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Initial Development and Validation of the Transgender Ally Identity Scale for Counselors

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INITIAL DEVELOPMENT AND VALIDATION OF THE TRANSGENDER

ALLY IDENTITY SCALE FOR COUNSELORS

by

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ABSTRACT

INITIAL DEVELOPMENT AND VALIDATION OF THE TRANSGENDER ALLY IDENTITY SCALE FOR COUNSELORS

Jamie D. Bower
Old Dominion University, 2016
Dissertation Chair: Dr. Jeffry Moe

The Transgenger Ally Identity Scale for Counselors (TAISC) is a 35-item scale measuring counselors' ally identity for working with transgender individuals. The purpose of the current study was to develop and initially validate the TAISC. Using a non-experimental survey design, the scale was developed (i.e., item development, external review, pilot study) and validation analyses were performed (i.e., exploratory factor analysis, internal consistency, validity, and social desirability analyses). Electronic data were collected from a nationwide sample of counseling students, professional counselors, and counselor educators (N=285). Participants completed a survey packet consisting of the TAISC, Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), Genderism and Transphobia Scale – Revised –Short Form (GTS-R-SF; Tebbe et al., 2014), Marlowe Crowne Social Desirability Scale – Short-Form C (MCSDS-C; Reynolds, 1982) and a demographic information form. A two-factor model was determined to be the best fit for the sample, accounting for approximately 37% of the total variance. The internal consistency estimate was acceptable for the TAISC total scale ($\alpha = .94$). Additionally, the TAISC was significantly, positively correlated with the MCKAS (Ponterotto et al., 2002) and significantly, negatively correlated with the GTS-R-SF (Tebbe et al., 2014) supporting convergent validity. Although further validation analyses are needed, initial results support the use of the TAISC in measuring transgender ally identity of counselors.

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CHAPTER ONE

STATEMENT OF THE PROBLEM

This chapter includes context for the study, statement of the problem, purpose of the study, and research questions. The first chapter also contains important definitions and assumptions of the study.

Introduction

In the last decade, transgender and other non-binary gender conforming individuals have become more visible in society (e.g., increased number of celebrities and other public figures coming out, more news coverage surrounding transgender hate crimes; Henricks & Testa, 2012). This increased visibility has sparked an increase in awareness among counseling professionals (Henricks & Testa, 2012), some of whom may be evaluating and treating gender identity concerns as a mental health issue. Despite the existence of literature on lesbian and gay issues in counseling, little empirical research has been dedicated to the exploration of transgender competence, ally identity, and factors predicting transgender competence. A lack of empirical inquiry makes it difficult to understand how prepared counselors are through their training programs, how counselors are defining competence, and whether their practice includes advocating on behalf of the transgender population.

Professional mandates such as the American Counseling Association *Code of Ethics* (ACA, 2014) require counselors to be competent when working with diverse clients. Multicultural competence has come to include the ability to work with lesbian, gay, bisexual, and transgender (LGBT) individuals, recognizing that one's sexual and gender identities represent cultural groups, just like race and religion. A counselor is ethically obligated to have awareness about one's level of preparedness and competence to work with clients from diverse

backgrounds on a multitude of dimensions (knowledge, attitudes, skills, and action) and from various perspectives (client worldview, counselor self-awareness, counseling relationship, and cultural interventions) (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016).

In order to positively impact sociopolitical needs of vulnerable populations, including the transgender community, and to provide culturally sensitive and responsive counseling services to those individuals, working beyond the advanced level of competence outlined in the multicultural counseling competences (MSJCCs; Ratts et al., 2016) is essential. To define this level beyond advanced competence, the concept of "ally" is to be considered. Being an ally for a specific population requires more than basic awareness, knowledge, skills, and actions; it requires consciously embedding an ally identity for vulnerable populations as an essential aspect of one's overall counselor identity.

Over the past several years, increasing literature has been published on LGBT issues in counseling. However, most of the literature and published data have focused on sexual minorities (i.e., lesbians, gays, and bisexuals) or the LGBT community as a whole. Additionally, most research that has been done on LGB competence has used the Sexual Orientation Counselor Competence Scale (Bidell, 2005). For example, Bidell (2013), and Rutter, Estrada, Feguson, and Diggs (2008) explored the impact of an LGB-affirmative counseling course on perceived competence and effectiveness of counseling students. Farmer, Welfare, and Burge (2013) examined LGB counselor competence in different practice settings. Bidell (2012) also used the SOCCS to look at the LGB competence of school counseling and mental health counseling students.

Further, literature on LGBT client perspectives of counseling effectiveness and outcomes is lacking. For example, only one study has explored the mental health experiences of

transgender individuals (Benson, 2013). Unfortunately, the lack of empirical literature about specific client needs, transgender-specific counseling issues, and barriers faced by transgender and gender-nonconforming individuals makes it difficult to create a strong foundation in understanding counseling competence related to working with this population. In this vein, the researcher sought to develop an instrument for better understanding counselors' levels of commitment to supporting the transgender community through behaviors and actions beyond what is expected from an advanced competence perspective, or what the researcher has coined *ally identity* for working with transgender individuals. The instrument developed for this study (i.e., Transgender Ally Identity Scale for Counselors [TAISC]) has a strong foundation in counseling competencies endorsed by numerous counseling organizations.

United States LGBT Statistics

It is estimated that there are between 5 and 9 million individuals within the U.S. adult population identifying as part of the LGBT community (3.5% of the U.S. adult population; Gates, 2014). Nationwide census statistics estimating the number of adults who identify as transgender are rare; two statewide surveys suggest approximately 0.3% of the U.S. adult population is transgender (Gates, 2011). Population-based statistics vary significantly due to inconsistency in survey language and definitions regarding sexual orientation and gender identity, inconsistency in survey administration, and variation in survey questions specific to LGBT identification (Gates, 2011). That being said, LGBT statistics are assumed underreported for a variety of reasons, such as one's level of outness, the language one uses to identify (e.g., a transgender individual who has fully transitioned may identify as male, even if they are still legally female), and societal heterosexism and transgender prejudices. Transphobia, transprejudice, and acts of hate result from stigmas associated with the transgender community

(Singh, Boyd, & Whitman, 2010). Heterosexism, transphobia, and transgender prejudices continue to make it difficult to accurately and empirically research LGBT communities; therefore, further investigation and instrument development about transgender counseling competence and ally identity are important next steps to better serving transgender clients.

LGBT Mental Health Concerns

Individuals who identify as LGBT experience greater occurrences of serious mental health related concerns across the developmental spectrum (Institute of Medicine [IOM], 2011). Although LGBT individuals face similar issues as their heterosexual counterparts, they also experience unique life stressors which include the following: coming out in a heteronormative society, difficulties in adoption and child rearing, problems associated with finding safe and nondiscriminatory housing, the lack of familial and religious support, and discrimination and oppression in the workplace, at school, and other areas of one's life (Godfrey, Haddock, Fisher, & Lund, 2006; Grant et al., 2011). However, it is not uncommon for LGBT clients to reframe or minimize the impact of their sexual orientation and/or gender identity, for fear of further stigmatization (Chaney & Marszalek, 2014).

LGB populations experience proportionally higher occurrences of serious psychological issues, such as depression, eating disorders (Cochran, Sullivan, & Mays, 2003; D'Augelli, 2002; Haas et al., 2010; Kosciw et al., 2012; Lloyd-Hazlett & Foster, 2013), suicidal ideation and attempts, self-harming behaviors, and other issues such as substance use and anxiety (IOM, 2011). Transgender individuals report a disproportionate rate of suicide attempts (41%) compared to the general population (1.6%) (Grant et al., 2011). Additionally, depression, low self-esteem, substance use, and HIV/AIDS affect transgender individuals disproportionally (Chang & Chung, 2015; O'Hara et al., 2013). Mistreatment, harassment/bullying, and

discrimination in places of employment and school are typical occurrences for the majority of those who identify as transgender (Grant et al., 2011). Transgender individuals face significant family rejection, social isolation, and poverty related to workplace discrimination resulting in unemployment (Chang & Chung, 2015; O'Hara et al., 2013).

The National Coalition of Anti-Violence Program's (NCAVP) annual report on lesbian, gay, bisexual, transgender, queer, and HIV-affected hate violence (2015) highlights the pervasiveness of discrimination, oppression, disrespect, and misunderstanding experienced daily for LGBT+ (i.e., lesbian, gay, bisexual, transgender, queer, and HIV-affected) populations within U.S. society. For the last several years, the NCAVP reports have shown a disproportionate impact of deadly violence for transgender women, transgender people of color, gay men, and bisexual men. Further, the number of homicides and the severity of hate crimes against LGBT+ individuals rose more than 11% between 2013 and 2014 (NCAVP, 2015). These statistics represent an extreme illustration of members of society acting on a perceived violation of heteronormative expectations. It is the societal experiences of LGBT individuals that result in issues of isolation, low self-esteem, depression, and suicidal ideation (the main reasons LGBT clients seek counseling services; Carroll, Gilroy, & Ryan, 2002).

The experiences of societal stereotyping and stigmatization that LGBT individuals share with people of color and those of other marginalized identities highlight the value of intersectionality as a valid aspect of mental health related concerns. There is an amplification of prejudice and discrimination experienced when multiple marginalized identities intersect (e.g., LGBT person of color), leading to an increase in one's mental health related concerns (Meyers, 2015). LGBT populations and other marginalized groups may experience similar processes of identification as a minority, but there are important distinctions in stress and daily challenges.

Experiencing these issues related to intersectionality can result in increased stress, rejection, and daily challenges all posing a threat to one's health and well-being. Contrary to the experience of most people of color, a majority of LGBT individuals are raised in families and communities that do not share their minority status. Additionally, addressing sexual and gender identity often results in discussions surrounding sexuality, a particularly uncomfortable and difficult topic for many people. Further, unlike various other cultural identities, the visibility of minority status differs for LGBT communities: sexual orientation, and at times gender identity, is not visually identified (Chaney & Marszalek, 2014; Israel & Selvidge, 2003).

Competence and Ally Identity

The worldview of counselors and clients reflect the historical and current experiences in society. Society (the counseling profession included) maintains rigid definitions of gender (Sangganjanavanich, 2014). Although advancements have been made in the multicultural counseling movement, literature remains limited for transgender-specific issues. The research that does exist focuses on LGB issues, misinterpreted as LGBT inclusive, and gender dysphoria, a mental health concern (Sangganjanavanich, 2014; Singh & Burnes, 2010). Possessing the knowledge, skills, and awareness about LGBT issues is necessary for successful counseling to occur with clients identifying as LGBT. Unfortunately, graduate training programs fail to prepare counselors to adequately work with LGBT clients (Carol & Gilroy, 2002; Matthews, 2005; Rutter, Estrada, Ferguson, & Diggs, 2008; O'Hara et al., 2013). This could be related to the overall lack of inclusion of LGBT affirmative practices in counselor training programs and the continued deficit model focus (Rutter et al., 2008; Singh & Burnes, 2010).

Despite recent development of LGBT specific counseling competencies, counseling professionals struggle to develop competence to work with LGBT populations (Benson, 2013;

O'Hara et al., 2013). Research highlights the importance of counselor preparation programs encouraging direct exposure and involvement with LGBT populations in order to enhance competence and perceived self-efficacy to work with LGBT clients (Barden & Greene, 2015). Additionally, several predictive factors have been linked to increased LGB competence and self-efficacy of counselors (e.g., professional experience, self-identification as LGBT, education level). These factors have not been studied rigorously across the LGBTQ spectrum of identities to note transferability from LGB to transgender populations. Further, advanced competence is directly linked with increased professional identity development (Gibson, Dollarhide, & Moss, 2010; Prosek & Hurt, 2014).

Additionally, multicultural and social justice competencies highlight the importance of advanced competence, including advocacy efforts for oppressed clients and communities (Ratts et al., 2016). Although limited research exists to understand how many counselors have adopted these standards of practice, the new expectation is that competent counselors are also advocating on behalf of marginalized populations (ACA, 2009; Israel, Ketz, Detrie, Burke, & Shulman, 2003; LaMantia, Wagner, & Bohecker, 2015). Advanced competence is thus a precursor to developing an ally identity. An ally will demonstrate behaviors and attitudes beyond their role as a competent counselor (e.g., correct misinformation and stereotypes, facilitate fairness and equity through removal of societal barriers, and actively participate in continuing education about transgender specific issues; ALGBTIC, 2013; LaMantia et al., 2015). Identity as an ally can further redefine one's role as a counselor and facilitate personal and professional identity. Ultimately, being an ally is important for social change. Allies are instrumental in addressing the discrimination, oppression, and societal misunderstanding of transgender individuals.

A competent counselor entering the initial stages of being an ally to the transgender community should at the least have an awareness of how transgender and other gender identities differ from one's own, be knowledgeable about current events and political issues involving LGBT communities, understand the intersecting identities a transgender individual may have and the role that plays in development, consult with competent supervisors, use inclusive and respectful language, and advocate on behalf of LGBT populations in a variety of ways (ACA, 2009; Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2013; LaMantia et al., 2015; Minnesota State University at Mankato: LGBT Center Resource Library, n.d.; Singh & Burnes, 2010). Therefore, ally identification should be considered a separate construct from competence, but one cannot become an ally without competence to work with transgender clients.

Further, it is important to note that counselors may be considered competent while also possessing indifference and ignorance to diverse populations. Counselors with advanced competence are able to conceptualize their knowledge, skills, and awareness into positive social change efforts. An ally might use their knowledge to actively confront oppression, by challenging those who joke about transgender populations. Further, allies are continuously and intentionally immersed in the culture, enhancing their own knowledge and self-awareness through reading and attendance at cultural events. Finally, allies use their skills and knowledge to create safe and equal environments for transgender individuals, educating others about LGBT issues through legislative and institutional changes (ALGBTIC, 2013; LaMantia et al., 2015; Ratts et al., 2016).

Validated self-report instruments exist to measure multicultural counseling competence (e.g., MCKAS) and LGB counseling competence (e.g., SOCCS). Additionally, a scale for

measuring transgender competence is in the initial stages of validation (Bidell, 2015). However, no instruments reflect the notion of advanced competence; and, no instruments exist to assess counselors' transgender ally identity. As transgender individuals become more visible in society and they continue to experience more extreme discrimination and mental health related concerns compared to LGB individuals (Henricks, & Testa, 2012), it is paramount counselors understand and adopt the MSJCCs notion of advanced competence.

Understanding transgender individuals' social environments is increasingly important, especially as a vulnerable and marginalized population (Ratts et al., 2016). Through counseling practice and social justice advocacy, oppression and discrimination can be addressed across systems. Counselors develop advanced competence based on their commitment to understanding how privileged or marginalized identities are impacted within each system. Counselors must not only incorporate knowledge, awareness, skills, and actions into counseling practice, but across interpersonal (e.g., assist transgender clients in fostering with those who may support their identity; relationships), institutional (e.g., connecting transgender individuals with supportive institutional resources to fight inequities), community (e.g., research norms and values to better understand societal impacts on transgender growth and development), public policy (e.g., advocate for equitable laws and policies for transgender persons), and international/global levels (e.g., learn about global politics that influence the health and/or well-being of transgender individuals) (Ratts et al., 2016). Ally identity can be seen as a natural outgrowth of advanced competence, leading toward an embedded identity.

Purpose of Study

The purpose of this study is the initial development and validation of the Transgender Ally Identity Scale for Counselors (TAISC). The TAISC is a scale designed to assess counselors'

levels of identity development as an ally to the transgender community. The TAISC is comprised of items specific to transgender counseling competence and transgender ally identity as outlined by multicultural counseling competencies (Ratts et al., 2016) and LGBTQIQA competencies (ACA, 2009; ALGBTIC, 2013). Although this scale has a foundation strongly tied to counselor competence, the TAISC measures ally identity, which is a different concept from counselor competence. The researcher posits that competence and ally identity are separate constructs, in that one's level of ally identity is dependent on one's level of competence.

Research Questions and Hypotheses

The following research questions will be examined through quantitative study:

Research Question 1: What is the factor structure of the TAISC?

(H1) The factor structure of the TAISC will be adequate for exploratory (i.e.,

principal axis factoring and a oblique rotation) procedures.

Research Question 2: What is the internal consistency of the TAISC for a sample of counseling students and professionals?

(H2) The internal consistency estimate, as measured by Cronbach's alpha, of the TAISC

will be strong for a sample of counseling students and professionals for the total scale.

Research Question 3: What is the relationship between the TAISC and the MCKAS?

(H3) There will be positive, significant relationships among the TAISC and MCKAS

total scales and subscales, providing evidence of convergent validity.

Research Question 4: What is the relationship between the TAISC and the GTS-R-SF?

(H4) There will be negative, significant relationships among the TAISC and GTS-R-SF

total scales and subscales, providing evidence of discriminant validity.

Research Question 5: What relationships, if any, exist between TAISC total scores and select demographic variables (i.e., age, gender, ethnocultural identification, sexual/affectional orientation, education level, religious affiliation and hours spent practicing religion, and the identification of a close friend/family member with the LGBTQ community)?

(H5) Participants' sexual orientation, religious affiliation, and education level will be possible predictors of one's TAISC total scores, therefore establishing criterion related validity.

Definition of Terms

Advocacy: *Advocacy* can be defined as action on behalf of marginalized groups and individuals for systemic changes. Advocacy also involves implementing empowerment strategies in counseling and with the community (Lewis, Arnold, House, & Toporek, 2003; Ratts et al., 2016).

Affirmative practice: *Affirmative practices* are defined as those that affirm identification as LGBT is an equally positive human experience and expression as heterosexual identity. Additionally, the absence of homophobia and/or self-reported competence is not sufficient for counselors to practice affirmatively (ACA, 2009).

Ally: *Ally*, as defined by (Washington & Evans, 1991), is "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 as an advocate with and for, the oppressed population." An *ally*, for the purpose of this study, is a competent counselor providing support and advocating on behalf of individuals who identify as LGBTQIQ (lesbian, gay, bisexual, transgender, queer, intersex, and questioning). Competent allies demonstrate behaviors and attitudes that may be

outside their role as counselors. Allies may identify as heterosexual, cisgender, and/or as members of the LGBTQIQ communities (ALGBTIC, 2013).

Bisexual: *Bisexual* is a term used to describe a man or woman who is emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with both men and women (ALGBTIC, 2013).

Cisgender: *Cisgender* refers to an individual whose gender identity aligns with the sex and gender they were assigned at birth (ALGBTIC, 2013).

Ethnocultural Identity: *Ethnocultural identity* refers to the aspect of one's self that includes both knowledge and evaluation of membership in one or more ethnocultural group (Tajfel, 1981). Ethnocultural identities, as informed by the U.S. Census Bureau's (1997) race and ethnicity classifications, include the following: African American or Black, American Indian or Alaskan Native, Asian, Hispanic or Latin(o/a), Native Hawaiian or Pacific Islander, and White.

Gay: The term *gay* refers to a man who is emotionally, physically, mentally and/or spiritually oriented to bond and share affection with other men. Gay is also an umbrella term, referring to individuals who identify as lesbian, gay, queer, and/or bisexual (ALGBTIC 2013).

Gender Dysphoria: *Gender dysphoria* is an intense, persistent discomfort resulting from the awareness that one's assigned sex and the resulting gender role expectations are inappropriate. Some consider gender dysphoria to be a health condition recognized by the American Psychiatric Association. Many transgender people do not experience gender dysphoria (ACA, 2009).

Gender Expression: *Gender expression* is the outward manifestation of internal gender identity, through clothing, hairstyle, mannerisms and other characteristics (ACA, 2009).

Gender Identity: *Gender identity* refers to the inner sense of being a man, a woman, both, or neither. Gender identity usually aligns with a person's biological sex, but sometimes does not (ALGBTIC, 2013).

Gender Roles: *Gender roles* are the social expectation of how an individual should act, think and feel, based upon the sex assigned at birth (ACA, 2009).

Non-binary Gender Conforming: *Non-binary gender conforming*, at times referred to as gender variant, can be defined as behaving in a way that does not match social stereotypes about female or male gender, usually through dress or physical appearance (ACA, 2009).

Heteronormative: *Heteronormative* is defined as the cultural bias that everyone follows or should follow traditional norms of heterosexuality. Additionally, this bias also includes the idea that relationships contain two individuals who have cisgender identities, where males identify with and express masculinity and females identify with and express femininity (ALGBTIC, 2013).

Heterosexism: *Heterosexism* is a form of oppression, incorporating a belief in the inherent superiority of one sexual identity over all others. It refers to the assumption that all people are or should be heterosexual (ALGBTIC, 2013).

Homosexual: The term *homosexual* was invented in the late 19th century to describe a type of male person viewed as an antisocial deviant, pervert, or even criminal (Silverstein, 1996). The term *homosexuality* continues to be associated with negative stereotypes, pathology, and the reduction of people's identities to their sexual behavior; therefore, it is not considered a culturally sensitive term (ACA, 2009).

Intersectionality: *Intersectionality* refers to the overlapping experiences of individuals' various identities and the interactions that may be a result of the power differentials between those identities (Crenshaw, 1989; Davis, 2008).

Lesbian: A *lesbian* is defined as a woman who is emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with other women (ALGBTIC, 2013).

LGBT: The acronym *LGBT* stands for lesbian, gay, bisexual, and transgender. The acronym LGBTQIQA (lesbian, gay, bisexual, transgender, queer, intersex, questioning, and ally) was developed for use in the counseling field, to be more inclusive of various gender, sexuality, relational, and other spectrums of identities (ALGBTIC, 2013). However, for the purpose of the current study, LGBT will be used to reflect those populations included most in empirical research.

Preparedness: For the purposes of this study, *preparedness* is defined as being open-minded, competent, and prepared to work with any client. Preparedness includes a counselor's willingness to allow a client to educate them on their personal worldview, doing one's best to treat each client with respect while also avoiding harm, and finally advocating for your clients and the LGBT population.

Queer: *Queer* refers to individuals who identify outside of the heteronormative imperative and/or the gender binary. Queer is also used as an umbrella term referring to the LGBTQIQA community. This term has historically been and still is used by those who hold negative attitudes/beliefs/actions towards the LGBTQIQA community (ALGBTIC, 2013).

Same-sex sexuality: The term *same-sex sexuality* is used in the professional literature as an alternative to the term homosexuality. Same-sex sexuality is considered a culturally sensitive term as it is applies to the human development of sexuality (Moe, Reicherzer, & Dupuy, 2011).

Sexual Orientation/Sexual Identity: *Sexual orientation* refers to the direction an individual is predisposed to bond with and share affection emotionally, physically, spiritually, and/or mentally (ALGBTIC, 2013). For the purposes of this study, *sexual identity* is used interchangeably with sexual orientation.

Trans: *Trans-* is a prefix that comes from the Latin root meaning "across, beyond, through" (Merriam-Webster, n.d.). *Trans* is often used interchangeably with transgender and transsexual.

Transgender: *Transgender* is an umbrella term used to describe those who challenge social gender norms, including gender queer people, gender-nonconforming people, transsexuals, cross dressers, and so on. People must self-identify as transgender for the term to be appropriately used to describe them (ACA, 2009).

Transsexual: *Transsexual* is a term that refers to a person who experiences intense, persistent, long-term discomfort with their body and self-image due to the awareness that their assigned sex is inappropriate. Transsexuals may take steps to change their body, gender role, and gender expression to align them with their gender identity (ACA, 2009).

Transitioning: *Transitioning*, for the purpose of this study, is the process of changing one's gender presentation permanently to accord with one's internal sense of one's gender.

