LGBTQ DIVERSITY TRAINING IN CLINICAL TRAINING PROGRAMS:

IMPLICATIONS FOR THE SAFE ZONE PROGRAM

by

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ABSTRACT

Due to increasing pressures to meet the health care needs of the LGBTQ community, further inquiry is needed to understand how the helping professions (i.e. psychology, social work, nursing) may be preparing future clinicians to work competently with diverse populations. The Safe Zone (SZ) Ally Training Program is a three-hour, campus-based diversity training program designed to increase awareness of and competence in working with LGBTQ individuals and the issues that impact them. SZ could serve as a useful tool for introducing students and faculty to basic cultural competencies in this area. The purpose of this study was to evaluate the effects of SZ training among clinical training programs. This study recruited 129 students and faculty from psychology, social work, and nursing programs to: 1) Determine the effects of the SZ training program on attitudes, knowledge, and understanding regarding LGBTQ individuals and issues; 2) Investigate the implications of SZ training for feelings of competency and preparedness in working with the LGBTQ community; and 3) Compare responses to SZ training across various demographic variables, including clinical training program. The main analyses were conducted using repeated-measures MANOVA and multiple regression. The results of these analyses were shown to support the a-priori hypotheses. Overall, the SZ Ally Training Program was evidenced to be beneficial in improving knowledge, understanding, and attitudes regarding the LGBTQ community. Most notably, the findings of this study suggest that basic cultural information attained through the SZ program may lead to greater self-efficacy to provide culturally competent services to this population.

LIST OF ABBREVIATIONS AND SYMBOLS

df Degrees of freedom: number of values free to vary after certain restrictions have been placed on the data

F Fisher's *F* ratio: A ration of two variances

M Mean: the sum of a set of measurements divided by the number of measurements in the set

p Probability associated with the occurrence under the null hypothesis of a value as extreme as or more extreme than the observed value

r Pearson product-moment correlation

t Computed value of *t* test

< Less than

= Equal to

≤ Less than or equal to

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LGBTQ DIVERSITY TRAINING IN CLINICAL TRAINING PROGRAMS

The LGBTQ community includes a diverse spectrum of individuals whose sexual identity, orientation, attractions, behaviors, or gender identity differ from the majority of society (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015; Ullerstam, 1966; Carroll, Gilroy, & Ryan, 2002). These sexual and gender minorities who identity as lesbian, gay, bisexual, transgender, gender nonconforming, queer, intersex, asexual, etc. will be referred to as LGBTQ for the purposes of this study. About 3.5% of U.S. adults self-identify as lesbian, gay, and bisexual (LGB), and 0.3% as transgender, which correspond to approximately 9 million people (Gates, 2011). However, precise population estimates for LGBTQ individuals are difficult to access despite numerous research efforts. Methodologically, there is often a great deal of variability in the researchers' definition and assessment of one's sexual/gender minority status.

In the United States, the field of psychology has continued to increase its focus on diversity and cultural competency in recent years. The ''Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists'' (American Psychological Association, 2002) included ''dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions'' (pp. 9–10). Although the guidelines refer to diversity in a general sense, many of these guidelines focus exclusively on racial/ethnic minority groups. As issues of sexual and gender diversity are brought to the forefront of society, it is understandable that clinical training research has also extended into this topic. However, there is little known about

how clinical training programs in the helping professions have expanded their training goals to include issues regarding sexual and gender diversity. Given the likelihood for interaction with this population in educational and clinical settings, it is important that we determine efficient methods for preparing students for culturally competent practice (Green, 2009).

Relevant Terminology

LGBTQ. Given the recent developments in research and societal views towards the LGBTQ community, the terminology surrounding this population has continued to evolve throughout the literature. The all-inclusive acronym "LGBTQ" is an umbrella term that has recently emerged in the culture and literature surrounding sexual and gender minorities. The acronym stands for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning, and is used to recognize any individual that identifies as a sexual and gender minority. However, it should be noted that research on these individual identities has not been evenly distributed throughout the literature.

Minority Stress. Despite recent political and social changes in societal acceptance of the LGBTQ community, many LGBTQ individuals experience high rates of discrimination and victimization, compared to cisgender heterosexual individuals. Minority stress refers to a unique set of psychosocial stressors and resources that impact a broad range of health and mental health outcomes for minority individuals (Meyer, 2003).

Cultural Competency. This study conceptualizes cultural competency as a process-oriented concept involving three broad dimensions: cultural knowledge, positive attitudes and beliefs, and the clinician's skills and use of culturally appropriate interventions (Tummala-Narra, 2012; Maxie, Arnold, & Stephenson, 2006; Sue, Arredondo, & McDavis, 1992).

Perceived Cultural Competency. For the purposes of this study, self-perceived cultural competence refers to an individual's perceptions of both their general cultural competence, and specific culturally-appropriate practices (Tummala-Narra, 2012).

Diversity Training. Diversity training is an instructional program aimed at facilitating positive intergroup interactions, reducing prejudice and discrimination, and enhancing the skills, knowledge, and motivation of participants to interact with culturally diverse groups (Bezrukova et al., 2016; Pendry et al., 2007)

Ally. An ally is defined as someone who does not identify as LGBTQ, yet actively works to develop an understanding of the needs and experiences of the LGBTQ community (Jones, Brewster, & Jones, 2014).

LGBTQ Affirmative Practice. LGBTQ affirmative practice refers to a culturally-sensitive health care model for work with sexual and gender minorities. A key component of this practice is that it actively strives to combat heteronormative standards, and establish a set of guidelines for treating LGBTQ individuals in a culturally competent manner (Davies, 1996; Crisp & Mcave, 2007).

The Current Study

The purpose of this study was to explore the use of the Safe Zone Ally Training Program as a clinical training tool for students and faculty in the helping professions. Information was gathered regarding participants' attitudes, beliefs, and behaviors regarding LGBTQ-identified individuals, and their feelings of competency when working with these individuals. The study aimed to determine the effect of the Safe Zone training program on participant's attitudes, knowledge, and understanding regarding LGBTQ individuals and issues, and how this may influence participant's feelings of competency and preparedness in working with LGBTQ-

identified clients in clinical settings. Additionally, post-hoc analyses were conducted to investigate whether levels of cultural competency differ as a function of various demographic variables, such as type of clinical training program, age, sexual identity, and amount of previous clinical/teaching experience with LGBTQ-identified individuals. These variables may provide information regarding the type of programs that may benefit most from cultural competency training in this capacity.

Theoretical Foundations

Societal stigma and experiences of discrimination and marginalization throughout the life course have had lasting effects on many LGBTQ individuals. These experiences have included overt discrimination, prejudiced laws and, in many cases, rejection from family (Fredriksen-Goldsen & Ellis, 2007). Recent literature has sought to understand the impact of these stressors on a range of health and mental health outcomes for the LGBTQ population (Fredriksen-Goldsen, Hoy-Ellis, Muraco, Goldsen, & Kim, 2015). To understand these complex mechanisms, many studies have adapted the minority stress theory (e.g. Meyer, 2003) in their investigation of these stressors. The minority stress model can be used to identify specific external and internal risk factors that are unique to the experience of LGBTQ individuals (Figure 1). For example, stigma manifests in various forms in the daily lives of many LGBTQ individuals and can include overt hate (e.g., assaulted or verbally attacked because of being LGBTQ), everyday discrimination (e.g., receiving poorer service), internalized stigma, and negative perceptions of social and health care-related services (Meyer, 2003; Hendricks & Testa, 2012). The minority stress model provides a theoretical foundation for how these stress processes may influence disparities in health outcomes and utilization of health care services.

To appropriately apply this theory, it is also important to consider the complexity and uniqueness of experiences within the LGBTQ community. For example, the convergence of multiple minority identities for LGBTQ older adults aged 60 or older can intertwine this process with important social and historical contexts (Fredriksen-Goldsen et al., 2015; Institute of Medicine, 2013). Many of these individuals developed within a historical and political context that held serious adverse consequences for being a member of the LGBTQ community (i.e., high rates of internalized stigma and the loss of social support networks). Therefore, it is important to consider a life-course perspective to understand the effects that these individual and environmental stressors have had throughout the lives of LGBTQ individuals. Moreover, this minority stress process can also have several implications for how LGBTQ individuals navigate the health care system (D'Augelli & Grossman, 2001).

While experiences of overt discrimination are especially stressful, the internalization of negative societal attitudes about LGBTQ people can be a critical stressor for many individuals and an important barrier to health care access and utilization. Internalized stigma has been associated with a greater likelihood to conceal one's sexual or gender identity from healthcare professionals, which can impede effective communication among physicians, as well as between patients and their families (Buckey & Browning, 2013). For example, internalized stigma exists when a gay cisgender man holds negative attitudes and beliefs about his own sexual identity and the gay community and therefore fails to adhere to a physical health and well-being lifestyle. Internalized stigma can have negative implications for one's mental health, including one's self-concept, use of social support, and ability to envision a future life course (Hoy-Ellis & Fredriksen-Goldsen, 2016; Meyer, 2003). To combat the potential effects of discrimination and stigma in health care settings, research has suggested that positive attitudes, knowledge, and

skills are important elements of culturally competent practice (Boroughs et al., 2015). Participating in LGBTQ diversity trainings that promote these aspects may be especially helpful for current and future health care providers in exploring these attitudes and learning relevant cultural information.

