EXAMINING THE RELATIONSHIP BETWEEN RELIGIOSITY, PROFESSIONAL IDENTITY DEVELOPMENT AND ATTITUDES ABOUT SEXUAL MINORITY ORIENTATION

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ABSTRACT

Despite improved attitudes regarding sexual minority orientation, lesbian, gay, bisexual, and transgender (LGBT) individuals continue to experience considerable stigma, discrimination, and victimization in American society. LGBT individuals exhibit increased rates of psychological symptoms because of stress associated with having a sexual minority orientation and have higher utilization rates of mental health services than heterosexuals. This study explored the impact of religiosity on counselor attitudes about sexual minority orientation. The relationship between professional identity development, religiosity, and attitudes about sexual minority orientation was examined. Specific objectives of this study were to (1) identify counselor characteristics that impact attitudes about sexual minority orientation; (2) explore the relationship between religiosity and attitudes towards gay and lesbian individuals; and, (3) explore the impact of professional identity development on attitudes about sexual minority orientation.

Results from this study did not find significant differences in attitudes towards gay and lesbian individuals between counselors of difference races, gender, level of education, or years of experience. Religious counselors endorsed more positive attitudes towards gay and lesbian individuals as compared to nonreligious counselors. Professional identity development did not mediate the relationship between religiosity and attitudes towards gay and lesbian individuals.
# LIST OF ABBREVIATIONS AND SYMBOLS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>a</td>
<td>Cronbach’s index of internal consistency</td>
</tr>
<tr>
<td>df</td>
<td>Degrees of freedom: number of values free to vary after certain restrictions have been placed on the data</td>
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<tr>
<td>F</td>
<td>Fisher’s F ratio: A ratio of two variances</td>
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<tr>
<td>M</td>
<td>Mean: the sum of a set of measurements divided by the number of measurements in the set</td>
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<tr>
<td>p</td>
<td>Probability associated with the occurrence under the null hypothesis of a value as extreme as or more extreme than the observed value</td>
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<tr>
<td>r</td>
<td>Pearson product-moment correlation</td>
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<tr>
<td>SD</td>
<td>Standard deviation: a measure of variability around the mean</td>
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<tr>
<td>t</td>
<td>Computed value of t test</td>
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<tr>
<td>&lt;</td>
<td>Less than</td>
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<td>=</td>
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ACKNOWLEDGMENTS

I have been very fortunate to have a village of people in my life that have provided me unwavering love, support, and encouragement. First, I would like to thank my family who have instilled in me a passion for education and the belief that I was capable of succeeding in anything I committed myself to despite obstacles. These values fostered a desire in me to serve others and have played a large role in my desire to pursue the counseling field and my interest in social justice issues. Their example has pushed me to continue to strive to take active steps to work to address issues that impact our communities and society.

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CHAPTER 1
INTRODUCTION

Research suggests that Americans currently hold more favorable attitudes about lesbian, gay, bisexual, and transgender (LGBT) individuals than during any previous time in history (Herek, 2015). Research conducted by the Pew Research Center in 2014 indicated that 62% of participants reported that gay and lesbian individuals should be accepted by society. This number rose from 51% in 2006 and was accompanied by increased support of same sex marriage (i.e., from 35% of participants endorsing acceptance to 50% endorsement in less than 10 years; Russell & Bohan, 2014). Despite improved attitudes regarding sexual minority orientation, LGBT individuals continue to experience considerable stigma, discrimination, and victimization in American society (Herek, 2000; Meyer, 2003). Many LGBT individuals are more open about their sexuality and increased attention has been placed on this population because of the awareness of discrimination against LGBT individuals, the LGBT community’s effort to obtain equal rights, and research documenting the existence of physical and mental health disparities. LGBT individuals also exhibit increased rates of psychological symptoms because of stress associated with having a sexual minority orientation and have higher utilization rates of mental health services than heterosexuals (Bostwick, Boyd, Hugh, West & McCabe, 2014; Oswalt & Wyatt, 2011; Pachankis & Goldfried, 2013; Sabin et al., 2015).

Discrimination against LGBT individuals is well-documented in America’s sociopolitical history (Borgman, 2009). Homosexuality was pathologized by the scientific and medical community for decades and attitudes of prejudice were embedded in American culture by laws
and practices that restricted or withheld rights of LGBT individuals. Values about sexuality began to shift dramatically in the early 1900s, after research surfaced in the 1940s and 1950s that suggested homosexuality was a normal variant of sexual development. The American Psychiatric Association (APA) removed homosexuality as a mental disorder from the Diagnostic and Statistical Manual (DSM) in 1973, marking the beginning of professional mental health organizations’ efforts to depathologize homosexuality. This was followed by a resolution in 1975 that acknowledged that necessity of actively working to address sexual stigma and prejudice. This resolution conveyed the message that labeling homosexuality as a mental illness “has always been based on valued-laden assumptions derived from sexual stigma rather than science” (Herek, 2007, p. 915). The APA asserted that:

Homosexuality per se implies no impairment in judgement, stability, reliability, or general social and vocational capabilities: Further, the American Psychiatric Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations (Congers, 1975, p. 63).

Since that time professional organizations have continued to acknowledge the necessity of addressing the unique needs of LGBT individuals. Educating the public about issues related to sexual orientation and identifying competencies and best practices to improve service delivery has become a major focus of the professional field. In 1990, the American Counseling Association’s (ACA) Governing Council passed a resolution supporting the importance of disseminating accurate information about sexual orientation. Since the early 1990s, ACA developed competencies for LGBT affirmative practices (2004) and revised the ACA Code of Ethics (2015). These steps taken by ACA emphasized the necessity of counselors providing
effective services to LGBT clients (Whitman & Bidell, 2014). In addition, efforts to ensure that LGBT clients receive effective mental health services have also been extended to accrediting bodies of counseling training programs. For example, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP, 2009) offered standards that specifically addressed counselors’ responsibility to become multiculturally competent, respectful of diversity, and to address discrimination (Whitman & Bidell, 2014).

Despite professional bodies’ efforts to improve training for professionals and to educate the public on the lack of validity to support the notion that homosexuality is a mental illness, stigma regarding sexual orientation continues to persist. The United States is a heteronormative society, and, sexual minorities often are perceived as invisible and inferior (Herek, 2010; Swank, Fahs, & Frost, 2013). LGBT individuals to face exclusion, discrimination, and victimization in their work places, homes, schools, and places of worship. To add, LGBT individuals also report higher rates of mood and anxiety disorders, depression, suicidality, self-injurious behaviors, and substance use disorders (Bostwick et al., 2014; Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Feinstein, Goldfried, & Davila, 2012). Based on these findings, LGBT individuals can be considered a vulnerable population due to frequent experiences of exclusion and discrimination that need advocacy from professionals in the helping fields.

The field of counseling evolved from professionals’ efforts to address the social needs of individuals in the community. This is reflected in the ACA’s 2014 Mission Statement which stated that the purpose of the ACA is “to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity” (ACA, 2014, p. 2). This statement acknowledges that honoring diversity is a core value of the field and
that counselors are expected to respect all people, regardless of differences. Further, as the
demographic composition of United States has continued to change, this emphasis on
multicultural competency, advocacy, and social justice issues will continue to be important in
future years.

It is vital for counselors to address diversity and advocate for all individuals. Unfortunately, many counseling theories have historically addressed client problems from an
individual level and minimized the impact of environmental conditions that contribute to their
distress (Ratts, 2009). The tendency to minimize the impact of the environment on clients’
issues is known as the fundamental attribution error. Fundamental attribution error negatively
impacts clients by projecting blame and inadvertently maintaining and perpetuating the status
quo (Chang, Crethar, & Ratts, 2010). Lewis (2011) explains that:

society often places unfair constraints on individuals, creating barriers to their
development and preventing them from achieving their goals. When counselors
began to view the opportunity for a good life as a basic human right, the nature of
their work takes a radically different turn. Their attention broadens from a focus
on the individual to a focus on the environment, and they begin to see
environmental change as a professional responsibility (p. 183).

On the other hand, contemporary perspectives and theories acknowledge the impact of
the environment and society on one’s quality of life. These perspectives consider important
ways to address barriers that negatively impact clients through advocacy and social justice. A
social justice perspective “acknowledges issues of power, privilege, and oppression. Moreover,
a social justice counseling approach uses social advocacy and activism as a means to address
inequitable social, political, and economic conditions that impede on the academic, career, and personal/social development of individuals, families, and communities” (Ratts, 2009, p. 160).

A social justice perspective is of particular relevance to marginalized groups who may have limited control over certain environmental stressors that are related to a poorer quality of life. Speaking from this framework, researchers have shown that counselors should be aware that “issues of social justice are integral to counseling because of the reality that clients do not exist as individuals independent of society, culture, and context” (Chang, Crethar, & Ratts, 2010, p. 63). These researchers went on to state that “counseling from any perspective that places all responsibility for change on the individual is relatively culturally impositional because it functions from the presumption that change occurs within the individual regardless of the environment” (Chang et al., p. 63). This awareness is essential because regardless of the population a counselor serves clients will present with stress that stems from societal conditions. Social justice work is an important part of clinical practice, regardless of the setting:

it... occurs when career or employment counselors become aware of inequitable hiring practices; when rehabilitation counselors note the obstacles their clients face in trying to obtain their rights to equal treatment to stop unfair and inhumane educational practices; when agency counselors dealing with specific populations try to offset the community’s tendency to marginalize particular groups of people. It happens whenever a counselor’s attempt to help his or her clients find their own strength is counterbalanced by environmental forces that weaken or stifle growth (Lewis, Lewis, Daniels, & D’andrea, 2011, p. 207).
Social justice is not a new concept to the field. Efforts to address the changing needs of clients can be viewed as a commitment to carry out the earliest principles and values of the counseling field, and the ethical code of the American Counseling Association (2014).

**Current Study**

Although mental health professionals are trained to be culturally aware and sensitive, they are also subject to the same negative messages about sexual minority orientation as any other member of society. Values about sexual behavior are often rooted in moral principles and religious teachings; and religion is an important factor in the lives of many American citizens. If counselors hold prejudices and biases towards LGBT individuals this could negatively impact therapy outcomes. Thus, exploring the variables that shape mental health professionals’ attitudes about sexual orientation could offer implications for clinical practice and provide insight into the therapeutic conditions LGBT clients experience.

Exploring the impact of religiosity on professional counselors’ attitudes about sexual orientation, while seeking to add to the literature base regarding ways counselors resolve value conflicts is important to consider. Although it is appropriate that emphasis is placed on improving therapeutic conditions for LGBT clients because of mental health disparities, the connection between serving this population and providing effective services for all clients should be noted. Identifying factors that influence counselor development has important implications for the training and supervision of new counselors. Advocacy and social justice work are also important to improving the quality of life for all clients, not only minority or marginalized groups.

The definition and meanings of terms used to describe sexual orientation and gender identity are not universally accepted and continue to evolve. LGBT is a term frequently used to
describe sexual orientation and gender identity. The LGBT acronym is not all inclusive and other acronyms are frequently used to make a distinction and include or exclude other groups. LGBT will be used throughout this paper as an umbrella term to reference previous research conducted about sexual orientation and gender identity. Other acronyms will only be used when referencing research that specifically included or excluded certain groups based on sexual orientation or gender identity.

Statement of the Problem

Heterosexuality is generally accepted as the dominant sexual orientation (Siebert, Rutledge, & Killian, 2014). A heterocentric culture can foster bias toward sexual minorities and perpetuate the belief that sexual minority orientations are inferior, deviant, or pathological (Swank, Fahs, & Frost, 2013). LGBT individuals represent a minority group in regard to sexual orientation and exhibit higher rates of psychological symptoms that are attributed to experiences of hostility, exclusion, discrimination, and violence (Kertzner, Meyer, Frost, & Stirratt, 2009). LGBT individuals report higher rates of depression, self-injurious behaviors, suicidality, and substance use, as compared to heterosexuals (Seil, Desai, & Smith, 2014). LGBT clients can be considered a vulnerable population because of frequent experiences of discrimination and disproportionate rates of psychological symptoms and disorders.

Despite an emphasis on affirmative therapy practices, LGBT clients continue to report negative experiences during the therapeutic process. Literature has suggested that LGBT clients experience microaggressions during therapeutic encounters and issues related to sexual orientation may be minimized or exaggerated (Shelton, Edward, & Delgado-Romero, 2013). Although mental health professionals may not consciously hold biases, they are privy to the same heterosexist messages of the general population. The U.S. is a heterocentric society and
negative attitudes about sexual minority orientation are fostered by a number of social practices, laws, and religious institutions (Borgman, 2009). This can result in people becoming desensitized to negative attitudes about sexual orientation and holding biases outside of an individual’s awareness (Shelton & Delgado-Romero, 2013). A heterocentric culture also places counselors at risk of internalizing negative attitudes about sexual minority orientation. “A number of studies indicate that counselors and other professionals are sometimes bearers of society’s homonegative values through their own religious beliefs” (Fallon et al., 2013, p. 41). Holding negative attitudes about sexual minority orientation can impair a counselor’s ability to provide effective services to LGBT clients. Those attitudes can also create a value conflict between a counselor’s personal values and professional values and impair a counselor’s ability to provide effective services to LGBT clients.

**Purpose of the Study**

LGBT individuals have higher utilization rates of mental health services because of frequent experiences of discrimination, stigma, and internalized homophobia (Oswalt & Wyatt, 2011; Shilo & Savaya, 2012). Creating a safe place where clients feel accepted and respected is important for effective work with any client, but is particularly important for clients who have experienced marginalization or discrimination. Because religion and spirituality are salient aspects of people’s lives it can have significant implications for clinical practice. Western religions have historically taken a strong position in opposition to homosexuality and deemed same sex relationships as immoral and sinful (Fallon et al., 2013). Many LGBT people experience conflict between their sexual identity and religious values and that experience may parallel counselors’ attempts to integrate their religious values with their professional values (Fallon et al., 2013).
Although a host of research has been conducted on the impact of religion on clients’ lives, less attention has been placed on the impact of religion and spirituality on counselors’ clinical work and ways they resolve value conflicts. Thus, the purpose of this study was to explore the impact of religiosity on counselor attitudes about sexual minority orientation. The relationship between professional identity development, religiosity, and attitudes about sexual minority orientation was examined.

There were three objectives of this study. The objectives were to (1) identify counselor characteristics that impact attitudes about sexual minority orientation; (2) explore the relationship between religiosity and attitudes towards gay and lesbian individuals; and (3) explore the impact of professional identity development on attitudes about sexual minority orientation;

**Research Questions and Hypothesis**

There were three research questions and three hypotheses. Each is offered below.

**Research Question 1:** What demographic variables are associated with negative attitudes about sexual minority orientation?

**Research Question 2:** Is there a relationship between scores on the Centrality of Religiosity Scale (CRS; Huber, 2003) and scores on the Attitudes Towards Lesbians and Gays-Revised (ATLG-R; Herek, 1994)?

**Research Question 3:** Do scores on the Professional Identity and Values Scale-Revised (PIVS-R; Healey, Hays, & Fish, 2010) mediate the relationship between religiosity and scores on the Attitudes towards Lesbians and Gays-Revised (ATLG-R; Herek, 1994)?
**Hypothesis 1**: It is hypothesized that counselors who report more years of professional experience and who have more contact with gay and lesbian individuals in their personal lives will report more positive attitudes about sexual minority orientation.

This is consistent with theories of professional development and Allport’s (1954) contact hypothesis. Allport suggests that experiences and contact with minority groups decreases prejudice and bias.

**Hypothesis 2**: It is hypothesized that counselors with high scores on the CRS will also score high on the ATLG-R.

Religious values have historically been used as one of the primary reasons for lack of acceptance of sexual minority orientation. Higher scores on the CRS reflect the importance of religion in one’s daily life and may be related to more reliance on religious teachings, texts, and organized beliefs. Some religions also teach more traditional gender roles and values about sexuality and this may result in more negative attitudes about gay and lesbian individuals.

**Hypothesis 3**: It is hypothesized that counselors with higher scores on the PIVS-R will score lower on the ATLG-R, indicating more positive attitudes towards gay and lesbian individuals.

Higher scores on the PIVS-R indicate higher levels of professional identity development. Counselors with an established professional identity may have more awareness of the values of the field and have leaned ways to integrate their professional and professional values. Counselors with a more established professional identity may also be more self-aware, reflective and be more accepting differences which may result in more positive attitudes towards gay and lesbian individuals.
Definition of Terms

The following definitions were provided to ensure an accurate understanding of the terms that were used throughout the study.