Transphobia: *Transphobia* is defined as an aversion, fear, hatred, or intolerance of individuals who are transgender, gender variant, or deviate from societal gender norms. Transphobia can be internalized, which is seen when transgender individuals believe they deserve ill treatment because of their identity (ALGBTIC, 2013).

Potential Contributions of the Study

The initial development and validation of the TAISC will expand the existing literature about transgender issues in counseling. Additionally, the TAISC can be used to measure transgender ally identity levels of counseling students and professionals. Furthermore, the sample for this study was recruited from a nationwide population of counseling students and professionals across the CACREP specialties, increasing the generalizability of the results. Finally, this study used rigorous research methods to create a psychometrically sound instrument. Although this study involves only the initial validation of the TAISC, support will be provided for the use of TAISC to measure transgender ally identity.

The main purpose behind the initial development and validation of the TAISC is to provide counseling students and professionals with an understanding of their level of transgender ally identity. Counselors are charged with the responsibility of acting as an ally while also providing appropriate services to diverse clientele (ACA, 2014). The TAISC can aid in the development of transgender competence and increase awareness of ally identity levels for working with transgender individuals. Further, the researcher hopes the development of the TAISC will raise awareness about transgender-specific issues in counseling. Specifically, the findings of this study will serve as a foundation in understanding the state of counseling competence for working with transgender individuals, and overall begin to reduce the gaps in the literature.

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter examines the literature surrounding the variables that are included in this study of transgender counseling competence. The four components of multicultural, sexual orientation, and transgender counseling competence (knowledge, attitudes/beliefs, skills, and action) are discussed in greater detail. Further, lesbian, gay, bisexual, and/or transgender (LGBT) counselor preparedness and transgender ally identity are explored. Finally, gaps in the literature are noted, as they relate to the purpose and direction of this study.

Multicultural Counseling Competence

The American Counseling Association *Code of Ethics* (ACA, 2014) highlights the need for counselors to provide services to diverse clientele. This professional mandate means counselors are obligated to be competent when working with diverse individuals, including those who identify as LGBT. Further, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016), defines *multicultural competence* as "the diversity of racial, ethnic, and cultural heritage; socioeconomic status; age; gender; sexual orientation and religious and spiritual beliefs, as well as physical, emotional, and mental abilities" (p. 60). Given this multidimensional definition of multicultural competence and the ethical obligation to work with diverse groups of individuals, there is a need for understanding counselors' perceived preparedness and competence level to work with clients identifying as LGBT (O'Hara et al., 2013).

An expanding view of what multicultural competence encompasses is based on an equally expanding understanding of what culture means (Arredondo & Perez, 2006; Ratts et al., 2016). Culture is no longer a term limited to racial and ethnic minority groups; culture includes

one's identification with any group of individuals, including but not limited to age, gender, sexual orientation, religion, ability, and socioeconomic status (ACA, 2014; Arredondo & Perez, 2006; Collins, Arthur, Wong-Wylie, 2010). Additionally, one's identification as a cultural being does not require marginalized status. Each person has a cultural makeup that is salient and important to the counseling process, regardless of whether that individual is part of a minority group. Further, counselors must recognize the value of the intersection of one's various identities. Intersectionality refers to the overlapping experiences of individuals' various identities and the interactions that may result in power differentials between those identities (Crenshaw, 1989; Bowleg, 2012). Multicultural competence exists when a counselor is able to understand how one's personal identification with various cultural groups can impact a client's life, the counseling relationship, and the process of counseling and act on that knowledge and awareness with proper counseling and advocacy skills (Ratts et al., 2016).

Multicultural Counseling Competencies

The concept of multicultural counseling competence was first introduced by Sue et al. (1982) and focused on counselor competence to work with racial and ethnic minority groups. Sue et al. (1982) highlighted the importance of knowledge, attitudes and beliefs, and skills related to the counselor's awareness of his or her worldview, the counselor's understanding of the differing worldview of the client, and an understanding of culturally appropriate interventions. Later, Sue, Arredondo, and McDavis (1992) proposed a set of standards for counselors' multicultural competence. Shortly after, Arredondo et al. (1996) operationalized the standards and encouraged counseling and psychology professionals to adopt them. The model of multicultural counseling competence has since been expanded for use with a multitude of cultural identities and the connection of one's identities (Ratts, Singh, Nassar-McMillan, Butler,

& McCullough, 2016). Ratts et al. (2016) published the Multicultural and Social Justice Counseling Competencies (MSJCC) to include action and advocacy as essential aspects of competence.

The integration of the multicultural counseling competencies into the profession has encouraged counselors to have a more holistic view of experiences of historically marginalized groups, and to make positive shifts toward integrating multicultural constructs in their professional practice (Ratts et al., 2016). Competency guidelines are meant to broaden counselors' perspectives and techniques for working with clients; when counselors understand the complexity of each individual they are able to be more effective in their practice (Collins & Arthur, 2010). Various aspects of multicultural counseling competencies (e.g., knowledge, awareness, skills, actions) are included in counseling standards (e.g., CACREP) and ethical codes (e.g., ACA), highlighting intended usefulness of the competencies (Collins & Arthur, 2010). If counseling competencies are appropriately implemented (e.g., reflective exercises, experiential learning, etc.) into counselor training, they can be useful in guiding effective counseling (Lewis, 2010; Murray, Pope, & Rowell, 2010).

MSJCCs. The multicultural and social justice competencies (Ratts et al., 2016) were built upon Sue et al.'s (1992) original multicultural counseling competencies (MCCs). The original competencies (Sue et al., 1992) targeted counselors who were considered majority members of society. The MCCs were founded on three main domains of competence—attitudes, knowledge, and skills—for working with minority clients. The new competencies, developed almost 25 years after the MCCs, represent the significant multicultural and social justice changes that have occurred in society.

The core framework of the MSJCCs place multiculturalism and social justice at the center of all counseling practice. The MSJCCs highlight the broad range of diversity present in counseling relationships. For example, they recognize the intersectional identities that may exist for counselor and client, including the marginalized counselor working with a privileged client. Further, the MSJCCs advise counselors address issues of power, privilege, and oppression faced by clients. As such, all client issues are to be seen from a cultural contextual framework, with attention being given to individual and systemic interventions (Ratts et al., 2016).

The MSJCCs are comprised of four quadrants, reflecting identities clients and counselors bring to a counseling relationship (Ratts et al., 2016). Counselors and clients have various identities (e.g., racial, ethnic, gender, sexual orientation, economic, disability and spiritual), which can be considered marginalized or privileged. Depending on how the client and counselor experience an interaction, it is possible for a client or counselor to be privileged or marginalized or possess both statuses simultaneously (Ratts et al., 2016). The four quadrants include the following:

1. Quadrant I: Privileged Counselor–Marginalized Client

2. Quadrant II: Privileged Counselor–Privileged Client

3. Quadrant III: Marginalized Counselor–Privileged Client

4. Quadrant IV: Marginalized Counselor–Marginalized Client

Additionally, the MSJCCs focus on four domains of competence (i.e., counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions), which are ultimately intended to be developmental. For example, Ratts et al. (2016) posit that counselor self-awareness is the first step in multicultural and social justice competence. Therefore, how counselors' understand their personally held internal beliefs, biases,

and values about various cultural groups will impact their understanding of clients' worldviews and the counseling relationship.

Further, within each of the first three domains (i.e., counselor awareness, client worldview, and counseling relationship) are developmental competencies (i.e., attitudes and beliefs, knowledge, skills, and action). In order for a counselor to achieve the most influential multicultural and social justice outcomes, they must take action by operationalizing their attitudes and beliefs, knowledge, and skills. Essentially, the MSJCCs highlight the link between multicultural competence and social justice competence for counselors through advocacy efforts for their individual client and/or at the systemic level. It is through advanced competence and multicultural insights that a counselor is able to engage in social justice and advocacy initiatives. Ultimately, when counselors incorporate social justice advocacy into counseling practice, they are better able to address client concerns through relevant interventions occurring at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels (Ratts et al., 2016).

Advocacy competencies. The Advocacy Competencies (Lewis, Arnold, House & Toporek, 2002), endorsed by the ACA, describe how counselors can advocate, depending on various situations. Advocacy is organized into two separate domains with six resulting forms of advocacy. The first domain is the counselors' level of involvement. This includes acting on behalf of a client or acting with the client. The second domain involves level of intervention. Intervention can occur at individual, systemic, and societal levels (Lewis, Ratts, Paladino, & Toporek, 2011). Further, the advocacy competencies highlight various levels of advocacy, including micro (e.g., individual; client/student), meso (e.g., systems; school/community) and macro (e.g., public; social/political).

The MSJCCs include advocacy as an essential component of multicultural counselor competence. Counselors' knowledge, attitudes and beliefs, and skills are directly linked to their actions in addressing issues of privilege and oppression faced by clients. The MSJCCs provide a thorough understanding and framework for utilizing the advocacy competencies during a variety of client/counselor situations. Specifically, the MSJCC incorporation of the advocacy component makes them a solid foundation for understanding transgender counselor competence and a counselors' level of ally identity.

Measuring Multicultural Counseling Competence

In response to the multicultural counseling movement, started by Sue et al. in the 1980s, and the revisions of the competencies outlining a counselor's best practice for working with culturally diverse clients, research demonstrating the cultural competence of counselors working with diverse clientele abounded. Researchers developed instruments to measure multicultural counseling competence. Some of those instruments include: a) The Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994); b) The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002); and, c) The Multicultural Awareness, Knowledge, and Skills Survey- Counselor Edition-Revised (MAKSS-CE-R; Kim, Cartwright, Asay, & D'Andrea, 2003). These scales have been highlighted due to their similar foundational concept of competence being comprised of the tripartite model (Sue et al., 1982). Additionally, these three instruments are the most widely used self-report measures of multicultural counseling competence (Dunn, Smith, & Montoya, 2006; Gamst, Liang, & Der-Karabetian, 2011).

MCI. The Multicultural Counseling Inventory (Sodowsky et al., 1994) is a 40-item scale measuring multicultural counseling competencies. Specifically, the MCI measures perceived

multicultural counseling skills, awareness, relationship, and knowledge. Sample items include: "When working with minority clients, I form effective working relationships with the clients" and "What working minority clients, I perceive that my race causes the clients to mistrust me." Item responses range from *very inaccurate* (1) to *very accurate* (4). Coefficient alphas for skills, awareness, relationship, and knowledge subscales, and the total scale are .81, .81, .72, .78, and .90, respectively (Sodowsky et al., 1994). Since initial development, a series of continuing validation and psychometric evaluation studies have confirmed acceptable content, criterion-related, and construct validity. Reliability estimates (ranging from .68 to .80 across subscales) of the MCI seem to be comparable across studies and samples (e.g., Johnson & Williams, 2015; Pope-Davis & Ottavi, 1994). The samples used to validate this scale were limited by geographical location and to a specific group of counseling psychologists (i.e., college counselors).

MAKSS-CE-R. The Multicultural Awareness, Knowledge, and Skills Survey- Counselor Edition-Revised (Kim et al., 2003) is a 33-item scale that assess a counselors' awareness, knowledge, and skills for working with racial and ethnic minorities. The MAKSS (D'Andrea, Daniels, & Heck, 1991) was based on Sue et al.'s (1982) model of cross-cultural counseling competence and focused on awareness, knowledge, and skills. The scale includes items such as, "The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities" and "At this time in your life, how would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act." Responses for items on each subscale range from 1 to 4 (Knowledge subscale: 1= *very limited*, 4= *very good;* Skills subscale: 1= *strongly disagree*, 4= *strongly agree;* Awareness subscale: 1= *very limited*, 4= *very aware*). Results indicated adequate internal

reliability with coefficient alphas of .80 for the awareness subscale, .87 for the knowledge subscale, .85 for the skills subscale, and .81 for the total scale. Construct validity of the MAKSS-CE-R was established through strong positive correlations with the MCI (Sodowsky et al., 1994) and factor analyses. Additionally, significantly higher scores evidenced criterion-related validity for participants with increased cultural exposure and knowledge. Data for initial validation studies was limited to counseling students actively enrolled in courses, with a majority of participants reporting not having taken a multicultural counseling course (Kim et al., 2003).

MCKAS. The Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002), a 32-item self-report instrument, was developed to measure a counselor's perceived level of knowledge and awareness of multicultural issues. Items include: "I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face" and "I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups." Item responses range from *not at all true* (1) to *totally true* (7). Items can be summed for subscale and total scale scores. Coefficient alphas for the MCKAS have been reported to range from .78 to .93 for the knowledge subscale and from .67 to .83 for the awareness subscale; total scale alphas were not provided (Ponterotto et al., 2002). Test-retest reliability was moderate for both subscales; the knowledge and skills subscale was .70 and the awareness subscale was .73 (Ponterotto et al., 2002). Convergent validity was established through comparison of correlations between other measures of multicultural competence and racism (Ponterotto et al., 2002). Reliability and validity estimates of the MCKAS seem to be comparable across studies and samples (e.g., Bidell, 2005, 2014). Although the MCKAS is similar to other multicultural counseling competency assessments in that the foundation comes from Sue et al.'s (1982) model of cross-cultural competence, the MCKAS is the only

multicultural competence measure that has gone through revisions to account for factor structures.

Strengths and limitations of multicultural competence assessments. Each of these instruments aims to promote an increased understanding of counselors' self-perceived levels of competence for working with cultural groups, specifically racial and ethnic groups. These scales have been used in other mental health related professions (e.g., psychology, social work) and have resulted in comparative psychometric properties. In counseling literature, multicultural competence assessments have most often been used in research related to evaluating counselors' levels of cultural competence, not to include LGBT related competence.

There are several limitations of the instruments available for measuring counselors' cultural competence. First, many of the authors admitted to the limited generalizability of results, due to limited cultural, professional, and geographical samples (Kim et al., 2003; Ponterotto et al., 2002). Secondly, it was identified by at least one author, the need for further research observing live versus self-reported multicultural competence (Sodowsky et al., 1994). Further, instruments were designed based on multicultural counseling competencies (Sue et al., 1992). These competencies were based on definitions of culture that did not include sexual and/or gender identity. Additionally, there is no scale for measuring levels of advanced competence as outlined in the MSJCCs (Ratts et al., 2016). Therefore, measuring a counselor's action and advocacy efforts require use of an additional instrument (e.g., The Social Issues Advocacy Scale; Nilsson, Marszalek, Linnemeyer, & Misialek, 2011; see below for more detailed information)

Utilizing self-report methods (e.g., MCKAS) to determine a counselor's level of multicultural competency creates concern for those aspects of one's cultural competence that are difficult to measure in this manner (e.g., biases, skills) even when accounting for social

desirability. Researchers suggest that counseling graduates are underprepared for working with culturally diverse individuals (Graham, Carney, Kluck, 2012; Grove, 2009; Hansen et al., 2006; Rock, Carlson, & McGeorge, 2010). Therefore, one might conclude that aspects that are difficult to measure, such as multicultural training and exposure to various cultural groups, are essential to enhancing one's level of multicultural competence (Chao, 2006; Diaz-Lazaro & Cohen, 2001; Dillon, Worthington, Savoy, Rooney, Becker-Schutte, & Guerra, 2004; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). Further, limited empirical research has focused on the use of these instruments to evaluate the effect of one's competency on counseling outcomes or how to use such measures as a training tool for counseling students (Dunn et al., 2006).

Measuring Social Justice and Advocacy

Various measures of social justice and advocacy can aid in supplementing a piece of multicultural counseling competence that is not measured by the previously mentioned scales. Without the inclusion of actions and advocacy efforts on assessments of competence, gaining an accurate measure of advanced competence is not possible. Fietzer and Ponterotto (2015) reviewed counseling, psychology, and social work literature for scales measuring social justice and advocacy. Four scales met their criterion (i.e., published in English, included psychometric properties, and did not focus on advocacy toward one specific group): the Activism Orientation Scale (AOS; Corning & Myers, 2002), the Social Issues Advocacy Scale; Nilsson, Marszalek, Linnemeyer, & Misialek, 2011, the Social Issues Questionnaire (SIQ: Miller et al., 2009), and the Social Justice Scale (SJS: Torres- Harding, Siers, & Olson, 2012). Although each of these measures lack strong psychometric properties, they will be discussed here as suggested supplemental assessments important for gaining a full measure of multicultural counseling competence.

AOS. The Activism Orientation Scale (Corning & Myers, 2002) is a 35-item scale aimed at measuring one's propensity to engage in social action across a wide range of behaviors. The instrument is composed of two subscales, conventional activism and high-risk activism. The conventional activism subscale has 28 items and includes items such as, "How likely is it that you will display a poster or bumper sticker with a political message?" Further, the high-risk activism scale has 7 items, such as, "How likely is it that you will engage in an illegal act as part of a political protest?" All items are rated on a 3-point Likert scale from 0 (*extremely unlikely*) to 3 (*extremely likely*). AOS has strong internal consistency, with coefficient alphas for each subscale ranging from .87 to .97 (Corning & Myers, 2002). Test-retest reliability was not reported. Discriminate validity was established through the lack of relationships with efficacy or interpersonal control measures (Corning & Myers, 2002). Further, criterion validity was indicated by the difference of mean total scores among groups of participants (Coring & Myers, 2002). Generalizability beyond the university setting is unclear, as only 16 participants were included in a follow-up study with non-university counselors and psychologists (Coring & Myers, 2002).

SIAS. The Social Issues Advocacy Scale (Nilsson et al., 2011) is a 21-item scale measuring social justice advocacy over four subscales (political and social advocacy, political awareness, social issues awareness, confronting discrimination). Item responses are rated on a 5-point scale (1= *strongly disagree,* 5= *strongly agree*). Sample items include: "I keep track of important bills/legislative issues that are being debated in Congress that affect my profession" and "It is my professional responsibility to confront colleagues who display signs of discrimination toward disabled individuals." The SIAS correlations between subscales ranged from .14 to .63, during initial validation studies (Nilsson et al., 2011). Theta coefficients (.89 to

.94) fell in the excellent range for all subscales (Nilsson et al., 2011). Validation studies included a sample of students, 78% of who identified as women, reducing generalizability (Nilsson et al., 2011). Further, no confirmatory analysis procedures have been done to verify factor structure (Fietzer & Ponterotto, 2015).

SIQ. The Social Issues Questionnaire (Miller et al., 2009) is a 52-item scale measuring social justice interest, from a career counseling perspective. The SIQ consists of six subscales: social justice self-efficacy, social justice outcome expectations, social justice interest, social justice commitments, social justice supports, and social justice barriers. Each item is rated on a Likert-type scale ranging from 0 (*strongly disagree*) to 9 (*strongly agree*) (Miller et al., 2009). Authors provided limited information about psychometric properties; however, reliability of each subscale of the SIQ was reported. Coefficient alphas for each subscale is as follows: .94 for self-efficacy, .81 for outcome expectations, .90 for interests, .93 for commitment, .90 for supports, and .79 for barriers (Miller et al., 2009).

SJS. The Social Justice Scale (Torres-Harding et al., 2012) is a 24-item scale measuring social justice across four subscales (i.e., attitudes toward social justice, perceived behavioral control, subjective norms, and behavioral intentions). Item responses are rated from 1 (*disagree strongly*) to 7 (*strongly agree*). Sample items include, "I am capable of influencing others to promote fairness and equality" and "I believe that it is important to allow individuals and groups to define and describe their problems, experiences, and goals in their own terms." Cronbach's alphas for each subscale (attitudes $\alpha = .95$; subjective norms $\alpha = .82$, perceived behavioral control $\alpha = .84$, and intentions $\alpha = .88$) for the original sample indicated internal consistency (Torres-Harding et al., 2012). Discriminant validity was established through significant negative correlations with constructs of racism and sexism (Torres-Harding et al., 2015). Internal structure

of the scale is difficult to determine, as two factor analyses ran on two separate samples indicated

mixed evidence for factor structure (Fietzer & Ponterotto, 2015).

<div align="center">**LGBT Counseling Competence**</div>

Multicultural counseling competence, as currently demonstrated through CACREP and

ACA guidelines (ACA, 2014; CACREP, 2016), includes LGBT competence. Historically,

multicultural competence did not inherently include LGBT competence, despite increased

multicultural competence being associated with greater LGBT competence (Bidell, 2012).

Multicultural and LGBT movements in counseling have grown at different rates from one

another (Bidell, 2012; Graham et al., 2012). The greatest strides in multicultural framework

development have involved race and gender (O'Hara et al., 2013), not sexual and gender

identity. Competence must be cultivated through intentional processes of professional

development. It is imperative that counselors possess a broader definition of what *cultural*

identity means and be willing to understand and develop the awareness, knowledge, skills, and

actions necessary to work effectively with LGBT individuals, just as they do with any other

cultural group (Arredondo et al., 1996; Ratts et al., 2016; Sue et al., 1992).

Since the beginning of the multicultural movement in counseling, there has been an

increased inclusion of topics dedicated to LGBT issues (Bidell, 2005; Israel & Selvidge, 2003;

O'Hara et al., 2013). Several developments following the creation of the MCKAS (Ponterotto et

al., 2002) were aimed at increasing the effectiveness and competence of counselors working in a

diverse society, specifically related to the LGBT population. For example, the Sexual Orientation

Counselor Competence Scale (SOCCS; Bidell, 2005), the Lesbian, Gay, Bisexual, Queer,

Intersex, Questioning, and Ally (LGBQIQA) competencies (ALGBTIC, 2013) and the

transgender competencies (ACA, 2009) have been a few of the major advancements to the counseling field.

Competencies for Working with LGBTQIQA Individuals

In 2005, the Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) published competencies for working with LGBT clients. Revisions (ALGBTIC, 2013) created a more complex, yet inclusive, understanding of how to counsel individuals identifying anywhere on the sexual and/or gender identity/expression spectrums. Competencies for working with transgender clients (ACA, 2009) were separated from competencies covering sexual orientation and other sexual identity and gender expression identities.

LGBQIQA competencies. The most current competencies highlight the importance of enhancing knowledge, skills, and awareness to work with lesbian, gay, bisexual, queer, intersex, questioning, and ally (LGBQIQA) clients (ALBGTIC, 2013). These competencies provide an outlined rationale for language used, definitions, and ACA-and CACREP-preferred acronyms. The competencies for lesbian, gay, bisexual, queer, and questioning (LGBQQ) individuals are organized in sections that follow CACREP (2016) core domains (i.e., human growth and development, social and cultural foundations, helping relationships, group work, professional orientation and ethical practice, career and lifestyle development, assessment, and research and program evaluation). The following are examples of guidelines from the LGBQIQA competencies: "recognize, acknowledge, and understand the intersecting identities of LGBQQ individuals;" "consult with supervisors/colleagues when their personal values conflict with counselors' professional obligations related to LGBQQ individuals about creating a course of

action that promotes the dignity and welfare of LGBQQ individuals;" and, "be current and well-informed on the most recent with LGBQQ individuals and communities" (ALGBTIC, 2013).

Authors note that individuals who identify as an ally and/or intersex face unique experiences, from LGBQQ individuals. Therefore, competencies for allies (for counselors who are allies and for working with ally clients) and intersex individuals are located in separate sections of the document. Ally competencies are broken down into four different domains including the following: (a) awareness (e.g., become aware of who they are and how they are different from and similar to LGBTQIQ people), (b) knowledge (e.g., educate themselves on current issues affecting LGBTQIQ individuals and communities through various methods), (c) supporting individuals' decisions about coming out, and (d) facilitating supportive environments (e.g., use inclusive and respectful language). Finally, the competencies express that social justice is an important aspect to understanding LGBQIQA experiences; for example, counselors should be able to apply the minority stress model to clients identifying within LGBQIQA populations (ALGBTIC, 2013).

