in their supervisory work. This investigation furthers our knowledge about how experienced clinical supervisors
personally define and implement LGB-affirmative supervision as they know it with supervisees. The results of this study may prove useful to the practice of supervision, to current supervisors who are seeking to provide LGB-affirmative supervision and to those involved in training who seek to increase the sensitivity of future supervisors regarding LGB issues, and the larger mental health field. Additionally, providing LGB-affirmative supervision will benefit current and future supervisees, especially LGB-identified supervisees, and will ultimately benefit LGB clients, the consumers of mental health services.

Sexual orientation issues in the counseling psychology field have never been more visible. There are more students today who are openly LGB or vocal allies that are looking for ways to integrate those identities into their professional identities and they need guidance to do so. Lark and Croteau (1998) also referenced the growing number of faculty and clinical supervisors who are open about their LGB identities and/or open about their affirmation of LGB people. As opportunities for LGB-affirmative training emerges, information that can guide and assist students, educators, mentors, supervisors, and the like is needed.

The purpose of this study was to explore the underlying dimensions of LGB-affirmative clinical supervision as provided to trainees by clinical supervisors with knowledge of LGB issues and people. This investigation offers an essential step in understanding how LGB-affirmative clinical supervision is understood and enacted in practice and was guided by the following research questions: How do clinical supervisors with knowledge of LGB issues and people implement LGB-affirmative clinical supervision? What are the conceptual dimensions that underlie LGB-affirmative supervision? Specifically, this study looked for how clinical supervisors incorporate and execute LGB-affirmative practices as informed by the APA (2021) into the clinical supervision component of training.
CHAPTER II

METHOD

Significance and Purpose of the Study

The purpose of this study was to explore the underlying dimensions of LGB-affirmative clinical supervision as provided to trainees by clinical supervisors with knowledge of LGB issues and people. This exploration was guided by the following descriptive research questions: How do clinical supervisors with knowledge of LGB issues and people implement LGB-affirmative clinical supervision? What are the conceptual dimensions that underlie LGB-affirmative supervision? Specifically, this exploratory study—meaning assuming little a priori knowledge—looked for how clinical supervisors incorporated and executed LGB-affirmative practices as informed by the APA (2021) into the clinical supervision component of training.

This investigation employed an idiothetic approach, a type of individual-differences approach in which both group and individual levels of analysis are the foci (Darcy et al., 2004). The overarching goal of this study was to tell a collective story, thus analysis focused on the group; however, examining data on the individual level as well gave voice to who individual participants were, highlighted what they uniquely brought to the larger story, and provided interesting and nuanced contextual information. An idiothetic approach also allowed for differences on a common (group) construct to be examined, as well as the extent to which the common structure was used by each individual (Darcy et al., 2004). The advantages of using an idiothetic approach include the ability to compare on a common construct, information on the fit of individuals to this common construct, how individuals use the common dimensions, the ability to generalize, and provide more unique individual information than normative approaches, which focus only on the group (Darcy et al., 2004).
This study utilized quantitative research methods in the form of surveys: the two-part Exploring Perceptions of LGB-Affirmative Clinical Supervision paired comparisons measure, constructed by the researcher; the Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI; Dillon & Worthington, 2003); and a questionnaire with background and contextual questions. Multidimensional scaling (MDS) was used as the primary statistical tool to discover the dimensions underlying clinical supervisors’ perceptions of LGB-affirmative clinical supervision. Though less traditionally used quantitative methods, both paired comparison and MDS are assessment and analytic tools associated with idiothetic studies (Darcy et al., 2004). Darcy et al. (2004) suggested that expanding the methodological approaches and analytic tools used in quantitative studies will result in more complex understanding of multicultural issues as they pertain to counseling. Additionally, cluster analysis was used as the primary follow-up analysis to MDS for purposes of interpreting the dimensions and to assist in describing the concrete actions supervisors take. The remainder of this chapter provides details of the following: participants, measures, data collection procedures, and data analysis.

**Participants**

A total of 35 clinical supervisors initiated the study; however, some surveys were incomplete. The final sample retained in phase 1 of data collection consisted of 26 clinical supervisors, with supervision experience ranging from 4 to 52 years, and who also self-identified as knowledgeable about LGB issues and people. Participants’ ages ranged between 32-75 years old. Of these 26 participants, 15 were retained for phase 2 and completed the paired-comparison portion of the study. See Table 1 below for participant educational and professional background information for both phases of data collection. Intentional efforts were made to recruit
professionals from varied educational and professional backgrounds in an attempt to garner a diversity of perspectives.

**Table 1**

*Frequency Data for Participant Educational and Professional Backgrounds*

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<th>Variable</th>
<th>Phase 1</th>
<th>Phase 2</th>
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<td>3 20.0</td>
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<td>Private Practice</td>
<td>3 11.5</td>
<td>1 6.7</td>
</tr>
<tr>
<td>University Counseling Center</td>
<td>14 53.8</td>
<td>7 46.7</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>1 3.8</td>
<td>1 6.7</td>
</tr>
</tbody>
</table>
Variables with a higher total than number of participants reflect endorsement of more than one response choice by participant(s).

Table 2 provides information about the demographic make-up of the sample. For all identity variables, participants were first asked to describe themselves in their own words to capture any additional information or nuance, and then to select from demographic checklists in order to assist with integrating findings with existing research. For most participants, the demographic checklists sufficed and included the language they chose to use, but for others, being able to describe themselves resulted in more nuanced data. It is important to note that participants were told to check all that applied to them on the demographic checklists, which at times resulted in multiple identity descriptors being endorsed by a participant on a single variable. Table 2 contains checklist data from participants who completed Phase 1 and Phase 2 of data collection. Checklist data was supplemented with participant self-descriptions, which are also included below.

**Table 2**

*Frequency Data for Participant Demographic Characteristics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Phase 1 Frequency</th>
<th>Phase 1 %</th>
<th>Phase 2 Frequency</th>
<th>Phase 2 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Identity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual/Straight</td>
<td>10</td>
<td>38.5</td>
<td>6</td>
<td>40.0</td>
</tr>
<tr>
<td>Pansexual</td>
<td>6</td>
<td>23.0</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Queer</td>
<td>5</td>
<td>19.2</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Lesbian</td>
<td>5</td>
<td>19.2</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Gay</td>
<td>4</td>
<td>15.4</td>
<td>2</td>
<td>13.3</td>
</tr>
</tbody>
</table>
Table 2 – continued

<table>
<thead>
<tr>
<th>Gender Identity</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisexual</td>
<td>3</td>
<td>11.5</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Asexual</td>
<td>1</td>
<td>3.8</td>
<td>1</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Gender Identity

<table>
<thead>
<tr>
<th>Gender Identity</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cisgender Female</td>
<td>19</td>
<td>73.0</td>
<td>10</td>
<td>66.7</td>
</tr>
<tr>
<td>Cisgender Male</td>
<td>3</td>
<td>11.5</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Genderfluid/Genderqueer</td>
<td>4</td>
<td>15.4</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Transgender Male</td>
<td>1</td>
<td>3.8</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Questioning or Unsure</td>
<td>1</td>
<td>3.8</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Racial Identity

<table>
<thead>
<tr>
<th>Racial Identity</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>24</td>
<td>94.3</td>
<td>13</td>
<td>86.7</td>
</tr>
<tr>
<td>Black</td>
<td>1</td>
<td>3.8</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Multiracial/Some Other Race (Latinx/Puerto Rican)</td>
<td>1</td>
<td>3.8</td>
<td>1</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Note. Variables with a higher total than number of participants reflect endorsement of more than one response choice by participant(s).

Regarding sexual identity for the initial 26 participants, 10 participants (38.5%) identified as Heterosexual or Straight. A total of 6 participants (23%) identified as Pansexual, with one person elaborating that “pansexual best describes me, although I defined as bisexual until recently.” Of the 26 participants, 5 (19.2%) identified as Queer, 5 (19.2%) as Lesbian with one participant also adding “Dyke,” and 4 (15.4%) as Gay. Additionally, 3 participants (11.5%) endorsed being Bisexual, with one person adding “bisexual, leaning toward opposite-gender attraction.” Lastly, 1 participant (3.8%) identified as Asexual. It is interesting to note that sexual
identity was the identity category where individual participants appeared to most freely and frequently endorse multiple labels to describe themselves, even though checking all that apply was stated on all identity variables. Some of this is likely due to overlap in sexual identity label terminology. Overall, this sample of experienced clinical supervisors identified themselves with a variety of sexual identity labels.

The majority of phase 1 participants identified as cisgender female ($N = 19, 73\%$); however, there were some richer elaborations worth sharing. One participant described herself as a “cisgender woman with androgynous gender expression,” while another reported “most frequently identifying as female but also aligning with fluid and non-binary identities at different times in life and will use a ‘they’ pronoun in those times.” Additionally, 3 participants identified as cisgender male (12\%), 4 participants (15\%) as genderfluid or genderqueer, 1 participant (3.8\%) as transgender male or, per his own description, “transmale and my demanded pronouns are he/his/him,” and 1 participant (3.8\%) as questioning or unsure.

When this study was initiated, it seemed important to separate sexual identity from gender identity and to be very specific about what was being looked at, asked about, and reported on. There was a period of time in the history of sexuality research where identities were grouped together and not addressed in studies, particularly tacking a ‘T’ for transgender on to the end of LGB and then not getting data about transgender people. It was important to not add to that history if justice could not be done to be fully inclusive of both the histories of sexuality and gender-affirmative care and training in the mental health fields, which was expansive for one study. Thus, a narrower focus was chosen. However, what happened over time—in the world and subsequently in the study—was that intersectionality of identities moved to the forefront of multicultural conversations. The shallowness and tacking on of identities decreased and people
were being considered in deeper, more complex ways. This study started with a focus on being LGB-affirmative to keep it focused, but numerous participants contributed data about gender identity as well because intersectionality is an important part of the current zeitgeist. Quantitative research helps with understanding well-defined, sometimes small groups of people or concepts—not because this suggests these are the only people or concepts to study, but because quantitative research understands the whole by looking at the little parts and then putting them back together. Thus, there continues to be value in studying sexuality and gender identity separately. Diversity of gender identity was not excluded from this study—rather, those folks were included as participants. Further discussion about how sexual identity and gender identity go together and intersect will be included in the final chapter but was beneficial to introduce now. Table 3 below illustrates how sexual and gender identities combined for the participants of this study. Multiple identities appearing together in a single box indicates that a participant endorsed more than one checklist item.

**Table 3**

*Sexual Orientation and Gender Crosstabulation Data*
Note. Multiple identity variables listed together indicates a participant that endorsed more than one demographic checklist item.

With respect to racial identity, the majority of participants ($N = 24, 92.3\%$) identified themselves as White and/or Caucasian. Other descriptors used one time each included “Euro-American,” “White European American,” and “Italian heritage.” Three participants who racially identified as White went on to report having Hispanic/Latino/Spanish origin, one Mexican American and two Puerto Rican, one of whom also added the written descriptor “Puerto Rican.” There was 1 participant (3.8\%) that identified as Black and 1 participant (3.8\%) that checked the demographic box for Multiracial/Some Other Race, described themselves as “Latinx,” and went on to report having Hispanic/Latino/Spanish origin, specifically Puerto Rican.

Lastly, on the background questionnaire, all 26 participants ($N = 26; 100\%$) responded ‘Yes’ to a question asking if they had participated in professional development opportunities aimed specifically at LGB-affirmative therapy and/or LGB-affirmative supervision. The next question asked those that responded yes to please estimate how many LGB-affirmative professional development activities they participate in annually, as well as to briefly describe their last two experiences and how they impacted them. Of the 26 participants who answered in the affirmative initially, 24 (92.3\%) provided some additional information. Of the 18 participants ($N = 18; 75\%$) that provided an estimated number of annual LGB-affirmative professional development activities, 8 cited 1-2 ($N =8; 44.4\%$), 6 cited 3-5 ($N = 6; 33.3\%$), and 4 reported taking part in 10 or more per year ($N = 4; 22.2\%$). The types of professional development activities mentioned as being attended or developed and presented included conference presentations/convention programs, workshops, trainings, continuing education opportunities (CEs), and webinars. There were some general themes regarding impact on the participants
including keeping current on language/terminology; increasing knowledge, sensitivity, and empathy; inspiring curiosity to learn and do more research; boosting desire to engage in conversations and network with others; gaining resources to utilize and share; and the evocation of a variety of feelings.

Thus, this was a very active and involved group of LGB-affirmative supervisors, which one would hope to find from a sample that self-selected into a study calling for participants who were knowledgeable about LGB issues and people—and not only was this an active group, but one ready and willing to share personal meaningful professional development, illustrating the value of additional enrichment. In fact, there could not have been a better, more appropriate group of participants driving this study. Responses on the background questionnaire assisted with verifying how LGB-affirmative the participants were both individually and as a group and vetted the amount of clinical experience participants had as well. LGB-CSI scores, which will be elaborated on in the next chapter, also helped to increase confidence in the sample.

Measures

Participants were asked to complete four online measures related to their conceptualization of LGB-affirmative clinical supervision: a questionnaire with background and contextual questions (Appendix A), the two-part Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure (Appendices B and C), and the Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (Appendix D). The four surveys were completed across two research sessions using the online survey research platform Qualtrics. The background questionnaire and the two-part Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure were created by this researcher for the purposes of this study in order to gain insight into how experienced clinical supervisors with knowledge of LGB issues and people
practice LGB-affirmative clinical supervision and assess the constructs central to the research questions. The Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory was selected to help provide a fuller description of participants and to help identify any individuals that may not be practicing LGB-affirmative supervision and therefore, would need to be excluded from the study (i.e., if the participant’s overall score was more than one standard deviation below the published mean) (Dillon & Worthington, 2003).

**Background Questionnaire**

Clinical supervisors were asked to fill out a background questionnaire which provided demographic information, as well as information concerning educational and professional work experiences. Demographic information requested included age, sex assigned at birth, gender identity, sexual orientation, racial identity, and socioeconomic background. Clinical supervisors were also asked information about highest degree earned, degree or area of specialization, years of post-degree experience, years of clinical supervision experience, and years of experience with LGB issues. Lastly, participants were asked several questions about their experiences and professional development regarding LGB issues, LGB-affirmative therapy, and LGB-affirmative supervision. For MDS and subsequent follow-up analyses, it is important to have information rich participants reporting on clinical work that they actually do rather than envisioning hypothetical situations of what they think they would do. This data was used to describe the sample, vet participant LGB-affirmativeness for participation, and to assist in the interpretation of MDS results.

**Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure**

The purpose of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure was to investigate how clinical supervisors practically understand LGB-affirmative
clinical supervision. It is a paired comparison measure and was created for the purposes of this investigation because there is currently no adequate questionnaire measuring the specific components of LGB-affirmative clinical supervision. In a paired comparisons task, individual participants make similarity ratings of all possible pairs of items of interest (David, 1963). The specific items can be either researcher provided or individual-generated (Darcy et al., 2004). Darcy et al. (2004) described that a distinct advantage of paired comparison approaches is that they have the potential to tap into the underlying dimensionality of psychological and sociological constructs that are salient to individuals and/or groups even though such dimensions may not be known to the respondent. An associated advantage is that, with paired comparisons, biased responding is minimized because of the nature of the task (Darcy et al., 2004). That makes this type of measure particularly well-suited to the present multicultural investigation, whereby a pressure likely existed to represent oneself in a socially desirable manner.

The Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure contains two parts designed to be completed in two separate research sessions. Since the objective of the study was to learn from experienced and knowledgeable clinical supervisors, the items on the questionnaire were generated by the study participants as opposed to being provided by the researcher. In Part 1, each participant was asked to write a minimum of 3 items–phrases or descriptors, rank ordered–that represented their own personal understanding of how they provide LGB-affirmative clinical supervision. If the participant had more than 3 descriptors to contribute, additional space was provided allowing them to list those important ideas. There was an example item (Appendix B) encouraging participants to think about specific, concrete actions they take and illustrating how to edit for brevity which would be important for the later item comparison rating task (Part 2). There was also a note encouraging participants to draw not only from their
knowledge, but from past experiences providing LGB-affirmative clinical supervision to trainees. It was originally decided that participants would be asked to write 3 items each because that number would allow for only the most important items to be named, a prioritizing of a top 3. However, there was an awareness that limiting it to 3 might keep responses surface level or make it frustrating for participants who had more to say. Asking each participant to submit a minimum of 3 responses to the researcher for review, a process which will be described more fully in the next chapter regarding results, as well as allowing space for additional items to be listed, was decidedly the best compromise.

In Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, participants completed paired comparisons of all items retained after the researcher review of the items submitted in Part 1. While this review process will be elaborated on more in the next chapter, providing some details here is important for context. A total of 100 items, describing LGB-affirmative supervision, were submitted by 26 clinical supervisor participants on Part 1 of the measure. Not all of these items could be retained to be rated. Not only would this have taken a tremendous amount of time and effort to do the similarity ratings that number of items would have produced, but even an initial scan revealed overlap in responses making it clear that eliminating repeating items would be the first way to make cuts. Remaining items were recorded onto notecards to allow for sorting and re-sorting into categories of similar items. Ultimately, 18 total items were included in Part 2, one representative item from each category identified in the review process. Participants rated the degree of similarity or dissimilarity between all possible LGB-affirmative clinical supervision item pairs using a 6-point Likert scale (1 = extremely similar and 6 = extremely dissimilar). Essentially, the core aspects of LGB-affirmative clinical supervision that participants identified in Part 1 were compared to one another during Part 2. The
Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure provided the data of central interest in the current investigation. The final set of items developed from Part 1 of the measure provided information about how clinical supervisors implement LGB-affirmative supervision. MDS and cluster analysis of the similarity ratings for these items on Part 2 of this measure provided information about the dimensions of LGB-affirmative clinical supervision for the participants.

**Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory**

The Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI) measures participants’ self-efficacy to perform LGB-affirmative counseling behaviors. LGB-affirmative counseling behaviors include (a) *advocacy skills*: identifying and utilizing community resources that are supportive of LGB clients’ concerns; (b) *application of knowledge*: counseling LGB clients through unique issues using knowledge of LGB issues in psychology; (c) *awareness*: maintaining awareness of attitudes toward one’s own and others’ sexual identity development; (d) *assessment*: assessing relevant issues and problems of LGB clients; and (e) *relationship*: building a working alliance with LGB clients (Dillon & Worthington, 2003). The LGB-CSI consists of 32 items and participants are asked to indicate their confidence in their current level of ability to perform LGB-affirmative counseling activities on a Likert scale ranging from 1 to 6 (1 = not at all confident and 6 = extremely confident). LGB-CSI total scores, which can range from 32.00 to 192.00, are obtained by summing all items. Higher scores are indicative of higher levels of self-efficacy to counsel gay, lesbian, and/or bisexual clients.

Psychometric evidence for the LGB-CSI was provided by scale developers. The LGB-CSI total scale, and the five subscales that comprise the total scale, have evidenced high internal consistency (Cronbach’s $\alpha > .70$) in past studies (Dillon & Worthington, 2003; Dillon et al.,
Existing internal consistency estimates for the subscales of the LGB-CSI are .88 (Advocacy Skills), .83 (Assessment), .87 (Awareness), .84 (Relationship), .94 (Application of Knowledge), and .93 (Total). In the sample for the current study, Cronbach’s alpha for the total scale was .94.

Research with the LGB-CSI has also yielded evidence of validity. Content validity of the items on the measure were determined through expert panel review (Dillon & Worthington, 2003). Construct validity was supported through exploratory and confirmatory factor analyses, as well as by findings indicating varying levels of self-efficacy commensurate with status in the field (Dillon & Worthington, 2003). Convergent validity for total scale and subscales was supported by correlations with measures of general counseling self-efficacy and attitudes toward LGB individuals (Dillon & Worthington, 2003). Lastly, discriminant validity was evidenced by an absence of relations between the total scale and subscales and measures of social desirability, self-deceptive positivity, and impression management (Dillon & Worthington, 2003). Overall, the LGB-CSI appears to be a useful instrument for measuring counseling self-efficacy as it relates to LGB issues and aided by its ease in administration and scoring and evidence of reliability and validity. This inventory helped provide descriptive data on participating clinical supervisors and served as a means to identity potential LGB non-affirmative supervisors that might need to be excluded from the study. The LGB-CSI was presented after Part 1 of the Exploring Perceptions of LGB-Affirmative Supervision Measure so that the items on the instrument did not influence participant item writing for the Exploring Perceptions of LGB-Affirmative Supervision Measure.
Procedure

Clinical supervisors were invited to participate in the study using the primary method of email, initially through listservs (Appendix E). Six divisions and associations within the APA, the ACA, and the American College Personnel Association (ACPA), as well as the Counselor Education and Supervision NETwork–Listserv (CESNET-L), were targeted for participant recruitment based on the number of members who identify as practitioners and/or because of an emphasis on LGB issues, increasing the likelihood of finding experienced clinical supervisors with strong knowledge of LGB issues and people, the desired sample for the study. In addition to CESNET-L, participant recruitment invitations for the study were sent to the following specific listservs: APA Division 44 Society for the Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues; APA Division 17 Section for Lesbian, Gay, Bisexual, and Transgender Issues (SLGBTI); APA Division 17 Section for Supervision & Training; APA Division 17 Discuss; ACA Division American College Counseling Association (ACCA); and ACPA Commission for Counseling and Psychological Services (CCAPS). Recruitment across multiple divisions and associations was intended to increase the possibility of obtaining a diverse sample.