1. Ally: a person who belongs to a dominant or privileged group who actively advocates and works to end oppression for a member of a minority or marginalized group.

2. Sexual minority orientation: gay and lesbian individuals who have same sex attractions and bisexual individuals who experience sexual attractions to both sexes.

3. Religion: sharing of organized beliefs and values among a group of people. Religion includes adherence to specific institutional principles and doctrines, use of sacred texts, and engaging in rituals.

4. Spirituality: a person’s unique way of discovering meaning in life and connecting with God, a higher power, the sacred, or transcendent being. Spirituality is highly personal and subjective and may or may not include participation in formal religious activities.

5. Professional Identity: the process by which counselors develop an understanding of the roles, tasks, and responsibilities they are expected to carry out in their professional work. Professional identity development involves the integration of personal and professional values in a way that allows the counselor to carry out their professional work in an authentic way.

6. LGBT: is a term frequently used to describe sexual orientation and gender identity. The LGBT acronym is not all inclusive and other acronyms are frequently used to make a distinction and include or exclude other groups. LGBT will be used throughout this paper as an umbrella term to reference previous research conducted about sexual orientation and gender identity. Other acronyms will only be used when referencing research that specifically included or excluded certain groups based on sexual orientation or gender identity.
Limitations

Three limitations were identified in this study. The first limitation was the potential presence of social desirability bias. Respect for diversity is clearly a value that is conveyed in ethical codes and some participants may not report survey answers that are inconsistent with professional values and ethical codes. Thus, the results may not accurately reflect the actual opinions of all participants. A second limitation was the potential inability to generalize the results of this study to professional counselors nationally. The third limitation was based on survey limitations. The survey used in this study excluded bisexuals and failed to capture attitudes related to gender identity. Therefore, specific information about attitudes towards individuals who identity as bisexual could be limited. Individuals who identified as transgender face unique challenges. People may respond to transgender individuals in ways that are different from gay, lesbian, or other bisexual people. The survey utilized in this study did not allow you to determine if attitudes about transgender individuals are similar or different from other sexual minorities.
CHAPTER 2
REVIEW OF THE LITERATURE

Historical and Sociocultural Context of Sexual Orientation

Gender and sexual orientation are social constructs and an awareness of their cultural, historical, and political context is essential to understanding sexual prejudice and stigma. Information about the history of sexual prejudice in the U.S. and sociopolitical events that shape attitudes about sexual orientation provide context about factors that impact the understanding of this issue. These events can be viewed as the catalyst that encouraged professional mental health organizations to focus on their professional responsibility to work to improve societal conditions for LGBT individuals. Multiculturalism and social justice issues are also discussed as they are connected to improving mental health services and the quality of life for all clients, but particularly those who are marginalized and occupy a minority status. The following paragraphs will provide background information needed to develop an understanding of these constructs.

Marriage, relationships, and sexual behavior were viewed differently in the early 19th Century than in contemporary times in the 21st Century. The term homosexuality was first used by the Hungarian writer, Karl Maria in a German language pamphlet in 1868 (Herek, 2010). At that time marriage was seen primarily as a way to legally obtain property rights and gain wealth. Sex was seen as something that should be restricted to married men and women for procreative reasons and was not generally viewed as something that was engaged in primarily for pleasure. Laws and religious teachings considered sexual behavior that occurred outside of marriage
sodomy. Sodomy included masturbation, extramarital sex, and any sexual acts between married couples that did not include vaginal intercourse and was not socially acceptable (Herek, 2010). The idea that one’s sexual attractions was an important part of one’s identity gained popularity with Sigmund Freud’s conceptualization of heterosexuality and homosexuality as object choice in the early 1900s (Herek, 2010). Although Freud did not believe homosexuality was the preferred outcome of sexual development, he did not consider it an indicator of mental illness (Herek, 2010). American psychoanalysts distanced themselves from Freud’s teachings during the 1940s and labeled homosexuality as an illness. This categorization of people by their sexual attractions established “a new dichotomy in which heterosexuality was equated with normalcy and homosexuality with disease” (Herek, 2010, p. 294). Herek (2010) discussed the impact of the distinction between heterosexuality and homosexuality and asserted that “the language of diagnosis served to perpetuate society’s long standing legal and religious condemnation of sodomy in general and of same sex desire in particular” (p. 694).

In the late 1940s and 1950s, scientists began to challenge the idea that homosexuality was abnormal. Alfred Kinsey (1948) published a book on sexual behavior in the human and suggested that homosexual experiences were more common than previously thought. This was a significant development as it violated society’s heterosexual assumption and questioned strongly held beliefs about typical sexual behavior. In 1951, Clellan Ford and Frank Beach published accounts about homosexual behaviors in different cultures and noted that it was common, considered to be normal, and socially acceptable, rather than being labeled as pathological sexual behavior. Information about the non-pathological nature of homosexual behavior continued to be disseminated during the mid-1950s with Evelyn Hooker conducting research comparing the psychological functioning of nonclinical samples of heterosexuals with comparable
homosexuals. Hooker utilized the scientific method to test assumptions of pathology in homosexuals and concluded that homosexuality in itself was not associated with pathology. These findings would later be replicated by a number of empirical studies and played a pivotal role in addressing inaccurate information about sexual orientation (Herek, 2010).

**Sexual Stigma and Prejudice**

Ideas about sexual orientation are embedded in a complex system of social and psychological processes. Although there was not agreement among professionals that homosexuality was a mental illness, it was listed in the first edition of the DSM that was published in 1952. The classification of homosexuality as a mental illness supported discriminatory behavior and laws which resulted in and gay and lesbian individuals being targeted frequently, arrested in social settings, prohibited from obtaining professional licenses, and banned from employment (Herek, 2010). Policies that viewed homosexuality as an illness and inferior were also carried out in the military during World War II. Military psychologists were charged with screening for homosexuals to prevent their entry into the services. Many professionals initially ignored this practice because of the need for military personnel. However, these policies began to be strictly enforced after the war and many gay and lesbian individuals received undesirable (“blue”) discharges and were labeled as sexual psychopaths (Herek, 2010, p. 694). Gay and lesbian military personnel were outed to their communities, denied benefits, and had difficulties securing employment because of their sexual orientation. Helping professionals also used psychotherapy to change sexual orientation including hormone treatments, electro-shock treatments, aversive conditioning, and castration. These efforts were ineffective and had significant implications for psychological and emotional well-being and even resulted in suicide for some people (Herek, 2010).
The term homophobia was first used in a news article in 1971 by psychologist George Weinberg. It was popularized in 1972 in Weinberg’s book, *Society and the Healthy Homosexual*. Weinberg’s book labeled the discriminatory experiences that many gay and lesbian individuals faced and suggested that the belief that homosexuality was abnormal and pathological constituted a social problem that deserved attention. Herek (2004) asserted that:

the term homophobia “crystallized the experiences of rejection, hostility, and invisibility that homosexual men and women in the mid-20th century North America had experienced throughout their lives. The term stood a central assumption of heterosexual society on its head by locating the ‘problem’ of homosexuality not in homosexual people, but in heterosexuals who were intolerant of gay men and lesbians (p. 8).

Labeling the experiences of gay and lesbian individuals was an important step in addressing the hostile societal conditions LGBT individuals faced. Since that time the term homophobia has been viewed as limited and others terms have been developed that describe negative attitudes and behaviors about sexual orientation more accurately. Sexual stigma, sexual prejudice, and heterosexism are related, but distinct terms that help explain attitudes about sexual orientation in a more holistic context. Herek (2004) defined sexual stigma as the “negative regard, inferior status, and relative powerlessness that society collectively accords to any nonheterosexual behavior, identity, relationships, or community” (Herek, 2007, p. 907). Sexual stigma describes the shared knowledge society collectively assigns to sexual minority orientation as an inferior status. The internalization, or agreement with this inferior status targeted at sexual minorities, is considered sexual prejudice. It should be noted that sexual prejudice is distinct from other forms of prejudice (e.g., racial, religious, and so forth) because it
is considered socially acceptable in some aspects of society and people may express negatives attitudes about sexual minorities more openly than they would other minority groups. Sexual stigma is culturally constructed and shared, and exists on individual and institutional levels. It is maintained and legitimized in society by language, social norms, laws, religion, and medicine by assignment of a deviant status (Herek, 2007). Structural sexual stigma that creates power differentials on institutional levels has been referred to as heterosexism. Heterosexism places people of a sexual minority orientation in a disadvantaged place in society by assigning them a deviant status, viewing them as inferior or invisible by promoting a heterosexual assumption, and allowing them less rights and power (Herek, 2009). These experiences have significant implications for the mental health of LGBT individuals and may have a direct impact on their quality of life. Herek (2008) discussed the consequences of stigma and explain that “compared to the nonstigmatized, individuals who inhabit a stigmatized role enjoy less access to valued resources, less influence over others, and less control over their own fate” (p. 66). Specifically, experiences of relational and institutional forms of discrimination including rejection and exclusion, stigma, work place and hiring discrimination, and marriage inequality have been associated with higher rates of psychological symptoms and disorders (Oswalt & Wyatt, 2011).

The stigma and exclusion LGBT individuals experience as a result of membership in a minority group also has implications for identity development. Social identity and social evaluation theory provided insight regarding the impact of stigma on identify development and suggested that the environment and social interactions offer valuable information that people use to make meaning of the world (Meyer, 2003). Cooley (1922) described the “looking glass” as the process by which people develop an identity of themselves based on their perception of and comparison to others (p. 184). According to this theory, negative appraisals from others may
promote the development of internalized homophobia and self-stigma in LGBT individuals (Meyer, 2003).

**Minority Stress Model**

Stress theories are frequently used to explain mental health disparities among minority groups. The minority stress model has been described as an extension of social stress theories and is based on the premise that minority stress is unique from the stressors that dominant or non-stigmatized groups experience (Meyer, 2003). The minority stress model has provided insight into the cause of mental health disparities among LGBT individuals. These disparities have included a higher prevalence of depression, mood and anxiety disorders, suicidal ideation, suicide attempts, and increased rates of alcohol abuse and tobacco use in comparison to the heterosexual population (Becker, Cortina, Tsai, & Eccles, 2014). According to the minority stress model, membership in a sexual minority orientation group has been considered a stress factor because of experiences of victimization, anticipating prejudice, examination of the cost-benefits of concealment, and internalizing homophobia (Becker et al., 2014). Meyer (2003) specifically conceptualized minority stress as:

(a) unique- that is, minority stress is additive to general stressors that are experienced by all people, and therefore, stigmatized people are required an adaption effort above that required of similar others who are not stigmatized; (b) chronic- that is, minority stress is related to relatively stable underlying social and cultural structures; and (c) socially based- that is, it stems from social processes, institutions, and structures beyond the individual rather than individual events or conditions that characterize general stressors or biological, genetic or other nonsocial characteristics of the person or group” (p. 676).
LGBT Youth

Discriminatory experiences have implications for people across the entire life span. LGBT youth have faced unique obstacles that may negatively impact their mental health and adult development. Adolescence has been characterized as a time of change. Efforts to navigate new experiences and identities as an adolescent and developing a sexual minority orientation in a heterocentric culture can be a challenging task. Adolescents typically have less coping skills as compared to adults, and may also have more difficulties finding support as a sexual minority (Becker et al., 2014). To illustrate this need for support, researchers stated, “Many LGB individuals lag behind their peers with respect to social development for reasons attributable to societal constraints on sexual minorities and the extra time is often required for LGB individuals to establish an LGB identity” (Pachankis & Goldfried, 2013, p. 49). Other authors have also echoed the significant concern for gay and lesbian students during adolescence because peer relationships are vital during this developmental stage (Shilo & Savaya, 2012).

The educational environment has also presented special challenges to LGBT youth. Research conducted by the Gay, Lesbian, and Straight Education Network (GLSEN, 2003) found that four out of five LGBT youth indicated that they had been harassed at school because of their sexual orientation (Bowers, Minchiello, & Plummer, 2010). Other researchers offered alarming statistics (e.g., sexual minority youth are more than four times more likely to report a suicide attempt that requires medical attention, more than three times more likely to report a suicide attempt [without medical intervention], and approximately two times more likely to report experiencing suicidal ideation as compared to their heterosexual peers) (Burton et al., 2013). LGBT youth also reported experiencing assault and skipping school more frequently because of fear of assault (Burton et al., 2013). Additionally, sexual minority youth who
experienced higher incidents of victimization, reported higher rates of psychological symptoms than sexual minority youth who reported lower levels of victimization (Burton et al., 2013). Specifically, research indicated that LGBT youth who reported high rates of victimization were 2.6 times more likely to report depressive symptoms and 5.6 times more likely to attempt suicide than those who reported lower levels of victimization (Burton et al., 2013). Overall, these statistics provided support for the minority stress model and insight into the scope of the sexual prejudice and stigma experienced by LGBT youth.

LGBT adolescents continue to face additional challenges as they move into adulthood and attempt to integrate themselves into a culture that has restricted their access to the rights that heterosexual individuals enjoy. Researchers have suggested that homosexuality is a normal variant of sexual behavior and highly resistant to change. Yet, LGBT individuals are often denied certain rights because of the notion that sexual orientation is a choice and therefore should not be afforded the same rights as heterosexual individuals.

Marriage equality is a key indicator of the inequalities LGBT individuals have faced. Heterosexual individuals are afforded the choice to marry due to their heterosexual privilege, but prior to the U.S. Supreme Court’s ruling in 2015, LGBT individuals were prohibited from marrying in many states, and legal challenges continue to persist today despite the U.S Supreme Court’s ruling. Marriage affords individuals a number of practical, legal, and emotional benefits and to deny sexual minorities this right solely based on sexual orientation renders them inferior, and can be considered an act of structural sexual prejudice or heterosexism (Herek, 2011).

The benefits of heterosexual marriages have been described by Herrick (2011). They have included financial security, employee benefits, tax benefits, and entitlement programs, which provide better economic security (i.e., a predictor of better health). According to Herrick
(2011), there are also emotional benefits of marriage, including the social support that is provided to married couples. This social support is particularly important to sexual minorities’ well-being because of frequent exclusion. Marriage also acts as a buffer against traumatic life events and serves as a deterrent to the dissolution of relationships (Herrick, 2011).

Another area that needs further review is civil unions. While some people believe that marriage is between a man and a woman, they support civil unions for same-sex couples. Although domestic partnerships and civil unions have been allowed in some states in the U.S. for some time, advocates hold the view that civil unions are not the equivalent of marriage from a social perspective and actually denote an inferior status. Herek (2011) explained this difference and suggested that:

creating a separate, quasi-marital status for same-sex couples perpetuates and may even compound the stigma historically associated with homosexuality… denying same sex couples the label of marriage- even if they receive all the other rights and privileges conferred by marriage- arguably devalues and delegitimizes these relationships. It conveys a societal judgement that committed intimate relationships with people of the same sex are inferior to heterosexual relationships and that the participants in a same-sex relationship are less deserving of society’s recognition than are heterosexuals couples. It perpetuates power differentials whereby heterosexuals have greater access than non-heterosexuals to the many resources and benefits bestowed by the institution of marriage. These elements are the crux of stigma… It creates a felt need among lesbians, gay men, and bisexuals to conceal their sexual orientation, which can have negative effects on their psychological and physical health. To the extent that stigma motivates
lesbians, gay men, and bisexuals to remain hidden, it further reinforces sexual prejudices among heterosexuals (p. 617).

**Language and Research on Sexual Orientation**

Messages about sexual behavior and what is socially acceptable often stem from a person’s culture, personal values, and religious teachings. In some cases, the message conveyed is that sexual minority orientation is abnormal, inferior, or immoral (Herek, 2010). Professional counselors must be able to separate society’s negative messages and rely on empirically-sound information about sexual orientation. This can be difficult as research about sexual development has historically been based on heterosexual individuals and may present a constricted view of sexual orientation.

Early research on sexual orientation has been criticized because of methodological flaws and inadequate theoretical grounding (Saewyc, 2011). Nonetheless, research on the sexual development of sexual minorities has increased in quality and quantity over the last few decades. This coincides with increased visibility of gay and lesbian individuals. To add, contemporary theories of sexual development appear more methodologically sound, including large-scale, population-based surveys, and longitudinal data (Saewyc, 2011).

