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Beyond Homophobia: Development and Validation of the Gay Affirmative Practice Scale (GAP)

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Beyond Homophobia: Development and Validation of the Gay Affirmative Practice Scale (GAP)

by

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Dedication

This dissertation is dedicated to “Granny,” Audrey Vivian Meadows, who always believed in me. Although she is not able to be with me in body, she remains with me in spirit every day of my life.

Special Dedication

The Response Set Study, discussed in pages 48-50 and 70-72 of this dissertation, is dedicated to the life and memory of Dr. Kathryn G. “Kate” Wambach. This portion of the dissertation was conducted in response to concerns expressed by Kate. Regrettably, she was taken from her loving partner, colleagues, friends, and adoring students before we were ready to let her go. As a professor, mentor, and dissertation committee member, she inspired me in many ways and was a shining example of how to live and teach with honesty, courage, humor, and grace.

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Beyond Homophobia: Development and Validation of the Gay Affirmative Practice Scale (GAP)

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Several studies have examined homophobia in the general population and in different groups of helping professionals such as social workers, counselors, psychologists, and nurses. However, few scales have been developed and validated to assess how practitioners interact with gay and lesbian clients in clinical settings. To address this deficit in the literature and to examine the degree to which practitioners engage in gay affirmative practice, this dissertation focused on the development and validation of the Gay Affirmative Practice Scale (GAP). Gay affirmative practice is a model of practice with gay and lesbian clients which treats them as equal to heterosexuals and considers their identities in the context of the oppression they experience.

This study consisted of four stages: 1) draft of an initial pool of items, 2) administration of the items to a pool of experts to assess the items' content

validity, 3) administration of the behavioral domain to assess which of two response sets yielded the greatest variability in responses, and 4) administration of the scale to clinicians to assess the reliability and validity of the instrument.

The final version of the GAP consists of two 15-item domains with strong evidence for their reliability and validity. Chronbach's alpha for the *belief* domain is .9307 and for the *behavior* domain is .9375. Both domains have strong factorial validity with each item loading on its respective domain at .60 or greater. The scale has convergent construct validity, as demonstrated by significant relationships with measures of homophobia, and discriminant construct validity, as demonstrated by a non-significant relationship with a measure of social desirability.

Significant relationships were found with GAP scores and measures of contact and feelings about gays and lesbians, training on gay and lesbian issues, current political party, sexual orientation, relationship status, primary role at agency, and primary practice area.

Use of this scale in future studies can yield important insight into factors that influence the degree to which clinicians practice affirmatively with gay and lesbian clients. In doing so, it is hoped that treatment with gay and lesbian clients will improve.

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Chapter 1: Statement of Problem

Since its beginning, social work has demonstrated a commitment to working with marginalized populations. Among the early recipients of assistance by social workers were people with mental illnesses, people with physical disabilities, and people who are poor (Popple & Leighninger, 1999). In the last twenty to thirty years, social work has increasingly expressed a willingness to include other disenfranchised groups such as gays and lesbians. The purpose of this research is to develop a scale that will assess practitioners' behaviors and beliefs in treatment with gays and lesbians.

STATEMENT OF PROBLEM

Despite its commitment to working with oppressed populations, a review of the literature indicated that social work did not lead the charge in advocacy and practice with gays and lesbians (DiNitto & McNeece, 1990). When members of the profession did act, it was largely in response to a social movement that began in the late 1960s by members of the gay and lesbian communities. The gay rights movement affected the approaches taken by social work and related professions such as psychiatry, psychology, and counseling. This movement affected how practitioners treated gays and lesbians, lead to an increase in education and research about the issues affecting this population, and resulted in research about the prevalence and correlates of attitudes regarding gays and lesbians.

In 1972, Weinberg (1972) coined the term "homophobia" to refer to "the dread of being in close quarters with homosexuals" (p. 4). This term reflected a

growing sentiment that it was not gays and lesbians whose behavior was pathologic but rather people's reactions to them that should be examined. In the last 25 years, the term homophobia has been used to refer to the broad range of negative attitudes regarding gays and lesbians (Hudson & Ricketts, 1980).

In 1973, following several months of debate among members of the American Psychiatric Association (APA), a decision was made to remove homosexuality from its classification as a mental illness in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 3rd edition (DSM III). According to Bayer (1987) this decision was highly politicized and based more on politics than on medical evidence:

> Instead of being engaged in a sober consideration of data, psychiatrists were swept up in a political controversy. The American Psychiatric Association had fallen victim to the disorder of the tumultuous era, when disruptive conflicts threatened to politicize every aspect of American social life. A furious egalitarianism that challenged every instance of authority had compelled psychiatric experts to negotiate the pathological status of homosexuality with homosexuals themselves. The result was not a conclusion based on an approximation of the scientific truth as dictated by reason, but was instead an action demanded by the ideological temper of the times. (pp. 3 - 4)

The decision to remove homosexuality as a mental illness had a wide reaching impact. Mental health professionals began to actively examine their individual and collective attitudes towards gays and lesbians and sought ways to improve their treatment of this population. Rather than focus on how to change the behaviors and psyches of gays and lesbians, the focus was on an examination of the attitudes of professionals who provide services to them. This shift was significant in that it lead practitioners from many disciplines to examine their own

feelings rather than emphasize the deficits of those who identified as gay, lesbian, or bisexual.

In response to the shift in attitudes about gays and lesbians, three fundamental changes occurred within the profession of social work. First, in 1972, *Social Work,* the primary journal of the National Association of Social Workers (NASW), the largest membership organization of social workers in the world, published its first article addressing issues relevant to gays and lesbians (Dietz, 1996). Second, in 1977, NASW published its first statement about gay and lesbians issues (Krajeski, 1996). This statement claimed that NASW would work to combat discrimination against gays and lesbians and that people should be free to choose how to express their sexuality (National Association of Social Workers, 1977). Third, and perhaps the most relevant to the proposed research, several researchers (e.g., DeCrescenzo, 1984; Herek, 1988; Hudson & Ricketts, 1980) set out to measure the extent of homophobia and characteristics of individuals that were correlated with having homophobic attitudes.

One of the first steps in scale construction is to define the construct(s) of interest (Spector, 1992). With a working definition of homophobia in place, several scholars began to develop scales to measure this construct. A review of 45 articles published between 1971 and 1987 found that 27 different measures were used to assess respondents' attitudes towards gays and lesbians (Schwanberg, 1993). Hudson and Ricketts (1980) report that from 1971 to 1978, at least 31 studies were conducted to assess homophobia in specified groups of people, among them college students, behavioral therapists, and people from different

countries. O'Donahue and Caselles (1993) found at least 539 published articles that examined attitudes toward gays and lesbians from 1979 to 1991. Although these studies were useful in assessing homophobic attitudes and factors associated with positive and negative reactions to gays and lesbians, the scales used have several limitations. Among the criticisms of these scales are problems in defining the construct homophobia; problems with the psychometric properties of the instruments, including failure to report the psychometric properties of the instruments and the use of arbitrary cutoff scores to determine what constitutes homophobic and non-homophobic reactions (O'Donahue & Casselles, 1993); and the use of instruments that have not undergone validation studies (Schwanberg, 1993).

In addition to the above criticisms, concern arises regarding the link between attitudes and behaviors. Many would agree that there is a relationship between the two and several scales have been used in such a manner as to suggest a direct relationship between attitudes and behavior. Fishbein and Ajzen (1975), however, argue that the relationship between attitudes and behaviors is actually indirect in that beliefs lead to attitudes, attitudes lead to intentions, and intentions lead to behaviors. In this manner, attitudes are a necessary precondition for behavior but do not always predict behavior: "Attitude is, at best, a necessary precondition for professional behavior with gay men and lesbian clients but it is not sufficient to ensure such behavior" (Oles, Black, & Cramer, 1999, p. 97). Thus, while studying attitudes towards gays and lesbians is an important

undertaking, educators and researchers should not be satisfied with attitudinal change alone.

Given the above issues, scales that assess behaviors are needed to effectively examine practitioners' treatment of gay and lesbian clients. This is particularly true in view of research that has shown that gays and lesbians are more likely than heterosexuals to seek therapeutic services (Rudolf, 1988). At present, only one scale, the Anticipated Professional Behavior (APB) scale, is available to assess professional behavior with gays and lesbians (Oles, Black, & Cramer, 1999). The APB consists of four case vignettes and asks respondents to indicate on a seven point scale what action they would take in response to the situation described in the vignette. Although a useful first attempt, each vignette is treated as a single item indicator, making interpretation of the results confusing at times.

Rapid assessment instruments (RAIs), brief paper-and-pencil tools, (Levitt & Reid, 1981) may be a more effective method by which to assess practitioners' behaviors and beliefs in treatment with gays and lesbians. As discussed by Fisher and Corcoran (1994), RAIs are frequently used in social work research and have many advantages over other types of instruments. RAIs are efficient, can be used to obtain information that is difficult to obtain through overt observation, enable respondents to disclose sensitive information that they may find difficult to verbalize, and allow comparisons from established norms or to the respondents' previously obtained scores. The difficulty of observing practitioners' treatment behaviors and beliefs with gay and lesbian clients, ease with which RAIs can be

administered, and the anonymity and confidentiality for both the practitioner and the client afforded by such instruments make RAIs a useful alternative by which to evaluate these constructs.

RELEVANCE TO SOCIAL WORK

In the years since the 1973 decision to depathologize homosexuality, the NASW and the Council on Social Work Education (CSWE) have passed several policies that address gays and lesbians. Following its first policy statement about gay and lesbian issues in 1977, NASW appointed the Task Force on Lesbian and Gay Issues in 1979 (Krajeski, 1996). In 1982, the CSWE entered the picture with the creation of the National Committee on Gay and Lesbian Issues (Krajeski, 1996). CSWE's 1988 Curriculum Policy Statement (CPS) gave accredited social work programs the choice to include content on sexual orientation; its 1992 CPS mandated inclusion of this content (Mackelprang, Ray, & Hernandez-Peck, 1996). According to Van Wormer (2000), "no other discipline has a comparable requirement" for including sexual orientation in the curriculum (p. 24).

Despite these policies, studies have identified various degrees of homophobia and heterosexism among social workers. A 1984 study found that social workers were more homophobic than nurses and psychologists (DeCrescenzo, 1984). In 1987, Wisniewski and Toomey (1987) found that 31% of respondents could be classified as "homophobic" on the basis of their scores on the Index of Homophobia (IHP) (Hudson & Ricketts, 1980). A more recent study suggests that homophobia among social workers may be decreasing. Berkman and Zinberg (1997) found that only 11% of 189 respondents could be classified as

homophobic on the basis of IHP scores. Although most therapists may not be homophobic, others may harbor homophobic attitudes which may compound problems the client is experiencing (Greene, 1994). Concern arises that gay and lesbian clients may be treated by homophobic therapists whose attitudes may increase the severity of the clients' problems.

Studies regarding heterosexism, defined by Morrow (1996) as the "promotion and valuing of heterosexuality over nonheterosexuality" (p. 2), suggest that social work as a profession is often guilty of this through its neglect of gay and lesbian issues. In a review of articles in *Social Work,* Dietz (1996) found that from 1965, the first year of publication, to 1994, only 28 articles contained content regarding nonheterosexuals in at least 50% of the paragraphs. This translates into less than one article per year for the first 30 years of publication. Morrow (1996) found similar evidence of neglect in a review of 27 social work textbooks used in one undergraduate social work program. Only 18.5% of the textbooks could be classified as "fully" or "moderately" inclusive of content regarding gays and lesbians. Mackelprang, Ray, and Hernandez-Peck (1996) offer additional evidence of heterosexism in social work. A review of accredited social work programs found that only 14% of programs offered a stand alone course on gay and lesbian issues, compared with 50% that offered a course on race/ethnicity, 30% that offered a course on gender issues, and 12% that offered a course on disability issues. In addition, Mackelprang and colleagues found that only 9% of programs indicated a "very strong" emphasis on recruiting, hiring, and maintaining gay and lesbian faculty while the majority (69%)

indicated “none to some” emphasis on gay and lesbian faculty. By contrast, 82% of programs indicated a very strong emphasis on faculty that are people of color and 47% indicated a very strong emphasis on female faculty. These findings suggest that social work continues to treat gay and lesbians as secondary in importance to most other populations.

To gain more insight into social workers’ attitudes and treatment of gays and lesbians, instruments can be developed to empirically assess their beliefs and behaviors in clinical settings. While direct observation is impractical due to the logistics of making such assessments, not to mention concerns about the confidentiality of the therapeutic setting, attempts can be made to assess behaviors and beliefs through the development of summated rating scales. Assessment of the beliefs and behaviors of practitioners when working with gays and lesbians may enable social workers to: 1) assess the effectiveness of educational approaches designed to prepare social work students and practitioners to better serve gay and lesbian clients, 2) provide insight into the relationship between attitudes and behaviors directed towards gays and lesbians, and 3) evaluate claims by those who profess anti-gay attitudes that they can treat gays and lesbians without bias.

FOCUS OF DISSERTATION RESEARCH

The purpose of this dissertation was to develop and validate a summated rating scale to assess practitioners’ beliefs about treatment and behaviors in therapeutic settings with gays and lesbians. Specifically, the following research questions were examined:

1) Can a two-dimensional scale be developed to assess practitioners' beliefs about treatment with gays and lesbians and behaviors in therapeutic settings?
2) How reliable and valid is the scale?
3) What is the relationship between the proposed scale and established measures of homophobia?
4) What demographic variables of practitioners are correlated with scores on the scale?

This chapter has defined the nature of the problem. Chapter 2 provides a review of relevant literature. Chapter 3 discusses gay affirmative practice (GAP), the model on which the scale is based. Chapter 4 discusses the methodology for this dissertation. Chapter 5 presents the findings and Chapter 6 contains a discussion of the findings and their implications for social workers and other helping professionals.

Chapter 2: Review of the Literature

Chapter 1 addressed the American Psychological Association's 1973 decision to depathologize homosexuality, leading to an interest in the concept of homophobia, defined by Weinberg (1972) as "the dread of being in close quarters with homosexuals" (p. 4). With this construct now defined, several scales were developed to assess homophobia and the characteristics of those scoring at different ends of the instrument. This literature review explores the research relevant to this issue and the consequences of homophobia for practitioners.

INSTRUMENTATION ISSUES

There are several problems in measuring homophobia. Chief among them is the definition of homophobia. Over time, the definition has broadened from the one offered by Weinberg to any negative attitude or reaction toward gays and lesbians (Haaga, 1991; Hudson & Ricketts, 1980). There are challenges in both conceptualizing and measuring the construct. Spector (1992) speaks to the importance of conceptualization when he states, "When scales go wrong, more often than not it is because the developer overlooked the importance of carefully defining and specifically delineating the construct" (p. 12). Differences also exist in the way that homophobia is measured. Schwanberg's (1993) review of studies on homophobia shows that instruments ranged from a single item indicator with as many as 17 points to a checklist of 84 adjectives used to describe traits of gays and lesbians. The variation in the scales indicates definitional problems in measuring homophobia. Does a scale that inquires about support for the civil

rights of gays and lesbians measure the same construct as a scale that asks respondents to identify adjectives that describe gays and lesbians? In the absence of an agreed upon definition and method for assessing homophobia, scales that purport to measure homophobia may actually be measuring very different constructs.

Paramount among issues in measuring homophobia is validity. Schwanberg (1993) found that only 11 of 45 studies on homophobia reported information about validity of the homophobia measures and that two studies "assumed" validity on the basis of comparisons to other groups and differences between subjects. Those that did attempt to assess validity may not have compared the instrument to appropriate criterion measures. For example, Hudson and Ricketts (1980) reported that the Index of Homophobia (IHP), also referred to the Index of Attitudes toward Homosexuals (IAH), has good construct validity based on its high correlation with the Sexual Attitudes Scale (SAS). O'Donahue and Caselles (1993) note that since the SAS is a measure of "sexual conservatism" (not homophobia), the IHP may do little more than assess sexual conservatism. In the absence of information about the IHP's discriminant validity, its relationship with the SAS is not sufficient to suggest that the IHP is a valid measure of homophobia (O'Donahue & Caselles, 1993).

Failure to report the validity and reliability of instruments is an additional issue in studying homophobia. In Schwanberg's (1993) review, about half the researchers failed to report reliability and/or validity estimates for the instruments used to assess homophobia; only 23 studies reported information about either

reliability or validity. Of those who did report this information, 14 reported reliability estimates, 11 reported validity estimates, and a mere five reported information about both reliability and validity (Schwanberg, 1993). The use of scales developed specifically for individual studies raises further concerns, particularly when these scales have not undergone validation testing. In Schwanberg's review, 15 studies used scales apparently developed for that particular study. Only two of these studies reported the instrument's validity. Fisher and Corcoran (1994) speak to the importance of providing information about the validity of instruments:

> For an instrument to be valid, it must to some extent be reliable. Conversely, a reliable instrument may not be valid. Thus, if an instrument reports only information on validity, we can assume some degree of reliability but if it reports only information on reliability, we must use more caution in its application. (p. 18)

Therefore, failure to assess and report validity of the instruments raises serious concerns about whether instruments used in these studies are accurate sources of information about this topic.

Also important to validity is the use of arbitrary cutoff scores to assess who is homophobic and who is not homophobic (O'Donahue & Caselles, 1993). This is a problem in many of the scales that have been used to assess homophobia, most notably the IHP (Hudson & Ricketts, 1980), the most widely used measure of homophobia (O'Donahue & Caselles, 1993). Hudson and Ricketts claim that on a scale of 0 to 100, 75 or higher indicates a "high grade homophobic," 50-74 indicates a "homophobic," 25-49 indicates a "non-homophobic," and a score of less than 25 indicates a "high grade non-homophobic." In a similar manner, Smith

(1971) administered the Homophobia Scale to 99 college students. He considered the 21 highest scores to be the homophobic group and the 21 lowest scores to be the non-homophobic group. While the authors suggest that the cutoff scores are appropriate determinations of homophobics and non-homophobics, they provide no rationale for choosing the cutoff points at which these determinations are made. Herek suggests that to make such classifications is to err because "like all other attitudes scales, there are no objective standards for classifying individuals as prejudice or not prejudice" (personal communication, July 30, 1999).

In summary, differences in the way homophobia is defined and measured lead to challenges in comparing scales used in different studies. The lack of information regarding validity and reliability testing raises concerns about the scales' ability to accurately assess homophobia. The use of arbitrary cutoff scores may also result in inaccurately classifying people on the basis of scale scores. These challenges suggest that scales that assess practice with gays and lesbians should: 1) clearly define the construct, 2) undergo extensive reliability and validity testing, and 3) refrain from using arbitrary scores to classify who is and is not affirming in their practice with gays and lesbians.

CORRELATES OF HOMOPHOBIA IN STUDENTS AND ADULTS

Despite fundamental problems in measuring homophobia, several studies have been conducted to assess homophobia in students and other adult groups. This section discusses some variables associated with homophobia in students and adults.

Gender

Gender differences in attitudes towards gays and lesbians have frequently been investigated (Simon, 1995). Many studies indicate significant gender differences (e.g., Herek, 1995; Maret, 1984; Pratte, 1993; Seltzer, 1992; Whitley, 1988), with men reporting significantly more homophobia than women. Kite's (1984) meta-analysis of 24 studies published between 1974 and 1983 found a small though significant gender difference in attitudes towards gays and lesbians; however, Kite also showed that much of the difference could be attributed to sample size and year of publication. Kite suggests that gender differences in attitudes towards gays and lesbians may thus not be as prevalent as some studies suggest.

Race

Some studies have found evidence of racial differences in attitudes towards gays and lesbians. Caucasians have been found to be less homophobic than those of other racial backgrounds. Waldner, Sikka, and Baig's (1999) study of 190 college students found that Caucasians were less homophobic than African-Americans. Hudson and Ricketts' (1980) study of 300 psychology, social work, and sociology students found significant differences in IHP scores in comparing Caucasians to Japanese, Chinese, Filipino, and other ethnic minority groups.

Contact with Gays and Lesbians

Contact with and/or knowing someone gay or lesbian also seems to be significantly correlated with lower homophobia. For example, Millham, Miguel,

and Kellogg's (1976) study of 795 undergraduate psychology students found that individuals who had prior experience with gays and lesbians had significantly more positive attitudes towards this population. The authors further found that having a gay or lesbian friend or relative "resulted in significantly lower personal anxiety, less advocation of repression, and lower moral reprobation scores in describing both male and female homosexual targets" (p. 8). In a study of 143 college students, Hansen (1982) found that people who reported knowing gays or lesbians were significantly less homonegative (homophobic) than those who did not report knowing gays or lesbians. O'Hare, Williams, and Ezoviski's (1996) study of 175 Rhode Island college students found that "knowing a gay person predicted that the individual would be significantly less homophobic" (p. 54).