At the onset of the study, the goal was to recruit 30 participants, a number chosen because of the Central Limit Theorem. The idea was that a sample size of 30 would support statistical analyses while also keeping the number of items generated for the paired comparison measure from becoming too large or burdensome for participants to rate. When listserv recruitment stalled, additional recruitment strategies were employed with HSIRB approval, such as sending email invitations to professional contacts (Appendix F), including authors cited in the literature review that had written about LGB-affirmative supervision, as well as reaching out to training directors at APA-accredited university counseling center (UCC) internship sites.
Additionally, this researcher was contacted by the CEO and Founder of Motivo, a website that connects new therapists with experienced clinical supervisors, after seeing the study posted to the CESNET-L listserv, who offered to advertise it in the Mondays with Motivo electronic newsletter. Thus, this study was advertised in the Motivo newsletter that went out to subscribers on 7/27/21. Listservs, professional contacts, and training directors all received an initial invitation (Appendix H), a follow-up email (Appendix I), and a final email (Appendix J) with two weeks of time in between, the exceptions being the Division 17 and ACA listservs that each had a two-post rule.

Initial invitations emailed to participants explained the purpose of the study and the extent of requested participation. A link hosting the study was contained within the invitation. After being directed to the survey website, clinical supervisors were presented with the informed consent document (Appendix K) and asked to decide whether or not they were willing to participate. The informed consent form included information about the central purpose of the study, the procedures used in data collection and extent of requested participation, a statement about potential risks associated with participating in the study, comments about protecting the confidentiality of the participants, and the rights of participants to withdraw from the study at any time (Creswell, 2007). If clinical supervisors had any questions as they considered participation, they were encouraged to contact the researcher via email or phone. No clinical supervisors contacted the researcher with any questions or concerns.

If willing to participate, clinical supervisors clicked that they agreed, which advanced them to the first measure—the background questionnaire. It was important that the background questionnaire was completed first because the open-ended questions concerning personal experiences of providing LGB-affirmative supervision to trainees were designed to prime
participants to write better items on the second measure. Once the background questionnaire was complete, clinical supervisors advanced to Part 1 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure. Before submitting Part 1 and moving on to the third and final measure of the first research session, participants were asked to provide an email address to be used to contact them when Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure was ready. Additionally, there was a statement reassuring participants of confidentiality and stating that because of the time to recruit participants, gather generated descriptors, and for the researcher to review and solidify the final item set to be compared and rated, it was necessary for Part 2 to occur in a second, future session. This process was already described in the recruitment invitation and the informed consent document that participants received as well. The researcher’s contact information was listed again at this point in case there were any questions or concerns and again no participants reached out.

Once participants were satisfied with the items they had generated and were ready to move forward, responses were submitted and they advanced to the third and final measure of the first research session, the LGB-CSI. As noted previously, this measure was presented last so that it did not influence the items participants wrote for Part 1 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure. Once clinical supervisors finished the LGB-CSI, they were done with the first session. Research session 1 closed with a final statement that participants would be contacted about completing Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, the item similarity ratings, using the email address that they provided as soon as the Part 2 measure was ready.

The second research session included the fourth and final measure of the study, Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, the paired
comparison ratings. This measure was also constructed and hosted on Qualtrics, the same survey research website as the prior measures. The link to Part 2 was distributed via the email addresses provided by participants once the measure was set up and items were ready for rating.

Participants were first directed to the Part 2 Informed Consent Document (Appendix L) before proceeding. Up to two additional reminder emails were sent, two weeks in between each, in an attempt to increase participant follow-through. At the end of the measure, participants were thanked, asked to re-enter their email address to link their Part 2 responses to Part 1, and reminded that they were being entered into a drawing for three $50 Amazon gift cards for completing the study. This random drawing was completed and gift cards were sent to the three winners electronically using the email addresses that they provided.

Analysis

Initial descriptive analyses were conducted on all quantitative data to assist in describing the sample. Frequency data regarding participant educational and professional backgrounds and identity variables were presented above in Tables 1 through 3. Descriptive statistics for the LGB-CSI will be presented in the next chapter with results. The following section outlines the analysis process for the current investigation.

After initial data cleaning and running frequency data, several analyses were conducted. MDS was used as the primary statistical tool to identify the conceptual dimensions of LGB-affirmative supervision. MDS techniques encompass a group of data analytic methods that can be used to uncover or represent the “hidden structure” of proximity data (Kruskal & Wish, 1978). MDS is a method that represents measurements of similarity or dissimilarity among pairs of objects as distances between points of a low-dimensional multidimensional space (Borg & Groenen, 2005; Schiffman et al., 1981). Darcy et al. (2004) describe the process of taking
respondents’ similarity ratings and converting them into numbers or “proximities” that represent the degree of perceived or actual similarity or dissimilarity between all pairs of items within a set. These proximities can then be arranged into data matrices, which are sometimes also called spatial configurations or “maps.” A researcher can have a set of matrices whereby each matrix represents the similarity ratings of an individual member of a larger group or a single matrix can be produced in which the ratings of a group of combined individuals are of interest (Kruskal & Wish, 1978; Treat et al., 2002). Once points have been located in multidimensional space, researchers seek to determine the hidden structure, or theoretical meaning, of this spatial representation of responses (Kruskal & Wish, 1978). This is done by reducing data to dimensions that represent the hidden structure of the data. Furthermore, by finding key differences at opposite ends of each dimension, researchers can attempt to develop indicators of variables that can be measured in the future.

The similarity ratings obtained from the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure were subjected to a weighted three-way unconstrained MDS analysis to uncover common constructs and examine each individual’s fit to this common structure (Darcy et al., 2004). Three-way MDS analysis was conducted, as opposed to two-way, because three-way allows for examination of both group and individual differences (i.e., only three-way MDS can be run with idiothetic studies telling a group story such as this one). As referenced above, MDS results provide a graphic or spatial representation of the data and its structure (Young & Hamer, 1987). MDS is almost always used as a descriptive model for representing and understanding data, as well as for its simplicity and ease of presentation (Darcy et al., 2004; Kruskal & Wish, 1978). This spatial representation summarized the dimensions of LGB-affirmative clinical supervision underlying the similarity ratings made by participating
clinical supervisors on the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure. According to Darcy et al. (2004), three-way MDS analyses represent the data of more than a single input matrix and yields a number of indices of interest: dispersion accounted for (DAF) by the group model, item coordinates on the particular dimensions for the group model, and dimension weights indicating how much each individual uses the group dimensions. Thus, goodness of fit or stress measures for the sample were yielded, as well as dimension weights, which indicate the importance of each dimension of LGB-affirmative clinical supervision for each participant. Small dimension weights indicate that the dimension accounts for little variance and is not used by that individual while large dimension weights indicate large variance and extensive usage by the participant (Darcy et al., 2004).

Additionally, analyzing the spatial representation of the dimensions informed the researcher of the nature and the number of dimensions underlying clinical supervisors’ understanding of LGB-affirmative clinical supervision. Similarity ratings are represented spatially such that the closer each item lies to another item on a particular dimension, the more similar the concepts represented by each item are to one another. Subsequently, the larger the distance between points or items, the more dissimilar they are perceived to be. A measure of fit or goodness of fit widely used in MDS is “stress,” which is the square root of a normalized “residual sum of squares” (Kruskal & Wish, 1978, p. 49). By analyzing a plot of stress values for solutions of different dimensions, one is able to determine the number of dimensions that best fit the data (Stalans, 2005). More specifically, the plot of stress values is examined for an elbow, which indicates a leveling off of reduction in stress when additional dimensions are added (Kruskal & Wish, 1978; Stalans, 2005). This process of determining how many dimensions are present in the data parallels examination of a scree plot in factor analysis.
The current study subscribes to nonmetric rather than metric assumptions. Nonmetric MDS is based on a measurement model that assumes that the relative similarity of pairs of objects can be represented in terms of the relative distance between pairs of points (Berry & Lewis-Beck, 1986). According to Borg and Groenen (2005), the advantage of using nonmetric rather than metric assumptions is that a wide variety of nonlinear relationships are allowed between the observed similarities and the recovered distances. Using a nonmetric method also allows the researcher to measure the similarity of object pairs with somewhat less concern about the level of measurement (Berry & Lewis-Beck, 1986).

Furthermore, MDS results can be interpreted more fully by conducting additional analyses of the MDS output. For the current study, the follow-up analysis consisted of a cluster analysis. Cluster analysis is a pattern-identifying analysis or method for combining similar objects into groups that will aid in the statistical interpretation of the dimensions (Heppner et al., 2008). Arabie et al. (1987) describe this process as seeking to “cluster” or partition data matrices into relatively homogenous subgroups of items, aggregate within, and then run an analysis for each such subgroup of items. Borgen and Barnett (1987) describe how cluster analysis can be used to categorize objects (e.g., counselor statements), people (e.g., counseling center clients), or variables (e.g., items on a test). The follow-up analysis for this study clustered the developed items that were based on the participant generated items to identify subgroups of items perceived as particularly similar to each other. The main benefit of using cluster analysis as the follow-up analysis lies in the definition of the method. It allowed the researcher to group similar data together and to identify patterns between the data elements. Examination of where the clusters lie in relationship to the dimensions identified through MDS provided greater understanding of the meaning of the dimensions. These findings will be further described in the next chapter.
CHAPTER III
RESULTS

The purpose of the current investigation was to explore the underlying dimensions of LGB-affirmative clinical supervision as provided to trainees by clinical supervisors with knowledge of LGB issues and people through the use of multidimensional scaling and cluster analysis. This study sought to understand how experienced LGB-affirmative clinical supervisors engage in supervision with trainees through posing the following research questions: How do clinical supervisors with knowledge of LGB issues and people implement LGB-affirmative clinical supervision? What are the conceptual dimensions that underlie LGB-affirmative supervision?

To answer these research questions, clinical supervisors completed the two-part Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, with each part answering one of the research questions. A qualitative thematic analysis was done on the items submitted on Part 1, which answers the first research question. The Part 2 paired comparison data was submitted to MDS and cluster analysis to identify the underlying dimensions of LGB-affirmative clinical supervision for the sample and answer the second research question. These results will be further explained below. Two additional measures were used to assist with descriptive data and to provide evidence of supervisor LGB-affirmativeness: the standardized LGB-CSI measure (Dillon & Worthington, 2003) and a developed background questionnaire.

This chapter presents the results of this study in the following order: preliminary analyses regarding participant eligibility, recommended LGB-affirmative supervision resources, the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure and recommended LGB-affirmative supervision practices, and dimensions of LGB-affirmative clinical supervision.
Preliminary Analyses: Participant Eligibility

The criteria for participation in the study was 5 or more years of clinical supervision experience and identifying as knowledgeable about LGB issues and people. Although participants initially self-selected into the study, inclusion criteria was cross-checked with responses on the background questionnaire and scores on the LGB-CSI. Exclusion criteria included not meeting the inclusion criteria (endorsed fewer than 5 years of clinical supervision experience on the background questionnaire and/or no indication of being LGB-affirmative or being LGB non-affirmative) or overall score on the LGB-CSI falling more than one standard deviation below the published mean for the measure, which would be indicative of lower levels of self-efficacy for working with LGB clients and perhaps meaning that this would not be the best representative of LGB-affirmative supervision.

After analyzing data from the first research session, 35 clinical supervisors agreed to participate in the study and submitted responses. However, 9 surveys could not be used as they never advanced past the initial background questionnaire, making the data incomplete. Of those 9 participants, 3 fell below the inclusion criteria of 5 years of clinical supervision experience, so it is possible they realized this and excused themselves. However, 5 of those 9 were experienced clinical supervisors that illustrated high levels of LGB-affirmativeness but did not proceed beyond the background questionnaire for unknown reasons. Lastly, 1 participant with incomplete survey data was an experienced clinical supervisor but did not fill in enough information to assess LGB-affirmativeness. There were 26 complete surveys submitted, 25 that met all inclusion criteria when cross-checked. One participant documented 4 years of clinical supervision experience at the time of filling out the survey but weighing that against their illustrated LGB-affirmativeness and the valuable items contributed about their clinical
supervision, this researcher requested and was granted an exception from the HSIRB to include their data. Thus, 26 experienced and LGB-affirmative clinical supervisors submitted completed surveys in the first research session. Background questionnaires and LGB-CSI scores were assessed. No participants fell more than one standard deviation (SD = 36.45) below the published mean (M = 151.21) on the LGB-CSI and all illustrated LGB-affirmativeness in information found on their background questionnaires (Dillon & Worthington, 2003). No participants were dismissed from the study based on inclusion criteria or exclusion criteria.

For the second research session, 25 of the original 26 participants were contacted using the email addresses they provided. One participant from the first research session failed to enter an email address, so while the data they initially contributed could be used, they unfortunately could not be invited back to complete the study. Consistent with the first research session, initial emails were sent, then reminder emails, and final reminders spaced two weeks apart – the messages were more tailored and sent to individual email addresses for the second research session as opposed to bulk emailing in an attempt to avoid spam folders and retain participation. Out of the 25 participants contacted, 18 returned to the study. Out of those 18, 3 opted out of the study at the informed consent page and 15 agreed to continue and completed (N = 15; 60%) Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, the fourth and final measure of the study.

**Examining the LGB-CSI**

As discussed previously, the LGB-CSI measures participants’ self-efficacy to perform LGB-affirmative counseling behaviors, including advocacy skills, application of knowledge, awareness, assessment, and relationship (Dillon & Worthington, 2003). In addition to using LGB-CSI scores to screen for potentially LGB non-affirmative participants, these data also
provided useful information about the sample. Total scores on the 32-item LGB-CSI can range from a minimum of 32.00 (1 = Not at all Confident) to a maximum of 192.00 (6 = Extremely Confident). Twenty-six clinical supervisors completed the LGB-CSI with scores ranging from 121.00 (minimum) to 192.00 (maximum), meaning that one participant felt extremely confident about their ability to perform all LGB-affirmative counseling behaviors presented on the measure and marked each item accordingly. The published mean for the LGB-CSI is 151.21 with a standard deviation of 36.45. Thus, scores falling below 114.76 would be one standard deviation below the mean. None of the 26 participating clinical supervisors fell below that score, thus no one was flagged as LGB non-affirmative and excluded from the study based on this exclusion criteria. The mean for this sample was 161.96 with a standard deviation of 19.24. This sample of self-identifying LGB knowledgeable clinical supervisors had a higher average score and less variation in scores on the LGB-CSI than the published descriptive statistics from the scale developers. Translating the sample mean to item level metric, the average item score for this sample was 5.06, indicating confidence in the ability to perform LGB-affirmative counseling behaviors.

LGB-CSI scores were also assessed for normality using SPSS. The skewness value for this sample, which provides an indication of the symmetry of the distribution, was -.421. Negative skewness values indicate a clustering of scores at the high end (right-hand side of the graph). Kurtosis, which was -.440, provides information about the ‘peakedness’ of the distribution. Kurtosis values below 0 indicate a distribution that is relatively flat. Histograms show the actual shape of the distribution for each group. LGB-CSI scores appeared to be reasonably normally distributed with no extremes or outliers. The Normal Q-Q Plot, or normal probability plot, of total LGB-CSI scores illustrated a reasonably straight line suggesting a
normal distribution. The Detrended Normal Q-Q Plot of total LGB-CSI scores showed no real clustering of points, with most collecting around the zero line, as was expected. A boxplot of the distribution of scores identified no outliers. Lastly, the Kolmogorov-Smirnov statistic was not statistically significant (alpha = .20), indicating no deviation from normality. Thus, the final conclusion based on all tests of normality was that the distribution of scores was reasonably normal.

The information learned about participants from the LGB-CSI data was extremely useful. This was a group of experienced clinicians that self-identified as knowledgeable about LGB issues and people, and self-selected into a study where those were criteria for participating. Therefore, there was an expectation that this group in particular would yield a higher average score on the measure, and have less score variation, than when the measure was developed and normed. Even with that expectation, it was important to have and build in checks about study criteria and knowledge base. In this case, the LGB-CSI yielded an unsurprising, but critical, result that confirms who this sample is and strengthens the case for their expertise, both individually and as a group.

**Recommended LGB-Affirmative Supervision Resources**

A great deal of interesting and valuable information was learned from participant contributions on the background questionnaire from items intended to both help describe who participants were and to get an idea of LGB-affirmativeness. Clinical supervisors were asked if they had read APA, ACA, and or other professional guidelines regarding work with LGB clients and to check all that apply. Space was allotted to name other guidelines that they were familiar with or use. All 26 participants endorsed familiarity with at least one set of professional guidelines. Out of the 26 total participants, 21 (N = 21; 81%) endorsed familiarity with the APA
guidelines and 11 (N = 11; 42.3%) the ACA guidelines. There were 2 participants (N = 2; 7.7%) that also endorsed using ‘Other’ guidelines, both citing the World Professional Association for Transgender Health (WPATH) Standards of Care (2012).

Participants were also asked to briefly describe any helpful or favorite LGB-affirmative resource(s) that they either use themselves or recommend to clients. Out of 26 participants, 18 (N = 18; 69.2%) chose to answer the question, offering at least one resource. The range of responses was 1 to 7 items, with 2 (M = 2.61; SD = 1.69) being the most common number of resources offered. Types of resources shared included websites/online resources, books, journal articles, LGB-affirmative campus offices and/or resource centers, the Gender Unicorn activity, minority stress models, and TED Talks (Appendix M). Four participants (N = 4; 22.2%) each identified the websites for these large, widely known LGB-affirmative organizations: The Trevor Project, Human Rights Campaign, and PFLAG. Additionally, 2 participants (N = 2; 11.1%) used this space to emphasize finding the APA’s latest Guidelines for Psychological Practice with Sexual Minority Persons (2021) to be particularly helpful, one describing them as “broad, intersectional, up-to-date, and strengths focused.”

**The Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure: Recommended LGB-Affirmative Supervision Practices**

As mentioned prior, the qualitative approach—a thematic analysis more specifically—used to create Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure will be elaborated on here in detail. This is important for multiple reasons. Not only does this allow for transparency of the researcher review process, but ultimately the items that were developed answer the first research question for the study: How do clinical supervisors with knowledge of LGB issues and people implement LGB-affirmative clinical supervision? Thus, the items that were derived through analysis of the Part 1 data matter very much.
On Part 1 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, each participant was asked to write a minimum of three items describing their top three ways of providing LGB-affirmative supervision to trainees. A total of 26 participants completed Part 1 of the measure, meaning that a minimum of 78 items would be submitted. However, 10 out of the 26 participants ($N = 10; 38.5\%$) opted to contribute additional items beyond the minimum requirement of three in the space that was allotted. The range of responses for all 26 participants was 3 to 8 items, with 3 ($M = 3.85; SD = 1.38$) being the most common number of responses submitted. A grand total of 100 items were submitted for researcher review by these 26 participants on Part 1 of the measure.

For the thematic analysis, all 100 participant-generated items were recorded onto notecards to assist with immersion in the data. Item notecards were read and re-read while thinking about the core ideas, then sorted and resorted into piles of similar ideas and categories. Categories were used as a means of identifying themes and sorting this large number of individual ideas into distinct groups. At 17 categories, the researcher could no longer break the items down any more distinctly. Within each category, one of the participant items was chosen as the most representative and then questions were posed about whether or not that item needed to be edited to better capture any of the other items and/or the category as a whole.

Consistent with rigorous qualitative research procedures, the categories/themes and representative items identified by the researcher were also reviewed by multiple auditors. The doctoral advisor served as an internal auditor and two professional psychologists familiar with qualitative research procedures served as external auditors. Nuanced conversations with auditors assisted with tightening language, as well as distinguishing and validating categories. Auditors were asked if they could see the categories, if they would change any of the names, if any items
seemed misplaced, if there was a category missing, or if any categories should be collapsed. Feedback from conversations with auditors allowed for category names and final representative items from each category to be refined. In the end, 18 items from 17 categories (see Table 4 below) comprised the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure: Part 2 (Appendix C). These 18 items are listed together at the start of this measure with a statement about how they are the items that were developed to represent the phrases that participants used to collectively explain LGB-affirmative clinical supervision during Part 1 of the study. The task for Part 2 of the study was to indicate the degree of similarity among items by comparing every LGB-affirmative clinical supervision item to each of the others using a 6-point Likert scale (1 = extremely similar; 6 = extremely dissimilar). These similarity ratings serve as the data for MDS and cluster analyses as detailed below.