Previous research has suggested that LGBTQ individuals are at an elevated risk for a variety of mental health problems compared to heterosexual individuals (Meyer, 2003). The higher prevalence of mental health problems has been attributed to the increased stigma, prejudice, and discrimination that LGBTQ individuals are likely to experience. Specifically, LGBTQ individuals are at a higher risk for psychological distress (Chae & Ayala, 2010; Cochran, Mays, & Sullivan, 2003; Conron, Mimiaga, & Landers, 2010), suicidal ideation (Conron et al., 2010), substance use (Green & Feinstein, 2012; Marshal et al., 2008), and depression and anxiety (Cochran, 2001), when compared to their heterosexual counterparts. Healthy People 2020, a national initiative from the U.S. Department of Health and Human Services, identified the LGBT community as a U.S. health priority, having been considered an at-risk and underserved population within the United States (U.S. Department of Health and Human Services, 2012). Despite the push at national levels to address the specific mental health concerns of LGBTQ individuals, it is unclear how the field of psychology and other related healthcare disciplines are preparing future providers to tackle these disparities.

Cultural Competence

Generally, cultural competence involves understanding the cultural influences that affect the ability of healthcare professionals to provide appropriate care for patients from diverse cultural groups (Boroughs et al., 2015; Hays, 2001; Sue, Zane, Nagayama, Hall, & Berger, 2009). Cultural competence is an ongoing learning process, that involves a great deal of

awareness into one's own cultural biases and values. Cultural competence specifically in relation to the LGBTQ community requires knowledge and understanding of the culture and preferences of the population, and about specific issues that affect sexual and gender minorities. For example, in a study on helpful and unhelpful therapeutic experiences for LGBTQ individuals, participants reported that basic counseling skills, therapist attitudes toward and knowledge about sexual and gender diversity, alliance, and confidentiality were the most important factors of the therapeutic experience (Israel, Gorcheva, Burnes, & Walther, 2008).

Self-perceived cultural competence refers to an individual's perceptions of both their general cultural competence, and specific culturally-appropriate practices (Tummala-Narra, 2012). This type of self-efficacy has been correlated with positive attitudes, formal training and courses, and clinical experience with LGBTQ individuals (Dillon & Worthington, 2003; O'Shaughnessy & Spokane, 2013). These attributes and experiences in LGBTQ issues may influence an individual's confidence to engage in culturally competent and affirmative practice (Alessi, 2015).

Current conceptualizations of LGBTQ diversity training models have developed from existing models of racial/ethnic cultural competency. For example, one model proposed by Sue, Arredondo, and McDavis (1992) highlights the importance of attitudes, knowledge, and skills in establishing and maintaining cultural competency. Striving to become educated on LGBTQ issues can be critical in the development of more positive attitudes and the identification as an ally of the community (Broido, 2000; Evans et al., 1993; Ji, 2007; Ji, Du Bois, & Finnessy, 2009). Positive attitudes refer to an individual's awareness of cultural differences and how their own culture may impact the way they may view others. Knowledge of history, policies, and LGBTQ culture can also promote engagement in supportive behaviors towards LGBTQ

individuals. It has also been suggested that the lack of knowledge regarding the LGBTQ community may be closely associated with the lack of engagement in LGBTQ advocacy (DiStefano, Croteau, Anderson, Kampa-Kokesch, & Bullard, 2000). According to the Guidelines for Psychotherapy with LGB Clients (APA, 2011), knowledge of appropriate terms, culture, and norms is also considered highly important in providing competent services to LGBTQ clients. Many individuals have reported being able to gain this knowledge through interpersonal interactions with LGBTQ identified individuals, educational settings, self-education, and diversity workshops and seminars (Broido, 2000; DiStefano et al., 2000; Ji et al., 2009).

LGBTQ Diversity in Clinical Training Programs

Over 40 years ago, the American Psychological Association adopted a resolution stating that "homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities" (Conger, 1975). The resolution called for psychologists to be proactive in removing the stigma of mental illness that had been previously associated with homosexuality. Since 1975, APA has made significant steps to provide LGBTQ individuals with culturally competent services in order to promote the mental health and well-being of the population. In 1991, Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991) published a study that suggested that the field of psychology needed to enhance the available education and training in working with LGBTQ clients. The study acknowledged that there was wide range in practicing psychologists' training and competence to work with LGBTQ individuals. Similar research inquiries pushed APA to develop specific guidelines for clinical practice with LGBTQ clients. In 2000, the Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (e.g. APA, 2000) were developed. The guidelines detailed appropriate and culturally competent tools to assist psychologists in providing clinical services to LGB individuals, and was the first formal

initiative by APA to do so. APA updated these guidelines in 2011 to reflect the current literature on LGB issues, such as emphasizing psychology's condemnation of efforts to change sexual orientation (i.e., conversion or reparative therapies). APA has released similar guidelines related to practice with transgender and gender non-conforming individuals. The Guidelines for Psychological Practice with Transgender and Gender Nonconforming People provided psychologists with standards that encouraged more culturally competent and affirmative clinical services to this population. Both guidelines operate as an introduction to LGBTQ cultural competency within this domain (e.g. APA, 2009).

The current literature on how the field of psychology is preparing clinical and counseling psychology doctoral students for work with LGBTQ clients is scarce. While many studies have suggested that psychology is lacking in sufficient training on LGBTQ issues, there has been little work done to examine the type and quality of training that is currently taking place (Boroughs et al., 2015; Buhrke & Douce, 1991; Iasenza, 1989). A study by Murphy, Rawlings, and Howe (2002) that included 125 practicing, doctoral-level psychotherapists from the APA member database found that 28% of these psychologists reported no formal training to work with LGBTQ clients, only 10% of participants reported that a graduate course in LGB issues was offered at their institution, and 22% reported that their graduate training program offered a module or seminar on clinical work with this population. The number of psychologists receiving LGBTQ competency training are a dramatic contrast to the number of psychologists expected to treat this at-risk population. When asked to rate how training on specific LGBTQ issues would affect their clinical work on a scale ranging from 1 (would not improve) to 7 (would improve substantially), participants rated all the concerns in the moderate range (between 3 and 5), suggesting that psychotherapists feel that training on any issue would be helpful (Murphy et al., 2002). Several

studies have documented efforts to incorporate more training in LGBTQ issues within psychology and social work programs (Alessi, 2013; Edwards, Robertson, Smith, & O'Brien, 2014; Martin et al., 2009; Sherry Whilde, & Patton, 2005). These studies suggest that diversity training initiatives can be effective in improving graduate students' self-reported competency to work with LGBTQ clients.

In comparison with social work and nursing professional students, clinical psychology graduate students and faculty may receive the most training to provide mental health services, such as psychotherapy, and are thus more likely to provide these services in their role as clinicians. However, students and faculty within the field of social work are also likely to provide mental health services to LGBTQ individuals sometime in their career (Arthur, 2015). Moreover, social workers frequently act as case managers connecting clients with needed health and social services within their communities. Additionally, students, faculty, and staff within the field of nursing frequently interact with LGBTQ individuals, and are in a unique position to address health and social issues related to the LGBTQ community (Scott, 2010; Carabez et al., 2015). Social work and nursing programs also have been criticized for their lack of access to LGBTQ information; however, there is a substantial lack of knowledge regarding LGBTQ cultural competency training for students and faculty within these programs. Training and exposure to culturally diverse groups at the graduate/professional level can be an important foundation to becoming a competent clinician. However, there are no formal LGBTQ competency training models in place for many clinical training programs.

Overall, many graduate clinical training programs have dedicated significant efforts to promote cultural competency within the department. However, these efforts have been more focused on addressing issues of race and ethnicity than of sexual orientation and gender identity

(Allison, Crawford, Echemendia, Robinson, & Knepp, 1994). Rutter, Estrada, Ferguson, and Diggs (2008) found that when psychologists have the opportunity to engage in formal training, significant improvements are made in their competence to treat LGBTQ clients. The need for widespread guidance and cultural competency training in working with LGBTQ individuals is evident to better prepare future clinicians for work with this population.

One study found that many clinical/counseling psychology graduate students reported feeling underprepared to incorporate LGBTQ issues into their clinical work (Dillon et al., 2004; Sherry, Whilde, & Patton, 2005). Given that the field of psychology and the general society have been moving towards a greater acceptance of the LGBTQ community, current graduate students may have different experiences regarding the availability of training in LGBTQ issues. However, there has not been any recent empirical data published to further investigate this issue in clinical training programs (Hope, 2015). Research seems to support similar patterns amongst social work and nursing programs. For example, Eliason and Raheim (2000) found that nursing students reported feeling uncomfortable working with diverse groups unless they had received some training or exposure to that group beforehand. Contrastingly, one study found that social work students were more likely to endorse acceptance of LGBTQ individuals compared to students in counseling psychology (Carrick, 2010; Newman et al., 2002).

In addition to preparing graduate students for work with LGBTQ individuals, faculty members are also likely to benefit from cultural competency training. While most of the literature has focused on training for graduate students, continuing education in cultural competence has been viewed as highly important for work with diverse populations (Delphin & Rowe, 2008). It is also likely that many faculty members may not have had the opportunity to receive specialized training in LGBTQ issues during their graduate training experience (Murphy

et al., 2002). For those that did have the opportunity to engage in this type of training, knowledge of the LGBTQ community has evolved dramatically in recent years and will continue to do so. Making an effort to stay informed and up-to-date with appropriate terminology, customs, and standards is essential to effectively work with all diverse populations. Providing faculty with specialized training may enable them to promote culturally competent methods within their own professional interactions, while also training graduate students to do the same.

There have been few studies to comparatively investigate the impact of LGBTQ diversity training on cultural competency across the helping professions. It is not clear whether differences exist amongst students in these programs in their reception to training materials or ideas about competency in this area. However, the variation in training requirements and available clinical experiences across psychology, social work, and nursing programs may contribute to significant differences amongst these groups.