Religiosity and Homophobia

Studies consistently find that higher levels of religious expression are correlated with higher homophobia levels. Irwin and Thompson (1977) have suggested that measures of religiosity are among the best predictors of attitudes towards gays and lesbians. Maret (1984), for example, found that religious fundamentalists were significantly more disapproving of homosexuality than non-fundamentalists in a study of 151 undergraduate students. Gentry (1987) found that greater church attendance was correlated with greater discomfort with gays and lesbians in a sample of 201 students at Tulane University. Using data from a national sample of 2,300 adults, Seltzer (1992) found that "people who more frequently attend church or consider themselves to be reborn Christians hold the most antihomosexual attitudes" (p. 395). Kunkel and Temple's (1992) study of

507 college students found that those who attended church each week were significantly more homophobic than those who never attended church. Johnson, Brems, and Alford-Keating's (1997) study of 714 people who identified as "exclusively heterosexual" found that "as level of religiosity increases, homophobia increases, and belief that homosexuality has a genetic basis decreases" (p. 64).

Correlates with Other Attitudinal Measures

Homophobia may also be related to other attitudes. Hudson and Ricketts (1980) found homophobia was positively correlated with conservative sexual attitudes. Kite and Deaux (1986) observed that homophobia and a measure of attitudes toward feminism were negatively related in 569 students at the University of Texas at Austin and Purdue University. Several studies (e.g., Bouton, Gallaher, Garlinghouse, Leal, Rosenstein, & Young, 1987; O'Hare, Williams, & Ezoviski, 1996) note a positive relationship between homophobia and fear of AIDS. In a sample of 368 undergraduates, Herek (1988) found that attitudes towards gays and lesbians were significantly correlated with sex role attitudes and traditional family ideology. More recently, Morrison, Parriag, and Morrison (1999) found that homophobia was positively correlated with machismo, authoritarianism, political conservatism, and sexism in a sample of 1,567 adolescents and adults.

Changes over Time

Several studies have examined changes in attitudes towards gays and lesbians over time. Seltzer's (1993) study of 2,308 adults found a negative change

in attitudes over a two year period: "respondents were much less likely in 1987 compared to 1985 to say they held a liberal or moderate view of homosexuality" (p. 89). However, a comparison of two comparable groups (N = 180) studied in 1986 and 1991 "suggests a decrease in negative attitudes toward homosexuality and/or homosexuals in the five year time span between 1986 and 1991" (Pratte, 1993). Authors of both studies suggest that these changes may be due to concerns about Acquired Immune Deficiency Syndrome (AIDS). Pratte writes:

> In 1986, the time of the first survey, a causal link between homosexuality and AIDS was deeply rooted in many people's minds. By 1991, with AIDS spreading in the heterosexual population, the focus had shifted away from homosexuals. This may have influenced attitudinal changes toward homosexuality. (p. 82)

An analysis of data collected in public opinion surveys by 21 different organizations from 1965 to 1996 lead Yang (1997) to suggest that "mass public opinion change has occurred within the past two decades, often to a striking degree" (p. 477). Yang found positive changes in attitudes towards gays and lesbians had occurred in the following areas: 1) more people believed that "homosexual relations in private between consenting adults (should be) left to the individual"; 2) more people believed sexual orientation is determined at birth; 3) more people knew someone who was gay or lesbian; 4) more people reported being "very sympathetic" and less people reported being "very unsympathetic" towards gays and lesbians; and 5) more people supported specific civil rights protections such as housing and employment protections.

In sum, several studies in the general population have shown a relationship between different demographic variables and homophobia. Variables that have

been found to be correlated with higher levels of homophobia include being male; having an ethnic identity other than Caucasian; being more religious; holding conservative attitudes toward sex, sex roles, family ideology, and politics; having a fear of AIDS; and having negative attitudes towards women. Attitudes toward gays and lesbians have also changed over time with much of the population identifying more positive attitudes and greater support for civil rights protections for gays and lesbians.

HOMOPHOBIA AMONG SOCIAL WORKERS

To date, there are apparently four published studies that have examined the prevalence of homophobia among social workers and variables that are correlated with this concept. The first was conducted by DeCrescenzo (1984). Despite the publication of several instruments that had been developed to assess homophobia, DeCrescenzo used an instrument that she developed to measure three aspects of homophobia: 1) whether respondents saw gays and lesbians in stereotypical terms; 2) the degree to which homosexuality was seen as evidence of psychopathology by the respondents; and 3) "general homophobia," which she described as identifying respondents who had liberal attitudes towards gays and lesbians but had concerns about being in close physical proximity to them. Validation of DeCrescenzo's instrument was limited to a review by a "panel of three independent judges" who evaluated the items based on their "relevance to the research topic and in terms of adequate measurement of the identified aspect of the study" (DeCrescenzo, 1984, p. 126). DeCrescenzo sampled 140 mental health professionals from eight agencies in the Los Angeles, California, area, but

did not specify the mental health disciplines they represented or provide other information about the sample.

Despite these methodological problems, DeCrescenzo (1984), herself a social worker, reported that social workers were the most homophobic and psychologists were the least homophobic. She does not indicate whether this difference was statistically significant, how other disciplines compared, or what variables were correlated with homophobia among social workers. She did suggest that lower homophobia among psychologists may be due to their greater concern about gay and lesbian issues. Conversely, she noted that social workers' greater homophobia may be attributed to low visibility of gay and lesbian issues among social workers, few articles in social work journals about gay and lesbian issues, little attention given to gay and lesbian issues at social work conferences, and few social workers in the study who indicated they knew a gay or lesbian person.

DeCrescenzo (1984) also found that those who identified as gay or lesbian on the basis of Kinsey scale scores perceived gays and lesbians "in the least stereotypic terms," whereas married people saw them more stereotypically. Married respondents also perceived gays and lesbians as being more clinically disturbed than did respondents who were not married. She also found a statistically significant relationship between the number of gay and lesbian clients mental health professionals served and the stereotype score on the scale she devised. She did not provide data to determine whether these findings hold true for the social workers in the sample.

Wisniewski and Toomey (1987) found additional evidence of homophobia among social workers. Using a sample of 127 social workers in the Columbus, Ohio, area, they assessed homophobia with the Index of Attitudes towards Homophobia (IAH) (Hudson & Ricketts, 1980) and examined other demographic variables. Using the classifications devised by Hudson and Ricketts, Wisniewski and Toomey found that of the 77 social workers who responded, 4% were high-grade nonhomophobics; 65% were low grade nonhomophobics; 25% were low grade homophobics; and 6% were high grade homophobics. In sum, 31% of social workers could be considered homophobic. Remember, however, that one limitation of the IAH is the use of arbitrary cut off scores to determine what constitutes a homophobic attitude (O'Donahue & Caselles, 1993). An individual who responds "neither agree, nor disagree" to every statement on the IAH would be labeled a "high grade homophobic" while "neutral responses might be expected of individuals who do not harbor negative attitudes towards homosexuals but who do not seek out or prefer the company of homosexual individuals" (O'Donahue & Caselles, 1993, p. 194). The findings that 31% of social workers are homophobic may thus be inflated.

Wisniewski and Toomey (1987) acknowledge the limitations of their study. In addition, they suggest that scores on the IAH may not correlate with practice behaviors with gays and lesbians:

> The literature assumes that the level of homophobia is negatively correlated with effectiveness of services provided to gay and lesbian clients. If this assumption proves true, then scores obtained in this study support the need for increased personal and academic training of social workers in gay and lesbian issues. If, on the other hand, the assumption proves false, the current focus on increasing awareness of homophobic

> attitudes of social workers needs to be reassessed. Clearly, more research relating to attitudes to quality of service delivery is needed as it applies to the homosexual client. (Wisniewski & Toomey, 1987, p. 455)

As noted in Chapter 1 of this proposal, attitudinal assessment of social or human service professionals alone is currently inadequate because there is insufficient information to determine the relationship between homophobic attitudes and effective or affirming practice with gays and lesbians.

Research by Hardman (1997) suggests that social workers in other countries are also concerned about homophobia in the profession. Unlike the other researchers, Hardman focused her study on attitudes and behaviors exclusively with lesbian clients due to concerns that previous studies, in using the "general term 'homosexual,'" focused on attitudes towards gay men (p. 546). Given this concern, Hardman devised a 30-item, three domain scale that assessed pathological attitudes (those that perceive lesbianism as a sickness), liberal humanist attitudes (those that perceive lesbianism as a "normal lifestyle option"), and lesbian feminist attitudes (those that focussed on the "value of women becoming lesbian as a response to their patriarchal oppression") (p. 548). Hardman mailed these items, along with two case vignettes aimed at gaining insight into social workers' "understanding of anti-lesbianism" and "consideration of lesbian context" (p. 548) and questions about demographic variables, to 120 social workers and first year MSW students in London, England. Seventy-five surveys were returned.

Although Hardman's (1997) article shows that she developed the items with much thought and effort, she provides no information regarding its reliability

and validity, nor does she indicate that her items were reviewed by outside experts or tested on a developmental sample prior to administration to the sample identified in the study. Thus, the validity of the instrument and the study's results are questionable. In addition, for reasons not clear, Hardman does not sum the items for each domain as would be expected with an instrument that appears to have been developed as a summated rating scale. Instead, she provides information about the response to each individual item and makes loose generalizations about the responses in each domain.

These problems not withstanding, Hardman (1997) found that ethnic origin and previous contact with lesbians were "of little value" in predicting responses to individual items on the scale (p. 554). Only one item, "I am personally disgusted by the thought of two women having sex together," produced a statistically significant gender difference--women were more likely than men to agree with this item. Hardman further found that the best predictor of responses was identity as a lesbian, with lesbians disagreeing with most of the liberal humanist responses and agreeing with most of the lesbian feminist responses. In discussing this difference, Hardman writes:

> This indicates that lesbian respondents are more likely to have an understanding of the lesbian context and it would be tempting to argue that lesbian clients ought to therefore have lesbian social workers. In the interests of anti-oppressive practice it should, however, be the responsibility of all social workers to have an understanding of the lesbian context. (pp. 556-557)

Despite the lack of validation of her scale, Hardman is concerned with the broader dimensions of attitudes towards gays and lesbians. Her work is also

interesting because it provides some information about homophobia among social workers in another cultural context.

The most comprehensive study of homophobia among social workers was conducted by Berkman and Zinberg (1997). They studied 187 heterosexual social workers, randomly selected from NASW membership using a mailed survey. In contrast to Wisniewski and Toomey (1987), Berkman and Zinberg found that only 11% of social workers were homophobic, based on their responses to Hudson and Ricketts' (1980) IHP. These findings further support Yang's (1997) claim of positive changes in attitudes towards gays and lesbians during the last two decades. Like Wisniewski and Toomey, Berkman and Zinberg also found that men were more homophobic than women but these differences were not statistically significant. They did, however, find a significant gender difference on a 13-item heterosexism scale created by the authors with men being more heterosexist than women. Age was also significantly correlated with scores on the heterosexism measure but not with the measures of homophobia. Both men and women were more homophobic towards men than towards women based on scores on Herek's (1988) Attitudes Toward Gay Men scale and Attitudes Toward Lesbians (ATLG) scale. Consistent with findings discussed earlier in this chapter, respondents who indicated that religion was an extremely important aspect of their lives were more homophobic than those who indicated otherwise. Berkman and Zinberg also found that those who knew someone gay or lesbian had lower levels of homophobia.

In discussing their findings, Berkman and Zinberg (1997) give much attention to the relationship between homophobia and treatment with gays and lesbians. They suggest that homophobia in practitioners may: 1) interfere with counseling, 2) affect transference and counter transference, 3) lead to inappropriate choices regarding the treatment modality, and 4) result in errors in treatment with clients. These concerns further support the need for increased research into the relationship between attitudes towards and practice with gays and lesbians.

Research confirms homophobia does exist in the social work profession, although the rate may have decreased in the past two decades. Of primary importance to this study is the impact of homophobia on practice with gays and lesbians, discussed later in this review. The studies discussed in this section, when considered in conjunction with the impact of homophobia on treatment with gay and lesbian clients, suggest that more research is needed into the relationship between attitudes and practice with this population.

HOMOPHOBIA IN SOCIAL WORK STUDENTS

Similar to research on homophobia among social workers, few researchers have examined homophobia among social work students. This section explores the relevant research in this area.

Tate (1991) investigated differences in homophobia scores between rural and urban groups of social work students (N = 71). There were no statistically significant differences between the groups, but Tate found that 17% of students could be classified as homophobic. Although he claims this finding was obtained

"using the same criteria as the Wisniewski and Toomey study (1987)," Tate used a different scale to assess homophobia (the Homophobia Scale by Bouton et al., 1987) (p. 17). Since the original article by Bouton et al. makes no reference to cutting scores, the appropriateness of applying cutting scores devised for another scale raises questions about the accuracy of the claim that 17% of students could be classified as homophobic.

Smoot (1991) compared homophobia levels among 161 social work, engineering, physical education, and psychology students. There were no statistically significant differences among the groups on the Heterosexuals Attitudes Toward Homosexuals (HATH) scale (Larsen, Reed, & Hoffman, 1980). Like other researchers, Smoot found that male respondents were more homophobic than female respondents.

Black, Oles, and Moore (1996) assessed homophobia in 233 social work students at different points in the curriculum. Using the IHP and a pre-test post-test design to assess the impact of two undergraduate and one graduate social work course on homophobia levels, the authors found that across time, graduate students had significantly lower levels of homophobia than did undergraduates. Male students, both undergraduate and graduate, were significantly more homophobic than women. Differences by race were also statistically significant, with Caucasian students significantly less homophobic than African-American and Latino students across all levels of the program. There were no significant differences in pre-test or post-test scores when social work students were compared to students majoring in other disciplines. An analysis of individual

items by the authors found that students expressed more homophobic attitudes when "the items raise questions about sexuality and personal experience" and less homophobic attitudes when "the items inquire about gay men in formal social settings" (p. 33). Black and colleagues also point out that responses to statements involving greater social distance created less homophobic responses:

> The findings suggest that students feel comfortable supporting the civil rights of gay and lesbian persons and that they accept the anti-discriminatory values in the social work profession. However, students appear more challenged in their support of gay and lesbians persons in less professional and personal situations—situations of less social distance. (p. 34)

Additional research by Black, Oles, and Moore (1998) examined the relationship between social work students' levels of homophobia and sexism. Similar to their earlier research, the authors used a pre-test post-test design to assess homophobia levels of 331 undergraduate and graduate students in Introduction to Social Work and Human Behavior in the Social Environment classes. Results on the IHP and the Sexist Attitudes Toward Women Scale (SATWS) (Benson & Vincent, 1980) indicated a significant correlation at both pre-test and post-test for the two scales, suggesting a relationship between homophobia and sexism in the group studied. This relationship was strongest for graduate students. In contrast to their 1996 study, the authors did not find a significant gender difference in scores on the IHP at either pre-test or post-test. Consistent with their 1996 study, there were no significant differences in IHP scores by major (social work versus other disciplines). Race was again significantly correlated with IHP scores, with African-American students having higher levels of homophobia than Caucasian and Latino students at both pre-test

and post-test. In addition, there was a significant correlation between IHP and SATWS scores for both Caucasian and Latino students, but not for African-American students.

Oles, Black, and Cramer (1999) and Cramer, Oles, and Black (1997) have studied the impact of different teaching strategies on homophobia and anticipated professional behavior in 110 social work students at undergraduate and graduate programs at four different universities. The instruction given to students varied with respect to: 1) instructor's sexual orientation, 2) instructor's disclosure of sexual orientation, 3) the use of guest speakers, and 4) the type of experiential learning course. All classes had assigned readings on gay and lesbian issues. Using the ATLG (Herek, 1988), Cramer et al. (1997) report that income, religion, and having lesbian friends were significant predictors of pre-test scores while having gay friends and having lesbian friends were the only significant predictors of post-test scores. Cramer, Oles, and Black also found significant differences in pre-test and post-test ATLG scores for each of the four different interventions but no significant differences among any of the four different class types. These findings have two implications: 1) the role of demographic variables such as income and religion in predicting homophobia among social work students may decrease after educational interventions and 2) education, in a variety of forms, can significantly reduce homophobia scores among social work students.

Using data from the Cramer et al. (1997) study, Oles et al. (1999) studied the relationship between attitudinal and behavioral change. The Anticipated Professional Behavior (APB) scale was developed for this study by one of the

study's authors. The APB consists of four case vignettes (two portraying a lesbian woman and two portraying a gay man). Students were asked how they would respond on a seven-point scale to each vignette. Each vignette has two anchors, one being the preferred response and one being a response deemed "unacceptable" by the authors. According to the authors, the APB was pilot tested with 24 social work educators with an average of 10 years experience working with gay and lesbian clients. Each vignette is analyzed separately and the results are not summed to form a composite score. In examining the relationship between the ATLG and the APB, the authors found a significant positive correlation at both pretest and posttest for one vignette; a significant positive correlation at pretest only for a second vignette; a significant positive correlation for posttest only on a third vignette; and no correlation between the ATLG and the APB for a fourth vignette. They also found that correlations of changes from pre-test to post-test on the ATLG and APB were "fewer and weaker" than the correlations the authors found between the scales mentioned above. Only two of the four vignettes were correlated with less homophobia as measured by the ATLG. Given that the vignettes are not comparable with respect to variables such as gender, race, and age, students may not be responding to differences in the sexual orientation of the clients but to other variables. This suggests that the APB may not be assessing professional behavior with gays and lesbians but with people who vary on many different characteristics, and this may explain the absence of consistent correlations between the APB and ATLG. This problem further reinforces the

need for measures to assess practice with gays and lesbians that have been thoroughly tested and validated.

Weiner's (1989) dissertation examined the relationship between racism, sexism, homophobia, and responses to case vignettes by 125 senior BSW students at five social work programs in the northeast. Weiner's vignettes did not vary, as did the APB, by gender, race, and age. She found strong statistically significant relationships in the expected directions between scores on the IHP and the Attitudes Toward Women Scale (Spence, Helmreich, & Stapp, 1973) and the Modern Racism Scale (McConahay, 1985) (i.e., students who are less homophobic are also less racist and sexist). Consistent with research by Berkman and Zinberg (1997) and other authors noted earlier in this chapter, Weiner further found that social contact with gays and lesbians, even at fairly low levels, was significantly associated with more positive attitudes towards gays and lesbians. Weiner did not, however, find a relationship between students' levels of homophobia and their responses to gay and lesbian client vignettes. Similar to Oles, Black, and Cramer (1999), Weiner's results suggest case vignettes may not be a valid method of assessing practice with gays and lesbians. Her results also suggest that there is not a relationship between homophobia and hypothetical practice situations with gays and lesbians. If further research confirms these findings, concerns about homophobia among social workers (discussed in the next section of this review) may not be as great as the literature suggests.

Research on homophobia among social work students has produced results similar to those found in the general population: Caucasians are less homophobic

than those from other ethnic groups and there is a positive relationship between homophobia and sexism. In addition, social work majors are no less homophobic than other majors. The level of social work education may influence social work students' level of homophobia as indicated by MSW students' significantly lower levels of homophobia when compared to undergraduate social work students and by the significant differences in pre-test and post-test scores following four different educational interventions in the Cramer et al. (1997) study.

The jury is still out on whether or not there is a relationship between homophobia and practice with gay and lesbian clients because the case vignettes that have been used to assess this practice may be inadequate to detect the relationship. One problem with case vignettes is the lack of agreement on what the appropriate response should be. Weiner (1989) suggests that assumptions are often made that different assessments of similar cases indicate bias when no bias is present. Thus case vignettes may not be the best means by which to assess practice with gays and lesbians.

PRACTICE IMPLICATIONS OF HOMOPHOBIA

Surprisingly little has been written about the consequences of homophobia among social workers and other professionals for gay and lesbian clients. Several authors claim that homophobia in social workers and other human service professionals reduces the effectiveness of the treatment provided. Travers (1998) writes: "The homophobic counselor can not effectively meet the needs of gay or lesbian clients" (p. 6). Peterson (1996) reiterates this claim in stating, "Lesbians and gay men receive inferior treatment from providers who are homophobic" (p.

xvii). Both authors suggest that the result of homophobia for gay and lesbian clients is a lower quality of services that may do more harm than good.

Messing, Schoenberg, and Stephens (1984) claim that homophobia may lead social workers to minimize or exaggerate the importance of sexual orientation in the gay or lesbian person's life. According to these authors, minimizing may be reflected in statements such as "It doesn't matter who one sleeps with" (p. 67). Underestimating the role of sexual orientation "ignores that for many lesbians and gay men, sexual orientation has a profound impact on their lives which must be taken into account when providing social work services" (p. 67). On the other hand, exaggerating the significance of sexual orientation may result in the social worker attributing the cause of the client's presenting problem to his/her identity as a gay/lesbian person and thus choosing to focus on that even when the problem is not directly related to the client's identity as a gay or lesbian person (Messing et al., 1984). These actions ultimately affect the treatment provided to gay and lesbian clients and may result in not effectively and directly addressing the problem identified by the client.