Transgender competencies. Competencies for working with transgender clients were created by ALGBTIC and endorsed by ACA in 2009. The competencies highlight the importance of the intersectionality of gender identities across the core CACREP (2016) domains. Competencies are written using a wellness, resilience, and strength based approach to counseling transgender individuals (ACA, 2009). These competencies include a glossary of transgender-affirmative language, with the warning that language is continuously changing. Transgender competencies encourage counselors to move beyond a deficit model, using multiculturalism, advocacy, and social justice perspectives to create trans-positive counseling environments (Singh

& Burnes, 2010) through acknowledgement of privilege, power, and oppression in clients' lives (ACA, 2009).

Authors advise using the transgender competencies in conjunction with other resources for working with transgender clients, as they are guidelines, not standards of practice. Further, it is suggested throughout the document that counselors working with transgender clients should obtain professional training and seek consultation when necessary, as each client will present with unique experiences and these competencies can only provide foundational support (ACA, 2009). The following are sample guidelines from the transgender competencies: (a) Recognize that the counselors' gender identity, expression, and concepts about gender are relevant to the helping relationship, and these identities and concepts influence the counseling process and may affect the counselor/client relationship; (b) Understand that gender identity and expression vary from one individual to the next, and that this natural variation should not be interpreted as psychopathology or developmental delay; and (c) Recognize the importance of educating professionals, students, and supervisees about transgender issues, and challenge misinformation and bias about transgender individuals (ACA, 2009).

Other competencies for working with LGBT clients. Although the Transgender competencies (ACA, 2009) are the only counseling specific competencies for working with transgender clients, other resources for mental health professionals exist. In 2011, the World Professional Association for Transgender Health (WPATH) published the Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7. WPATH's SOC has a limited wellness perspective, but is considered the main guideline used by professionals in health settings. The SOC document positions counselors and other health professionals as gatekeepers for medical transitions for transgender individuals. Previous

versions of the SOC have been criticized for taking a pathologizing approach, using maligning pronouns, and creating barriers for medical transition care (Stroumsa, 2014). The current SOC version supports the slowly changing notion that health care for transgender people is valid and necessary (Stroumsa, 2014). The SOC includes topics covering diagnosis, treatment, hormone therapy, surgical procedures, and more. Sample guidelines from the SOC document are as follows: "Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria," and "It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions- as are all decisions regarding health care."

Finally, the American Psychological Association (APA) published Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients in 2012 and Guidelines for Psychological Practice with Transgender and Gender Nonconforming People in 2015. The guidelines were developed in response to survey findings indicating that less than 30% of psychology students and professionals were competent to work with transgender individuals (Grant et al., 2011). The documents are composed of guidelines for affirmative practice with sexual and/or gender identity issues in various areas of psychological clinical care, research, education, and training. The guidelines clearly state that they are not mandatory, rather they are meant to facilitate development and professional practice with LGB clients (APA 2012, 2015). The LGB guidelines outline suggestions for dealing with (a) attitudes toward homosexuality and bisexuality, (b) relationships and families, (c) issues of diversity, (d) economic and workplace issues, (e) education and training, and (f) research (APA, 2012). The transgender focused guidelines cover (a) foundational knowledge and awareness; (b) stigma, discrimination and barriers to care; (c) life span development; (d) assessment, therapy, and intervention; and (e)

research, education, and training (APA, 2015). Albeit intended for psychological practice, the guidelines are both thorough additions for the mental health profession (Borough, Bedoya, O'Cleirigh, & Safren, 2015).

Application of Developmental Competencies to LGBT Populations

MSJCCs were developed in 2015, which limits the time in which researchers have been able to look at whether counselors have adopted these standards of practice, and what outcomes have resulted. Applying the MSJCC foundation to work with LGBT populations, in addition to utilizing the LGBQIQA (ALGBTIC, 2013) and transgender competencies (ACA, 2009), can help counselors understand their competence for working with this population. Additional information about the development competencies and research supporting each follows.

Attitudes and beliefs. Counselors should have an awareness of personal biases and attitudes held about LGBT individuals (Graham et al., 2012; Matthews, Selvidge, & Fisher, 2005). Although one's values do not need to match that of a client's to provide services to LGBT clients, bias can result in inferior treatment of clients (Myers, 2015). Negative attitudes and bias has been shown to impact a counselor's ability to effectively serve LGBT clients (Crisp, 2006; Matthews, 2005; Matthews et al., 2005). Further, counselors should be aware of the worldview of those who identify as LGBT. Counselors should never assume life experiences, based on one's sexual and/or gender expression.

Knowledge. Counselors should have a basic understanding of sexual and gender identity development, the coming out process, basic terminology, and other information specific to identification with each of the LGBT communities. Counselors should also be able to apply and adapt this knowledge to unique client experiences (ACA, 2009; ALGBTIC, 2013). Bidell (2013) reported that graduate students who received a full course on LGBT individuals during their

counseling training were more competent and effective counselors. Because most graduate counseling programs do not thoroughly cover LGBT related issues in multicultural courses (Rutter et al., 2008; Singh & Burnes, 2010), intentional learning and consultation is advised.

Skills. Counselors should have the skills to work with LGBT individuals. Research indicates that graduate multicultural counseling courses skip skill development and focus, albeit inadequately, on knowledge and awareness (Graham et al., 2012). Counselors should use basic foundational skills, as they do with all clients, but it is suggested that there are specific skills to consider when working with LGBT clients (Van Den Bergh & Crisp, 2004). For example, creating a LGBT-safe environment, assessing (not assuming) an individual's sexual and gender identity, treating the presenting challenge (not the individual's LGBT identification), supporting individuals who may be struggling with their sexual and/or gender identity, recognizing indicators of internalized homophobia, determining how out an individual is and who supports the individual's identification as LGBT, including significant others and family members in treatment when appropriate, referring individuals to LGBT-friendly resources, obtaining supervision to deal with personal attitudes and biases about LGBT individuals, and engaging in ongoing training and continuing education around LGBT needs (Van Den Bergh & Crisp, 2004).

Actions. The final aspect of a counselors' developmental competence is advocacy. Counselors should possess skills to advocate with and on behalf of clients who identify as LGBT (Brubaker, Harper, & Singh, 2011). Advocacy can include working to promote institutional change at multiple levels through appropriate channels (Arrendondo et al., 1996). Advocacy can also include disseminating accurate information through research and outreach, attending cultural community events, and contacting lawmakers in support of LGBT legislation (Israel & Selvidge, 2003; Ratts et al., 2016). Ultimately, advocating for clients involves a willingness to

explore the impact of societal institutions, communities, and policies and laws, on marginalized and privileged populations and a collaboration to make positive changes to reduce oppression and discrimination for marginalized clients (e.g., LGBT; Ratts et al., 2016).

Measuring LGB Competence

Several instruments have been developed and validated to measure competence with LGB clients. Despite usability across disciplines, many sexual orientation focused competency measures were developed with and for psychology and counseling psychology students and professionals. The only scale that was developed with and for counseling professionals is the Sexual Orientation Counseling Competence Scale (SOCCS; Bidell, 2005). Additionally, the SOCCS is the only LGB competency instrument to incorporate Sue et al.'s (1992) model of multicultural competence (i.e., knowledge, awareness, skills). However, the Gay Affirmative Practice Scale (GAP; Crisp, 2006), the Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI; Dillon & Worthington, 2003), and the Lesbian, Gay, Bisexual Working Alliance Self-Efficacy Scale (LGB-WACES; Burkard, Pruitt, Medler, & Stark-Booth, 2009) have also been widely used to assess LGB counseling competence and will be discussed here.

GAP. The Gay Affirmative Practice Scale (Crisp, 2006) is a 30-item scale for assessing social workers' affirmative practices with gay and lesbian clients. The GAP consists of two 15-item domains measuring beliefs about treatment with gay and lesbian clients and behaviors in clinical settings with these clients. Sample items include: "Practitioners should verbalize respect for lifestyle of gay/lesbian clients," and "I help clients identify their internalized homophobia." Items are rated on how strongly they agree or disagree with each statement. Higher scores on the GAP indicate more affirmative practice with gay and lesbian clients. Crisp (2006) reports high

internal consistency with Cronbach's alpha of .95. Factorial validity was obtained through CFA factor loadings greater than .60 for each item (Crisp, 2006). The GAP demonstrated high internal consistency, discriminant, convergent, and construct validity across various psychometric evaluations with social worker and psychologists (e.g., Alessi, Dillon, & Kim, 2015; Love, Smith, Lyall, Mullins, & Cohn, 2015). Limitations of the GAP include the lack of inclusion of all LGBTQ groups. Additionally, the GAP is no longer relevant with regard to terminology and counseling profession standards. Finally, the GAP does not include relevant items specific to LGBT counseling knowledge, advocacy, and training, as this scale was designed for and normed with social workers.

LGB-CSI. The Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (Dillon & Worthington, 2003) is a 32-item instrument designed to measure mental health practitioners' and trainees' levels of affirmative counseling behaviors across five domains. Those domains include applying of one's knowledge of LGB issues, performing advocacy skills, having self-awareness of one's and other's sexual identity development, developing a relationship with LGB clients, and assessing relevant underlying issues and problems of LGB clients (Dillion & Worthington, 2003). Sample items include: "Identify my own feelings about my own sexual orientation and how it may influence a client," and "Directly apply my knowledge of the coming out process with LGB clients." Items are rated on a 6-point Likert scale ranging from *not at all confident* (1) to *highly confident* (6), with total scores obtained by summing all items. High internal consistency estimates were obtained for subscales of the LGB-CSI: .93 (Advocacy Skills), .89 (Assessment), .86 (Awareness), .87 (Relationship), .96 (Knowledge), and .96 (Total) (Dillon & Worthington, 2003). The LGB-CSI has shown evidence for discriminate, convergent, and construct validity across psychometric evaluations (Alessi et

al., 2015; Dillon & Worthington, 2003; O'Shaughnessy & Spokane, 2013). Additionally, there has been strong reliability for the total scale across various studies (Alessi et al., 2015). The main limitation of the LGB-CSI is that it was constructed for and normed with counseling psychologist professionals and trainees. Usability with counseling students and professionals may be limited.

LGB-WACES. LGB Working Alliance Self-Efficacy Scale (Burkard et al., 2009) is a 32-item self-report measure of counselor self-efficacy to work with LGB clients. Items on the LGB-WACES make up three sub-scales: emotional bond (e.g., "I am able to feel compassion for the struggle that an LGB client might experience in the coming out process."), establishing tasks (e.g., "I can help LGB clients to establish social relationships in the gay community."), and setting goals (e.g., "I can work collaboratively with an LGB client to meet his/her specific counseling goals."). Items are rated on an 11-point scale, ranging from 0 to 10 (0= *cannot do at all*, 5= *moderately certain can* do, 10= *certainly can do*). Convergent validity was demonstrated through positive relationships with measures of general counseling efficacy and multicultural counseling competence (Burkard et al., 2009). Discriminant validity was established through inverse correlations with scales measuring negative attitudes toward LGB persons (Burkard et al., 2009). Test-retest reliability varied across subscales; coefficients were in the moderate to high range on the Bond ($r = .90$) and Task ($r = .79$) subscales, whereas in the low range for the Goals subscale ($r = .63$). The internal consistency coefficient of the original sample was .98 for the total scale (Burkard et al., 2009). This instrument was validated with two samples of counseling and counseling psychology students. Participants identified as mostly heterosexual, white females, limiting generalizability (Burkard et al., 2009).

SOCCS. The Sexual Orientation Counseling Competence Scale (Bidell, 2005) is a self-report 29-item scale measuring three main components of competence for working with LGB populations. The SOCCS is comprised of three subscales to represent the main components of competence, awareness, skills, and knowledge. The awareness subscale assesses attitudes about LGB individuals, the skills subscale measures the counselors' perceived ability to use appropriate skills and provide efficient counseling to LGB clients, and the knowledge subscale assesses general knowledge about social and counseling experiences of LGB individuals (Bidell, 2005). Sample questions include: "I have experience counseling lesbian and gay couples," and "The lifestyle of LGB clients is unnatural or immoral." Item responses range from *not at all true* (1) to *totally true* (7). Following reverse coding of seven items, item are summed for subscale and total scale scores (Bidell, 2005). The coefficient alpha for the overall SOCCS was .90, and the test-retest reliability correlation coefficient was .84 for the original sample. In various studies, psychometric evaluations were comparable across reliability and validity measures (e.g., Farmer et al., 2013; O'Shaughnessy & Spokane, 2013). The SOCCS is a stronger measure of LGB competence, as the counseling competencies were used as a foundation for this scale (Bidell, 2005). Additionally, the SOCCS was developed with counseling professionals.

The SOCCS (Bidell, 2005) fostered discussion surrounding the sexual orientation competence of counselors (Farmer, 2011; Graham, 2009; Logan & Barret, 2005; Matthews, 2005; Rainey & Trusty, 2007). The SOCCS is "the first valid and reliable scale… for measuring counselors' attitude, skill, and knowledge competencies when working with LGB clients" (Bidell, 2005, p. 268). The SOCCS was instrumental in the extension of sexual orientation as an important aspect of multicultural counselor competence. Bidell's (2005) article outlining the SOCCS has been cited, used, and critiqued numerous times since its publication (i.e., Bidell,

2012; Farmer, 2011; Graham, 2009; Logan & Barret, 2005; Matthews, 2005; Rainey & Trusty, 2007) to evaluate counselor competence. Despite focusing on LGB competence, gender identity was not included as a part of the SOCCS. Bidell believes transgender competence requires an entirely different set of competencies. A rationale beyond stating that sexual identity/orientation and gender identity are different phenomena requiring different competencies was not hypothesized (Bidell, 2005). This premise, however, is found in the transgender competencies and appears to be the consensus in literature on transgender counseling competence (ACA, 2009; Worthen, 2013). Finally, it is important to note that the SOCCS may not be the best indicator of school counselors' competence (Moe, Bacon, & Leggett, 2015). The SOCCS lacks items that address LGBT affirmative interventions specific to school counseling, such as consultation with teachers or parents (DePaul, Walsh, & Dam, 2009).

Measuring Transgender Competence

As explained previously, valid and reliable instruments exist to measure LGB competence. However, a validated instrument for assessing counselors' abilities to work with transgender clients does not exist. The SOCCS-Version 3 (Bidell, 2015), a new transgender competency scale in the validation phase, and the Genderism and Transphobia Scale (GTS-R; Tebbe, Moradi, & Ege, 2014), a scale for measuring a counselor's bias toward transgender and other gender variant individuals will be discussed here.

SOCCS-V3. The Sexual Orientation Counselor Competence Scale-Version 3 (SOCCS-V3; Bidell, 2015) is an adapted version of the original SOCCS (Bidell, 2005) aimed at measuring transgender clinical competence. The SOCCS-V3 is a 29-item scale, which in structure looks identical to the SOCCS. Essentially, SOCCS items have simply been modified to assess transgender/gender identity competence. For example, item number 2 on the SOCCS reads, "The

lifestyle of a LGB client is unnatural or immoral;" item number 2 on the SOCCS-V3 reads, "The lifestyle of a transgender individual is immoral." Similarly, item number 27 on the SOCCS reads, "Personally, I think homosexuality is a mental disorder or a sin and can be treated through counseling or spiritual help.;" and, item number 27 on the SOCCS-V3 reads, "I think being transgender is a mental disorder" (Bidell, 2005, 2015). The SOCCS-V3 lacks any psychometric data, as this instrument is in its initial stages of validation. Despite Bidell (2005) stating that transgender and sexual orientation competence are distinct constructs, requiring unique competencies, the SOCCS-V3 appears to disregard this notion of uniqueness.

GTS-R. The Genderism and Transphobia Scale- Revised (Tebbe et al., 2014) is a 22-item Likert-type scale designed to measure anti-trans attitudes. The GTS-R is a revised, more consistent version of the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005). The GTS-R contains two subscales; the first measuring genderism (i.e., cognitions supporting negative evaluations of trans persons) and transphobia (i.e., negative emotional and/or affective responses toward trans persons), and the second measuring gender bashing (i.e., overt acts of aggression toward trans persons). Sample items include: "Women who see themselves as men are abnormal," and "If I encountered a male who wore high-heeled shoes, stockings, and makeup, I would consider beating him up." Items on the GTS-R are rated on a scale from 1 to 7 (1= *strongly agree*, 7= *strongly disagree*). Reliability and validity measures from the original sample yielded acceptable Cronbach's alphas for subscale (.95 for genderism/transphobia, .86 for gender bashing) and total scale (.94) scores (Tebbe et al., 2014). The GTS-R showed strong convergent validity with other measures of prejudice, including anti-LGB attitudes (Tebbe et al., 2014).

In an effort to better understand counselors and their competence for working with transgender clients, using the GTS or GTS-R can highlight subtle or overt attitudes toward trans persons. The value of counselors' attitudes is highlighted in multicultural counseling competency (Arredondo et al., 1996). Multicultural counseling experts emphasize that even subtle and unconscious expressions of prejudice against clients can prevent development of an effective therapeutic relationship (Alessi et al., 2015; Sue & Capodilupo, 2008). Having affirmative attitudes toward LGBT individuals is necessary for counselors to engage in affirmative practice with clients. Counseling professionals who bring biased attitudes into their relationships with clients risk impacting wellbeing of clients and overall effectiveness of counseling (Alessi et al., 2015).

Hill (2002) noted that misunderstanding and negative attitudes toward transgender and other gender-variant individuals was directly related to transphobia, genderism, and gender-bashing. Further, counselors who act as a competent ally to LGBT individuals maintain an affirmative attitude and demonstrate behaviors outside their role as a competent counselor. A counselor lacking awareness or holding negative biases toward transgender persons may be lacking competence, and therefore, lacking an ally identity.

Strengths and Limitations of Assessments of Competence

Several strengths and limitations are shared across instruments that have been developed for measuring counselor competence. First, although the most widely used measures of competence (e.g., MCKAS, MCI, and SOCCS) have foundations in cultural competencies (i.e., Sue et al., 1982), no scale accounts for recent changes in multicultural competencies (i.e., MSJCCs). That is, none of these scales of competence assess actions and social justice advocacy of counselors. Secondly, very few empirical studies have utilized competency scales for

measuring counseling outcomes and effectiveness. Therefore, limited information exists on whether competence and client outcomes are linked, especially related to working with LGBT populations. Third, each of these assessments of competence has the potential to raise awareness about one's growth areas with regard to cultural competence; however, due to the self-report nature of each of these instruments, socially desirable responses can impact validity of scores and distort actual competency levels. Fourth, a majority of these instruments have been created for and with psychology and social work students, which can be seen as a limitation; however, numerous studies have shown consistency in validity and reliability measures across mental health professions. Finally, across measures of competence, limited attention as given to LGBT competency. Specifically, no validated scale exists to assess counselors' competence to work with transgender clients.

Counseling LGBT Individuals

Research suggests that LGBT individuals seek counseling services at a higher rate than those identifying as heterosexual (Bieschke, McClanahan, Tozar, Grzegorek, & Park, 2000; Bradford, Ryan, & Rothblum, 1994), yet LGBT clients often report dissatisfaction with counseling experiences (Grove, 2009). Nystrom (1997) reported that 46% of LGBT individuals had experienced a homophobic counselor, and 34% experienced refusal, from a counselor, to acknowledge sexual orientation or viewed one's sexual or gender identity as a temporary issue. Further, research indicates that counselors report a sense of ignorance and insensitivity to transgender issues (Shipherd, Green, & Abramovitz, 2010).

Historically, counseling approaches have been pathologizing to individuals who do not conform to societal expectations surrounding sexual orientation and gender identity (Carroll & Gilroy, 2002). The removal of homosexuality from the *Diagnostic and Statistical Manual of*

Mental Disorders (*DSM*) in 1973 did not end all speculation that same-sex attraction merited a mental health diagnosis (Daley & Mulé, 2014; Toscano & Maynard, 2014). In 1980, the *DSM* included gender identity disorder of childhood (GIDC), which was possibly an effort to continue pathologizing non-conforming gender role and sexual orientation identification (Toscano & Maynard, 2014).

Further, in 1994, GIDC was replaced with gender identity disorder (GID). According to Toscano and Maynard (2014), significant distress, depression, anxiety, and adjustment reactions can result when individuals are diagnoses with GID. In 2013, the most current edition of the *DSM* was published; gender dysphoria (GD) replaced GID, maintaining similar language and criteria for diagnosis. The *DSM* still posits that individuals who are gender-variant require a diagnosis for gender transition surgeries, further extending the tradition of the medical and pathologizing view of LGBT individuals (Benson, 2013; Lev, 2005; Toscano & Maynard, 2014). Various consequences can arise for individuals who are diagnosed with GD. Clinicians who are unfamiliar with gender identity issues may use GD as a diagnostic tool to highlight client deficits. Reversely, a GD diagnosis can also facilitate healthcare support and provide access to other resources for individuals considering the transition process (LaMantia et al., 2015).

LGBT clients often reframe or minimize the impact of their sexual orientation and/or gender identity/expression, for fear of further stigmatization (Chaney & Marszalek, 2014). Many LGBT individuals screen counselors in an attempt to determine if they are LGBT friendly and have experience working with LGBT clients (Benson, 2013; Liddle, 1997). Additionally, transgender individuals have been taught to regard counselors as an access to medical treatment (e.g., gender transition surgeries), increasing distrust for addressing personal concerns (Benson,

2013). That being said, it is important for counselors to consider that a client's primary reason for seeking counseling may not be related to their sexual or gender identity (ACA, 2009).

Although counselors report an awareness of personal biases, they lack the knowledge and skills to work with LGBT clients (Graham et al., 2012). This is especially true for counselors who have not provided services to LGBT clients and have not had previous training specific to working with LGBT clients (Graham et al., 2012). Graduate training programs fail to prepare counselors to adequately work with LGBT clients (Carol & Gilroy, 2002; Matthews, 2005; O'Hara et al., 2013). Counselors report that curricula did not address counseling related issues or basic terminology related to LGBT populations (Brubaker et al., 2011; Frank & Cannon, 2010). Counselors report having little training related to LGB populations during their counseling courses, and no training related to gender identity (Benson, 2013). On average, discussions surrounded LGBT populations occur in only one or two courses (Bidell, 2012; Jennings, 2014; Matthews, 2005), and LGBT specific training opportunities are limited for counseling students.

Limited research has looked at the LGBT competence of school counselors and clinical mental health counselors (Farmer et al., 2013). School counseling students have reported low levels of multicultural competence, specifically related to LGBT populations (Bidell, 2012). Overall, researchers indicate school counselors are not prepared to work with LGBT youth. One study hypothesized this was due to an inability to create the environments LGBT youth need to feel safe enough to approach school counselors with sexual and gender identity concerns (Lloyd-Hazlett & Foster, 2013).