Table 4

*Thematic Analysis Results: Final LGB-Affirmative Clinical Supervision Categories and Items*

<table>
<thead>
<tr>
<th>Category</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>LGB Beliefs, Attitudes, &amp; Biases</strong></td>
</tr>
<tr>
<td></td>
<td>Item 1: Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual orientations</td>
</tr>
<tr>
<td>2</td>
<td><strong>LGB Clinical Issues</strong></td>
</tr>
<tr>
<td></td>
<td>Item 2: Demonstrate understanding of common LGB clinical issues</td>
</tr>
<tr>
<td>3</td>
<td><strong>Provide LGB-Affirmative Resources</strong></td>
</tr>
<tr>
<td></td>
<td>Item 3: Provide LGB-affirmative resources</td>
</tr>
<tr>
<td>4</td>
<td><strong>LGB-Affirmative Therapeutic Practices</strong></td>
</tr>
<tr>
<td></td>
<td>Item 4: Teach LGB-affirmative therapeutic practices</td>
</tr>
<tr>
<td>5</td>
<td><strong>Open Identity Discussions</strong></td>
</tr>
<tr>
<td></td>
<td>Item 5: Initiate open discussions about identities in supervision</td>
</tr>
<tr>
<td></td>
<td>Item 6: Encourage open discussions about identities in therapy</td>
</tr>
<tr>
<td>6</td>
<td><strong>Inclusive Language</strong></td>
</tr>
<tr>
<td></td>
<td>Item 7: Use affirmative and inclusive language</td>
</tr>
</tbody>
</table>
Table 4 – continued

Category 7: Evaluating Awareness, Knowledge, & Skill with LGB Issues & Clients
Item 8: Gauge supervisee awareness, knowledge, and skill with LGB issues and clients

Category 8: Training Environment
Item 9: Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings

Category 9: Supervisory Relationship
Item 10: Create a supportive, honest, and LGB-affirming supervisory relationship

Category 10: Discerning Quality, Affirming LGB Literature & Research
Item 11: Assist with finding and reviewing reliable LGB-affirmative literature and research

Category 11: Vulnerability and Self-Disclosure
Item 12: Model vulnerability and appropriate self-disclosure of sexual orientation

Category 12: Transference & Countertransference
Item 13: Address transference and countertransference

Category 13: Microaggressions & Systemic Oppression
Item 14: Discuss microaggressions and other experiences of oppression

Category 14: Normalization of Diverse Sexual & Gender Orientations/Identities
Item 15: Model openness and normalize any/all topics related to gender/sexuality

Category 15: Minority Stress Experiences
Item 16: Consider and validate minority stress experiences

Category 16: Education on LGB Experiences & Oppressions
Item 17: Provide education on common LGBTQ+ identities, experiences, and oppressions

Category 17: Processing & Exploring Identities
Item 18: Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision

Dimensions of LGB-Affirmative Clinical Supervision

In this investigation, dimensions of LGB-affirmative clinical supervision were examined based on responses to the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure. The purpose of this measure was to explore how experienced clinical supervisors with
knowledge of LGB issues and people were providing LGB-affirmative supervision to trainees. The measure was created for the purposes of this study because there is currently no adequate questionnaire measuring the specific components of LGB-affirmative clinical supervision. In particular, this questionnaire directs participants to indicate the degree of similarity (Part 2) among 18 participant-generated items related to LGB-affirmative clinical supervision (Part 1); each statement is compared to every other statement using a 6-point Likert scale (1 indicating extremely similar and 6 indicating extremely dissimilar). Items rated similarly might be fundamentally the same or indicative of overlap, while those rated as dissimilar identified unique components of supervision. These ratings were analyzed using multidimensional scaling, then further examined with cluster analysis. This section presents the results of these analyses, which answer the second research question: What are the conceptual dimensions that underlie LGB-affirmative supervision?

Multidimensional scaling (MDS) is an analysis that seeks to discover underlying dimensions of a construct through the analysis of similarity (or dissimilarity) ratings (Young & Hamer, 1987). In this study, the statistical tool PROXSCAL was chosen as the analytical tool for several reasons: it provides the decomposition of normalized stress for individuals and provides a representation of the proximity data in the common space for both the total group and for individuals. Normalized stress is a preferred goodness-of-fit measure because “it’s value is independent of the scale and the number of dissimilarities” (Groenen & van de Velden, 2004, p. 11). Inclusion of both group and individual proximity data allows for exploration of how various aspects of participants’ identity might be related to their conceptualization of LGB-affirmative clinical supervision.
One-, two-, three-, and four-dimensional MDS models were run and examined to determine the best model fit for this data set (see Table 5). As a rule, the number of dimensions to items ratio is $1 > 4$ (Kruskal & Wish, 1978), thus no more than 4 dimensions were explored with the 18 items available. In the current investigation, the 18 participant-developed items were enough to support one-, two-, three-, and/or four-dimension solutions. Additional statistics were used to determine interpretability of dimensions. The statistics used to determine the best model fit for this sample were goodness-of-fit measures: normalized raw stress and dispersion accounted for (DAF), which provides a measure of the variance accounted for and is derived from normalized raw stress. For MDS analysis, the ideal normalized raw stress score is as close to .02 as possible, while the desired dispersion accounted for is ideally as close to 1.0 as possible.

**Table 5**

*Comparison of Multidimensional Scaling (MDS) Models*

<table>
<thead>
<tr>
<th>MDS Model</th>
<th>Normalized Raw Stress</th>
<th>Dispersion Accounted For</th>
</tr>
</thead>
<tbody>
<tr>
<td>One dimension</td>
<td>.17</td>
<td>.83</td>
</tr>
<tr>
<td>Two dimensions</td>
<td>.07</td>
<td>.93</td>
</tr>
<tr>
<td>Three dimensions</td>
<td>.04</td>
<td>.96</td>
</tr>
<tr>
<td>Four dimensions</td>
<td>.03</td>
<td>.97</td>
</tr>
</tbody>
</table>

The four-dimensional solution was chosen as the model to interpret based on a review of goodness-of-fit and interpretability. In comparing goodness-of-fit between models, the four-dimensional model accounted for more variance and yielded lower stress than the three-dimensional solution. The four-dimensional model also provided additional, unique information to help understand how this group of clinical supervisors understands the underlying dimensions of LGB-affirmative supervision as it added the fourth ‘supervisor process’ dimension, which was
distinct from the first three dimensions. It was critically important to include the fourth dimension as it is the dimension that speaks to providing an atmosphere of safety, depth of dialogue, and frequent opportunities to discuss cultural variables in the supervisory relationship, which significantly contributes to alliance building and increased satisfaction (Gatmon et al., 2001). Lastly, the normalized raw stress for the four-dimensional solution was below .05—indeed it approached the .02 ideal value—indicating a better fit than the other possible solutions (0 being the best possible fit) (Stalans, 2005).

After determining model fit, the meaning of the dimensions for the full participants group was determined through an analysis of the group common space (see Figure 1).

**Figure 1**

*Multidimensional Scaling Group Spatial Representation of Dimensions*
The common space provides a visual representation to interpret dimensions. Initial understanding of each of the four dimensions can be gained by examining the placement of specific Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure items in space. The items at each end of a dimension serve to anchor the dimension and aid in the interpretability of it. Furthermore, the items at opposite ends of a dimension represent ideas that contrast with one another and are useful in further understanding the construct underlying the dimension. In addition to the spatial representation, the group dimension weights provided additional information to the interpretation of the dimensions and verified the end anchors of each dimension (see Table 6). Taken together, the dimension weights and spatial representation portray the relationship among the individual items. All possible combinations of two dimensions are represented in the figure, and the combination of these pairs provides the full, four-dimensional picture.

Table 6

*Multidimensional Scaling Group Dimension Weights*

<table>
<thead>
<tr>
<th>Item</th>
<th>Dimension 1</th>
<th>Dimension 2</th>
<th>Dimension 3</th>
<th>Dimension 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item1</td>
<td>.69</td>
<td>-1.44</td>
<td>-1.16</td>
<td>.41</td>
</tr>
<tr>
<td>Item2</td>
<td>-1.42</td>
<td>.30</td>
<td>.20</td>
<td>1.45</td>
</tr>
<tr>
<td>Item3</td>
<td>-.22</td>
<td>.40</td>
<td>2.28</td>
<td>.12</td>
</tr>
<tr>
<td>Item4</td>
<td>-1.32</td>
<td>.53</td>
<td>.80</td>
<td>-.59</td>
</tr>
<tr>
<td>Item5</td>
<td>-.40</td>
<td>-.98</td>
<td>-.91</td>
<td>-1.27</td>
</tr>
<tr>
<td>Item6</td>
<td>-.88</td>
<td>-1.46</td>
<td>-.77</td>
<td>-.04</td>
</tr>
<tr>
<td>Item7</td>
<td>-1.81</td>
<td>-.76</td>
<td>.70</td>
<td>-.62</td>
</tr>
</tbody>
</table>
Table 6 – continued

<table>
<thead>
<tr>
<th>Item</th>
<th>.09</th>
<th>-.31</th>
<th>.37</th>
<th>2.31</th>
</tr>
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<tbody>
<tr>
<td>Item9</td>
<td>1.04</td>
<td>1.20</td>
<td>-.95</td>
<td>-.85</td>
</tr>
<tr>
<td>Item10</td>
<td>.90</td>
<td>-.10</td>
<td>.76</td>
<td>-1.16</td>
</tr>
<tr>
<td>Item11</td>
<td>-.41</td>
<td>2.09</td>
<td>.67</td>
<td>-.41</td>
</tr>
<tr>
<td>Item12</td>
<td>.85</td>
<td>-.54</td>
<td>-.80</td>
<td>-1.71</td>
</tr>
<tr>
<td>Item13</td>
<td>2.18</td>
<td>-.48</td>
<td>.13</td>
<td>.16</td>
</tr>
<tr>
<td>Item14</td>
<td>-.71</td>
<td>.65</td>
<td>-1.14</td>
<td>.92</td>
</tr>
<tr>
<td>Item15</td>
<td>.36</td>
<td>-1.40</td>
<td>.89</td>
<td>-.46</td>
</tr>
<tr>
<td>Item16</td>
<td>-.33</td>
<td>.88</td>
<td>-1.62</td>
<td>-.12</td>
</tr>
<tr>
<td>Item17</td>
<td>.29</td>
<td>1.46</td>
<td>1.09</td>
<td>.78</td>
</tr>
<tr>
<td>Item18</td>
<td>1.08</td>
<td>-.05</td>
<td>-.54</td>
<td>1.08</td>
</tr>
</tbody>
</table>

Note. Item 1-18 = Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure items

The first dimension has a single item anchoring it on each end of the continuum. At one end of the continuum is the following anchor item: Use affirmative and inclusive language (Item 7). On the other end of the continuum is the following item: Address transference and countertransference (Item 13). The second dimension is anchored on one end of the continuum with one item: Encourage open discussions about identities in therapy (Item 6). There is one item that anchors the opposite end of this dimension: Assist with finding and reviewing reliable LGB-affirmative literature and research (Item 11). The third dimension also has a single item anchoring it on each end of the continuum: Provide LGB-affirmative resources (Item 3) at one end and consider and validate minority stress experiences (Item 16) at the other end. Finally, the fourth dimension has single items anchoring it on either end of the continuum: Gauge supervisee
awareness, knowledge, and skill with LGB issues and clients (Item 8) at one end and model vulnerability and appropriate self-disclosure of sexual orientation (Item 12) at the other end.

In sum, once the number of dimensions was determined, the next step was interpretation of those dimensions. This was a planned two-task process. The first was to examine the extreme items, which are listed above, and the second was the cluster analysis, which would assist with understanding how dimensions were defined and meaningful, as well as ultimately help to name the dimensions. In the initial look, the end points were examined to see if they made conceptual sense and they did appear to fit some meaning of supervision. However, it was apparent that some dimensions were easier to start making sense of than others. Dimension 1, for example, clearly exemplified a process dimension of supervision, Dimension 2 a ‘learning and understanding’ dimension, and Dimension 4 a ‘roles of the supervisor/supervisor actions’ dimension. As expected, the cluster analysis helped gain a more nuanced understanding of item relatedness in the common space, helping develop a more meaningful picture of the dimensions. These ideas helped to create a fuller picture of how this sample of clinical supervisors conceptualizes LGB-affirmative supervision.

Cluster Analysis

Cluster analysis was also performed in SPSS as the planned follow-up to MDS. A hierarchical clustering approach, specifically Ward’s method, was chosen due to the lack of prior knowledge about the likely number of clusters. Ward’s minimum-variance method is a popular hierarchical clustering technique with a long-held reputation for being one of the best available due to its strength (Arabie, Carroll, & DeSarbo, 1987).

To understand SPSS cluster analysis results, Ward’s Linkage output was examined using two different lenses: a dendrogram where jumps in distance between items can be seen visually
and an agglomeration schedule where jumps in distance between items can be seen numerically. Identification of the number of clusters suggested by participant item similarity ratings was based on examination of the plot of the number of clusters (see Figure 2 below) and confirmed by examining the agglomeration schedule fusion coefficients (see Table 7 below), which provides a technique for identifying the stage(s) in the development of clusters that result in a large jump in the fusion coefficient (Aldenderfer & Blashfield, 1984). This examination is similar to that of a scree test in factor analysis and consists of looking for points in the plot of number of clusters where fusion coefficients change drastically. Cluster analysis results indicated 7 clusters.

**Figure 2**

*Dendrogram Using Ward Linkage Illustrating Clusters*
After identifying the 7 clusters of items, the 4-dimensional MDS solution was revisited, including determining which dimension and which ends of the continuum on that dimension were associated with each cluster. Additionally, it proved helpful to take a closer look at the object points (items) in common space shown above in Figure 1 and to physically draw each dimension, circling item clusters on either end. This process is further described and illustrated (see Figures 3 through 8) in the discussion chapter. These clusters added invaluable information regarding dimension interpretation.

**Final Description of Dimensions**

The first dimension is about awareness—how you find it and how you show it. This dimension is anchored on one end by Item 13 (Address transference and countertransference) with Item 1 (Model and encourage supervisee exploration of beliefs, attitudes, and biases about
LGB sexual orientations) and Item 18 (Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision) clustering nearby. On the other end of the continuum is Item 7 (Use affirmative and inclusive language) with Item 4 (Teach LGB-affirmative therapeutic practices) clustering closest. Awareness is about knowledge of self as indicated by these items that clustered together showing both process and reflection, but on a specific thing. This dimension speaks to the work that you have to do to be a good therapist to LGB clients.

The second dimension focuses on learning and understanding about LGB issues and clients. It is anchored on one end of the continuum with Item 11 (Assist with finding and reviewing reliable LGB-affirmative literature and research), which clustered with Item 17 (Provide education on common LGBTQ+ identities, experiences, and oppressions). On the other end of the continuum is Item 6 (Encourage open discussions about identities in therapy), which clustered with Item 5 (Initiate open discussions about LGB-identities in supervision). Taking this dimension in its entirety, it focuses on how knowledge of others is developed. Out of all of the dimensions, this was the clearest prior to conducting the cluster analysis.

The third dimension is about specific skills and knowledge, focusing on teaching supervisees about what they need to know. It is anchored at one end of the continuum by Item 3 (Provide LGB-affirmative resources). There is one anchor on the other of the continuum as well, Item 16 (Consider and validate minority stress experiences), which clusters with Item 14 (Discuss microaggressions and other experiences of oppression). At first glance, one might wonder how distinguished Dimensions 2 and 3 are because, on the surface, this is another knowledge dimension. However, Dimension 3 pulls away from 2 because it is specific. Dimension 2 focuses on understanding identities people may hold while Dimension 3 focuses on
understanding experiences of holding a minoritized identity. This is the active LGB-affirmative dimension where one would learn about taking an LGB-affirmative stance.

The fourth dimension is about the process of LGB-affirmative supervision, and more specifically the relational process of supervision. On one end of the continuum was Item 8 (Gauge supervisee awareness, knowledge, and skill with LGB issues and clients), which clustered with Item 2 (Demonstrate understanding of common LGB clinical issues). On the other end of the continuum was Item 12 (Model vulnerability and appropriate self-disclosure of sexual orientation), which clustered with Item 10 (Create a supportive, honest, and LGB-affirming supervisory relationship), Item 15 (Model openness and normalize any/all topics related to gender/sexuality), and Item 9 (Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings). This cluster of four items is a relational process of supervision cluster, particularly for developing LGB-affirmative therapists. This is also a unique dimension in that it addresses training and supervision as the primary training vehicle, a point emphasized throughout this study. It focuses on the supervisor and the supervisor’s process while encompassing competence, climate, and assessment.

Taken together, the four dimensions illustrate the distinctions that these clinical supervisors make involving the construct of LGB-affirmative supervision. These dimensions provide a nuanced understanding of LGB-affirmative supervision, and ultimately answer the second research question for the study: What are the conceptual dimensions that underlie LGB-affirmative supervision? Through an analysis of the dimensions using both MDS and cluster analysis results, it appears they are separating out aspects of LGB-affirmative clinical supervision based on subtle, yet impactful differences: awareness, understanding LGBTQ+ identities, learning about minority identity experiences, and the relational process of supervision.
The first three dimensions are focused on the supervisee. The supervisor is a part of it, of course, but they are much more about the development of awareness, knowledge, and skills within the supervisee. The fourth dimension is about the supervisor and how the supervisor uses themselves as a tool in the supervision process.

The results discussed in this chapter indicate that this sample of experienced clinical supervisors have had a variety of LGB-affirmative supervision experiences. They identified eighteen nuanced aspects of LGB-affirmative clinical supervision that help us to understand their conceptualizations of LGB-affirmative clinical supervision. Using these conceptualizations, four dimensions of LGB-affirmative clinical supervision were identified. The following chapter discusses the results, what was learned about the research questions and other important takeaways, implications for future research and practice, as well as the limitations of the current investigation.
CHAPTER IV
DISCUSSION

The current study explored the underlying dimensions of LGB-affirmative clinical supervision as provided to trainees by clinical supervisors with knowledge of LGB issues and people. Achieving this objective first required learning about how experienced clinical supervisors were engaging in LGB-affirmative supervision with trainees. Two research questions were addressed as part of this investigation. The first two sections of this chapter provide a discussion of the current research findings in the context of the two research questions and highlight other important takeaways, while also addressing connections the findings have to previous literature and research. The next two sections provide a discussion of implications for future supervision practice and training, as well as future research. Limits of the current investigation and a conclusion are provided at the end of the chapter.

A Return to the Research Questions

The current study addressed the following two research questions: How do clinical supervisors with knowledge of LGB issues and people implement LGB-affirmative clinical supervision? What are the conceptual dimensions that underlie LGB-affirmative clinical supervision?

A Model of LGB-Affirmative Clinical Supervision

The two-part Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure was created at the onset of the study because no adequate questionnaire measuring the specific components of LGB-affirmative clinical supervision was available. On Part 1 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, clinical supervisor participants were asked to submit items describing ways that they were providing LGB-affirmative supervision to trainees. After a thorough review process and thematic analysis to identify
categories, 18 items were chosen, merged, or further developed to represent what participants collectively used to describe LGB-affirmative clinical supervision on Part 2 of the measure. After data collection ended and results were analyzed, the true significance of the items emerged. These 18 items answered the first research question: How do clinical supervisors with knowledge of LGB issues and people implement LGB-affirmative clinical supervision?

Not only was the first research question answered by this final list, but these 18 items could make a succinct and practical model of LGB-affirmative supervision (see Table 8 below). This model could be used as a training tool by supervisors to develop and enrich their own LGB-affirmative practice, or to teach LGB-affirmative practice to new supervisors. Recall the Integrative Affirmative Supervision (IAS) model (Halpert et al., 2007) that combined four supervision models (Bruss et al., 1997; Buhrke, 1989; House & Holloway, 1992; Pett, 2000) to create the most comprehensive and inclusive LGB-affirmative supervision model at the time. The IAS model contained three core conditions that helped to solidify the success and usefulness of the model: safety, respect, and empowerment (Halpert et al., 2007). The Model of LGB-Affirmative Supervision developed in this study embodies those core conditions.