Homophobia may also lead to treatment providers changing the topic or cutting clients short when they talk about gay and lesbian issues. McHenry and Johnson (1993) note that doing so devalues "any positive experiences that may emerge when the client fully explores his/her feelings" and denies "the client access to the full range of experiences" (p. 147). The results, according to McHenry and Johnson, are that clients may cease to bring up gay and lesbian issues and that this component of their lives is poorly addressed in treatment.

Another way that practitioners express bias against gays and lesbians is by viewing them strictly in terms of their sexual behavior and/or defining them as gay or lesbian solely on the basis of their sexual behavior (Brown, 1996). According to Brown, this error may lead to practitioners failing to view celibate persons as gay or lesbian, assuming that adolescents can not have identities as gays and lesbians, assuming that same sex relationships are just a phase, and informing clients that they are not really gay or lesbian because they fail to meet some arbitrarily defined criterion.

Homophobia in practitioners, when combined with the internalized homophobia experienced by the clients they serve, can perpetuate self-hatred by gay and lesbian clients (McHenry & Johnson, 1993). Appleby and Anastas (1998) write about the range of responses of gays and lesbians to these negative feelings:

> total denial of one's sexual orientation, contempt for the more 'obvious' members of the community, distrust of other gay people, projection of prejudice onto others, sometimes marrying someone of the other sex to gain social approval, increased fear, and withdrawal from friends and relatives. (p. 30)

Others add that self-hatred in gays and lesbians contributes to high rates of suicide and substance abuse among members of this group (Bradford & Ryan, 1988; Shernoff & Scott, 1988).

At its extreme, homophobia in social workers and other practitioners can lead to the use of conversion or reparative therapies, treatment aimed at changing the sexual orientation of the gay, lesbian, or bisexual person. Although the NASW, American Psychological Association, American Counseling Association, and American Psychiatric Association have written policies rejecting the use of

this treatment, many practitioners continue to support its use. NASW's National Committee on Lesbian, Gay, and Bisexual Issues (2000) has stated that such therapies "cannot and will not change sexual orientation" (p. 2). The committee further states: "NASW discourages social workers from providing treatments designed to change sexual orientation or from referring clients to practitioners or programs that do so" (p. 2). Despite this, organizations to which social workers belong such as the National Association for the Research and Therapy of Homosexuality (NARTH) (1999) and the North American Association of Christian Social Workers (NACSW) support the use of such therapies. NACSW's Executive Director Rick Chamiec-Case, MSW, MAR, expresses a position on the use of reparative therapies that is in direct contrast to NASW's position on this issue: "We do believe, however, that it is consistent with respect for religious diversity to honor the requests of individuals who seek the use of reparative therapy, and support those of our members who provide this type of counseling" (personal communication, October 4, 1998).

Homophobia in social workers and other human service professionals may have many consequences for gay and lesbian clients. At a minimum, homophobia may result in negative feelings among gay men and lesbians if practitioners cut them short when they discuss gay and lesbian issues or give other clues about discomfort with gay and lesbian individuals. In the extreme, homophobia may lead to the use of reparative therapies aimed at changing the sexual orientation of gay and lesbian clients. The development of valid and reliable measures of

practitioners' beliefs and behaviors in treatment can help social workers and other helping professionals to better evaluate these claims and their practice.

CONCLUSION

Although many instruments have been developed to assess homophobia, and several studies have been conducted regarding homophobia among social workers and social work students, there are many problems with both the instruments and the studies. The psychometric properties of scales that assess homophobia have not been well established. Arbitrary cutoff scores are generally used to determine who is and is not homophobic, suggesting that homophobia is an all or nothing concept. Although many authors suggest a link between attitudes and behavior, the scales used to assess this relationship are generally comprised of case vignettes that also suffer from failure to define the construct of interest, lack of reliability and validity testing, and responses that may be attributable to characteristics other than respondents' behaviors with gays and lesbians. The literature discussed in this chapter clearly supports the need to rigorously validate scales to assess practitioners' beliefs and behaviors in treating gay and lesbian clients. This is particularly true when the potential practice implications of homophobia and bias against gays and lesbians are considered.

The purpose of this dissertation was to use standard methods of validity and reliability testing to develop a scale to assess the degree to which social workers and other practitioners engaged in affirmative practice with gays and lesbians. A well validated measure can help the profession move beyond an examination of attitudes and an assumed relationship between attitudes and

behavior and will enable educators, researchers, and practitioners to better assess the extent to which clinicians are engaging in affirmative practice behaviors and beliefs in treatment with gays and lesbians and the effects of such practices.

Chapter 3: Overview of Gay Affirmative Practice

The Gay Affirmative Practice Scale (GAP) developed in this dissertation research is based on models of affirmative practice with gay and lesbian clients. According to Davies (1996), gay affirmative practice "affirms a lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity" (p. 25). This chapter provides an overview of gay affirmative practice, identifies key components of gay affirmative practice, and describes domains of the GAP that are derived from this model.

OVERVIEW OF GAY AFFIRMATIVE PRACTICE

A direct consequence of the decision to remove homosexuality from the DSM III was "the development of lesbian and gay affirmative models, approaches which dealt with understanding and serving the mental health needs of these groups without pathologizing the state of being homosexual" (Morgan & Nerison, 1993, p. 138). Evidence of the shift from pathology to affirmative practice is seen in publications that address services with gays and lesbians (e.g., Dulaney & Kelly, 1982; Rabin, Keefe, & Burton, 1986). These and many other articles identify ways in which services can be provided to gays and lesbians that validate their identities and affirm their experiences as gays and lesbians rather than trying to cure them of their homosexuality.

Although much has been written about gay affirmative practice in the psychological literature, the focus has largely been on gay affirmative *psychotherapy*. Despite this, gay affirmative practice is applicable to many

practice settings and treatment modalities, including those in which social workers are employed:

> The concept of *gay- or lesbian-affirmative practice* is becoming the goal to which those practicing in the mental health and substance abuse fields are striving. There is no particular approach to psychotherapy or other forms of mental health treatment nor any particular modality of treatment—individual, couple, family, or group—that cannot be made useful for lesbian, gay, or bisexual people if approached affirmatively. (Appleby & Anastas, 1998, p. 286)

Garnets and Kimmel (1993) have identified two "waves" of gay affirmative practice. According to these authors, the first wave:

> assisted gay men and lesbians in understanding and accepting their sexual orientation as a natural part of themselves, helped them develop strategies for coping and forming a positive sense of identity, and taught them the effect of social attitudes, prejudice, discrimination, and heterosexism on psychological functioning. (p. 34)

Thus, the first wave focused on the individual with the goal of improving the individual lives of gays and lesbians. The second wave, according to Garnets and Kimmel, addresses practitioners, researchers, and educators and encourages further research regarding this model. This wave, the authors claim, has four primary themes:

1. Reducing bias in practice and theory through the use of education, training, research, and application of professional guidelines;
2. Applying gay affirmative practice into different areas of practice;
3. Empirically testing gay affirmative models, theories, and approaches;

4. Examining ways in which gay affirmative paradigms may lead to reconceptualizing different areas of study such as sexuality, gender roles, and family relationships.

The study described in this dissertation is targeted at the second wave: empirical testing of the degree to which social workers and other helping professionals are applying principles of gay affirmative practice. Assessing this will give insight into variables that may be correlated with gay affirmative practice and may suggest ways in which educational methods can be enhanced to increase social workers' knowledge and use of this model.

COMPONENTS OF GAY AFFIRMATIVE PRACTICE

Appleby and Anastas (1998) have articulated six fundamental principles of gay affirmative practice. Although described elsewhere by psychologists (e.g., Clark, 1997; Davies, 1996), these principles are chosen as the basis for the scale because they were identified by social workers and appear applicable to the many settings in which social workers are employed. These six principles are:

Principle 1: *Does not assume that a client is heterosexual.* Appleby and Anastas (1998) suggest that presumption of heterosexuality is a common mistake made by social workers and other practitioners and can have painful consequences for the client:

> In dealing with a situation where the sexual orientation of the client is unknown, having an attitude and using language that conveys openness to either a heterosexual or homosexual possibility are critically important. If a presumption of heterosexuality is made, as usually it is, or if it is assumed that the client's most important ties are only biological ones, it

> can be actively, if unwittingly, painful and alienating to the client seeking help. (p. 36)

Thus, it is not simply enough to have an open mind about clients' sexual orientation. Social workers and other practitioners should attempt to convey this openness in different ways such as by using gender neutral terminology when inquiring about relationship status and asking about clients' sexual orientation on intake forms. Behaviors such as these convey support and affirmation for the client's identity as a gay or lesbian person.

Principle 2: *Believes that homophobia in the client and society is the problem, rather than sexual orientation.* In order to practice affirmatively with gays and lesbians, practitioners must believe that homophobia, rather than homosexuality, is the problem. Those who support the use of conversion therapies for gays and lesbians cannot be said to practice affirmatively with gays and lesbians. Davies (1996) states that those who believe that "homosexuality is sick, unnatural, or perverted" are incapable of working affirmatively with gays and lesbians (p. 28). Tozer and McClanahan (1999) further state: "Conversion therapies reflect a deeply homophobic and heterosexist culture. They are explicit acts that perpetuate the historical context asserting that homosexuality is something to be abolished" (pp. 730 - 731). Affirmative practitioners thus focus on assisting clients in living in a world that is homophobic and oppressive, rather than trying to change clients' sexual orientation. As Appleby and Anastas (1998) state:

> Rather than seeking causes or explanations for homosexuality, the social worker is directed to explore and help the client to overcome the oppression (discrimination and bigotry), specifically those obstacles,

> internalized or external, that may stand in the way of healthy functioning as a lesbian, gay, or bisexual person. (p. 406).

Principle 3: *Accepts an identity as a gay, lesbian, or bisexual person as a positive outcome of the helping process.* At the core of gay affirmative practice is "the movement to remove stigma long associated with homosexual orientation" (Morin, 1991, p. 245). Morin and Rothblum (1991) claim that assisting clients in the development of "a positive identity despite the many societal barriers that exist" is a central concern of gay affirmative practice (p. 948). Thus, a key principle in affirmative practice is working with gays and lesbians to counter the many negative messages they have received and to help them develop a positive self-image as gays and lesbians. Clark (1997) suggests that one role of gay affirmative practitioners is to "help lessen the shame and guilt surrounding homosexual thoughts, feelings and behavior…and to approve homosexual thoughts, behavior and feelings when reported by your client" (pp. 332 - 333). Thus, practitioners who work affirmatively with gays and lesbians help to decrease negative feelings, increase positive expression of gay/lesbian feelings, and support the development of a gay or lesbian identity as a positive outcome of the helping process.

Principle 4: *Works with clients to decrease internalized homophobia that the client may be experiencing so that the client can achieve a positive identity as a gay or lesbian person.* Of paramount importance in work with gays and lesbians is decreasing their internalized homophobia. Shildo (1994) suggests that "internalized homophobia may be one important determinant of psychopathological conditions in lesbians and gay men" and thus should be

routinely assessed in practice with them (p. 181). In addition to the consequences discussed in Chapter 2 of this dissertation, Shildo, summarizing the literature, states that internalized homophobia may lead to difficulties in intimate and affectional relationships, under and over achievement, difficulties in sexual functioning, unsafe sex, avoidance in coping with AIDS, domestic violence, substance abuse, eating disorders, fragmentation and borderline-like features, and suicide. Given the potential consequences of internalized homophobia, addressing it is critical to "increase the range of emotional expression and personal choices available to clients" and to work affirmatively with gay and lesbian clients (Appleby & Anastas, 1998, p. 290).

Principle 5: *Is knowledgeable about different theories of the coming out process for gays and lesbians.* Several authors have presented theories of coming out (the process by which gays and lesbians acknowledge their sexual orientation and share their identities with people at different levels of their lives) and suggest that this is a critical part of development for gays and lesbians (Cass, 1979; Coleman, 1981/1982; Woodman & Lenna, 1980). According to Cramer (1995), "the identity and disclosure process is ongoing and central to understanding the life experiences of lesbians and gay men, even when the problem for which a gay man or lesbian is seeking counseling is not the coming out process" (p. 1). Knowledge about the coming out process and challenges faced by clients at different stages of the process can thus aid social workers in providing treatment to clients at different stages of the process and in validating and supporting their different experiences.

Principle 6: *Deals with one's own homophobia and heterosexual bias.* This is a key point in the literature on gay affirmative practice. It is not simply enough to consider oneself non-homophobic. Heterosexual bias and homophobia must be actively examined in order to practice affirmatively with gays and lesbians. Liddle (1997) states: "A mere lack of bias is not adequate preparation to consider oneself a gay-affirmative therapist" (p. 17). Appleby and Anastas (1998) agree that "The absence of misinformed and negative or biased practice is not enough for sensitive and effective practice with lesbian, gay, and bisexual clients" (p. 287). Van Wormer, Wells, and Boes (2000) point out the importance of addressing homophobic and biased feelings when they state:

> To be effective in working with lesbians and gays, the helping professional has to honestly explore his or her deepest and most intimate feelings concerning homosexuality. All people, gay and nongay, have feelings regarding homosexuality. If the counselor or therapist thinks that gays and lesbians are "okay" but is repulsed at the thought of what gays and lesbians do affectionately or sexually, the counselor or therapist is homophobic or erotophobic. Feelings such as these need to be dealt with on a personal level before working successfully with lesbian and gay clients. (p. 115)

Thus, in order to be affirming in practice with gay and lesbian clients, practitioners must strive not only to be non-homophobic but to truly acknowledge and understand the nature of their own prejudices against gays and lesbians.

In addition to the above principles, Davies (1996) claims that holding any of the following beliefs precludes practitioners from working affirmatively with gay and lesbian clients:

1. Homosexuality is sinful or against God's wishes;

2. Homosexuality is sick, unnatural, or perverted;
3. Homosexuality is inferior to heterosexuality;
4. Monogamy is the only healthy way to have a relationship;
5. Gay and lesbian relationships can only be short-term, sexual, or lacking depth;
6. Gays and lesbians are more likely to sexually abuse children;
7. Gay and lesbian parents are inferior to heterosexual parents;
8. Bisexuals can decide to be gay/lesbian or heterosexual.

Practitioners who hold these beliefs cannot work with gay and lesbian clients in ways that convey respect for individuals and seek to affirm their identities as gays and lesbians, a central theme of gay affirmative practice. In addition, concern arises that these beliefs about gays and lesbians lead to beliefs *about treatment* with gays and lesbians. For example, a belief that homosexuality is against God's wishes may lead to a belief that gays and lesbians should be treated for their homosexuality so that they may no longer be sinners; a belief that gays and lesbians are more likely to sexually abuse children may lead practitioners to treat gays and lesbians for pedophilia when there is no other indication of such a disorder.

Other characteristics of gay affirmative practice have also been described in the literature. These include working with gay and lesbian clients to expand the range and depth of their feelings and accept these feelings as normal (Clark, 1997); reassuring clients that their experiences are normal, helping them make

sense of their feelings, and delineating some of the tasks necessary for integration of their sexual identity into their personality structure (Davies, 1996); using language that suggests health rather than pathology (Morin & Charles, 1983); being knowledgeable about gay and lesbian resources (Appleby & Anastas, 1998; Cramer, 1995) and being able to make appropriate referrals to gay affirmative resources; and recognizing the multiple identities experienced by ethnic minority gays and lesbians and the importance of extended families for gays and lesbians, and understanding that families of origin of gays and lesbians may need education and support (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). These behaviors assist practitioners in responding to gay and lesbian clients in a way that affirms their identities as gay men and lesbians as a positive one and equal to heterosexual identity.

Practitioners have struggled with how to define gay affirmative practice (Morin & Rothblum, 1991) and there is no how-to list for conducting gay affirmative practice. Despite these limitations, the central concept of gay affirmative practice is the acknowledgement that a gay or lesbian identity is equal to a heterosexual identity and should be embraced as such. Furthermore, gay affirmative practitioners work to challenge the negative messages that clients may have internalized as a consequence of their identities as gays and lesbians. As summarized by Tozer and McClanahan (1999), an affirmative practitioner:

> Celebrates and advocates the validity of lesbian, gay, and bisexual persons and their relationships. Such a therapist goes beyond a neutral or null environment to counteract the life-long messages of homophobia and heterosexism that lesbian, gay, and bisexual individuals have experienced and often internalized. (p. 736)

Thus, affirmative practice is not passive but active and strives to consciously assist gays and lesbians in improving the quality of their lives by celebrating who they are and challenging the homophobic and heterosexist systems around them.

ASSESSMENT OF GAY AFFIRMATIVE PRACTICE

On the basis of the conceptual model that has been briefly outlined, the scale to assess affirmative practice with gays and lesbians that is the focus of this dissertation has two domains: 1) beliefs about treatment with gays and lesbians and 2) behaviors in treatment with gays and lesbians. The beliefs about treatment domain was chosen because the literature clearly states that beliefs that homosexuality should be changed and/or treated by the helping professional are inconsistent with gay affirmative practice. Conversely, beliefs that an identity as a gay or lesbian person should be supported by helping professionals and that gay and lesbian clients deserve practitioners' support and encouragement during the "coming out" process and other developmental phases are consistent with gay affirmative practice. The behaviors in treatment domain was chosen because the literature describes behaviors that are consistent with gay affirmative practice, such as the practitioner inquiring about clients' sexual orientation and using terminology that suggests the client is not assumed to be heterosexual. Conversely, behaviors such as focusing on a clients' sexual orientation as the underlying cause of problems and attempting to change clients' sexual orientation are inconsistent with gay affirmative practice.

Chapter 4: Methodology

This chapter describes the procedure followed to develop and validate the Gay Affirmative Practice Scale (GAP). Four distinct stages were used to complete the research: 1) draft of an initial pool of items, 2) administration of the items to a pool of experts to assess the content validity of the items, 3) administration of the behavioral domain to assess which of two response sets yielded the greatest variability in the responses, and 4) administration of the scale to clinicians to assess the reliability and validity of the instrument. Each step is discussed in this chapter.

SCALE CONSTRUCTION

Construction of scale items was based on the domain sampling model (Nunnally & Bernstein, 1994). According to this model, "the definition of a construct describes a domain from which potential items (observational or self-report) can be ideally sampled" (Springer, Abell, & Hudson, 2002, p. 411). In this study, the domain is *gay affirmative practice*, and thus the definition of this construct is critical to the creation of scale items. Once the construct has been adequately defined, the traditional path to item generation is through a review of the literature (DeVellis, 1991; Spector, 1991). The literature review serves as a vehicle from which to obtain a thorough understanding of the construct and to define the boundaries of the construct.

A extensive review of the literature on gay affirmative practice produced 23 articles on practice with gay and lesbian clients that were reviewed for this study. Appendix A contains a list of the articles used to generate the items. From

this review, 543 items were created. After duplicate items and those which did not appear to assess the behavior or belief domains were eliminated, 372 items remained: 167 in the behavior domain and 205 in the belief domain.

CONTENT VALIDITY STUDY

Lynn (1986) describes content validity as "the determination of the content representativeness or content relevance of the items of an instrument by the application of a two-stage (development or judgment) process" (p. 382). The 372 items were mailed to people familiar with gay affirmative practice. Respondents were identified largely by a "snowball" sampling method. The Council on Social Work Education's Commission on Sexual Orientation and Gender Expression (CSOGE) assisted in identifying experts who were willing to review the items. Two authors of social work books on practice with gays and lesbians also agreed to review the items. Following this process, a total of 12 experts were contacted by email and asked to complete the survey.

The ten reviewers who agreed to assist were sent a packet with the items (see Appendix B) along with a self-addressed return envelope. Consistent with methods described by Lynn (1986) and Waltz and Bausell (1981), reviewers were asked to rate each item for its relevance to the construct using a four point scale (1 = "not relevant," 2 = "somewhat relevant," 3 = "quite relevant," and 4 = "very relevant"). In addition, reviewers were also asked to comment on the response options and to provide comments about each item. When scoring items as a 1 or 2, reviewers were asked whether: (1) the item should be reworded, and if so, how; (2) the item duplicates another item in the pool; and 3) the item is not relevant and

should be dropped entirely. Although the initial intent was to retain items with a mean score greater than or equal to 3.0, doing so would have resulted in a total of 264 items being retained for administration to the sample. Thus, the 35 items with the highest mean scores were retained, except when two items identified for retention assessed similar constructs. When this occurred, one of the two items was eliminated and the item with the next highest mean score was retained. For example, several items in the behavior domain assessed how frequently practitioners assisted clients in dealing with homophobia; the item with the highest mean score was retained. In addition, five items from each domain that were reverse scored were chosen for inclusion in the scale because including reverse scored items in a questionnaire can reduce acquiescence response (DeVellis, 1991) and make the questionnaire more valid (Torabi & Ding, 1998). Additional information about the results of this stage can be found in Chapter 5.