Counselors struggle to develop competence for work with LGBT clients. That being said, when counselors are more knowledgeable about diversity and aware of LGBT communities, they exhibit higher levels of cultural competence and are more effective clinicians (Benson, 2013;

Bidell, 2012; DePaul et al., 2009; Dillion, Worthington, Soth-Mcnett, & Schwartz, 2008;

Graham et al., 2012). Possessing the knowledge, skills, and awareness about LGBT issues is

necessary for successful counseling to occur with clients identifying as LGBT. Counselors who

posses competence to work with LGBT clients are able to minimize barriers to treatment for

LGBT clients. There are several predictors of increased LGB competence and self-efficacy; self-

identification with the LGBT population (Dillon et al., 2008; Matthews et al., 2005), professional

experience (e.g., years of experience as a counselor, experience working with LGBT clients;

Dillon et al., 2008; Graham et al., 2012; Matthews et al., 2005), obtaining a doctoral graduate

education (Bidell, 2005), and attendance at LGBT-specific trainings (Graham et al., 2012) are

some of the most common factors identified as being associated with LGBTQ competence.

Transgender Issues in Counseling

Society, counselors included, continues to maintain rigid definitions of gender identity

(Henricks & Testa, 2012). Identifying as transgender is considered a deviation from the

established societal gender norms (i.e., male or female) (dickey & Loewy, 2010). Additionally,

transgender individuals experience more extreme discrimination and mental health related

concerns compared to those identifying as LGB. Although LGBT related advancements have

been made in the multicultural counseling movement, counseling literature remains limited for

transgender specific issues. The empirical research that has been done shows limited competence

and a lack of preparedness to work with transgender clients (O'Hara et al., 2013). This highlights

the gap between counselor competence and the lived experiences of transgender individuals.

Historically, transgender individuals have been lumped together with the LGBQIQ

communities (Sangganjanavanich, 2014); however, transgender issues are often excluded from

literature identified as LGBT, or research lacks substantial data on transgender participants. The

quality and usability of existing empirical data related to transgender experiences should be considered as inconclusive. Counselors are taught to aspire to be competent, yet counselors identified as competent continue to foster the cyclical process of pathologizing transgender clients who internalize transphobic responses from society (dickey & Loewy, 2010).

Research highlights the importance of counselor preparation programs encouraging direct exposure and involvement with LGBT populations to enhance competence and perceived self-efficacy to work with LGBT clients (Barden & Greene, 2015). No evidence exists showing a direct causal relationship between competence and effective counseling; however, research focused on counselor competence is problematic due to the use of self-report measures. These measures cannot accurately reflect the competence that counselors actually possess when working in various multicultural situations, nor can they measure the advocacy efforts that have been considered for LGBT populations. It is suggested that counselors who are competent and advocate on behalf of marginalized populations should be considered effective.

Ally Identity of Counselors

The standard expectation for counselors is to act competently and ethically. Acting as a competent counselor means having the awareness, knowledge, and skills to work with various cultural groups. However, counselor competence, as outlined in the MSJCCs, goes beyond performing a set of tasks (Ratts et al., 2016). Competence involves more subtle elements including conceptualizing personally held attitudes, beliefs, values, and biases about various cultural groups, understanding social contexts, and the willingness to be an ally to a vulnerable population. In essence, the MSJCCs have advanced the level of competence that is expected of all counselors.

In 1991, Washington and Evans proposed an LBG ally development model for heterosexual individuals. This model focused on how heterosexuals can recognize their privilege and power, and become allies toward lesbians, gays, and bisexuals. Four developmental levels were outlined in this model: awareness, knowledge/education, skills, and action (Washington & Evans, 1991). The first level, awareness, involves the recognition that heterosexuals must come to understand who they are and how they differ from LGB individuals. Knowledge/education, the second level, includes acquiring knowledge able sexual orientation and what societal experiences are for these populations. The third level of development is skills. During this level, individuals learn to communicate knowledge learned about LGB individuals. Finally, the fourth level is action. At this level, all awareness, knowledge, and skills are put into action to end oppression of LGB populations (Washington & Evans, 1991). Although developmental levels of this LGB ally identity model reflect the developmental levels of advanced competence, as outlined in the MSJCCs, the current study conceptualizes ally identity as something beyond advanced competence.

Beyond the notion of advanced competence is ally identity. *Ally* is a term consistent with current LGBTQIQA literature. Ally is defined 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 as an advocate with and for, the oppressed population" (Washington & Evans, 1991, p. 195). The LGBT ally identity development process can occur once a counselor is competent (i.e., the counselor has as a solid understanding of their own awareness, clients worldview, and the counseling relationship; the counselor is also able to conceptualize knowledge, awareness, and skills into actions) and has an increased level of action/advocacy beyond what is outlined in the MSJCCs (LaMantia et al., 2015; Ratts et al., 2016). In addition to

the actions expected by competent counselors, an ally will demonstrate behaviors and attitudes beyond their role as a counselor (ALGBTIC, 2013). Some things an ally might do include the following: correct misinformation and stereotypes, challenge transphobic remarks, use inclusive language in everyday interactions, create a visible identity as an ally, facilitate fairness and equity through removal of societal barriers, actively participate in continuing education about transgender specific issues, and constantly engage in self-reflection (ALGBTIC, 2013; LaMantia et al., 2015).

Similar to social justice and advocacy efforts for racial and ethnic minorities (e.g., Sue et al., 1992), transgender social justice and advocacy development begins with competence (ALGBTIC, 2013). Advanced levels of competence are shown to be linked to increased personal and professional identity of counselors (Prosek & Hurt, 2014). Further, personal beliefs and values are thought to be an important aspect of one's counselor identity (Prosek & Hurt, 2014), with advanced competence maintaining congruence between personal and professional identities (Gibson, Dollarhide, & Moss, 2010). Therefore, one may conclude that identity as an ally, which is a developmental status beyond advanced competence, can further redefine one's role as a counselor and facilitate personal and professional identity by creating a sense of purpose as a distinguished part of the counseling community. It is through training, supervision, and foundational experiences that counselors are able to develop both a personal and professional identity (Prosek & Hurt, 2014). Without a strong foundation of competence (knowledge, skills, awareness, actions), counselors may not be able to conceptualize their role as allies to the transgender community. However, a competent counselor with a strong ally identity will be able to advocate for and on behalf of the transgender community as a result of a conceptualized identity as a counselor.

Allies are consciously integrating their conceptualized attitude and beliefs, knowledge, and skills into their everyday practice as counselors. Ally identified counselors exhibit attitudes and behaviors that go beyond the scope of practice of a counselor acting within the first three developmental domains of competence (i.e., counselor self-awareness, client worldview, counseling relationship; Ratts et al., 2016). Allies focus on strengths and reliance of clients, have a social justice and human rights agenda, and are third-party change agents (LaMantia et al., 2015). Active allies create an open and supportive environment to discuss, educate, and celebrate differences (ALGBTIC, 2013). Counselors incorporating the MSJCC framework, LGBQIQA competencies, and transgender competencies into their practice, should have a strong sense of professional identity as a counselor, since they are acting at the most advanced level of competence.

Barriers to an Ally Identity

Despite advocacy being a central aspect of counseling, not all counselors have adopted the action phase of the multicultural counseling competencies (Fickling & González, 2016). Due to the fact that achieving this advanced level of competence (i.e., having the knowledge, awareness, and skills to use advocacy interventions) is a precursor to ally identity, it can therefore be inferred that not all counselors are acting as allies. Overall, the literature that has been reviewed surrounding multicultural competence and LGBT competence points to the lack of a clear understanding of the true state of competence for counselors working with transgender individuals. Further it is unclear what counselors are doing to advocate for and on behalf of transgender individuals.

Just as some counselors have not been able to incorporate the action phase into their standards of practice, there are also several reasons counselors have not embedded an ally

identity into their personal and professional identity. Some counselors may not know how or may not desire to work beyond the scope of competence to remove societal barriers that exist for marginalized populations. Additionally, those who do not support LGBT rights may challenge individuals who identify as allies to the transgender community (Moe et al., 2014). This may cause allies to question whether they should allow their ally identity to be visible, making integration of this aspect of their professional identity difficult. Further, becoming an ally involves a commitment beyond what is already outlined by the profession. In order for counselors to move toward transgender ally identity, they must change their attitudes, behaviors, and have a true understanding of how privilege and oppression has impacted their lives (Perrin, Bhattacharyya, Snipes, Calton, & Heesacker, 2014). These examples highlight some of the reasons why it is possible that few counseling professionals have adopted an ally identity and why the current study relevant and timely.

CHAPTER 3

METHODOLOGY

This chapter focuses on methodology that was employed for this study. It contains information on the research design, item development, and data collection procedures and instruments. This chapter also includes initial validation procedures for the Transgender Ally Identity Scale for Counselors (TAISC).

Although there are instruments available to assess sexual orientation competence and transgender competence (e.g., SOCCS; Bidell, 2005; SOCCS-V3; Bidell, 2015), these instruments do not measure the construct of transgender ally identity. The establishment of a counselors' identification as an ally for transgender individuals is imperative considering the vulnerability of the transgender population. The purpose of this study is the initial development and validation of the Transgender Ally Identity Scale for Counselors (TAISC). The TAISC is a scale designed to assess counselors' transgender ally identity.

A non-experimental survey design was used to inform the development of the TAISC. Non-experimental surveys are convenient to distribute electronically and have the potential to reach numerous potential participants (Creswell, 2014). Additionally, this survey design allows for exploratory research of a topic that has been sparsely investigated in the counseling field. However, the design of this study is purely descriptive; no direct cause and effect relationships can be inferred based on the results. Further, it is possible that a low participation will occur with survey methods; and, participant demographics may impact how people respond. Finally, it is important to consider the fact that participants may lie, misread items, or answer in socially desirable ways (Creswell, 2014).

The survey design used for this study included two stages. Stage one involved the development and testing of the scale. After initial generation of scale items, an expert review was conducted to finalize items and establish content validity. Stage two involved the use of quantitative methodology to pilot and initially validate the scale. For this study, exploratory factor analysis, reliability, and validity analyses were performed.

Research Questions and Hypotheses

Research Question 1: What is the factor structure of the TAISC?

(H1) The factor structure of the TAISC will be adequate for exploratory (i.e.,
principal axis factoring and an oblique rotation) procedures.

Research Question 2: What is the internal consistency of the TAISC for a sample of counseling students, professionals, and educators?

(H2) The internal consistency estimate, as measured by Cronbach's alpha, of the TAISC
will be strong for a sample of counseling students, professionals, and educators for the
total scale.

Research Question 3: What is the relationship between the TAISC and the MCKAS?

(H3) There will be positive, significant relationships among the TAISC and MCKAS
total scales and subscales, providing evidence of convergent validity.

Research Question 4: What is the relationship between the TAISC and the GTS-R-SF?

(H4) There will be negative, significant relationships among the TAISC and GTS-R-SF
total scales and subscales, providing evidence of discriminant validity.

Research Question 5: What relationships, if any, exist between TAISC total scores and select demographic variables (i.e., age, gender, ethnocultural identification, sexual/affectional

orientation, education level, religious affiliation and hours spent practicing religion, and the

identification of a close friend/family member with the LGBTQ community)?

> (H5) Participants' sexual orientation, religious affiliation, and education level will be
>
> possible predictors of one's TAISC total scores, therefore establishing criterion related
>
> validity.

Stage One: Scale Development

Item Development

The Transgender Ally Identity Scale for Counselors (TAISC) aims to measure

counselors' self-perceived transgender competence as it relates to their identity as an ally. This

scale includes items related to awareness (attitudes/beliefs), knowledge, skills, and action for

working with transgender clients in the context of counseling. Items are written in a framework

that reflects the revised multicultural and social justice competencies (Ratts et al., 2016).

The development of initial instrument items was based on three competencies and two

scales relevant to multicultural counseling competence. First, Ratts et al.'s (2016)

conceptualization of multicultural counselor and social justice competence (e.g., knowledge,

awareness/attitudes/beliefs, skills, action) was instrumental in creating items for the TAISC.

Given that awareness, knowledge, skills, and actions are embedded within the first three

developmental domains (i.e., counselor self-awareness, client worldview, and counselor-client

relationship) of the MSJCCs, each domain was represented in scale development. Second, the

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC)

transgender competencies endorsed by the American Counseling Association (ACA, 2009) were

used to highlight important transgender specific guidelines endorsed by the counseling

profession. Third, the ally development section of the LGBQIQA competencies (ALGBTIC,

2013) was used to help inform the ally identity aspect of the items. Additionally, the MCKAS (Ponterotto et al., 2002) and SOCCS (Bidell, 2005), previously validated instruments on multicultural and sexual orientation counseling competence, respectively, informed the item development. Items on the TAISC were aimed at measuring counseling competence from an action/advocacy framework; in other words, items aimed to measure a counselor's development as an ally for transgender individuals.

Based on a thorough review of the above-mentioned documents and scales, an initial pool of 44 items was generated by the researcher to assess knowledge, awareness (attitudes/beliefs), counseling skills, and action as they relate to a counselor's ally identity when working with transgender clients. Eleven items per subscale (knowledge, awareness, skills, action) were identified. Items identified as part of the skill subscale were focused on a counselor's ability to do specific tasks associated with the transgender population. "I routinely assess for my client's gender identity without making assumptions," is a sample item from this subscale. The knowledge subscale included items related to the information and understanding a counselor has about the transgender population. A knowledge item from the scale includes, "I would not be able to identify transgender-positive resources in my community." The awareness subscale included items focused on attitudes, beliefs, and awareness related to a counselor's transgender ally identity. "It is important to my identity as a counselor that I attend transgender cultural events," is a sample item from this subscale. Initial scale items and the sources that informed each item can be found in Appendix A.

Expert Review

An expert review was conducted to ensure that the TAISC items aligned with the purpose of the scale and provide evidence of content validity. Potential expert reviewers were selected

based on evidence of research and publications in the areas of LGBT and transgender-specific issues in counseling. Expert reviewers were published in several peer-reviewed journals and many were instrumental in writing LGBTQIQA competencies. The researcher was intentional about selecting potential reviewers who would be knowledgeable about transgender issues and were counselor educators and/or counseling professionals.

Eleven experts were invited, via email, to participate in the review process. Invitations included a brief description of the study, information pertaining to serving as an expert reviewer, and the initial scale items. Four experts agreed to participate. Demographic information was not obtained from expert reviewers. Participants were given three weeks to provide feedback on each scale item (i.e., relevance to construct; appropriateness for intended audience; grammar and syntax; additional comments) and item relevance to suggested subscales. Additionally, reviewers were asked to offer suggestions for item addition and reduction (See Appendix B for instructions given to expert reviewers).

Following the analysis of all feedback provided from expert reviewers, adjustments were made to several items at the researchers discretion. Major changes included the removal of four items, enhancing clarity and wording of multiple items, and moving few items to different subscales. After making all changes, 40 scale items remained for the pilot and initial validation of the TAISC (See Appendix C).

Stage Two: Piloting and Initial Validation

There were several methods used to assess the reliability and validity of the TAISC. First, an exploratory factor analysis (EFA) was conducted to determine the internal factor structure of the TAISC as well as establish construct validity. Second, Cronbach's alpha coefficients were calculated for the total scale and any respective subscales to determine the internal consistency of

the TAISC thereby establishing reliability. Third, the relationships between the TAISC and MCKAS (Ponterotto et al., 2002), the TAISC and GTS-R-SF (Tebbe, Moradi, & Ege, 2014) were explored. Finally, the relationship between the TAISC and MCSDS-C (Reynolds, 1982) were explored. The Darden College of Education Human Subjects Review Committee at Old Dominion University approved the study.

Participants

The target population for this study was counseling graduate students (both master's and doctoral levels), counselor educators, and counseling professionals (both licensed and non-licensed) across specialties (i.e., addictions, career, clinical mental health, family, school, student affairs, and college counseling). In order to use factor analysis a sufficient sample size was required (Beavers et al., 2013). Consensus appears to be to recruit as many participants as possible, specific recommendations include recruiting a sample of at least 5 times the number of items (for this study, approximately 200; Hatcher, 1994) and between 300 and 400 participants total (Dimitrov, 2012; Field, 2009). Sample size can be conditional upon the strength of the factors and the items (Beavers et al., 2013; Tabachnick & Fidell, 2007). While attempts were made to maximize participation, a sample size of 250 was considered to be the minimum necessary for validation analyses.

Procedure

Using convenience sampling, attempts were made to recruit a nationwide sample of counseling students, professionals, and educators. Several phases of participant recruitment took place. In each request for participation, participants were encouraged to forward the request to colleagues/peers who may be eligible and interested in participating.

First, 200 contact persons (i.e., one program director per counseling program) for CACREP-accredited programs across the United States were sent email requests for participation and asked to forward the request to faculty and students of their counseling programs. The contact information for these programs was obtained from the online CACREP directory; all counseling masters and doctoral programs that listed a contact person with a valid email address were included. Two requests were sent to these contact persons, these requests were sent one week apart.

Second, requests for participation were posted on the following counseling related list-servs: CESNET, COUNSGRADS, and ALGBTIC. These listservs were included for their potential to reach the intended sample of counselors. CESNET is a professional listserv of more than 1300 counselors, counselor educators, and supervisors. It was expected that this listserv would provide the most counselors educators and supervisors. COUNSGRADS is a listserv of approximately 1250 graduate counseling students. Although daily posting and responsiveness is lower than that of CESNET, the researcher chose to include this listserv in hopes of reaching potential counseling students who may not subscribe to CESNET. Further, the ALGBTIC listserv (information about number of subscribers is not provided) was chosen to target those participants who have an interest in LGBT issues in counseling.

The first CESNET post was sent the same day as the first email to CACREP program directors. One week after the initial post, the request for participation was posted again. A final call for participants, via CESNET, was made a week after this second post. Only one post was made to COUNSGRADS and ALGBTIC listservs. These posts occurred on the same day the second calls were sent to CACREP programs and CESNET. It was expected that the potential number of participants would be lower, based on the number of members and daily posts.

Finally, a request for participation was posted to the American School Counseling Association's (ASCA) Scene page to increase the number of participants who identified as school counselors. Due to the researcher not being a member of ASCA, a colleague made a post on behalf of the researcher. A second call was not made to ASCA Scene, due to the fact that the initial post was not made until after the final request was made on CESNET. Participant numbers had drastically declined (initial posts resulted in 291 participants, while the final posts resulted in only 42 participants) and the researcher decided to close the survey. In each request, participants were encouraged to forward the request to colleagues/peers who may be eligible and interested in participating.

Each request included a brief description of the study, anticipated completion time, and a direct link to the electronic Qualtrics survey. Clicking the link sent participants to the informed consent document (see Appendix D); if participants agreed to the terms, they were able to begin the remainder of the survey. For those who agreed to participate, they were required to complete the TAISC, MCKAS, GTS-R-SF, MCSDS-C, and demographic information. Each participant completed the same survey packet, and all surveys were presented in the same order.

An incentive was offered to participants upon completion of the survey, to improve response rates. The researcher decided that a motivating incentive involved voting for a charity to receive a donation. Therefore, when participants completed all scale items and demographic questions, they were asked a final question regarding the donation. As a token of appreciation, participants were asked to select a charitable organization to which they would like a $100.00 donation made. Participants were provided with four options of charities, and a brief description of each organization. The options were as follows: (a) The Human Rights Campaign: Largest national lesbian, gay, bisexual and transgender civil rights organization; (b) National Center for

Transgender Equality: The nation's leading social justice advocacy organization winning life-saving change for transgender people; (c) The Trevor Project, Inc.: Leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24; and, (d) It Gets Better Project: A worldwide movement communicating to lesbian, gay, bisexual and transgender youth that it gets better, and creating and inspiring the changes needed to make it better for LGBT youth. Participants were informed that the charitable organization who received the highest number of votes would receive a $100.00 donation, made by the researcher, in gratitude for the participants' time completing the survey. As this was the final question in the survey, respondent identities remained anonymous to the researcher.

Data Collection Instruments

The following instruments were used for this study: a researcher designed demographic questionnaire, the Transgender Ally Identity Scale for Counselors (TAISC), the Genderism and Transphobia Scale – Revised – Short Form (GTS-R-SF; Tebbe, Moradi, & Ege, 2014), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), the Marlowe-Crowne Social Desirability Scale – Short Form (MCSDS-C; Reynolds, 1982).

TAISC. The TAISC is a 40-item scale assessing counselors' level of identity as an ally to the transgender community. Items are rated on a 5-point Likert scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*), with higher scores indicating a stronger sense of ally identity (see Appendix E). There are 10 items to measure awareness and beliefs about transgender issues, 10 items to measure knowledge about transgender issues, 10 items to measure skills related to working with transgender populations, and 10 items to measure one's actions/advocacy related to

transgender issues. Reverse coding is required for eight TAISC items. Items were reordered before distribution to avoid any response bias.

Multicultural Counseling Knowledge and Awareness Scale (MCKAS). The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; see Appendix F) is a 32-item self-report scale developed to measure counselor's perceived level of multicultural counseling competence in relation to multicultural knowledge (20 items) and multicultural awareness (12 items; Ponterotto et al., 2002). Questions are answered on a Likert scale ranging from 1 (*not at all true*) to 7 (*totally true*). Higher scores on the MCKAS indicate higher awareness and competence (Ponterotto et al., 2002). Coefficient alphas for the MCKAS, based on original samples, were reported to range from .78 to .93 for the knowledge subscale and from .67 to .83 for the awareness subscale; total scale alphas were not provided (Ponterotto et al., 2002). The 10-month test-retest reliability for the knowledge subscale was .70 and .73 for the awareness subscale (Ponterotto et al., 2002). Convergent validity was established through significant relationships between the MCKAS and similar measures of multicultural counseling competence. Criterion related validity was established through the comparison of scores on the MCKAS with education level and ethnicity (Ponterotto et al., 2002). The MCKAS is the only multicultural competence measure that has gone through revisions to account for factor structures; therefore, it is the cleanest measure available (Lawley, 2007).

Genderism and Transphobia Scale – Revised – Short Form (GTS-R-SF). The Genderism and Transphobia Scale – Revised – Short Form (GTS-R-SF; Tebbe et al., 2014; see Appendix G) is the most recently revised version of the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005). The GTS-R-SF is a self-report scale developed to measure negative attitudes and behaviors toward transgender and other gender-variant individuals. The GTS-R-SF

is a shortened version of the GTS; this version eliminated overlapping questions on previous version of the GTS. The GTS-R-SF consists of 13 items; that is 8 genderism/transphobia questions and 5 gender-bashing questions. Questions are answered on a Likert scale ranging from 1 (*strongly agree*) to 7 (*strongly disagree*). Overall scores and subscale scores can be calculated. Higher scores on the GTS-R-SF indicate a greater sense of negative attitudes and behaviors toward transgender and other gender-variant individuals. The GTS is usable across disciplines and is the first valid instrument developed to measure anti-trans attitudes and behaviors (Hill & Willoughby, 2005). The genderism and transphobia subscale (α=.95), gender bashing subscale (α =.86), and the overall scale (α =.94) have strong internal consistency (Tebbe et al., 2014). Further, correlations indicate significant positive relationships with anti-LGB attitudes establishing convergent validity (Tebbe et al., 2014).

Marlowe–Crowne Social Desirability Scale (Short- Form C). The Marlowe-Crowne Social Desirability Scale- Short Form C (MCSDS-C; Reynolds, 1982) is a 13-item self-report tool used to measure participants' tendency to answer in socially favorable ways (see Appendix H). The short form-C consists of 13 true/false items and has an alpha of .76 (Reynolds, 1982). The MCSDS-C is derived from the original 33-item Marlowe–Crowne Social Desirability Scale (Crowne & Marlowe, 1960). The MCSDS-C is significantly correlated with a large effect size with the original 33-item version. Reynolds (1982) observed correlation coefficients between the MCSDS-C and the original version of the Marlowe-Crowne and found that $r = .93$ when the short form-C was compared to the original MCSDS. Five items on the MCSDS-C are reverse coded. Scores are summed for a total score, with higher scores reflecting higher levels of socially desirable responding.