The Safe Zone Program

Boroughs et al. (2015) suggested that specifically, knowledge of disparities affecting LGBTQ individuals, LGBTQ identity development, stigma and discrimination, intersectionality of multiple identities, and unique workplace issues are key topics for the development of culturally competent practice. In addition to incorporating major themes of the Model of Therapeutic Effectiveness (Chochinov et al., 2013), the Safe Zone Ally Training Program includes many of these points during the training session, suggesting that it may be a useful tool for clinical training programs. The exact origin of the Safe Zone program is not clear; however, these programs are extremely popular at universities, businesses, and community health programs across the country (Finkel, Storaasli, Bandele, & Schaefer, 2003). To date, 71% of the 303 APA-accredited clinical psychology and counseling programs exist on campuses that also

have Safe Zone or similar training programs. The Safe Zone Program could offer a cheap and easily accessible method for training clinical graduate students and faculty across disciplines in LGBTQ cultural competency and knowledge.

The University of Alabama Safe Zone Program is an initiative of UA Division of Student Affairs, and is run collaboratively by a committee of faculty, staff, and graduate students. UA first established a Safe Zone Program in 2002; however, the current Ally Training program was first developed in 2007 as an initiative of the Capstone Alliance, an LGBTQ faculty and staff organization. The UA Safe Zone Ally Training Program is a three-hour diversity-training program designed to increase awareness of and competence in working with LGBTQ individuals and the issues that impact them. The Safe Zone Program aims to provide a visible network of allies for LGBTQ individuals within the campus community. Safe Zone allies distribute information regarding sexuality, gender identity, campus and community resources, and methods for reporting harassment and/or discrimination. The purpose of the Safe Zone program is to foster a University climate where everyone is treated with dignity and where all "LGBTQ individuals are free to thrive academically, professionally, and personally" (UA Safe Zone, 2017). The program allows participants to develop a working knowledge of appropriate and respectful LGBTQ terminology, recognize the impact that a negative campus climate has on individuals who identify as LGBTQ, and identify areas of personal growth as a member of the campus community.

Need for Study

To date, there has been no controlled study that has examined the effectiveness of the Safe Zone program in improving knowledge of and attitudes toward issues faced on campus by LGBTQ individuals. Most studies that have explored the effects of the Safe Zone program have

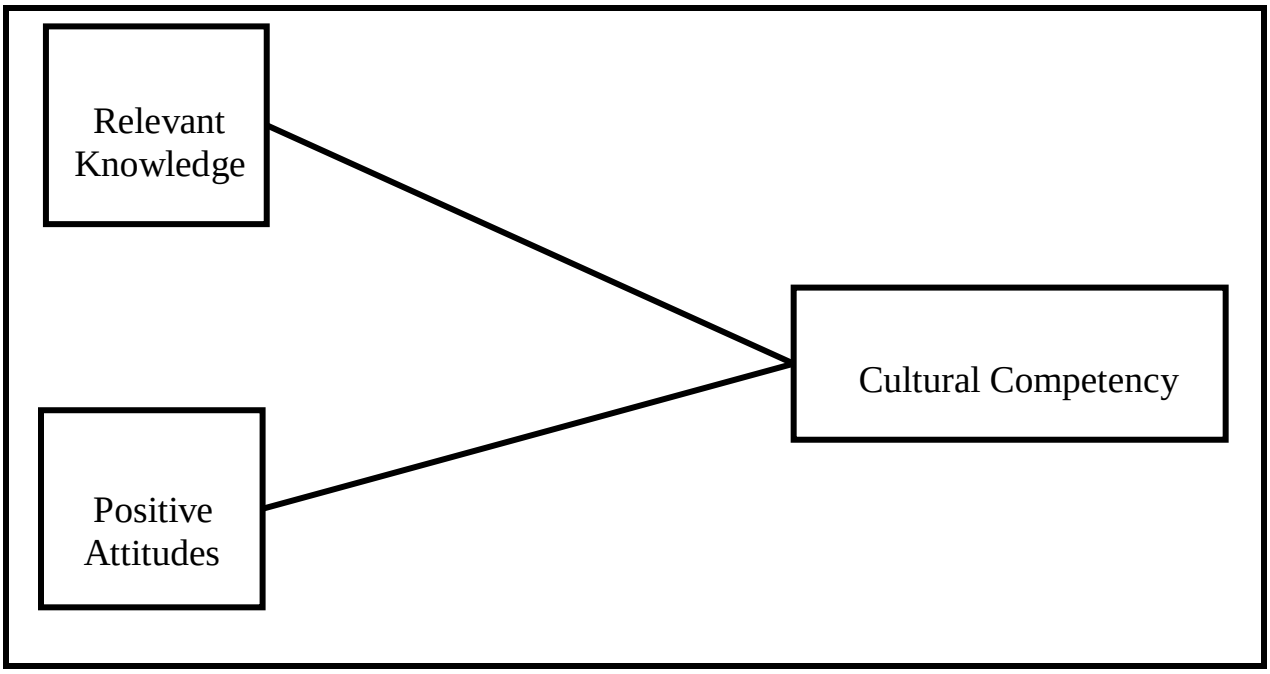
been either purely qualitative or anecdotal in nature (Finkel et al., 2003). However, Evans (2002) reported that Safe Zone was successful in raising the visibility of LGBTQ individuals on campus. Finkel et al. (2003) found that participants reported a significant increase in positive attitudes towards the LGBTQ community after receiving Safe Zone training, which helped facilitate a more open and positive environment for LGBTQ individuals. A similar study found positive effects on attitudes and beliefs, and that participants generally reported positive evaluations of the Safe Zone training content (Scher, 2008). The Safe Zone program is promising in its ability to educate students and faculty, and provide them with the necessary tools to be culturally competent and skilled psychologists who are advocates for their LGBTQ clients. However, no study has attempted to directly explore the effect of Safe Zone training on various LGBTQ cultural competency skills.

Aims and Hypotheses

The main purpose of this study is to explore the use of the UA Safe Zone Ally Training Program as a clinical training tool for graduate/professional students and faculty in psychology, social work, and nursing programs. The study consisted of three main aims:

Aim 1. The Safe Zone Program may offer a promising, inexpensive, and effective tool for preparing clinical students and faculty for culturally competent practice with LGBTQ-identified individuals. Thus, the first aim of the study was to determine the effect of the Safe Zone Ally training program on attitudes, knowledge, and understanding regarding LGBTQ individuals and relevant issues. It was hypothesized that after completing Safe Zone training, participants will report an overall increase in positive attitudes, beliefs, and knowledge regarding the LGBTQ community.

Aim 2. The next aim of the study was to determine the effect of Safe Zone training on feelings of competency and preparedness in working with LGBTQ-identified clients in clinical settings. Basic cultural knowledge and positive attitudes and beliefs are useful tools for engaging in culturally competent clinical practice with LGBTQ individuals. Receiving specialized



diversity training in LGBTQ issues was also expected to influence perceived cultural competence. It was hypothesized that positive attitudes and knowledge of the LGBTQ community would predict greater perceived competency to provide clinical services to these individuals (see Figure 1).

Figure 1. Conceptual Model Predicting LGBTQ Competency

Aim 3. The final aim of the study was to investigate whether responses to LGBTQ diversity training vary as a function of various demographic variables, such as clinical training program, age, and degree of previous clinical/teaching experience with LGBTQ-identified individuals. These variables may provide information regarding the type of programs that may benefit most from cultural competency training in this area. Due to the

lack of research comparing students and faculty in the helping professions, no a priori hypotheses were made. However, it was expected that students with additional training experience (i.e. diversity course, workshop) or previous clinical experience (i.e. providing therapy service to LGBTQ-identified clients) would report higher levels of perceived cultural competence than those without such experiences.

METHODS

Participants and Recruitment

Participants in this study included students and faculty within psychology, nursing, and social work clinical training programs at The University of Alabama. Each of the participants attended one of the five Safe Zone training sessions held in each of the three training programs for the purposes of this study. Participants were identified and recruited via department or school-wide email and recruitment flyers. Recruitment was based solely on the individual's membership as a student, faculty, or staff member at UA. The training was an elective opportunity for students, faculty, and staff within the psychology, social work, and nursing schools/ departments, and any student, faculty, or staff from these departments was eligible for participation in this study. Additionally, those interested in only participating in the Safe Zone training session were not required to participate in the research study.

Permission to conduct the study within the social work and nursing departments required several meetings throughout the project with various faculty and staff at each of the professional schools. These individuals facilitated introductions and suggested appropriate faculty to contact in order to conduct the training within each school. Within the School of Social Work, preference for research participation was given to undergraduate and graduate courses that emphasized professional ethics and diversity training.

Procedure

A Request for Waiver of Written Documentation of Informed Consent was submitted and approved by the University of Alabama Internal Review Board, as this would be the only

documentation of a participant's identity. SZ Ally Training sessions were conducted by the UA Safe Zone Office over the course of five three-hour sessions offered within the UA Department of Psychology, Capstone College of Nursing, and School of Social Work. Pre- and post-training questionnaires were completed either online, or hard copies were distributed to participants, to assess demographic information, previous training/clinical experience with LGBTQ individuals, knowledge and attitudes towards the LGBTQ community, and self-efficacy to perform clinical work with LGBTQ clients. In most cases, the pre- and post-training questionnaires were distributed electronically to participants via Qualtrics. The Qualtrics link was provided to participants so that they could use personal laptops and mobile devices to complete the pre- and post-training questionnaires. If these devices were unavailable, participants also had the option of completing printed paper versions. Participants also provided feedback on the Safe Zone training experience.

At each training session, attendees were informed that the primary investigator would like to gather information regarding the knowledge, attitudes, and experiences within the department or school about LGBTQ individuals as well as the perceived need for additional training/education in this area, and were instructed to read the "Research Participation Request." Potential participants were informed that submission of the completed questionnaires would be taken as evidence of informed consent to participate, as per the approved waiver of written consent.

Confidentiality was maintained by asking participants not to write or sign their names on the survey. Each "Research Participation Request" provided a unique, random 8-digit integer formulated by random.org assigned as the ID number. Participants were asked to tear off or keep this integer until the end of the training. The primary investigator chose random 8-digit integers

as ID numbers so that participants would be most likely to feel assured that the researcher could not in any way memorize or associate the ID numbers with the participant. Participants entered their unique ID at the beginning of each questionnaire so that responses could be linked. Using this method, no identifying information was collected regarding participant identity. Because the principle risk to the research was that some of the questions may make participants uncomfortable, individuals were made aware that they may skip questions they might not want to answer both verbally (see Appendix A) and in the "Research Participation Request" document (see Appendix B).