RESPONSE SET STUDY

Of interest in this dissertation was how frequently practitioners would engage in particular practice behaviors. The items in the behavior domain were thus written so that subjects would respond according to the frequency of their behavior using a five-point scale (never, rarely, sometimes, usually, always). However, concern arose that use of this response set would result in responses clustered on the "never" and "rarely" responses. In order to address this concern, a study was conducted to assess whether this frequency response set or the Likert response set (strongly agree to strongly disagree) would yield the greatest variability in responses for the behavior domain. Using the steps described below,

a sample of 300 social work graduates was selected for this part of the study using a list provided by the Dean's office at the University of Texas at Austin School of Social Work.

1. The list of graduates (Ph.D., MSSW, and BSW) from 1969 to 1999 produced 3,352 names.
2. As the list contained people who obtained multiple degrees from UT, it was sorted such that if either their first or second degree from UT was an MSSW, they were included in the list.
3. This list was then sorted to include only those that received their MSSW from 1969 to 1999, and thus had at least 2 years post-MSSW practice experience. This reduced the list to 2,128 names.
4. Since most PhD graduates hold faculty or administrative positions, people with the title "Dr." or a second degree of PhD were also eliminated (N = 69), leaving 2,059 names.
5. Using the random select command in SPSS 10.0.5, 300 graduates were selected to receive the questionnaire.
6. From this set of 300 names, the random select command was again used to select 150 graduates. Those selected were sent the version with the frequency response option; the remainder were sent the version with the Likert-scale response option.

In addition to the questions with one of the respective response sets, both groups were sent the same cover letter and demographic questions along with a self-

addressed stamped envelope in which to return the questionnaire. A copy of the materials sent to respondents can be found in Appendix C.

Responses were returned by 51 individuals. In order to assess which version of the scale had the greatest response variability, a reliability analysis of the items comprising each version was conducted. The variance for the scale as a whole was examined along with the range of the item means for each version. Results of this stage are discussed in Chapter 5.

ADMINISTRATION TO CLINICIANS

Finally, the measurement package (consisting of the scale items, instruments to assess validity of the scale, and demographic items) was mailed to a sample of clinicians.

Subjects

The final sample consisted of members of the National Association of Social Worker (NASW) and American Psychological Association (APA). In order to reduce mailing expenses and response time all were residing in the United States. Only members engaged in direct practice with clients were of interest in this study. The NASW identifies direct practitioners as those whose "function" has been self-identified as "clinical/direct practice" (Beverly Young, InFocus, personal communication, December 21, 2001). The APA identifies direct practitioners as those who are licensed and have "paid the special practice assessment (a mandatory fee that all members who provide/supervise mental health services must pay)" (Kyle Fennel, American Psychological Association, personal communication, December 21, 2001). The researcher requested that

1,500 members' names be randomly selected from those who met the above criteria for the respective organization.

Sample Size

A total of 3,000 individuals (1,500 from each organization) were mailed the instrument packet. The decision to sample such a large group was based on the following:

1. Tinsley and Tinsley (1987) recommend that a minimum of five to ten respondents per item are needed to conduct the factor analysis. Given that the factor analysis was conducted on 80 items, a minimum sample size of 400 usable surveys was needed.
2. Previous research using mailed surveys to assess social workers' attitudes towards gays and lesbians yielded response rates between 32% and 63% (Harris, Nightengale, & Owen, 1995; Hardman, 1997). Using this minimum response rate of 32%, a return of 960 usable surveys could be expected.
3. In view of the terrorist attacks on the World Trade Center and the Pentagon on September 11, 2001, and the subsequent disruption in the mail system when envelopes containing anthrax were sent to members of Congress and other individuals were infected by anthrax, concern arose that respondents might be reluctant to open mail from a source unfamiliar to them. Given this, it seemed wise to expect a much lower response rate than the studies cited above and to assume that the response rate might be as low as half the lowest response rate noted above.

4. Given that 400 responses were needed and a minimum response rate of 16% was assumed, a minimum sample of 2500 was needed. In order to further safeguard against a low response rate, this number was rounded up to a total of 3,000 total packets mailed.

Measures

In order to assess the construct validity of the GAP, scales that assessed homophobia and social desirability were included in the instrument packet sent to NASW and APA members. Scales that assess homophobia were administered to assess convergent construct validity based on the theory that the domains of the GAP should be strongly correlated with measures of homophobia. A scale that assesses social desirability was administered to assess discriminant construct validity based on the theory that there should be a low correlation between the GAP and measures of social desirability. Each instrument is described below. Permission to use each instrument was obtained from the author(s) unless the instrument was in the public domain.

Attitudes Toward Lesbians and Gay Men Scale (ATLG)

Items in the ATLG are measured on a 20-item summated rating scale designed to measure attitudes towards lesbians and gay men. It consists of two subscales that measure 1) attitudes about lesbian women and 2) attitudes about gay men. Herek (1988) created the two subscales (the Attitudes Toward Lesbians [ATL] and Attitudes Toward Gay Men [ATG]) because his research demonstrated that the gender of the gay man or lesbian woman individual influenced reactions

of respondents and that the term "homosexuality" was frequently associated with gay men and not applied to lesbian women.

The ATLG is a nine-point Likert scale with the "strongly agree" response scored as 9 and "strongly disagree" response scored as 1. The range of scores is from 20 (reflecting extremely positive attitudes toward lesbians and gay men) to 180 (reflecting extremely negative attitudes toward lesbians and gay men). Scores for the 10-item subscales range from 10 to 90, with lower scores reflecting more positive attitudes. Herek suggests that the subscale scores be used as separate measures but when appropriate, the total score for the ATLG may also be used. Herek also says that the scale can be used with five-and seven-point response scales (personal communication, July 30, 1999). He also recommends using a 10-item "short form" of the scale unless there is a compelling reason not to do so (personal communication, July 30, 1999). Based on this information, the short form of the scale was used with a five-point response scale. The five-point response scale is less cumbersome than a seven-point scale and is consistent with the response scale used in the Heterosexuals Attitudes Towards Homosexuality (HATH) scale (Larsen, Reed, & Hoffman, 1980), also used to assess construct validity in this study, and the scale developed by this researcher. The scores for the short form of the ATLG thus range from 10 (reflecting extremely positive attitudes toward lesbians and gay men) to 50 (reflecting extremely negative attitudes toward lesbians and gay men).

The ATLG has been administered to and validated with college students and members of gay and lesbian organizations. The scale has demonstrated high

internal consistency with an alpha of .90 for the ATLG, .89 for the ATG, and .77 for the ATL. Herek (1988) has found the scale correlates significantly in the expected direction with attitudes toward sex roles, traditional family ideology, and with reports of positive contact with lesbians and gay men (a finding that is consistent with other research in this area).

Heterosexuals' Attitudes Toward Homosexuality (HATH)

Larsen, Reed, and Hoffman (1980) constructed the HATH to measure cognitive beliefs about gays and lesbians. Items in the HATH are measured on a five-point Likert scale with the "strongly agree" response scored as 5 and the "strongly disagree" response scored as 1. The range of scores is from 20 to 100 with higher scores reflecting more positive beliefs about gays and lesbians. The HATH has been validated with college students. The instrument has a split-half reliability of .86, and when corrected with the Spearman-Brown prophecy formula, has a split-half reliability of .92 (Larsen et al., 1980). Larsen et al. found that the scale correlated significantly in the expected direction with instruments that assess religious ideology, authoritarianism, and feelings of inadequacy.

Marlowe-Crowne Social Desirability Scale (SDS)

The Marlowe-Crowne Social Desirability Scale (SDS) was developed to assess socially desirable responses in research subjects (Crowne & Marlowe, 1960). The scale was initially developed with 33 true-false items; however, since that time, several shorter versions have been developed due to concerns about the length of the original scale (Fisher & Fick, 1993) and that many of the items contributed little to the overall measure (Strahn & Gerbasi, 1972). The M-C 1(10)

is a short version of this scale that consists of 10 of the original 33 items in the scale (Strahn & Gerbasi, 1972). An analysis of eight short versions of the Marlowe-Crowne scale found the M-C 1(10) to be "the scale of choice" based on the length (10 items), correlation with the original scale (.958), and high internal consistency (.876) (Fisher & Fick, 1993).

The theoretical scoring range is 0 to 10 with lower scores reflecting lower social desirability. Crowne and Marlowe (1960) defined the socially desirable response for each item and respondents are given one point for each item they answer in a way that is consistent with this response and no points for answers that are not consistent with a socially desirable response.

Demographic Items

Based on the review of the literature and items of interest to this researcher, 20 demographic items were included as part of the instrument packet. These items inquired about the respondents' personal characteristics such as gender, race, sexual orientation; religious and political affiliation; and contact with and feelings about gays and lesbians. Appendix D contains a copy of the entire instrument packet, consisting of 140 items and the cover letter sent to potential respondents.

Mailing Procedure

The University of Texas at Austin University Mailing Services (UMS) distributed the instrument packet. A cover letter and a self-addressed business reply envelope in which to return the survey were included in the materials that were mailed to potential respondents. Materials were sent by UMS via third class

mail to the potential respondents using mailing labels provided by the NASW and APA. The packets were mailed on January 25, 2002. According to UMS, materials should have been received by the respondents no later than February 1, 2002. Respondents were requested to return the materials to the researcher by February 15, 2002.

Determining Reliability and Validity

Reliability

Internal consistency reliability of the scale was established through an analysis of responses obtained in the administration to clinicians. Due to pragmatic and financial limitations of this researcher, internal consistency reliability was the only type of reliability calculated. Test-retest reliability was not conducted due to the financial and logistical difficulty of having respondents complete two sets of measures. Parallel-forms was also ruled out as a method for assessing reliability since the focus was on developing an initial version of the scale. Split-halves reliability was not used because there is no standard method for dividing the test into halves and the manner in which the test is divided can affect reliability estimates (Crocker & Algina, 1986); internal consistency reliability is considered a more effective method for computing reliability (Nunnally & Bernstein, 1994). Thus, internal consistency reliability was the most logical method for establishing reliability in this study.

The standard error of measurement (SEM) was also computed for each domain. The SEM is an estimate of the standard deviations of error of measurement and is less influenced by differences in variance and standard

deviation in different samples or populations than coefficient alpha (Springer, Abell, & Nugent, in press). The SEM should be computed in order to compensate for differences in sample standard deviations. A small SEM provides further evidence that the scale is reliable. SEM is computed as:

$$\text{SEM} = \sigma_{\text{o}} \sqrt{(1 - r_{tt})}$$

where

σ_{o} =*standard deviation of observed scores, and*

r_{tt} = *coefficient alpha*

Validity

Three types of validity were assessed: content, construct, and factorial. Due the difficulty in identifying groups of clinicians that would be openly biased in their practice with gay and lesbian clients, known-groups validity was not assessed in this study. As discussed by several authors, validating a scale is an ongoing process and does not end on completion of the aforementioned types of analyses.

Content validity can be thought of as the degree to which items in an instrument represent the construct of interest and is often established by having independent experts assess whether the items adequately assess the construct (Springer, 1997). As discussed in the content validity study, experts in gay affirmative practice were asked to review each item to assess if it measured beliefs about treatment or behaviors in treatment with gay and lesbian clients. An instrument must have content validity to have other forms of validity (DeVellis,

1991; Nunnally & Bernstein, 1994). In this study, the process for establishing content validity discussed earlier was a necessary precursor to other steps in the process.

The second type of validity assessed was construct validity, both convergent and discriminant forms. The assessment of construct validity is closely tied to theory and is concerned with theoretical relationships between variables (DeVellis, 1991; Springer, 1997). As described by Campbell & Fiske (1959), validation is often convergent in that it is concerned with showing that two different methods of assessment lead to similar ends. In this case, as Campbell and Fiske suggest, it was hypothesized that GAP scores would be correlated with scores on existing measures that were theoretically related to it. Although the limited empirical research correlating homophobia and practice behaviors provides mixed results, the theoretical literature on gay affirmative practice consistently suggests a strong relationship between practitioners' homophobia and their ability to practice affirmatively with gay and lesbian clients. Thus, it was expected that people who held more positive attitudes towards gays and lesbians would be more affirming in their treatment with this population than those who held more negative attitudes towards gays and lesbians. Based on this, significant correlations with the ATLG and HATH were expected. As multi-dimensional scales are collections of unidimensional scales (Hudson, 1985), convergent construct validity was established for each domain rather than for the scale as a whole.

The GAP was hypothesized a priori to have two domains: 1) practice behaviors with gays and lesbians and 2) beliefs about practice with gays and lesbians. It was expected that significant correlations between the behavior domain and the ATLG (which measures attitudes) and between the beliefs domain and the HATH (which measures beliefs) would be found. It was hoped that the subscales would correlate highly ($\geq$ .70) with their respective known-instruments. This threshold was agreed upon by members of the dissertation committee as a reasonable correlation because there is no cutoff point for determining that construct validity exists (DeVellis, 1991). A correlation of greater than or equal to .70 was thus considered evidence of initial convergent construct validity.

As discussed by Spector (1992), discriminant construct validity indicates that two measures are loosely associated with each other. A valid measure of beliefs and behaviors with gays and lesbians should not be highly correlated with a measure of social desirability. Based on this, it was expected that the total GAP score would have a low correlation ($\leq$ .30) with the Marlowe-Crowne Social Desirability Scale (M-C 1(10)). This threshold was also agreed upon by members of the dissertation committee as a reasonable correlation and is consistent with claims by DeVellis (1991) that the correlation for discriminant construct validity be lower than the correlations for convergent construct validity. A correlation of less than or equal to .30 was thus considered evidence of initial discriminant construct validity.

Confirmatory factor analysis (CFA) using the multiple groups method (Nunnally & Bernstein, 1994) was used to establish factorial validity. This

method, in contrast to principal components factor analysis, allows the researcher to examine the correlation between each of the individual items and each of the domains in the scale. This in turn allows the researcher to confirm or disconfirm a priori hypotheses about factor loadings. As Stevens (1996) indicates, CFA is indicated when there is a strong theory base, when the number of factors is determined a priori, when the factors are fixed a priori as either correlated or uncorrelated, and when the variables are fixed to load on a specific factor. The GAP was developed based on a review of the literature, the number of domains (factors) was fixed a priori at two (beliefs and behaviors), the factors are intuitively correlated and were treated as such, and the items were fixed to load on the domain that they were expected to capture.

Examining Relationships between Demographic Variables and GAP Scores

Pearson's *r* was used to examine correlations between interval level variables (age, percent of time spent in direct practice with clients, number of workshops with a *focus* on gay/lesbian issues, number of workshops with *content* on gay/lesbian issues, number of gay/lesbian friends, number of gay/lesbian family members, number of gay/lesbian clients, percent of clients who are gay/lesbian, lesbian feeling thermometer, and gay feeling thermometer) and scores on the final 30-item version of the GAP.

T-tests were also used to examine the relationships between two-category variables (gender and organizational membership) and scores on the final 30-item version of the GAP. One-way analysis of variance (ANOVA) was used to examine the relationships between categorical variables with three or more

categories (relationship status, sexual orientation, religious affiliation, race, highest degree received, current political party, organization, primary role, and primary area of practice) and GAP scores. Tukey's post-hoc analyses were conducted to assess where significant differences existed. Some of the categories of these variables were collapsed because of the small number of respondents in each category. Following this, t-tests were performed when the variable was collapsed to only two categories and one way ANOVA tests were conducted when the variable contained more than two categories.

HUMAN SUBJECTS APPROVAL

Permission to conduct the response set study and the administration to clinicians study was obtained from the University of Texas at Austin (UT) Institutional Review Board (IRB).

STATISTICAL SOFTWARE

All analyses were conducted using SPSS, version 10.0.5.

Chapter 5: Results

The results for validation stage discussed in Chapter 4 are presented in this chapter. Demographic characteristics for the subjects are described, followed by results of the statistical tests that were conducted.

SCALE CONSTRUCTION

Following a review of the literature of 23 articles on practice with gays and lesbians, 543 scale items were generated. Further analysis of these items revealed that many did not assess the behavior or belief domains but rather a construct such as knowledge about gays and lesbians, attitudes toward gays and lesbians, or comfort with gays and lesbians. Duplicate items and items which did not meet the definitions for the behaviors and belief domains were eliminated from the item pool, leaving 372 items: 167 items in the belief domain and 205 in the behavior domain.

CONTENT VALIDITY STUDY

In order to assess the content validity of the pool of 372 items, 12 experts on gay affirmative practice were identified by means of a snowball sampling method. Of the ten who agreed to participate, eight returned the questionnaires.

Characteristics of Expert Reviewers

The expert reviewers consisted of two men and six women. The average age was 53.50 years. Six of the reviewers held a doctoral degree, one held a Master's degree, and one held a Bachelor's degree. Seven identified as gay or

lesbian while one identified as heterosexual. Six identified as social workers, one as a marriage and family counselor, and one as a human resources manager. The reviewers' practice experience ranged from 4.5 years to 30.0 years with a mean of 17.4 years (*SD*: 7.79). At the time of the study, five reviewers reported spending 50% or more of their time in social work education, two reported spending 50% of their time in direct practice, and one reported spending 50% of his/her time in human resources.

Item Results

A total of 244 items (140 [68.3%] in the belief domain and 104 [62.3%] in the behavior domain) had a mean score greater than or equal to 3.0, the initial cut-off point for retaining items, based on a four point scale with a score of four representing items that were more relevant to the construct. The mean reviewers' score for the behavior domain was 2.98; the mean reviewers' score for the belief domain was 3.01. Since the goal of the study was to develop a scale with 40 or fewer items in each of the two domains, 40 items were retained from each domain. This allowed for a "cushion" so that additional items could be eliminated following additional item analysis. Further analysis revealed that the means for negatively worded (reverse scored) items were much lower than the means for positively worded items. Although reviewers had been advised of the inclusion of these items and these items were clearly marked in the packet sent to reviewers, no reverse scored item had a mean score greater than 2.5. Despite this problem, a decision was made to include five reverse scored items in each domain because reverse scored items may decrease the potential for acquiescent response bias

(DeVellis, 1991) and including both positively and negatively worded items in a questionnaire may make the questionnaire more valid (Torabi & Ding, 1998). Additional decision criteria for which items to retain for the positively and negatively worded items is discussed below.

Positively Worded Items

1. Only items with a mean score greater than or equal to 3.0 were considered for inclusion.
2. Items with the highest mean scores were retained, except when two or more items assessed a similar construct. For example, in the belief domain, eight items assessed practitioners' belief that awareness of their attitudes or feelings about gays and lesbians impacted their practice with gay/lesbian clients. Only one of these items was retained.

Negatively Worded Items

The concepts captured in the five reverse scored items for each domain that were retained were emphasized heavily in the literature. For example, several authors state that attempts to change a client's sexual orientation is detrimental to the client and clearly inconsistent with gay affirmative practice (Association for Gay, Lesbian, and Bisexual Issues in Counseling [AGLBIC], 1999; Garnets et al., 1991; Milton & Coyle, 1998) and that practitioners should focus on the client's presenting problem, rather than his/her sexual orientation in treatment (AGLBIC, 1999; Garnets et al., 1991; Liddle, 1996). Items which addressed these issues were included in the two domains along with other items stressed in the literature.

Information about the items retained in each domain and their mean reviewer score can be found in Tables 1 and 2.