Table 8

*Model of LGB-Affirmative Clinical Supervision*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual orientations</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate understanding of common LGB clinical issues</td>
</tr>
<tr>
<td>3.</td>
<td>Provide LGB-affirmative resources</td>
</tr>
<tr>
<td>4.</td>
<td>Teach LGB-affirmative therapeutic practices</td>
</tr>
<tr>
<td>5.</td>
<td>Initiate open discussions about identities in supervision</td>
</tr>
<tr>
<td>6.</td>
<td>Encourage open discussions about identities in therapy</td>
</tr>
<tr>
<td>7.</td>
<td>Use affirmative and inclusive language</td>
</tr>
<tr>
<td>8.</td>
<td>Gauge supervisee awareness, knowledge, and skill with LGB issues and clients</td>
</tr>
</tbody>
</table>
As previously stated, a core purpose of this study was to identify concrete actions to take in order to provide LGB-affirmative supervision. The presentation of the 18 participant-developed items and of the discovered underlying dimensions are an important step in this direction. In order to make the actions supervisors are recommending even more explicit and concrete, the original 100 items that were written by participants and collapsed into the 18 core items were revisited for additional strategies for accomplishing those core items. Recall that the final 18 items were developed by choosing a representative item and then combining it with other items or tweaking the language to better capture other participant contributions. During the review of the categories, only certain items offered additional clearly distinct actions that were not captured in the original items (Table 9). To see a complete list of the 100 participant items used to develop the 18 measure items, see Appendix N.

**Table 9**

*Additional Concrete LGB-Affirmative Supervision Action Items from Participants*

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Model Item 1: Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB orientations
Table 9 – continued

- Provide active monitoring of services being provided by supervisees to LGB clients to help ensure that supervisee biases are being managed and harm is mitigated
- Discuss personal experiences that would help/hinder a supervisee’s ability to work with a client that is LGBTQ+ in order to “open the door” regarding the supervisee’s sexual orientation and/or give additional information needed to protect LGBTQ+ clients working with the supervisee
- Challenge supervisee assumptions regarding gender, identity, and orientation when appropriate

Model Item 4: Teach LGB-affirmative therapeutic practices
- Challenge supervisee to integrate LGB issues into client conceptualizations

Model Item 7: Use affirmative and inclusive language
- Ask about supervisee and their clients’ pronouns and share mine

Model Item 8: Gauge supervisee awareness, knowledge, and skill with LGB issues and clients
- Inquire about client orientation and how it is known, or assumed

Model Item 9: Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings
- Respond with open acceptance of topics when they come up
- Be open to feedback and adapting supervision as necessary to meet the needs of supervisees

Model Item 10: Create a supportive, honest, and LGB-affirming supervisory relationship
- Define/negotiate supervision roles and expectations
- Address concerns, reservations, and qualms of both the supervisee and supervisor
- Model self-acceptance and encourage the same in student therapists
- Admit to my own areas of ignorance and actively engage in self-correction

Model Item 16: Consider and validate minority stress experiences
- Help supervisee critically analyze the effects of minority stress on client’s life

Model Item 18: Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision
- Ask new supervisees to describe themselves using the ADDRESSING Model (Hays, 2001) and disclose my own identities in this conversation

Additionally, this study could not have had a better and more appropriate group of participants driving its creation, particularly in the context of gaps in the literature which will be
revisited in the next section. As a reminder, the criteria for participation in this study was 5 or more years of clinical supervision experience and identifying as knowledgeable about LGB issues and people. Although participants self-selected into the study, inclusion criteria were cross-checked with participant responses on the background questionnaire and scores on the LGB-CSI. The range of years of clinical supervision experience for participants was 4 to 52 years (M = 12.94; SD = 10.29). Recall that HSIRB granted an exception for one participant with 4 years of clinical supervision experience at the time of initial data collection to be included due to illustrated LGB-affirmativeness and richness of items contributed. Regarding years of experience with LGB issues, the reported range for participants was 5 to 60 years (M = 18.85; SD = 11.57).

The way that this group of participants responded on the LGB-CSI, the self-report measure regarding self-efficacy to perform LGB-affirmative counseling behaviors, can also be examined. The published mean for the LGB-CSI is 151.21 with a standard deviation of 36.45 (Dillon & Worthington, 2003), while the mean for this participant sample was 161.96 with a standard deviation of 19.24. Thus, this sample of self-identifying LGB knowledgeable, experienced clinical supervisors had a higher average score and less variation in scores than the published descriptive statistics from the scale developers. Translating the sample mean to item level metric, the average item score for this sample was 5.06 out of 6.00, indicating confidence in the ability to perform LGB-affirmative counseling behaviors. Dillon and Worthington (2003), who created the LGB-CSI, wrote that self-identified LGB-affirmative clinicians may hold higher levels of interest in LGB-affirmative practice and more optimistic outcome expectations regarding LGB-affirmative counseling and/or supervision, thereby influencing their self-efficacy in these areas. Dillon and Worthington (2003) went on to say that it is also likely that self-
identified LGB individuals on average are more efficacious in providing LGB-affirmative services because of membership in the target group, as well as because of their participation in activities that foster self-efficacy in this area. Indeed, on the sexual orientation identity variable on the background questionnaire, where instructions said check all that apply, more labels under the LGB umbrella were endorsed by this group of participants (N = 23; 67.7%) versus heterosexual or asexual. The group diversity in terms of sexual identity likely supported their LGB-affirmative counseling efficacy. Inclusion of heterosexual identified clinical supervisors as participants is also critical as LGB-affirmative supervision should be provided by all supervisors.

There were other ways that this group of participants stood out. All 26 participants endorsed familiarity with at least one set of professional guidelines for working with LGB clients. Out of the 26 total participants, 21 (N = 21; 81%) endorsed familiarity with the APA guidelines and 11 (N = 11; 42.3%) the ACA guidelines. There were 2 participants (N = 2; 7.7%) that also endorsed using ‘Other’ guidelines, both citing the World Professional Association for Transgender Health (WPATH) Standards of Care (2012). A data scan was done for any potential correspondence between which guidelines were endorsed and the expected professional organization home based on specific professional degrees. The majority of study participants had doctoral level degrees (N = 20; 77%) in either counseling psychology or clinical psychology and, thus, it was unsurprising to find that all of those participants endorsed familiarity with APA guidelines. Additionally, 5 out of the 6 participants with master’s level degrees endorsed familiarity with ACA guidelines—the one exception endorsing a counseling psychology background versus counseling. Lastly, participants were optionally asked to briefly describe any helpful or favorite LGB-affirmative resources that they either use themselves or recommend to
clients and 18 (69.2%) chose to do so. Appendix M is a compilation of these recommendations and includes websites/online resources, books, journal articles, activities, models, and more.

In addition to a strong sample of experienced LGB-affirmative clinical supervisors driving the creation of this model (Table 8), core concepts from this developed Model of LGB-Affirmative Clinical Supervision also overlap with core concepts from LGB-affirmative therapy that were discussed in the chapter one literature review. LGB-affirmative therapy speaks to therapists needing to examine their own feelings, attitudes, and biases toward LGB individuals (Clark, 1987), which is in line with Model Item 1 (Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual minorities). LGB-affirmative therapy requires an increase in knowledge about sexual minority clients, which is complementary to Model Item 17 (Provide education on common LGBTQ+ identities, experiences, and oppressions) (Long, 1996; Pachankis & Goldfried, 2004). LGB-affirmative therapy stresses helping clients become aware of how oppression has affected them, which is similar to Model Items 14 and 16 (Discuss microaggressions and other experiences of oppression; Consider and validate minority stress experiences) (Clark 1987; Shannon & Woods, 1991). Lastly, LGB-affirmative therapy celebrates and advocates the authenticity and integrity of LGB persons and their relationships, which complements Model Items 10 and 15 (Create a supportive, honest, and LGB-affirming supervisory relationship; Model openness and normalize any/all topics related to gender/sexuality) (Bieschke, 2000). Beyond these connections to LGB-affirmative therapy, the other items in the model are equally valuable, emphasizing important supervisor actions. For example, teaching, modeling, and assessing are all critical aspects of supervision, as is developing an effective supervisory relationship.
**LGB-Affirmative Clinical Supervision Dimensions**

At the onset of the study, there was no anticipation about arriving at the end with a model of LGB-affirmative clinical supervision. There was, however, an expectation of uncovering the underlying dimensions of the clinical supervision being conducted by a group of experienced and LGB-affirmative clinical supervisors. The idea for the study was born from this researcher’s own experiences as a student with inconsistent training in LGB issues, knowing the great benefits of elective courses, special trainings, mentorship, and above all, invaluable supervision that helped shape the clinician that exists today. No memories of key supervisors sharing models of LGB-affirmative clinical supervision can be recalled, yet it was clear that those supervisors were LGB-affirmative in practice and in the space that was shared. This researcher can remember consulting guidelines, sharing resources, going over handouts, processing client sessions, discussing clinical issues, and getting to know one another. It is interesting to think about what those past influential supervisors might say if asked about how they were integrating LGB-affirmative practice into their styles of clinical supervision.

The primary purpose of this study was to explore the underlying dimensions of LGB-affirmative clinical supervision as provided to trainees by clinical supervisors with knowledge of LGB issues and people, and once again, the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure provided the data of central interest. On Part 2 of this paired comparison measure, participants submitted similarity ratings for each pairing of the 18 participant-developed items describing LGB-affirmative clinical supervision (Part 1) using a 6-point Likert scale (1 indicating extremely similar and 6 indicating extremely dissimilar). Items rated similarly might be viewed as fundamentally the same or be indicative of overlap, while those rated as dissimilar identified unique components of supervision. One-, two-, three-, and four-dimensional
MDS models were run and examined and the four-dimensional solution was determined to be the best model fit for this data set.

Interpreting the meaning of these dimensions required analysis of the group common space. Each of the four dimensions could be examined by viewing the placement of measure items in space. The items at either end of a dimension serve as an anchor for that dimension and aid in interpretation, as items at the opposite ends represent contrasting ideas. A follow-up cluster analysis was conducted to help gain a more nuanced understanding of item relatedness in the common space. Cluster analysis findings were integrated with MDS findings by physically drawing each dimension based on the anchor items and circling item clusters at the ends of each of 4 dimensions (see Figures 3 through 8).

**Figure 3**

*4D Solution Items in Common Space: Dimension 1 x Dimension 2*
Figure 4

4D Solution Items in Common Space: Dimension 1 x Dimension 3

Figure 5

4D Solution Items in Common Space: Dimension 2 x Dimension 3
Figure 6

4D Solution Items in Common Space: Dimension 1 x Dimension 4

Figure 7

4D Solution Items in Common Space: Dimension 2 x Dimension 4
MDS and cluster analysis provide tools for seeing the underlying structure of objects in space. These figures provide visual representation of the four dimensions, and the clusters that go along with each dimension. This provides invaluable information regarding interpretation that helps to create a fuller picture of how this sample of clinical supervisors conceptualized LGB-affirmative supervision.

Like with Part 1 data, a lot of time was spent with these items, thinking and reflecting. This researcher thought about the items on the opposite ends of the dimensions and what they had in common, even as contrasting items. Item clusters and how they went together were examined. All the various aspects of supervision and how those might be organized into constructs or categories were pondered through an LGB-affirmative lens. These four dimensions provide a nuanced understanding of LGB-affirmative supervision, and ultimately answer the second research question for the study: What are the conceptual dimensions that underlie LGB-
affirmative supervision? Through an analysis of the dimensions, it seems as though these clinical supervisors are separating out aspects of LGB-affirmative clinical supervision based on subtle, yet impactful differences: Awareness, Understanding LGBTQ+ Identities, Learning about Minority Identity Experiences, and the Relational Process of Supervision (see Table 10). The first three dimensions are focused on the supervisees and the development of awareness, knowledge, and skills within the supervisee, while the fourth dimension is about the supervisor and how the supervisor uses themselves as a tool in the supervision process. Again, these dimensions complement some core LGB-affirmative therapy concepts discussed previously that address exploring and understanding feelings, attitudes, and biases (Awareness), increasing knowledge about sexual minority clients (Understanding LGBTQ+ Identities), exploring and validating minority stress experiences and oppressions (Learning about Minority Identity Experiences) and demonstrating understanding of and normalizing any/all topics related to sexuality (Relational Process of Supervision) (Clark, 1987; Leslie, 1995; Long, 1996; Pachankis & Goldfried, 2004; Shannon & Woods, 1991).

Table 10

LGB-Affirmative Clinical Supervision Dimensions

<table>
<thead>
<tr>
<th>Dimension 1: Awareness</th>
</tr>
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<tbody>
<tr>
<td>Item 13 ←------------------→ Item 7</td>
</tr>
<tr>
<td>Address transference &amp; countertransference</td>
</tr>
<tr>
<td>Cluster: Items 1, 18, 13</td>
</tr>
<tr>
<td>Model &amp; encourage supervisee exploration of beliefs, attitudes, &amp; biases about LGB sexual orientations</td>
</tr>
<tr>
<td>Encourage thoughtful, intersectional discussions about identities &amp; how those impact clinical work</td>
</tr>
</tbody>
</table>
Table 10 – continued

& supervision

Address transference & countertransference

**Dimension 2: Understanding LGBTQ+ Identities**

Item 11 \(\leftarrow\) Item 6

<table>
<thead>
<tr>
<th>Assist w/ finding &amp; reviewing reliable LGB-affirmative literature &amp; research</th>
<th>Encourage open discussions about identities in therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster: Items 11, 17</td>
<td>Cluster: Items 5, 6</td>
</tr>
<tr>
<td>Assist w/ finding &amp; reviewing reliable affirmative literature &amp; research</td>
<td>Initiate open discussions about LGB-identities in supervision</td>
</tr>
<tr>
<td>Provide education on common LGBTQ+ identities, experiences, &amp; oppressions</td>
<td>Encourage open discussions about identities in therapy</td>
</tr>
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</table>

**Dimension 3: Learning about Minority Identity Experiences**

Item 3 \(\leftarrow\) Item 16

<table>
<thead>
<tr>
<th>Provide LGB-affirmative resources</th>
<th>Consider &amp; validate minority stress experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster: Item 3</td>
<td>Cluster: Items 14, 16</td>
</tr>
<tr>
<td>Provide LGB-affirmative resources</td>
<td>Discuss microaggressions &amp; other experiences of oppression</td>
</tr>
<tr>
<td></td>
<td>Consider &amp; validate minority stress experiences</td>
</tr>
</tbody>
</table>

**Dimension 4: The Relational Process of Supervision**

Item 8 \(\leftarrow\) Item 12

<table>
<thead>
<tr>
<th>Gauge supervisee awareness, knowledge, &amp; skill w/ LGB issues &amp; clients</th>
<th>Model vulnerability &amp; appropriate self-disclosure of sexual orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster: Items 2, 8</td>
<td>Cluster: Items 10, 15, 12, 9</td>
</tr>
</tbody>
</table>
Table 10 – continued

<table>
<thead>
<tr>
<th>Demonstrate understanding of common LGB clinical issues</th>
<th>Create a supportive, honest, &amp; LGB-affirming supervisory relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauge supervisee awareness, knowledge, &amp; skill w/ LGB issues &amp; clients</td>
<td>Model openness &amp; normalize any/all topics related to gender/sexuality</td>
</tr>
<tr>
<td></td>
<td>Model vulnerability &amp; appropriate self-disclosure of sexual orientation</td>
</tr>
<tr>
<td></td>
<td>Advocate for a training environment that empowers supervisees to be heard, ask questions, &amp; process feelings</td>
</tr>
</tbody>
</table>

Dimension 1 is about awareness—how it is found and how it is shown. Awareness is about knowledge of self as indicated by items that clustered together showing both process and reflection, but about specific things. This dimension speaks to the personal work supervisees have to do to be good therapists to LGB clients. Dimension 2 focuses on learning and understanding about LGB issues and clients. It speaks to how supervisees develop knowledge of others. Dimension 3 is about specific skills and knowledge, focusing on teaching supervisees about what they need to know. There is some overlap between Dimensions 2 and 3; however, Dimension 3 pulls away from 2 because of its specificity. Dimension 2 focuses on understanding identities people may hold while Dimension 3 focuses on understanding experiences of holding a minoritized identity. The idea that people and their experiences need to be understood is not a new concept in the literature. The minority stress model highlights that minority identity is not harmful—rather poor treatment due to holding a minority identity is harmful. For example, Meyer (2003) said that feedback from others that is incompatible with one’s self-identity, a process called identity interruptions, can cause distress. Dimension 4 is about the relational process of supervision, particularly for developing LGB-affirmative therapists. This is also a unique
dimension in that it addresses supervision/the supervisor as the primary training vehicle, a point emphasized throughout this study (Bruss et al., 1997; Efstation et al., 1990; Murphy et al., 2002). It focuses on the supervisor and the supervisor’s process while encompassing competence, climate, and assessment. Taken together, these four dimensions illustrate distinctions that these clinical supervisors made about the construct of LGB-affirmative supervision.

A Place in the Literature

The present investigation expands upon prior research that had begun exploring LGB-affirmative supervision. Previous research in this area primarily addressed LGB training in graduate programs and LGB-affirmative therapy (Alderson, 2004; Anhalt et al., 2003; Bieschke et al., 2007; Israel, Gorcheva, Burnes et al., 2008; Pachankis & Goldfried, 2004; Phillips & Fischer, 1998; Sherry et al., 2005; Wiederman & Sansone, 1999). A review of the literature shows how graduate programs have continued to improve over time regarding incorporating training on LGB issues into coursework and practicum experiences with less emphasis on supervision. Since supervision is a major training arena where therapists have the potential to learn about clients and themselves, it becomes an important area for also teaching supervisees how to work with minority populations (Murphey et al., 2002; Bruss et al., 1997). However, relatively absent from discussions of cultural influences in supervision was a focus on LGB concerns (Bernard & Goodyear, 2004).

The APA (2021) has made it clear for years that providing LGB-affirming therapy is best practice, but how have clinical supervisors been incorporating LGB-affirmative practice into the supervision they provide? How are clinical supervisors imparting LGB-affirmative practice to the next generation of clinicians? Singh and Chun (2010) emphasized that the earliest LGB-affirmative models of LGB supervision, because of their atheoretical nature, were designed to be
“add-ons” and intended to be used in tandem with more traditional supervision models (Stoltenberg & Delworth, 1987) that were theoretically based—adding that a critique of these was that they were not straightforward in application (Bruss et al., 1997; Buhrke, 1989; Halpert et al., 2007; House & Holloway, 1992; Pett, 2000). If an extra step is created and you want people to stick with it, you better make it straightforward. Any kind of complication is a barrier to follow-through and in this case, the stakes are high. The Model of LGB-Affirmative Clinical Supervision developed in this study could supplement any of the mainstream supervision models.

Recall that the combination of Pett’s (2000) characteristics, the Burkard et al. (2009) definition, and two model adaptations (Bruss et al., 1997; Halpert et al., 2007) helped piece together a conceptual foundation of LGB-affirmative supervision. Indeed, Burkard et al. (2009) marked the first attempt to define LGB-affirmative supervision in the literature, and they borrowed language from Tozer and McClanahan (1999) who defined LGB-affirmative counseling. The researchers defined LGB-affirmative supervision as an approach that “celebrates and advocates the validity of LGB persons and their relationships” and further stated that, “such a supervisor goes beyond a neutral or null environment to counteract the life-long messages of heterosexism that LGB individuals have experienced and often internalized” (p. 177). Burkard et al. (2009) emphasized that LGB non-affirmative supervision is more than intentional or unintentional bias that pathologizes or invalidates supervisees and/or their clients. LGB non-affirmative supervision is also neutral where the supervisor does not respond to or incorporate LGB concerns during supervision or presentations of client cases.

Furthermore, Burkard et al. (2009) found that supervisees that experienced LGB-affirmative supervision felt supported, validated, and respected by their supervisors and felt
subsequently more confident in their clinical work. Students that received LGB-affirmative supervision also reported having a higher quality training experience, a stronger working alliance with their supervisor, and more positive client outcomes (Burkard, Johnson et al., 2006; Burkard et al., 2009). Supervisees that experienced LGB non-affirmative supervision felt less trustful, withdrew from supervision, and reported experiencing negative effects on their clinical work and client care (e.g., distrusted supervisors’ clinical recommendations regarding LGB issues; stopped addressing important clinical and supervision issues with supervisor) (Burkard et al., 2009). These supervisees not only reported experiencing negative emotions such as anger, fear, and distress because of LGB non-affirming events, but there were negative effects on their supervision relationships as well (Burkard et al., 2009). It seems reasonable to argue that LGB non-affirmative supervision has the potential to undermine supervisee growth and development as therapists and professionals. Such a connection raises an important ethical question: Is LGB non-affirmative supervision unethical if it impedes supervisee professional development and results in diminished client care? With stakes such as these, clinical supervisors simply cannot be passive regarding LGB concerns in supervision.