Measures

Measures other than the demographic questionnaire were administered before and after the Safe Zone training session to measure change. The demographic questionnaire was only administered at Time 1.

Demographic Information. Demographic information was collected on age, ethnicity, sexual orientation, and gender identity. Participants were also asked to document any previous training in LGBTQ cultural competency, and previous experiences in working with LGBTQ individuals in an educational or clinical setting.

Attitudes and Knowledge. The Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale for Heterosexuals (LGB-KASH; Worthington, Dillon, & Becker-Schutte, 2005) is a 29-item measure composed of five factors (internalized affirmativeness, civil rights attitudes, knowledge, religious conflict, and hate) designed to assess knowledge and attitudes towards LGB individuals. The wording of this scale was modified to also include transgender (T) individuals, so that "LGBTQ" was used in items throughout as a more widely accepted umbrella term for the community. The modified measure was used to assess the participants' attitudes and

knowledge about LGBTQ individuals. The LGB-KASH utilizes a 5-point Likert scale (1 = very uncharacteristic of me and my views to 5 = very characteristic of me and my views) to respond to statements such as "I am knowledgeable about the significance of the Stonewall Riot to the Gay Liberation Movement" (Knowledge), "LGBT people deserve the hatred they receive" (Hate), "I think marriage should be legal for same-sex couples" (Civil Rights Attitudes), "I can accept LGBT people even though I condemn their behavior" (Religious Conflict), and "Feeling attracted to another person of the same-sex would not make me uncomfortable" (Internalized Affirmativeness). The LGB-KASH has established good internal consistency for each of its subscales (Knowledge α = .80, Hate α = .81, LGBT Civil Rights α = .87, Religious Conflict α = .76, and Internalized Affirmativeness α = .83) and has demonstrated adequate discriminant, convergent, and construct validity (Worthington et al., 2005).

Perceived Cultural Competence. The Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory - Short Form (LGB-CSI-SF) was developed to facilitate LGB-affirmative counseling training by offering a brief version of the original 32-item LGB-CSI measure (Dillon & Worthington, 2003). The LGB-CSI-SF is composed of five factors that assess self-efficacy to perform lesbian, gay, and bisexual (LGB) affirmative counseling/therapy behaviors (Application of Knowledge, Advocacy Skills, Self-Awareness, Relationship, and Assessment). Participants respond using a 5-point Likert scale (1 = not confident to 5 = extremely confident) to rate their ability to perform 15 therapy/counseling-related tasks and behaviors. The LGB-CSI-SF validation sample consisted of 575 licensed mental health professionals and graduate students/trainees, and displayed good internal consistency and test–retest reliability (Application of Knowledge α = .87, Advocacy α = .92, Self-Awareness α =.87, Assessment α = .87, Relationship α = .81). Convergent validity was supported by correlations

between the LGB-CSI-SF subscales, and instruction in LGB issues and personal/professional relations with LGB individuals. Affirmative attitudes toward LGB persons were positively correlated with total scores (Dillon, Alessi, Craig, Ebersole, Kumar, & Spadola, 2015). The measure was used to assess participants' self-perceived clinical competence regarding LGBTQ issues.

The Ally Identity Measure (AIM) is a 19-item measure composed of three factors (Knowledge and Skills, Openness and Support, and Oppression Awareness) used to assess the skills to support LGBT individuals, knowledge of the LGBT experience, awareness of LGBT oppression, and engagement in action among heterosexual allies to the LGBT community. Each of the items on the AIM are rated on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). Sample items include "I have developed the skills necessary to provide support if a sexual minority person needs my help" (Knowledge and Skills), "I have taken a public stand on important issues facing sexual minority people" (Openness and Support), and "I think sexual minority groups are oppressed by society in the United States" (Oppression Awareness). Internal consistency for each of the three subscales ranged from α = .76 to α =.88, and demonstrated good convergent and discriminant validity (Jones, Brewster, & Jones, 2014). This measure was also used to assess participants' self-perceived clinical competence regarding LGBTQ issues and role as an ally to the LGBTQ community.

RESULTS

Preliminary Analyses

A power analysis using the statistical program, G*Power, determined that 129 participants was appropriate to detect small to medium effect sizes (Faul, Erdfelder, Buchner, & Lang, 2009; Faul, Erdfelder, Lang, & Buchner, 2007). SPSS Program Version 23 was used for all data analyses. Composite scores were first calculated from each participant's scores on each of the administered measures. A repeated-measures MANOVA was conducted to examine the hypotheses associated with Aim 1 (i.e., that individuals would report increased knowledge and attitudes toward LGBTQ individuals). To address Aim 2, a combination of repeated-measures MANOVA and multiple regression analyses were run to examine the effect of SZ training on competency and feelings of preparedness to work with LGBTQ individuals in a clinical setting. Lastly, an examination of interaction effects from the repeated-measures MANOVA and post-hoc pairwise comparisons were used to explore differences among training programs (Aim 3).

Descriptive Statistics

Participants in this study included 129 students (N=123) and faculty (N=6) within psychology (N=18), nursing (N=84), social work (N=18), and other (N=9) clinical training programs at UA. Table 1 displays the complete descriptive statistics for the sample.

Table 1. Demographic Characteristics across Clinical Training Programs

Age	**Total** N = 129	**Psychology** N = 18	**Social Work** N = 18	**Nursing** N = 84	**Other** N = 9
18 – 29	117	12	17	79	9
30 – 39	4	2	1	1	--
40 – 49	4	2	--	2	--
50 – 59	2	1	--	1	--
60 +	2	1	--	1	--
Gender Identity					
Male	12	3	2	6	1
Female	116	14	16	78	8
Other	1	1	--	--	--
Race/Ethnicity					
White/ Caucasian	108	16	11	76	5
Black/African American	15	1	5	6	3
Asian	3	--	1	1	--
Hispanic/Latino	1	--	--	1	--
Classification					
Undergraduate	101	2	9	81	9
Graduate	22	13	9	--	--
Faculty	6	3	--	3	--
Sexual Orientation					
Heterosexual	121	15	15	83	8
Gay	1	--	1	--	--
Bisexual	4	2	1	1	--
Unsure	1	--	--	--	1
Previous Training					
Yes	10	4	2	3	1
No	114	14	14	78	8
Unsure	5	0	2	3	--
Teaching Experience					
1-3 Students	5	1	2	2	--
4-5+ Students	7	4	--	3	--
Clinical					
1-3 Clients/Patients	10	2	3	5	--
4-5+ Clients/Patients	4	3	1	--	--

To ensure confidentiality for psychology participants who may work closely with the primary investigator, age was coded as a categorical variable. The sample consisted of mostly individuals aged 18-29 years old (N=117). Considering the demographic makeup surrounding UA, a large representation of racial/ethnic minorities was not expected to be achieved with the current sample. For example, 84% of the sample was comprised of white/Caucasian individuals (N=108), while black/African American individuals account for about 11.6% (N=15). There was little variability in regard to gender, with about 90% of participants identifying as cisgender female (N=116). However, one participant identified as "non-binary". Additionally, most of the sample included heterosexual individuals (N=121); however, there was also a small representation of gay (N=1) and bisexual (N=4) individuals.

Most participants reported limited exposure to any previous training, teaching, and clinical experiences in LGBTQ issues. Despite the UA Safe Zone Office's large and visible campus presence, only 10 participants reported previously attending a Safe Zone workshop. 12 participants reported a previous teaching experience with an LGBTQ-identified student. Furthermore, only 10.9% of participants (N=14) across the psychology, social work, and nursing departments reported providing clinical services to an LGBTQ-identified client or patient. The limited degree of exposure in this sample may be influenced by variability in curriculum and clinical experiences available to students and faculty in each discipline. For example, 78.3% of the sample was comprised of undergraduate nursing students who may have not had an opportunity to engage in LGBTQ training, teaching, or clinical experiences.

Aim 1: Effects on Attitudes and Knowledge

The first aim of the study was to determine the effect of the Safe Zone Ally training program on attitudes, knowledge, and understanding regarding LGBTQ individuals and relevant

issues. It was hypothesized that after completing Safe Zone training, participants would report an overall increase in positive attitudes, beliefs, and knowledge regarding the LGBTQ community. To test this hypothesis, a three-way repeated-measures MANOVA was used to assess for significant changes in scores on each of the subscales of the LGB-KASH following the SZ diversity training workshop. Tables 2 and 3 provide a summary of this data.

Table 2. Multivariate Tests for LGB-KASH (N=129)

Effect	*Λ*	*F*	*df*	*df error*	*p*
Department	.506	6.244	15	334.429	.000**
Time	.770	7.223	5	121	.000**
Time x Department	.907	.805	15	334.429	.672

*** Correlation is significant at the 0.001 level (2-tailed)* *** Correlation is significant at the 0.05 level (2-tailed).*

Table 3. Univariate Tests for Time (LGB-KASH)

DV	*df*	*df error*	*F*	*p*	*Time*	*Means*
Hate	1	125	.077	.781	Time 1 Time 2	7.98 7.93
Knowledge	1	125	36.255	.000**	Time 1 Time 2	9.03 13.88
Civil Rights	1	125	.903	.344	Time 1 Time 2	24.74 25.34
Religion	1	125	.184	.669	Time 1 Time 2	19.07 18.51
Affirmativeness	1	125	3.485	.064	Time 1 Time 2	14.76 15.93

*** Correlation is significant at the 0.001 level (2-tailed)* *** Correlation is significant at the 0.05 level (2-tailed).*

Significant multivariate effects were found for both IVs (department and time). There was no significant interaction effect observed on any of the LGB-KASH subscales. Additionally, there was one significant univariate effect of time found on the Knowledge subscale. The results of this analysis reveal that compared to baseline scores (M=9.03, SD=4.75), participants reported gaining additional LGBTQ-specific knowledge after attending the SZ training (M=13.88, SD=5.84). This result was expected due to Safe Zone's high focus on providing basic cultural information to participants. There were no significant differences found on the hate, civil rights attitudes, religious conflict, or internalized affirmativeness subscales of the LGB-KASH. Overall, the results of this repeated-measures MANOVA support the hypothesis that SZ training can have a significant and positive influence on participants' access to LGBTQ cultural knowledge, a key component of culturally competent practice.