Table 1. Belief Domain Mean Reviewers' Scores

(Items in bold represent reverse scored items)

Item	*M*
21) **Practitioners should focus on gay/lesbian clients' sexual orientation in their treatment with them**.	2.0
22) In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families.	3.57
23) Practitioners should inform clients about gay affirmative resources in the community.	3.63
24) Practitioners should acknowledge to clients the impact of living in a homophobic society.	3.88
25) Practitioners should help clients identify their internalized homophobia.	3.75
26) Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.	3.38
27) Practitioners must address their own homophobia in order to be effective with gay/lesbian clients.	3.75
28) Practitioners should assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.	3.63
29) Practitioners should help gay/lesbian clients understand the multiple sources of stress in their lives.	3.63
30) My attitudes about gay/lesbian people affect my practice with gay/lesbian clients.	3.63
31) Practitioners should provide interventions that facilitate the safety of gay/lesbian clients.	3.5
32) Practitioners should make an effort to learn about diversity within the gay/lesbian community.	3.63
33) Practitioners should be knowledgeable about gay/lesbian resources.	3.88

34) Practitioners should **not** make an issue of sexual orientation when it is **not** relevant to treatment.	3.5
35) Practitioners should educate themselves about gay/lesbian lifestyles.	3.63
36) Practitioners should display gay affirmative materials in the places where they interact with clients.	3.5
37) Practitioners should be knowledgeable about laws affecting gay/lesbian clients.	3.5
38) Practitioners should be knowledgeable about health issues affecting gay/lesbian clients.	3.63
39) Practitioners' attitudes about homosexuality are relevant to treatment with gay/lesbian clients.	3.75
40) Practitioners' lack of knowledge about homosexuality is relevant to treatment with gay/lesbian clients.	3.71
41) Practitioners should assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.	3.43
42) Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.	3.57
43) Practitioners should challenge misinformation about gay/lesbian clients.	3.71
44) Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients.	3.5
45) Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals.	3.75
46) Practitioners should be knowledgeable about issues unique to gay/lesbian couples.	3.75
47) Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.	3.43
48) Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients.	3.5
49) Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients.	3.5

50) Adoption of a gay/lesbian identity is a positive outcome of any process in which the individual is working on his/her sexual orientation.	3.38
51) Practitioners should assist clients in working through the stages of the coming out process.	3.5
52) Practitioners should help clients reduce shame about homosexual feelings.	3.38
53) I am knowledgeable about gay/lesbian resources.	4.0
54) **Practitioners should help gay/lesbian clients change their sexual orientation.**	2.25
55) Practitioners' attempts to change the sexual orientation of a gay/lesbian client are detrimental to the client.	3.75
56) Discrimination creates problems that gay/lesbian clients may need to address in treatment.	3.5
57) **My beliefs about gays/lesbians have *no* relevance to my practice with gay/lesbian clients.**	1.63
58) **Practitioners' value systems about gay/lesbian individuals *do not* affect their practice with them.**	1.75
59) **Practitioners should assume clients are heterosexual unless directly told otherwise.**	1.88
60) Practitioners should respond to a client's sexual orientation when it is relevant to treatment.	3.75

Table 2. Practice Domain Mean Reviewers' Scores

(Items in bold represent reverse scored items)

Item	***M***
61) I help clients reduce shame about homosexual feelings.	4.0
62) I help gay/lesbian clients address problems created by societal prejudice.	3.88
63) I assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.	3.88
64) I help gay/lesbian clients feel good about themselves as gay/lesbian individuals.	3.88

65) **I assume clients are heterosexual unless directly told otherwise.**	2.38
66) In my practice with gay/lesbian clients, I support the diverse makeup of their families.	3.75
67) I help gay/lesbian clients overcome negative attitudes about homosexuality.	3.75
68) I inform clients about gay affirmative resources in the community.	3.75
69) I assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.	3.75
70) I assist clients in working through the stages of the coming out process.	3.75
71) I refer gay/lesbian clients to health care professionals who are sensitive to their needs.	3.63
72) I facilitate a client's search for his or her sexual identity.	2.25
73) **I assist a client in changing his/her sexual orientation.**	2.25
74) I accept the adoption of a gay/lesbian identity as a positive outcome of any process in which the individual is questioning his/her sexual identity.	3.5
75) I support the language used by gay/lesbian clients to describe their sexual orientation when they come out.	3.5
76) I verbalize respect for the lifestyles of gay/lesbian clients.	3.5
77) I make an effort to learn about diversity within the gay/lesbian community.	3.5
78) I acknowledge to clients the impact of living in a homophobic society.	3.5
79) I respond to a client's sexual orientation when it is relevant to treatment.	3.5
80) I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.	3.5
81) I work to develop attitudes necessary for effective practice with gay/lesbian clients.	3.43
82) I provide interventions that facilitate the safety of gay/lesbian clients.	3.43
83) I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.	3.38
84) I actively explore my own feelings of homophobia.	3.38

85) I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.	3.38
86) **I advise gay/lesbian clients to come out even when they are not ready to do so.**	1.88
87) **I focus on gay/lesbian clients' sexual orientation in my treatment with them.**	2.0
88) I include the extended families of gay/lesbian clients in treatment when it is appropriate.	3.38
89) I help gay/lesbian clients understand the multiple sources of stress in their lives.	3.38
90) I help clients identify their internalized homophobia.	3.38
91) I educate myself about gay/lesbian concerns.	3.38
92) I affirm for clients that people who are gay, lesbian, or bisexual can lead emotionally healthy lives.	3.38
93) **I assume that all gay/lesbian clients have similar lifestyles.**	1.86
94) I verbalize acceptance of clients' sexual orientation, regardless of whether the client identifies as gay, lesbian, bisexual, or heterosexual.	3.29
95) I am open-minded when tailoring treatment for gay/lesbian clients.	3.29
96) I encourage gay/lesbian clients to establish a gay/lesbian support system.	3.88
97) I create a climate that allows for voluntary self-identification by gay/lesbian clients.	3.63
98) I validate the diversity of gay/lesbian relationships for gay/lesbian clients.	3.38
99) I discuss sexual orientation in a non-threatening manner with clients.	3.38
100) I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.	3.38

RESPONSE SET STUDY

In order to determine whether a frequency response set or a Likert response set would yield the greatest variability in responses, 150 questionnaires with each type of response set were mailed to University of Texas at Austin School of Social Work alumni.

Response Rate

Of the 300 questionnaires sent to alumni, 51 were completed and returned (a response rate of 17%). An additional 34 (11.3%) were returned by the U.S. mail as "undeliverable." Another 23 (7.6%) respondents returned the questionnaire by mail but did not complete it and indicated they were not in direct practice while 5 (1.6%) respondents contacted the student by email and indicated they were not in direct practice.

Participant Characteristics

Of the 51 completed questionnaires, 27 (53%) returned the frequency version of the scale while 24 (47%) returned the Likert version of the scale. The mean age for all respondents was 44.18. The sample consisted of 17 (34%) males, 32 (62%) females, and 2 (4%) who did not disclose their gender. Forty-three (84%) of the respondents were heterosexual, three were bisexual (6%), three (6%) were gay/lesbian, and two (4%) did not respond to this question. The mean number of years in direct practice was 12.07 (*SD*: 8.68), and the mean percent of time in direct practice with clients was 51% (*SD*: 36.26). Additional information about each of the two groups and the sample as a whole is found in Table 3.

Table 3. Demographics for Response Set Study Respondents			
	Frequency Version	**Likert Version**	**Total Sample**
N	27 (53%)	24 (47%)	51
Age			
Range	30 - 75	27 - 60	27 - 75
M	43.9	44.5	44.2
SD	10.1	9.9	9.9
Year graduated			
Range	1970 - 1999	1973 - 1999	1970 - 1999
Mean	1988	1986	1987
Gender			
Male	10 (20%)	7 (14%)	17 (34%)
Female	16 (31%)	16 (31%)	32 (62%)
Missing	1 (2%)	1 (2%)	2 (4%)
Sexual Orientation			
Heterosexual	23 (45%)	20 (39%)	43 (84%)
Bisexual	2 (4%)	1 (2%)	3 (6%)
Gay/Lesbian	1 (2%)	2 (4%)	3 (6%)
Missing	1 (2%)	1 (2%)	2 (4%)
Years in direct practice			
Range	0 - 26	1 - 26	0 - 26
M	10.9	13.4	12.1
SD	8.5	8.9	8.7
% time in direct practice with clients			
Range	0 - 100	0 - 100	0 - 100
M	49.1	53.3	51.1
SD	35.8	37.5	36.3

Results

Although both scales had strong reliability coefficients, the frequency response set had greater variance, standard deviation, and range of scores than the Likert response set. The coefficient alpha and standardized alpha for the frequency response set were also slightly higher, suggesting that the frequency response set had greater internal consistency than the Likert response set. This analysis thus supports the initial decision to use the frequency response set in an effort to determine how often practitioners engage in aspects of gay affirmative practice. A summary of the scale statistics and item means can be found in Table 4.

Table 4. Scale Statistics and Item Means for Frequency and Likert Response Sets

	Frequency Version ($N = 27$)	**Likert Version** ($N = 24$)
Scale Statistics		
Coefficient Alpha	.9608	.9360
Standardized Alpha	.9670	.9501
M	147.75	153.0
Variance	955.14	342.38
SD	30.91	18.50
Item Means		
M	3.69	3.83
Minimum	1.5	1.64
Maximum	4.6	4.34
Range	3.1	2.73
Max/Min	3.07	2.67
Variance	0.61	0.45

ADMINISTRATION TO CLINICIANS

Response Rate

Of the 3,000 surveys sent to members of the NASW and APA, 488 were returned completed for a response rate of 16.3%. Although the response rate appears to be low, the number of surveys returned represents one of the largest studies conducted to examine homophobia in social workers and psychologists.

It should be noted that the survey was mailed on January 25, 2002, with a letter that asked respondents to return the instrument by February 15, 2002. On their completed questionnaires, 92 of the 488 respondents indicated that they did not receive the packet until *after* the February 15, 2002, response date. Many of those that responded also called or emailed the researcher and inquired whether they should return it since they had received it after the requested response date and were requested to do so. Though several factors may have contributed to the low response rate (e.g., lack of time to complete the survey or lack of interest in the topic), the mail delay may have contributed to the lower than expected response rate.

Participant Characteristics

Age, Gender, Relationship Status, Sexual Orientation, and Race

Respondents' ages ranged from 24 to 85 (*M*: 52.45, *SD*: 9.67). Of the 488 respondents, 362 (74.2%) were female and 125 (25.6%) were male. The majority, 338 (69.3%), reported their relationship status as married, followed by 47 (9.6%) who checked single. Most respondents were heterosexual with 420 (86.1%)

identifying as such, while 48 (9.8%) identified as gay/lesbian, and 17 (3.5%) identified as bisexual. Respondents were overwhelmingly Caucasian/White with 449 (92.0%) checking this category. Additional information about respondents' characteristics can be found in Tables 5 and 6.

Table 5. Number and Percent of Respondents in Age Categories

Age range	**N (%)**
24-25	1 (0.2)
26-35	14 (2.9)
36-45	92 (18.9)
46-55	207 (42.4)
56-65	128 (26.2)
66-75	34 (7.0)
76-85	10 (2.0)

Table 6. Respondents' Gender, Relationship Status, Sexual Orientation, and Race

Gender	***N* (%)**
Male	125 (25.6)
Female	362 (74.2)
Missing	1 (0.2)
Relationship Status	
Single	47 (9.6)
Married	338 (69.3)
Divorced	36 (7.4)
Widowed	16 (3.3)
Living with long term partner	22 (4.5)
Long term relationship but not living together	7 (1.4)
Missing	22 (4.5)
Sexual Orientation	
Heterosexual	420 (86.1)

Bisexual	17 (3.5)
Gay/Lesbian	48 (9.8)
Missing	3 (0.6)
Race/Ethnicity	
African American/Black	12 (2.5)
Asian American	5 (1.0)
Caucasian/White	449 (92.0)
Hispanic/Latino	5 (1.0)
Mexican American	4 (0.8)
Native American	1 (0.2)
Puerto Rican	5 (1.0)
Other	3 (0.6)
Missing	4 (0.8)

Religious Affiliation and Political Party

The most common religious affiliations reported were "other" and "none" with 107 (21.9%) checking each of these responses. Of those who indicated a specific religious affiliation, the most commonly reported affiliation was Catholic, with 79 (16.2%) checking this category, followed by Reform Jewish with 43 (8.8%) respondents checking this category. Although three of the 13 categories for religious affiliation indicated on the survey addressed Jewish denominations (Conservative Jewish, Orthodox Jewish, and Reform Jewish), the researcher noticed that many people wrote another type of Jewish affiliation such as "just Jewish" or "Jewish NOS" on the survey. Thus a decision was made to add the category "Jewish NOS" for "Jewish Not Otherwise Stated" to the data set; nine (1.8%) respondents were included in this category (see Table 7).

Table 7. Current Religious Affiliation	
Religion	***N* (%)**
Baptist	15 (3.1)
Catholic	79 (16.2)
Episcopal	27 (5.5)
Fundamentalist	4 (0.8)
Lutheran	8 (1.6)
Methodist	30 (6.1)
Presbyterian	29 (5.9)
Conservative Jewish	8 (1.6)
Orthodox Jewish	13 (2.7)
Reform Jewish	43 (8.8)
Jewish NOS	9 (1.8)
Other	107 (21.9)
None	107 (21.9)
Missing	9 (1.8)

The most common political party identified was Democrat with 337 (69.1%) checking this option, followed by 57 (11.7%) who checked Independent, and 42 (8.6%) who checked Republican (see Table 8).

Table 8. Current Political Party	
Party	***N* (%)**
Democrat	337 (69.1)
Republican	42 (8.6)
Independent	57 (11.7)
Green	5 (1.0)
Libertarian	1 (0.2)
Reform	2 (0.4)
Other	8 (1.6)
None	29 (5.9)
Missing	7 (1.4)

Organization, Degree, Role at Agency, Practice Area, and Percent of Time Spent in Direct Practice

Membership in the NASW and APA was fairly evenly represented with 257 (52.7%) indicating NASW membership and 220 (45.1%) indicating APA membership. Both masters and doctorate level practitioners were well represented with 241 (49.4%) indicating that their highest degree received was a master's degree and 237 (48.6%) indicating a doctorate as their highest degree received (see Table 9). Since the sample was limited to direct practitioners as defined by the NASW and APA, it was expected that the majority of respondents would identify "provider of direct services" as their primary role at their agency; this was the case with 324 (66.4%) of respondents checking this option. The majority of respondents indicated "mental health" as their primary area of practice (see Table 11). Respondents reported spending from 0 to 100 percent of their time in direct practice; the mean percent of time spent in direct practice was 66.8% and the standard deviation was 32.87. Despite the fact that 29 respondents indicated spending 0% of their time in direct practice, the decision was made to include all respondents in the analysis, based on the fact that the NASW and APA had identified them as direct practitioners. Additional information can be found in Tables 9 – 12.

Table 9. Highest Degree Received

Degree	Bachelor's	Master's	Doctorate	Other	Missing
***N* (%)**	6 (1.2)	241 (49.4)	237 (48.6)	2 (0.4)	2 (0.4)

Table 10. Primary Role at Agency	
Role	***N* (%)**
Provider of direct services	324 (66.4)
Supervisor of direct practice staff	29 (5.9)
Administrator	25 (5.1)
Educator	30 (6.1)
Researcher	6 (1.2)
Other	24 (4.9)
Missing	50 (10.2)

Table 11. Primary Area of Practice	
Area	***N* (%)**
Addiction/substance abuse	15 (3.1)
Adolescents	20 (4.1)
Aging	10 (2.0)
Child welfare	28 (5.7)
Health	27 (5.5)
International	1 (0.2)
Mental health	289 (59.2)
School practice	26 (5.3)
Other	47 (9.6)
Missing	25 (5.1)

Table 12. Percent of Time Spent in Direct Practice					
N	**Minimum**	**Maximum**	**Range**	***M***	***SD***
474	0	100	100	66.80	32.87

Contact with, Training on, and Feelings about Gays and Lesbians

The mean number of gay or lesbian friends for respondents was 5.71 (*SD*: 7.18) while the mean number of gay or lesbian family members was much smaller with a mean of .61 (*SD:* 1.04). The mean number of gay or lesbian clients was 2.93 (*SD*: 6.34) and the mean percent of current clients who were gay or lesbian

was 7.42 (*SD*: 12.99). Respondents reported having attended from 0 to 40 (*M*: 1.65, *SD*: 3.43) workshops with a *focus on* gay and/or lesbian issues and from 0 to 50 (*M*: 4.25, *SD*: 6.50) workshops with *content on* gay and/or lesbian issues. Table 13 provides additional information on each of these variables.

Table 13. Contact with and Training on Gays and Lesbians

	N	**Minimum**	**Maximum**	**Range**	***M***	***SD***
# of gay or lesbian *friends*	453	0	50	50	5.71	7.18
# of gay or lesbian *family members*	466	0	10	10	.611	1.04
# of gay or lesbian *clients*	455	0	75	75	2.93	6.34
% of clients who are gay/lesbian	436	0	100	100	7.42	12.99
# of workshops with specific *focus* on gay/lesbian issues	467	0	40	40	1.655	3.43
# of workshops with *content* on gay/lesbian issues	413	0	50	50	4.25	6.50

Respondents' feelings about gay men and lesbians were very positive and appeared to be similar, as indicated by a mean score of 82.19 (range: 15 - 100; *SD*: 17.85) on the lesbian feeling thermometer and a mean score of 81.27 (range: 15 - 100; *SD*: 17.52) on the gay male feeling thermometer (see Table 14).

Table 14. Lesbian and Gay Feeling Thermometer Scores						
	N	**Minimum**	**Maximum**	**Range**	***M***	***SD***
Lesbian feeling thermometer	469	15	100	85	82.19	17.85
Gay feeling thermometer	469	15	100	85	81.27	17.52

Reliability Analyses of the GAP

Belief Domain

Item Analysis

The inter-item correlation matrix for the domain was inspected for negative correlations with items. According to DeVellis (1991), items that are "positively correlated with some and negatively correlated with others in a homogeneous set should be eliminated if no pattern of reverse scoring eliminates the negative correlations" (p. 82). There were no patterns of negative correlations related to a failure to reverse-score any of the items. Inspection of the inter-item correlations revealed that two items exhibited a positive correlation with some items and a negative correlation with other items. Items 21 and 31 were thus deleted. No other items were found to have positive and negative correlations with other items.

In addition to examining for negative correlations, the corrected item-total correlations were examined for each item. In order to maximize reliability, an item should correlate substantially with the other items in its domain. Items that performed poorly, as indicated by a correlation of less than .40, were considered for deletion since their deletion should not have resulted in a substantial

conceptual loss. Items 41, 54, 55, 57, 58, 59, and 60 were considered for deletion on the basis of this criteria. In total, nine items were deleted on the basis of the criteria described in this section.

Cronbach's Alpha

The initial Cronbach's alpha for the belief domain was .9255. The "alpha if item deleted" statistic was examined to identify any items which would substantially increase the overall internal consistency of the scale, as measured by Cronbach's alpha. Aside from some of the above items discussed in the item analysis section, no items were identified which, if deleted, would increase the alpha above its current score of .9255. Thus, no additional items were considered for deletion on the basis of the "alpha if item deleted" score. The corrected item-total correlation and "alpha if item deleted" for each item in the belief domain can be found in Table 15.

Table 15. Initial Reliability and Factor Analysis for Belief Domain				
Item	**Corrected Item-Total Scale Correlation**	**Alpha if Item Deleted**	**Belief Loading**	**Behavior Loading**
21) Practitioners should focus on gay/lesbian clients' sexual orientation in their treatment with them.	-.1185	.9301	-.062	.000
22) In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families.	.5973	.9226	.626	.397
23) Practitioners should inform clients about gay affirmative resources in the community.	.4944	.9234	.530	.366
24) Practitioners should acknowledge to clients the impact of living in a homophobic society.	.4033	.9236	.519	.379
25) Practitioners should help clients identify their internalized homophobia.	.4033	.9245	.450	.349
26) Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.	.5682	.9227	.603	.451
27) Practitioners must address their own homophobia in order to be effective with gay/lesbian clients.	.5267	.9231	.565	.300

28) Practitioners should assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.	.5737	.9229	.599	.384
29) Practitioners should help gay/lesbian clients understand the multiple sources of stress in their lives.	.5522	.9233	.574	.388
30) My attitudes about gay/lesbian people affect my practice with gay/lesbian clients.	.4042	.9248	.461	.249
31) Practitioners should provide interventions that facilitate the safety of gay/lesbian clients.	.5123	.9233	.541	.335
32) Practitioners should make an effort to learn about diversity within the gay/lesbian community.	.7088	.9219	.726	.422
33) Practitioners should be knowledgeable about gay/lesbian resources.	.6281	.9221	.697	.404
34) Practitioners should not make an issue of sexual orientation when it is not relevant to treatment.	.2471	.9256	.283	.226
35) Practitioners should educate themselves about gay/lesbian lifestyles.	.6552	.9222	.671	.444
36) Practitioners should display gay affirmative materials in the places where they interact with clients.	.5602	.9227	.603	.389
37) Practitioners should be knowledgeable about laws affecting gay/lesbian clients.	.5341	.9232	.550	.312

38) Practitioners should be knowledgeable about health issues affecting gay/lesbian clients.	.5543	.9232	.554	.319
39) Practitioners' attitudes about homosexuality are relevant to treatment with gay/lesbian clients.	.5273	.9232	.557	.233
40) Practitioners' lack of knowledge about homosexuality is relevant to treatment with gay/lesbian clients.	.5862	.9228	.609	.333
41) Practitioners should assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.	.3859	.9245	.420	.280
42) Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.	.6071	.9222	.640	.472
43) Practitioners should challenge misinformation about gay/lesbian clients.	.6040	.9225	.630	.378
44) Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients.	.6316	.9223	.654	.372
45) Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals.	.6231	.9222	.652	.447
46) Practitioners should be knowledgeable about issues unique to gay/lesbian couples.	.7111	.9221	.723	.433

47) Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.	.7327	.9219	.747	.453
48) Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients.	.7258	.9217	.742	.418
49) Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients.	.7077	.9217	.728	.380
50) Adoption of a gay/lesbian identity is a positive outcome of any process in which the individual is working on his/her sexual orientation.	.3563	.9253	.414	.234
51) Practitioners should assist clients in working through the stages of the coming out process.	.5586	.9229	.589	.426
52) Practitioners should help clients reduce shame about homosexual feelings.	.6218	.9226	.644	.420
53) I am knowledgeable about gay/lesbian resources.	.4194	.9244	.467	.530
54) Practitioners should help gay/lesbian clients change their sexual orientation.	.3024	.9274	.380	.222
55) Practitioners' attempts to change the sexual orientation of a gay/lesbian client are detrimental to the client.	.3719	.9249	.426	.360
56) Discrimination creates problems that gay/lesbian clients may need to address in treatment.	.6073	.9231	.622	.415

57) My beliefs about gays/lesbians have *no* relevance to my practice with gay/lesbian clients.	.3275	.9264	.399	.081
58) Practitioners' value systems about gay/lesbian individuals *do not* affect their practice with them.	.3252	.9264	.395	.121
59) Practitioners should assume clients are heterosexual unless directly told otherwise.	.2935	.9262	.357	.219
60) Practitioners should respond to a client's sexual orientation when it is relevant to treatment.	.2963	.9252	.332	.198

Behavior Domain

Item Analysis

As with the belief domain, the inter-item correlation matrix was inspected for negative correlations. No patterns of negative correlations related to a failure to reverse-score any of the items were found. However, all five of the reverse scored items (items 65, 73, 86, 87, and 93) were correlated positively with some items and negatively correlated with other items and were thus considered for deletion.