Hitchings (1999) stressed that there is general agreement about many of the issues involved in working with LGB clients, but what is essentially missing is the ‘how to’ within the supervisory relationship. To help fill this gap in the research, the current study focused on exploring how experienced clinical supervisors implement and apply LGB-affirmative practice with their supervisees. The goal was to learn specific and concrete LGB-affirmative actions that clinical supervisors are performing with supervisees. Part 1 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure resulted in 18 items that describe how clinical supervisors with knowledge of LGB issues and people implement LGB-affirmative clinical
supervision, and together these 18 items made a practical training model (Table 8). To see the original 100 action items offered by participants on Part 1 of the measure, please see Appendix N. Table 9 highlights participant items that stood out as distinct from the developed 18 representative items. Additionally, the multidimensional scaling results, and follow-up analysis, helped to inform previously known ideas by providing a novel conceptualization of various aspects of LGB-affirmative clinical supervision. More specifically, the MDS and cluster analysis results provided information about the four dimensions of LGB-affirmative clinical supervision as conceptualized by experienced LGB-affirmative clinical supervisors: (1) Awareness, (2) Understanding LGBTQ+ identities, (3) Learning about Minority Identity Experiences, and (4) the Relational Process of Supervision (Table 10).

**Why LGB?**

Clinical supervisor participants provided an invaluable expansion to the current study by integrating the practice of attending to both sexual identity and gender identity in supervision. As a reminder, 100 total items were initially submitted by 26 clinical supervisors describing the LGB-affirmative supervision that they perform with trainees. Some of those item submissions widened the study’s scope from LGB to LGBTQ+ and included gender identity/gender expression, as examples. An important goal of this study from the beginning was to tell a group story, hearing directly from clinical supervisors with knowledge of LGB issues and people how they implement LGB-affirmative supervision with trainees. If you reference the final 18 items in the LGB-Affirmative Clinical Supervision Model (Table 8), half of the items use the terms LGB and LGB-affirmative or some variation, while the other half became more expansive. Regardless of how the study was framed, the intention was to follow the data—in this case, the clinician’s voices—and to learn from them as experts. As discussed previously, the mental health fields need
less theory, conceptualizing, and mainstream or majority group model adaptations and more practical application directly from clinicians.

When this research was initiated, there was a choice to make regarding scope and focus. This researcher wants to be clear about recognizing the difference between sexual identity and gender identity and that this was a study about sexual identity. So, why not be inclusive of sexuality and gender identity, one might ask? This group of participants may have seen the terms LGB and LGB-affirmative as dated and they would have been right. It is not a new phenomenon for clinicians to be ahead of research. Researchers, however, are sometimes ahead of clinicians and give us space to pause and dig deeper into specificity in some areas. Both researcher and clinician lenses are valuable and complement one another.

Inclusion is important. Mental health fields emphasize inclusivity, but what does inclusion look like? It might not mean merging identities. When everyone is put in the same bucket, even if well-intentioned, that can result in people being missed and nuance lost. Fassinger and Arseneau (2007) wrote about how the increasingly frequent addition of “T” to “LGB” spoke to the public and professional conflation of all sexual and gender minority concerns under a shared umbrella of invisibility, isolation, and discrimination. However, there are particular dimensions of experience that differentiate these four identities in important ways, shaping group-specific trajectories for the development and enactment of identity (Fassinger & Arseneau, 2007). Fassinger and Arseneau (2007) wrote their article with the intention of addressing differences between and within LGBT groups of people, with the ultimate aim of focusing practice (e.g., counseling and therapy, education, training, and advocacy) more sharply. It was this researcher’s intention, not to leave anyone out, but to shine light in a certain direction and all identities deserve that. It is also worth noting that helping fields continue to separate
guidelines for sexual minority persons and transgender and gender nonconforming people. It is not the same lived experience.

**Implications for Supervision Practice and Training**

The results of the current study suggest implications for future practice and training. There is a lot of potential for the 18 items developed from the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure. It is a practical LGB-affirmative clinical supervision model that could help with development and growth across four dimensions. This could be a tool to help train supervisors, used in supervision practicums and supervision of supervision seminars. It could be provided and taught as a guide as is, but this researcher can also imagine adapting it into an assessment and/or self-assessment tool. Supervisors could use it to assess supervisees and supervisees could use it to assess themselves. Similar methods were used in this researcher’s past supervision experiences. It was validating being on a similar page with the supervisor and it would also be important to know if you were not. It could be given at the beginning of a semester to get a baseline, again around midterms to track progress, and at the end for final evaluation. What is more exciting is that trainees would be able to see their overall strengths and growth edges because of how the items are organized into dimensions (see Table 11 below) and could use this to help set goals for what they want to work on.

**Table 11**

*LGB-Affirmative Clinical Supervision Model: Dimensions and Items*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Item</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>1, 18, 13, 4, 7</td>
<td>5</td>
</tr>
<tr>
<td>Understanding LGBTQ+ Identities</td>
<td>11, 17, 5, 6</td>
<td>4</td>
</tr>
<tr>
<td>Learning about Minority Identity Experiences</td>
<td>3, 14, 16</td>
<td>3</td>
</tr>
</tbody>
</table>
Additionally, these results, along with previous literature, continue to support the importance of supervisor multicultural competence. It is critically important for clinical supervisors to be willing to address multicultural issues with supervisees, for both supervisory relationships and trainee and client outcomes (Burkard, Johnson et al., 2006; Gatmon et al., 2001). Anhalt et al. (2003) reported that the greatest feelings of inadequacy trainees in their study described were related to low levels of helpfulness in supervision regarding LGB issues relative to therapy with LGB clients. As such, continued training toward multicultural competence of supervisors-in-training seems important. In particular, training specific to initiating and maintaining on-going multicultural dialogue seems especially important for supervisors-in-training (Burkard, Johnson et al., 2006; Gatmon et al., 2001). It is not enough to be knowledgeable about multicultural issues, supervisors-in-training also need to know how to discuss multicultural issues with future trainees.

**Implications for Research**

The results of the current study suggest several implications for future research. As this study was exploratory in nature, there are multiple follow-up research studies that could be conducted. Exploring this topic with broader, more varied groups of clinical supervisors would be beneficial in understanding the dimensions even further. Research with larger samples could also be conducted to verify the dimensions. Additionally, in future studies, it would be useful to have participants rate how well the final items captured their core ideas about LGB-affirmative supervision. With this in mind, descriptive statistics were run to look at item variation in stress by participant and participant variation in stress by item. Looking at the descriptive data,
Participant 12 yielded the highest stress value and had high variation in how well the model fits by item. Participant 12’s demographics and LGB-CSI scores were reviewed for additional ways they might stand out as different from other participants and the significant difference of note is that they are a supervisor of color, which is a lens that the majority of participants in the study did not have. This is an example illustrating the value of recruiting a more racially diverse sample in the future, which is discussed further in the limitations section below. Item 1 fits especially poorly for this participant and Item 14 also exhibits relatively high stress. Item 1, in general, yields high stress values and high variation in stress across participants (e.g., Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual orientations). Item 14 also has somewhat high variation in stress across participants (e.g., Discuss microaggressions and other experiences of oppression). Future studies could monitor how these items continue to perform across samples to determine if this was an anomaly, or if the development stages for these two items need to be revisited and possibly updated. Also, should future studies want to pursue participant-generated items again, it might help to recruit different participants for Part 1 and Part 2. Recruitment was a struggle with one group of participants and time commitment might have been the issue. Asking participants to be available for two separate research sessions might have been too much of a demand and ultimately a deterrent to participation.

Next, recall the large number (92%) of study participants working in a university context, academics and university counseling center practitioners. Even with a fairly evenly split mix of both, that still makes for a relatively narrow scope. Consideration was given to how the professional context of participants may have impacted their contributions to the model/dimensions of LGB-affirmative supervision. This researcher ran a MANOVA between the
two groups of participants, those with primarily academic roles and those with primarily clinical roles, using dimension weights as dependent variables. It was discovered that the model fit both groups well and that dimension weights were comparable across both groups. Recognizing the limited power to find statistically significant MANOVA results in this sample, separate ANOVAs for each dimension were also run and resulted in no evidence of there being a difference in how well the model fit. Still, future studies could benefit from having a wider range of supervisors. Furthermore, the initial Phase 1 sample of 26 participants was 2/3 practitioners. In Phase 2, where 11 participants chose not to return to complete the study, 8 of those that dropped out were practitioners, and 3 were academics. Perhaps it is more difficult to get practitioners to do the two phases of data collection.

Additionally, this researcher checked to see if specific items or dimensions may have been impacted by those who dropped out of Phase 2 of the study. This required going back to the original list of 100 items and highlighting those that were given by participants who dropped out, and then looking at whether this might have left some of the final 18 items less supported than others. Only 1 item stood out as possibly being impacted by participant attrition and that was Item 8 (Gauge supervisee awareness, knowledge, and skill with LGB issues and clients). Out of the 6 items that contributed to this category, 5 of those items came from participants that dropped out of the study, including the participant that contributed the most representative item. However, after looking for item variation in stress by participant, Item 8 exhibited low stress values across the remaining 15 participants that completed the study. Item 8 was also clustered in Dimension 4, the Relational Process of Supervision dimension, and Dimension 4 dimension weights for the 15 returning participants were comparable across the participant group and illustrate good model fit.
Some participants also saw the LGB and LGB-affirmative scope of this study as a limitation. Although the focus on a specific group is a useful quantitative research strategy, the parsing out of small groups may not be fully appreciated by participants. While the choice was made to focus the study on sexual identity, there was also a desire to listen to the voices of participants and to tell a group story about the clinical work that they do. The researcher learned that this was a group of extremely LGB-affirmative clinicians—as illustrated by background questionnaire responses and LGB-CSI scores—that also have care and consideration for other identities. Future studies could be expanded to other populations. If a study was initiated today, this researcher would likely choose to focus on gender-nonconforming folks—and just gender-nonconforming without sexual identity—because gender identity focus is more in line with the current zeitgeist and it would be interesting to see what clinical supervisors would highlight specifically about this population. Another potential alternate research strategy would be to run two studies at once—one on gender identity and one on sexuality. In such a study, both groups would be included, but would respond to different measures.

Furthermore, after discovering the four dimensions of LGB-affirmative clinical supervision, the researcher was reminded of the five subscales on the LGB-CSI, another measure used in this study. Recall that the LGB-CSI measures participants’ self-efficacy to perform LGB-affirmative counseling behaviors. When Dillon and Worthington (2003) developed their self-report measure, the subscales became the way that inventory items were organized. The subscales are as follows: Application of Knowledge, Advocacy Skills, Awareness, Assessment, and Relationship. The four dimensions of LGB-affirmative clinical supervision uncovered in this study were: Awareness, Understanding LGBTQ+ Identities, Learning about Minority Identity Experiences, and the Relational Process of Supervision. Notice that there are similarities.
Awareness is an important component of both measures. Understanding LGBTQ+ Identities and Learning about Minority Identity Experiences are both knowledge dimensions and Application of Knowledge is represented on the LGB-CSI. Components of relationship also show up in both measures. That leaves Advocacy Skills, which is a part of LGB-affirmative clinical supervision Dimension 3 (Learning about Minority Identity Experiences) and Assessment, which is included in LGB-affirmative clinical supervision Dimension 4 as part of the supervisor’s process. Thus, there are a great many conceptual connections that can be made here. For future research, a participant sample that is varied in their levels of self-efficacy and LGB-affirmativeness rather than a select group of experts would allow statistical analysis of correlation among these two measures. Carrying out such a study could serve as a way of assessing validity of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure: Parts 1 and 2, which was created for this study, helping make a stronger case for making it a measure. It worked as it was intended to in this research study, and the 18 items that were developed in Part 1 of the measure—that comprise a model of LGB-affirmative clinical supervision—are strong. Another version of the measure could be created using researcher provided items and those 18 items can be given to participants to rate, no second research session required.

**Limitations**

As with any research, this study was not without limitations. First, the results of the study are likely to generalize well to those who are similar to the clinical supervisors that participated in the study but may not adequately capture conceptualizations of LGB-affirmative clinical supervision for those with significantly different backgrounds and/or identities. The 26 clinical supervisor participants were relatively diverse regarding age, sexual identity, years of work experience, years of clinical supervision experience, and years of experience with LGB issues—
the latter two of which were sought out and are considered great strengths of the study. It was wonderful to see so much sexual identity representation in this particular sample. However, there was lack of diversity regarding race, gender identity, socioeconomic status, workplace, and degree with the majority of participants being White, cisgender female, working in a university setting, and having a doctorate. Future studies might want more representation across other identities, particularly regarding race and sexuality identity as there is increased focus on the importance of moving away from sexual identity literature being White sexual identity literature (Jackson, Lange, & Duran, 2021). One can imagine that there would be additional dimensions about intersectionality or integration of varied aspects of self if clinical supervisors of color were more central in the participant group. An example illustrating the importance of this was discussed above in reference to Participant 12 as an implication for future research.

There were some other recruitment-related issues that should be addressed in follow-up studies. Attempts were made to recruit diverse, experienced LGB-affirmative clinical supervisors across discipline and region using various professional organization division and association listservs. When listserv recruitment stalled, additional recruitment strategies were employed with HSIRB approval. These included emailing study invitations to personal professional contacts, as well as authors cited that had written about LGB-affirmative supervision and reaching out to training directors at APA-accredited university counseling center internship sites. The researcher was transparent in describing the recruitment strategy and while care was taken to generate a broad and varied reach, the study sample was homogenous regarding race, gender identity, socioeconomic status, workplace, and degree. Future studies might want to either expand recruitment strategies to further broaden the sampling pool or have a strategy for more specifically targeting participants. For this study, the researcher was primarily seeking out
experienced clinical supervisors with LGB expertise and hoping that casting a wide net would capture diversity on other identity variables. However, for any future study wanting to focus more on the intersection of race and sexual identity, as an example, recruitment should specifically focus on clinical supervisors of color as opposed to hoping to get enough representation in a general sample.

Efforts to recruit a larger participant group would also be helpful in exploring findings further in future studies. A recruitment goal of 30 participants was initially set, a number chosen due to the Central Limit Theorem and because that sample size would support statistical analyses while also keeping the number of items generated for a paired comparison measure from becoming too large and burdensome for participants to rate. After four months of recruiting participants for Part 1, only 26 participants had completed the initial surveys. Out of those 26 participants, 15 returned for the second round of data collection and completed the study. Out of the 11 participants that chose not to return, 8 were practitioners and 3 were academics. Thus, another limitation of the current study was participant attrition between the two rounds of data collection. Time has been spent reflecting on who the participants are—practitioners that are years out of school and busy working. This is a participant pool that will not be as incentivized as a student pool, but more interested if caught at the right time and if they are particularly interested in the topic. The time commitment might have been too much of a demand and a deterrent to participation. Future studies might have more recruitment success if the time commitment is broken down and different clinical supervisors are recruited for the first and second rounds of data collection, or future studies might just focus on paired comparison data using the items developed here.
Additionally, with MDS research, one possible threat to internal validity is a lack of variation in the sample on an important dimension. This can result in not seeing that dimension in the obtained spatial representation of results, essentially missing a dimension because there are not enough data points representing that dimension. Recall that one-, two-, three-, and four-dimensional MDS models were run and examined to determine the best model fit for the data set, and while the 18 participant-developed items supported all four solutions, the four-dimension solution was chosen as the model to interpret based on a review of goodness-of-fit measures and interpretability. Thus, it can be assumed that this did not happen with the current study. During Part 2 of data collection, some participants noticeably rated more toward the extremes of the Likert scale, while others hovered more towards the middle, and this researcher wondered how that might impact findings. These differences are likely reflected in variation in how well the final MDS model fits individual participants and can be seen in variation in dimension weights. Ultimately, regardless of variation from participant to participant, overall trends were the main focus—telling a group story—and that came through in the data. A suggestion for attending to this limitation in future studies, should this be an issue, might be to accumulate data from across multiple studies to verify the existence of each dimension and to identify whether additional dimensions exist.

Finally, it is crucial to note the perspective of the researcher because all research is conducted within a sociocultural context and filtered through a framework. This researcher identifies as a White, bisexual, cisgender, woman who is an advocate for LGB-affirmative practice and training, including providing and teaching LGB-affirmative clinical supervision to all trainees. This perspective impacted the creation of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure and influenced conceptualizations of the dimensions.
Furthermore, the researcher’s personal identity background and challenges could have influenced the conception and development of the current investigation. For future research, using a team approach would help mitigate this issue because multiple perspectives would be present in the development of the study, particularly when aspects of identity are so intimately involved.

**Conclusion**

Given the current socio-political climate where the rights of the LGBTQ+ population continue to be up for public debate, it is a critical time to remain focused and unwavering in showing up for those that count on mental health professionals, both trainees and clients alike. The information shared by clinical supervisors in this study addressed existing gaps in the literature regarding the empirical study of LGB-affirmative supervision. Clinical supervisors shared candid details regarding their experiences of providing LGB-affirmative supervision with trainees, moving beyond theory and abstract ideas, and speaking to practical ‘how to’ application. From these details, numerous action items—a succinct model’s worth—were identified which will hopefully shed light for those who are or will inevitably work with this vulnerable client population, be it therapists-in-training or more advanced therapists with little LGB-affirmative experience. For clinicians already established in their LGB-affirmative supervision practice, the dimensions uncovered might serve as a cross-check of components, either reinforcing their practice or inspiring new directions to grow.

Having greater knowledge and understanding of how clinical supervisors practice LGB-affirmative supervision may help to promote more effective and sensitive supervision training and benefit current and future supervisors, current and future trainees, and ultimately the clients in our care. Additionally, assisting trainees in effectively adopting LGB-affirmative practice may help to develop psychologists with stronger, more persistent anti-heterosexualist attitudes,
ultimately helping to reduce the perpetuation of sexual prejudice within the field of psychology. While there are limitations to the current investigation, the implications for future practice and research are many and varied. This study set out to use expert actively practicing supervision voices to tell a group story and that was accomplished. This was a story about a group of very LGB-affirmative clinicians with a lot of years of experience among them, that care about inclusion, affirmation of other identities, and intersectionality.
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Appendix A

Background Questionnaire

The following series of questions will ask for demographic information, as well as information concerning your educational and professional experiences. I am most interested to know what you say about yourself and feel it is important to put descriptions in the literature about how people identify themselves. However, in order to assist with integrating findings from this study and cross-check with other research, please also respond to the demographic checklists provided, if possible.

Age: ______

Please indicate your sex assigned at birth.

- Female
- Male
- Intersex

In your own words, please describe your gender identity.

Please indicate the gender that best describes you. Check all that apply, if any.

- Agender
- Bigender
- Cisgender Male
- Cisgender Female
- Demigender
- Fa’afafine
- Genderfluid
- Genderqueer
- Mahu
- Non-Binary
- Questioning or Unsure
- Third Gender
- Two-Spirit
- Transgender Male
- Transgender Female

In your own words, please describe your sexual orientation.

Please indicate the sexual orientation that best describes you. Check all that apply, if any.

- Asexual
- Bisexual
- Gay
- Heterosexual or Straight
Lesbian
Pansexual
Queer
Questioning or Unsure
Same-Gender Loving

In your own words, please describe your racial identity.

The following three questions concerning race and ethnicity were used on the 2020 Census:

Please indicate the racial identity that best describes you. Check all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Korean
- Filipino
- Japanese
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Biracial
- Multiracial
- Some Other Race

Are you of Hispanic, Latino, or Spanish origin?

- No, I am not of Hispanic, Latino, or Spanish origin
- Yes, I am of Hispanic, Latino, or Spanish origin

If you answered yes, please select all that apply:

- Mexican
- Mexican American
- Chicano
- Puerto Rican
- Cuban
- Another Hispanic, Latino, or Spanish origin: ____________________________

(Please describe in your own words)
In your own words, please briefly describe your childhood/family of origin’s socioeconomic status.

In your own words, please briefly describe your current/adult family’s socioeconomic status.

Current or most recent workplace environment and position: ________________________________

(Academia, University Counseling Center, Community Mental Health Clinic, etc.)

Highest degree earned: __________________________

Area of specialization: ________________________________

(Counseling Psychology, Clinical Psychology, etc.)

Years of post-degree work experience: __________________

Years of clinical supervision experience: _________________

Years of experience with LGB issues: __________________

Have you read professional guidelines regarding work with LGB clients? Check all that apply. There is space provided to list additional sources that you use or are familiar with.