Aim 2: Effects on Cultural Competency

The second aim of the study was to determine the effect of SZ training on feelings of competency and preparedness in working with LGBTQ-identified patients in clinical settings. It was hypothesized that positive attitudes and knowledge of the LGBTQ community would predict greater perceived competency to provide appropriate clinical services to these individuals (see Figure 1). To examine the effect of SZ training on self-perceived clinical competency, two independent analyses were run on each of the remaining measures. A repeated-measures MANOVA was used to assess for significant changes in scores on the LGB-CSI-SF and AIM following the SZ diversity training workshop.

Results from the first repeated-measures MANOVA focused on the total score and each of the subscales of the LGB-CSI-SF. Significant multivariate effects and an interaction effect was observed for each of the IVs. Univariate analyses also reveal significant time effects for the

total score and each of the subscales of the LGB-SI-SF. The results highlight the impact of SZ training on each of the dimensions of cultural competency covered under this measure. Participants reported an overall increase in their ability to apply training materials to LGBTQ affirmative clinical behaviors (F (1,124) = 57.71, p = < .001). Specifically, participants reported greater self-efficacy in the application of knowledge (F (1,124) = 44.55, p = < .001), advocacy skills (F (1,124) = 47.91, p = < .001), self-awareness (F (1,124) = 9.48, p = < .001), relationship/interpersonal skills (F (1,124) = 22.59, p = < .001), and assessment skills (31.91, p = < .001). See tables 4 and 5 for a summary of this information.

Table 4. Multivariate Tests for LGB-CSI (N=128)

Effect	*Λ*	*F*	*df*	*df error*	*p*
Department	.548	5.382	15	331.669	.000**
Time	.663	12.209	5	120	.000**
Time x Department	.808	1.778	15	331.669	.037*

*** Correlation is significant at the 0.001 level (2-tailed)* *** Correlation is significant at the 0.05 level (2-tailed).*

Table 5. Univariate Tests for Time (LGB-CSI)

DV	*df*	*df error*	*F*	*p*	*Time*	*Means*
CSI Total	1	124	57.707	.000**	Time 1 Time 2	45.4375 57.9688
Knowledge	1	124	44.553	.000**	Time 1 Time 2	6.8359 10.2500
Advocacy	1	124	47.912	.000**	Time 1 Time 2	7.0859 11.0391

Awareness	1	124	9.476	.003**	Time 1 Time 2	11.9297 13.0859
Assessment	1	124	31.912	.000**	Time 1 Time 2	9.5234 11.3984
Relationship	1	124	22.592	.000**	Time 1 Time 2	10.0625 12.1953
*** Correlation is significant at the 0.001 level (2-tailed)*				* *Correlation is significant at the 0.05 level (2-tailed).*		

The second component of Aim 2 focused on results from the AIM. A repeated-measures MANOVA was also used to explore SZ training's effect on participants' self-perceived clinical competence regarding LGBTQ issues. Significant multivariate effects were observed for group and time; however, there was no significant interaction. Compared to time 1, the results revealed significant differences on the AIM total score and two out of three of the AIM subscale scores. After the SZ training, participants reported enhanced abilities to support LGBTQ individuals (F (1,125) = 48.64, $p < .001$), increased knowledge of the LGBTQ experience and utilization of appropriate skills (F (1,125) = 74.87, $p = < .001$), and readiness for engagement in action among heterosexual allies (F (1,125) = 12.64, $p = < .001$). There was no significant effect of SZ training on the awareness of LGBTQ oppression (F (1,125) = .37, p = .06); however, the data appears to be trending towards significance. The results of these analyses support the hypothesis that SZ training can also have a significant impact on participants' perceptions of their self-efficacy to engage in LGBTQ-affirmative clinical practices. Tables 6 and 7 provide an overview of these results.

Table 6. Multivariate Tests for AIM (N=129)

Effect	*Λ*	*F*	*df*	*df error*	*p*
Department	.645	6.577	9	229.5	.000**
Time	.610	26.222	3	123	.000**
Time x Department	.877	1.844	9	229.5	.060

*** Correlation is significant at the 0.001 level (2-tailed)* *** Correlation is significant at the 0.05 level (2-tailed).*

Table 7. Univariate Tests for Time (AIM)

DV	*df*	*df error*	*F*	*p*	*Time*	*Means*
AIM Total	1	125	48.636	.000**	Time 1 Time 2	55.12 67.43
Skills	1	125	74.870	.000**	Time 1 Time 2	16.07 26.3
Openness	1	125	12.637	.001**	Time 1 Time 2	20.85 24.1
Awareness	1	125	3.7	.057	Time 1 Time 2	16.2 17.03

*** Correlation is significant at the 0.001 level (2-tailed)* *** Correlation is significant at the 0.05 level (2-tailed).*

To investigate the last component of aim 2, multiple regression analyses were used to predict participant's self-perceived cultural competency (LGB-CSI-SF; AIM) based on general attitudes and knowledge towards the LGBTQ community (LGB-KASH). Table 8 presents a comprehensive list of correlations between each of the study's main variables. These correlations were analyzed for consistency before running the main analyses.

Table 8. Correlation of Variables at Time 1 and Time 2.

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1	**(Time 1)** LGBT-KASH	1																														
2	Hate	0.017	1																													
3	Knowledge	**.709****	-0.069	1																												
4	Civil Rights	**.573****	**-.443****	**.362****	1																											
5	Religion	-0.044	**.327****	**-.362****	**-.561****	1																										
6	Affirmativeness	**.720****	**-.339****	**.608****	**.688****	**-.608****	1																									
7	**(Time 2)** LGBT-KASH	**.763****	-0.132	**.470****	**.509****	0.046	**.514****	1																								
8	Hate	0.015	**.437****	-0.082	**-.283****	**.346****	**-.252****	0.1	1																							
9	Knowledge	**.579****	-0.084	**.520****	**.380****	-0.103	**.429****	**.743****	-0.067	1																						
10	Civil Rights	**.465****	**-.439****	**.304****	**.811****	**-.491****	**.620****	**.546****	**-.438****	**.385****	1																					
11	Religion	-0.038	**.271****	**-.248****	**-.458****	**.831****	**-.549****	**.191***	**.310****	-0.097	**-.432****	1																				
12	Affirmativeness	**.671****	**-.349****	**.567****	**.699****	**-.562****	**.897****	**.633****	**-.213***	**.473****	**.664****	**-.517****	1																			
13	**(Time 1)** LGB-CSI-SF	**.442****	-0.152	**.435****	**.339****	-0.06	**.282****	**.352****	-0.094	**.411****	**.222***	-0.015	**.234****	1																		
14	Knowledge	**.439****	-0.122	**.557****	**.269****	**-.200***	**.388****	**.255****	-0.118	**.304****	**.201***	-0.137	**.299****	**.753****	1																	
15	Advocacy	**.380****	-0.09	**.416****	**.251****	-0.055	**.234****	**.294****	0.027	**.312****	0.131	-0.025	**.228****	**.766****	**.607****	1																
16	Self-Awareness	**.279****	-0.131	0.123	**.308****	0.038	0.139	**.264****	-0.048	**.241****	0.172	0.061	0.13	**.571****	**.194***	**.236****	1															
17	Assessment	0.1	-0.072	0.112	0.065	0.109	-0.052	0.111	-0.133	**.260****	0.016	0.117	-0.08	**.767****	**.382****	**.427****	**.379****	1														
18	Relationship	**.440****	-0.155	**.386****	**.378****	-0.118	**.345****	**.382****	-0.093	**.398****	**.321****	-0.074	**.293****	**.823****	**.589****	**.458****	**.380****	**.634****	1													
19	**(Time 2)** LGB-CSI-SF	**.326****	-0.172	**.195***	**.307****	0.046	**.174***	**.501****	**-.237****	**.562****	**.383****	0.072	**.241****	**.550****	**.324****	**.281****	**.411****	**.542****	**.494****	1												
20	Knowledge	**.380****	-0.082	**.267****	**.289****	0.017	**.225***	**.526****	-0.11	**.573****	**.312****	0.072	**.277****	**.537****	**.411****	**.309****	**.339****	**.458****	**.488****	**.889****	1											