Demographic questionnaire. The demographic questionnaire (see Appendix I) was developed by the researcher to include variables identified in the literature to impact counselor competence as well as demographic information that will be used to describe the sample. Demographic questions included age, gender (male, female, transgender, other- write in), sexual orientation (heterosexual, gay/lesbian, bisexual, queer, other-write in), and ethnocultural identity (African American, American Indian/Alaskan Native, Asian, Hispanic/Latin(o/a), Multiple Heritage, Native Hawaiian/Pacific Islander, White, Other- write in). Additionally, background information supported by the literature discussed in Chapter two were included: primary role(s) in the counseling field (i.e., addictions counselor, community mental health counselor, college counselor, school counselor, counselor educator, counseling student, or other-write in), whether the participant had a close friend of family member who self-identified as LGBTQ (yes or no), highest level of education (i.e., current masters student, completed masters, current doctoral student, completed doctorate degree), religious/spiritual affiliation (open ended), and average number of hours spent weekly practicing their religion (open-ended). There were 9 items on the demographic form.

Exploratory Factor Analysis (EFA)

An exploratory factor analysis (EFA) was utilized to explore the factor structure of the TAISC. Although TAISC items were established from the multicultural counseling and social justice competencies (Ratts et al., 2015), the factor structure is difficult to predict. An EFA is appropriate for determining initial factor models of new instruments when factor structure is unknown (Dimitrov, 2012; Thompson, 2004). The Kaiser-Meyer-Olkin measure of sample adequacy (.60 or higher) and Barlett's test of sphericity (.05 or less) were used to determine if the data were appropriate for factor analysis (Dimitrov, 2012; Field, 2009).

In order to identify the best factor model, principal axis factoring was the extraction method utilized in this study. Principal axis factoring analyzes the common variance accounted for by items that explain a particular construct (Dimitrov, 2012; Thompson, 2004). The use of a promax rotation was chosen based on the reasonable assumption that factors would be correlated given the theoretical foundation of the items (Thompson, 2004).

The retention of factors was determined using the examination of the eigenvalues, scree plot, and variance accounted for by various factors, and factor loadings. Factors with eigenvalues greater than 1.0 were considered to be potential factors, as these values represent the amount of variance explained by a construct (Dimitrov, 2012; Field, 2009; Thompson, 2004). Discretion was used when considering which factors to retain as many authors (e.g., DeVellis, 2012; Field, 2009; Thompson, 2004) note that important factors may fall slightly below the 1.0 criterion. The scree plot was examined to determine the number of factors that were represented beyond the point of inflection (Dimitrov, 2012; Field, 2009; Thompson, 2004). Finally, the variance accounted for by various factor models was examined to determine which factor model accounts for the most variance while also representing optimal factor loadings (Field, 2009; Thompson, 2004). Although various values have been suggested for the cut-off of factor loadings, .30 is considered to be the minimum factor loading required for an item to be retained (Field, 2009). For this study, therefore, items were retained based on the .30 factor loading criterion. Finally, the retained items were examined for redundancy and content consistency; factor loadings were compared on redundant items to determine which factor to retain.

Internal Consistency

Cronbach's alpha coefficients were calculated for the total TAISC scale to establish internal consistency and reliability. Cronbach's alpha is a common measure for determining

reliability of a scale (DeVellis, 2012; Thompson, 2004). Higher values of Cronbach's alphas constitute higher levels of internal consistency. Although acceptable criterion values differ in the literature, a value of .80 or higher was considered acceptable for this study (DeVellis, 2012; Field, 2009).

Construct Validity

Convergent validity for the TAISC was established using correlation analyses to examine the relationship between the TAISC total scale and the MCKAS total scale (Ponterotto et al., 2002). Convergent validity is established when scales measuring related constructs are significantly, positively correlated (DeVellis, 2012). The MCKAS and TAISC were determined to measure similar constructs, multicultural competence. Therefore, the MCKAS was considered to be an appropriate scale for determining convergent validity, and positive, significant relationships were anticipated between the scores on both scales.

Discriminant validity for the TAISC was also established using correlation analyses to examine the relationship between the TAISC total scale, the GTS-R-SF total scale (Tebbe et al., 2014). The GTS-R-SF and TAISC were determined to measure different constructs, anti-trans attitudes and level of transgender ally identity. Therefore, the GTS-R-SF was considered to be an appropriate scale for determining discriminant validity, and negative, significant relationships were anticipated between the scores on both scales.

Social Desirability

Social desirability occurs when participants choose answers that they consider to be socially acceptable instead of answering with what would be their true response (Crowne & Marlowe, 1960). Multicultural counseling competence is viewed as a highly desirable and expected characteristic; therefore, it is possible that participants may have overestimated their

transgender ally identity (Tracey, 2016). To investigate the presence of social desirability bias, bivariate correlations were conducted using the MCSDS-C total scores and the TAISC-Revised total scores. Additionally, a regression analysis were conducted. These analyses explored whether social desirability was a significant predictor of TAISC total scores.

Criterion Validity

To analyze results for the final research question, demographic variables were utilized to determine the relationships, if any, between various factors and one's level of ally identity as a counselor. Previous research indicates LGBT identification, professional experience (e.g., years of experience as a counselor, experience working with LGBT clients), education level, attendance at LGBT specific trainings, and religious affiliation are all predictors of one's level of multicultural and LGB competence (Bidell, 2005; Dillon el al., 2008; Graham et al., 2012; Matthews et al., 2005). A forced entry multiple regression was run on demographic variables to estimate factors that are possible predictors of one's transgender ally identity (as indicated by TAISC total score).

CHAPTER FOUR
RESULTS

The purpose of this study was to develop and initially validate the TAISC, a scale created

to measure counselors' transgender ally identity. Initial validation analyses were performed using

exploratory factor analysis procedures (i.e., principal axis factoring extraction with oblique

rotation) to determine the underlying factor structure of the TAISC. Additionally, internal

consistency coefficients were calculated for the TAISC total scale to determine reliability. Then,

the relationship between scores on the TAISC and the MCKAS (Ponterotto et al., 2002), the

TAISC and the GTS-R-SF (Tebbe et al., 2014) were explored to establish convergent and

discriminant validity, respectively. Finally, MCSDS-C (Reynolds, 1982) was used to account for

socially desirable responding. The results of these analyses will be discussed in this chapter as

well as participant demographics.

Participant Demographics

The 285 participants represented a national sample of counseling students, counseling

professionals, and counselor educators. Of the participants, 80.4% identified as female (n=229),

16.1% identified as male (n=46), 2.5% identified as transgender (n=7), and 1.1% identified by a

different term (e.g., genderqueer, cisgender woman) or they preferred not to be labeled (n=3).

The median age of the participants was 31 with ages ranging from 22 to 77 years *(M*=35.3,

SD=11.9). Regarding ethnocultural identity, 76.5% of participants identified as White (n=218),

9.8% reported multiple heritage (n=28), 6.3% identified as African American (n=18), 2.8%

identified as Hispanic/Latin(o/a) (n=8), 1.8% identified as Asian (n=5), 1.8% identified as Other

(n=5) (write-in answers included "Middle Eastern," "West Indian," and "Prefer not to label"),

0.7% identified as American Indian/Alaskan Native (n=2), and 0.4% identified as Native

Hawaiian/Pacific Islander (n=1). When asked to define their sexual/affection orientation, 70.5%

of participants identified as heterosexual (n=201), 9.4% identified as bisexual (n=31), 9.1% identified as gay/lesbian (n=26), 4.9% identified as other (n=14) with participants writing in different terms (e.g., "fluid," "asexual," "pansexual," and "as mine.") or the preference for no labels, and 4.6% identified as queer (n=13). Additionally, 90.5% (n=258) participants reported they had a close friend and/or family member who self-identified as part of the LGBTQ community.

Regarding participants' education levels, 50.5% reported being a current master's counseling student (n=144), 22.1% reported being a current doctoral counseling student (n=63), 13.7% reported completing their master's degree in counseling (n=39), and 13.7% reported completing their doctoral degree in counseling (n=39). Regarding professional setting, participants were asked to select all roles they current held in the counseling field (therefore, percentage totals more than 100%): 60% of participants reported being counseling students (n=171), 29.1% were community mental health counselors (n=83), 21.4% were counselor educators (n=61), 15.1% school counselors (n=43), 9.8% reported selected "other" as a primary role in the counseling field (n=28) (write in responses included: "art therapist," "clinical psychologist," "marriage and family therapist," "counselor in private practice," and "behavioral health director."), 7.7% addictions counselors (n=22), and 7.4% reported being college/admissions counselors (n=21).

Participants reported on their religious affiliation, if any, and the average weekly time (in hours) spent practicing their religion. For reporting purposes, participants who responded with any organized religions were considered religious, those who responded by stating they were agnostic, atheist, spiritual, or had no religious affiliation were considered not religious. Therefore, 55.4% of participants reported being religious (n=158), with 1.0 hours being the mean

number of hours spent practicing their religion weekly (*SD*=3.76). The number of hours reported ranged from 0 to 30 hours weekly.

Exploratory Factor Analysis (EFA)

Data Screening

The data set was screened for sampling adequacy, missing data, multivariate outliers, normality, and linearity. A total of 333 participants consented to participant in this study. A forced response was required for all TAISC, MCKAS, GTS-R-SF, and MCSDS-C items through the Qualtrics online survey. Therefore, any missing values were found only in the 9 demographic items. Additionally, the study was limited to counselor educators, counseling students and counseling professionals across CACREP specialty areas. Participants who identified as outside the counseling profession were removed. The skewness and kurtosis of total score on all TAISC items was assessed for normality. The skewness of the TAISC items ranged from -3.23 to .86, and the kurtosis ranged from -1.38 to 8.39, indicated nonnormality. Although the data were non-normally distributed, no additional data were removed due to scoring falling within a normal distribution as assessed by the Kolmogorov-Smirnov (D[285]=.04, *p*=.20) and Shapiro-Wilk (D[285]=.99, *p*=.11) tests and the Q-Q Plot. After reviewing all data for missing values, outliers, and normality it was determined that 285 participants' data were usable for analyses.

The Bartlett's test of sphericity was significant (x^2[780]=4846.546, *p* < .001) and the Kaiser-Meyer-Olkin measure of sampling adequacy was high (.927), indicating that the data were suitable for factor analysis. However, it is important to note that the sample size is on the smaller end recommended by many authors, based on the ratio of 5 to 10 participants per item (i.e., approximately 6 participants per item; Field, 2009; Tabachnick & Fidell, 2007).

Factor Analysis

An EFA was conducted to explore the underlying factor structure of the 40-item TAISC. Initial analysis of the total sample (*n*=285) using principal axis factoring and a promax rotation yielded 3 adjusted eigenvalues greater than one (adjusted eigenvalues ranged from 1.16 to 11.87). Those factors explained approximately 38% of the total variance (see Table 1).

Table 1
Initial Eigenvalues and Extraction Sums of Squared Loadings

Factor	Initial Eigenvalues	Adjusted Eigenvalues	% of Variance	% Cumulative
1	12.34	11.87	29.67	29.67
2	2.56	2.04	5.10	34.76
3	1.74	1.16	2.90	37.66
4	1.46	.97	2.42	40.08
5	1.36	.80	2.00	42.07
6	1.28	.74	1.85	43.92
7	1.11	.60	1.48	45.40
8	1.06	.52	1.30	46.70
9	1.04	.45	1.13	47.83

Visual inspection of the scree plot (see Figure 1) showed two main factors above the point of inflection. With a sample of more than 200 participants, the scree plot provides a reliable criterion for factor selection (Field, 2009). The data analysis was performed again extracting only two factors. After examination of the pattern matrix for the two-factor model, all items were cross-loaded on both factors (see Table 2). To obtain the cleanest factor structure, few items should be cross-loaded (Osborne, 2005; Thompson, 2004); therefore, items with cross-loadings below the .30 threshold were deleted and items with cross-loadings above .30 were assigned to the factor with the largest loading (see Table 2).

Figure 1
Scree Plot for EFA
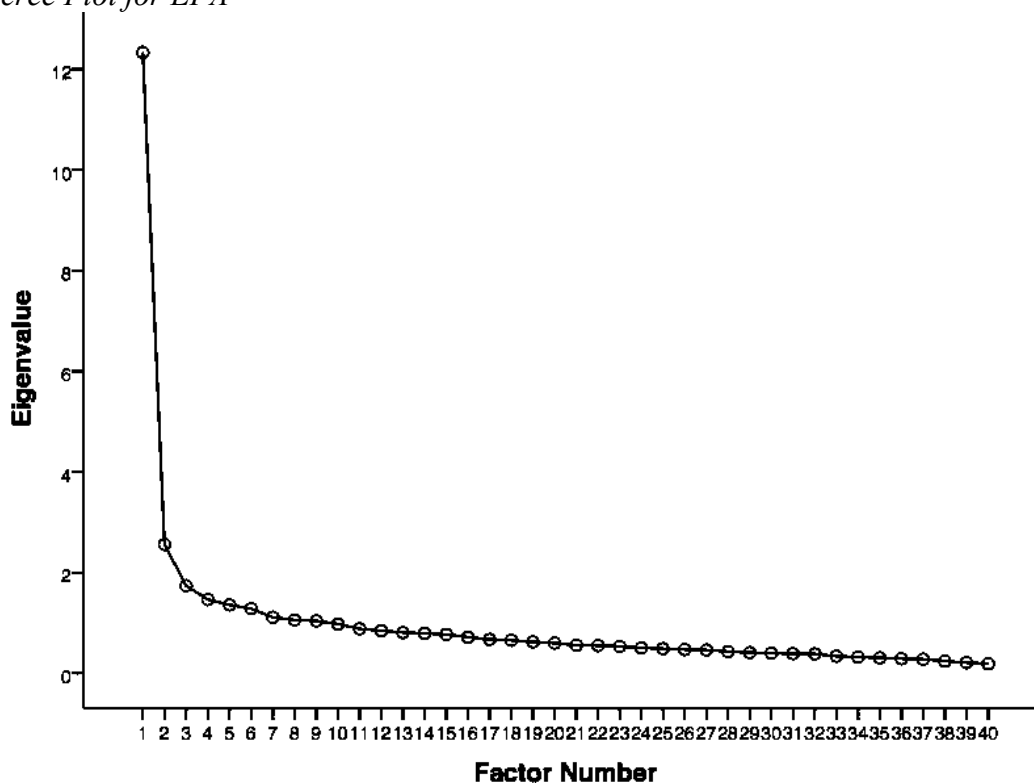
Table 2
Pattern Matrix for Two-Factor Model

Scale Item	Factor 1	Factor 2
1. I support that transitioning may be an important process for some transgender individuals.	.06	**.56**
2. I could diagnosis a client presenting with appropriate criteria for gender dysphoria.	**.58**	-.12
3. I could write my client a letter in support of their transgender medical services.	**.50**	.10
5. I think transgender issues should be included in multicultural counseling discussions.	-.24	**.82**
6. I understand the importance of using least restrictive gender language when working with transgender clients.	-.06	**.60**
7. I am able to educate and engage others on the topic of transgender issues.	**.73**	.09
8. I have written to my elected officials about transgender related issues.	**.58**	-.11
10. I would not be able to identify transgender- positive resources in my community. *	**.46**	.13
12. I have never diagnosed a transgender client with gender dysphoria. *	**.53**	-.23
13. I have attended trainings (e.g., workshops, conference sessions) that have focused on transgender issues.	**.73**	-.08
14. I have done research on transgender issues.	**.61**	-.03
15. I believe when working with transgender clients, counselors should create a welcome and affirming environment.	-.23	**.75**
16. I know that transgender individuals also have a sexual orientation (e.g., lesbian, gay,	.02	**.53**

bisexual, heterosexual, etc.).

17. It is important to my identity as a counselor that I attend transgender cultural events (e.g., pride, transgender day of remembrance).	.20	**.51**
18. I should advocate on behalf of transgender clients.	.11	**.65**
19. I have educated others about the facts and statistics of transgender victimization.	**.70**	.13
20. I routinely assess for my clients' gender identity.	**.57**	.06
21. I advocate for gender- neutral bathrooms at my place of employment/education.	**.57**	.09
22. I apply knowledge about identity development models to my work with clients.	**.65**	-.08
23. I am afraid to act on behalf of transgender individuals. *	**.34**	.16
24. I have several LGBT related items (e.g., books, posters, brochures) displayed in my office.	**.50**	.17
25. To my knowledge, I have never worked with a transgender client. *	**.65**	-.13
27. I use transgender affirmative language.	**.56**	.16
28. I do not stay up-to-date on events relevant to transgender issues. *	**.54**	-.01
29. I routinely ask my clients what pronouns they use.	**.57**	-.00
30. I am familiar with the culture of transgender individuals.	**.71**	-.03
31. I believe it is important to highlight the strengths and resilience of transgender clients.	-.02	**.57**
33. I have/would correct someone who was speaking about transgender individuals in an oppressive and stereotypical way	.13	**.43**
34. I have presented (e.g., workshop, conference session, class presentation) on transgender related issues.	**.70**	-.08
35. It is important to acknowledge intersecting identities of transgender individuals.	.07	**.66**
36. I address social inequities impacting transgender clients' mental health.	**.70**	.06
37. I have reflected on my own identity and how my life experiences are similar and different from transgender individuals'.	**.37**	.36
38. I advocate on behalf of the transgender community.	**.70**	.11
39. I believe action is the only way to change society.	.03	**.32**
40. I understand the implications associated with giving someone a diagnosis of gender dysphoria.	**.54**	.02

Note: * Reverse coded item. Extraction method: Principal axis. Rotation method: Promax.

The diagonals of the anti-image correlation matrix of the two-factor model were examined; every item had a value greater than .50, therefore supporting the inclusion of each item in the factor analysis. Finally, all communalities with the exception of ten items were above .30 (see Table 3). This confirms that most items shared some common variance with other items.

Although fixed values do not exist for determining the percentage of variance necessary to confirm adequacy for exploratory procedures, three instruments for measuring counseling competence were reviewed to determine appropriate percentages. The three-factor solution of the SOCCS (Bidell, 2005) accounted for approximately 40% of the total variance; the MCKAS (Ponterotto et al., 2002) three-factor model was approximately 38%; and the three-factor model of the MAKSS-CE-R (Kim et al., 2003) accounted for 29% of the total variance. The two-factor

model for the TAISC items accounted for approximately 37% of the total variance thereby

providing evidence of construct validity and supporting the first hypothesis: The factor structure

of the TAISC will be adequate for exploratory (i.e., principal axis factoring extraction and a

promax rotation) procedures.

The extraction communalities were examined and found to account for different amounts

of variance ranging from .01 to .63. There were five items eliminated using .30 as the primary

factor loading criterion. Factor loadings of .30 or above are considered the minimum cutoff value

in factor analysis literature (e.g., Field, 2009). The factor loadings of the remaining items ranged

from .32 to .82 for across two factors (see Table 2). The loadings on factors one and two were

examined, items with cross-loadings above .30 were assigned to the factor with the largest

loading. The revised TAISC (See Appendix J) contains a total of 35 items. Five items require

reverse coding.

Table 3
Communalities, Factor Loadings, Item-total Correlations, Means, and Standard Deviations

Scale Item	h	r**	M	SD
1. I support that transitioning may be an important process for some transgender individuals.	.27	.39	4.69	.68
2. I could diagnosis a client presenting with appropriate criteria for gender dysphoria.	.26	.50	3.39	1.09
3. I could write my client a letter in support of their transgender medical services.	.32	.60	3.91	1.01
4. I have had the opportunity to help transgender clients identify and/or remove systemic barriers within social institutions, but I chose to do nothing about it. *	.04			
5. I think transgender issues should be included in multicultural counseling discussions.	.47	.42	4.77	.53
6. I understand the importance of using least restrictive gender language when working with transgender clients.	.31	.41	4.61	.61
7. I am able to educate and engage others on the topic of transgender issues.	.63	.78	3.91	.96
8. I have written to my elected officials about transgender related issues.	.30	.52	2.16	1.07
9. I have referred transgender clients because I did not feel competent to work with them. *	.15			

10. I would not be able to identify transgender- positive resources in my community. *	.30	.57	3.77	1.08
11. I seek consultation/supervision when I am working with a client whose clinical needs are outside my level of competence.	.04			
12. I have never diagnosed a transgender client with gender dysphoria. *	.18	.39	2.19	1.10
13. I have attended trainings (e.g., workshops, conference sessions) that have focused on transgender issues.	.46	.67	3.33	1.33
14. I have done research on transgender issues.	.36	.60	3.38	1.30
15. I believe when working with transgender clients, counselors should create a welcome and affirming environment.	.39	.36	4.84	.43
16. I know that transgender individuals also have a sexual orientation (e.g., lesbian, gay, bisexual, heterosexual, etc.).	.30	.44	4.72	.59
17. It is important to my identity as a counselor that I attend transgender cultural events (e.g., pride, transgender day of remembrance).	.44	.62	3.84	1.04
18. I should advocate on behalf of transgender clients.	.53	.63	4.46	.74
19. I have educated others about the facts and statistics of transgender victimization.	.63	.79	3.75	1.17
20. I routinely assess for my clients' gender identity.	.37	.63	3.33	1.03
21. I advocate for gender-neutral bathrooms at my place of employment/education.	.40	.66	3.27	1.16
22. I apply knowledge about identity development models to my work with clients.	.36	.58	3.81	.86
23. I am afraid to act on behalf of transgender individuals. *	.21	.47	4.29	.73
24. I have several LGBT related items (e.g., books, posters, brochures) displayed in my office.	.38	.64	3.27	1.05
25. To my knowledge, I have never worked with a transgender client. *	.32	.56	3.32	1.36
26. I know that transgender individuals have a disproportionate rate of suicide.	.27			
27. I use transgender affirmative language.	.47	.68	4.05	.83
28. I do not stay up-to-date on events relevant to transgender issues. *	.30	.55	3.69	1.07
29. I routinely ask my clients what pronouns they use.	.32	.58	3.28	1.01
30. I am familiar with the culture of transgender individuals.	.48	.68	3.54	.93
31. I believe it is important to highlight the strengths and resilience of transgender clients.	.31	.43	3.28	.52

32. Coming out should be done at the pace I see as appropriate for my transgender client. *	.01			
33. I have/would correct someone who was speaking about transgender individuals in an oppressive and stereotypical way	.30	.47	4.44	.64
34. I have presented (e.g., workshop, conference session, class presentation) on transgender related issues.	.41	.65	2.69	1.42
35. It is important to acknowledge intersecting identities of transgender individuals.	.51	.58	4.46	.66
36. I address social inequities impacting transgender clients' mental health.	.55	.73	3.84	.89
37. I have reflected on my own identity and how my life experiences are similar and different from transgender individuals'.	.43	.64	4.20	.76
38. I advocate on behalf of the transgender community.	.60	.78	3.75	1.01
39. I believe action is the only way to change society.	.11	.30	4.05	.81
40. I understand the implications associated with giving someone a diagnosis of gender dysphoria.	.31	.56	3.83	.99

Note: h=communalities; r=item-total correlation; **Correlations are significant at the .01 level (2-tailed); * reverse-scored item

TAISC Scoring

Although a two-factor model was determined to best represent this sample, it is proposed that until further validation is completed, scoring for the TAISC should be done as one 35-item scale (combining items from both factors). It was determined that items retained by factors one and two assess for participants' transgender ally identity. However, due to the high number of cross-loadings, it is possible that items are also measuring other constructs and might be too complex for assignment to only one factor.