Nonetheless, as research has increased, a number of obstacles still exist for LGBT populations. For example, one obstacle is a need to clearly delineate terms that describe sexual orientation and gender identity. Terms currently used often describe related, but different dimensions of human sexuality. A final limitation is an inability to determine if attitudes about transgender individuals are similar or different from attitudes towards gay and lesbian individuals.
Saewyc (2011) explained the difficulty in interpreting research about sexuality and noted that “societal understandings about sexual orientation have generally been far more simplistic than the evidence reflects, yet we must translate research in ways that the public and professionals can understand” (p. 258). Saewyc also noted that values and perceptions about sexuality impact personal liberties and quality of life of individuals. She noted that professionals should be aware that there are “significant risks when research findings from a topic that generates social controversy are misapplied” (Saewyc, p. 258). In other words, research has the ability to be used in ways that are both beneficial and harmful to individuals and society.

Gender identity, sexual identity, and sexual orientation are often used interchangeably in the literature. However, they are distinct constructs that must be clearly stated. Sexual orientation describes the emotional, romantic, or sexual feelings toward another person and is composed of one’s sexual identity, practice, and preferences (Perrin-Wallqvist & Lindblom, 2015). According to Perrin-Wallqvist and Lindblom

practice refers to what individuals do, their experience, their relations with others, and with whom they have sexual relations. Identity comprises how individuals feel, what they call themselves, as well as their preferences regarding with whom they want to share their life and have an intimate relationship (pp. 467-468).

Sexual orientation is frequently described in dichotomous terms, but researchers have suggested that sexual orientation is actually a more dynamic and fluid process (Perrin-Wallqvist & Lindblom, 2015; Thompson & Morgan, 2008). Levy (2009) explained that “sexual identity is not simple or clean-cut and does not stand alone. It intersects with other aspects of identity such as race, ethnicity, class, gender, religion, education, and so forth” (p. 982).
Same sex attractions are not a new phenomenon and can be traced back for centuries. The terms heterosexual and homosexual were first used in 1893 by Dr. Krafft-Ebing in his book, *Psychopathia Sexualis*. The publication of this book marked the beginning of homosexuality being viewed as an inferior orientation. The term homosexual was widely used by the 1950s, after Alfred Kinsey reports were published. Kinsey questioned the idea that people were exclusively heterosexual or homosexual and developed a classification system that viewed sexual behavior along a continuum (Levy, 2009).

Sexual identity is typically discovered during adolescence, which is already a challenging time as youth are attempting to navigate a variety of developmental tasks that have significant implications for adult development. Sexual identity development of LGBT individuals has been described as complicated because of a stigmatized identity and existence of hostile attitudes about sexual minority orientation (Rosario, Schrimshaw, & Hunter, 2004). Sexual minority youth are faced with the task of developing their identity in an environment that often denies, marginalizes, and pathologizes LGBT individuals. This scenario often results in people concealing their sexual identity, which can lead to internalized homophobia. The opportunity to come out, when they no longer conceal their identity as LGBT, is an important aspect of sexual identity development among gay and lesbian individuals. Rust (2003) described coming out as:

> the process by which individuals come to recognize that they have romantic or sexual feelings towards members of their own gender, adopt lesbian or gay (or bisexual) identities, and then share these identities with others. Coming out is made necessary by a heterosexist culture in which individuals are presumed heterosexual unless there is evidenced to the contrary (p. 227).
Etiology and Development of Orientation

Several theories have offered explanations of sexual identity development in gay and lesbian individuals. However, early theories about sexual orientation generally described sexual orientation in a linear fashion without consideration of race, gender, or differences in the order that people move through various stages of identity development (Saewyc, 2011). Stage models have suggested that sexual identity development for sexual minorities begins with an awareness of desire for the same sex and is completed when an individual accepts and integrates an LGBT identity.

Cass (1979) developed a model that consists of six stages of sexual identity development and includes identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis as the stages. Identity confusion is the first stage and consists of an individual feeling a conflict between same sex desire and presumed heterosexuality. In the second stage, identity comparison, people realize they are different from heterosexuals, but still assume a heterosexual identity. During identity acceptance, people have a personal acceptance of their orientation but are selective regarding whom they disclose their identity. Identity pride and identity synthesis are the final two stages. During identity pride, individuals possess a positive sexual identity and may express anger about a heterosexist culture. Identity synthesis describes the final stage and is characterized by an integration of one’s public and private behavior and an awareness that sexual identity is only one aspect of their larger identity (Levy, 2009).

An individual’s belief about the etiology and ability to control sexual minority orientation impacts one’s attitudes and the level of bias or acceptance. Attribution theory was introduced by Heider (1944, 1958) and later expanded by Weiner (1979, 1985). This theory suggested that
individuals attempt to understand their environment by attributing behavior to internal or external factors that can be viewed as either controllable or uncontrollable. When personal responsibility is attributed to a behavior, people who exhibit these behaviors are perceived more negatively and the behavior is stigmatized. Smith et al. (2011) also explained factors that impact prejudices and suggested that most people “are less likely to express prejudice when it can be recognized as such unless they feel their prejudices are justified” (p. 1112). However, some people view sexual orientation as a choice and feel that holding biases against this group is acceptable. According to Smith et al. (2011), research suggested that people with “stronger antigay attitudes saw being gay or lesbian as more fluid or changeable and culturally-specific, rather than biologically-based. Conversely, beliefs in the immutability, biological basis, and historical cross-cultural universality of being LGBT were associated with tolerance” (p. 1113). Smith et al. (2001) asserted that “when people are seen as responsible for their behavior and life choices, then discrimination is more likely to been seen as justified and often done without shame, and as a result individuals feel justified to be more overt in their expressions of prejudice” (p.1112).

Smith et al. (2001) surveyed 180 students to determine how their beliefs about the etiology of sexual orientation would impact the acceptance of legislation and polices that supported gay and lesbian rights. The results of this study were consistent with other findings, suggesting that greater beliefs that a same sex orientation is a result of social influences were associated with less support of legislation related to gay and lesbian rights. Conversely, the belief that same sex orientation was due to biology was related to more support of legislation for gay rights. This line of research suggested that providing information about the etiology of
sexual orientation could play a significant role in assisting professionals in developing competency to work with LGBT clients and in advocacy work.

LGBT individuals are faced with the same universal life challenges that heterosexuals face, in addition to unique obstacles created by a heteronormative and heterocentric culture (Swank, Fahs, & Frost, 2013). Failure to recognize these barriers may unintentionally reinforce the idea that LGBT individuals are solely responsible for the stressors associated with discriminatory experiences. Some of the special issues that LGBT client may face include identity development, family and relationship issues, parenting, legal and work place issues, and being a member of multiple minority groups (Pachankis & Goldfried, 2013). Although heterosexism has been frequently used to describe overt acts of discrimination, the term heterocentrism provides a more accurate description of the bias LGBT individuals face. Heterocentrism describes implicit and explicit bias against LGBT individuals and is evident on an individual level when people internalize negative attitudes about LGBT individuals. It is manifested on a cultural level when laws restrict LGBT people from full rights that are afforded to heterosexuals. Pachankis and Goldfried (2013) described the impact of socialization and a culture that renders people of a sexual minority orientation invisible by assigning everyone a heterosexual orientation by default. They asserted that “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” (p. 46). This finding is of particular significance to professionals’ efforts to develop LGBT competency as they are subject to the same messages and cultural ideas as other members of society.
Counselor Competency

Counselors must consider societal norms regarding what is considered socially acceptable and what is considered right or wrong. Messages that are embedded in society through social norms, religious beliefs, and political ideology can be hard to ignore and living in a heteronormative society can make developing competency to work with LGBT individuals a complex task. Working effectively with LGBT clients requires specialized training and many professionals are not prepared to properly assist this population (Pachankis & Goldfried, 2013).

While it is not appropriate for counselors to assume that all LGBT clients are presenting to therapy because of issues related to sexual orientation, it is important that counselors have an accurate understanding of the unique issues that LGBT clients face as a result of living in a heteronormative culture and are knowledgeable of effective ways to address their concerns. Pachhankis and Goldfried (2013) explained this further:

Many clinicians think that clients can and ought to be treated in the same manner as their heterosexual counterparts. Despite such good intentions, it is essential to recognize that LGBT clients present unique issues in the therapeutic context. LGBT-affirmative therapies utilize the body of knowledge that addresses issues specific to LGBT individuals with the purpose of bridging the gaps left by the heterocentric assumptions of prevailing therapy models (p. 47).

Working effectively with LGBT clients requires professionals to view culture from a holistic perspective. For example, “sexual orientation does not exist in isolation, but intersects with other multicultural aspects of human diversity. Such interconnectedness of identities can amplify disparities” (Bidell, 2014, p. 170). Other factors that impact clients must be considered. Factors such as race, ethnicity, and socioeconomic status may expose clients to additional stress,
discrimination, and stigma, further complicating presenting problems (Bidell, 2014). Being cognizant that LGBT individuals do not represent a homogenous group is important to properly serve this population. For example, gay men frequently face experiences that are different from lesbians and bisexuals and face unique challenges because of their attractions to both sexes and adherence to dichotomous models of sexuality. Evans and Barker (2010) explained that “there is non-acceptance, suspicion and stigma from both gay and straight communities towards bisexuality” (p. 377). Counselors must be aware that differences exist within the LGBT community and that each client’s needs will be different based on their unique experiences.

The complexity of issues related to sexual orientation require that counselors are self-aware and are mindful of how their values and personal experiences may impact their work with clients. Counselors are not expected to be value free, but are prohibited from expressing biases toward clients. Counselors are expected to abide by ethical codes and to treat all clients with dignity and respect. Although a person may not exhibit or acknowledge explicit bias, implicit bias can occur unconsciously. Researchers have described implicit bias as “actions or judgements that are under the control of automatically activated evaluation, without the performer’s awareness of that causation” (Greenwald, McGhee, & Schwartz, 1998, p. 1464). According to Boysen (2009), “modern perspectives on bias indicate that blatant, old-fashioned prejudices and stereotypes are less of a problem that they once were, but more subtle forms of bias remain” (p. 240). For example, Boysen (2009) found that explicit bias was uncommon among counselors, but suggested that implicit bias may be more prevalent. Implicit bias can manifest in the form of microaggressions.
Sexual Orientation Microaggressions

Sue et al. (2007) defined a microaggression as a “brief, commonplace and daily, verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (p. 271). Although the term was originally used to describe the experiences of racial minorities it has been expanded to include other minority groups including sexual minorities. Three forms of microaggressions have been identified: assaults, microinsults, and microinvalidations. Microassaults are akin to traditional forms of discrimination and are intentional deliberate acts that are harmful or oppressive to minority groups. These behaviors include name calling, derogatory language, avoidant behavior, and discriminatory behavior. Microinsults are gestures, snubs, and verbal slights that generally exist outside of awareness. Sue (2010) suggested that microaggressions convey insensitivity to minority groups while microinvalidations “exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of certain groups” (p. 37).

Although many clients have reported positive relationships with their therapists, they also acknowledge the impact of heterosexist and heteronormative culture through sexual orientation microaggressions. An awareness of language and attitudes that may be microaggressions can help counselors develop trusting relationships with clients. Microaggressions are of significance in work with LGBT clients because of their ubiquitous and subtle nature. They often occur “outside of the level of conscious awareness of the perpetrator and are committed by well-meaning individuals (Platt & Lenzen, 2013, p. 1012). Shelton and Delgado-Romero (2011) explained that “mental health practitioners who disagree with heterosexism are not immune to societal or psychological stigmatization of LGBTQ individuals and may unintentionally perpetuate
biased views in their work with LGBQ clients (p. 211). This idea has been supported by the fact that LGBT individuals have higher rates of mental health utilization than their heterosexual peers, but often report dissatisfaction with the services received.

Microaggressions are particularly harmful to the therapeutic process because unlike traditional forms of discrimination they are more difficult to identify. In order to deal with sexual orientation microaggressions the client often has to disclose their identity as a sexual minority before they feel safe doing so, or they may have to challenge the therapist’s professional role as the expert. Further, microaggressions also negatively impact therapy outcomes and are associated with feelings of powerless, rejection, confusion, and diminish help-seeking behaviors (Shelton & Delgado-Romero, 2011). This ultimately focuses attention and psychological resources away from the presenting clinical issue and shifts attention to dealing with the impact of the microaggression. These experiences are counter to the purpose of seeking therapy and impact its effectiveness.

Sue (2010) developed a typology of sexual orientation microaggressions and identified seven themes: oversexualization, homophobia, heterosexist language/terminology, sinfulness assumption, assumption of abnormality, denial of individual heterosexism, and endorsement of heteronormative culture/behaviors. Sue’s first theme was oversexualization. This is a hyper-focus on an individual’s sexuality. This theme describes how sexual minority orientation may immediately be associated with sexual behavior and other important aspects of a person’s identity are minimized or excluded. The second theme is homophobia, which describes the fear that homosexuality is contagious and intentional acts of avoidance to prevent becoming gay or lesbian. The third theme is the use of heterosexist language, which reflects a heteronormative culture and denies and devalues the existence of sexual minority orientations. The fourth theme
is sinfulness, typically associated with religious beliefs and reflects the idea that non-heterosexual relationships are morally wrong or deviant. The assumption of abnormality is the fifth theme, which reflects the idea that non-heterosexual orientations are pathological and that LGBT individuals need psychological treatment and that their orientation is transient. The final two themes that Sue (2010) identified are denial of individual heterosexism and endorsement of heteronormative culture and behaviors. These themes suggest that individuals of the majority group often deny holding biased attitudes and that social norms are based on a heterosexual orientation and exclude sexual minority orientations.

Shelton and Delgado-Romero (2011) interviewed LGBQ clients about their experiences in psychotherapy and identified seven themes that reflected microaggressions. They found that even in situations where clients reported a positive relationship with their therapist, they felt that “subtle discrimination” was present (p. 218). The first two themes identified in the study were an “assumption that sexual orientation is the cause of all presenting issues” and “avoidance and minimizing of sexual orientation” (Shelton & Delgado-Romero, p. 214). Participants also reported therapists’ “attempts to over identify with LGBQ clients,” “making stereotypical assumptions about LGBQ clients,” and “experiencing expressions of heteronormative bias” (Shelton & Delgado-Romero, p. 216). The final two themes were the “assumption that LGBQ individuals need psychotherapeutic treatment” and “warnings about the dangers of identifying as LGBQ” (Shelton & Delgado-Romero, p. 216).

The microaggressions that sexual minorities experience have been found to be similar, and yet distinct from those experienced by racial minorities. Research has suggested that microaggressions have a cumulative impact on individuals’ physical and psychological well-being. To add, unlike racial minorities, sexual minorities may be less visible as they can choose
whether to disclose their sexual orientation in various situations. Nonetheless, the decision to disclose or conceal one’s sexual orientation creates a dilemma, each choice results in a unique consequence. For example, coming out to others places individuals at risk of rejection and loss of support, while concealing one’s orientation is related to the development of internalized stigma (Platt & Lenzen, 2013). This stigma has been further described by Pachankis and Goldfried (2013):

LGB individuals who hide their sexual identity experience a discrepancy between their true selves and the selves that they present others. These individuals may feel inauthentic as if they are living a lie. They may also feel that if others knew their true sexual identity, they would be rejected. These individuals likely to avoid social situations in which they feel their sexuality will be called into question (p. 46).

The decision to disclose one’s sexual orientation or to not disclose has significant implications that can even be considered risks for one’s social status, relationships, and emotional well-being. Although concealing one’s sexual orientation has been associated with poor psychological adjustment, coming out in an unsupportive or hostile environment comes at a psychological cost as well. These stressors are example of the unique experiences an “invisible minority” face (Platt & Lenzen, 2013, p. 1028).

**Professional Associations**

Professional bodies, including the American Psychological Association (APA) and the American Counseling Association (ACA) have developed minimal competencies and guidelines to assist mental health professionals in addressing the mental health needs of LGBT clients. Examples include offering gay affirmative practices, a clinical approach viewing gay, lesbian, or
bisexual orientations as healthy forms of sexual expression, and so forth (Greenberg, Pievsky, & McGrath, 2015). According to Greenberg et al. (2015) gay informative practices includes:

(a) not assuming the patient is heterosexual; (b) viewing discrimination against lesbian and gay individuals, and not lesbian, or gay identity as problematic; (c) viewing a nonheterosexual identity as a positive result of treatment; (d) working to minimize the patient’s own negative feelings about being lesbian or gay; (e) being knowledgeable about the social policies affecting lesbians and gay individuals and about the coming out process; and (f) dealing with one’s own biases (p. 135).

**Affirmative Practice and Ally Development**

Over time, mental health professionals have gained a better understanding of the challenges LGBT individuals face and actively work to promote social equality for this group. Affirmative counselors “espouse more than simply an absence of harmful and negative behaviors and attitudes toward, and a mere acceptance of GLBT clients, but they also value them as individuals and behave in ways that convey this” (Lynch, Bruhn, & Henriksen, 2013, p. 2).