- APA’s Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients
- ACA’s Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (now SAIGE as of 2020) Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals
- Other(s): ____________________________________________
  ____________________________________________

Please briefly describe any favorite LGB-affirmative resource(s). What has been most helpful to you? Do you have 1 or 2 resources that you would recommend? (Could be for you professionally or for clients, etc.)
Have you participated in professional development opportunities aimed specifically at LGB-affirmative therapy and/or LGB-affirmative supervision?

- Yes
- No

If yes, please estimate how many LGB-affirmative professional development activities you participate in annually. Briefly describe the last two experiences and how they impacted you (just a few sentences).

Lastly, please think about your own experiences of providing clinical supervision to trainees. Before proceeding to the next measure, take a few minutes to simply recall 1 or 2 supervisory experiences that you view as successful, effective, or representative of you as an LGB-affirmative clinical supervisor. Hold these experiences in mind as you proceed and complete the remainder of the survey.
Appendix B

Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure:
Part 1

This is a two-part measure designed to be completed in two sessions. In Part 1, participants are asked to generate and submit descriptions of LGB-affirmative clinical supervision. The student researcher will process all submissions to create a final item set for the second part of the measure. In Part 2, participants will compare and rate each of the core aspects of LGB-affirmative clinical supervision to each other.

Part 1: LGB-Affirmative Clinical Supervision Item Development

In Part 1 of this measure, you have the opportunity to have your unique voice heard. You will be writing three phrases or descriptors, rank ordered, that represent your own personal understanding of LGB-affirmative clinical supervision. Draw from your knowledge and past experiences of providing LGB-affirmative clinical supervision to trainees, including the 1 or 2 you recalled during the background questionnaire, to generate 3 specific, concrete actions you perform with your supervisees. If you have more than 3 items that you would like to share in order to represent yourself as an LGB-affirmative clinical supervisor and the supervision that you do, optional space will be provided.

To be able to complete Part 2 of the measure that will involve comparing items to one another, it is better for each item to be brief—just a few words or a phrase. Here is an example to help you write your personal descriptors of LGB-affirmative clinical supervision.

Example:

Turn this long version… In doing LGB-affirmative clinical supervision, I believe it is my responsibility to bring up issues of sexual orientation within the supervisory relationship, even if it does not seem apparent that such issues are central.

Into this brief version… Initiate sexual orientation discussions.

In the spaces allotted below, briefly describe the top three ways that you provide LGB-affirmative clinical supervision to trainees.

Item 1: __________________________________________________________

Item 2: __________________________________________________________

Item 3: __________________________________________________________
Optional: If you have additional descriptors that you feel represent your supervision and/or you as an LGB-affirmative clinical supervisor that you would like to share, you can do so in the space below. Please number the items if you add more than one.

______________________________________________________________

______________________________________________________________

______________________________________________________________

When you are happy with your phrases/descriptors and are ready to submit and proceed to the final measure of the first research session, please click below to continue. If you have any questions or concerns about this part of the measure, feel free to contact the student researcher at lindsey.n.dollar@wmich.edu or 765-620-6526.

Because it will take time to recruit participants, gather descriptors, and for the student researcher to review and determine the final item set that will be compared and rated, it is necessary for Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure to occur in a second, future session. This process was also described in the recruitment invitation and the informed consent document. For this reason, the student researcher will need to be able to contact you to let you know when Part 2 of the measure is ready to be completed. Please provide an email address that you check regularly. This will also enable me to link your responses from Part 1 and Part 2. I will actively safeguard your confidentiality throughout the duration of this study.

E-mail address: ____________________________________________

If you are ready to proceed to the last measure of this session, please click below to submit and continue. If you would no longer like to participate, you can close your browser now and leave the study without penalty. If you have questions or concerns that you would like to address with me before advancing, my contact information is located above.

SUBMIT AND PROCEED TO NEXT MEASURE

DECLINE AND END PARTICIPATION
Appendix C

Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure:
Part 2

These are the items that were developed to represent the phrases participants used to collectively explain LGB-affirmative clinical supervision during Part 1 of the study:

1. Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual orientations
2. Demonstrate understanding of common LGB clinical issues
3. Provide LGB-affirmative resources
4. Teach LGB-affirmative therapeutic practices
5. Initiate open discussions about identities in supervision
6. Encourage open discussions about identities in therapy
7. Use affirmative and inclusive language
8. Gauge supervisee awareness, knowledge, and skill with LGB issues and clients
9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings
10. Create a supportive, honest, and LGB-affirming supervisory relationship
11. Assist with finding and reviewing reliable LGB-affirmative literature and research
12. Model vulnerability and appropriate self-disclosure of sexual orientation
13. Address transference and countertransference
14. Discuss microaggressions and other experiences of oppression
15. Model openness and normalize any/all topics related to gender/sexuality
16. Consider and validate minority stress experiences
17. Provide education on common LGBTQ+ identities, experiences, and oppressions
18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision

Part 2: LGB-Affirmative Clinical Supervision Item Comparison Ratings

The task for Part 2 is to indicate the degree of similarity (or dissimilarity) by comparing each LGB-affirmative clinical supervision item to each of the others using a 6-point Likert scale (1 = extremely similar; 6 = extremely dissimilar).

Example: If you think that the phrase "Accept all sexual orientations as equally valid" is only somewhat similar to the phrase "Provide education about LGB clinical issues,” you might choose to mark a 3 on that item comparison.

Please complete each of the following matrix tables by filling in one number for each pair in the space provided. Each item will be listed at the top of its own matrix table, and you are being
asked to compare it to each of the remaining items, for a total of 17 matrix tables, each table getting smaller as you move along through comparisons. To assist with keeping the items in mind and to help ease scrolling, the first nine tables have been broken into smaller ones, as indicated by the words 'Continued' in those tables.

This task will take an estimated 30 minutes to complete.

**Item 1: Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual orientations (Rate similarity to each item below)**

<table>
<thead>
<tr>
<th>1 - Extremely similar (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>6 - Extremely dissimilar (6)</th>
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<tbody>
<tr>
<td>2. Demonstrate understanding of common LGB clinical issues (1)</td>
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<tr>
<td>3. Provide LGB-affirmative resources (2)</td>
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<tr>
<td>4. Teach LGB-affirmative therapeutic practices (3)</td>
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<tr>
<td>5. Initiate open discussions about identities in supervision (4)</td>
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<tr>
<td>6. Encourage open discussions about</td>
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</table>
identities in therapy (5)

7. Use affirmative and inclusive language (6)

<table>
<thead>
<tr>
<th>1 - Extremely similar (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>6 - Extremely dissimilar (6)</th>
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<tbody>
<tr>
<td>Item 1 (Continued): Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual orientations (Rate similarity to each item below)</td>
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<tr>
<td>8. Gauge supervisee awareness, knowledge, and skill with LGB issues and clients (7)</td>
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<tr>
<td>9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (8)</td>
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<tr>
<td>10. Create a supportive, honest, and LGB-affirming supervisory relationship (9)</td>
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<tr>
<td>11. Assist with finding and reviewing reliable LGB-affirmative literature and research (10)</td>
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</tr>
</tbody>
</table>
12. Model vulnerability and appropriate self-disclosure of sexual orientation (11)

13. Address transference and countertransference (18)

---

**Item 1 (Continued): Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual orientations (Rate similarity to each item below)**

<table>
<thead>
<tr>
<th>1 - Extremely similar (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>6 - Extremely dissimilar (6)</th>
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<tbody>
<tr>
<td>14. Discuss microaggressions and other experiences of oppression (13)</td>
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<td>15. Model openness and normalize any/all topics related to gender/sexuality (14)</td>
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<td>16. Consider and validate minority stress experiences (15)</td>
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<td>17. Provide education on common LGBTQ+ identities,</td>
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</table>
experiences, and oppressions (16)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (17)

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**Item 2: Demonstrate understanding of common LGB clinical issues (Rate similarity to each item below)**

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<tr>
<th>Item</th>
<th>1 - Extremely similar (1)</th>
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</table>
identities in therapy (4)

7. Use affirmative and inclusive language (5)

8. Gauge supervisee awareness, knowledge, and skill with LGB issues and clients (6)

**Item 2 (Continued): Demonstrate understanding of common LGB clinical issues (Rate similarity to each item below)**

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<th>1 - Extremely similar (1)</th>
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<td>9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (7)</td>
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<td>10. Create a supportive, honest, and LGB-affirming supervisory relationship (8)</td>
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<tr>
<td>11. Assist with finding and reviewing reliable LGB-affirmative</td>
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</table>
12. Model vulnerability and appropriate self-disclosure of sexual orientation (10)

13. Address transference and countertransference (11)

**Item 2 (Continued): Demonstrate understanding of common LGB clinical issues (Rate similarity to each item below)**

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<td>16. Consider and validate minority stress experiences (14)</td>
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<td>17. Provide education on common</td>
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177

LGBTQ+ identities, experiences, and oppressions (15)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (16)

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**Item 3: Provide LGB-affirmative resources (Rate similarity to each item below)**

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7. Use affirmative and inclusive language (4)

8. Gauge supervisee awareness, knowledge, and skill with LGB issues and clients (5)

| Item 3 (Continued): Provide LGB-affirmative resources (Rate similarity to each item below) |
|--------------------------------------------------|--------|--------|--------|--------|--------|
| 1 - Extremely similar (1) | 2 (2) | 3 (3) | 4 (4) | 5 (5) | 6 - Extremely dissimilar (6) |

9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (6)

10. Create a supportive, honest, and LGB-affirming supervisory relationship (7)

11. Assist with finding and reviewing reliable LGB-affirmative literature and research (8)
12. Model vulnerability and appropriate self-disclosure of sexual orientation (9)

13. Address transference and countertransference (10)

Item 3 (Continued): Provide LGB-affirmative resources (Rate similarity to each item below)

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</table>
experiences, and oppressions (14)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (16)

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### Item 4: Teach LGB-affirmative therapeutic practices (Rate similarity to each item below)

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<tr>
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<td>6. Encourage open discussions about identities in therapy (2)</td>
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<td>7. Use affirmative and inclusive language (3)</td>
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<td>8. Gauge supervisee awareness, knowledge,</td>
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</table>
and skill with LGB issues and clients (4)

9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (5)

10. Create a supportive, honest, and LGB-affirming supervisory relationship (6)

11. Assist with finding and reviewing reliable LGB-affirmative literature and research (7)

Item 4 (Continued): Teach LGB-affirmative therapeutic practices (Rate similarity to each item below)

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<td>12. Model vulnerability and appropriate self-disclosure of sexual orientation (8)</td>
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<td>13. Address transference and countertransference (9)</td>
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<td>14. Discuss microaggressions and other experiences of oppression (10)</td>
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<td>17. Provide education on common LGBTQ+ identities, experiences, and oppressions (13)</td>
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<td>18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical</td>
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Item 5: Initiate open discussions about identities in supervision (Rate similarity to each item below)

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<td>7. Use affirmative and inclusive language (2)</td>
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<td>8. Gauge supervisee awareness, knowledge, and skill with LGB issues and clients (3)</td>
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<tr>
<td>9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (4)</td>
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</table>
10. Create a supportive, honest, and LGB-affirming supervisor relationship (5)

11. Assist with finding and reviewing reliable LGB-affirmative literature and research (6)

12. Model vulnerability and appropriate self-disclosure of sexual orientation (14)

Item 5 (Continued): Initiate open discussions about identities in supervision (Rate similarity to each item below)

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<tr>
<td>13. Address transference and countertransference (1)</td>
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experiences of oppression (2)

15. Model openness and normalize any/all topics related to gender/sexuality (3)

16. Consider and validate minority stress experiences (4)

17. Provide education on common LGBTQ+ identities, experiences, and oppressions (5)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (6)

Item 6: Encourage open discussions about identities in therapy (Rate similarity to each item below)

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8. Gauge supervisee awareness, knowledge, and skill with LGB issues and clients (2)

9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (3)

10. Create a supportive, honest, and LGB-affirming supervisory relationship (4)

11. Assist with finding and reviewing reliable LGB-affirmative literature and research (5)

12. Model vulnerability and appropriate self-disclosure of
Item 6 (Continued): Encourage open discussions about identities in therapy (Rate similarity to each item below)

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**Item 7: Use affirmative and inclusive language (Rate similarity to each item below)**

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8. Gauge supervisee awareness, knowledge, and skills with LGB issues and clients (1)

9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (2)

10. Create a supportive, honest, and LGB-affirming supervisory relationship (3)

11. Assist with finding and reviewing reliable LGB-affirmative literature and research (4)
12. Model vulnerability and appropriate self-disclosure of sexual orientation (5)

13. Address transference and countertransference (6)

**Item 7 (Continued): Use affirmative and inclusive language (Rate similarity to each item below)**

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experiences, and oppressions (10)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (11)

| Item 8: Gauge supervisee awareness, knowledge, and skill with LGB issues and clients (Rate similarity to each item below) |
|---|---|---|---|---|---|
| 1 - Extremely similar (1) | 2 (2) | 3 (3) | 4 (4) | 5 (5) | 6 - Extremely dissimilar (6) |
| 9. Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (1) | | | | | |
| 10. Create a supportive, honest, and LGB-affirming supervisory relationship (2) | | | | | |
| 11. Assist with finding and reviewing reliable LGB-affirmative literature and research (3) | | | | | |
12. Model vulnerability and appropriate self-disclosure of sexual orientation (4)

13. Address transference and countertransference (5)

Item 8 (Continued): Gauge supervisee awareness, knowledge, and skill with LGB issues and clients (Rate similarity to each item below)

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experiences, and oppressions (9)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (10)

**Item 9: Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (Rate similarity to each item below)**

<table>
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</tr>
<tr>
<td>11. Assist with finding and reviewing reliable LGB-affirmative literature and research (2)</td>
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<tr>
<td>12. Model vulnerability and appropriate self-disclosure of sexual orientation (3)</td>
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<tr>
<td>13. Address transference and</td>
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14. Discuss microaggressions and other experiences of oppression (5)

Item 9 (Continued): Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings (Rate similarity to each item below)

<table>
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<th>Item</th>
<th>Description</th>
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<tr>
<td>15.</td>
<td>Model openness and normalize any/all topics related to gender/sexuality</td>
<td>1 - Extremely similar (1)</td>
</tr>
<tr>
<td>16.</td>
<td>Consider and validate minority stress experiences</td>
<td>2 (2)</td>
</tr>
<tr>
<td>17.</td>
<td>Provide education on common LGBTQ+ identities, experiences, and oppressions</td>
<td>3 (3)</td>
</tr>
<tr>
<td>18.</td>
<td>Encourage thoughtful, intersectional discussions about identities</td>
<td>4 (4)</td>
</tr>
</tbody>
</table>

6 - Extremely dissimilar (6)
and how those impact clinical work and supervision (9)

Item 10: Create a supportive, honest, and LGB-affirming supervisory relationship (Rate similarity to each item below)

<table>
<thead>
<tr>
<th>Item</th>
<th>1 - Extremely similar (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>6 - Extremely dissimilar (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Assist with finding and reviewing reliable LGB-affirmative literature and research (1)</td>
<td>〇</td>
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<tr>
<td>12. Model vulnerability and appropriate self-disclosure of sexual orientation (2)</td>
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<tr>
<td>13. Address transference and countertransference (3)</td>
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<td>〇</td>
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<td>〇</td>
<td>〇</td>
<td>〇</td>
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<tr>
<td>14. Discuss microaggressions and other experiences of oppression (4)</td>
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<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>15. Model openness and normalize any/all topics related to gender/sexuality (5)</td>
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<td>〇</td>
</tr>
</tbody>
</table>
16. Consider and validate minority stress experiences (6)

17. Provide education on common LGBTQ+ identities, experiences, and oppressions (7)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (8)

| Item 11: Assist with finding and reviewing reliable LGB-affirmative literature and research (Rate similarity to each item below) |
|---|---|---|---|---|---|
| | 1 - Extremely similar (1) | 2 (2) | 3 (3) | 4 (4) | 5 (5) | 6 - Extremely dissimilar (6) |
| 12. Model vulnerability and appropriate self-disclosure of sexual orientation (1) | | | | | | |
| 13. Address transference and countertransference (2) | | | | | | |
| 14. Discuss microaggressions and other | | | | | | |
experiences of oppression (3)

15. Model openness and normalize any/all topics related to gender/sexuality (4)

16. Consider and validate minority stress experiences (5)

17. Provide education on common LGBTQ+ identities, experiences, and oppressions (6)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (7)

<table>
<thead>
<tr>
<th>Item 12: Model vulnerability and appropriate self-disclosure of sexual orientation (Rate similarity to each item below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Extremely similar (1)</td>
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<tr>
<td>-----------------------------</td>
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<tr>
<td>13. Address transference and countertransference (1)</td>
</tr>
</tbody>
</table>
14. Discuss microaggressions and other experiences of oppression (2)

15. Model openness and normalize and/all topics related to gender/sexuality (3)

16. Consider and validate minority stress experiences (4)

17. Provide education on common LGBTQ+ identities, experiences, and oppressions (5)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (6)

**Item 13: Address transference and countertransference (Rate similarity to each item below)**

<table>
<thead>
<tr>
<th>Item</th>
<th>1 - Extremely similar (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>6 - Extremely dissimilar (6)</th>
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<tr>
<td>14. Discuss microaggressions and other</td>
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<td>○</td>
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<td>○</td>
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</tr>
</tbody>
</table>
experiences of oppression (1)

15. Model openness and normalize any/all topics related to gender/sexuality (2)

16. Consider and validate minority stress experiences (3)

17. Provide education on common LGBTQ+ identities, experiences, and oppressions (4)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (5)

**Item 14: Discuss microaggressions and other experiences of oppression (Rate similarity to each item below)**

<table>
<thead>
<tr>
<th>1 - Extremely similar (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>6 - Extremely dissimilar (6)</th>
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<tbody>
<tr>
<td>15. Model openness and normalize</td>
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<tr>
<td>Item</td>
<td>Description</td>
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<tr>
<td>15</td>
<td>Model openness and normalize any/all topics related to gender/sexuality (Rate similarity to each item below)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Consider and validate minority stress experiences (1)</td>
<td>1-6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Provide education on common LGBTQ+ identities, experiences, and oppressions (3)</td>
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<td></td>
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</tr>
<tr>
<td>18</td>
<td>Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (4)</td>
<td>1-6</td>
<td></td>
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</tbody>
</table>

**Item 15:** Model openness and normalize any/all topics related to gender/sexuality (Rate similarity to each item below)
17. Provide education on common LGBTQ+ identities, experiences, and oppressions (2)

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (3)

Item 16: Consider and validate minority stress experiences (Rate similarity to each item below)

<table>
<thead>
<tr>
<th>Item 17: Provide education on common LGBTQ+ identities, experiences, and oppressions (1)</th>
<th>1 - Extremely similar (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>6 - Extremely dissimilar (6)</th>
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</tr>
</tbody>
</table>
18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (2)

Item 17: Provide education on common LGBTQ+ identities, experiences, and oppressions (Rate similarity to each item below)

<table>
<thead>
<tr>
<th>1 - Extremely similar (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>6 - Extremely dissimilar (6)</th>
</tr>
</thead>
</table>

18. Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision (1)

Thank you very much for your participation!

Once you click submit below, you are finished with the second and final research session and your participation in the study is complete. To be entered into the drawing to receive one of three $50 Amazon gift cards, and to link your data to Part 1, please re-enter your email address:

SUBMIT
Appendix D

Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory

Instructions: Below is a list of activities regarding counseling/psychotherapy. Indicate your confidence in your current ability to perform each activity by marking the appropriate answer beside each question ranging from Not at all Confident to Extremely Confident. Please answer each item based on how you feel now, not on your anticipated (or previous) ability. I am interested in your actual judgments, so please be honest in your responses.

How confident am I in my ability to …?

Not at all Confident

Extremely Confident

____ 1. Directly apply sexual orientation/identity development theory in my clinical interventions with lesbian, gay, and bisexual (LGB) clients.

____ 2. Directly apply my knowledge of the coming out process with LGB clients.

____ 3. Identify specific mental health issues associated with the coming out process.

____ 4. Understand the socially constructed nature of categories and identities such as lesbian, bisexual, gay, and heterosexual.

____ 5. Explain the impact of gender role socialization on a client’s sexual orientation/identity development.

____ 6. Apply existing American Psychological Association guidelines regarding LGB-affirmative counseling practices.

____ 7. Use current research findings about LGB clients’ critical issues in the counseling process.

____ 8. Assist LGB clients to develop effective strategies to deal with heterosexism and homophobia.

____ 9. Evaluate counseling theories for appropriateness in working with an LGB client’s presenting concerns.

____ 10. Help a client identify sources of internalized homophobia and/or biphobia.

____ 11. Select affirmative counseling techniques and interventions when working with LGB clients.

____ 12. Assist in the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes.

____ 13. Facilitate an LGB-affirmative counseling/support group.

____ 14. Recognize when my own potential heterosexist biases may suggest the need to refer an LGB client to an LGB-affirmative counselor.