Cronbach's Alpha

The initial Cronbach's alpha for the behavior domain was .9481. When corrected-item total correlations were examined for each item, two other items (items 63 and 74) were considered for deletion on the basis of a correlation less than .40. Analysis of the "alpha if item deleted" statistics did not identify any

additional items which, if deleted, would increase the overall scale alpha above its present alpha of .9481. Thus, no additional items were considered for deletion on the basis of the reliability analysis. In total, seven items were considered for deletion based on the criteria described in these two sections. The corrected item-total correlation, "alpha if item deleted" statistic, and initial factor loading for each item in the behavior domain can be found in Table 16.

Table 16. Initial Reliability and Factor Analysis for Behavior Domain

Item	Corrected Item-Total Scale Correlation	Alpha if Item Deleted	Belief Loading	Behavior Loading
61) I help clients reduce shame about homosexual feelings.	.7177	.9457	.382	.738
62) I help gay/lesbian clients address problems created by societal prejudice.	.7451	.9455	.435	.764
63) I assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.	.3926	.9507	.289	.463
64) I help gay/lesbian clients feel good about themselves as gay/lesbian individuals.	.7652	.9454	.432	.782
65) I assume clients are heterosexual unless directly told otherwise.	.1016	.9504	.131	.152
66) In my practice with gay/lesbian clients, I support the diverse makeup of their families.	.6908	.9460	.390	.717
67) I help gay/lesbian clients overcome negative attitudes about homosexuality.	.8067	.9452	.457	.821

68) I inform clients about gay affirmative resources in the community.	.6751	.9459	.457	.700
69) I assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.	.5296	.9470	.173	.558
70) I assist clients in working through the stages of the coming out process.	.6954	.9457	.458	.720
71) I refer gay/lesbian clients to health care professionals who are sensitive to their needs.	.5598	.9468	.326	.592
72) I facilitate a client's search for his or her sexual identity.	.6030	.9465	.350	.631
73) I assist a client in changing his/her sexual orientation.	.0135	.9518	.195	.071
74) I accept the adoption of a gay/lesbian identity as a positive outcome of any process in which the individual is questioning his/her sexual identity.	.3983	.9479	.347	.435
75) I support the language used by gay/lesbian clients to describe their sexual orientation when they come out.	.6339	.9463	.360	.657
76) I verbalize respect for the lifestyles of gay/lesbian clients.	.6440	.9464	.500	.665
77) I make an effort to learn about diversity within the gay/lesbian community.	.9842	.9460	.479	.705
78) I acknowledge to clients the impact of living in a homophobic society.	.7474	9456	.500	.765
79) I respond to a client's sexual orientation when it is relevant to treatment.	.6079	.9468	.273	.626

80) I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.	.6563	.9460	.431	.685
81) I work to develop attitudes necessary for effective practice with gay/lesbian clients.	.7764	.9454	.480	.792
82) I provide interventions that facilitate the safety of gay/lesbian clients.	.7178	.9456	.414	.739
83) I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.	.6381	.9462	.501	.665
84) I actively explore my own feelings of homophobia.	.4513	.9475	.391	.484
85) I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.	.7721	.9457	.451	.786
86) I advise gay/lesbian clients to come out even when they are not ready to do so.	-.0138	.9519	.226	.043
87) I focus on gay/lesbian clients' sexual orientation in my treatment with them.	-.2883	.9517	-.055	-.254
88) I include the extended families of gay/lesbian clients in treatment when it is appropriate.	.5731	.9467	.361	.604
89) I help gay/lesbian clients understand the multiple sources of stress in their lives.	.7561	.9457	.409	.771
90) I help clients identify their internalized homophobia.	.6606	.9461	.439	.685
91) I educate myself about gay/lesbian concerns.	.6218	.9465	.491	.644
92) I affirm for clients that people who are gay, lesbian, or bisexual can lead emotionally healthy lives.	.7638	.9457	.490	.779

93) I assume that all gay/lesbian clients have similar lifestyles.	.0955	.9452	.139	.125
94) I verbalize acceptance of clients' sexual orientation, regardless of whether the client identifies as gay, lesbian, bisexual, or heterosexual.	.5390	.9469	.325	.569
95) I am open-minded when tailoring treatment for gay/lesbian clients.	.7307	.9458	.374	.746
96) I encourage gay/lesbian clients to establish a gay/lesbian support system.	.7028	.9458	.474	.724
97) I create a climate that allows for voluntary self-identification by gay/lesbian clients.	.7078	.9460	.400	.725
98) I validate the diversity of gay/lesbian relationships for gay/lesbian clients.	.7941	.9452	.527	.809
99) I discuss sexual orientation in a non-threatening manner with clients.	.6026	.9467	.321	.623
100) I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.	.7567	.9455	.456	.773

Confirmatory Factor Analysis

A confirmatory factor analysis using the multiple groups method (Nunnally & Bernstein, 1994) was conducted on the original 80-item version of the scale to further identify items for deletion in order to pare each domain to no more than 20 items. The number of domains was fixed at two and were titled *belief* and *behavior*. This analysis was used to determine the degree to which each of the items correlated with the domains they were intended to measure. As a

general rule, item correlations are considered moderately high when they load on their intended domain at or about .60 (Nunnally & Bernstein, 1994). Analysis of the factor loading for each item identified 17 items that loaded on the belief domain at or above this level and 29 items that loaded on the behavior domain at or above this level. All but four of the 80 items (items 53, 73, 86, and 93) loaded on its intended domain at a level higher than its loading on the other domain. On the basis of the factor analysis, a decision was made to retain 15 items in each domain from those that loaded at .60 or greater on their respective domains so that only items with a factor loading of .60 or greater on its respective domain would be included in the final version of the scale.

Belief Domain

For the belief domain, each of the nine items (21, 31, 41, 50, 54, 57, 58, 59, and 60) previously considered for deletion on the basis of the reliability analysis had a loading of less than .60 and not greater than .541 on the belief domain, confirming the decision to delete these items from the scale.

The process of choosing the final 15 items for this domain was based on both subjective and objective factors. Item 36 ("Practitioners should display gay affirmative materials in the places where they interact with clients") was deleted because the "neither agree nor disagree" response was the modal response, with 212 respondents checking this option, suggesting that the majority of respondents did not feel strongly about this item. Although four other items (21, 25, 50, and 59) had the neutral response as the mode, these items had been eliminated earlier in the process. In addition, item 36 had the lowest factor loading (.603) and the

lowest corrected item-total correlation (.5602) of the items considered for the final version. Item 40 ("Practitioners' lack of knowledge about homosexuality is relevant to treatment with gay/lesbian clients") was also eliminated because it had a low factor loading (.609), and a low corrected item-total correlation (.5862), and was similar to other items with stronger factor loadings, corrected item-total correlations, and "alpha if item deleted" scores. The final version of this domain thus consisted of items 22, 26, 32, 33, 35, 42, 43, 44, 45, 46, 47, 48, 49, 52, and 56. Information about the factor loading for each item is presented in Table 16.

Behavior Domain

Confirmatory factor analysis for the behavior domain revealed that all seven items identified for deletion as a result of the reliability analysis had loadings on this domain no greater than .466, thus confirming the decision to delete these items from the final version of the scale. Four additional items (items 69, 71, 84, and 94) had a factor loading on the behavior domain less than .60. A decision was thus made to consider the 28 items (items 61, 62, 64, 66, 67, 68, 70, 72, 75, 76, 77, 78, 79, 80, 81, 82, 83, 85, 88, 89, 90, 91, 92, 95, 96, 97, 98, 99, and 100) with factor loadings on the behavior domain equal to or greater than .60 for inclusion in the final version of this domain.

Decisions about whether to retain or delete additional items were made on the basis of both objective and subjective factors. Item 75 ("I support the language used by gay/lesbian clients to describe their sexual orientation when they come out") was deleted from the scale because it had the most missing data (67 cases) of any item in the domain and comments written on the questionnaires, such as

"huh?" and "I don't understand this statement," suggesting that this item was confusing. Item 88 ("I include the extended families of gay/lesbian clients in treatment when it is appropriate") was deleted because it had the lowest factor loading (.604) of any of the items that were considered for the scale and did not appear to contribute much conceptually. In choosing items to delete for this domain, an attempt was also made to avoid items similar to those chosen for inclusion on the belief domain so that items in the scale would not appear to assess similar concepts and would capture a diverse range of constructs. Items 64, 66, 67, 76, 77, 81, 96, and 98 were deleted because they were addressed by similar items on the belief domain. Items 70, 72, 89 and 92 were deleted because other items appeared to be more strongly emphasized in the literature. Information about the factor loadings for each item is presented in Table 16.

Final Version of the scale

The final 30-item version of the scale consists of two 15-item domains created via the processes discussed in this chapter and has an overall Cronbach's alpha of .9482. The belief domain consists of items 22, 26, 32, 33, 35, 42, 43, 44, 45, 46, 47, 48, 49, 52, and 56. The behavior domain consists of items 61, 62, 68, 78, 79, 80, 82, 83, 85, 90, 91, 95, 97, 99, and 100. Using five-point response sets, the theoretical range of scores is 30 to 150 with higher scores representing more affirmative practice with gay and lesbian clients. A copy of the scale can be found in Appendix E.

Reliability Analyses

Belief Domain

Cronbach's alpha for the 15 item belief domain is .9307, slightly higher than the alpha of .9034 for the initial 40 item version of this domain. Corrected-item total correlations for each item range from .5557 to .7748, above the minimum expected correlation of .40 discussed earlier. All inter-item correlations are positive. The "alpha if item deleted" for each item ranges from .9231 to .9295, indicating that if any item is deleted, the scale alpha will decrease below its current level of .9307. The results of the reliability analysis for this version of the domain thus suggest strong internal consistency.

Behavior Domain

The Cronbach's alpha for the 15-item behavior domain is .9375, a slight decrease from the alpha of .9491 for the 40-item version. Corrected-item total correlations for each item ranges from .5893 to .7862, above the minimum correlation of .40 discussed earlier. All inter-item correlations are positive. The "alpha if item deleted" for each item ranges from .9305 to .9360, suggesting that if any item is deleted, the scale alpha will decrease below its current level of .9375. The results of the reliability analysis for this version of the domain thus suggest strong internal consistency.

Both domains well exceed the minimum criteria suggested by Nunnally (1978) that a scale should have an alpha of at least .70 to demonstrate internal consistency. Springer, Abell, and Nugent (in press) have set the following standards for reliability:

< .70 = Unacceptable

.70 - .79 = Undesirable

.80 - .84 = Minimally acceptable

.85 - .89 = Respectable

.90 - .95 = Very good

> .95 = Excellent

Based on these standards, the reliability for both domains is "very good." Additional information about the reliability for each of the final items can be found in Table 17.

Standard Error of Measurement

The standard error of measurement (SEM) was computed for each domain using the method described on page 57. The SEM is 1.91 for the belief domain and 2.71 for the behavior domain. Both scores are within the recommendation set by Hudson (1999) that the SEM should be less than five percent (6.0 for each of these two domains) of the possible range of scores and provide further evidence of the reliability of the two domains.

Confirmatory Factor Analysis

Confirmatory factor analysis was run on the final version of the scale. Each item loaded on the intended domain at or above .60. The findings of this analysis (see Table 17) provide evidence of factorial validity of the GAP with two distinct factors in the final version.

Table 17. Reliability and Factor Analysis for Final Version of Scale				
Item	**Corrected Item-Total Scale Correlation**	**Alpha if Item Deleted**	**Belief Loading**	**Behavior Loading**
22) In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families.	.5557	.9292	.622	.333
26) Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.	.5660	.9295	.638	.392
32) Practitioners should make an effort to learn about diversity within the gay/lesbian community.	.7238	.9244	.765	.396
33) Practitioners should be knowledgeable about gay/lesbian resources.	.7102	.9249	.752	.375
35) Practitioners should educate themselves about gay/lesbian lifestyles.	.6821	.9255	.729	.411
42) Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.	.6126	.9282	.680	.442
43) Practitioners should challenge misinformation about gay/lesbian clients.	.5891	.9283	.651	.390
44) Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients.	.6848	.9254	.735	.354

45) Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals.	.6480	.9268	.708	.431
46) Practitioners should be knowledgeable about issues unique to gay/lesbian couples.	.7503	.9241	.785	.386
47) Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.	.7702	.9236	.802	.423
48) Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients.	.7748	.9239	.809	.398
49) Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients.	.7428	.9237	.784	.391
52) Practitioners should help clients reduce shame about homosexual feelings.	.6162	.9273	.670	.413
56) Discrimination creates problems that gay/lesbian clients may need to address in treatment.	.6349	.9272	.677	.454
61) I help clients reduce shame about homosexual feelings	.7255	.9322	.376	.770
62) I help gay/lesbian clients address problems created by societal prejudice.	.7862	.9305	.417	.821
68) I inform clients about gay affirmative resources in the community.	.6680	.9339	.437	.722
78) I acknowledge to clients the impact of living in a homophobic society.	.7817	.9308	.464	.815

79) I respond to a client's sexual orientation when it is relevant to treatment.	.6271	.9351	.268	.666
80) I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.	.6684	.9347	.412	.731
82) I provide interventions that facilitate the safety of gay/lesbian clients.	.7012	.9329	.417	.751
83) I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.	.6032	.9360	.468	.668
85) I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.	.7649	.9316	.430	.797
90) I help clients identify their internalized homophobia.	.6588	.9340	.439	.712
91) I educate myself about gay/lesbian concerns.	.5893	.9356	.492	.641
95) I am open-minded when tailoring treatment for gay/lesbian clients.	.7149	.9329	.362	.751
97) I create a climate that allows for voluntary self-identification by gay/lesbian clients.	.7210	.9327	.394	.758
99) I discuss sexual orientation in a non-threatening manner with clients.	.6028	.9354	.344	.649
100) I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.	.7638	.9312	.441	.800

Validation Analyses of the GAP

Convergent Construct Validity

Evidence of convergent construct validity was obtained by examining Pearson's *r* correlations between scores on the belief domain and scores on the HATH and the behavior domain and the ATLG. As discussed in Chapter 4, it was anticipated that the above correlations would be greater than or equal to .70. The correlation between the belief domain of the GAP and the HATH is .624 (p = .000) while the correlation between the behavior domain and the ATLG is -.466 (p =.000). Although the correlations are not as strong as hoped, both correlations are significant at the .01 level, are in the expected direction, and fall within the acceptable range of greater than or equal to .40 (Downie & Heath, 1967). Overall, there is evidence that the two domains of the GAP correlate at least adequately with the instruments with which they are expected to correlate, thus providing evidence of convergent construct validity.

Discriminant Construct Validity

Evidence of discriminant construct validity was obtained by examining the correlation between the Social Desirability Scale and the entire 30 item scale. As discussed in Chapter 3, it was expected that the correlations would be less than or equal to .30. The correlation between these two instruments was .021 and was nonsignificant (p = .691) This finding provides strong evidence that the GAP does not measure socially desirable responses and is evidence of its discriminant construct validity.

Relationships between demographic variables and 30-item GAP scores

Gender, Age, Relationship Status, Sexual Orientation, and Race

There was no significant effect of gender (t = .364, p = .716), race (F = 1.420, p = .196), or age (r = .011, p = .840) on the 30-item GAP score. There were, however, significant effects of relationship status (F = 3.883, p = .002) and sexual orientation (t= 6.178, p = .000) on GAP scores. Married respondents had significantly lower scores than those living with a long term partner. When this variable was collapsed into two categories, married (N = 244) and other (N = 122), married respondents had significantly lower GAP scores than all other respondents (t = 4.085, p = .000). Gay/lesbian and bisexual respondents had significantly higher GAP scores than heterosexual respondents; when sexual orientation was collapsed to compare heterosexual respondents (N = 311) to gay/lesbian and bisexual respondents (N = 54), a significant relationship (t = 6.178, p = .000) was found with gay/lesbian and bisexual respondents having significantly higher GAP scores.

Religious Affiliation and Political Party

The thirteen categories for religious affiliation were collapsed into five categories due to the small number of respondents in some of the categories. The five categories were Protestant (N = 76), Catholic (N = 63), Jewish (N = 55), Other (N = 83), and None (N = 82). Although a significant effect on GAP scores was found (F = 2.472, p = .044), there were no significant differences in scores of the different religious groups. There was also a significant effect of current political party on GAP scores (F = 3.700, p = .003) with Democrats having

significantly higher GAP scores than Republicans. When this variable was collapsed so that Democrats (N = 255) were compared to all other parties (N = 111), a significant effect was still found (t = 3.759, p = .000).

Organization, Degree, Role at Agency, Practice Area, and Percent of Time Spent in Direct Practice

There was no significant effect of organizational membership on GAP scores (t = 1.320, p = .188) and no significant correlation with the percent of time spent in direct practice to clients and GAP scores (r = .033, p = .527). There was a significant effect of degree on GAP scores (F = 4.247, p = .002) with respondents with a bachelor's degree having significantly lower scores than those with a either a master's or a doctorate degree. However, because there is a small number of respondents with their bachelor's degree (N = 5), this finding should be interpreted with caution. When respondents with their bachelor's degree or "other" degree (N = 1) were excluded from the analysis, there was no significant effect of degree on GAP scores (t = 1.534, p = .126).

There was a significant effect of primary role at agency on GAP scores (F = 2.499, p = .031) with educators having significantly higher scores than supervisors of direct practice staff. Primary area of practice also had a significant effect on GAP scores (F = 4.784, p = .000) with those whose primary area is mental health having significantly higher scores than those whose primary area is either aging or school practice. When this variable was collapsed into two categories of mental health (N = 231) and all other areas of practice (N = 135), a significant effect on GAP scores was found (t = 3.696, p = .000) with mental health practitioners having significantly higher scores than all other practitioners.

Contact with, Training on, and Feelings about Gays and Lesbians

Significant but weak positive relationships were found with the GAP score and the number of workshops with *content* on gay/lesbian issues (r = .178, p = .001), the number of workshops with a *focus* on gay/lesbian issues (r = .230, p = .000), the number of gay/lesbian friends (r = .292, p = .000), the number of gay/lesbian family members (r = .177, p = .001), the number of gay/lesbian clients (r = .165, p = .002), and the percent of clients that are gay/lesbian (r = .279, p = .000). Moderate relationships with GAP scores were found with the lesbian feeling thermometer (r = .495, p = .000) and the gay male feeling thermometer (r = .413, p = .000).

SUMMARY OF FINDINGS

Overall, there is initial evidence to support the reliability and validity of the 30-item version of the GAP. Internal consistency reliability for the two domains is "very good" based on standards set by Springer, Abell, and Nugent (in press). The low standard error of measurement for each domain, which is less than five percent of the range of possible scale scores, provides further evidence that the scale is reliable.

Evidence of the scale's validity has also been demonstrated. The GAP contains only items with mean expert reviewer scores greater than 3.28. The scale also has factorial validity as demonstrated by the confirmatory factor analysis with each item loading on its expected domain with a correlation greater than or equal to .60. Although the relationships between the two domains of the GAP and measures of homophobia are not as strong was initially expected, a moderate but

significant relationship exists and supports the GAP's convergent construct validity. The low and nonsignificant correlation between the GAP and the Social Desirability Scale indicates that the GAP does not measure social desirability, a construct that is theoretically unrelated to gay affirmative practice. Thus, the scale has strong discriminant construct validity. In sum, this results of this study provide initial evidence to support the reliability and validity of the GAP.

Chapter 6: Discussion and Implications

INTRODUCTION

The focus of this study was the development and validation of a measure of gay affirmative practice. The chapter begins with a discussion of the reliability and validity analyses of the scale and variables that are correlated with GAP scores, examines the utility of the GAP, identifies limitations of the current study, discusses the implications for social work, and recommends additional research on this topic. The chapter concludes with comments on the practical significance of this study.