21	Advocacy	**.335****	**-.151**	0.172	**.326****	0.005	**.225***	**.516****	**-.172**	**.533****	**.384****	0.043	**.296****	**.414****	**.284****	**.347****	**.239****	**.330****	**.314****	**.820****	**.760****	1													
22	Self-Awareness	0.138	**-.227****	0.083	0.171	-0.029	0.156	**.269****	**-.265****	**.343****	**.259****	-0.05	**.215***	**.292****	0.09	0.028	**.510****	**.299****	**.202***	**.674****	**.494****	**.453****	1											
23	Assessment	0.153	**-0.096**	0.043	0.141	0.158	**-0.023**	**.336****	**-0.122**	**.431****	**.204***	0.155	0.022	**.543****	**.271****	**.294****	**.315****	**.662****	**.470****	**.865****	**.719****	**.628****	**.529****	1										
24	Relationship	**.361****	**-.243****	**.232****	**.419****	-0.048	**.249****	**.492****	**-.313****	**.506****	**.510****	-0.007	**.294****	**.479****	**.274****	**.198***	**.375****	**.444****	**.510****	**.886****	**.707****	**.653****	**.554****	**.722****	1									
25	**(Time 1)** AIM	**.688****	**-.209***	**.745****	**.608****	-.511**	**.768****	**.468****	**-.211***	**.471****	**.518****	**-.412****	**.683****	**.537****	**.570****	**.447****	**.232****	**.202***	**.530****	**.274****	**.316****	**.319****	0.157	0.112	**.334****	1								
26	Knowledge /Skills	**.485****	0.003	**.700****	**.197***	**-.256****	**.433****	**.259****	-0.056	**.315****	**.183***	-0.163	**.314****	**.536****	**.631****	**.497****	0.116	**.270****	**.439****	**.212***	**.306****	**.249****	0.076	0.136	**.186***	**.823****	1							
27	Open & Support	**.691****	**-.298****	**.667****	**.687****	**-.558****	**.848****	**.545****	**-.224***	**.496****	**.598****	**-.450****	**.799****	**.441****	**.456****	**.365****	**.212***	0.102	**.496****	**.237****	**.262****	**.306****	0.135	0.037	**.328****	**.920****	**.600****	1						
28	Opp. Awareness	**.475****	**-.258****	**.337****	**.719****	**-.466****	**.586****	**.306****	**-.302****	**.311****	**.554****	**-.457****	**.570****	**.262****	**.181***	0.121	**.293****	0.093	**.311****	**.232****	0.163	**.202***	**.224***	0.12	**.339****	**.628****	**.210***	**.575****	1				
29	**(Time 2)** AIM	**.550****	**-.292****	**.459****	**.576****	**-.320****	**.591****	**.640****	**-.267****	**.696****	**.620****	**-.305****	**.660****	**.376****	**.286****	**.269****	**.232****	**.209***	**.399****	**.674****	**.653****	**.657****	**.459****	**.457****	**.664****	**.608****	**.365****	**.654****	**.456****	1			
30	Knowledge /Skills	**.419****	**-0.096**	**.369****	**.308****	**-0.079**	**.311****	**.550****	-0.1	**.716****	**.331****	**-0.075**	**.360****	**.364****	**.239****	**.261****	**.228****	**.288****	**.328****	**.725****	**.729****	**.716****	**.464****	**.540****	**.620****	**.421****	**.363****	**.407****	**.195***	**.874****	1	
31	Open & Support	**.593****	**-.361****	**.508****	**.650****	**-.435****	**.719****	**.624****	**-.264****	**.578****	**.675****	**-.401****	**.787****	**.363****	**.330****	**.290****	0.17	0.134	**.419****	**.520****	**.513****	**.518****	**.337****	**.308****	**.568****	**.685****	**.390****	**.779****	**.466****	**.914****	**.659****	1	
32	Opp. Awareness	**.332****	**-.341****	**.208***	**.559****	**-.356****	**.481****	**.383****	**-.421****	**.372****	**.652****	**-.367****	**.543****	0.146	0.083	0.043	**.190***	0.038	**.212***	**.373****	**.288****	**.323****	**.350****	**.238****	**.453****	**.395****	0.047	**.436****	**.641****	**.691****	**.387****	**.596****	

**** Correlation is significant at the 0.01 level (2-tailed)** *** Correlation is significant at the 0.05 level (2-taile**

The first multiple regression analysis predicted participant's scores on the LGB-CSI-SF. Four out of five LGBT-KASH subtests were found to be significant predictors of self-perceived cultural competency (Hate, Knowledge, Civil Rights, Religious Conflict), accounting for a total variance of about 43.2% ($R^2 = .43$, $p < .001$). Internalized Affirmativeness was not found to be a significant predictor of self-perceived cultural competency. Table 9 summarizes the data and presents additional statistics on this analysis.

Table 9. Multiple Regression Results: LGB-CSI-SF (N=128)

Variance Explained

R	*R^2*	*Adjusted R^2*	*Std. Error of the Estimate*
.657	.432	.409	9.67235

ANOVA results for LGB-CSI-SF

	Sum of Squares	*df*	*Mean Square*	*F*	*p*
Regression	8740.173	5	1748.035	18.685	.000
Residual	11507.17	123	93.554		
Total	20247.34	128			

Regression Coefficients

	Unstandardized Coefficients		*Standardized Coefficients*		
	B	*Std. Error*	*Beta*	*t*	*p*
(Constant)	27.884	6.718		4.151	.000
Hate	-.700	.307	-.178	-2.283	.024
Knowledge	1.105	.171	.513	6.451	.000
Civil Rights	.631	.228	.279	2.768	.007
Religious Conflict	.358	.121	.247	2.957	.004
Internalized Affirmativeness	-.157	.171	-.096	-.918	.361

The second multiple regression analysis predicted scores on the AIM. The results revealed three of the five LGBT-KASH subscales as significant predictors of the LGBTQ competency domains covered under the AIM (Knowledge, Civil Rights, Internalized Affirmativeness), accounting for a total variance of about 65.6% (see tables 9 and 10 for additional statistics from this analysis). The results of the two multiple regression analyses support the hypothesis that attitudes and knowledge are significant predictors of self-perceived cultural competency.

Table 10. Multiple Regression Results: AIM (N=129)

Variance Explained

R	*R^2*	*Adjusted R^2*	*Std. Error of the Estimate*
.818	.670	.656	9.44993

ANOVA results for AIM

	Sum of Squares	*df*	*Mean Square*	*F*	*p*
Regression	22267.509	5	4453.502	49.871	.000
Residual	10984.041	123	89.301		
Total	33251.550	128			

Regression Coefficients

	Unstandardized Coefficients		*Standardized Coefficients*		
	B	*Std. Error*	*Beta*	*t*	*p*
(Constant)	26.941	6.564		4.151	.000
Hate	-.407	.300	-.081	-1.359	.177
Knowledge	1.319	.167	.478	7.877	.000
Civil Rights	.644	.223	.222	2.891	.005
Religious Conflict	.005	.118	.002	.039	.969
Internalized Affirmativeness	.565	.167	.271	3.387	.001

Group Differences

The final aim of the study was to investigate whether responses to LGBTQ diversity training vary as a function of various demographic variables, such as clinical training program, age, and degree of previous clinical/teaching experience with LGBTQ-identified individuals. These variables may provide information to the type of programs that may benefit most from cultural competency training, such as Safe Zone, in this capacity. Due to the lack of research comparing students and faculty in the helping professions, no a priori hypotheses were made; however, it was expected that there would be differences amongst each clinical training program in their responses to SZ training and perception of LGBTQ cultural competency skills and knowledge.

To complete this analysis, data from the repeated-measures MANOVAs used in aims 1 and 2 was used in combination with post-hoc pairwise comparisons. An interaction effect between time and group was only observed for the LGB-CSI-SF ($F(15,331.67) = 1.78$, $p < .05$). Post-hoc pairwise comparisons were analyzed to test for significant differences between each of the groups. Do to the risk of inflating the type 1 error rate, a Bonferroni correction for multiple comparisons was utilized. Table 11 summarizes the significant results from these analyses.

Table 11. Significant Pairwise Comparisons

	Effect	***M***	***Std. Error***	***p***
LGB-CSI-SF - Relationship				
(Nursing) - (Social Work)		-1.41	.65	.031*
AIM - Total				
(Psychology) – (Nursing)		15.23	3.24	.000**

*** Correlation is significant at the 0.001 level (2-tailed)* *** Correlation is significant at the 0.05 level (2-tailed).*

Compared to nursing students/faculty, psychology students/faculty reported a significantly more positive effect of SZ training on self-perceptions of LGBTQ cultural competency.

Participants in the school of social work fell between these other disciplines such that there was no significant difference between psychology and social work or nursing and social work participants. Other demographic variables such as age, gender, and race/ethnicity did not yield significant results, likely due to limited variation amongst the sample.

DISCUSSION AND CONCLUSION

The purpose of this study was to explore the use of the Safe Zone Ally Training Program as a clinical training tool for students and faculty in the helping professions. The study aimed to determine the effect of the Safe Zone training program on participant's attitudes, knowledge, and understanding regarding LGBTQ individuals and issues, and how this may influence participant's feelings of competency and preparedness in working with LGBTQ-identified clients in clinical settings. In exploration of Aim 1, the study determined that SZ training can have a significant and positive influence on participants' knowledge and attitudes toward the LGBTQ community. With regard to Aim 2, the data supported that attitudes and knowledge are significant predictors of self-perceived cultural competency (e.g., analyses regarding LGB-CSI-SF and AIM subscales), which may enable individuals to engage in more LGBTQ-affirmative practices. Analyses for Aim 3 revealed that clinical psychology training programs may be more likely to be positively impacted by SZ training, compared to nursing and social work students/faculty.

One implication of the results of this study may be to provide clinical training programs with an effective, cheap, and easily accessible tool for training students and faculty in LGBTQ cultural competency. Many major universities with clinical psychology training programs already have an established Safe Zone program. Utilizing this existing resource by encouraging clinical students and faculty to receive SZ training can be advantageous and efficacious for a variety of reasons. In addition to providing these individuals with relevant diversity training,

creating partnerships with other campus organizations can be mutually beneficial by creating a more inclusive environment amongst students, faculty and staff across the entire campus.

Due to the increasing amount of interaction that physical and mental health care workers will have with LGBTQ individuals throughout their career, it is important that there are clear initiatives taken to facilitate culturally competent training in this area. There are unique societal stressors associated with the LGBTQ community that require health and mental health professionals as allies. Research has established that increased knowledge and more positive attitudes toward LGBTQ individuals among clinicians in training allows them to be able to provide culturally competent services to this population. The implications of this study suggest that basic cultural information provided through a university Safe Zone program can promote changes in knowledge and attitudes towards the LGBTQ community, which in turn facilitates self-efficacy to provide culturally competent services.