Although there is not a consensus regarding the definition of the term ally, the term has been typically used to describe individuals who take active steps to promote positive change for oppressed groups. Washington and Evans (2001) defined an ally as “a person who is a member of the ‘dominant’ or ‘majority’ group who works to end oppression in his or her personal and professional life through support of, and advocate for, the oppressed population” (Borgman, 2009, pp. 508-509). In recent years, this term has been expanded to specifically describe heterosexual individuals who advocate for the rights of LGBT individuals.
Asta and Vacha-Haase (2013) discussed the process of becoming an ally and acknowledged the difficulties associated with ally development and emphasized the importance of being self-aware in order to be a change agent. “To become an LGBT ally, a heterosexual individual must learn to recognize the structure of privilege and heterosexism, validate the experiences of LGBT individuals, challenge heterosexist attitudes and behaviors, and work to create social equality for LGBT individuals” (Perrin, Bhattacharyya, Snipes, Calton, & Heesacker, 2014, p. 241). Simply put, “allies are not born; they are trained” (Ji, 2007, p. 183). Statements such as this reflect the impact of living in a heteronormative culture and the importance of efforts to increase awareness about the attitudes, behaviors, and social policies that create oppressive conditions for minority groups.

Research on ally development has provided insight into the interconnection between all forms of oppression and social injustice. Asta and Vacha-Haase (2013) explained that for many people “ally work was not necessarily motivated by relationships with LGBT individuals but was rooted in their view that the LGBT movement is one piece of their overall goal furthering the social justice movement” (p. 495). This awareness was an essential component of multicultural competence and the ability to improve mental health services and societal conditions for all clients regardless of sexual orientation.

**Religion, Spirituality, and Sexual Prejudice**

Multicultural competence involves the willingness to examine how one’s values influences their worldview. Research has indicated that a large percentage of Americans identify as religious and incorporate religion and spirituality into the daily aspects of their lives (Halkitis et al., 2009). According to the Gallup Poll (2009), 94% of Americans identified with a specific religious affiliation, 90% engaged in prayer regularly, and 55% attended religious services at
least once a month (Vogel, McMinn, Peterson, & Gathercoal, 2013). Research has shown that religion played an important role in personality development and impacted social relationships (Balkin, Schlosser, & Levitt, 2009).

Religion and spirituality have influenced peoples’ daily lives in a number of significant ways including the development of personal morals and values, political beliefs, civic participation, and attitudes about sexual behavior (Halkitis et al., 2009; McMillen, Helm, & McBride, 2011). Religious doctrines and sacred texts have also influenced social norms and have played a large role in defining acceptable sexual behavior. According to Worthington (2004), “religion and sexuality are inextricably intertwined for many people because virtually every religion regulates sexual behavior and dictates a specific set of values regarding human sexuality” (p. 741).

Because religion and spirituality are salient aspects of many people’s lives, it is important to explore how religious and spiritual values inform and impact the clinical practices of helping professionals. In this framework, Bishop, Avila-Juarbe, and Thumme (2003) explained that:

those things that we consider transcendent have affected the way we view the universe and the way we give credit for the outcomes of our actions. Spirituality is not only a significant and integral part of human experience, but spirituality is also an integral part of human development (pp. 36-37).

Not only should values be explored, but appropriately defining religion and spirituality is also an important of understanding these issues. Hodge and McGrew (2006) noted the need to define these constructs. “The definitions that helping professionals ascribe to constructs such as spirituality and religion have important ramifications. How constructs are conceptualized shapes decisions in clinical practice and research settings” (p. 637).
Spirituality and religion must be distinguished and utilized in the appropriate context. The two terms can be difficult to conceptualize because although they have some distinct differences, they are not necessarily binary concepts. For example, religion traditionally refers to formal, organized beliefs and traditions, whereas spirituality refers to a more unique, subjective way of experiencing religion or the sacred. On the other hand, Hill and Pargament (2008) discussed the fallacy of polarizing religion and spirituality and explained the interrelationships of the two. They asserted the importance of understanding spirituality in a social context and how it impacts peoples’ daily lives and personal choices. Hill and Pargament (2008) also explained that “most people experience spirituality within an organized religious context and fail to see the distinction between [the] phenomena” (p. 4). Overall, the concepts of religion and spirituality are not deemed good or bad, or better than or less than, instead, they are interrelated constructs.

Measures of religiosity have also been developed that assist in accurately describing how people live out their religious and spiritual values. Religiosity has been defined as a multidimensional construct that includes the degree to which one believes in God and the way one holds that belief (Shen, Yelderman, Haggard, & Rowatt, 2013). For instance, the way people hold religious beliefs as well as the degree to which they hold religious beliefs can be measured by a variety of distinct terms. The terms have included intrinsic and extrinsic religiosity, cognitive rigidity and flexibility, right wing authoritarianism (RWA), religious fundamentalism (RF), and a quest orientation. Whitley (2009) explains that an intrinsic orientation reflects an internalization of religious values and effort to live those values out in one’s daily life. In contrast, an extrinsic orientation describes the use of religions to meet non-religious goals (social status, acceptance, etc.).
Batson (1976) identified quest orientation as an additional dimension of religious orientation. Quest orientation describes a religious view that consists of a search for answers about the meaning of life. Quest orientation is described as a “flexible type of religiosity” and people with a quest orientation accept uncertainty about some issues (Whitley, 2009, p. 22). Conversely, religious fundamentalism is “the belief that there is one set of religious teachings that clearly contains the fundamental, basic, intrinsic, essential, inerrant truth about humanity and deity… this truth must be followed today according to the fundamental unchanging practices of the past” (Altemeyer, 1996, p. 118). Religious fundamentalism is thought to extend past membership in specific faith groups or denominations. Lean and Finken (2011) discussed how this is related to prejudice views. Lean and Finken contended that “it is how people are religious, their fundamentalist attitude, rather than their specific religion or content of their beliefs that is the better predictor of prejudice” (p. 45).

Religion has generally been thought to have positive benefits for individuals and society. However, it has also been associated with intolerance for out groups and has historically been used as a way to promote and justify intolerant and discriminatory views about sexual minority orientation (Borgman, 2009; Edwards, 2012; Lean & Finken, 2011). While all religious or faith groups do not hold negative attitudes towards LGBT individuals, certain Christian groups have historically espoused negative messages about homosexuality, and supported conversion therapy to help legitimize prejudiced attitudes and discriminatory behavior (Borgman, 2009). Christianity is also referenced here as it is the dominant religion in the United States and has historically had the most social privilege. Thus, many of the social norms related to sexual behavior are influenced by Christian religious beliefs and in some cases those values are
associated with prejudiced attitudes towards gay and lesbian individuals. Whitley (2009) explained that:

the relationship between religion and prejudice may be especially problematic in the case of attitudes towards lesbians and gay men. Although most religions teach tolerance toward outgroups, many of the world’s prominent religions condemn homosexuality. It thus, appears that although most religions proscribe some forms of prejudice, such as racial/ethnic prejudice, at the same time they may permit other forms of prejudice, such as prejudice against people who are perceived to violate the religion’s value system (p. 23).

The paradoxical relationship between religiosity and prejudice may be related to lack of a universal definition of religion and valid measures of religiosity. Lean and Finken (2011) discussed the complexity of the relationship between religion and prejudice and suggested that it is impacted by a number of factors such as how religion is defined, the target of prejudice, and statistical methods used to measure it.

A small portion of research has focused on counselors’ religious identity and sexual prejudice. Balkin et al. (2009) attempted to address the literature gap by exploring the relationship between professional counselors’ religious identity and attitudes about homophobia, sexism, and cultural diversity. Balkin et al. discussed the importance of counselors’ religious beliefs/orientations as they have significant implications for clinical practice and impact how they view certain behaviors. This study consisted of 114 professionals and graduate students. In the study, 80% of participants were women, 20% men, and 1 participant did not indicate their gender. In regard to race, 85% indicated that they were Caucasian, 5% African-American, 3% Asian descent, 2% biracial, and 1% Hispanic/Latino, and 1% Native American. The majority of
participants (i.e., 72%) identified as Christian, while 16% reported that they were another
religion or did not identify with a religion, and 6% identified as Jewish.

Participants completed the Religious Identify Development Scale (RIDS; Veerasamy,
2003), the Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1996) and the Attitudes Towards
Lesbians and Gay Men-Revised-Short-Form (ATLG-R-S; Herek, 1998), and the Multicultural
Awareness, Knowledge, and Skills Survey-Counselor Edition-Revised (MAKSS-CE-R; Kim,
Cartwright, Asay, & D'Andrea, 2003). Results of this study were consistent with past findings
and indicated that counselors who exhibited rigid and authoritarian religious views held more
homophobic attitudes. An interesting finding was that counselors who questioned their religious
beliefs less frequently, who were more easily influenced by others regarding their faith, and who
accepted others outside of their religion were more knowledgeable about multicultural issues, but
also endorsed more sexist behaviors and stereotypical gender roles. There were several
limitations to this study (i.e., low response rate which resulted in an inability to generalize
results; use of self-report measures, which omit client perspectives, and social desirability). The
authors suggested that future research should examine how religious identity impacts other
aspects of identity, how various aspects of identity relate to multicultural competence, and how
religious identity informs counselors’ clinical work. Balkin et al. (2009) stressed the importance
of counselors, educators, and supervisor being cognizant of the impact of religious beliefs on the
delivery of counseling services due to their work with diverse group of clients.

Satcher and Leggett (2007) studied homonegativity among professional school
counselors (PSCs). They explored specific factors (race, age, contact with gays or lesbians,
political affiliation, training experiences related to sexual minority orientation, clinical work with
clients who were gay, lesbian, or questioning their sexual orientation, and church attendance)
that influenced differences in homonegativity among PSCs. The study consisted of 215 counselors who were members of a state branch of the ACA. In regard to the makeup of the sample, 84% were White and 16% were African-American. Of the sample, 21% of participants were between the ages of 20 and 35, 36% were between the ages of 36 and 50, and 42% were over 50. The majority of participants attended church regularly, with 48% attending 3 to 6 times a month, 29% attending more than 7 times, 12% attending one or twice, and 10% reporting no attendance. Most participants (42%) reported having a gay or lesbian friend and 33% reported receiving training about sexual minority orientation within the last year. Of the sample, 42% of counselors also reported counseling clients who sought therapy because they were gay, lesbian, or questioning their sexuality.

Participants completed two survey instruments, the Homonegativity Scale (HS; Morrison et al., 1999) and the Modern Homonegativity Scale (MHS; Morrison & Morrison, 2002). The HS was developed to measure prejudice against gay and lesbian individuals based on moral objections to homosexuality. It consists of 6 items and uses a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The reliability coefficient for the MHS was .82. The MHS was developed to measure prejudice against gay and lesbian individuals by soliciting responses about civil rights and social justice issues. This instrument included 13 items and also used a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The reliability coefficient for the MHS was .93.

Results from this study indicated that as a group, PSCs did not hold negative prejudices about gay and lesbian individuals based on moralistic or traditional objections to homosexuality. Significant differences were found when PSCs were compared to each other in regard to having a gay or lesbian acquaintance, participating in training about gay and lesbian sexual orientation
within the last year; working with gay, lesbian or questioning clients; and frequency of church attendance. PSCs who did not attend church on a monthly basis had the lowest HS scores, as compared to PSCs who attended church 7 or more times a month and had the highest HS scores. Significant differences were also found when PSCs were compared by race, political affiliation, having a gay or lesbian acquaintance, participating in training about gay and lesbian sexual orientation within the last year, working with gay, lesbian or questioning clients, and frequency of church attendance. Specifically, African-Americans and democrats had lower MHSs scores than Whites and Republicans. PSCs who attended church 7 or more times a month had the highest MHS scores. Limitations of this study included the geographic location of respondents, limited number of male participants, and use of measures with limited reliability and validity across populations due to limited use. The authors’ suggested that future research should be conducted to verify reliability and validity of the instruments across populations.

Borgman et al. (2009) explored the processes by which professionals integrate their identities as LGB allies with their religious identities. Borgam et al. (2009) utilized a phenomenological approach to develop an understanding of the process of becoming a Christian LGB ally. Their study consisted of 11 doctoral level counseling and clinical psychology professionals (8 women and 3 men) between the ages of 29 and 55. Participants were obtained through chain sampling and advertisement on professional organizations’ list serves. Participants worked in the Midwest across a variety of settings including hospitals, academic departments, university counseling centers, and outpatient counseling centers. Selection criteria included self-identification as a heterosexual LGB ally, identification with Christian beliefs, and a conflict between their identify as a Christian LGB ally.
Borgman et al. (2009) organized the results of their study around five overarching core aspects: “experiences of conflict, analytic process of resolving the conflict, characteristics of being, experiences influencing conflict and resolution, and professional expression of being a Christian LGB ally” (p. 511). Participants described their conflict as an intense, internal discord that resulted in questioning their beliefs about sexual orientation and identity, God, and themselves. These feelings provided a desire to resolve this through integration. They reported a willingness to explore who they were and who they desired to be. Participants described being an ally as an active process that includes working to address injustices. Participants also expressed an awareness of the importance of acknowledging one’s bias and rigidity. This awareness was also related to redefining or examining their idea of what it means to be a Christian. Participants in this study reported that being a Christian and LGB ally can be complementary experiences. Some reported that spirituality was a driving force in their desire to be an ally and that it was related to living out their Christian values. Unlike spirituality, Christian-based religious beliefs were found to be a barrier to ally development. The church was also perceived as a source of negative messages about sexual orientation. Participants also reported that the conflict resolution process assisted them in working effectively with clients. They expressed that integration of their professional and religious values was their goal and allowed them to be authentic in their clinical work with clients.

Limitations of this study were similar to those found in other qualitative research. Specific limitations include characteristics of the sample which may prevent generalization of results to other Christian LGB allies, sole use of self-report and interview data, and only including participants who reported a conflict and wished to integrate their identities.
Suggestions for future research included focus on the impact of variables such as race gender, ethnicity, geographic environment, and various religious orientations.

Fallon et al. (2013) also discussed how counselors reconcile spiritual value conflicts related to sexual orientation to effectively serve LGBT clients. The authors explored the parallel process of counselors and clients expressing value conflicts related to religion/spirituality and sexual orientation. Fallon et al. (2013) explained the importance of religion and spirituality and how they are neither mutually exclusive, nor do they automatically coexist. “Spirituality involved discovering meaning in life events that is deeply personal to the individual... whereas religion represents the organization of beliefs shared in common by a group of people usually accompanied by rituals, doctrines, and practices” (p. 39). Although all counselors may not identify as religious they may still adopt heteronormative values from larger society that are heavily influenced by religious beliefs. Fallon et al. (2013) suggested that value conflicts can be resolved through engagement in critical thinking and examining one’s personal values, beliefs, and assumptions. Critical thinking has been associated with cognitively complexity skills that are necessary for counselors to be effective in case conceptualization, assessment, and ethical decision making. Fallon et al. (2013) also described ways in which professional and religious/spiritual values may converge with principles such as dignity, justice, autonomy, relief of human suffering, and a value for relationships.

Issues related to morality, religion, and sexuality are often controversial. While it is important that counselors are willing to speak out against discrimination and social injustices, they must do so in a responsible way that promotes understanding and fosters open dialogue. Researchers should provide information in an appropriate context and not promote generalizations, or oversimplify complex issues. Hunsberger and Jackson (2005) discussed the
importance of interpreting research about the relationship between religion and prejudice in the appropriate context and explain:

Religious persons and groups do many helpful, cooperative, and tolerant things in our world; there are surely many non-prejudiced religious persons as well as prejudiced nonreligious persons on this planet; and the frequently reported positive associations between religion and prejudice are often specific to certain definitions of religion and religious orientation, targets of prejudice, and group and cultural contexts. In spite of this, we cannot ignore the religion-prejudice links found in research on this issue (p. 821).

This statement underscored the importance of preserving the integrity of research by presenting findings and results in an accurate manner and discussing their meaning and relevance in a way that the intended audience can understand. Hunsberger and Jackson (2005) neither ignored the impact of religion on prejudice, nor suggested that all religious people are prejudiced towards certain groups.

**Ethics and Value Conflicts**

Counselors assume significant responsibility in their professional roles. This responsibility demands that counselors remain aware of the impact of power differentials in the client-therapist relationship and knowledgeable of the ways they may indirectly and unintentionally influence and convey their values to clients. Francis and Dugger (2014) described the ways counselors communicate their values to clients and explained that:

Counselors may inadvertently communicate their personal values through nonverbal and extra verbal responses to client disclosures by which client stories they focus on and which they avoid, by how convincingly they communicate caring and respect for a client,
by which interventions they select, by the suggestions they make or the homework they assign, and by their willingness to continue seeing a client (p. 92).