Additional Validation Analyses

Internal Consistency

The internal consistency estimates were acceptable for the revised 35-item TAISC total scale ($\alpha = .94$). The Cronbach's alpha coefficient for the TAISC-Revised total scale met the criterion of .80 (Field, 2009). The results support the second hypothesis: The internal consistency

estimates of the TAISC will be strong for a sample of counseling students, counseling

professionals, and counselor educators for the total scale.

Construct Validity

Convergent validity was established by significant, positive correlations between the

TAISC-Revised and the MCKAS (Ponterrotto et al., 2002). The internal consistency of the

MCKAS was calculated using the current sample (N= 285). The internal consistency estimate

was strong for the 32-item total MCKAS scale (α = .91) and acceptable for the MCKAS

Awareness (α = .82) and Knowledge subscales (α = .91). The results of this analysis are

comparable with the internal consistency results provided by the authors for the MCKAS

Awareness (α = .85) and Knowledge (α = .85) subscales (Ponterotto et al., 2002). Additionally,

the MCKAS total score was significantly, positively correlated with the TAISC-Revised total

scale (r = .60, p < .01) (see Table 4). These results provide support for the third hypothesis:

There will be positive, significant relationships among the TAISC and MCKAS total scales and

subscales providing evidence of convergent validity.

Further, discriminant validity was also established by significant, negative correlations

between the TAISC-Revised and the GTS-R-SF (Tebbe et al., 2014). The internal consistency of

the GTS-R-SF was calculated using the current sample (N= 285). The internal consistency

estimate was strong for the 13-item total GTS-R-SF scale (α = .89). The results of this analysis

are fairly comparable with the internal consistency results provided by the authors for the GTS-

R-SF total scale (α = .95). Additionally, the GTS-R-SF total score was significantly, negatively

correlated with the TAISC-Revised total scale (r = -.56, p < .01) (see Table 4). These results

provide support for the fourth hypothesis: There will be negative, significant relationships among

the TAISC and GTS-R-SF total scales and subscales providing evidence of discriminant validity.

Table 4
Convergent and Discriminant Validity of the TAISC-Revised

	TAISC- Revised Total	MCKAS Total	GTS-R-SF Total
TAISC- Revised Total	1.00	.60**	-.56**
MCKAS Total		1.00	-.40**
GTS-R-SF Total			1.00

Note: **Correlation is significant at the .01 level (2-tailed)

Criterion Validity

Criterion related validity was established using a forced entry multiple regression to examine the relationship between scores on the TAISC-Revised total scale and demographic variables provided by participants (i.e., age, gender, ethnocultural identification, sexual/affectional orientation, education level, religious affiliation and hours spent practicing religion, the identification of a close friend/family member with the LGBTQ community). Criterion-related validity is determined to be predictive of results on a scale (Dimitrov, 2012). In this study, religious affiliation, age, and one's sexual/affectional orientation were determined to be possible predictors of scores on the TAISC-Revised total scale (see Table 5).

Table 5
Summary of Multiple Regression Analysis for Criterion Validity

Variable	B	SE_B	β	t	Sig.
Religious Affiliation	-6.81	2.13	-.18	-3.20	.002**
Age	.19	.09	.12	2.15	.03*
Sexual/Affectional Orientation	12.90	2.36	.31	5.47	.000**
LGBTQ Connection	5.67	3.54	.09	1.66	.09
Ethnocultural Identity	1.24	1.97	.04	.66	.51
Gender	1.24	1.97	.04	.63	.53

Note: *p<.05; **p<.01; *B*= unstandardized regression coefficient; SE_B= Standard error of the coefficient; β=standardized coefficient. Dependent variable: TAISC-Revised total scores.

Social Desirability

The MCSDS-C (Reynolds, 1982) was used to assess for social desirability. Correlation analysis indicated no significant relationship between MCSDS-C total scores and TAISC-Revised total scores. Additionally, a linear regression analysis between MCSDS-C total scores and TAISC-Revised total scores was conducted. As depicted by the adjusted R^2 (.003), it is likely social desirability accounts for less than 1% of the variation in the TAISC-Revised total scores (see Table 6).

Table 6
Regression Predicting Socially Desirable Responding on the TAISC

	R	R^2	Adjusted R^2	Std. Error of the Estimate	Durbin-Watson
MCSDS-C Total Score	.08	.006	.003	18.90	2.02

Note: Dependent variable: TAISC-Revised total scores

CHAPTER FIVE

DISCUSSION

The initial results support the use of the TAISC in measuring counselors' transgender ally identity. However, there are several considerations for future development and validation of the TAISC. In this chapter, a summary of this study, relationships to previous studies, and implications for counseling professionals and future research will be discussed. Finally, the strengths and limitations will be covered.

Summary of the Research

The purpose of this study was the initial development and validation of the Transgender Ally Identity Scale for Counselors (TAISC). The TAISC is an instrument designed to measure counselors' levels of transgender ally identity. A non-experimental survey design was used to inform the development of the TAISC and included two stages. Stage one included the development of initial scale items and an expert review process for content validity. Initial scale development was based on the multicultural and social justice counseling competencies (Ratts et al., 2016), transgender competencies (ACA, 2009), and the ally development section of the LGBQIQA competencies (ALGBTIC, 2013). Eleven expert reviewers were invited to participate in the review process. Four expert reviewers provided feedback, which resulted in several adjustments to the TAISC. A 40-item scale with four subscales (i.e., knowledge, awareness, skills, action) resulted from stage one.

Stage two involved the use of quantitative methodology to pilot and initially validate the scale. The data were screened for sampling adequacy, missing data, outliers, and normality resulting in a final sample of 285 participants for analyses. The sample represented a nationwide population of counseling students, counseling professionals, and counselor educators across

CACREP specialty areas. The results from the EFA indicated that a two-factor model was most appropriate for this sample, accounting for approximately 37% of the total variance, providing evidence of construct validity. This two-factor model resulted in a 35-item scale. Due to cross-loadings (see Chapter 4, Table 2) and the potential complexity of items, it was determined that scoring for the TAISC would be based on the total scale, versus two subscales.

Internal consistency estimates were acceptable for the revised 35-item TAISC total scale (α = .94). Convergent validity was established by significant, positive correlations between the revised TAISC and MCKAS (Ponterrotto et al., 2002). The internal consistency estimate was strong for the 32-item total MCKAS scale (α = .91) and acceptable for the MCKAS Awareness (α = .82) and Knowledge subscales (α = .91). Additionally, discriminant validity was also established by significant, negative correlations between the revised TAISC and the GTS-R-SF (Tebbe et al., 2014). The internal consistency estimate was strong for the 13-item total GTS-R-SF scale (α = .89).

Further, the relationship between scores on the revised TAISC total scale and demographic variables (i.e., age, gender, ethnocultural identification, sexual/ affectional orientation, education level, religious affiliation and hours spent practicing religion, the identification of a close friend/ family member with the LGBTQ community) were examined to establish criterion related validity. Religious affiliation, age, and one's sexual/ affectional orientation were factors determined to be possible predictors of scores on the TAISC-Revised total scale. Finally, the MCSDS-C (Reynolds, 1982) was used to account for social desirability. Analyses indicated that socially desirable responding could account for less than 1% of the variation in the revised TAISC total scores.

Strengths of Study

This study is the first attempt at developing a scale for measuring transgender ally identity. It has the potential to expand the current literature about transgender ally identity, helping to differentiate this construct with transgender counseling competence. Additionally, with further development the TAISC has the potential to influence practice and training of counseling professionals.

Limited empirical research exists on transgender issues in counseling. Several studies have been conducted to develop and validate instruments for measuring counseling competence (e.g., MAKSS-CE-R; Kim et al, 2003; MCKAS; Ponterotto et al., 2002; MCI; Sodowsky et al., 1994). However, limited studies have focused on LGBT populations (e.g., SOCCS; Bidell, 2005; GAP; Crisp, 2006; LGB-CSI; Dillon & Worthington, 2003) and only one has focused specifically on transgender competence (i.e., SOCCS-V3; Bidell, 2015). A major strength of this study is the fact that it is the first empirical contribution about transgender ally identity to be offered to the counseling field.

Another strength of this study is the exploratory procedures used for this study (i.e., principal axis factor extraction with a promax rotation) are consistent with initial validation analyses used by other researchers. Similar to other research studies related to multicultural counseling competency, the foundation of this study was the counseling competencies. The researcher's use of the newest version of the competencies (i.e., MSJCCs, Ratts et al., 2016) makes this study timely.

Finally, the use of the MCSDS-C (Reynolds, 1982) to account for social desirability is another strength of this study. Social desirability should be assessed given the potential influence on responses to self-report instruments. Although further investigation of the TAISC is needed,

the initial results support the use of the TAISC in measuring transgender ally identity levels for counseling students and professionals. Due to social desirability accounting for less than 1% of total scores on the TAISC, initial evidence for the TAISC indicates that participants may not be endorsing a response set.

Limitations

There are several limitations of this study. First, the low number of initial scale items may impact the overall usability of the TAISC. Although the researcher thoroughly examined all available resources related to transgender counseling competence and transgender ally identity, the research acknowledges the limitation of starting with a 44-item scale. DeVellis (2012) recommends an initial item pool with three to four times the number of items than the final version of the scale. Therefore, in order to meet the expectation of scale development for a final scale of 35 items, there should have been 105 items in the initial item pool.

The second limitation of this study is the overall item review process for establishing content validity. A low response rate (i.e., response from only 4 out of 11) from expert reviewers may limit the content validity evidence. Several authors note the importance of expert review of scale items in scale development (e.g., DeVellis, 2012; Dimitrov, 2012). Although feedback provided from four reviewers was incorporated, the results of the expert review were not considered as heavily as initially intended. Further, with limited experts reviewing scale content and the lack of time to do a pilot prior to national sampling, many items are still in need of modification.

A third limitation of this study is the sample size and sample composition. Although 333 participants agreed to participate in the pilot study, after data screening only 285 participants had complete data. Given the importance of sample size in factor analysis, obtaining a large sample

was recommended (Dimitrov, 2012; Field, 2009). Specifically, it was recommended 5-10 participants per item (Field, 2009) and between 300 and 400 total participants (Dimitrov, 2012; Field, 2009). For this study, there were approximately 6 participants per item for the EFA. Although this is within the recommended 5-10 range, and data were suitable for factor analysis, the lower number of participants could have affected results. Additionally, the method used for participant recruitment is a limitation. Solicitation for participation was limited to emails sent to CACREP identified program directors and listservs to which the researcher had access. Although these avenues provided numerous opportunities for participant recruitment, emails sent to CACREP program directors relied heavily on accurate contact information and their willingness to distribute to their institution's students and faculty. Further, allowing participants to choose multiple roles, versus one primary role, on the demographic questionnaire made it difficult to determine the composition of the sample and whether it was comparable to the counseling profession in general.

Selection bias is a fourth limitation of this study. Participants who agreed to participate in this study may have been more conscientious and interested in LGBT related issues in counseling. One's personal and/or professional motivations can play a significant role in one's decision to participants in research studies. Selection bias reduced the generalizability of the results to all counseling students, educators, and professionals.

A fifth limitation of this study is the potential for socially desirable responses. Although the MCSDS-C (Reynolds, 1982) was utilized to account for this phenomenon, participants' responses on self-report scales can be affected by social desirability (Heppner, Wampold, Owen, Thompson, & Wang, 2015). Considering the results of this study, it is possible that participants

overestimated their knowledge, skills, awareness, and actions associated with working with the transgender population.

A sixth limitation of this study is the ordering bias of the instruments. Each participant took the exact same survey. Despite questions being grouped by topic (i.e., TAISC, MCKAS, GTS-R-SF, MCSDS-C) and having clearly defined instructions for each scale, items on each scale were ordered in the same way for each participant. Questions early on in the survey may have impacted answers for subsequent questions (Serenko & Bontis, 2013).

A seventh limitation of the study was the conscious choice by the researcher to exclude the SOCCS (Bidell, 2005) and SOCCS Version 3 (Bidell, 2015) to support the TAISC's ability to measure counselors' transgender competence. Although the SOCCS is limited to measuring LGB competence, Bidell's (2015) transgender version of the scale, the SOCCS Version 3, is currently undergoing initial validation procedures. Although the SOCCS is a validated instrument, the researcher believes both versions of the SOCCS do not accurately reflect the multicultural and social justice competencies (Ratts et al., 2016) and the transgender competencies (ACA, 2009).

Finally, due to the limited understanding of the construct of transgender counseling competence, the construct of transgender ally identity was difficult to conceptualize. A validated instrument for measuring transgender counseling competence and a model of transgender ally identity were missing components that could have made development of an instrument for measuring the transgender ally identity of counselors more attainable. Revisions and further validation procedures are essential to creating a stronger version of the TAISC.

Expanding Previous Research

Limited research has focused on transgender issues in counseling, which makes it difficult to create a strong foundation in understanding counseling competence related to working with this population. The current study examines behaviors and actions beyond what is expected from an advanced competence perspective. The TAISC aims to measure transgender ally identity; however, due to the foundation of the scale being multicultural and social justice counseling competencies (i.e., MSJCC, LGBQIQA competencies, Transgender competencies), several other constructs are highlighted within the construct of transgender ally identity (e.g., multicultural counseling competence; transgender attitude and bias development). While each of these constructs helps to inform an understanding of ally identity, transgender ally identity is a unique construct requiring further investigation.

Presently used instruments for measuring counseling competence (e.g., MCKAS, SOCCS) reflect the tripartite model of competence (i.e., knowledge, awareness, skills; Sue et al., 1992). For example, sexual orientation counseling competence, describes a counselor's ability to work with lesbian, gay, and bisexual clients within the tripartite framework. The SOCCS (Bidell, 2005) was developed to measure this construct. Further, multicultural counseling competence has come to be understood as a counselor's knowledge, attitudes and beliefs, skills, and actions (Ratts et al., 2016). The most updated and frequently cited measure of multicultural counseling competence is the MCKAS (Ponterotto et al., 2002). This instrument does not account for recent revisions to the counseling profession's standards of competence (i.e., MSJCCs; Ratts et al., 2016). Similar to the SOCCS, the foundation of the MCKAS is Sue et al.'s (1992) tripartite conceptualization of competence. Unlike previous multicultural counseling competence assessments, the TAISC does not have foundations in the tripartite model of competence.

Instead, items on the TAISC have been informed by the newest conceptualized understanding of advanced competence (i.e., Ratts et al., 2016).

Implications for Future Research

Additional research is needed to better understand and validate the TAISC. First, items will go through a revision process. This revision process will include further review of each item to ensure items represent the greatest content validity. A content analysis of relevant literature may be necessary to ensure the construct of transgender ally identity is represented appropriately, without too much complexity. Following item revisions, an expert review process will occur; a larger number of participants will be solicited in order to obtain more feedback. Additionally, a pilot will occur with a small group of participants to address any remaining item issues before nationwide sampling occurs.

Following these revisions, another nationwide sample will be collected, and an EFA will be conducted. It is expected that revised items will be more clearly defined, measuring only one construct, which should minimize cross-loadings. The goal will be to determine if the factor structure discovered during the original EFA, conducted for the current study, is the best-fitting model (Dimitrov, 2012). Following further validation analyses of the TAISC, it would be valuable to collect data from other mental health providers (e.g., social workers, psychologists) to determine the transferability across various mental health professions. With additional research on the validity of the scale, and different samples, the TAISC could be used in practice and training.

Implications for Counseling Students, Educators, and Professionals

The results of this study may be used to measure counselors' transgender ally identification levels with further validation. It is important to note that implications mentioned

here are future-focused, proposing only potential utility of the scale. The TAISC requires revisions before it can be used for research, training, or educative purposes.

Given the importance of being multiculturally competent and able to work with diverse populations, the TAISC could be used to increase counselors' awareness of their levels of ally identification with the transgender population. The importance of identifying as an ally to the transgender population, in addition to being a competent counselor, cannot be overstated given the vulnerability of transgender persons in the United States and the lack of preparedness to work with this population, as reported by counselors. Reponses on the TAISC could provide a baseline for understanding the relationship between competence and being an ally; ultimately, highlighting the importance of advocacy and action in one's everyday counseling practice.

Additionally, the TAISC could be used in training and supervision practices with counseling students. Counselor educators are tasked with ensuring that students are prepared to work with diverse persons, including those who identify as transgender (CACREP, 2009). Therefore, the TAISC could be incorporated into multicultural counseling courses and during supervision to provide a foundational understanding about the importance of developing an ally identity for the transgender community, and ultimately raise awareness about the meaning and importance of being an ally.

Further, this scale has the potential to be used for evaluation purposes. Counseling programs could implement this instrument as part of a systematic evaluation of students to ensure appropriate multicultural developmental milestones are being achieved, to raise awareness of personal actions and/or behaviors toward transgender clients, and to assist in gatekeeping practices. The TAISC has the potential to be utilized in other professional development situations, as well.

Conclusion

The TAISC is a two-factor 35-item instrument designed to measure the transgender ally identity of counseling students, counseling professionals, and counselor educators. Although there were several limitations of this study, the results provide initial validation evidence for the TAISC. That being said, more research is needed to improve scale items and further validate the instrument. Once additional validation studies are performed, the TAISC may provide a timely and groundbreaking step toward a better understanding of counselors' transgender ally identification.

CHAPTER SIX

MANUSCRIPT

Initial Development and Validation of the Transgender Ally Identity Scale for Counselors

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Abstract

The purpose of the current study was to develop and initially validate the Transgender Ally Identity Scale for Counselors (TAISC). The TAISC is a 35-item scale measuring counselors' transgender ally identity. Using a non-experimental survey design, the scale was developed and validation analyses were performed. Electronic data were collected from a nationwide sample of counseling students, professional counselors, and counselor educators (N=285). A two-factor model was determined to be the best fit for the sample, accounting for approximately 37% of the total variance. The internal consistency estimate was acceptable for the TAISC total scale (α = .94). Although further validation analyses are needed, initial results support the use of the TAISC in measuring transgender ally identity of counselors.

Keywords: transgender, ally identity, exploratory factor analysis, validation analyses

Initial Development and Validation of the Transgender Ally Identity Scale for Counselors

In the last decade, transgender and other non-binary gender conforming individuals have become more visible in society (e.g., increased number of celebrities and other public figures coming out, more news coverage surrounding transgender hate crimes; Henricks & Testa, 2012). This increased visibility has sparked an increase in awareness among counseling professionals (Henricks & Testa, 2012), some of whom may be evaluating and treating gender identity concerns as a mental health issue. Despite the existence of literature on lesbian and gay issues in counseling, little empirical research has been dedicated to the exploration of transgender competence, ally identity, and factors predicting transgender competence. A lack of empirical inquiry makes it difficult to understand how prepared counselors are through their training programs, how counselors are defining competence, and whether their practice includes advocating on behalf of the transgender population.

Professional mandates such as the American Counseling Association *Code of Ethics* (ACA, 2014) require counselors to be competent when working with diverse clients. Multicultural competence has come to include the ability to work with lesbian, gay, bisexual, and transgender (LGBT) individuals, recognizing that one's sexual and gender identities represent cultural groups, just like race and religion. A counselor is ethically obligated to have awareness about one's level of preparedness and competence to work with clients from diverse backgrounds on a multitude of dimensions (knowledge, attitudes, skills, and action) and from various perspectives (client worldview, counselor self-awareness, counseling relationship, and cultural interventions) (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016).

In order to positively impact sociopolitical needs of vulnerable populations, including the transgender community, and to provide culturally sensitive and responsive counseling services to

those individuals, working beyond the advanced level of competence outlined in the multicultural counseling competences (MSJCCs; Ratts et al., 2016) is essential. To define this level beyond advanced competence, the concept of "ally" is to be considered. Being an ally for a specific population requires more than basic awareness, knowledge, skills, and actions; it requires consciously embedding an ally identity for vulnerable populations as an essential aspect of one's overall counselor identity.

Over the past several years, increasing literature has been published on LGBT issues in counseling. However, most of the literature and published data have focused on sexual minorities (i.e., lesbians, gays, and bisexuals) or the LGBT community as a whole. Additionally, most research that has been done on LGB competence has used the Sexual Orientation Counselor Competence Scale (Bidell, 2005). For example, Bidell (2013), and Rutter, Estrada, Feguson, and Diggs (2008) explored the impact of an LGB-affirmative counseling course on perceived competence and effectiveness of counseling students. Farmer, Welfare, and Burge (2013) examined LGB counselor competence in different practice settings. Bidell (2012) also used the SOCCS to look at the LGB competence of school counseling and mental health counseling students.

Further, literature on LGBT client perspectives of counseling effectiveness and outcomes is lacking. For example, only one study has explored the mental health experiences of transgender individuals (Benson, 2013). Unfortunately, the lack of empirical literature about specific client needs, transgender-specific counseling issues, and barriers faced by transgender and gender-nonconforming individuals makes it difficult to create a strong foundation in understanding counseling competence related to working with this population. In this vein, the researcher sought to develop an instrument for better understanding counselors' levels of

commitment to supporting the transgender community through behaviors and actions beyond what is expected from an advanced competence perspective, or what the researcher has coined *ally identity* for working with transgender individuals. The instrument developed for this study (i.e., Transgender Ally Identity Scale for Counselors [TAISC]) has a strong foundation in counseling competencies endorsed by numerous counseling organizations.

Advanced Competence and Ally Identity

The worldview of counselors and clients reflect the historical and current experiences in society. Society (the counseling profession included) maintains rigid definitions of gender (Sangganjanavanich, 2014). Although advancements have been made in the multicultural counseling movement, literature remains limited for transgender-specific issues. The research that does exist focuses on LGB issues, misinterpreted as LGBT inclusive, and gender dysphoria, a mental health concern (Sangganjanavanich, 2014; Singh & Burnes, 2010). Possessing the knowledge, skills, and awareness about LGBT issues is necessary for successful counseling to occur with clients identifying as LGBT. Unfortunately, graduate training programs fail to prepare counselors to adequately work with LGBT clients (Carol & Gilroy, 2002; Matthews, 2005; Rutter, Estrada, Ferguson, & Diggs, 2008; O'Hara et al., 2013). This could be related to the overall lack of inclusion of LGBT affirmative practices in counselor training programs and the continued deficit model focus (Rutter et al., 2008; Singh & Burnes, 2010).

Despite recent development of LGBT specific counseling competencies, counseling professionals struggle to develop competence to work with LGBT populations (Benson, 2013; O'Hara et al., 2013). Research highlights the importance of counselor preparation programs encouraging direct exposure and involvement with LGBT populations in order to enhance competence and perceived self-efficacy to work with LGBT clients (Barden & Greene, 2015).

Additionally, several predictive factors have been linked to increased LGB competence and self-efficacy of counselors (e.g., professional experience, self-identification as LGBT, education level). These factors have not been studied rigorously across the LGBTQ spectrum of identities to note transferability from LGB to transgender populations. Further, advanced competence is directly linked with increased professional identity development (Gibson, Dollarhide, & Moss, 2010; Prosek & Hurt, 2014).