Beyond basic competencies, the findings from this study may also have several direct implications for current models of competent practice with diverse populations. The model of therapeutic effectiveness (Chochinov, McClement, Hack, McKeen, Rach, Gagnon, Sinclair, & Taylor-Brown, 2013) is an empirical model comprised of 3 primary domains (personal growth and self-care; therapeutic approaches; and creation of a safe space) and 3 hybrid domains (therapeutic humility; therapeutic pacing; and therapeutic presence). The combination of all three primary domains is considered optimal therapeutic effectiveness. LGBTQ diversity training programs, such as the Safe Zone Program, can be used to promote culturally competent practice with LGBTQ individuals because they appeal to several key components of therapeutic effectiveness. In providing participants with basic information on LGBTQ individuals and the issues facing the community, Safe Zone training can contribute to the personal growth and self-

care domain by enhancing the participants' ability to be self-aware of one's own attitudes/beliefs, and openness to learning more about the community. Additionally, aspects of the therapeutic approaches domain are evidenced in Safe Zone's focus on advocacy and support. The model of therapeutic effectiveness identifies the ability to advocate for the client, and support client needs as central themes in this domain. Lastly, the creation of a safe space for the client is considered extremely important in a therapeutic setting. This is also one of the most central themes of Safe Zone training, and no doubt the origin of its name. The Safe Zone program seeks to empower its participants to foster an affirmative and supportive environment for LGBTQ individuals within their community. Chochinov et al. (2013) explains that the enhancement and utilization of these therapeutic techniques is likely to facilitate competent practice and therapeutic effectiveness.

As with any research, this study has limitations. One limitation to the study is the reliance on self-report surveys to collect data. Participants may vary in the estimation of their own attitudes, knowledge, and clinical skills, and this was not accounted for in this study. It is also important to highlight potential issues with outdated vocabulary and wording of certain items used in the LGB-KASH. Additionally, since the study focuses on attitudes toward sexual and gender minorities, social desirability may also have influenced responses. Participants were aware that they were a part of a research study, and this may have influenced some participants to favor more positive responses.

Another limitation is that this study focuses on self-perceived clinical competency instead of objectively measuring such competencies. It is not clear whether attitudes and knowledge directly influence behavioral changes that coincide with clinical competency. However, there is evidence that suggests that these are important foundations for change. Although, there is

research that supports a relationship between these two concepts, objective measures of LGBTQ cultural competence would no doubt provide more useful information.

The study sample may also limit the generalizability of findings. For example, the training for psychology students/faculty was an open training where anyone could choose to attend based on their personal availability. Their willingness to attend the Safe Zone training may be confounded with other factors, such as personal interest in LGBTQ issues, creating a selection bias in the sample. However, this study attempted to balance this by collaborating with university courses to administer the training. Trainings for the social work and nursing students/faculty occurred in place of a regularly scheduled course, and this may have allowed for a more diverse set of individuals to attend. Although selection bias was expected to have some influence on the data, it is noteworthy that pre-post changes were found for most subscales.

Overall, it is important that the fields of psychology, social work, and nursing incorporate LGBTQ information as a means of training competent psychologists, social workers, and nurses. The implications of such a commitment to this initiative would have several positive benefits for advancing the field in this area. Additionally, society will benefit from the potential of having more psychologists, social workers, and nurses available that are trained to work competently with LGBTQ clients and students. Thus, any knowledge regarding the training of these psychologists, social workers, and nurses, who are often entrusted to help others overcome difficult situations and troubling issues, is undoubtedly important. While additional initiatives to address LGBTQ experiences in clinical training programs will also be needed to facilitate competency, the Safe Zone program could be used as an introduction to general knowledge on LGBTQ issues, particularly in undergraduate and graduate training programs. It is recommended that clinical training programs that exist at universities with an established Safe Zone program to

incorporate the training experience into curriculum or workshop opportunity, especially for first-year students who are less likely to have had clinical experience with this population. While acknowledging that cultural competency is a continuous learning process, diversity training programs, like Safe Zone, are a beneficial resource for training clinicians in the helping professions.

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APPENDIX A RESEARCH QUESTIONNAIRE

1. At the University of Alabama, you are in:

1 – Department of Psychology

2 – School of Social Work

3 – Capstone College of Nursing

4 – College of Community Health Sciences

5 – other (please specify)

_____

2. In your department/school are you:

1 – student

2 – faculty

3 – staff

4 – other (please specify)

_____

3a. If in the Department of Psychology, are you:

1 – clinical graduate student

2 – experimental graduate student

3 – faculty

4 – staff

5 – other (please specify)

_____

3b. If in the Capstone College of Nursing, are you:

1 – BSN student

2 – MSN student

3 – MSN with nurse practitioner (NP) concentration student

4 –doctoral level student

5 – faculty

6 – staff

7 – other (please specify)

_____

3c. If in the School of Social Work, are you:

1 – BSW student

2 – MSW student

3 – PhD student

4 – faculty

3d. If in College of Community Health Sciences, are you:

1 - student

2 - resident

3 - fellow

4 - faculty

5 – staff

6 – other (please specify)

_____

5 - staff

6 – other (please specify)

_____

4. If graduate student, year in graduate/professional program:

1 – first year

2 – second year

3 – third year

4 – fourth year

5 – fifth year

6 – sixth year

7 – seventh year or above

5. Sexual Orientation:

1 – bisexual

2 – gay

3 – heterosexual

4 – lesbian

5 – unsure

6 – other

_____

6. Gender Identity:

1 – female

2 – male

3 – transgender

4 – third gender

5 – other (please specify)

_____

7. Ethnicity:

1 – American Indian or Alaskan Native

2 – Asian

3 – Black or African American

4 – Hispanic or Latino/Latina

5 – Native Hawaiian or Other Pacific Islander

6 – White/Caucasian or Other European Descent

7 – other (please specify)

8. Age:

1 – 18-29

2 – 30-39

3 – 40-49

4 – 50-59

5 – 60+

_____

9. Have you ever attended a UA Safe Zone training before?

_____No _____Yes _____Unsure

10. Other than Safe Zone, have you ever attended a formal LGBTQ training program, workshop, academic course, etc.? If so, please circle below what you have attended before:

a. academic course (undergrad)

b. academic course (grad)

c. workshop (describe):_____

d. training program (describe):_____

e. other (describe):_____

11. To your knowledge, for how many LGBTQ or otherwise non-heterosexual identified students (undergraduate and/or graduate) have you in some way facilitated their academic progress (e.g., program matriculation, admission, advising, paperwork completion, etc.)?

Undergraduate Students:

_____0 _____1 _____2 _____3 _____4 _____5+

Graduate Students:

_____0 _____1 _____2 _____3 _____4 _____5+

12. To your knowledge, how many students have you taught that identified as LGBTQ or otherwise non-heterosexual?

_____Not Applicable (Mark here if you do not/have not taught any courses)

_____0 _____1 _____2 _____3 _____4 _____5+

13. When teaching, how comfortable do you feel discussing issues of sexual and gender identity as they relate to course material?

_____Not Applicable (Mark here if you have not taught any courses.)

1 Not At All Comfortable	2	3	4	5	6 Very Comfortable

14. When teaching, has there ever been a time during class in which an uncomfortable situation or conflict/argument has arisen regarding sexual and/or gender identity (e.g., social acceptability, moral or political correctness, etc.)?

_____Not Applicable (Mark here if you have not taught any courses.)

_____No

_____Yes (describe):_____

_____

_____

_____

15. When teaching, has there ever been a time during class in which a student has made an inappropriate comment regarding sexual and/or gender identity but a conflict/argument did not occur?

_____Not Applicable (Mark here if you have not taught any courses.)

_____No

_____Yes (describe):_____

_____

_____

_____

16. If your answer to either question 12 or 13 was yes, how confident are you that you were able to handle the comment, situation, or conflict/argument in an appropriate manner?

_____Not Applicable (Mark here if you have not taught any courses.)

1 Not At All Confident	2	3	4	5	6 Very Confident

17. To your knowledge, how many clients have you seen for therapy or assessment services that identified as LGBTQ or otherwise non-heterosexual?

_____Not Applicable (Mark here if you do not/have not seen clients for therapy or assessment services.)

_____0 _____1 _____2 _____3 _____4 _____5+

18. When seeing a client who identified as LGBTQ or otherwise non-heterosexual for therapy or assessment services, to what degree did/do you feel appropriately trained to work with the client?

_____Not Applicable (Mark here if you do not/have not seen LGBTQ identified clients.)

1	2	3	4	5	6
Not Appropriately Trained					Very Appropriately Trained

19. When seeing a client who identified as LGBTQ or otherwise non-heterosexual for therapy or assessment services, how much confidence did/do you have that you were able to establish and maintain rapport and a therapeutic alliance?

_____Not Applicable (Mark here if you do not/have not seen LGBTQ identified clients.)

1	2	3	4	5	6
Not At All Confident					Very Confident

20. When seeing a client who identified as LGBTQ or otherwise non-heterosexual for therapy or assessment services, how much confidence do/did you have that your supervisor could answer questions and provide resources specific to issues involving the client's sexual and/or gender identity?

_____Not Applicable (Mark here if you do not/have not seen LGBTQ identified clients.)

1	2	3	4	5	6
Not At All Confident					Very Confident

LGBT-KASH

Instructions: Please use the scale below to respond to the following items. Circle the number that indicates the extent to which each statement is characteristic or uncharacteristic of you or your views. Please try to respond to every item.

NOTE: LGBT = Lesbian, Gay, Bisexual, and/or Transgender

1	2	3	4	5	6
Very **uncharacteristic** of me or my views					Very **characteristic** of me or my views

Please consider the ENTIRE statement when making your rating, as some statements contain two parts.