This description underscores the importance of being aware of one’s personal values, ways they can impact clinical practice, and effective ways to manage them. Ethical codes are an important tool that guides clinical practice and ethical decision-making. The American Counseling Association’s Code of Ethics “establishes norms and expectations for practitioners” and reflects the profession’s moral principles by identifying the “collective values of the profession” (Francis & Suzanne, 2014, p. 131). The ACA Code of Ethics (2014) stated that “the primary responsibility of counselors is to respect the dignity and promote the welfare of clients” (p. 4). This requires that counselors respect diversity, promote client autonomy, and avoid imposing their personal values on clients. It is important to note that the ACA Code of Ethics does not prohibit counselors from holding personal values, but rather expects that counselors would manage those values when they are acting in their profession roles so that they do not negatively impact service provision.

Although counselors are expected to be accepting of differences and to embrace diversity, they may struggle to internalize certain professional values when they are in conflict with their personal values. This can create an ethical conflict for counselors which may have significant consequences for client care and the reputation of the profession. Some professionals have chosen to make referrals to other professionals when they feel a value conflict exists between them and a client. Professional literature has yielded inconsistent recommendations regarding the appropriateness of value-based referrals and ways to resolve value-based conflicts.

Value-based referrals may be more common than expected. One study cited that 40% of the participants reported referring a client because of a value conflict (Kocet & Herlihy, 2014).
Over time, this has become a controversial approach as some scholars have suggested that counselors are expected to provide services to a diverse group of clients and should possess or develop the skills that are necessary to effectively serve them. Thus, situations where a counselor would need to refer a client due to a value conflict should be extremely rare (Kocet & Herlihy, 2014).

Counselors-in-training are strongly encouraged to develop an awareness of the field’s professional values and determine if they are able to effectively carry them out in their roles as counselors (Kocet & Herlihy, 2014). Remley and Helighy (2010) took a stronger stance regarding value conflicts. They asserted “if a counselor’s values were so strong that he or she could not counsel clients who held differing beliefs, we would be concerned that the counselor is not well-suited for the counseling profession” (p.23).

Several recent court cases have highlighted the controversy related to religious-based, value-based conflicts. Bruff v. North Mississippi Health Services (2001) was one of the first cases that centered on a counselor’s right to refuse to counsel specific groups of clients. Sandra Bruff was terminated from her position with an Employee Assistance Program (EAP) after she refused to counsel a lesbian client regarding relationships issues. She informed the client that homosexual behaviors were in conflict with her religious beliefs and refused to provide counseling for relationships concerns. Bruff also informed her employer that she would not counsel clients on any issues that conflicted with her religious values. Bruff was initially placed on unpaid leave and then eventually terminated after she refused to accept other positions within the company. The court ruled against Bruff citing that although employers are legally obligated to make reasonable accommodations for employees’ religious beliefs, that it was unreasonable for Bruff to expect accommodations that would create undue hardship on her employer. It...
should be noted that the court’s decision did not take a position on if Bruff acted ethically in her refusal to counsel specific clients, but determined that she did not have a legal right to be accommodated in the manner that she wished (Herlihy, Hermann, & Greden, 2014).

An U.S. District Court also ruled against a counselor in Walden vs. Centers for Disease Control and Prevention (2010). Similar to the outcome of Bruff’s case, the court ruled that counselors could not be inflexible regarding their willingness to accept accommodations that employers offered (Herlihy et al., Hermann, & Greden, 2014). Walden informed a client during an intake session that counseling a LGBT client was in conflict with her religious beliefs. Walden’s employer agreed to allow her to refer LGBT clients to other counselors, but requested that she refrain from stating the reason for referral to clients. She was later terminated after she refused to adhere to that request and did not seek transfer to another position within the agency. Like the Bruff case, the court ruled against Walden due to her failure to comply with the employer’s efforts to accommodate her and her insistence on disclosing her values directly to clients, which resulted in a nontherapeutic environment for clients (Herlihy et al., 2014).

Counseling students have also filed lawsuits against counselor education programs for dismissal from programs due to refusal to counsel specific clients. In Ward v. Wilbanks (2010) counseling student, Julea Ward at East Michigan University filed suit against the program after she informed her practicum supervisor that she could not practice gay affirming counseling and refused to participate in formal remediation. The court ruled in favor of the university and upheld the counseling department’s decision to dismiss Ward from the program. Ward would later appeal this decision in circuit court and the case would be decided through a jury trial.

In Keeton v. Anderson-Wiley (2010), Jennifer Keeton, a counseling student at Augusta State University stated that she condemned homosexuality. She was placed on remediation due
to concerns about her ability to separate her personal values from her professional responsibilities as a counselor. Keeton refused to complete remediation and was dismissed from the program. The court ruled against Keeton based on the premise that she failed to comply with the standards established by the counseling program. The courts noted that it was not Keeton’s “personal beliefs that were [the faculty’s] concern, but her inability to separate her personal beliefs in the judgement-free zone of a professional counseling situation” (Keeton v. Anderson-Wiley, 2010, p. 20). The court further explained their decision and stated that “Keeton does not have a constitutional right to disregard the limits [the university] has established for its clinical practicum and set her own standards for counseling clients in the clinical practicum” (Keeton v. Anderson-Wiley, p. 20).

These cases and their decisions have significant implications for clients and the counseling profession. The field of counseling and its ethical codes were built on principles of justice, dignity, respect, and autonomy. Respecting the rights of counselors to hold their personal values, while simultaneously ensuring that clients receive quality services in a respectful, value free environment can present challenges when value conflicts occur. This is particularly true of training programs as counselor educators act as gatekeepers and are tasked with the responsibility of preparing new counselors to become ethical practitioners. Values inform clinical assessment and ultimately impacts the outcome of therapy. Priest and Wickel (2011) explained that “values play an important role in the therapeutic process; they help determine what changes can and should be made and who should make those changes” (p. 142). Issues related to counselors’ ability to properly manage value conflicts and develop multicultural competency and ethical decision making skills will continue to rise in importance as American society becomes more diverse. Kocet and Herlihy (2014) provided suggestions for addressing
values based conflicts including ethical bracketing, which is defined as “the intentional separating of a counselor’s personal values from his or her professional values in order to provide ethical and appropriate counseling to all clients, especially those whose world views, values, belief systems, and decisions differ significantly from those of the counselor” (p. 182). Ethical bracketing includes several steps that are designed to assist the counselor in managing their values such as immersion self-reflection, seeking supervision and consultation, and considering participation in personal counseling, if necessary. Shiles (2009) also expressed concerns about “the glorification of the referral in the psychological literature” and explained that simply referring cases does not prevent a value conflict and is not a long term solution” (p. 147).

Values about religion and spirituality have important implications for clinical practice and can be utilized by counselors to increase empathy towards clients (Balking, Watts, & Ali, 2014). As perceptions about sexual orientation have changed, people have become aware of the impact of heterosexism (Borgman, 2009). Rabow (1993) discussed intolerance in society and explained that “appreciation of diversity is something we as a society, purportedly strive for but have not yet achieved, and widespread lack of understanding, even animosity, between groups is a pressing social and political problem” (p. 483).

Although efforts are being made to decrease stigma and sexual prejudice, LGBT individuals continue to experience significant consequences as a result of bias and discrimination. This awareness has led many individuals to become heterosexual allies. Some counselors strive to integrate their personal and professional identities and express that they “invisibly” brought aspects of themselves to their professional work, but were intentionally
seeking opportunities to make their attitudes and values visible though advocacy (Borgman, 2009, p. 519).

**Professional Identity Development and Professional Acculturation**

Professional identity serves as the reference point for understanding one’s professional roles and responsibilities. Counselors are called to serve a diverse group of clients with complex needs. The nature of their work requires that they are able to express empathy toward others, display respectfulness of differences, and be multiculturally competent. Counselors’ professional identity have significant implications for client care by informing clinical practice and impacting ethical decision making by influencing the development of professional values. Although a consensus does not exist regarding the definition of professional identity development, it is generally characterized by an immersion in the professional community and integration of personal values with the values of the profession. Healey and Hays (2012) described professional identity development as “a process by which an individual reaches an understanding of his or her profession in conjunction with his or her own self-concept, enabling the articulation of occupational roles, philosophy, and professional approach to people within and outside of the individual’s chosen field” (p. 55). Skovholt and Ronnestad (1992) also discussed professional identity development and assert that “counselors’ identities differ from identities formed in many other professions because, in addition to forming attitudes about their professional selves, counselors develop a therapeutic self that consists of a unique personal blend of the developed professional and personal selves” (p. 507). These definitions shed light on the relationship between personal development and professional identity.

Professional acculturation is also a critical component of professional identity development. It is described as a socialization process in which professionals learn the values,
roles, and responsibilities of the field. This process is characterized by an “immersion in a professional culture through which one learns professional appropriate attitudes, values, models of thinking, and strategies for problem solving” (Gibson, Dollarhide, Moss, 2010, p. 22). Gibson et al. (2010) explained the necessity of professional acculturation and suggested that professionals who are not properly acculturated may experience role confusion that interferes with competency including difficulties with ethical decision-making.

Wilcoxon, Jackson, and Townsend (2010) also discussed the acculturation process and factors that influence worldview. They noted that the acculturation process for counselors included assuming the responsibility to care and advocate for clients and engage in duties that were unique to their professional role. They further suggested that these duties “require an expansion of one’s personal worldview to accommodate professional identity, particularly as one evolved from novice into competent maturity” (p. 7). This line of research is consistent with other research on professional development and suggests that counselors have to learn how to manage their personal values, while embracing the professional values of the field.

Professional values can be defined as “precepts, traditions and expectations that become the professional template of decision-making and action for counselors” (Wilcoxon et al., 2010, p. 7). Professional organizations and accrediting bodies have played a significant role in establishing the values of the field. Respecting diversity and promoting client autonomy are core values of the field and provide the foundation on which other interventions are built. The ACA Code of Ethics (2014) clearly explains the professions’ position on diversity and managing personal values. Section A.4.b states:

counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and
research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor’s values are inconsistent with the client’s goals or are discriminatory in nature (p. 5).

Attending to one’s own personal development enables the counselor to attend to dynamics that may be beneficial to clients or consider what could negatively impact one’s ability to properly assist clients. As counselors-in-training begin, they are taught look at ways their personal experiences shape their worldview and to remain cognizant of their own biases and personal values that may negatively impact their work with clients. Reflection and self-awareness are important components of counselor competency. In order for a counselor to understand others, they must first develop an understanding of themselves. “Competency as a professional counselor is contingent upon one’s ability to embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts” (Francis & Dugger, 2014, p. 92). The integration of personal values with one’s professional identity is also an important aspect of competency. Integration of personal and professional values enables counselors to embrace the values of the field, exhibit congruence, and be genuine with the client. Coll, Doumas, Trotter, and Freeman (2013) discussed the relationship between personal development and competency. They explained:

knowing theory and possessing the diagnostic and interviewing skills do not necessarily make a person a good counselor. Rather, individual aspects of the counselor such as personal attributes, self-awareness, and attitudes regarding self-care, health, and lifestyle affects one’s ability to function in the professional counseling role. (p.54)
Coll et al. (2013) suggested that the counselor’s personal characteristics and their way of being with clients, not just their clinical abilities, are important to therapy outcomes. Counseling is distinct from many professional fields because of an emphasis on the personal and professional development of counselors. Training programs generally utilize teaching approaches that ensure the acquisition of specific skills and knowledge while also emphasizing the importance of personal growth. Instructional methods are frequently based on the premise that students need to develop a broad range of skills, but acknowledge that reflection, self-awareness, and professional development are as equally important as foundational knowledge. A counselor’s personal identity serves as the starting point for their professional self and must also be cultivated in order for them to be effective in their work with others.

The importance of the “person of the counselor” and the “therapeutic self” has been discussed in the literature on counselor development, suggesting that the relationship between personal growth, professional development, and competency are interconnected (Auxier, Hughes, & Kline, 2003, p. 25). According to Ronnestad and Skovholt (2003), one of the most important tasks for professionals is to “to create a counseling/therapy role which is highly congruent with the individuals’ self-perceptions (including values, interests, attitudes), which makes it possible for the practitioner to apply his/her professional competence in an authentic way” (p. 20). This process is known as integration. Integration “involves shedding values, beliefs, and use of methods which no longer fit the personality and the self of the therapist” (Ronnestad & Skovholt, 2003, p. 27). Successful integration of the personal and professional self allows the counselor to experience congruence and reconcile value conflicts in order to express empathy towards the client. Effective counselors must prioritize the needs of the client.
and carry out their professional roles and responsibilities in a way that conveys genuine respect and understanding. Elliot (2011) explained that:

> if the counselor is not genuine in the desire to be accepting of and empathic towards the client, the counselor’s lack of authenticity will be apparent and will prevent the counselor from communicating the conditions of unconditional positive regard and empathy and thus will inhibit the counselor’s ability to be therapeutic as well as ethical (p. 43).

Thus, simply following ethical codes or possessing certain skills does not necessarily translate to successful therapy outcomes. Counselors have to establish genuine, authentic relationships with clients that create a safe space for clients to grow and resolve issues. Communicating empathy and genuineness is particularly important for clients who are marginalized or who have frequently experienced discrimination.

Research on the effectiveness of psychotherapy also provides support for this theory and evidence that therapy outcomes are shaped significantly by the counselor, regardless of the interventions that are utilized. Ronnestad and Skovholt (2003) explained that “when studying a specific intervention, it may be surprising that variation in outcomes across methods is smaller than variation in outcomes among counselors/therapists within methods” (p. 6). This suggests that “it makes a bigger difference who the therapist is than which method is used,” and underscores the importance of the person as the counselor and professional identity development (Ronnestad & Skovholt, 2003, p. 6).

**Summary and Conclusion**

The field of counseling has evolved significantly since its inception in the 1900s. The profession evolved from the progressive guidance movement that focused on prevention efforts
and helped individuals find purpose. During the early years, a variety of disciplines performed counseling-related tasks and professionals in psychology, education, history, law, philosophy, and sociology worked together to address the needs of individuals and communities (Gladding, 2012). By the Industrial Revolution in the mid- to late 1800s, the humanistic perspective that focused on personal growth and self-awareness defined the field and professionals worked to help people improve their quality of life. These early pioneers of counseling identified themselves as teachers, advocates, and social reformers. Their work was influenced by changes in America’s demographic makeup, the social reform movement, and the spread of public education (Gladding, 2012).

According to Gladding (2012), “counseling emerged during a socially turbulent period that straddled the ending of one century and the beginning of another, a period marked by great change that caused a major shift in the way individuals viewed themselves and others” (p. 8). The historical beginnings of counseling have significant implications for the future of the field. Although the field has experienced a number of changes in its effort to professionalize, its purpose to promote personal growth and wellness, assist those in need, advocate for the disadvantaged, and to improve societal conditions remains the same.

ACA identified establishing a collective professional identity as an important aspect of relaying to the public who counselors are and what counselors do. In 2005, ACA developed 20/20: A Vision for the Future of Counseling in an effort to address issues that impact the future of counseling. The 20/20 initiative discussed new trends that are expected to develop in the field (e.g., increased emphasis on multicultural competence due to a more diverse population, the importance of advocacy in prevention efforts and promoting wellness in clients) (Kaplan & Gladding, 2011). Providing effective services to LGBT clients will continue to be of
significance to the professional field. LGBT clients have high utilization rates of mental health services and can benefit from advocacy efforts aimed at addressing issues that impact quality of life and the provision of effective mental health services.
CHAPTER 3

METHODOLOGY

Design of Study

This chapter provides a description of the methodology used in this study. There are four sections in this chapter that provide detailed information regarding the research design, participants, survey instruments and their psychometric properties, data collection procedures, and data analysis used in this study.

A correlational research design was used to explore the impact of religiosity on counselor attitudes about sexual minority orientation. The relationship between religiosity and professional identity development and attitudes about sexual minority orientation was examined. To examine this relationship, three research questions were examined. The research questions were (1): What demographic variables are associated with negative attitudes about sexual minority orientation? (2): Is there a relationship between scores on the Centrality of Religiosity Scale (CRS) and scores on the Attitudes Towards Lesbians and Gays- Revised (ATLG-R)?; and (3) Do scores on the Professional Identity and Values Scale-Revised (PIVS-R) mediate the relationship between religiosity and scores on the Attitudes towards Lesbians and Gays-Revised (ATLG- R)?