____ 15. Examine my own sexual orientation/identity development process.

____ 16. Identify the specific areas in which I may need continuing education and supervision regarding LGB issues.
17. Identify my own feelings about my own sexual orientation and how it may influence a client.
18. Recognize my real feelings versus idealized feelings in an effort to be more genuine and empathic with LGB clients.
19. Provide a list of LGB-affirmative community resources, support groups, and social networks to a client.
20. Refer an LGB client to affirmative social services in cases of estrangement from their families of origin.
21. Refer LGB clients to LGB-affirmative legal and social supports.
22. Provide a client with city, state, federal, and institutional ordinances and laws concerning civil rights of LGB individuals.
23. Help a same-sex couple access local LGB-affirmative resources and support.
24. Refer an LGB elderly client to LGB-affirmative living accommodations and other social services.
25. Refer an LGB client with religious concerns to an LGB-affirmative clergy member.
26. Integrate clinical data (e.g., mental status exam, intake assessments, presenting concern) of an LGB client.
27. Complete an assessment for a potentially abusive same-sex relationship in an LGB-affirmative manner.
29. Assess the role of alcohol and drugs on LGB clients’ social, interpersonal, and intrapersonal functioning.
30. Establish an atmosphere of mutual trust and affirmation when working with LGB clients.
31. Normalize an LGB client’s feelings during different points of the coming out process.
32. Establish a safe space for LGB couples to explore parenting.

Once you click to submit this survey, you are finished with the first research session. You will be contacted about completing Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure using the email address you provided as soon as the measure is ready. After that final measure is complete, you will be entered into a drawing to receive one of three $50 Amazon gift cards.

If you know any clinical supervisors that might be particularly interested in this survey, please feel free to pass this study on to them.

Thank you very much for your participation!
Appendix E

Participant Recruitment Invitation–Listserv

Hello,

My name is Lindsey Dollar and I am a doctoral candidate in the Counseling Psychology program at Western Michigan University. I am requesting your assistance with participant recruitment for my doctoral dissertation research project titled *Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision*. This study has been approved by WMU’s Human Subjects Institutional Review Board (IRB Project Number 21-04-02).

The purpose of my study is to learn more about how experienced clinical supervisors are providing lesbian, gay, and bisexual (LGB) affirmative supervision to trainees. I am looking for participants with 5 or more years of clinical supervision experience and who also identify as knowledgeable about LGB issues and people.

Below is a copy of my email invitation to potential participants. I would greatly appreciate it if you would please forward this invitation to the members of your listserv. If you need any additional information or have any questions for me, you can contact me directly at this email or my cell number listed below.

Thank you very much for your help.

Lindsey Dollar, MA, DTLLP  
*she/her/hers*  
Doctoral Candidate  
Counseling Psychology  
Western Michigan University  
Cell: 765-620-6526

-----------------------------------

Dear Clinical Supervisor,

My name is Lindsey Dollar and I am a doctoral candidate in the Counseling Psychology program at Western Michigan University. I am reaching out to you, as a member of this professional organization, to invite you to participate in my doctoral dissertation research focused on learning how experienced clinical supervisors understand and implement LGB-affirmative clinical supervision with trainees. I am inviting clinical supervisors with 5 or more years of clinical supervision experience and who identify as knowledgeable about LGB issues and people to participate.

The study includes four online measures to be completed in two research sessions. One measure has two parts that need to be split across two time points (i.e., Part 2 relies on the information collected in Part 1, so I would contact you when the second part is ready). Participation in the first session, which includes a background questionnaire, a measure of LGB-affirmative
counseling behaviors, and Part 1 of an LGB-affirmative supervision measure will take approximately 20 minutes to complete. The second session, Part 2 of the LGB-affirmative supervision measure, will take an estimated 30 minutes. Please keep in mind that there are no correct answers and that I am interested in how you as an individual provide LGB-affirmative clinical supervision. After completing the second session, you will be entered into a drawing to win one of three $50 Amazon gift cards, which would be sent to you electronically.

This study has been reviewed and approved by the HSIRB at Western Michigan University. Your participation in this study is completely voluntary. All research data and information collected during the study will be confidential. Overall LGB training in graduate programs and LGB-affirmative counseling have been well-researched while LGB issues in supervision have gotten significantly less focus. Results from this study will not only help further our knowledge and understanding about LGB-affirmative supervision but will also have positive training implications and improve the standard of care for LGB clients.

If you would like to learn more about the study, please click on the following link, which will direct you to the informed consent document that outlines the study in more detail. Should you choose to participate, you can proceed from there: 
LGB-Affirmative Clinical Supervision Survey

Please only participate once, even if you receive more than one request. I apologize for cross-postings on listservs. A follow-up email may be sent to recruit additional participants during this phase of the study. As I am soliciting participants via listservs, I am not able to remove any individual email addresses from further contact. If you have already participated, choose not to participate, or are not eligible to participate, please disregard. Additionally, if you know any clinical supervisors that might be particularly interested in this survey, please feel free to pass this study on to them.

Please contact me at 765-620-6526 or lindsey.n.dollar@wmich.edu or my faculty research advisor, Mary Z. Anderson, PhD, at 269-387-5113 or mary.anderson@wmich.edu should you have any questions or concerns. You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 with any additional questions or concerns.

Thank you in advance for your time and consideration.

Sincerely,

Lindsey Dollar, MA, DTLLP
she/her/hers
Doctoral Candidate
Counseling Psychology
Western Michigan University
Cell: 765-620-6526
Appendix F

Participant Recruitment Invitation–Professional Contact

Hello, [insert name of professional contact here] –

My name is Lindsey Dollar and I am a doctoral candidate in the Counseling Psychology program at Western Michigan University. I am reaching out to you [insert how I know them, for example, as an important author that I have cited in my research including article title] to request assistance with my doctoral dissertation project titled Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision. This study has been approved by WMU’s Human Subjects Institutional Review Board (IRB Project Number 21-04-02).

The purpose of my study is to learn more about how experienced clinical supervisors are providing LGB-affirmative supervision to trainees. I am looking for participants with 5 or more years of clinical supervision experience and who also identify as knowledgeable about LGB issues and people.

Below is a copy of my email invitation to potential participants. I would greatly appreciate it if you would consider participating in my study, if appropriate. Additionally, if you know any clinical supervisor colleagues, or perhaps any of your co-authors, that might also be interested, please feel free to pass this study on to them with my gratitude. If you need more information or have any questions for me, you can contact me directly at this email or at my cell number below.

Thank you for your consideration.

Lindsey Dollar, MA, DTLLP
she/her/hers
Doctoral Candidate
Counseling Psychology
Western Michigan University
Cell: 765-620-6526

Dear Clinical Supervisor,

My name is Lindsey Dollar and I am a doctoral candidate in the Counseling Psychology program at Western Michigan University. I am reaching out to invite you to participate in my doctoral dissertation research focused on learning how experienced clinical supervisors understand and implement LGB-affirmative clinical supervision with trainees. I am inviting clinical supervisors with 5 or more years of clinical supervision experience and who identify as knowledgeable about LGB issues and people to participate.

My study includes four online measures to be completed in two research sessions. One measure has two parts that need to be split across two time points (i.e., Part 2 relies on the information
collected in Part 1, so I would contact you when the second part is ready). Participation in the first session, which includes a background questionnaire, a measure of LGB-affirmative counseling behaviors, and Part 1 of an LGB-affirmative supervision measure will take approximately 20 minutes to complete. The second session, Part 2 of the LGB-affirmative supervision measure, will take an estimated 30 minutes. Please keep in mind that there are no correct answers and that I am interested in how you as an individual provides LGB-affirmative clinical supervision. After completing the second session, you will be entered into a drawing to win one of three $50 Amazon gift cards, which will be sent to you electronically.

This study has been reviewed and approved by the HSIRB at Western Michigan University. Your participation in this study is completely voluntary. All research data and information collected during the study will be confidential. Overall LGB training in graduate programs and LGB-affirmative counseling have been well-researched while LGB issues in supervision have gotten significantly less focus. Results from this study will not only help further our knowledge and understanding about LGB-affirmative supervision but will also have positive training implications and improve the standard of care for LGB clients.

If you would like to learn more about the study, please click on the following link, which will direct you to the informed consent document that outlines the study in more detail. Should you choose to participate, you can proceed from there: LGB-Affirmative Clinical Supervision Survey

Please only participate once, even if you receive more than one request. Follow-up emails may be sent to recruit additional participants during this phase of the study. If you have already participated, choose not to participate, or are not eligible to participate, please disregard. Additionally, if you know any clinical supervisors that might be particularly interested in this survey, please feel free to pass this study on to them.

Please contact me at 765-620-6526 or lindsey.n.dollar@wmich.edu or my faculty research advisor, Mary Z. Anderson, PhD, at 269-387-5113 or mary.anderson@wmich.edu should you have any questions or concerns. You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 with any additional questions or concerns.

Thank you in advance for your time and consideration.

Sincerely,

Lindsey Dollar, MA, DTLLP
she/her/hers
Doctoral Candidate
Counseling Psychology
Western Michigan University
Cell: 765-620-6526
Appendix G

Participant Recruitment Invitation–Training Director

Hello,

My name is Lindsey Dollar and I am a doctoral candidate in the Counseling Psychology program at Western Michigan University. I have trained and worked in three university counseling centers thus far, including completing my pre-doctoral internship at Bowling Green State University’s Counseling Center last year. I am reaching out to you, as Training Director of an APA-accredited UCC internship site, to request assistance with participant recruitment for my dissertation research project titled *Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision*. This study has been approved by WMU’s Human Subjects Institutional Review Board (IRB Project Number 21-04-02).

The purpose of my study is to learn more about how experienced clinical supervisors are providing LGB-affirmative supervision to trainees. I am looking for participants with 5 or more years of clinical supervision experience and who also identify as knowledgeable about LGB issues and people.

UCCs mean a lot to me, professionally and personally, as the first setting I saw taking LGB-affirmative stances and, perhaps by no coincidence, have also been where I have had my most meaningful supervision. Below is a copy of my email invitation to potential participants. I would greatly appreciate it if you would both consider my study for yourself, if appropriate, and please forward the invitation to the members of your staff that provide supervision to trainees in your internship program. If you need additional information or have any questions for me, you can contact me directly at this email or my cell number listed below.

Thank you very much for your help.

Lindsey Dollar, MA, DTLLP
she/her/hers
Doctoral Candidate
Counseling Psychology
Western Michigan University
Cell: 765-620-6526

-----------------------------------

Dear Clinical Supervisor,

My name is Lindsey Dollar and I am a doctoral candidate in the Counseling Psychology program at Western Michigan University. I am reaching out to invite you to participate in my doctoral dissertation research focused on learning how experienced clinical supervisors understand and implement LGB-affirmative clinical supervision with trainees. I am inviting clinical supervisors
with 5 or more years of clinical supervision experience and who also identify as knowledgeable about LGB issues and people to participate.

My study includes four online measures to be completed in two research sessions. One measure has two parts that need to be split across two time points (i.e., Part 2 relies on the information collected in Part 1, so I would contact you when the second part is ready). Participation in the first session, which includes a background questionnaire, a measure of LGB-affirmative counseling behaviors, and Part 1 of an LGB-affirmative supervision measure will take approximately 20 minutes to complete. The second session, Part 2 of the LGB-affirmative supervision measure, will take an estimated 30 minutes. Please keep in mind that there are no correct answers and that I am interested in how you as an individual provides LGB-affirmative clinical supervision. After completing the second session, you will be entered into a drawing to win one of three $50 Amazon gift cards, which will be sent to you electronically.

This study has been reviewed and approved by the HSIRB at Western Michigan University. Your participation in this study is completely voluntary. All research data and information collected during the study will be confidential. Overall LGB training in graduate programs and LGB-affirmative counseling have been well-researched while LGB issues in supervision have gotten significantly less focus. Results from this study will not only help further our knowledge and understanding about LGB-affirmative supervision but will also have positive training implications and improve the standard of care for LGB clients.

If you would like to learn more about the study, please click on the following link, which will direct you to the informed consent document that outlines the study in more detail. Should you choose to participate, you can proceed from there: LGB-Affirmative Clinical Supervision Survey

Please only participate once, even if you receive more than one request. Follow-up emails may be sent to recruit additional participants during this phase of the study. If you have already participated, choose not to participate, or are not eligible to participate, please disregard. Additionally, if you know any clinical supervisors that might be particularly interested in this survey, please feel free to pass this study on to them.

Please contact me at 765-620-6526 or lindsey.n.dollar@wmich.edu or my faculty research advisor, Mary Z. Anderson, PhD, at 269-387-5113 or mary.anderson@wmich.edu should you have any questions or concerns. You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 with any additional questions or concerns.

Thank you in advance for your time and consideration.

Sincerely,

Lindsey Dollar, MA, DTLLP
she/her/hers
Doctoral Candidate
Counseling Psychology
Western Michigan University
Cell: 765-620-6526
Hello,

I hope this message finds you well. I would like to again express my appreciation for your participation in Part 1 of my dissertation study and for your patience while this next part was developed.

I am contacting you about participating in this final measure of my dissertation research. Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure is now ready. It should take approximately 30 minutes to complete. Here is the web address that will take you there, first to the informed consent document and then to the measure should you choose to continue: https://wmich.co1.qualtrics.com/jfe/form/SV_bexXnOSplrRMgB0

As a reminder, you will be entered into a drawing to receive one of three $50 Amazon gift cards at the completion of this final measure. If you have any questions or concerns, please feel free to contact me by phone 765-620-6526 or email lindsey.n.dollar@wmich.edu.

Thank you for your time,

Lindsey Dollar

Hello,

I hope this message finds you well. In November, as a clinical supervisor knowledgeable about LGB issues and people, you completed Part 1 of my dissertation study. I would like to express my appreciation for your participation. I have not been in contact until now because my original inclusion criteria was 5 or more years of clinical supervision experience and you had
marked 4 at that time; however, I have requested an exemption from my university’s HSIRB to include your data from Part 1 and to now invite you to Part 2.

This final measure of my dissertation research, Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, was created using items collected in Part 1. It should take an estimated 30 minutes to complete, with most participants finishing well-under that approximation. Here is the web address that will take you there, first to the informed consent document and then on to the measure:

https://wmich.co1.qualtrics.com/jfe/form/SV_bexXnOSpIrRMgB0

Thank you for your consideration. My entire study was designed with a targeted group in mind, and I consider your contribution to be invaluable. As a reminder, you will be entered into a drawing to receive one of three $50 Amazon gift cards at the completion of this final measure. If you have any questions or concerns, please feel free to contact me by phone 765-620-6526 or email lindsey.n.dollar@wmich.edu.

Best,

Lindsey Dollar
Appendix I

Electronic Communication—Reminder

Hello,

I hope this message finds you well. I recently sent a message about participating in the final measure of my dissertation research. I am hoping that you received this information; however, I am resending it in case you did not.

I would like to again express my appreciation for your participation in Part 1 of my dissertation study and for your patience while this next part was developed. Part 2 of the Exploring Perceptions of LGB-Affirming Clinical Supervision Measure is now ready. It should take approximately 30 minutes to complete. Here is the web address that will take you there, first to the informed consent document and then to the measure should you choose to continue:
https://wmich.co1.qualtrics.com/jfe/form/SV_bexXnOSpIrRMgB0

As a reminder, you will be entered into a drawing to receive one of three $50 Amazon gift cards at the completion of this final measure. If you have any questions or concerns, please feel free to contact me by phone 765-620-6526 or email lindsey.n.dollar@wmich.edu.

Thank you for your time,
Lindsey Dollar

Hello,

I hope this message finds you well. I recently sent a message about participating in the final measure of my dissertation research. I am hoping you received this information; however, I am resending it in case you did not. In November, as a clinical supervisor knowledgeable about LGB issues and people, you completed Part 1 of my dissertation study. I would like to express
my appreciation for your participation. I have not been in contact until now because my original inclusion criteria was 5 or more years of clinical supervision experience and you had marked 4 at that time. I have since requested an exemption from my university’s HSIRB to include your data from Part 1 and to invite you to Part 2.

This final measure of my dissertation study, Part 2 of the Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure, should take an estimated 30 minutes to complete – with most participants finishing well under that approximation. Here is the web address that will take you there, first to the informed consent document and then on to the measure:

https://wmich.co1.qualtrics.com/jfe/form/SV_bexXnOSpIrRMgB0

Thank you for your consideration. My entire study was designed with a targeted group of experts in mind. Thus, I consider your contribution to be invaluable. As a reminder, you will be entered into a drawing to receive one of three $50 Amazon gift cards at the completion of this final measure. If you have any questions or concerns, please feel free to contact me by phone 765-620-6526 or email lindsey.n.dollar@wmich.edu.

Best,

Lindsey Dollar
Appendix J

Electronic Communication–Final

Hello,

I hope this message finds you well. I am reaching out one last time about participating in the second and final measure of my dissertation research. I would like to again express my appreciation for your participation in Part 1 of my study and for your patience while this next phase was developed. My entire study was designed with a targeted group in mind. You are 1 of only 24 experienced clinical supervisors with LGBTQ+ knowledge being asked to return for Part 2 and thus, I consider your contribution to be invaluable.

Here is the web link for Part 2 of the Exploring Perceptions of LGB-Affirming Clinical Supervision Measure, which will direct you first to the informed consent document and then on to the measure. It should take an estimated 30 minutes to complete, with most participants so far finishing well under that approximation. As this is the last call, I am setting a completion deadline of 4/29/22. If you need more time, please reach out and let me know.

https://wmich.co1.qualtrics.com/jfe/form/SV_bexXnOSpIrRMgB0

As a reminder, you will be entered into a drawing to receive one of three $50 Amazon gift cards at the completion of this final measure. If you have any questions or concerns, feel free to contact me by phone 765-620-6526 or email lindsey.n.dollar@wmich.edu.

Thank you for your time and assistance,

Lindsey Dollar
Hello,

I hope this message finds you well. I am reaching out one last time about participating in the final measure of my dissertation research. I would like to again express my appreciation for your participation in Part 1 of my study and for your patience and understanding about the gap in time hearing back from me. Based on the data provided in Part 1, I felt strongly about needing to try to get a complete data set contribution from you.

Here is the web link for Part 2 of the Exploring Perceptions of LGB-Affirming Clinical Supervision Measure, which will direct you first to the informed consent document and then on to the measure. It should take an estimated 30 minutes to complete, with most participants finishing well-under that approximation. As this is the last call, I am setting a completion deadline of 7/22/22. If you need more time, please reach out and let me know.

https://wmich.co1.qualtrics.com/jfe/form/SV_bexXnOSpIrRMgB0

As a reminder, you will be entered into a drawing to receive one of three $50 Amazon gift cards at the completion of this final measure. If you have any questions or concerns, feel free to contact me by phone 765-620-6526 or email lindsey.n.dollar@wmich.edu.

Thank you for your time and assistance,

Lindsey Dollar
Appendix K

Informed Consent Document – Data Collection Part 1

Western Michigan University
Department of Counselor Education and Counseling Psychology

Principal Investigator: Mary Z. Anderson, PhD
Student Investigator: Lindsey N. Dollar, MA

Title of Study: Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision

You are invited to participate in this research project titled “Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision.”

STUDY SUMMARY: This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. Participation in this study is completely voluntary and you can refuse to participate, stop participating at any time, or choose to not answer any question without prejudice or penalty. The purpose of this study is to learn how experienced clinical supervisors with knowledge of lesbian, gay, and bisexual (LGB) issues and people understand and provide LGB-affirmative clinical supervision and it will serve as Lindsey N. Dollar’s dissertation for the requirements of the Counseling Psychology PhD program. There has been substantial research covering LGB training in graduate programs and LGB-affirmative counseling; however, less is known in this area as it pertains to supervision, one of the major arenas of training in mental health fields. If you take part in the research, you will be asked to complete four online measures – three in the first session and one in a second session. This is because one of the measures is two-part, with Part 2 requiring the information gathered in Part 1 to be created. All research data and information collected from you is confidential. Participation in the first session will take approximately 20 minutes to complete. The second session will take an estimated 30 minutes.

Possible risk and costs to you for taking part in the study may be discomfort from questions about yourself and your experience. Potential benefits may be a sense of satisfaction or other positive emotions as a result of participating in a study on an under-researched topic intended to have positive training implications and subsequently improve standards of care for LGB clients. Your alternative to taking part in the research study is not to take part in it.