RELIABILITY AND VALIDITY ANALYSES

Reliability Analyses

Reliability is often discussed as a "necessary but not sufficient" condition for validity. Internal consistency reliability is concerned with the homogeneity of the items that comprise a scale and assesses the degree to which the items measure the same construct (DeVellis, 1991). One domain of the GAP is intended to measure beliefs about treatment with gay and lesbian clients; the other is intended to measure behaviors in treatment. The high coefficient alpha for each domain suggests that each item in the domain measures the intended construct. The low standard error of measurement for each of the domains further supports the reliability of each domain and suggests that little measurement error is present in the scale.

Validity Analyses

The four validity analyses conducted collectively provide support for the validity of the scale, and combined with the reliability analyses, suggest that the scale does measure gay affirmative practice. First, content validity is seen as a prerequisite for other forms of validity. The final version of the scale contains only items with a mean expert reviewer score greater than or equal to 3.28 (on a scale from one to four, with four representing more relevant items), substantially above the level of 3.0 recommended in the literature. Thus, the scale can be said to have good evidence of content validity.

Second, the confirmatory factor analysis provides evidence that each item is correlated with other items in its respective domain and assesses a component of that particular domain.

Third, the convergent construct validity analysis provides evidence that there is a relationship between measures of homophobia and the two domains of the GAP. The assessment of construct validity is inherently related to theory. Along this line, the literature suggests that there should be a strong relationship between attitudes towards gays and lesbians and gay affirmative practice. However, because this relationship has not previously been empirically tested, it is impossible to identify how strong this relationship might be expected to be. Although the relationship was not as strong as one might wish, DeVellis (1991) claims that "there is no cutoff that defines construct validity" (p. 48). The findings of a moderate but significant relationship provide evidence for the validity of the

scale while suggesting that the relationship between homophobia and gay affirmative practice may not be as strong as has been suggested in the literature.

The lower than expected correlations with the domains of the GAP and the ATLG and HATH may also be due to a lack of clarity about which form of homophobia the ATLG and HATH were measuring (cognitive or affective). While it may be that the relationship between gay affirmative practice and homophobia is not as strong as suggested, it may also be that some forms of homophobia are more strongly associated with gay affirmative practice than others.

Fourth, the discriminant construct validity analysis provides additional evidence of the validity of the GAP and suggests that the GAP does *not* measure social desirability, a construct that is theoretically different from gay affirmative practice. Schwanberg (1993) has criticized validation studies of homophobia instruments for their failure to evaluate social desirability. The absence of a relationship between social desirability and GAP scores may suggest that responses were not influenced by this trait.

RELATIONSHIPS BETWEEN DEMOGRAPHIC VARIABLES AND GAP SCORES

Several findings concerning demographic variables support findings from other studies on correlates of homophobia discussed in Chapter 2 of this dissertation. The lack of significant relationships between GAP scores and age and gender is consistent with findings by Berkman and Zinberg (1997) on correlates of homophobia in social workers. The finding that married respondents had significantly lower GAP scores than did all other respondents is consistent

with research by DeCrescenzo (1984) in which married respondents saw gays and lesbians in the most stereotypic terms. The weak but significant relationships between variables that examined contact with gays and lesbians (number of gay/lesbian friends, number of gay/lesbian family members, number of gay/lesbian clients, and percent of clients who are gay/lesbian) and GAP scores is consistent with findings by several authors (Hansen, 1982; Millham et al., 1976; O'Hare et al., 1996) that contact with gays and lesbians is associated with more positive attitudes. The finding that Democrats had significantly higher GAP scores than did respondents with other political affiliations is consistent with previous research that people with more conservative political values have less positive attitudes towards gays and lesbians (Morrison, Parriag, & Morrison, 1999). Although much remains to be studied on the relationship between homophobia and gay affirmative practice, it may be that similar factors are related to these measures.

While previous research has found that higher levels of religious expression are associated with higher levels of homophobia (Gentry, 1987; Irwin & Thompson, 1977; Maret, 1984; Seltzer, 1992), the relationship between denomination and GAP scores is unclear. While this study found that respondents' religious denomination does impact GAP scores, differences in denominational groups were not found. Clearly more research on the relationship between religion and spirituality on GAP scores is needed.

Although the sexual orientation of respondents has rarely been discussed in the literature, it is not surprising that gay/lesbian and bisexual respondents had

significantly higher GAP scores than did heterosexual respondents. Being gay or lesbian does not guarantee affirmative practice but people who identify as gay and lesbian may, by virtue of their own identity, be more aware of the struggles that gay and lesbian clients face and make more effort to practice affirmatively with them in clinical settings.

The findings of significant but weak relationships between GAP scores and variables related to training on gay/lesbian issues (number of workshops with *content* on and number of workshops with a *focus* on gay/lesbian issues) is consistent with research by Cramer, Oles, and Black (1997) that training on gay/lesbian issues may reduce homophobia scores. This finding also supports claims in the literature by Appleby and Anastas (1998) and Cramer (1995) that knowledge about gay and lesbian issues is key to affirmative practice with this population. It is also important to note that the relationship between workshops with a *focus* on gay/lesbian issues and GAP scores was stronger than the relationship between workshops with *content on* gay/lesbian issues and GAP scores. This may suggest that training specifically on gay/lesbian issues has the ability to improve GAP scores more than broad trainings that include content on gays and lesbians and should be explored in additional research on this issue.

The finding of no significant differences in the GAP scores of social workers and psychologists is encouraging in view of previous research that found social workers to be more homophobic than psychologists. Although social work has historically lagged behind psychology with respect to gay and lesbian issues,

these findings suggest that recent attention given to this area may be positively affecting social workers' practice with gay and lesbian clients.

The finding of no significant effect of race on GAP scores should be interpreted with caution due to the high percent (92%) of White respondents in this study. The racial/ethnic composition of this sample is fairly similar to that of the NASW membership, with 89% of a sample of NASW members identifying as "White" (NASW, 2000). The racial/ethnic composition of the APA membership is less clear. Although 76% of APA members identified their race as "White," 17% did not provide information on their race or ethnicity (APA, 2000). Additional research with more racially diverse samples is needed before claims about the effect of race on GAP scores can be made.

The findings regarding respondents' primary role and practice area warrant additional research into factors that may contribute to these findings. Given their role in the agencies, it may be that educators are more sensitive to gay and lesbian clients' needs. Mental health practitioners may be more sensitized to gay affirmative practice because they may work with clients on a broader range of issues than do practitioners in more specialized areas such addiction, aging, and school practice. However, these ideas are speculation at best and need additional research before conclusions about these relationships are drawn.

The absence of a significant relationship between the percent of time spent in direct practice and GAP scores suggests that this does not influence GAP scores and that other factors such as the amount of contact with gays and lesbians and training on gay and lesbian issues may have a greater effect on GAP scores.

Finally, the moderate but significant relationship between GAP scores and feeling thermometer scores further supports the moderate but significant relationship between the ATLG and HATH and the domains of the GAP that was found in the validity analyses. While attitudes have a significant effect on practice with gay and lesbian clients, other factors (e.g., demographics) discussed here also influence GAP scores.

UTILITY OF THE GAP SCALE

The key issue with any measurement instrument is its utility (Springer, 1997). The GAP has many uses for social workers and other helping professionals. First, as a rapid assessment instrument, the GAP can be easily administered and scored by a variety of helping professionals in a brief amount of time. Second, the GAP can be used by practitioners as a self-assessment instrument to evaluate the degree to which they practice affirmatively with gay and lesbian clients. Third, the scale can be used to assess the effectiveness of different types of educational interventions on practitioners' work with gay and lesbian clients. Such studies might consist of a training on gay and lesbian issues or treatment approaches being given to one group of practitioners while being withheld from another and using the GAP to assess the impact of the training. In addition, following test-retest reliability studies, the GAP may be administered to individuals before and after different training methods and content on gay and lesbian issues to evaluate the magnitude of change in each group. Fourth, the GAP can be used to evaluate claims by students and other helping professionals that despite holding anti-gay attitudes, they can practice affirmatively with gay

and lesbian clients. While many remain skeptical about these claims, this scale may be used to evaluate such claims and to further identify factors which impact clinicians' practice and beliefs about practice with gay and lesbian clients.

STUDY LIMITATIONS

A chief limitation of this study is the low response rate in the administration to clinicians. Although the poor response rate may be partially attributable to the fact that many respondents did not receive the survey until after the requested return date of February 15, 2002, concern arises that the non-responders may hold different views from the responders. This concern limits the generalizability of the current study as it is not known to what degree the pool of respondents is representative of social workers and psychologists as a group.

The use of memberships lists from the NASW and APA to obtain the sample also limits the study's generalizability. Social workers and psychologists who are members of these organizations may hold different views than those who are not members of the NASW and APA, further limiting the generalizability of the findings to a broader group of clinicians. Additionally, the views of social workers and psychologists may not represent the views of many other helping professionals such as nurses and counselors.

The study is further limited by the high (92%) percent of respondents who identified their race/ethnicity as "Caucasian/White." This study sheds little light on gay affirmative practice among people of other racial or ethnic groups.

Another study limitation is that it did not examine known-groups discriminant validity to distinguish between those who would be reasonably

expected to have higher scores on the scale and those who would be reasonably expected to have lower scores on the scale. Conducting such a validity study would further reinforce claims that the scale is a valid measure of gay affirmative practice. Nevertheless, this validation study of the GAP was based on a large number of respondents and the GAP appears to have sufficient reliability and validity.

IMPLICATIONS FOR SOCIAL WORK PRACTICE, EDUCATION, RESEARCH, AND THE PROFESSION

Practice

Clinicians who want to improve their practice with gay and lesbian clients have had few tools by which to evaluate their beliefs and practice with this population. The GAP can be used in conjunction with other methods, such as feedback from supervisors, co-workers, and clients to assess practitioners' work with gay and lesbian clients and ultimately to improve the quality of services provided to members of this group. This self evaluation process is consistent with the ethics of social work as a profession which encourage competence and respect for diversity. In addition, by evaluating their practice with gay and lesbian clients, social workers demonstrate a commitment to culturally competent practice with gay and lesbian clients, consistent with the increasing emphasis in the profession on cultural competency with diverse groups.

Education

The moderate relationship between the domains of this scale and measures of homophobia may suggest that educational efforts targeting attitudes towards

gay and lesbians clients are insufficient to insure gay affirmative practice. While attitudes may be an important component of affirmative practice with gay and lesbian clients, they may not be sufficient to insure affirmative practice with such clients (Oles et al., 1999). It may be equally, if not more, important to educate students and practitioners about components of gay affirmative practice and ways in which they can apply this model to the many settings in which they practice. It may also be that as Fishbein and Ajzen (1975) suggest, the relationship between attitudes and behavior is not direct and is mediated by intentions. Thus, social workers' intentions towards gay and lesbian clients may be more highly correlated with their practice than are their attitudes. Social work education about gay and lesbian clients might thus address attitudes, intentions, beliefs about treatment, and behavior in treatment with gay and lesbian clients rather than focusing almost exclusively on the relationship between attitudes and behavior.

It has long been assumed that those who hold homophobic attitudes are incapable of practicing affirmatively and without bias with gay and lesbian clients. However, this study suggests that because the relationship between attitudes (as measured by the ATLG and HATH and scores on the feeling thermometers) and GAP scores was not as strong as expected, the relationship between homophobia and the ability to practice affirmatively may not be as strong as has been emphasized in the literature. The absence of such a strong relationship may thus support the claims of those who profess that though they hold anti-gay attitudes, they can practice without bias towards gay and lesbian clients. While such claims have often been dismissed as naïve and ignorant, it may be that

educators need to focus their attention on helping students and practitioners to acquire skills and beliefs consistent with gay affirmative practice rather than simply minimizing these assertions. At the same time, until further studies can be conducted on the relationship among attitudes, beliefs, intentions, and behaviors in practice with gay and lesbian clients, educators should continue to caution those who make such statements about the potential for their attitudes to negatively impact their clients and recommend that they refrain from working with gay and lesbian clients if they cannot practice affirmatively with them.

Research

For the past 30 years, research has focused largely on social workers' attitudes towards gay and lesbian clients. While this research has contributed to the knowledge base, it is time to move the focus from attitudes to an examination of beliefs and behaviors in practice with gay and lesbian clients. In doing so, the research can move from an assumed relationship between homophobia and practice to one that is empirically tested. The development and validation of the GAP is one step in that direction.

The development and validation of this scale may also encourage others to embark on similar studies. This scale can be used in validation studies for related measures of affirmative practice and culturally competent practice with gay and lesbian clients. The development of additional measures may facilitate research in this area and increase knowledge about practice with gays and lesbian clients.

Profession

Social work has historically lagged behind related professions with regard to gay and lesbian clients, choosing to be reactive rather than proactive in its stances on gay and lesbian issues. Gay affirmative practice has typically been discussed much more by other disciplines than by social work. Although recent works by Appleby and Anastas (1998) and Hunter, Shannon, Knox, and Martin (1998) have increased awareness of affirmative practice in social work, much work remains in this area. Publications about this scale along with information about gay affirmative practice will increase knowledge about this model within social work and other related professions.

RECOMMENDATIONS FOR FUTURE RESEARCH ON THE GAP

Additional studies with the GAP should use multiple methods of distributing questionnaires to increase the response rate. In addition to distributing surveys by mail, surveys can be distributed via email, posted on the web, given to potential respondents at local and national conferences and continuing education workshops, and given to those who take advanced licensing and certification tests. The use of such methods may improve the response rate and result in a more diverse sample than the one in this study.

Future research should also attempt to obtain samples of sufficient size of African-American, Mexican-American, and other racial and ethnic groups so that knowledge about the effect of race and ethnicity on GAP scores can be obtained. Given the small percent of NASW and APA members who identify as racial or ethnic minorities, future studies that sample these groups should utilize stratified

sampling methods to increase the percent of ethnic minority respondents. In addition, sampling from organizations such as the National Association of Black Social Workers and the Latino Social Work Organization to increase the diversity of the sample should be considered.

When conducting additional validation studies, it may be helpful to administer other instruments besides those currently used in this study, such as validated measures of cultural competency like the Multicultural Awareness-Knowledge-and Skills Survey (MAKSS) (D'Andrea, Daniels, & Heck, 1990) and the Multicultural Counseling Awareness Scale (MCAS) (Ponterotto, Sanchez, & Magids, 1990). As the GAP is based on a model of culturally competent practice with gays and lesbians, it may be useful to assess the relationship between it and measures of cultural competency. It may also be useful to administer the GAP with more recently developed measures of homophobia such as the Modern Homophobia Scale (Raja & Stokes, 1999) and the Homonegativity Scale (Morrison, Parriag, & Morrison, 1999) to assess the relationship between the GAP and these constructs. Newer measures of homophobia may reflect changes in how this attitude is conveyed and thus have a stronger relationship to scores on the GAP. When considering which measures of homophobia to administer, the researcher should be clear about the specific type of homophobia (affective or cognitive) he/she is interested in.

Attempts should also be made to identify groups that would be appropriate for assessment of known-groups validity. Such studies are important because "known-groups validity is one of the more convincing methods for establishing

the validity of an instrument" (Springer, 1997, p. 174). The scale could be administered to those who openly support and practice reparative or conversion therapies, and would thus be expected to have much lower scores on the GAP, and those employed by gay and lesbian counseling centers who would be expected to have higher scores on the GAP.

In addition to additional validation studies, additional reliability studies would also be useful. Test-retest reliability studies should be conducted to assess how stable GAP scores are over time. If the scale is found to have good test-retest reliability, it may be appropriate for use in pretest-posttest experimental studies to evaluate the impact of different teaching methods and content on gay affirmative practice.

Multiple regression analyses should also be conducted to identify the combination of variables that account for the greatest variance in GAP scores and to identify characteristics of practitioners who engage in gay affirmative practice.

Of particular interest to this researcher is the administration of this scale to practitioners who treat gay and lesbian clients with substance abuse and dependency disorders. The current literature suggests that homophobia in substance abuse treatment providers (SATPs) may contribute to gay and lesbian clients' denial of substance abuse problems (Crisp & DiNitto, in press). While research by Eliason (2000) found that SATPs generally had positive attitudes toward gay and lesbian clients, as has been discussed elsewhere in this dissertation, it is not known how these attitudes impact practice with gay and lesbian clients. Distributing this scale to practitioners whose primary role is that

of treating clients with chemical dependency and substance abuse problems may yield additional insight into substance abuse treatment with gay and lesbian clients.

The changing realities of social work research often make the acquisition of external funding a prerequisite for conducting further research. Thus, opportunities to obtain external funding for studies such as those recommended above and those which use the GAP should be explored. Although foundation grants for research on gay and lesbian issues continue to be limited, federal funding sources such as the National Institutes on Drug Abuse and National Institute of Mental Health are increasingly willing to support research in this area (Rabasca, 2000) and should be considered potential sources of funding. Other sources such as women's organizations, university research offices, and academic departments which appear willing to fund gay and lesbian research (Crisp, in press) should also be pursued.

CONCLUDING THOUGHTS

As discussed elsewhere in this dissertation, there have been many studies on homophobia but few on the relationship between attitudes towards gays and lesbians and behaviors and beliefs in practice settings with them. This scale was developed in an attempt to bridge the gap between attitudes and behaviors, and by doing so, gain insight into the relationship between the two. While this study provides initial evidence of the reliability and validity of the Gay Affirmative Practice Scale, the findings are of little practical significance unless they benefit those the scale is ultimately designed to assist: gays and lesbians who use social

work and other clinical services. Gay affirmative practice is increasingly accepted as the model from which to approach treatment with gay and lesbian clients and is consistent with many social work values. Clinicians whose practice is based on this model convey support and affirmation for gay and lesbian clients' identities, support clients' right to self-identify, assist clients with the challenges of living in an oppressive and homophobic world, help clients express positive feelings about gay/lesbian identities, and explicitly reject the use of reparative therapies. Given research that shows gays and lesbians are more likely than heterosexuals to use therapeutic services (Rudolf, 1988), it is particularly important that clinicians have measures by which to evaluate their competency with gay and lesbian clients and be trained to treat them affirmatively. This scale provides an initial means by which to assess practice and may thus lead to improved services for gay and lesbian clients.

Appendix A: References Used for Creation of Scale Items

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Appendix B: Expert Review Packet

COVER LETTER

3412 Primrose Trail
Georgetown, Texas 78628
January 26, 2001

Dear

Thank you for agreeing to assist in the expert review process for the Gay Affirmative Practice (GAP) scale. As you may recall from the email I sent you, the development and validation of this scale is the focus of my dissertation and is supervised by Dr. Diana DiNitto.

Attached is a list of potential items that have been created to measure gay affirmative practice. As defined by Davies, gay affirmative practice "*affirms a lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity*" (1996, p. 25). My intent in developing the scale is to assess the degree to which practitioners work with adult clients in ways that are consistent with the above definition. To achieve that goal, 372 items have been generated to assess two domains of this construct: **practice behaviors** with gay/lesbian clients and **beliefs about practice** with gay/lesbian clients. You may notice that many items are similar to each other, however, please note that the items differ by at least one or two words. These items will serve as the pool for the eventual construction of the instrument but not all items will be used.

A brief note about language used in the scale. A primary challenge in the development of this scale has been the terminology used to describe both gay men and lesbians. "Gay men and lesbians" is a double-barreled item which is problematic for use in scale construction. Research by G. Herek has found that people often associate the term "homosexual" with gay men. Given these issues and after much thought and discussion, the term "gay/lesbian" was chosen to refer to gay men and lesbians. Any comments on how to improve this wording, or any other wording used in the items, is greatly appreciated.

I would like to have a relevancy score for each item to assist in deciding which items to include in the scale. Please consider each of the potential scale items in

relation to their relevance to gay affirmative practice as defined above by Davies. Please rate each item on the basis of the following four point scale:

Not relevant Somewhat relevant Quite relevant Very relevant

Please return the questionnaire to me by **February 16, 2001**, in the enclosed envelope. If you have any questions or need additional information, please contact me by email at c_crisp@att.net or by phone at (512) 863-7212. Thank you again for your willingness to assist with this process.

Respectfully,

Catherine Crisp, MSW, LMSW-ACP
Doctoral Candidate
School of Social Work
University of Texas at Austin

enclosures

BACKGROUND QUESTIONS FOR REVIEWERS

In order to report on the background of the pool of experts who considered the relevancy of these items, please respond to the questions below:

1) How many years of direct practice experience have you had: _____

2) What is your highest attained level of professional education:

   _____ Bachelor Degree

   _____ Master Degree

   _____ Doctorate Degree

   _____ Other (please list)_____

3) What is your professional identification:

   _____ Social Worker

   _____ Psychologist

   _____ Other (please specify)

4) In what area do you spend over 50% of your time:

   _____ Social work education

   _____ Psychology education

   _____ Direct practice with clients

   _____ Other (please specify)

5) What is your gender:

   _____ Male

   _____ Female

6) What is your sexual orientation:

_____ Gay/lesbian

_____ Bisexual

_____ Heterosexual

7) What is your age: _____

QUESTIONNAIRE

The items in this section are intended to assess beliefs about practice with gay and lesbian clients. The response option set I plan to use with this domain is below. Your suggestions as to a different format are welcomed.