Additionally, multicultural and social justice competencies highlight the importance of advanced competence, including advocacy efforts for oppressed clients and communities (Ratts et al., 2016). Although limited research exists to understand how many counselors have adopted these standards of practice, the new expectation is that competent counselors are also advocating on behalf of marginalized populations (ACA, 2009; Israel, Ketz, Detrie, Burke, & Shulman, 2003; LaMantia, Wagner, & Bohecker, 2015). Advanced competence is thus a precursor to developing an ally identity. An ally will demonstrate behaviors and attitudes beyond their role as a competent counselor (e.g., correct misinformation and stereotypes, facilitate fairness and equity through removal of societal barriers, and actively participate in continuing education about transgender specific issues; ALGBTIC, 2013; LaMantia et al., 2015). Identity as an ally can further redefine one's role as a counselor and facilitate personal and professional identity. Ultimately, being an ally is important for social change. Allies are instrumental in addressing the discrimination, oppression, and societal misunderstanding of transgender individuals.

A competent counselor entering the initial stages of being an ally to the transgender community should at the least have an awareness of how transgender and other gender identities differ from one's own, be knowledgeable about current events and political issues involving LGBT communities, understand the intersecting identities a transgender individual may have and

the role that plays in development, consult with competent supervisors, use inclusive and respectful language, and advocate on behalf of LGBT populations in a variety of ways (ACA, 2009; Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2013; LaMantia et al., 2015; Minnesota State University at Mankato: LGBT Center Resource Library, n.d.; Singh & Burnes, 2010). Therefore, ally identification should be considered a separate construct from competence, but one cannot become an ally without competence to work with transgender clients.

Further, it is important to note that counselors may be considered competent while also possessing indifference and ignorance to diverse populations. Counselors with advanced competence are able to conceptualize their knowledge, skills, and awareness into positive social change efforts. An ally might use their knowledge to actively confront oppression, by challenging those who joke about transgender populations. Further, allies are continuously and intentionally immersed in the culture, enhancing their own knowledge and self-awareness through reading and attendance at cultural events. Finally, allies use their skills and knowledge to create safe and equal environments for transgender individuals, educating others about LGBT issues through legislative and institutional changes (ALGBTIC, 2013; LaMantia et al., 2015; Ratts et al., 2016).

Validated self-report instruments exist to measure multicultural counseling competence (e.g., MCKAS) and LGB counseling competence (e.g., SOCCS). Additionally, a scale for measuring transgender competence is in the initial stages of validation (Bidell, 2015). However, no instruments reflect the notion of advanced competence; and, no instruments exist to assess counselors' transgender ally identity. As transgender individuals become more visible in society and they continue to experience more extreme discrimination and mental health related concerns

compared to LGB individuals (Henricks, & Testa, 2012), it is paramount counselors understand and adopt the MSJCCs notion of advanced competence.

Understanding transgender individuals' social environments is increasingly important, especially as a vulnerable and marginalized population (Ratts et al., 2016). Through counseling practice and social justice advocacy, oppression and discrimination can be addressed across systems. Counselors develop advanced competence based on their commitment to understanding how privileged or marginalized identities are impacted within each system. Counselors must not only incorporate knowledge, awareness, skills, and actions into counseling practice, but across interpersonal (e.g., assist transgender clients in fostering with those who may support their identity; relationships), institutional (e.g., connecting transgender individuals with supportive institutional resources to fight inequities), community (e.g., research norms and values to better understand societal impacts on transgender growth and development), public policy (e.g., advocate for equitable laws and policies for transgender persons), and international/global levels (e.g., learn about global politics that influence the health and/or well-being of transgender individuals) (Ratts et al., 2016). Ally identity can be seen as a natural outgrowth of advanced competence, leading toward an embedded identity.

Purpose and Research Questions

The purpose of this study was the initial development and validation of the Transgender Ally Identity Scale for Counselors (TAISC). The following research questions will be examined: What is the factor structure of the TAISC? What is the internal consistency of the TAISC for a sample of counseling students and professionals? What is the relationship between the TAISC and the MCKAS? What is the relationship between the TAISC and the GTS-R-SF? What relationships, if any, exist between TAISC total scores and select demographic variables (i.e.,

age, gender, ethnocultural identification, sexual/affectional orientation, education level, religious affiliation and hours spent practicing religion, and the identification of a close friend/family member with the LGBTQ community)?

Method

Instrument Development

To develop the initial items for the original 44-item TAISC, the authors conducted a review of literature. Specifically, initial items were reflective of advanced competence (e.g., MSJCCs), ally identity (e.g., LGBQIQA Competencies), and transgender counseling competence (e.g., Transgender Competencies).

Procedures

Using convenience sampling, attempts were made to recruit a nationwide sample of counseling students, professionals, and educators. Requests were made through online listservs (e.g., ALGBTIC, CESNET, COUNSGRADS) and email distribution to CACREP counseling program directors. Data were collected using an online survey tool that included a consent form, the TAISC, Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), Genderism and Transphobia Scale - Revised - Short Form (GTS-R-SF; Tebbe et al., 2014), Marlowe-Crowne Social Desirability Scale - Short Form C (MCSDS-C; Reynolds, 1982), and a demographic questionnaire.

Participants

The 285 participants represented a national sample of counseling students and counseling professionals. Of the participants, 80.4% identified as female (n=229), 16.1% identified as male (n=46), 2.5% identified as transgender (n=7), and 1.1% identified by a different term (e.g., genderqueer, cisgender woman) or they preferred not to be labeled (n=3). The median age of the

participants was 31 with ages ranging from 22 to 77 years. 76.5% of participants identified as White (n=218), 9.8% reported multiple heritage (n=28), 6.3% identified as African American (n=18), 2.8% identified as Hispanic/Latin(o/a) (n=8), 1.8% identified as Asian (n=5), 1.8% identified as Other (n=5) (write-in answers included "Middle Eastern," "West Indian," and "Prefer not to label"), 0.7% identified as American Indian/Alaskan Native (n=2), and 0.4% identified as Native Hawaiian/Pacific Islander (n=1). When asked to define their sexual/affection orientation, 70.5% of participants identified as heterosexual (n=201), 9.4% identified as bisexual (n=31), 9.1% identified as gay/lesbian (n=26), 4.9% identified as other (n=14) with participants writing in different terms (e.g., "Fluid," "Asexual," "Pansexual," and "As mine.") or the preference for no labels, and 4.6% identified as queer (n=13). Additionally, participants reported on whether they had a close friend and/or family member who self-identified as part of the LGBTQ community. 90.5% of participants (n=258) said "yes" they did.

Regarding participants' education levels 50.5% reported being a current master's counseling student (n=144), 22.1% reported being a current doctoral counseling student (n=63), 13.7% reported completing their master's degree in counseling (n=39), and 13.7% reported completing their doctoral degree n counseling (n=39). Regarding professional setting, participants were asked to select all roles they current held in the counseling field (therefore, percentage totals more than 100%). 60% of participants reported being counseling students (n=171), 29.1% were community mental health counselors (n=83), 21.4% were counselor educators (n=61), 15.1% school counselors (n=43), 9.8% reported selected "other" as a primary role in the counseling field (n=28) (write in responses included: "art therapist," "clinical psychologist," "marriage and family therapist," "counselor in private practice," and "behavioral

health director."), 7.7% addictions counselors (*n*=22), and 7.4% reported being

college/admissions counselors (*n*=21).

Participants reported on their religious affiliation, if any, and the average weekly time (in

hours) spent practicing their religion. For reporting purposes, participants who responded with

any organized religions were considered religious, those who responded by stating they were

agnostic, atheist, spiritual, or had no religious affiliation were considered "not religious." 55.4%

of participants reported being religious (*n*=158), with 1.0 hours being the mean number of hours

spent practicing their religion weekly. The number of hours reported ranged from 0 to 30 hours

weekly.

Data Collection Measures

TAISC. The TAISC is a 40-item scale assessing counselors' level of identity as an ally to

the transgender community. Items are rated on a 5-point Likert scale ranging from 1 (*Strongly*

Disagree) to 5 (*Strongly Agree*), with higher scores indicating a stronger sense of ally identity.

There are 10 items to measure awareness and beliefs about transgender issues, 10 items to

measure knowledge about transgender issues, 10 items to measure skills related to working with

transgender populations, and 10 items to measure one's actions/advocacy related to transgender

issues. Reverse coding is required for eight TAISC items. Items were reordered before

distribution to avoid any response bias.

Multicultural Counseling Knowledge and Awareness Scale (MCKAS). The MCKAS

is a 32-item self-report scale developed to measure counselor's perceived level of multicultural

counseling competence in relation to multicultural knowledge (20 items) and multicultural

awareness (12 items) (Ponterotto et al., 2002). Questions are answered on a Likert scale ranging

from 1 (*not at all true*) to 7 (*totally true*). Higher scores on the MCKAS indicate higher

awareness and competence (Ponterotto et al., 2002). Coefficient alphas for the MCKAS, based on original samples, were reported to range from .78 to .93 for the knowledge subscale and from .67 to .83 for the awareness subscale; total scale alphas were not provided (Ponterotto et al., 2002). The 10-month test-retest reliability for the knowledge subscale was .70 and .73 for the awareness subscale (Ponterotto et al., 2002). Convergent validity was established through significant relationships between the MCKAS and similar measures of multicultural counseling competence. Criterion related validity was established through the comparison of scores on the MCKAS with education level and ethnicity (Ponterotto et al., 2002). The MCKAS is the only multicultural competence measure that has gone through revisions to account for factor structures; therefore, it is the cleanest measure available (Lawley, 2007).

Genderism and Transphobia Scale – Revised – Short Form (GTS-R-SF). The GTS-R-SF (Tebbe et al., 2014) is the most recently revised version of the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005). The GTS-R-SF is a self-report scale developed to measure negative attitudes and behaviors toward transgender and other gender-variant individuals. The GTS-R-SF is a shortened version of the GTS; this version eliminated overlapping questions on previous version of the GTS. The GTS-R-SF consists of 13 items; that is 8 genderism/transphobia questions and 5 gender-bashing questions. Questions are answered on a Likert scale ranging from 1 (*strongly agree*) to 7 (*strongly disagree*). Overall scores and subscale scores can be calculated. Higher scores on the GTS-R-SF indicate a greater sense of negative attitudes and behaviors toward transgender and other gender-variant individuals. The GTS is usable across disciplines and is the first valid instrument developed to measure anti-trans attitudes and behaviors (Hill & Willoughby, 2005). The genderism and transphobia subscale (α=.95), gender bashing subscale (α=.86), and the overall scale (α=.94) have strong internal

consistency (Tebbe et al., 2014). Further, correlations indicate significant positive relationships with anti-LGB attitudes establishing convergent validity (Tebbe et al., 2014).

Marlowe–Crowne Social Desirability Scale (Short- Form C). The MCSDS-C (Reynolds, 1982) is a 13-item self-report tool used to measure participants' tendency to answer in socially favorable ways. The short form-C consists of 13 true/false items and has an alpha of .76 (Reynolds, 1982). The MCSDS-C is derived from the original 33-item Marlowe–Crowne Social Desirability Scale (Crowne & Marlowe, 1960). The MCSDS-C is significantly correlated with a large effect size with the original 33-item version. Reynolds (1982) observed correlation coefficients between the MCSDS-C and the original version of the Marlowe-Crowne and found that $r = .93$ when the short form-C was compared to the original MCSDS. Five items on the MCSDS-C are reverse coded. Scores are summed for a total score, with higher scores reflecting higher levels of socially desirable responding.

Demographic questionnaire. The demographic questionnaire was developed by the researcher to include variables identified in the literature to impact counselor competence as well as demographic information that will be used to describe the sample. Demographic questions included age, gender (male, female, transgender, other- write in), sexual orientation (heterosexual, gay/lesbian, bisexual, queer, other-write in), and ethnocultural identity (African American, American Indian/Alaskan Native, Asian, Hispanic/Latin(o/a), Multiple Heritage, Native Hawaiian/Pacific Islander, White, Other- write in). Additionally, background information supported by the literature discussed in Chapter two were included: primary role(s) in the counseling field (i.e., addictions counselor, community mental health counselor, college counselor, school counselor, counselor educator, counseling student, or other- write in), whether the participant had a close friend of family member who self-identified as LGBTQ (yes or no),

highest level of education (i.e., current masters student, completed masters, current doctoral student, completed doctorate degree), religious/spiritual affiliation (open ended), and average number of hours spent weekly practicing their religion (open-ended). There were 9 items on the demographic form.

Results

Content Analysis

The authors addressed content validity of the TAISC through expert review by four experts in the field with knowledge of transgender counseling competence and transgender issues in counseling. No demographic information was collected. The experts reviewed the initial 44-item draft of the TAISC. Following the review, the researcher incorporated feedback and adjusted items as necessary. In addition to removal of items, several items were reworded to enhance clarity. A 40-item scale resulted from the expert review process.

Exploratory Factor Analysis

An EFA was conducted to explore the underlying factor structure of the 40-item TAISC. Initial analysis of the total sample (n=285) using principal axis factoring and a promax rotation yielded 3 adjusted eigenvalues greater than one (adjusted eigenvalues ranged from 1.16 to 11.87). Those factors explained approximately 38% of the total variance. Visual inspection of the scree plot showed two main factors above the point of inflection. With a sample of more than 200 participants, the scree plot provides a reliable criterion for factor selection (Field, 2009). The data analysis was performed again extracting only two factors. After examination of the pattern matrix for the two-factor model, all items were cross-loaded on both factors. To obtain the cleanest factor structure, few items should be cross-loaded (Osborne, 2005; Thompson, 2004);

therefore, items with cross-loadings below the .30 threshold were deleted and items with cross-loadings above .30 were assigned to the factor with the largest loading.

The diagonals of the anti-image correlation matrix of the two-factor model were examined; every item had a value greater than .50, therefore supporting the inclusion of each item in the factor analysis. Finally, all communalities with the exception of ten items were above .30. This confirms that most items shared some common variance with other items.

Although fixed values do not exist for determining the percentage of variance necessary to confirm adequacy for exploratory procedures, three instruments for measuring counseling competence were reviewed to determine appropriate percentages. The three-factor solution of the SOCCS (Bidell, 2005) accounted for approximately 40% of the total variance; the MCKAS (Ponterotto et al., 2002) three-factor model was approximately 38%; and the three-factor model of the MAKSS-CE-R (Kim et al., 2003) accounted for 29% of the total variance. The two-factor model for the TAISC items accounted for approximately 37% of the total variance thereby providing evidence of construct validity and supporting the first hypothesis: The factor structure of the TAISC will be adequate for exploratory (i.e., principal axis factoring extraction and a promax rotation) procedures.

The extraction communalities were examined and found to account for different amounts of variance ranging from .01 to .63. There were five items eliminated using .30 as the primary factor loading criterion. Factor loadings of .30 or above are considered the minimum cutoff value in factor analysis literature (e.g., Field, 2009). The factor loadings of the remaining items ranged from .32 to .82 for across two factors. The loadings on factors one and two were examined, items with cross-loadings above .30 were assigned to the factor with the largest loading. The revised TAISC contains a total of 35 items. Five items require reverse coding.

TAISC Scoring. Although a two-factor model was determined to best represent this sample, it is proposed that until further validation is completed, scoring for the TAISC should be done as one 35-item scale (combining items from both factors). It was determined that items retained by factors one and two assess for participants' transgender ally identity. However, due to the high number of cross-loadings, it is possible that items are also measuring other constructs and might be too complex for assignment to only one factor.

Internal Consistency

The internal consistency estimates were acceptable for the revised 35-item TAISC total scale ($a = .94$). The Chronbach's alpha coefficient for the TAISC-Revised total scale met the criterion of .80 (Field, 2009). The results support the second hypothesis: The internal consistency estimates of the TAISC will be strong for a sample of counseling students and professionals for the total scale.

Construct Validity

Convergent validity was established by significant, positive correlations between the TASIC-Revised and the MCKAS (Ponterrotto et al., 2002). The internal consistency of the MCKAS was calculated using the current sample ($N = 285$). The internal consistency estimate was strong for the 32-item total MCKAS scale ($a = .91$) and acceptable for the MCKAS Awareness ($a = .82$) and Knowledge subscales ($a = .91$). The results of this analysis are comparable with the internal consistency results provided by the authors for the MCKAS Awareness ($a = .85$) and Knowledge ($a = .85$) subscales (Ponterotto et al., 2002). Additionally, the MCKAS total score was significantly, positively correlated with the TAISC-Revised total scale ($r = .60, p < .01$). These results provide support for the third hypothesis: There will be

positive, significant relationships among the TAISC and MCKAS total scales and subscales providing evidence of convergent validity.

Further, discriminant validity was also established by significant, negative correlations between the TASIC-Revised and the GTS-R-SF (Tebbe et al., 2014). The internal consistency of the GTS-R-SF was calculated using the current sample (*N*= 285). The internal consistency estimate was strong for the 13-item total GTS-R-SF scale (*a* = .89). The results of this analysis are fairly comparable with the internal consistency results provided by the authors for the GTS-R-SF total scale (*a* = .95). Additionally, the GTS-R-SF total score was significantly, negatively correlated with the TAISC-Revised total scale (*r* = -.56, *p* < .01). These results provide support for the fourth hypothesis: There will be negative, significant relationships among the TAISC and GTS-R-SF total scales and subscales providing evidence of discriminant validity.

Criterion Validity

Criterion related validity was established using a forced entry multiple regression to examine the relationship between scores on the TAISC-Revised total scale and demographic variables provided by participants (i.e., age, gender, ethnocultural identification, sexual/affectional orientation, education level, religious affiliation and hours spent practicing religion, the identification of a close friend/family member with the LGBTQ community). Criterion-related validity is determined to be predictive of results on a scale (Dimitrov, 2012). In this study, religious affiliation, age, and one's sexual/affectional orientation were determined to be possible predictors of scores on the TAISC-Revised total scale.

Social Desirability

The MCSDS-C (Reynolds, 1982) was used to assess for social desirability. Correlation analysis indicated no significant relationship between MCSDS-C total scores and TAISC-

Revised total scores. Additionally, a linear regression analysis between MCSDS-C total scores and TAISC-Revised total scores was conducted. As depicted by the adjusted R^2 (.003), it is likely social desirability accounts for less than 1% of the variation in the TAISC-Revised total scores.

Discussion

Limitations

There are several limitations of this study. First, the low number of initial scale items may impact the overall usability of the TAISC. Although the researcher thoroughly examined all available resources related to transgender counseling competence and transgender ally identity, the research acknowledges the limitation of starting with a 44-item scale. DeVellis (2012) recommends an initial item pool with three to four times the number of items than the final version of the scale. Therefore, in order to meet the expectation of scale development for a final scale of 35 items, there should have been 105 items in the initial item pool.

The second limitation of this study is the overall item review process for establishing content validity. A low response rate (i.e., response from only 4 out of 11) from expert reviewers may limit the content validity evidence. Several authors note the importance of expert review of scale items in scale development (e.g., DeVellis, 2012; Dimitrov, 2012). Although feedback provided from four reviewers was incorporated, the results of the expert review were not considered as heavily as initially intended. Further, with limited experts reviewing scale content and the lack of time to do a pilot prior to national sampling, many items are still in need of modification.

A third limitation of this study is the sample size and sample composition. Although 333 participants agreed to participate in the pilot study, after data screening only 285 participants had

complete data. Given the importance of sample size in factor analysis, obtaining a large sample was recommended (Dimitrov, 2012; Field, 2009). Specifically, it was recommended 5-10 participants per item (Field, 2009) and between 300 and 400 total participants (Dimitrov, 2012; Field, 2009). For this study, there were approximately 6 participants per item for the EFA. Although this is within the recommended 5-10 range, and data were suitable for factor analysis, the lower number of participants could have affected results. Additionally, the method used for participant recruitment is a limitation. Solicitation for participation was limited to emails sent to CACREP identified program directors and listservs to which the researcher had access. Although these avenues provided numerous opportunities for participant recruitment, emails sent to CACREP program directors relied heavily on accurate contact information and their willingness to distribute to their institution's students and faculty. Further, allowing participants to choose multiple roles, versus one primary role, on the demographic questionnaire made it difficult to determine the composition of the sample and whether it was comparable to the counseling profession in general.

Selection bias is a fourth limitation of this study. Participants who agreed to participate in this study may have been more conscientious and interested in LGBT related issues in counseling. One's personal and/or professional motivations can play a significant role in one's decision to participants in research studies. Selection bias reduced the generalizability of the results to all counseling students, educators, and professionals.

A fifth limitation of this study is the potential for socially desirable responses. Although the MCSDS-C (Reynolds, 1982) was utilized to account for this phenomenon, participants' responses on self-report scales can be affected by social desirability (Heppner, Wampold, Owen, Thompson, & Wang, 2015). Considering the results of this study, it is possible that participants

overestimated their knowledge, skills, awareness, and actions associated with working with the transgender population.

A sixth limitation of this study is the ordering bias of the instruments. Each participant took the exact same survey. Despite questions being grouped by topic (i.e., TAISC, MCKAS, GTS-R-SF, MCSDS-C) and having clearly defined instructions for each scale, items on each scale were ordered in the same way for each participant. Questions early on in the survey may have impacted answers for subsequent questions (Serenko & Bontis, 2013).

A seventh limitation of the study was the conscious choice by the researcher to exclude the SOCCS (Bidell, 2005) and SOCCS Version 3 (Bidell, 2015) to support the TAISC's ability to measure counselors' transgender competence. Although the SOCCS is limited to measuring LGB competence, Bidell's (2015) transgender version of the scale, the SOCCS Version 3, is currently undergoing initial validation procedures. Although the SOCCS is a validated instrument, the researcher believes both versions of the SOCCS do not accurately reflect the multicultural and social justice competencies (Ratts et al., 2016) and the transgender competencies (ACA, 2009).

Future Research Directions

Additional research is needed to better understand and validate the TAISC. First, items will go through a revision process. This revision process will include further review of each item to ensure items represent the greatest content validity. A content analysis of relevant literature may be necessary to ensure the construct of transgender ally identity is represented appropriately, without too much complexity. Following item revisions, an expert review process will occur; a larger number of participants will be solicited in order to obtain more feedback. Additionally, a pilot will occur with a small group of participants to address any remaining item issues before

nationwide sampling occurs. Following these revisions, another nationwide sample will be

collected, and an EFA will be conducted. It is expected that revised items will be more clearly

define, measuring only one construct, which will help minimize cross-loadings The goal will be

to determine if the factor structure discovered during the original EFA, conducted for the current

study, is the best-fitting model (Dimitrov, 2012). Following further validation analyses of the

TAISC, it would be valuable to collect data from other mental health providers (e.g., social

workers, psychologists) to determine the transferability across various mental health professions.

With additional research on the validity of the scale, and different samples, the TAISC could be

used in practice and training.