The following information in this consent document will provide more detail about the research study. Please ask any questions if you need more clarification and to assist you in deciding if you wish to participate in the research study. You are not giving up any of your legal rights by agreeing to take part in this research. After all of your questions have been answered and the consent document is reviewed, if you decide to participate in this study, please indicate this by clicking the “I agree to participate in this research study” button below.
Who can participate in this study?
Clinical supervisors with 5 or more years of clinical supervision experience and that identify as knowledgeable about LGB issues and people are invited to participate in the study. Specific professional organizations are being contacted for participant recruitment based on the number of members that identify as practitioners and as interested in LGB issues.

What will you be asked to do if you choose to participate in this study? What information is being measured during the study?
Participation in the study involves completing four online measures: one that asks you to provide demographic information and answer background questions concerning your educational and professional experiences, one which asks you to share your understandings and descriptions of the LGB-affirmative clinical supervision that you provide supervisees and then to later compare and rate those responses to one another, and one that asks about LGB-affirmative counseling behaviors.

Where will this study take place?
The study measures will be completed online. You will be given access to the measures after you have read this informed consent form and clicked on the link below with the words “I agree to participate in this research study” should you decide you wish to proceed and participate.

What is the time commitment for participating in this study?
The study includes four online measures to be completed in two research sessions. One of the measures has two participant parts that need to be split across two time points (i.e., the latter part relies on the information collected in the first, so I will contact you when the second part is ready to be completed). Participation in the first session will take an estimated 20 minutes. The second session will take approximately 30 minutes to complete.

What are the risks and costs of participating in this study and how will these risks be minimized?
Possible risk and costs to you for taking part in the study may be discomfort from questions about yourself and your experiences. To minimize risk, you can refuse to participate, stop participating at any time, or choose to not answer any question without prejudice or penalty.

What are the benefits of participating in this study?
You will have the opportunity to have your “voice heard” by contributing important information about your experiences of providing LGB-affirmative clinical supervision. Some participants may feel a sense of satisfaction or other positive emotions as a result of participating in a study on an under-researched topic that is intended to have positive training implications and subsequently improve the standard of care for LGB clients.

Is there any compensation for participating in this study?
After completing all of the measures, you will be given the opportunity to be entered into a drawing for one of three $50 Amazon gift cards. The approximate chance of being selected in the drawing is 1 in 10.
What will happen to my information collected for this study after it is over?
All research data and information collected during the study will be confidential. All research data and information will be collected and stored during the study using a secure, password protected website and computer with up-to-date Trend Micro Antivirus+ Security software protection, as well as backed-up on an encrypted USB drive–both owned by the student researcher. At the conclusion of the study, all data will be stored on a password protected device and kept in the locked university office of the principal investigator, Dr. Mary Z. Anderson. In accordance with federal regulations and the American Psychological Association, data will be maintained for 5 years after the study has been completed.

The information collected about you for this research will not be used by or distributed to investigators for other research. Findings may be reported for publication but no identifying information about participants will be reported.

Should you have any questions prior to or during the study, you can contact the principal investigator, Mary Z. Anderson, PhD, at 269-387-5113 or mary.anderson@wmich.edu or the student investigator, Lindsey N. Dollar, MA, at 765-620-6526 or lindsey.n.dollar@wmich.edu. You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298.

This consent document has been approved for use for one year by the Western Michigan University Institutional Review Board (WMU IRB) on [insert study approval date].

Participating in this survey online indicates your consent for use of the answers you supply.

Buttons to click:

I AGREE TO PARTICIPATE IN THIS RESEARCH STUDY (Survey following upon clicking)
I DO NOT AGREE TO PARTICIPATE IN THIS RESEARCH STUDY (Browser closes)
Appendix L

Informed Consent Document – Data Collection Part 2

Western Michigan University
Department of Counselor Education and Counseling Psychology

Principal Investigator: Mary Z. Anderson, PhD
Student Investigator: Lindsey N. Dollar, MA

Title of Study: Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision

You are invited to participate in Part 2 of the research project titled “Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision.”

STUDY SUMMARY: This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. Participation in this study is completely voluntary and you can refuse to participate, stop participating at any time, or choose to not answer any question without prejudice or penalty. The purpose of this study is to learn how experienced clinical supervisors with knowledge of lesbian, gay, and bisexual (LGB) issues and people understand and provide LGB-affirmative clinical supervision and it will serve as Lindsey N. Dollar’s dissertation for the requirements of the Counseling Psychology PhD program. There has been substantial research covering LGB training in graduate programs and LGB-affirmative counseling; however, less is known in this area as it pertains to supervision, one of the major arenas of training in mental health fields. You are being contacted because you previously completed Part 1 of this research. Part 2 is the fourth and final online measure and will take approximately 30 minutes to complete. All research data and information collected from you is confidential.

Possible risk and costs to you for taking part in the study may be discomfort from questions about yourself and your experience. Potential benefits may be a sense of satisfaction or other positive emotions as a result of participating in a study on an under-researched topic intended to have positive training implications and subsequently improve standards of care for LGB clients. Your alternative to taking part in the research study is not to take part in it.

The following information in this consent document will provide more detail about the research study. Please ask any questions if you need more clarification and to assist you in deciding if you wish to participate in the research study. You are not giving up any of your legal rights by agreeing to take part in this research. After all of your questions have been answered and the consent document is reviewed, if you decide to participate in this study, please indicate this by clicking the “I agree to participate in this research study” button below.
**Who can participate in this study?**
Clinical supervisors with 5 or more years of clinical supervision experience and that identify as knowledgeable about LGB issues and people who previously participated in Part 1. You are being contacted using the email address that you previously provided.

**What will you be asked to do if you choose to participate in this study? What information is being measured during the study?**
Participation in Part 2 of the study involves comparing and rating descriptions of LGB-affirmative clinical supervision gathered from all participants in Part 1.

**Where will this study take place?**
The study measures will be completed online. You will be given access to the measure after you have read this informed consent form and clicked on the link below with the words “I agree to participate in this research study” should you decide you wish to proceed and participate.

**What is the time commitment for participating in this study?**
Part 2 of the study includes one online measure and re-entering your email address to connect your data to Part 1. It is expected to take approximately 30 minutes to complete.

**What are the risks and costs of participating in this study and how will these risks be minimized?**
Possible risk and costs to you for taking part in the study may be discomfort from questions about yourself and your experiences. To minimize risk, you can refuse to participate, stop participating at any time, or choose to not answer any question without prejudice or penalty.

**What are the benefits of participating in this study?**
You will have the opportunity to have your “voice heard” by contributing important information about your experiences of providing LGB-affirmative clinical supervision. Some participants may feel a sense of satisfaction or other positive emotions as a result of participating in a study on an under-researched topic that is intended to have positive training implications and subsequently improve the standard of care for LGB clients.

**Is there any compensation for participating in this study?**
After completing this final measure, you will be entered into a drawing for one of three $50 Amazon gift cards. The approximate chance of being selected in the drawing is 1 in 10.

**What will happen to my information collected for this study after it is over?**
All research data and information collected during the study will be confidential. All research data and information will be collected and stored during the study using a secure, password protected website and computer with up-to-date Trend Micro Antivirus+ Security software protection, as well as backed-up on an encrypted USB drive—both owned by the student researcher. At the conclusion of the study, all data will be stored on a password protected device and kept in the locked university office of the principal investigator, Dr. Mary Z. Anderson. In accordance with federal regulations and the American Psychological Association, data will be maintained for 5 years after the study has been completed.
The information collected about you for this research will not be used by or distributed to investigators for other research. Findings may be reported for publication but no identifying information about participants will be reported.

Should you have any questions prior to or during the study, you can contact the principal investigator, Mary Z. Anderson, PhD, at 269-387-5113 or mary.anderson@wmich.edu or the student investigator, Lindsey N. Dollar, MA, at 765-620-6526 or lindsey.n.dollar@wmich.edu. You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298.

This consent document has been approved for use for one year by the Western Michigan University Institutional Review Board (WMU IRB) on May 2, 2022.

Participating in this survey online indicates your consent for use of the answers you supply.

Buttons to click:

I AGREE TO PARTICIPATE IN THIS RESEARCH STUDY  (Survey following upon clicking)

I DO NOT AGREE TO PARTICIPATE IN THIS RESEARCH STUDY  (Browser closes)
Appendix M

Recommended LGB-Affirmative Supervision Resources

Organization Websites:

- The Trevor Project (https://www.thetrevorproject.org/)
- Human Rights Campaign (https://www.hrc.org/)
- PFLAG (https://pflag.org/)
- GLSEN (https://www.glsen.org/)
- WPATH (https://www.wpath.org/)
- Trans Student Educational Resources (TSER) (https://transstudent.org/)
- It Gets Better Project (https://itgetsbetter.org/)
- GLAAD (https://www.glaad.org/)
- Everyone Is Gay (https://everyoneisgay.com/)
- Family Acceptance Project (https://familyproject.sfsu.edu/)
- Queer Theology (https://www.queertheology.com/)
- Mazzoni Center (https://www.mazzonicenter.org/)
- EDGE New Jersey (https://edgenj.org/)
- Chase Brexton Health Care (https://chasebrexton.org/)
- World Health Organization (https://www.who.int/)

Books:

- Affirmative Counseling with LGBTQI+ People (Ginicola, Smith, & Filmore)
- A Clinician’s Guide to Gender-Affirming Care: Working with Transgender and Gender Nonconforming Clients (Chang & Singh)
- Mindfulness and Acceptance for Gender and Sexual Minorities: A Clinician’s Guide to Fostering Compassion, Connection, and Equality Using Contextual Strategies (Skinta, Curtin, & Pachankis)
- Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients (Bieschke, Perez, & DeBord)
- The Gender Quest Workbook: A Guide for Teens and Young Adults Exploring Gender Identity (Testa & Coolhart)
- The Velvet Rage (Downs)
- My Gender Workbook (Bornstein)
- Gender Outlaw (Bornstein)
- Queer: A Graphic History (Barker & Scheele)
- Non-fiction books by queer people

Journal Articles:


Other(s):

- Campus resource centers: LGBTQ+ and Women & Gender
- Gender Unicorn Activity (https://transstudent.org/gender/)
- Minority stress models
- John Dehlin’s TED Talk “The Ally Within”
- Two participants (N = 2; 11.1%) also specifically emphasized finding the APA’s (2021) latest sexual minority guidelines particularly helpful— one describing them as “broad, intersectional, up-to-date, and strengths-focused.”
Appendix N

Initial 100 Participant Items Organized by Category and Item on Exploring Perceptions of LGB-Affirmative Clinical Supervision Measure: Part 1

Category 1: LGB Beliefs, Attitudes, & Biases
Item 1: Model and encourage supervisee exploration of beliefs, attitudes, and biases about LGB sexual orientations

- I encourage student therapists to explore their own attitudes and biases so they can be nonjudgmental with their clients
- Definitely going to ask the trainee to look deep at internalized homophobia – their own or the clients
- Provide active monitoring of services being provided by supervisees to LGB clients to help ensure that supervisee biases are being managed and harm is mitigated
- By providing acceptance of supervisees’ learned homophobia and providing a space for them to talk through these biases, especially as they relate to their religious identities. I seek to provide a space where supervisees can learn about the ethics of our profession related to providing LGB-affirming services and reconcile this emerging part of their identity with long held beliefs connected to another part of their identity. I intentionally avoid shaming supervisees who hold anti-LGB biases to promote open dialogue
- Discussing personal experiences that would help/hinder a supervisee’s ability to work with a client that is LGBTQ in order to “open the door” regarding the supervisee’s sexual orientation and/or give me information I would need to protect LGBTQ clients working with this supervisee
- Consistently interrogate my own heterosexist biases
- Challenge supervisee assumptions regarding gender, identity, and orientation when appropriate

Category 2: LGB Clinical Issues
Item 2: Demonstrate understanding of common LGB clinical issues

- Demonstrate understanding of LGB clinical issues
- Share experiences of counseling LGBTQ+ clients
- Being aware of common experiences like coming out
- Really important we look at spiritual abuse/disconnect/being kicked out because of identity
- Guide their strategies for working with parents of LGBTQi youth

Category 3: Provide LGB-Affirmative Resources
Item 3: Provide LGB-affirmative resources

- Provide LGB affirming resources to supervisee
- Providing resources and articles written by LGB-identified scholars
• Providing resources and articles about working with LGB clients that are recent and up to date
• Provide ethics and research articles to supervisees to review and discuss in supervision
• Provide resources and trainings on affirmative services in supervision
• Provide resources and readings early on in supervision
• Books and reference material. Our school has a library dedicated to LGBTQ

Category 4: LGB-Affirmative Therapeutic Practices
Item 4: Teach LGB-affirmative therapeutic practices

• Teach affirming therapeutic practices with the community
• Examine supervisee interventions to determine if they are affirming
• I encourage student therapists to take an affirmative, nonjudgmental stance in their therapy when they encounter clients working on sexual orientation issues
• Challenge supervisee to integrate LGB issues in client conceptualization
• Encourage supervisees to attend trainings and professional development on LGBTQ+ topics
• Drawing on feminist, strengths-based, and LGB-affirming models

Category 5: Open Identity Discussions
Item 5: Initiate open discussions about identities in supervision
Item 6: Encourage open discussions about identities in therapy

• Encouraging open identity discussions
• Initiate open exploration of sexual orientation and other intersecting identities
• Initiate sexual orientation questions and discussions
• Broach topics surrounding LGBTQ+ issues and concerns
• Ask questions about trainee’s experience working with queer folx
• Discussing sexual orientation
• Initiate racial, cultural, and sexual identity/gender identity topics into case discussions
• It is important to work to understand the ways a supervisee’s clients’ gender and sexual orientation impacts their worldview and how that may show up in their presenting concerns and/or the therapy room
• Initiate racial, cultural, and sexual identity/gender identity topics into information desired from new client appointment
• Initiate conversations around sexual orientation/affection, intersex, and gender identity/expression
• Initiate discussions on sexual orientation, in relation to specific clients, and as a separate marginalized identity variable
• Focus attention to consideration of LGBTQi presence

Category 6: Inclusive Language
Item 7: Use affirmative and inclusive language

• Using affirmative language and not assuming gender of supervisee’s partner
• Use sensitive language in all didactic trainings and supervisory discussions
• It is necessary not to assume/engage in heteronormative language and approaches
• Ask about supervisees and their clients’ pronouns and share mine
• Ask the pronouns that my trainees would like to be used
• Discuss pronouns used

Category 7: Evaluating Awareness, Knowledge, & Skill with LGB Issues & Clients
Item 8: Gauge supervisee awareness, knowledge, and skill with LGB issues and clients

• Gauge awareness and knowledge of LGBTQ+ issues
• Making sure that the trainee has gotten info about the client’s orientation
• Encourage supervisees to explore language/meaning of client’s orientation to the client & related to presenting concerns
• Support supervisees to increase their comfort level with discussing sex and sexuality with their clients (regardless of client sexual orientation)
• Inquire about client orientation & how it is known (or assumed)
• Ask supervisees about gender identity and sexual orientation of every client presented

Category 8: Training Environment
Item 9: Advocate for a training environment that empowers supervisees to be heard, ask questions, and process feelings

• Creating space to be heard in the supervision room and in all staff spaces/meetings
• Provide space for supervisees to ask any questions
• Provide brave space for supervisees to process their own feelings
• Respond with open acceptance of topic when it comes up
• Open to feedback and adapting supervision as necessary to meet the needs of supervisees
• Advocating for appropriate staff cultural responsiveness towards our supervisees
• Supporting trans-identified supervisees through making name changes in our system and communication with team and helping them to consider how to navigate licensure systems as they are working through the process

Category 9: Supervisory Relationship
Item 10: Create a supportive, honest, and LGB-affirming supervisory relationship

• Develop a safe, open, honest, and supportive personal relationship
• Define/negotiate supervision roles/expectations
• Address concerns, reservations, and qualms of both the supervisee and supervisor
• I model self-acceptance and encourage the same in student therapists
• Admit to my own areas of ignorance and actively engage in self-correction
• Modelling humility, curiosity in developing as a clinician (generally & with LGB clients)
• Talk about how we will recognize and address LGBTQ issues (e.g., supervisee/client, supervisee/supervisor, supervisor/client, supervisee/site, supervisor/site)

Category 10: Discerning Quality, Affirming LGB Literature & Research
Item 11: Assist with finding and reviewing reliable LGB-affirmative literature and research

- Assist supervisee to review scholarly literature
- Show supervisees how to find reliable resources
- I encourage student therapists to read affirmative literature
- Assist supervisee to develop knowledge of LGB people
- Discuss research related to LGBTQ individuals when working with supervisees or bring up the absence of research for the LGBTQ individuals (i.e., This study looks at depressed students, but did not assess for sexual orientation – what might be unique for that population?)

Category 11: Vulnerability and Self-Disclosure
Item 12: Model vulnerability and appropriate self-disclosure of sexual orientation

- By modeling vulnerability, openness, and appropriate self-disclosure about my sexual orientation
- Utilize self-disclosure to normalize sexual orientation discussions and model passion and experience with sexual minorities
- Self-disclosure and openness to conversations/learning opportunities
- Disclose sexual orientation and identity
- Model self-disclosure of LGB experience on professional behavior
- Using self-disclosure
- Present myself as a queer supervisor openly and proudly so that the supervisee could connect with me on that level or hopefully feel comfortable asking questions that would in turn help supervisees with their queer clients

Category 12: Transference & Countertransference
Item 13: Address transference and countertransference

- Having transference and countertransference discussions
- Many of my trainees have been LGB+ people. When they have an LGB+ client, let’s take apart any transference and/or countertransference that might be happening

Category 13: Microaggressions & Systemic Oppression
Item 14: Discuss microaggressions and other experiences of oppression

- Creating space to talk about microaggressions and experiences of oppression from the larger campus
- Discuss any micro or macro aggressions

Category 14: Normalization of Diverse Sexual & Gender Orientations/Identities
Item 15: Model openness and normalize any/all topics related to gender/sexuality

- Model openness to any/all topics related to gender/sexuality
• Talk about the normalcy of ALL orientations – even the ones we may not have heard of or understand – so do some research, but not at the expense of asking the client to teach you

Category 15: Minority Stress Experiences
Item 16: Consider and validate minority stress experiences
• Validating minority stress experiences
• Help supervisee critically analyze the effects of minority stress on client’s life
• Encourage thinking about impact of sexual minority stress/identity development on client’s mental health/functioning
• Be sensitive to impact of internalized oppression on supervisee

Category 16: Education on LGB Experiences & Oppressions
Item 17: Provide education on common LGBTQ+ identities, experiences, and oppressions
• Provide knowledge of sexual orientation/affection, intersex, and gender identity/expression
• Discuss similarities and differences in gender identity and sexual orientation
• Discuss intersexuality
• Foster practical discussions about system navigation of LGBTQ+ clients and supervisees in hostile spaces
• Provide education on common oppressions experienced by queer folx in our area
• Attendance in LGBTQ support groups
• Attendance in group develop for the trans population

Category 17: Processing & Exploring Identities
Item 18: Encourage thoughtful, intersectional discussions about identities and how those impact clinical work and supervision
• Initiating thoughtful, intersectional discussions about identities, including sexual orientation, to the extent the supervisee feels comfortable sharing
• As a supervisor it is important to explore my and my supervisee’s gender identity and sexual orientation and how that interacts with each other, our work with clients, and our approach to this field
• Encouraging the processing and discussion of client demographic data related to client experiences
• Inquire what is important to them re gender and sexuality, that they would like me to know and to be aware/sensitive of
• Work with students on identifying their own intersectional identities
• Considering with supervisee how their identity impacts their clinical content
• Ask new supervisees to describe themselves using the ADDRESSING model. I disclose my own identities in this conversation
• Initiate racial, cultural, and sexual identity/gender identity topics into getting to know trainee
Appendix O

HSIRB Approval Letter

Date: May 2, 2021

To: Mary Anderson, Principal Investigator
    Lindsey Dollar, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: IRB Project Number 21-04-02

This letter will serve as confirmation that your research project titled “Exploring the Dimensions of Lesbian, Gay, and Bisexual Affirmative Clinical Supervision” has been approved under the exempt category of review by the Western Michigan University Institutional Review Board (IRB). The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., add an investigator, increase number of subjects beyond the number stated in your application, etc.). Failure to obtain approval for changes will result in a protocol deviation.

In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB for consultation.

The Board wishes you success in the pursuit of your research goals.

A status report is required on or prior to (no more than 30 days) May 1, 2022 and each year thereafter until closing of the study. The IRB will send a request.

When this study closes, submit the required Final Report found at https://wmich.edu/research/forms.

Note: All research data must be kept in a secure location on the WMU campus for at least three (3) years after the study closes.