Measures

Participants were administered a demographic survey that solicited information about gender, ethnicity, age, educational level, years of post-Masters clinical experience, and current practice setting. Education level was categorized as: Master’s degree, Educational Specialist
degree, or Doctoral degree (i.e., Ed.D. or Ph. D). Years of experience was categorized as: Professionals with 1 - 5 years, Professionals with 6 - 10 years, or Professionals with 10 or more years of experience. The surveys used in this study were: The Centrality of Religiosity Scale (CRS, Huber, 2003), Attitudes Towards Lesbians and Gay Men-Revised (ATLG-R; Herek, 1994), and the Personal Identity and Values Scale-Revised (PIVS-R; Healey, Hays, & Fish, 2010). Each is described subsequently.

**Centrality of Religiosity Scale**

The Centrality of Religiosity Scale (CRS; Huber, 2003) measures the centrality and salience of religion in personality. The CRS has been widely used as a measure of religiosity in more than 100 studies. The CRS is based off Charles Glock’s (1968) multidimensional model of religion: the intellectual, the experiential, the ideological, private practice, and public practice. The CRS has been validated and is correlated to self-report measures of the importance of religion in daily life and the salience of religious identity. The CRS was developed in three different lengths that include 5, 10, or 15 items. The CRS-5 was utilized in this study because the survey items on that version most related to the purpose and objectives of the current study. The internal consistency of the CRS-5 was reported to be .85 (Huber, 2003)

Scores on the CRS range from 1.0 to 5.0 and are calculated by summing the total score and dividing it by the total number of scored items. Frequencies of participation in prayer is coded as 5 (several times a day or once a day), 4 (more than once a week), 3 (once a week or one or three times a month), 2 (a few times a year or less often), or 1 (never). Frequencies of participation in religious services is coded as 5 (more than once a week or once a week), 4 (one or three times a month), 3 (a few times a year), 2 (less often), or 1 (never). The CRS categorizes
people who score 4.0 to 5.0 as “highly-religious,” 2.1 to 3.9 as “religious,” and 1.0 to 2.0 as “not-religious.”

Attitudes Towards Lesbians and Gay Men-Revised

The Attitudes Towards Lesbians and Gay Men-Revised (ATLG-R; Herek, 1994) offered 20 evaluative statements about attitudes toward gay and lesbian individuals on a 5-point Likert scale. The ATLG-R is divided into two Subscales, one measuring attitudes towards gays (ATG-R) and the other scale attitudes towards lesbians (ATL-R). The ATLG-R’s reliability and validity have been documented in a number of studies (Herek, 2009). A systematic review of instruments used to measure homophobia also found that the ATLG-R has been used most frequently to measure homophobia and had the strongest evidence of validation (Grey, Robinson, Coleman, & Bockting, 2013). Examples of survey items include “female homosexuality is a sin,” “male homosexuality is a natural expression of sexuality in men,” and “female homosexuality is a threat to many of our basic social institutions.”

The ATLG-R (Herek, 1994) has high internal consistency, alpha > .80. Test-retest reliability (rs > .80) and discriminate validity have also been established. The ATLG-R can be self-administered or administered orally and is scored by summing survey items for each scale. Items 1, 3, and 4 are reverse scored on ATL-R Subscale and items 15 and 18 are reversed on the ATG-R Subscale. The ATLG-R is also correlated to several theoretically related constructs. Research has found that individuals who support gay rights have lower scores on the ATLG-R. Conversely, support for discriminatory practices towards gay and lesbian individuals, high religiosity, traditional beliefs about gender and family roles, and limited contact with gay and lesbian individuals was associated with higher scores on the ATLG-R.
Personal Identity and Values Scale-Revised

The Personal Identity and Values Scale-Revised (PIVS-R; Healey et al, 2010) was developed to measure professional identity development in counselors. The PIVS-R contains 32 items and is divided into two Subscales: Professional Orientation and Values and Professional Development, these subscales assess counselors’ attitudes, beliefs, and practices regarding their professional roles. A 6-point Likert scale is used to indicate agreement or disagreement with survey items. Cronbach’s alpha for the total Subscale is reported to be .80. Convergent and content validity have also been established for the PIVS-R. The PIVS–R is scored by survey items. A total score can be obtained by adding the two Subscales together. Items 2, 8, and 9 are reversed scored on the Professional Orientation and Values Subscale. Items, 1, 4, 5, and 6 are reverse scored on the Professional Development Subscale.

The Professional Orientation and Values Subscale on the PIVS-R (2010) provides philosophical beliefs about the field (advocacy, wellness, social justice, etc.) and also evaluates personal values (self-awareness, spirituality, belonging, etc.) that may impact professional values. The Professional Orientation and Values Subscale includes items such as “awareness of social justice issues is an integral part of being a competent counselor,” “my work as a counseling professional is fundamentally connected to my personal spirituality,” and “counseling professionals work best when professional expectations are congruent with personal values.”

The Professional Development Subscale on the PIVS-R (2010) represents three stages of professional development. Examples of survey items include “I feel confident in my role as a counseling professional,” “at this stage in my career, I have developed a professional approach that is congruent with my personal way of being,” and “I have developed a clear role for myself within the counseling profession that I think is congruent with my individuality.”
At stage 1, counselors take on the beliefs of more experienced professionals that they perceive as experts. Stage 2 describes counselors that have some experience, are learning to be more independent, and are beginning to develop their unique counseling philosophy. At the final stage, counselors have a well-established professional identity, are confident in their role and abilities as a counselor and are seeking opportunities for professional development. Counselors at this stage have also integrated their personal and professional values and are able to carry out their professional responsibilities in an authentic way.

Participants

Professional counselors across the southeast (i.e., Alabama, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Virginia and West Virginia) were recruited for participation in this study. Graduate students who had not competed a Master’s degree were excluded from participation in the study. This step was taken to ensure that counselors have developed minimal competencies and had opportunities for clinical contact with clients as a result of completing a Master’s program. Recruitment for participation was also restricted to the southeastern region of the U.S.

Approach to Data Collection

Permission to conduct this study was obtained from the University of Alabama’s Institutional Review Board (IRB). Cluster sampling was used to obtain research participants. This sampling method was chosen instead of random sampling in order to address concerns about low response rates due to social desirability. The length of the measures were also given consideration in order to prevent participant fatigue and encourage full completion of all survey instruments.
A list of state counseling associations and CACREP-accredited counseling programs in the southeastern region of the U.S. was developed. This list was developed by conducting an Internet search to identify the contact information (i.e., phone numbers and email addresses) for state counseling associations and a directory search on CACREP’s website for accredited programs. A recruitment letter was submitted electronically to state counseling associations and CACREP-accredited counseling programs. The letter included information about the study, how to access the survey, and contact information from the researcher. Membership directories, website for counseling programs, and listservs were used to gather contact information to recruit participants for the study. The IRB approval letter was included in these request and was require from some state associations to review the request for participation.

Participants were directed to a website with a link to the survey. Informed consent was given to participants before beginning the survey. The informed consent included information explaining that participation was voluntary, details about the nature of the study, the risks associated with participation in the study, the amount of time required to complete the survey, and information about the researcher. Debriefing information was provided after participants completed the survey and included the purpose of the study, hypothesis, and information about the researcher.

A total of 75 schools where contacted and provided the recruitment letter to request to participation in the study. Departmental websites of CACREP programs were reviewed to obtain email addresses for faculty members. Information regarding faculty members’ educational background was reviewed to determine if faculty members had obtained degrees in counseling and met inclusion criteria. Requests to participate in the study was sent to approximately 565
faculty members across Alabama, Georgia, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

State counseling associations in Alabama, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and West Virginia were contacted through email addresses obtained from their websites. These state counseling associations were provided the recruitment letter. Since the email address for Georgia’s counseling association was not available on their website, they were contacted by phone to determine if a listserv was available. A Georgia representative of the association reported that they did not have a listserv for the state association. Contact information for Virginia’s counseling association was also not available on their website.

Alabama and North Carolina Counseling Associations agreed to distribute the initial request to participate and requested a 30-day reminder. Requests were also sent through the message page on associations websites when available. Divisions of counseling associations were also contacted in order to provide the opportunity to request more counselors to participate in the study. A reminder email was sent to participants approximately one month after the initial request. According to Heppner and Heppner (2004), reminder letters increase return rates by approximately 10%. Response rates were low for the study. This may be related to the timing of data collection as many faculty members are not working full-time during the summer months. It was also not possible to confirm when requests were distributed to counselors. A spike in responses appeared related to the distribution of the initial counseling board requests and the days following reminder emails.

Data Analysis

All data were checked to ensure accuracy prior to beginning data analysis. Gender, race/ethnicity, age, level of education, years of post-master’s experience, and current practice
setting, and contact with gay and lesbian clients was obtained from the demographic survey. Descriptive statistics, such as the mean (M), range, and standard deviation (SD) provided a description of the sample. SPSS was used to analyze the data. Outliers that fell more than 3 standard deviations above or below the group mean were deleted from the data set. An alpha level of .05 was be used for all analyses.

An independent samples t-test was used to compare differences in mean scores on the ATLG-R (Herek, 1994) between participants of different race, gender, and contact with gays and lesbian clients. A one-way ANOVA was used to determine mean differences in scores on the ATLG-R between counselors with different levels of education, years of post-master’s experience, and level of religion.

A Pearson’s correlation coefficient was used to examine the relationship between scores on the ATLG-R (Herek, 1994) and CRS scores. A regression was used to predict scores on the ATLG-R. Level of education, years of post-master’s experience, and scores on the CRS (Huber, 2003), and PIVS-R (Healey et al., 2010) were used as predictor variables. Finally, a mediation was used to determine if the PIVS-R impacted scores on the CRS and the ATLG-R.
CHAPTER 4

RESULTS

This chapter is divided into three sections: participant sample, measures, and statistical analysis. Descriptive statistics is utilized to provide information regarding the sample, an explanation of statistical procedures utilized to answer to the primary research questions of the study is provided, and correlations between specific variables and survey scores are discussed.

Participant Sample

Participants were provided a link to the survey through electronic mail. A total of 155 participants accessed the survey and gave informed consent to participate in the study. Thirty-one surveys were discarded as participants because they accessed the survey but did not respond to any items. Nine additional surveys were discarded due to missing data for multiple or key survey items. The final sample included a total of 115 participants. The sample consisted primarily of participants who identified as female (82%). Male participants constituted 17% of total participants and 1% preferred to self-describe or not to state gender. In regards to racial/ethnic makeup, 71% of participants indicated they were White, 24% identified as Black, 3% identified as Hispanic/Latino, and 1% identified as American Indian/Alaska Native and Asian. Figure 1 displays the racial and ethnic makeup of the sample.
Participants ranged in age from 25 to 75 years of age. The youngest participants were between 22 and 35 years of age and included approximately 24% of participants. The majority of participants (28%) were between 36 and 45 years of age. Another 24% were between 46 and 55 years of age. People over 55 years of age composed the smallest percentage of participants. People between 55 and 65 years of age comprised 2% of the sample and 8% reported being between 66 and 75 years of age. Participants who did not include their age was noted as 3%.

*Figure 2* displays the age of participants.
A Master’s degree was reported as the highest level of education obtained by the majority of participants (57%). Completion of a doctoral degree (Ph.D or Ed.D.) was indicated by 36% of participants and 7% had an earned Educational Specialist (Ed.S.) degree. The majority of counselors were licensed (76%), with 24% reporting that they were not licensed. A majority of participants (48%) reported having over 10 years of experience in counseling. Thirty-five percent of participants reported 1 - 5 years of experience, and 17% reported working as a counselor for 6 - 10 years. In figure 3, years of post-master’s experience is shown.
Figure 3. Participants’ Years of Post-Master’s Experience.

The majority, of participants (90%), indicated that they were currently working with gay or lesbian clients or had worked with them in the past. A small percentage of the sample (10%) reported that they had not provided clinical services to gay or lesbian clients. In regards to practice setting, the majority of participants indicated working in private practice (39%) and community mental health agencies (24%). Work in “other settings” was reported by 20%. Of the participants, work in outpatient clinics was reported by 10% of the sample, while work in inpatient clinics and psychiatric hospitals was reported as 6% and 2%, respectively. Figure 4 displays practice settings.
Measures

Overall, the large majority of participants (61%) scored in the “not religious” range on the CRS. In this study, 31% of participants scored in the “religious” range, and the smallest percentage of participants (8%) scored in the “highly religious” range. Scores on the CRS are displayed in Figure 5.
Scores on the ATLG-R (Herek, 1994) reflected a range of attitudes towards gay and lesbian individuals. Lower scores on the ATLG-R reflect positive attitudes, whereas higher scores reflect negative attitudes. The lowest score on the ATLG-R was 20, while the highest was 81 ($X = 34.83$, $SD = 16.09$). Scores on the ATLG-R were also divided into low, middle, and high ranges for additional analysis. Scores for the ATLG-R are displayed in figure 6. The majority of participants (70%) were grouped in the low score range (scores between 20 - 40) reflecting more positive attitudes about gays and lesbian individuals. Approximately 21% of participants were grouped in the middle range (scores between 41 and 60) and 9% of participants were placed in the highest range (scores between 61 to 81), endorsing more negative attitudes. These results suggest that overall the majority of participants endorsed positive attitude about gays and lesbian individuals. Scores on the PIVS-R ranged from 125 to 213 ($X = .155.06$, $SD 11.423$.)

![Figure 6](#).

**Figure 6.** Participants Scores on the ATLG-R.
Statistical Analysis

Research Question 1 examined the demographic survey and the ATLG-R (Herek, 1994). It was hypothesized that counselors who reported more years of professional experience and more contact with gay and lesbian individuals would report more positive attitudes about sexual minority orientation. Race, gender, level of education, years post-master’s experience, and contact with gay and lesbian individuals were examined to determine how they impacted attitudes towards gay and lesbian individuals. Results of this study found that years of experience was not an indicator of lower scores the ATLG-R and more positive attitudes towards gay and lesbian individuals. However, contact with gay and lesbian individuals was associated with lower scores the ATLG-R and more positive attitudes towards gay and lesbian individuals.

An independent samples $t$ test was conducted to determine if there were differences in scores on the ATLG-R between genders and racial/ethnic groups. Significant differences at $\alpha = .05$ were not found between males and females on scores on the ATLG-R, $t(111) = -0.754, p = .452$. Tables 1 and 2 display the means and standard deviation for genders. An independent samples $t$ test found, at $\alpha = .05$, no significant differences in scores on the ATLG-R between racial groups $t(107) = -1.902, p = .060$. Thus, gender and race did not appear to shape attitudes towards gay and lesbian individuals in either a positive or negative way.

Table 1.

**Table of Means and Standard Deviations**

<table>
<thead>
<tr>
<th>Gender</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>32.05</td>
<td>16.625</td>
</tr>
<tr>
<td>Female</td>
<td>35.12</td>
<td>16.057</td>
</tr>
</tbody>
</table>
Table 2.

Table of Means and Standard Deviations

<table>
<thead>
<tr>
<th>Race</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>33.66</td>
<td>16.656</td>
</tr>
<tr>
<td>Black/African American</td>
<td>40.48</td>
<td>15.545</td>
</tr>
</tbody>
</table>

Subscales of the ATLG-R were also examined for gender differences. An independent samples t test was utilized to determine if males and females endorsed different attitudes towards gay men as compared to lesbian females. No significant differences were found, at $\alpha = .05$, in males and females on scores on the ATL subscale, $t(111) = -1.123, p = .264$. Similarly, no significant differences were found, at $\alpha = .05$, in males and females on scores on the ATG subscale, $t(111) = -.427, p = .670$. The means and standard deviations are displayed in Tables 3 and 4. These findings suggest that males and females share similar attitudes about sexual minority orientation regardless of if the person is male or female.

Table 3.

Table of Means and Standard Deviations

<table>
<thead>
<tr>
<th>Gender</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14.42</td>
<td>7.313</td>
</tr>
<tr>
<td>Female</td>
<td>16.46</td>
<td>7.193</td>
</tr>
</tbody>
</table>

Table 4.