1. I feel qualified to educate others about how to be affirmative regarding LGBT issues.

1	2	3	4	5	6

2. I have conflicting attitudes or beliefs about LGBT people.

1	2	3	4	5	6

3. I can accept LGBT people even though I condemn their behavior.

1	2	3	4	5	6

4. It is important to me to avoid LGBT individuals.

1	2	3	4	5	6

5. I could educate others about the history and symbolism behind the “pink triangle.”

1	2	3	4	5	6

6. I have close friends who are LGBT.

1	2	3	4	5	6

Reminder: Use the following scale in your responses.

1	2	3	4	5	6
Very **uncharacteristic** of me or my views					Very **characteristic** of me or my views

7. I have difficulty reconciling my religious views with my interest in being accepting of LGBT people.

1	2	3	4	5	6

8. I would be unsure what to do or say if I met someone who is openly lesbian, gay, bisexual, or transgender.

1	2	3	4	5	6

9. Hearing about a hate crime against a LGBT person would not bother me.

1	2	3	4	5	6

10. I am knowledgeable about the significance of the Stonewall Riot to the Gay Liberation Movement.

1	2	3	4	5	6

11. I think marriage should be legal for same sex couples.

1	2	3	4	5	6

12. I keep my religious views to myself in order accept LGBT people.

1	2	3	4	5	6

13. I conceal my negative views toward LGBT people when I am with someone who doesn't share my views.

1	2	3	4	5	6

14. Please circle the number five on the scale below.

1	2	3	4	5	6

Reminder: Use the following scale in your responses.

1	2	3	4	5	6
Very **uncharacteristic** of me or my views					Very **characteristic** of me or my views

15. I sometimes think about being violent toward LGBT people.

1	2	3	4	5	6

16. Feeling attracted to another person of the same sex would not make me uncomfortable.

1	2	3	4	5	6

17. I am familiar with the work of the National Gay and Lesbian Task Force.

1	2	3	4	5	6

18. I would display a symbol of gay pride (pink triangle, rainbow, etc.) to show support of the LGBT community.

1	2	3	4	5	6

19. I would feel self-conscious greeting a known LGBT person in a public place.

1	2	3	4	5	6

20. I have had sexual fantasies about members of my same sex.

1	2	3	4	5	6

21. I am knowledgeable about the history and mission of the PFLAG organization.

1	2	3	4	5	6

22. I would attend a demonstration to promote LGBT civil rights.

1	2	3	4	5	6

Reminder: Use the following scale in your responses.

1	2	3	4	5	6
Very **uncharacteristic** of me or my views					Very **characteristic** of me or my views

23. I try not to let my negative beliefs about LGBT people harm my relationships with the lesbian, gay, bisexual, and/or transgender individuals I know.

1	2	3	4	5	6

24. It is wrong for courts to make child custody decisions based on a parent's sexual orientation.

1	2	3	4	5	6

25. Hospitals should acknowledge same sex partners equally to any other next of kin.

1	2	3	4	5	6

26. LGBT people deserve the hatred they receive.

1	2	3	4	5	6

27. It is important to teach children positive attitudes toward LGBT people.

1	2	3	4	5	6

28. I conceal my positive attitudes toward LGBT people when I am with someone who is homophobic.

1	2	3	4	5	6

29. Health benefits should be available equally to same sex partners as to any other couple.

1	2	3	4	5	6

Riddle Scale

Instructions: Please circle the number of the statement that best describes your current attitudes towards LGBT individuals.

1. **Repulsion**
   Homosexuality is seen as a crime against nature. LGBT people are sick, crazy, immoral, sinful, wicked, etc. Anything is justified to change them: prison, hospitalization, negative behavior therapy, violence. etc.

2. **Pity**
   Heterosexual chauvinism. Heterosexuality is more mature and certainly to be preferred. Any possibility of becoming "straight" should be reinforced, and those who seem to be born LGBT should be pitied

3. **Tolerance**
   Homosexuality is just a phase of adolescent development that many people go through and most people grow out of. Thus, LGBT people are less mature than heterosexuals and should be treated with the protectiveness and indulgence one uses with a child. LGBT people should not be given positions of authority because they are still working through their adolescent behavior.

4. **Acceptance**
   Still implies there is something to accept. Characterized by such statements as "you're not a lesbian, you're a person" or what you do is your own business or "it's fine with me, just don't flaunt it."

5. **Support**
   Work to safeguard the rights of LGBT individuals. People at this level may be uncomfortable themselves, but they are aware of the homophobic climate and irrational unfairness.

6. **Admiration**
   Acknowledges that being LGBT in our society takes strength. People at this level are willing to truly examine their homophobic attitudes, values, and behaviors.

7. **Appreciation**
   Value the diversity of people and see LGBT people as a valid part of that diversity. These people are willing to combat homophobia in themselves and others.

8. **Nurturance**
   Assumes that LGBT people are indispensable in our society. They view LGBT people with genuine affection and delight and are willing to be allies and advocates.

LGB-CSI-SF

Instructions: Please use the scale below to respond to the following items. Circle the number that indicates the extent to which you feel capable to perform the following counseling-related tasks/behaviors. Please try to respond to every item.

NOTE: LGBT = Lesbian, Gay, Bisexual, and/or Transgender

1	2	3	4	5
Not confident				**Extremely** confident

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

1	2	3	4	5

2. Assist LGB clients to develop effective strategies to deal with heterosexism & homophobia.

1	2	3	4	5

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

1	2	3	4	5

4. Refer LGB clients to affirmative legal & social supports.

1	2	3	4	5

5. Help a same-sex couple access local LGB-affirmative resources & support.

1	2	3	4	5

6. Refer a LGB client to affirmative social services in cases of estrangement from their families of origin.

1	2	3	4	5

7. Identify my own feelings about my own sexual orientation & how it may influence a client.

1	2	3	4	5

Reminder: Use the following scale in your responses.

1	2	3	4	5
Not Confident				**Extremely** Confident

8. Examine my own sexual orientation/identity development process.

1	2	3	4	5

9. Recognize my real feelings vs. idealized feelings to be more genuine & empathic with LGB clients.

1	2	3	4	5

10. Assess for stress felt by LGB victims of hate crimes based on their sexual orientations/identities.

1	2	3	4	5

11. Integrate clinical data (e.g., mental status exam, intake assessments, presenting concern) of a LGB client.

1	2	3	4	5

12. Assess the role of alcohol & drugs on LGB clients social, interpersonal, & intrapersonal functioning.

1	2	3	4	5

13. Establish a safe space for LGB individuals.

1	2	3	4	5

14. Normalize a LGB client's feelings during different points of the coming out process.

1	2	3	4	5

15. Establish an atmosphere of mutual trust & affirmation when working with LGB clients.

1	2	3	4	5

AIM

Instructions: Please use the scale below to respond to the following items. Circle the number that indicates the extent to which you agree or disagree with each statement. Please try to respond to every item.

NOTE: LGBT = Lesbian, Gay, Bisexual, and/or Transgender

1	2	3	4	5
Strongly **Disagree**				Strongly **Agree**

1. I know about resources (for example: books, Web sites, support groups, etc.) for sexual minority people in my area.

1	2	3	4	5

2. I have developed the skills necessary to provide support if a sexual minority person needs my help.

1	2	3	4	5

3. I know about resources for families of sexual minority people (for example: PFLAG).

1	2	3	4	5

4. I know of organizations that advocate for sexual minority issues.

1	2	3	4	5

5. I keep myself informed through reading books and other media about various issues faced by sexual minorities groups, in order to increase my awareness of their experiences.

1	2	3	4	5

6. I am aware of the various theories of sexual minority identity development.

1	2	3	4	5

7. I am aware of policies in my workplace and/or community that affect sexual minority groups.

1	2	3	4	5

Reminder: Use the following scale in your responses.

1	2	3	4	5
Strongly **Disagree**				Strongly **Agree**

8. If requested, I know where to find religious or spiritual resources for sexual minority people.

1	2	3	4	5

9. I have engaged in efforts to promote more widespread acceptance of sexual minority people.

1	2	3	4	5

10. I have taken a public stand on important issues facing sexual minority people.

1	2	3	4	5

11. I try to increase my knowledge about sexual minority groups.

1	2	3	4	5

12. I am comfortable with knowing that, in being an ally to sexual minority individuals, people may assume I am a sexual minority person.

1	2	3	4	5

13. If I see discrimination against a sexual minority person or group occur, I actively work to confront it.

1	2	3	4	5

14. I regularly engage in conversations with sexual minority people.

1	2	3	4	5

15. I am open to learning about the experiences of sexual minority people from someone who identifies as an LGBTQ person.

1	2	3	4	5

Reminder: Use the following scale in your responses.

1	2	3	4	5
Strongly **Disagree**				Strongly **Agree**

16. I think that sexual minority groups are oppressed by society in the United States.

1	2	3	4	5

17. I think sexual minority individuals face barriers in the workplace that are not faced by heterosexuals.

1	2	3	4	5

18. Sexual minority adolescents experience more bullying than heterosexual adolescents.

1	2	3	4	5

19. Sexual minority adolescents experience more depression and suicidal thoughts than heterosexual adolescents.

1	2	3	4	5

THE UNIVERSITY OF ALABAMA®
Office of the Vice President for
Research & Economic Development
Office for Research Compliance

October 21, 2016

Kaleb Murry
Department of Psychology
College of Arts and Sciences
The University of Alabama
Box 870348

Re: IRB # 12-OR-378-R3 (Revision) "The Effects of LGBTQ Diversity Training on Competency, Knowledge, and Attitudes in Graduate Clinical Training Programs"

Dear Mr. Murry:

The University of Alabama Institutional Review Board has reviewed the revision to your previously approved expedited protocol. The board has approved the change in your protocol.

Please remember that your approval period expires one year from the date of your original approval, February 9, 2016, not the date of this revision approval.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants.

Good luck with your research.

[redacted]

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