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APPENDIX A

Transgender Ally Identity Scale for Counselors (TAISC) – Initial Items

Skills
1. I routinely assess for my clients' gender identity without making assumptions. (T; MSJCC-relationship, skills)
2. I have several LGBT related items (e.g., books, posters, brochures) displayed in my office. (T)
3. I could diagnosis a client presenting with appropriate criteria for gender dysphoria. (T; MSJCC-worldview, skills)
4. I have never diagnosed a client with gender dysphoria. / (T)
5. I routinely ask my clients what pronouns they prefer. (LGBQIQA; T)
6. I have never worked with a transgender client. /
7. I use transgender affirmative language. (LGBQIQA; T; MSJCC-awareness, skills)
8. I apply knowledge about identity development models to my work with clients. (MSJCC-relationship, skills)
9. I seek consultation/supervision when I am working with a client that challenges my clinical strengths as a counselor. (LGBQIQA)
10. I have referred transgender clients because I did not feel competent to work with them. / (LGBQIQA; T)
11. I could write my client a letter in support of their transgender medical services. (T)

Knowledge
12. I have attended trainings (e.g., workshops, conference sessions) that have focused on transgender issues. (SOCCS; LGBQIQA; MSJCC- awareness, knowledge)
13. I would not be able to identify transgender-positive resources in my community, if I had a client ask for them. / (T; MSJCC- awareness, knowledge)
14. I know that transgender individuals also have a sexual orientation (e.g., lesbian, gay, bisexual, heterosexual, etc.). (T)
15. I understand the importance of using least restrictive gender language when working with transgender clients. (LGBQIQA; T; MSJCC-relationship, knowledge)
16. I understand the sense of loss that occurs for male-to-female (MTF) transgender individuals, as they give up their male privilege. (T; MSJCC-worldview, knowledge)
17. I know that transgender individuals have a disproportionate rate of suicide when compared to other minority populations. (T; MSJCC-worldview, knowledge)
18. It is important to acknowledge intersecting identities of transgender individuals. (LGBQIQA; T; MSJCC- relationship, knowledge)
19. I understand gender dysphoria, the diagnosis criteria, and implications associated with giving someone that diagnosis. (LGBQIQA; T; MSJCC-worldview, knowledge)
20. I am able to educate and engage others on the topic of transgender issues. (LGBQIQA; T)
21. I am not aware of the facts and statistics of transgender victimization. / (T; MSJCC-worldview, knowledge)
22. I am familiar with the culture of transgender individuals. (LGBQIQA; T; MSJCC)

Awareness
23. I support that transitioning may be an important process for transgender individuals. (LGBQIQA; MSJCC- worldview, attitudes/beliefs)
24. I believe when working with transgender clients, counselors should create a welcome and affirming environment for clients to feel comfortable being themselves. (LGBQIQA; T)
25. I have reflected on my own identity and how my life experiences are similar and different from transgender individuals'. (MSJCC- relationship, attitudes/beliefs)
26. I believe it is important to highlight the strengths and resilience of transgender clients. (T)
27. Coming out should be done at the pace I see as appropriate for my transgender client. / (LGBQIQA)
28. I think transgender issues should be included in multicultural counseling discussions. (T)
29. I should advocate on behalf of their transgender clients. (LGBQIQA; T)
30. It is important to my identity as a counselor that I attend transgender cultural events (e.g., pride, transgender day of remembrance). (LGBQIQA; T; MSJCC-awareness, attitudes/beliefs)
31. I am afraid to act on behalf of transgender individuals, for fear that I will be judged. / (LGBQIQA; T)
32. I believe action is the only way to change society. (MSJCC)
33. I have close friends who identify as transgender.

Action
34. I advocate on behalf of the transgender community. (T; MSJCC-Community)
35. I have/would correct someone who was speaking about transgender individuals in an oppressive and stereotypical way. (LGBQIQA)
36. I advocate for/gender-neutral bathrooms at my place of employment/education. (T; MSJCC- Public Policy)
37. I have written to my congress representative about transgender related issues. (LGBQIQA; T; MSJCC-Public Policy)
38. I have presented (e.g., workshop, conference session, class presentation) on transgender related issues. (MSJCC-Institutional)
39. I understand the facts and statistics of transgender victimization. (T; MSJCC- Institutional)
40. I have never had the opportunity to help transgender clients identify and/or remove systemic barriers within social institutions. / (MSJCC-Institutional)
41. I have done research on transgender issues. (MSJCC-Interpersonal)
42. I stay up-to-date on historical and current events relevant to transgender issues. (LGBQIQA; T; MSJCC-Public Policy, International/Global Affairs)
43. I am not up-to-date on political climates relevant to transgender issues. / (LGBQIQA; T; MSJCC-International/Global Affairs)
44. I address social inequities impacting transgender clients' mental health. (MSJCC-Institutional)

Note:
T = transgender competencies helped inform this item
LGBQIQA = LGBQIQA competencies helped inform this item
MSJCC = multicultural and social justice competencies helped inform this item
SOCCS = sexual orientation counselor competence scale helped inform this item
/ = Reverse coded

APPENDIX B

Instructions for Expert Reviewers

Dear Expert Reviewer:

Thank you for agreeing to provide feedback on my scale items. I ask that you consider the prompts below, but you may also offer any additional feedback you deem important for the direction of this research study.

1. Are items appropriately placed in subscales (paying close attention to wording of items and item content)?

2. Are items specific enough to the transgender population?

3. Is wording and vocabulary appropriate for application to various counseling professionals?

4. Should any items be eliminated?

5. Should any items be added?

6. Any additional comments?

Scale items follow.

Thank you again for your time and consideration.

Jamie

APPENDIX C

Transgender Ally Identity Scale for Counselors (TAISC)
Revised Items with Reflected Changes

1. I routinely assess for my clients' gender identity ~~without making assumptions~~.
2. I have several LGBT related items (e.g., books, posters, brochures) displayed in my office.
3. I could diagnosis a client presenting with appropriate criteria for gender dysphoria.
4. I have never diagnosed a client with gender dysphoria. /
5. I routinely ask my clients what pronouns they ~~prefer~~ use.
6. To my knowledge, I have never worked with a transgender client. /
7. I use transgender affirmative language.
8. I apply knowledge about identity development models to my work with clients.
9. I seek consultation/supervision when I am working with a client ~~that challenges my clinical strengths as a counselor~~ whose clinical needs are outside my level of competence.
10. I have referred transgender clients because I did not feel competent to work with them. /
11. ~~I could write my client a letter in support of their transgender medical services.~~
12. I have attended trainings (e.g., workshops, conference sessions) that have focused on transgender issues.
13. I would not be able to identify transgender-positive resources in my community, ~~if I had a client ask for them~~. /
14. I know that transgender individuals also have a sexual orientation (e.g., lesbian, gay, bisexual, heterosexual, etc.).
15. I understand the importance of using least restrictive gender language when working with transgender clients.
16. ~~I understand the sense of loss that occurs for male-to-female (MTF) transgender individuals, as they give up their male privilege.~~
17. I know that transgender individuals have a disproportionate rate of suicide ~~when compared to other minority populations~~.
18. It is important to acknowledge intersecting identities of transgender individuals.
19. I understand ~~gender dysphoria, the diagnosis criteria, and~~ the implications associated with giving someone ~~that~~ a diagnosis of gender dysphoria.
20. I am able to educate and engage others on the topic of transgender issues.
21. I am not aware of the ~~facts and statistics of~~ historical events relevant to the transgender ~~victimization~~ community. /
22. I am familiar with the culture of transgender individuals.
23. I support that transitioning may be an important process for some transgender individuals.
24. I believe when working with transgender clients, counselors should create a welcome and affirming environment ~~for clients to feel comfortable being themselves~~.
25. I have reflected on my own identity and how my life experiences are similar and different from transgender individuals'.
26. I believe it is important to highlight the strengths and resilience of transgender clients.
27. Coming out should be done at the pace I see as appropriate for my transgender client. /
28. I think transgender issues should be included in multicultural counseling discussions.
29. I should advocate on behalf of ~~their~~ transgender clients.

30. It is important to my identity as a counselor that I attend transgender cultural events (e.g., pride, transgender day of remembrance).
31. I am afraid to act on behalf of transgender individuals~~, for fear that I will be judged~~. /
32. I believe action is the only way to change society
33. ~~I have close friends who identify as transgender.~~
34. I advocate on behalf of the transgender community.
35. I have/would correct someone who was speaking about transgender individuals in an oppressive and stereotypical way.
36. I advocate for/gender-neutral bathrooms at my place of employment/education.
37. I have written to my ~~congress representative~~ <u>elected officials</u> about transgender related issues.
38. I have presented (e.g., workshop, conference session, class presentation) on transgender related issues.
39. I understand the facts and statistics of transgender victimization.
40. I have ~~never~~ had the opportunity to help transgender clients identify and/or remove systemic barriers within social institutions<u>, but I chose to do nothing about it.</u> /
41. I have done research on transgender issues.
42. I <u>don't stay up-to-date on</u> ~~historical and~~ current events relevant to transgender issues. /
43. ~~I am not up-to-date on political climates relevant to transgender issues. /~~
44. I address social inequities impacting transgender clients' mental health.

Notes:
/ = Reverse coded items.
<u>Underline</u> indicates added content
~~Strikethrough~~ indicates eliminated content

APPENDIX D

Informed Consent Document

PROJECT TITLE: **Measuring Counselors' Transgender Ally Identity**

INTRODUCTION
The purpose of this form is to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. The research involves the completion of a survey that should take approximately 10-15 minutes. This survey will ask you questions about your transgender ally identity as a counselor, your perceived multicultural competence, and demographic information.

RESEARCHERS
Primary Researcher:
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DESCRIPTION OF RESEARCH STUDY
Limited research exists exploring the transgender ally identity of professional counselors across specialties. This research seeks to pilot and initially validate a scale for measuring counselors' transgender ally identity. Additionally, this research will explore factors (e.g., education level, experience, etc.) related to one's level of ally identity.

RISKS AND BENEFITS
RISKS: With participation in any research there are risks of discomfort in reporting personal beliefs. Data will remain confidential and anonymous. The researchers will reduce risks by removing any linking identifying information when reporting on results. And, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: There are no benefits for your participation in this study.

NEW INFORMATION
If the researchers find new information during this study that would reasonably change your decision about participating, then they will inform you.

CONFIDENTIALITY
All information obtained from and about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications, but the researcher will not identify you personally.

WITHDRAWAL PRIVILEGE
It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time. The researchers reserve the right to withdraw your participation in this study, at any time, if they observe potential problems with your continued participation.

COMPENSATION FOR ILLNESS AND INJURY
If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm or discomfort arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Dr. Jeffry Moe at jmoe@odu.edu or Dr. Petros Katsioloudis, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at pkatsiol@odu.edu, who will be glad to review the matter with you.

VOLUNTARY CONSENT
By agreeing to participate in this research, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, the researcher should be able to answer them:

Jamie D. Bower
jbowe025@odu.edu

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should contact Dr. Ed Gomez, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at egomez@odu.edu.

And importantly, by agreeing, you are telling the researcher YES, that you agree to participate in this study.

APPENDIX E

Transgender Ally Identity Scale for Counselors (TAISC) – Survey Version

Instructions: Answer each item as it applies to you, using the following likert-scale.
1- Strongly disagree
2- Disagree
3- Neither agree nor disagree
4- Agree
5- Strongly agree

1. I support that transitioning may be an important process for some transgender individuals.
2. I could diagnosis a client presenting with appropriate criteria for gender dysphoria.
3. I could write my client a letter in support of their transgender medical services.
4. I have had the opportunity to help transgender clients identify and/or remove systemic barriers within social institutions, but I chose to do nothing about it. *
5. I think transgender issues should be included in multicultural counseling discussions.
6. I understand the importance of using least restrictive gender language when working with transgender clients.
7. I am able to educate and engage others on the topic of transgender issues.
8. I have written to my elected officials about transgender related issues.
9. I have referred transgender clients because I did not feel competent to work with them.
10. I would not be able to identify transgender-positive resources in my community. *
11. I seek consultation/supervision when I am working with a client whose clinical needs are outside my level of competence.
12. I have never diagnosed a transgender client with gender dysphoria. *
13. I have attended trainings (e.g., workshops, conference sessions) that have focused on transgender issues.
14. I have done research on transgender issues.
15. I believe when working with transgender clients, counselors should create a welcome and affirming environment.
16. I know that transgender individuals also have a sexual orientation (e.g., lesbian, gay, bisexual, heterosexual, etc.).
17. It is important to my identity as a counselor that I attend transgender cultural events (e.g., pride, transgender day of remembrance).
18. I should advocate on behalf of transgender clients.
19. I have educated others about the facts and statistics of transgender victimization.
20. I routinely assess for my clients' gender identity.
21. I advocate for gender-neutral bathrooms at my place of employment/education.
22. I apply knowledge about identity development models to my work with clients.
23. I am afraid to act on behalf of transgender individuals. *
24. I have several LGBT related items (e.g., books, posters, brochures) displayed in my office.
25. To my knowledge, I have never worked with a transgender client. *
26. I know that transgender individuals have a disproportionate rate of suicide.
27. I use transgender affirmative language.
28. I do not stay up-to-date on events relevant to transgender issues. *

29. I routinely ask my clients what pronouns they use.
30. I am familiar with the culture of transgender individuals.
31. I believe it is important to highlight the strengths and resilience of transgender clients.
32. Coming out should be done at the pace I see as appropriate for my transgender client.*
33. I have/would correct someone who was speaking about transgender individuals in an oppressive and stereotypical way.
34. I have presented (e.g., workshop, conference session, class presentation) on transgender related issues.
35. It is important to acknowledge intersecting identities of transgender individuals.
36. I address social inequities impacting transgender clients' mental health.
37. I have reflected on my own identity and how my life experiences are similar and different from transgender individuals'.
38. I advocate on behalf of the transgender community.
39. I believe action is the only way to change society.
40. I understand the implications associated with giving someone a diagnosis of gender dysphoria.

* Reverse coded items.

APPENDIX F

Multicultural Counseling Knowledge and Awareness Scale (MCKAS)

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

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

not at all true   somewhat true   totally true

----

1. I believe all clients should maintain direct eye contact during counseling. (A)

2. I check up on my minority/cultural counseling skills by monitoring my functioning – via consultation, supervision, and continuing education. (K)

3. I am aware some research indicates that minority clients receive "less preferred" forms of counseling treatment than majority clients. (K)

4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive. (A)

5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients. (K)

6. I am familiar with the "culturally deficient" and "culturally deprived" depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination. (K)

7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted. (A)

8. I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation. (K)

9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illnesses than are majority clients. (K)

10. I think that clients should perceive the nuclear family as the ideal social unit. (A)

11. I think that being highly competitive and achievement oriented are traits that all clients should work towards. (A)

12. I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups. (K)

13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions. (K)

14. I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility. (K)

15. I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment. (K)

16. I am knowledgeable of acculturation models for various ethnic minority groups. (K)

17. I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups. (K)

18. I believe that it is important to emphasize objective and rational thinking in minority clients. (A)

19. I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups. (K)

20. I believe that my clients should view a patriarchal structure as the ideal. (A)

21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship. (K)

22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs. (K)

23. I am aware of institutional barriers which may inhibit minorities from using mental health services. (K)

24. I think that my clients should exhibit some degree of psychological mindedness and sophistication. (A)

25. I believe that minority clients will benefit most from counseling with a majority who endorses White middle-class values and norms. (A)

26. I am aware that being born a White person in this society carries with it certain advantages. (A)

27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients. (K)

28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs. (K)

29. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face. (A)

30. I believe that all clients must view themselves as their number one responsibility. (A)

31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development), which may dictate referral of the minority client to a member of his/her own racial/ethnic group. (K)

32. I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions. (K)

Scoring: The Knowledge items are designated by the symbol K after the item, and the Awareness items are designated by the symbol A after the item. The following items should be reverse scored: 1, 4, 7, 10, 11, 18, 20, 24, 25, and 30. Scale scores are calculated by adding items in each subscale. Higher scores indicate greater self-assessed competence in respective areas (i.e., knowledge, awareness).

Citation: Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). A revision of the Multicultural Counseling Awareness Scale. *Journal of Multicultural Counseling and Development, 30*, 153-180. doi:10.1002/j.2161-1912.2002.tb00489.x

APPENDIX G

Genderism and Transphobia Scale – Revised – Short Form (GTS-R-SF)

Instructions: Please indicate your level of agreement with each item using the following scale:

Strongly Disagree - Disagree - Somewhat Disagree - Neutral - Somewhat Agree - Agree - Strongly Agree

      1   2   3   4   5   6   7

Genderism and Transphobia subscale
1. If I found out that my best friend was changing their sex, I would freak out.

2. If a friend wanted to have his penis removed in order to become a woman, I would openly support him. **

3. Men who cross-dress for sexual pleasure disgust me.

4. Women who see themselves as men are abnormal.

5. I would avoid talking to a woman if I knew she had a surgically created penis and testicles.

6. A man who dresses as a woman is a pervert.

7. Sex change operations are morally wrong.

8. It is morally wrong for a woman to present herself as a man in public.

Gender-Bashing subscale
9. I have beat up men who act like sissies

10. I have behaved violently toward a woman because she was too masculine.

11. If I saw a man on the street that I thought was really a woman, I would ask him if he was a man or a woman.

12. I have behaved violently toward a man because he was too feminine.

13. If I encountered a male who wore high-heeled shoes, stockings, and makeup, I would consider beating him up.

Scoring: ** Indicates reverse-scored item. After reverse scoring, scores are summed or averaged to produce a total score. Higher scores indicate greater levels of anti-trans prejudice.

Citation for GTS: Hill, D. B., & Willoughby, B. L. B. (2005). The development and validation of the Genderism and Transphobia Scale. *Sex Roles, 53*, 531–544.

Citation for GTS-R-SF: Tebbe, E. A., Morati, B., & Ege, E. (2014). Revised and abbreviated forms of the Genderism and Transphobia Scale: Tools for assessing anti-trans prejudice. *Journal of Counseling Psychology, 61*, 581-592. doi:10.1007/s11199-005-7140-x

APPENDIX H

Marlowe-Crowne Social Desirability Scale – Short Form C (MCSDS-C)

Instructions:
Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is *true* or *false* as it pertains to you.

1. It is sometimes hard for me to go on with my work if I am not encouraged.

2. I sometimes feel resentful when I don't get my own way.

3. On a few occasions, I have given up doing something because I thought too little of my ability.

4. There have been times when I felt like rebelling against people in authority even though I knew they were right.

5. No matter who I'm talking to, I'm always a good listener.

6. There have been occasions when I took advantage of someone.

7. I'm always willing to admit it when I make a mistake.

8. I sometimes try to get even, rather than forgive and forget.

9. I am always courteous, even to people who are disagreeable.

10. I have never been irked when people expressed ideas very different from my own.

11. There have been times when I was quite jealous of the good fortune of others.

12. I am sometimes irritated by people who ask favors of me.

13. I have never deliberately said something that hurt someone's feelings.

Scoring:
1. True items: 1, 5, 7, 9, 10, 13. False items: 2, 3, 4, 6, 8, 11, 12. Items that are geared to being more socially desirable responses receive a score of 1 and items that are not socially desirable receive a score of 0 (total scores range 0 to 10).

Citation: Crowne, D. P. & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Counseling Psychology, 24*, 349-354. Reynolds, W. M. (1982).

Development of reliable and valid short form of the Marlowe-Crowne Social Desirability Scale. *Journal of Clinical Psychology, 38*, 119-125.

APPENDIX I

Demographic Questionnaire

The following questions are related to personal and professional demographic information about

yourself. Please fill in or select the answer that best describes you.

1. Age: _____

2. Gender (select all the apply)

    ____ Female

    ____ Male

    ____ Transgender

    ____ Other (Please Identify) _____

3. Ethnocultural Identity:

    ___ African American/Black

    ___ American Indian/Alaskan Native

    ___ Asian

    ____ Hispanic/Latin(o/a)

    ____ Multiple Heritage

    ____ Native Hawaiian/Pacific Islander

    ___ White

    ___ Other (Please Identify)_____

4. How would you define your sexual/affectional orientation:
    ____ Heterosexual

    ____ Gay/Lesbian

    ____ Bisexual

    ____ Queer

____ Other (Please Identify) _____

4. Do you have any close friends and/or relatives who self-identify as part of the LGBTQ community?

____ Yes

____ No

5. What is your role in the counseling field? (select all that apply):

___ Addictions Counselor

___ Community Mental Health Counselor

___ College Counselor

___ School Counselor

___ Counselor Educator

___ Counseling Student

___ Other (Please Identify) _____

6. Please select the highest level of counseling-related education you have:

___ Current Master's Student

___ Completed Master's degree

___ Current Doctoral Student

___ Completed Doctorate degree

7. What is your religious affiliation, if any? _____

8. In a typical week, how many hours do you spend doing something religious (e.g., attending church services, praying, reading scripture from a religious text, meditating)?

_____

APPENDIX J

Transgender Ally Identity Scale for Counselors (TAISC) – Revised

Instructions: Answer each item as it applies to you, using the following likert-scale.
1- Strongly disagree
2- Disagree
3- Neither agree nor disagree
4- Agree
5- Strongly agree

1. I support that transitioning may be an important process for some transgender individuals.
2. I could diagnosis a client presenting with appropriate criteria for gender dysphoria.
3. I could write my client a letter in support of their transgender medical services.
4. I think transgender issues should be included in multicultural counseling discussions.
5. I understand the importance of using least restrictive gender language when working with transgender clients.
6. I am able to educate and engage others on the topic of transgender issues.
7. I have written to my elected officials about transgender related issues.
8. I would not be able to identify transgender-positive resources in my community. *
9. I have never diagnosed a transgender client with gender dysphoria. *
10. I have attended trainings (e.g., workshops, conference sessions) that have focused on transgender issues.
11. I have done research on transgender issues.
12. I believe when working with transgender clients, counselors should create a welcome and affirming environment.
13. I know that transgender individuals also have a sexual orientation (e.g., lesbian, gay, bisexual, heterosexual, etc.).
14. It is important to my identity as a counselor that I attend transgender cultural events (e.g., pride, transgender day of remembrance).
15. I should advocate on behalf of transgender clients.
16. I have educated others about the facts and statistics of transgender victimization.
17. I routinely assess for my clients' gender identity.
18. I advocate for gender-neutral bathrooms at my place of employment/education.
19. I apply knowledge about identity development models to my work with clients.
20. I am afraid to act on behalf of transgender individuals. *
21. I have several LGBT related items (e.g., books, posters, brochures) displayed in my office.
22. To my knowledge, I have never worked with a transgender client. *
23. I use transgender affirmative language.
24. I do not stay up-to-date on events relevant to transgender issues. *
25. I routinely ask my clients what pronouns they use.

26. I am familiar with the culture of transgender individuals.
27. I believe it is important to highlight the strengths and resilience of transgender clients.
28. I have/would correct someone who was speaking about transgender individuals in an oppressive and stereotypical way.
29. I have presented (e.g., workshop, conference session, class presentation) on transgender related issues.
30. It is important to acknowledge intersecting identities of transgender individuals.
31. I address social inequities impacting transgender clients' mental health.
32. I have reflected on my own identity and how my life experiences are similar and different from transgender individuals'.
33. I advocate on behalf of the transgender community.
34. I believe action is the only way to change society.
35. I understand the implications associated with giving someone a diagnosis of gender dysphoria.

Scoring: * Reverse coded items. After reverse scoring, scores are summed to produce a total score. Higher scores indicate greater levels of transgender ally identity.

VITA

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EDUCATION

Ph.D., Counselor Education and Supervision, Old Dominion University   2016
M.Phil.Ed., Professional Counseling, University of Pennsylvania   2011
M.S.Ed., Counseling and Psychological Services, University of Pennsylvania   2010
B.A. Psychology, Cedar Crest College   2009
B.A. Philosophy, Cedar Crest College   2009

PROFESSIONAL EXPERIENCE

Old Dominion University, Norfolk, VA
    Darden Dissertation Fellow   Aug 2015-May 2016
    Graduate Teaching and Research Assistant   Aug 2013-Aug 2015
    Director of CARE Now   Aug 2013-Aug 2015

PROFESSIONAL AFFILIATIONS

American Counseling Association
Association for Counselor Education and Supervision
Southern Association for Counselor Education and Supervision
Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling
Chi Sigma Iota International