Table of Means and Standard Deviations

<table>
<thead>
<tr>
<th>Gender</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17.63</td>
<td>9.816</td>
</tr>
<tr>
<td>Female</td>
<td>18.66</td>
<td>9.510</td>
</tr>
</tbody>
</table>
A one-way ANOVA was used to determine if level of education (master’s, educational specialist, or Ph. D) and years of post-master’s experience impacted scores on the ATLG-R. The data were screened for normality and homogeneity of variances. No significant differences were found between groups based on level of education, \( F(2, 114) = 1.106, p < .001 \). In regard to years of past master experiences, no significant differences were found between groups, \( F(2, 114) = .715, p < .001 \). Participants with a doctoral degree (Ph.D./Ed.D) had the lowest scores on the ATLG-R, reflecting positive attitudes, while participants with an educational specialist degree (Ed.S.) had the highest scores on the ATLG-R, reflecting negative attitudes. Professional experience also did not appear to result in more positive attitudes about gay and lesbian individuals. Counselors with the least amount of experience (1 to 5 years) reported scores similar to professionals with the most years of experience (more than 10 years).

An independent samples \( t \) test was conducted to determine if there were differences between counselors with different levels of contact with gay and lesbian clients. Significant differences were found, at \( \alpha = .05 \), between participants who reported contact with gay and lesbian clients and participants who reported no contact with gay and lesbian clients, \( t(113) = -2.299, p = .023 \). Table 5 displays means and standard deviations. Mean scores for the CRS for the no contact group were in the middle range (21-40). The contact group constituted 50% of all participants who scored in the middle range on the ATLG-R. These findings suggest that the no contact group had higher scores on the ATLG-R, endorsing more negative attitudes towards gay and lesbian individuals as compared to the rest of participants.
Research Question 2 explored the relationship between religiosity and attitudes towards gay and lesbian individuals. It was hypothesized that counselors with high scores on the CRS (Huber, 2003) would also score high on the ATLG-R, reflecting more negative attitudes about gay and lesbian individuals. Data from this study did not support this hypothesis.

A one-way ANOVA was used to determine if there were differences in scores on the ATLG-R between participants of different levels of religion. A significant difference in scores on the CRS was found between groups, $F(2, 114) = 17.786, p < .001$. Figure 7 displays mean scores for the ATLG-R and levels of religion (CRS). A Tukey post hoc multiple comparison test indicated that there were significant differences between two groups. Differences were found between the not religious and religious groups ($p < .001$) and the not religious and highly religious groups ($p < .001$). Table 6 contains means and standard deviations. Religious participants had lower scores, reflecting more positive attitudes towards gay and lesbian individuals compared to non-religious people. Participants who were highly religious had the lowest scores on the ATLG-R, endorsing more positive attitudes towards gay and lesbian individuals than all other participants.

Table 5.

Table of Means and Standard Deviations

<table>
<thead>
<tr>
<th>Contact with gay and lesbian individuals</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33.67</td>
<td>15.481</td>
</tr>
<tr>
<td>No</td>
<td>44.75</td>
<td>18.523</td>
</tr>
</tbody>
</table>


Table 6.

Means and Standard Deviations

<table>
<thead>
<tr>
<th>Level of Religion</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Religious</td>
<td>41.11</td>
<td>16.971</td>
</tr>
<tr>
<td>Religious</td>
<td>25.56</td>
<td>7.991</td>
</tr>
<tr>
<td>Highly Religious</td>
<td>23.00</td>
<td>6.245</td>
</tr>
</tbody>
</table>

Figure 7. Means Plot for CRS and ALTG-R Scores

Correlational analysis was used to determine the relationship between scores on the ALTG-R and CRS. A significant inverse correlation at $\alpha = .05$ was found between scores on the ALTG-R and scores on CRS, $r = -.466$, $p < .000$. See Table 7. These findings suggest that the more religious people were, the lower they scored on the ALTG-R, endorsing more positive attitudes about gay and lesbian individuals. Conversely, participants who were categorized as not religious, had the highest scores on the ALTG-R, reflecting more negative attitudes.
Table 7.

Correlations for ATLG-R and CRS scores

<table>
<thead>
<tr>
<th></th>
<th>ATLG</th>
<th>CRS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATLG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td>1</td>
<td>-.466</td>
</tr>
<tr>
<td>Sig, (2-tailed)</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>Sum of Squares and Crossproducts</td>
<td>29540.522</td>
<td>-546.609</td>
</tr>
<tr>
<td>Covariance</td>
<td>259.127</td>
<td>-4.795</td>
</tr>
<tr>
<td>N</td>
<td>115</td>
<td>115</td>
</tr>
<tr>
<td>CRS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td>-.466</td>
<td>1</td>
</tr>
<tr>
<td>Sig, (2-tailed)</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Sum of Squares and Crossproducts</td>
<td>-546.609</td>
<td>46.643</td>
</tr>
<tr>
<td>Covariance</td>
<td>-4.795</td>
<td>.409</td>
</tr>
<tr>
<td>N</td>
<td>115</td>
<td>115</td>
</tr>
</tbody>
</table>

Research Question 3 examined if professional identity development mediated the relationship between religiosity and attitudes towards gay and lesbian individuals. It was hypothesized that counselors with higher scores on the PIVS-R (Healey et al., 2010) would score lower on the ATLG-R (Herek, 1994), indicating more positive attitudes towards gay and lesbian individuals.

A multiple regression analysis was conducted to predict scores on the ATLG-R. Level of education, years of post-master’s experience, and scores on the CRS and PIVS-R were used as predictor variables. A significant regression equation was found, $F(4, 110) = 8.444, p \leq .001$, with an adjusted $R^2 = .207$, confirming a linear relationship between predictor and dependent variables. Thus, approximately 21% of the variance in ATLG-R scores can be attributed to the variation in the combination of level of education, years post-master’s experience and scores on the CRS and PIVS-R, scores ($\beta = -.11.603, t = -5.437, p < .001$). It can be concluded that there is
a non-zero relationship between the criterion variable and the linear combination of the predictor variables. Only CRS scores \((p \leq .001)\) contributed significantly to the regression. However, post-master’s experience \((p = .548)\), level of education \((p = .329)\) and PIVS-R score \((p = .231)\) did not contribute significantly to the regression. Coefficients are displayed in Table 8. These results suggest that religion (as measured by CRS scores) had more of an impact on attitudes towards gay and lesbian individuals than other factors (i.e., level of education, years of post-master’s experience, and PIVS-R scores) examined in the study.

A mediation was conducted to determine if PIVS-R scores affected the relationship between CRS scores and ATLG-R scores. In step 1 of the mediation model the regression equation was not significant, \(F(6, 108) = .770, p = .595\), with an adjusted \(R^2 = -.012\). In step 2 of the mediation model the regression equation was significant, \(F(7, 107) = 5.523, p = \leq .001\), with an adjusted \(R^2 = .265\). Only CRS scores \((p \leq .001)\) contributed significantly to the regression, \(\beta = -10.758, t = -4.27, p \leq .001\). Coefficients are displayed in Table 9 and 10. A Sobel test was conducted and found that professional identity did not mediate the relationship between CRS scores and ATLG-R scores \((z = -.089, p = .372)\).

Table 8.

Coefficients for multiple regression

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>74.860</td>
<td>18.356</td>
<td>.</td>
<td>4.078</td>
<td>.000</td>
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<tr>
<td>Post-Master’s Experience</td>
<td>.981</td>
<td>1.627</td>
<td>.055</td>
<td>.603</td>
<td>.548</td>
</tr>
<tr>
<td>Level of Education</td>
<td>-1.520</td>
<td>1.549</td>
<td>-.089</td>
<td>-.981</td>
<td>.329</td>
</tr>
<tr>
<td>CRS Score</td>
<td>-11.603</td>
<td>2.134</td>
<td>-.461</td>
<td>-5.437</td>
<td>.000</td>
</tr>
<tr>
<td>PIVS-R Score</td>
<td>-.144</td>
<td>.120</td>
<td>-.102</td>
<td>-1.204</td>
<td>.231</td>
</tr>
</tbody>
</table>
### Table 9.

**Coefficients for multiple regression**

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
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<td>8.678</td>
<td></td>
<td>16.503</td>
<td>.000</td>
</tr>
<tr>
<td>Gender</td>
<td>1.210</td>
<td>2.624</td>
<td>.046</td>
<td>.461</td>
<td>.646</td>
</tr>
<tr>
<td>Race</td>
<td>-.077</td>
<td>.818</td>
<td>-.009</td>
<td>-.094</td>
<td>.925</td>
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<tr>
<td>Post-Master’s Experience</td>
<td>1.820</td>
<td>1.357</td>
<td>.144</td>
<td>1.341</td>
<td>.183</td>
</tr>
<tr>
<td>Level of Education</td>
<td>1.043</td>
<td>1.264</td>
<td>.086</td>
<td>.825</td>
<td>.411</td>
</tr>
<tr>
<td>Contact</td>
<td>1.012</td>
<td>3.566</td>
<td>.027</td>
<td>.284</td>
<td>.777</td>
</tr>
<tr>
<td>CRS Score</td>
<td>2.135</td>
<td>1.746</td>
<td>-.120</td>
<td>1.222</td>
<td>.224</td>
</tr>
</tbody>
</table>

### Table 10.

**Coefficients for multiple regression**

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>65.635</td>
<td>20.180</td>
<td></td>
<td>3.253</td>
<td>.002</td>
</tr>
<tr>
<td>Gender</td>
<td>1.650</td>
<td>3.254</td>
<td>.045</td>
<td>.507</td>
<td>.613</td>
</tr>
<tr>
<td>Race</td>
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<td>1.014</td>
<td>-.059</td>
<td>-.670</td>
<td>.504</td>
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<tr>
<td>Post-Master’s Experience</td>
<td>1.217</td>
<td>1.695</td>
<td>.068</td>
<td>.718</td>
<td>.475</td>
</tr>
<tr>
<td>Level of Education</td>
<td>-1.183</td>
<td>1.571</td>
<td>-.069</td>
<td>-.753</td>
<td>.453</td>
</tr>
<tr>
<td>Contact</td>
<td>8.206</td>
<td>4.420</td>
<td>.157</td>
<td>1.857</td>
<td>.066</td>
</tr>
<tr>
<td>CRS Score</td>
<td>-10.758</td>
<td>2.179</td>
<td>-.427</td>
<td>-4.937</td>
<td>.000</td>
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<tr>
<td>PIVS-R Score</td>
<td>-.155</td>
<td>.119</td>
<td>-.110</td>
<td>-1.303</td>
<td>.195</td>
</tr>
</tbody>
</table>
CHAPTER 5
DISCUSSION

Overview

Mental health disparities among LGBT individuals continue to be a significant public health concern. Previous research indicates that sexual minorities have elevated rates of substance abuse and psychiatric disorders as compared to the heterosexual population (Bostwick et al., 2014; Kertzner, et al., 2009; Seil et al., 2014). The U.S. Department of Health and Human Services’ Healthy People 2020 initiative identified improving the health, well-being, and safety of sexual minorities as one of its goals (Kerridge et al., 2016). Although attitudes towards LGBT individuals appear to be improving, professionals must continue to focus efforts on providing effective services to this population. This current study contributes to the literature by providing insight into factors that influence counselor’s attitudes about sexual minority orientation and hopefully points to effective service provisions for LGBT clients. This chapter will include an examination of the research questions and hypothesis, limitations of the current study, and implications for practice and future research.

Research Question 1

This study aimed in Research Question 1 to examine demographic variables that were associated with negative attitudes about sexual minority orientation. Among the demographic variables examined in this study (i.e., race, gender, level of education, years post-Master’s experience, and contact with gay and lesbian individuals), differences in scores on the ATLG-R
(Herek, 1994) were only found between participants who reported having provided services to gays and lesbian individuals and participants who had not provided services to gay and lesbians individuals.

Previous research on gender differences in attitudes towards gay and lesbian individuals have found that overall men endorse more negative attitudes towards gay and lesbian individuals (Herek, 2000). Further, sexual minority orientations are stigmatized in society and people may experience discomfort about being labeled as gay or lesbian (Herek, 2000). Sexual minority orientation has also been associated with gender inversion (e.g., gay men being perceived more like women, and lesbian women more like men). Although women experience some social pressure to confirm to cultural gender roles, they have more flexibility than men in regards to traditional gender roles (Herek, 2013). Research suggests that men may endorse anti-gay attitudes in an effort to reaffirm their masculinity (Herek, 2000). Results from this study differed from previous research in that significant differences in attitudes towards gays and lesbians were not found between the genders. Male participants in the current study actually had slightly lower scores on the ATLR-G and the ATG subscale, endorsing more positive attitudes towards gay and lesbian individuals than women participants.

Findings from this study were consistent with previous research that suggests that more contact with gays and lesbian individuals is associated with more positive attitudes about sexual minority orientation. From this framework, it is widely accepted that more contact with gay and lesbian individuals is associated with less prejudiced attitudes (Whitman & Bidell, 2014). Furthermore, Bidell (2014) found that contact with gay and lesbian individuals was the strongest predictor of LGB affirmative counselor competency. Aligning with Whitman and Bidell (2014) and Bidell (2014), this study showed that contact with gay and lesbian individuals was
associated with lower scores on the CRS (Huber, 2003), indicating more positive attitudes toward gay and lesbian individuals.

Although training programs have placed more emphasis on multicultural competency and affirmative practices in recent years, counseling programs have historically been based on heterocentric models of society (Pachankis and Godfried, 2004). Counselors and students in training have reported receiving minimal training and express doubts about their competency to work with gay and lesbian individuals (Bidell, 2014). In the current study, participants with more education did not score lower on the ATLG-R, which suggests that having a higher level of education or more clinical experience alone did not result in a decrease in negative attitudes towards gay and lesbian individuals. These findings may reflect a knowledge gap or lack of specific training related to clinical practice with gay and lesbian individuals.

Overall, participants in this study reported more positive attitudes towards gay and lesbian individuals. However, a small percentage of participants reported higher scores, endorsing more negative attitudes towards gay and lesbian individuals. These results suggest that although the field appears to be more tolerant and affirmative towards gay and lesbian individuals, that there is still work to be done. Certainly, while strides were found in this study, efforts to uphold Pachankis and Godfried’s (2004) position (i.e., “when even a moderate level of therapist homophobia exists, it may impede interventions with lesbian and gay clients” [p. 229]), are still crucial. Their findings pointed to significant intrapersonal dynamics and professional experiences that shape counselor’s attitudes in either a positive or negative way. Such insight may assist counselor educators in creating training experiences that increase reflective thinking and multicultural competence.
Research Question 2

This study aimed in Research Question 2 to determine the relationship between scores on the Centrality of Religiosity Scale (CRS; Huber, 2003) and scores on the Attitudes Towards Lesbians and Gays- Revised (ATLG-R; Herek, 1994). Literature on counselor development discusses the impact of personal values and experiences on one’s professional work (Priest & Wickel, 2011). Religion is an important part of the lives of many people and understanding how it impacts counselors’ professional work has significant implications for counseling training programs and clinical practice (Halkitis et al., 2009; McMillen et al., 2011). Although religion is often associated with prosocial values, it has also been used as a way to justify intolerance (Borgman, 2009; Lean & Finken, 2011). Findings from this current study suggested a shift among counselors towards more positive attitudes about gay and lesbian individuals. In contrast to Satcher and Leggett’s (2007) findings, religious participants in this current study reported more positive attitudes about gay and lesbian clients as compared to the less religious participants.

Overall, research regarding the link between religion and prejudice does not suggest that all religious people hold negative attitudes about LGBT individuals. Rather, it appears that how people choose to live out religious beliefs, rather than simply being religious is most important (Lean & Finken, 2011). Findings from this study, aligning with Lean and Finken, suggest that religion was not an indicator of holding more negative attitudes towards gay and lesbian individuals. Nonetheless, this result may be related to the type of instrument used to measure religion. The CRS (Huber, 2003) is not related to a specific religious affiliation or denomination (Bidell, 2014). This measure of religiosity was also not related to religious fundamentalism or
an extrinsic religious orientation, which are often associated with more negative attitudes
towards gay and lesbian individuals (Bidell, 2014).

Certainly, more contemporary research is needed related to attitudes and religion. Allport
and Ross’ research (1967) found that regardless of religious affiliation, people hold either an
intrinsic (believing in religious teachings and living a life consistent with those beliefs) or
extrinsic orientation (using religion for secondary gain or for social reasons). Batson (1976)
extended this research by developing the idea of a quest orientation defined by self-reflection,
open-mindedness, and a willingness to examine and change beliefs. Quest orientation was also
found to be associated with the least amount of prejudice towards gay and lesbian individuals
(Biddell, 2014). Perhaps, in this study, the positive attitudes towards gay and lesbian individuals
among the counselors was related to an intrinsic orientation or a quest orientation (i.e., reflective
thinking is a skill that is encouraged among counselors).

Findings from this study were also consistent with research that found religious
counselors often integrate their religious and professional identities. Borgman et al. (2009) found
that for many counselors, respecting differences in others and advocating for marginalized
groups was part of their religious identity. It appears that for many people prosocial religious
values were manifested in their professional work as acceptance of others and respect for
diversity (Fallon et al., 2013). The results from this study were consistent with Borgman et al.
(2009) regarding LGB allies which suggested that supporting gay and lesbian individuals and
holding a Christian identity can be complimentary experiences. Essentially, religious counselors
in this study appeared to hold more positive attitudes towards gay and lesbian individuals
because of the way their religious views were consistent with the values (e.g., dignity, respect,
justice, etc.) embraced by the field of counseling (ACA, 2014).
The findings from this study also highlighted the complexity of issues related to values, sexuality, and religion. These findings are important because they shed light on the way counselors manage value conflicts and integrate their professional identities and have significant implications for clients, training programs, and employers. The nature of counselors’ work places them in situations where they will work with clients from diverse backgrounds. Counselors must be able to convey a sense of acceptance and respect for individuals who are different from them culturally. The ability to develop positive, trusting relationships with clients and be sensitive to cultural differences is an essential component of counselor competency and has a significant impact on therapy outcomes.

**Research Question 3**

This study aimed in Research Question 3 to determine if professional identity development mediated the relationship between religiosity and attitudes towards gay and lesbian individuals. This study underlined the importance of being aware of the impact of counselors’ religious values on their professional work identity and development. The field of counseling is unique from other disciplines in that the personal and the professional self are of equal importance. The therapeutic encounter is a very intimate experience and rapport is considered to be the cornerstone of successful outcomes (Coll et al., 2013). Although knowledge and skills are essential parts of competency, the counselor’s personal characteristics and rapport with clients is perhaps most important (Coll et al., 2013). Literature on counselor professional development discusses the “person of the counselor” and the “therapeutic self” (Auxier et al., 2003). These concepts acknowledge that counselors bring their unique experiences, beliefs, and values into their work with clients. Professional acculturation allows counselors to develop an awareness of
their role as a counselor and integrate aspects of their personal identity into their professional role (Wilcoxon et al., 2010).

Integration of personal and professional identities is important to counselors’ ability to develop trust and rapport with clients. The integration of personal and professional identities allows the counselor to be genuine with clients and foster empathy for those who are different from them (Coll et al., 2013; Elliott, 2011). Ronnestad and Skovoholt (2003) suggested that integration “involves shedding values, beliefs, and use of methods that no longer for the personality and the self of the therapist” (p. 27). Professional development also influences ethical decision making (Gibson et al., 2010). A clear understanding of the counselor’s professional role allows the counselor to manage value conflicts. Part of ethical practice includes being multicultural competent and being aware the impact of one’s values, beliefs, and life experiences may impact work with clients. These experiences can be a positive influence on one’s work with clients, but also have the potential to impede rapport building and impact therapeutic work in a negative way.

Professional identify development is one of the most consequential issues in counseling as it serves as reference point for one’s role and responsibilities and continues throughout the lifespan of the counselor’s career. Findings from this study reflect the impact of religion on counselor’s professional work. In this study religion was the most significant factor related to attitudes towards gay and lesbian individuals. This suggests that religious values have significant implications for the way counselors view human nature and clients, which ultimately impact the goals and interventions that are chosen. Counselor educators should be mindful of the influence of religion on counselor’s development and identify curriculum and training experiences that assist counselors in using religion as an avenue to enhance their work with clients.
Implications for Clinical Practice

The field of counseling is rooted in advocacy and social justice (Chang et al., 2010; Gladding, 2012; Kaplan & Gladding, 2011). Counselors continue to play a vital role in educating the public about human rights and social justice issues. Dismantling myths and perceptions that LGBT individuals are deviant or inferior simply because of their sexual orientation helps to educate people about sexual development, creates opportunities for dialogue about these issues, and helps create safe spaces for LGBT people to live and work free from bias and discrimination.

There were three overarching findings identified from this study. They were (1) for counselors to be competent in providing services to LGBT clients and act as advocates for clients who may be marginalized or experience discrimination; (2) to identify ways to improve training programs to assist students in developing multicultural competence; and, (3) the important role religion plays in some counselors’ professional work.

1. This study shed light on the importance of counselors being competent in providing services to gay and lesbian individuals and working to remove stigma about sexual minority orientation. Homosexuality was not removed from the DSM until 1973. Although attitudes towards gay and lesbian individuals appear to be improving, addressing stigma about issues related to sexual orientation remains an important part of the counselors’ work. Certainly, in the past, research has played a significant part in moving society from stigma to science (Herek, 2007). Nonetheless, counselors must remain aware of the psychological theories related to sexual orientation and use language that conveys respect for and acceptance of gay and lesbian clients. Research indicates that people report more accepting attitudes towards gay and lesbian individuals when they have an accurate understanding of issues related to sexual identity and
orientation (Smith et al., 2011). Educating the public about sexual orientation and increasing dialogue about the impact of stigma and discrimination on LGBT people’s health and daily lives can help people become more tolerant. Counselors can advocate and assist with this education and understanding.

Counselors live in a heterocentric society and sexual prejudice remains more acceptable than other forms of prejudice in the American society (Herek, 2007). Being aware of the impact of negative sociocultural messages on implicit bias is essential to counselors’ ability to work effectively with LGBT clients and to carry out affirmative clinical practices. Being aware of what the counselor brings to the therapeutic encounter can also be considered a perquisite to creating a place where clients feel safe disclosing intimate things about themselves and exploring solutions to presenting issues. Therapeutic rapport is often considered the cornerstone of therapy. Premature termination of therapy may occur when clients do not feel safe in the therapeutic encounter or if their needs are not being meet.

Mental health professionals should use research and empirical knowledge to guide their clinical work and develop effective interventions for gay and lesbian clients. LGBT individuals experience disproportional rates of mental health symptoms and disorders. Ensuring that these clients receive effective services and treatment is essential to improving the LGBT quality of life. Counselors have to be cognizant of the unique needs vulnerable clients face that may impact their ability to benefit fully from clinical services.

2. This study provided insight into ways counselor educators can improve training programs to assist counselors in developing multicultural competency. Counseling literature on professional identity development discusses the importance of attending to the person as a counselor (Auxier et al., 2003; Skovholt & Ronnestad, 2012). Professional identity development
is thought to continue across the lifetime of one’s professional career (Moss, Gibson, & Dollarhide, 2014). Understanding factors that influence counselor development can assist counselor educators in providing more effective training for counseling students. Accrediting bodies and professional organizations have identified standards and values that reflect the mission and values of the field. Professional acculturation is an important aspect of counselors’ ability to be effective in their professional roles. Identifying ways to improve training programs to assist students in becoming reflective professionals and developing multicultural competence is essential to ensuring that counselors are prepared to provide effective services to all clients.

3. The current study also provided insight into the role religion plays in shaping counselors’ attitudes sexual orientation. Similar to the ways clients’ personal values influence their behaviors and decisions, counselors’ work with clients are impacted by their personal values (Borgman, 2009; Priest & Wickel, 2011). Religion is salient in many people’s lives and is often a significant influence on their decisions, beliefs, and relationships with others. Research suggests that the client-counselor relationship, not specific interventions themselves are more predictive of therapy outcomes. Understanding how counselors successfully reconcile or integrate their personal and professional values assists counselors in developing more positive, authentic relationships with clients, which may positively impact therapy outcomes.

Limitations

Although the main research questions of the study were addressed, there were limitations to the study. The small sample size was a limitation of the current study. Motivating people to take time to complete a survey can be challenging. Specific inclusion criteria were chosen in order to ensure professionals has similar training experiences. Although this approach has some benefits, it may have also restricted the potential response pool, which prevents generalization of the research findings.
The nature of the topic also presented challenges. Issues related to religion and sexuality are very important to many people, however, they may also be controversial, perceived as sensitive in nature, or considered private. In this study the potential for social desirability bias could have been a factor, as participants may have been reluctant to endorse values or beliefs that conflict with professional values of the field or ethical codes.

**Future Research**

Improved attitudes about sexual minority orientation and shifts in the sociopolitical climate in America is associated with LGBT individuals being more open about their lives. Despite more acceptance, LGBT people continue to face unique stressors and challenges. Thus, providing effective services to this population remains an important societal issue. This study underlined the need for additional research. Future studies should focus on factors that impact the delivery of quality services to specific client populations.

Although research regarding the experiences of gay and lesbian individuals has increased, such as in this study, less information is available regarding mental health issues and the therapeutic experiences of transgender people. Identifying the needs of transgendered individuals and developing effective, culturally sensitive interventions is important to addressing gaps in current service delivery to sexual minorities. Clients of a sexual minority orientation may also be members of other minority groups or groups that occupy a marginalized status. Studies that examine the impact of intersectional identities on clinical symptomology should also be explored.

Counselor educators serve as gatekeepers for entry into the profession. As society continues to change, counselors will need to be trained to work with more complex presenting issues from their clients. Identifying specific training experiences that assist counselors in
successfully managing value conflicts and developing multicultural competence are also of relevance. Finally, studies that examine how clients’ perception of therapy may differ from counselors can provide insight into ways to improve therapeutic conditions for LGBT clients.

Research has played a significant role in educating the public about sexual orientation and increasing awareness of social justice issues. The development of additional scales that measure religiosity may increase understanding of the impact of religion on counselors’ professional work and ways it can be used to provide better services to clients.

Conclusions

People’s attitudes towards sexual minorities has been studied extensively over recent decades (Meyer, 2003, Pachankis & Doldfried, 2013; Swank, et al, 2013). A variety of terms and concepts such as homophobia, heterosexism, and sexual microaggressions have been the subject of both research and debate (Herek, 2007; Saewyc, 2011). Research suggests that increased acceptance of sexual minority orientation is a result of sociocultural changes in the United States (Hetzel, 2011). Support for same sex marriage and anti-discrimination laws in education, housing, and the workplace appear to have increased (Herek, 2011). However, many LGBT individuals continue to report experiencing discrimination and have high utilization of mental health services (Bostwick et al., 2014; Oswalt & Wyatt, 2011). This suggests while many people hold the belief that rights of LGBT peoples should be protected, some people continue to hold negative attitudes about sexual minority orientations.

The findings from this study reflect the complexity of issues related to values, religion, and attitudes about sexual orientation. As society continues to change as a result of shifting demographics, technological advances, and more open expression of personal beliefs, counselors will be tasked with serving a more diverse population than in any previous point in history. This
will require that counselors remain reflective and aware of their ethical obligations to respect the dignity and welfare of all clients. Counselors should continue to strive to carry out the values of the field in order to improve the quality of life for all clients.
REFERENCES


APPENDIX A

Demographic Questionnaire
Demographic Questionnaire

1. What is your age?

2. What is your gender?
   - male
   - female
   - prefer not to say
   - prefer to self-describe

3. What is your ethnicity?
   - American Indian or Alaskan Native
   - Asian
   - Black or African American
   - Hispanic/Latino
   - Native American or other Pacific Islander
   - White
   - Other

4. How many years of post-Masters experience do you have in counseling?

5. What is your highest degree completed in counseling?
   - Masters
   - Educational Specialist
   - Ph. D

6. Are you a licensed counselor?
   - Yes
   - No

7. What is your current practice setting?
   - Private practice
   - Outpatient clinic
   - inpatient program
   - Community mental health agency
   - Inpatient program
   - Psychiatric hospital

8. Do you currently or have you provided clinical services to gay/lesbian clients?
APPENDIX B

Centrality of Religion Scale (CRS)
### Centrality of Religion Scale (CRS)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Items for the basic version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellect</td>
<td>1. How often do you think about religious issues?</td>
</tr>
<tr>
<td>Ideology</td>
<td>2. To what extent do you believe that God or something divine exists?</td>
</tr>
<tr>
<td>Public Practice</td>
<td>3. How often do you take part in religious service?</td>
</tr>
<tr>
<td>Private Practice</td>
<td>4. How often do you pray?</td>
</tr>
<tr>
<td>Experience</td>
<td>5. How often do you experience the situation in which you have the feeling that God or something divine intervenes in your life?</td>
</tr>
</tbody>
</table>
APPENDIX C

Professional Identity and Values Scale- Revised
Professional Identity and Values Scale- Revised

This inventory will assess your attitudes, beliefs and practices regarding your role in the counseling profession. As you take this inventory, apply the questions to your current role in the counseling profession, be it work with clients, students, or supervisees. Please indicate your agreement with each question by circling the number that best fits with your response impression.

SD= Strongly Disagree    D=Disagree    DS=Disagree Somewhat    AS=Agree Somewhat
A=Agree    SA=Strongly Agree

Use the scale above to determine your numbered selection.

1. Awareness of social justice issues is an integral part of being a competent counselor.
2. Clients should be dependent on counselors to help them cope with life issues.
3. Building a strong relationship with a client is essential to the counseling process.
4. Therapeutic interventions should be flexible with regard to a client’s presenting concerns.
5. Having a holistic perspective is an essential part of being a counseling professional.
6. Assisting clients in advocating for their needs is an important component of one’s role as a counseling professional.
7. Client empowerment is a fundamental component in the counseling process.
8. I believe most mental health issues are the result of diagnosable illness, requiring long-term medical and/or behavioral intervention.
9. It is a counselor’s primary goal to take responsibility for finding and connecting clients with community resources.
10. An integral part of the counseling process is assisting clients in recognizing their strengths.
11. An important part of a counselor’s role is to provide an objective perspective for clients.
12. Community service is valuable for my work as a counseling professional.
13. It is important for counseling professionals to be involved in promoting the counseling profession.
14. Building strong professional relationships with other counselors is important to me.
15. The quality of my professional work is more important than the quantity of work completed.

16. My personal wellness is important to my work as a counseling professional.

17. My work as a counseling professional is fundamentally connected to my personal spirituality.

18. Counseling professionals work best when professional expectations are congruent with personal values.

Professional Development

1. Overall, I do not feel confident in my role as a counseling professional.

2. My approach to my work in counseling is largely modeled after those I perceive to be experts.

3. Feedback from supervisors and experts serve as the primary means by which I gauge my professional competence.

4. I am unsure about who I am as a counseling professional.

5. I understand theoretical concepts but I am unsure how to apply to them.

6. I am still in the process of determining my professional approach.

7. I always gauge my professional competence based on both internal criteria and external evaluation.

8. In making professional decisions, I balance my internal professional values and the expectations of others.

9. Based on my level of experience within the counseling profession, I have begun developing a specialization with the field.

10. I have developed personal indicators for gauging my own professional success.

11. I feel confident in my role as a counseling professional.

12. I feel comfortable with my level of professional experience.

13. At this stage in my career, I have developed a professional approach that is congruent with my personal way of being.

14. I have developed a clear role for myself within the counseling profession that I think is congruent with my individuality.
APPENDIX D

Revised Long Versions (ATLG-R)
Attitudes Toward Lesbians (ATL-R) Subscale

1. Lesbians just can't fit into our society.

2. A woman's homosexuality should not be a cause for job discrimination in any situation.

3. Female homosexuality is bad for society because it breaks down the natural divisions between the sexes.

4. State laws against private sexual behavior between consenting adult women should be abolished.

5. Female homosexuality is a sin.

6. The growing number of lesbians indicates a decline in American morals.

7. Female homosexuality in itself is no problem unless society makes it a problem.

8. Female homosexuality is a threat to many of our basic social institutions.

9. Female homosexuality is an inferior form of sexuality.

10. Lesbians are sick.

Attitudes Toward Gay Men (ATG-R) Subscale

11. Male homosexual couples should be allowed to adopt children the same as heterosexual couples.

12. I think male homosexuals are disgusting.

13. Male homosexuals should not be allowed to teach school.

14. Male homosexuality is a perversion.

15. Male homosexuality is a natural expression of sexuality in men.

16. If a man has homosexual feelings, he should do everything he can to overcome them.

17. I would not be too upset if I learned that my son were a homosexual.

18. Sex between two men is just plain wrong.

19. The idea of male homosexual marriages seems ridiculous to me.

20. Male homosexuality is merely a different kind of lifestyle that should not be condemned.
APPENDIX E

IRB Approval
September 26, 2017

Fatima Johnson  
College of Education  
Box 870231

Re: IRB#: 17-OR-323 “Examining the Relationship between Religiosity, Professional Identity Development and Counselor Attitudes”

Dear Ms. Johnson:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. You have also been granted the requested waiver of written documentation of informed consent. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

Your application will expire on September 25, 2018. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Request for Study Closure Form.

Please use reproductions of the IRB approved stamped consent form to provide to your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

[Signature]

Director & Research Compliance Officer