1 Strongly disagree
2 Disagree
3 Neither agree nor disagree
4 Agree
5 Strongly agree

For example, respondents will be asked to indicate their level of agreement with the item below.

Practitioners should verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.

1	2	3	4	5
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Please note that items with * prior to the ID number will be reverse scored when the scale is administered.

If you would like to write comments about the items in the margins or below each item, please feel free to do so. In addition, if there are some items you prefer over others, please indicate which these items are by placing a star (*) in the margin next to the ID number. Please circle your preferred response for each item.

Belief Domain

1. *Practitioners should focus on gay/lesbian clients' sexual orientation in their treatment with them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

2. Practitioners should accept the adoption of a gay/lesbian identity as a positive outcome of any process in which the individual is questioning his/her sexual identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

3. Practitioners should facilitate a client's search for his or her sexual identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

4. Practitioners should acknowledge the dangers that gay/lesbian clients may experience when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

5. Practitioners should address their homophobia in practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

6. Practitioners should actively explore attitudes about working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

7. Practitioners should educate themselves about the rites of passage specific to gay/lesbian populations.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

8. Practitioners should educate themselves about the cultural traditions specific

to gay/lesbian populations.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

9. Practitioners should actively address their own heterosexism in practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

10. In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

11. Practitioners should gather information about clients' sexuality during the first few sessions.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

12. Practitioners should encourage gay/lesbian clients to question society's values about homosexuality.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

13. Practitioners should continuously reassess their assumptions about homosexuality.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

14. *Practitioners should minimize the importance of sexual orientation on gay/lesbian clients' interpretations of their life experiences.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

15. *Practitioners should minimize the importance of sexual orientation on gay/lesbian clients' life experiences.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

16. Practitioners should affirm clients' knowledge about gay/lesbian issues.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

17. Practitioners should use supervision to improve their practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

18. *Practitioners should encourage clients to have relationships with people of the opposite gender when they are questioning whether they are gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

19. Practitioners should inform clients about gay affirmative resources in the community.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

20. Practitioners should acknowledge to clients the impact of living in a homophobic society.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

21. Practitioners should verbalize acceptance of a client's sexual orientation, regardless of whether the client identifies as gay, lesbian, bisexual, or heterosexual.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

22. *Practitioners should underestimate the importance of intimate relationships for gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

23. Practitioners should help gay/lesbian clients overcome negative attitudes about homosexuality.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

24. Practitioners should help clients identify their internalized homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

25. Practitioners should help clients reduce their internalized homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

26. Practitioners should verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

27. Practitioners should strive towards peer relationships with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

28. Practitioners should not attempt to change the sexual orientation of gay/lesbian clients without strong evidence that this change is desired by the client.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

29. *Practitioners should use heterosexual frames of reference when working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

30. Practitioners should seek collaborative rather than authoritative relationships with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

31. Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

32. Practitioners should facilitate exploration of sexual orientation issues by their clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

33. In their practice with gay/lesbian clients, practitioners should verbalize respect for the diversity of lifestyles within the gay/lesbian community.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

34. Practitioners must address their homophobia in order to be effective with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

35. Practitioners should assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

36. Practitioners should help gay/lesbian clients understand the multiple sources of stress in their lives.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

37. Practitioners should be open-minded when tailoring treatment for gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

38. My attitudes about gay/lesbian people affect my practice with gay/lesbian

clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

39. Practitioners should include the extended families of gay/lesbian clients in treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

40. Practitioners should seek consultation to improve their practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

41. Practitioners should provide interventions that facilitate the safety of gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

42. Practitioners should provide interventions that facilitate disclosure by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

43. *Practitioners should assume that gay/lesbian clients have similar lifestyles.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

44. Practitioners should create a climate that allows for voluntary self-disclosure by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

45. Practitioners should examine their own values when working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

46. Practitioners should make an effort to learn about diversity within the gay/lesbian community.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

47. *Practitioners should ask clients to teach them about gay/lesbian culture.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

48. Practitioners should actively explore their values about working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

49. Practitioners should help gay/lesbian clients strengthen their identities as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

50. Practitioners should be knowledgeable about gay/lesbian resources.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

51. Practitioners should refer gay/lesbian clients to gay affirmative resources.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

52. Practitioners should not make an issue of sexual orientation when it is not relevant to treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

53. Practitioners should respond to a client's sexual orientation when it is relevant to treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

54. Practitioners should help gay/lesbian clients feel good about themselves as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

55. Practitioners should acknowledge to clients that the era in which people grow up influences their experiences of being gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

56. Practitioners should acknowledge to clients that the age of coming out influences peoples' experiences of being gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

57. Practitioners should disclose their sexual orientation to gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

58. Practitioners should discuss sexual orientation in a non-threatening manner with clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

59. Practitioners should display gay affirmative materials in the places where they interact with clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

60. Practitioners should actively explore their own feelings of homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

61. Practitioners should work to reduce their own homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

62. Practitioners should demonstrate comfort about gay/lesbian issues to gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

63. *Practitioners should assume that clients will outgrow gay/lesbian feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

64. Practitioners should consider the degree to which internalized homophobia may impact gay/lesbian clients' development of a gay/lesbian identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

65. Practitioners should be knowledgeable about laws affecting gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

66. Practitioners should be knowledgeable about health issues affecting gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

67. Practitioners should acknowledge that their lack of knowledge about homosexuality is relevant to treatment with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

68. Practitioners' sexual orientation is relevant to their treatment with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

69. Practitioners should acknowledge that their sexual orientation is relevant to treatment with clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

70. Practitioners should acknowledge that their attitudes about homosexuality are relevant to their treatment with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

71. Practitioners' attitudes about homosexuality are relevant to treatment with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

72. Practitioners should provide clients with accurate information about gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

73. Practitioners should help gay/lesbian clients address problems created by discrimination against them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

74. Practitioners' lack of knowledge about homosexuality is relevant to treatment with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

75. Practitioners should question clients' disapproving statements about gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

76. Practitioners should assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

77. Practitioners should validate the diversity of gay/lesbian relationships for gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

78. Practitioners should acknowledge the ways prejudice creates problems that gay/lesbian clients may want to address in treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

79. Practitioners should acknowledge the ways discrimination creates problems that gay/lesbian clients may want to address in treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

80. Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

81. Practitioners should challenge misinformation about gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

82. Practitioners should educate other professionals about gay/lesbian issues.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

83. Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

84. Practitioners should use professional development opportunities to improve their practice skills with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

85. Practitioners should acknowledge to gay/lesbian clients that their lives are affected by societal prejudice.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

86. Practitioners should acknowledge to gay/lesbian clients that their lives are affected by discrimination they experience.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

87. Practitioners should use professional development opportunities to increase their knowledge about practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

88. Practitioners should challenge anti-gay comments made by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

89. Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

90. Practitioners should be knowledgeable about issues unique to gay/lesbian couples.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

91. Practitioners should confront anti-gay comments made by co-workers.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

92. As part of their standard assessment procedures, practitioners should inquire about clients' sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

93. Practitioners should acknowledge the differences between gay/lesbian individuals and heterosexuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

94. Practitioners should acknowledge the similarities between gay/lesbian individuals and heterosexuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

95. *Practitioners should make assumptions about gay/lesbian clients' relationships.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

96. *Practitioners should make assumptions about gay/lesbian clients' sexual activities.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

97. *Practitioners should support a change in sexual orientation as a goal of treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

98. Practitioners should accept a change in sexual orientation as a standard therapeutic aim.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

99. Practitioners should support gay/lesbian clients' exploration of heterosexual feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

100. Practitioners should be flexible when tailoring treatment for gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

101. Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

102. Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

103. Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

104. Practitioners should educate themselves about gay/lesbian lifestyles.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

105. Practitioners should educate themselves about gay/lesbian concerns.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

106. Practitioners should make their value system about gay/lesbian people known to their clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

107. *Practitioners should help gay/lesbian clients identify factors that caused them to be gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

108. Practitioners should help gay/lesbian clients address the stress they experience as a consequence of being disapproved by others.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

109. Practitioners should acknowledge their personal biases about gay/lesbian individuals when working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

110. Practitioners should refer gay/lesbian clients to health care professionals who are sensitive to their needs.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

111. Practitioners should encourage gay/lesbian clients to develop relationships with both gay/lesbian and non-gay/lesbian friends.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

112. Practitioners should encourage gay/lesbian clients to participate in the larger community, both gay and non-gay.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

113. Practitioners should help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

114. Practitioners should refer gay/lesbian clients to religious organizations that support them as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

115. Practitioners should verbalize their attitudes about gay/lesbian people when working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

116. Practitioners should value the risks clients take when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

117. Practitioners should acknowledge the risks clients take when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

118. Practitioners should question their values about homosexuality.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

119. Practitioners should accept the diversity of sexual behavior among gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

120. Practitioners should support the diversity of sexual behavior among gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

121. Practitioners should acknowledge the diversity of sexual behavior among gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

122. Practitioners should consider heterosexist assumptions in current lifespan development theories in their practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

123. Practitioners should consider heterosexist assumptions in current lifespan development theories in their client assessment procedures.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

124. Practitioners should affirm for clients that people who are gay, lesbian, or bisexual can lead emotionally healthy lives.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

125. Practitioners should affirm for clients that people who are gay, lesbian, or bisexual can lead fulfilling lives.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

126. Practitioners should acknowledge that their attitudes about gay/lesbian people affect their practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

127. Practitioners should seek new knowledge about practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

128. Practitioners should help gay/lesbian clients identify prejudice they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

129. Practitioners should help gay/lesbian clients identify discrimination they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

130. Practitioners should support the language used by gay/lesbian clients to describe their sexual orientation when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

131. *Practitioners should underestimate homophobic behaviors to which gay/lesbian clients are exposed.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

132. Practitioners should support clients in their decisions regarding to whom to come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

133. *Practitioners should underestimate heterosexist behaviors to which gay/lesbian clients are exposed.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

134. Practitioners should assist clients in working through the stages of the coming out process.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

135. Practitioners should actively address their own homophobia in practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

136. *Practitioners should assist a client in changing his/her sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

137. Practitioners should consider very carefully before entering into a contract to eliminate homosexual feelings in a client.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

138. Practitioners should help gay/lesbian clients identify oppression they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

139. Practitioners should facilitate appropriate expression of anger by gay/lesbian

clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

140. Practitioners should facilitate identification of anger by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

141. Practitioners should encourage gay/lesbian clients establish a gay/lesbian support system.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

142. Practitioners should encourage clients to question basic assumptions about being gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

143. Practitioners should facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

144. Practitioners should facilitate identification of anger by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

145. Practitioners should facilitate identification of anger by gay/lesbian clients about oppression they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

146. Practitioners should encourage appropriate expression of affection by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

147. Practitioners should help clients reduce guilt about homosexual thoughts.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

148. Practitioners should help clients reduce shame about homosexual behaviors.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

149. Practitioners should help clients reduce guilt about homosexual feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

150. Practitioners should help clients reduce shame about homosexual thoughts.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

151. Practitioners should help clients reduce guilt about homosexual behaviors.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

152. Practitioners should help clients reduce shame about homosexual feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

153. Practitioners should approve homosexual feelings reported by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

154. Practitioners should approve homosexual behaviors reported by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

155. Practitioners should approve homosexual thoughts reported by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

156. Practitioners should question heterosexist statements expressed by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

157. Practitioners should question homophobic statements expressed by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

158. Practitioners should encourage less focus on the label "gay" or "lesbian" when clients are struggling with self-identification as a gay/lesbian person.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

159. Practitioners should help gay/lesbian clients address problems created by societal prejudice.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

160. Practitioners should use an understanding of societal prejudice experienced by gay/lesbian clients to guide their practice with them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

161. Practitioners should acknowledge to clients that the length of time since coming out influences peoples' experiences of being gay.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

162. Practitioners should consider the coming out stage that gay/lesbian clients are in when planning their interventions with them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

163. Practitioners should create a climate that allows for voluntary self-identification by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

164. I am knowledgeable about gay/lesbian resources.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

165. Practitioners' negative assumptions based on sexual orientation may have a detrimental impact on clients' treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

166. Practitioners should support gay/lesbian clients when they try out different lifestyles.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

167. Practitioners must be aware of their homophobia in order to be effective with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

168. *Practitioners should help gay/lesbian clients change their sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

169. Societal prejudice creates problems that gay/lesbian clients may need to address in treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

170. Practitioners should treat bisexuality as a stable identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

171. I am knowledgeable about issues unique to gay/lesbian couples.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

172. My sexual orientation is relevant to the helping process.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

173. Practitioners' attempts to change the sexual orientation of a gay/lesbian client are detrimental to the client.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

174. Sexual orientation is a core characteristic that influences clients' perceptions of themselves.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

175. I am comfortable with my own homosexual feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

176. I am knowledgeable about laws affecting gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

177. Discrimination creates problems that gay/lesbian clients may need to address in treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

178. *Sexual orientation should be the focus of treatment with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

179. Practitioners should assess the degree to which gay/lesbian clients want their sexual orientation to be the focus of treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

180. Practitioners should assist gay/lesbian clients in making decisions about how

to come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

181. Practitioners should assist gay/lesbian clients in making decisions about when to come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

182. Practitioners should assist gay/lesbian clients in making decisions about to whom to come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

183. Practitioners should assess clients' sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

184. Interventions with gay/lesbian clients should consider the stage of coming out the client is in.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

185. *My beliefs about gays/lesbians have no relevance to my practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

186. *Practitioners' value systems about gay/lesbian individuals do not affect their practice with them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

187. *Becoming heterosexual would help gay/lesbian clients address problem areas of their lives.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

188. Practitioners should encourage gay/lesbian clients to explore alternative methods of coming out (by letter, in person, or by phone).

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

189. Gender identity is a core characteristic that influences clients' perceptions of themselves.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

190. Practitioners should inform gay/lesbian clients about dangers they may experience when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

191. It is important to support the language used by clients to describe their sexual orientation when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

192. In order to provide effective treatment with gay/lesbian clients, practitioners must be comfortable with their own homosexual feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

193. A client's sexual orientation should not be the focus of treatment unless he or she specifically requests it.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

194. *Practitioners should advise gay/lesbian clients to come out even when they are not ready to do so.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

195. *Practitioners should assume clients are heterosexual unless directly told otherwise.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

196. Adoption of a gay/lesbian identity is a positive outcome of any process in which the individual is working on his/her sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

197. I am knowledgeable about health issues affecting gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

198. Practitioners should educate other professionals about practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

199. My sexual orientation influences my practice with clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

200. Practitioners can not work effectively with gay/lesbian clients unless they actively address their own homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

201. Sexual orientation is a core characteristic that influences clients' perceptions of their worlds.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

202. Gender identity is a characteristic that influences clients' perceptions of their worlds.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

203. Practitioners can not work effectively with gay/lesbian clients unless they actively address their own heterosexism.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

204. Gay/lesbian clients are better served by gay/lesbian practitioners.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

205. Adoption of a gay/lesbian identity is a positive outcome of any process in which the individual is questioning his/her sexual identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

The items in this section are intended to assess practice behaviors with gay and lesbian clients. The response option set I plan to use with this domain is below. Your suggestions as to a different format are welcomed.

6 Never
7 Rarely
8 Sometimes
9 Usually
10 Always

For example, respondents will be asked to indicate how frequently they engage in the behavior indicated by each item as in the example below:

I verbalize respect for the lifestyles of gay/lesbian clients.

1	2	3	4	5
Never	Rarely	Sometimes	Usually	Always

Please note that items with ***** prior to the ID number will be reverse scored when the scale is administered.

If you would like to write comments about the items in the margins or below each item, please feel free to do so. In addition, if there are some items you prefer over others, please place a star (*) in the margin next to the ID number of the item you prefer. Please circle your preferred response for each item.

Practice Domain

1. I educate other professionals about practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

2. I accept the adoption of a gay/lesbian identity as a positive outcome of any process in which the individual is questioning his/her sexual identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

3. In my practice with gay/lesbian clients, I support the diverse makeup of their families.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

4. I acknowledge that my sexual orientation is relevant to treatment with clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

5. I seek consultation to improve my practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

6. I provide interventions that facilitate the safety of gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

7. I use supervision to improve my practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

8. I provide interventions that facilitate disclosure by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

9. *I encourage clients to have relationships with people of the opposite gender when they are questioning whether they are gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

10. As part of my standard assessment procedures, I inquire about clients' sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

11. I question clients' disapproving statements about gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

12. I help gay/lesbian clients overcome negative attitudes about homosexuality.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

13. I verbalize my attitudes about gay/lesbian people when working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

14. I refer gay/lesbian clients to health care professionals who are sensitive to their needs.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

15. *I focus on gay/lesbian clients' sexual orientation in my treatment with them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

16. *I help gay/lesbian clients change their sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

17. I help gay/lesbian clients address problems created by societal prejudice.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

18. I help gay/lesbian clients address problems created by discrimination against them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

19. I acknowledge to gay/lesbian clients that their lives are affected by societal prejudice.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

20. I assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

21. I treat bisexuality as a stable identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

22. I acknowledge that my attitudes about gay/lesbian people affect my practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

23. I support the language used by gay/lesbian clients to describe their sexual orientation when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

24. I facilitate identification of anger by gay/lesbian clients about oppression they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

25. I assess the degree to which gay/lesbian clients want their sexual orientation to be the focus of treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

26. I inform gay/lesbian clients about dangers they may experience when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

27. I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

28. I facilitate a client's search for his or her sexual identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

29. *I assume clients are heterosexual unless directly told otherwise.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

30. I strive towards peer relationships with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

31. I seek collaborative rather than authoritative relationships with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

32. I verbalize respect for the lifestyles of gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

33. I make an effort to learn about diversity within the gay/lesbian community.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

34. *I ask clients to teach me about gay/lesbian culture.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

35. I support gay/lesbian clients when they try out different lifestyles.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

36. I actively explore my values about working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

37. I address my homophobia in practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

38. I acknowledge to clients the impact of living in a homophobic society.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

39. I examine my own values when working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

40. *I advise gay/lesbian clients to come out even when they are not ready to do so.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

41. *I make an issue of sexual orientation when it is not relevant to treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

42. I respond to a client's sexual orientation when it is relevant to treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

43. I help gay/lesbian clients feel good about themselves as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

44. I verbalize acceptance of a client's sexual orientation, regardless of whether the client identifies as gay, lesbian, bisexual, or heterosexual.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

45. I facilitate exploration of sexual orientation issues by my clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

46. *I assume that gay/lesbian clients have similar lifestyles.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

47. In my practice with gay/lesbian clients, I verbalize respect for the diversity of lifestyles within the gay/lesbian community.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

48. I work to develop attitudes necessary for effective practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

49. I help gay/lesbian clients strengthen their identities as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

50. I acknowledge to clients that the age of coming out influences peoples' experiences of being gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

51. I gather information about clients' sexuality during the first few sessions.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

52. I display gay affirmative materials in the places where I interact with clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

53. I inform clients about gay affirmative resources in the community.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

54. I actively explore my own feelings of homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

55. I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

56. I disclose my sexual orientation to gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

57. I discuss sexual orientation in a non-threatening manner with clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

58. I assess clients' sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

59. *I assume that clients will outgrow gay/lesbian feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

60. I consider the degree to which internalized homophobia may impact gay/lesbian clients' development of a gay/lesbian identity.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

61. I underestimate the importance of intimate relationships for gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

62. I use heterosexual frames of reference when working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

63. I actively explore my attitudes about working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

64. I provide clients with accurate information about gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

65. I use an understanding of societal prejudice experienced by gay/lesbian clients to guide my practice with them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

66. I do not attempt to change the sexual orientation of gay/lesbian clients without strong evidence that this change is desired by the client.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

67. I help gay/lesbian clients develop positive identities as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

68. I validate the diversity of gay/lesbian relationships for gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

69. I include the extended families of gay/lesbian clients in treatment when it is appropriate.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

70. I confront anti-gay comments made by co-workers.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

71. I make my value system about gay/lesbian clients known to them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

72. *I make assumptions about gay/lesbian clients' relationships.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

73. I accept a change in sexual orientation as a standard therapeutic aim.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

74. I support gay/lesbian clients' exploration of heterosexual feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

75. I am flexible when tailoring treatment for gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

76. I help gay/lesbian clients understand the multiple sources of stress in their

lives.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

77. I encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

78. I educate myself about gay/lesbian lifestyles.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

79. *I help gay/lesbian clients identify factors that caused them to be gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

80. I help gay/lesbian clients address the stress they experience as a consequence of being disapproved by others.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

81. I encourage gay/lesbian clients to consider alternative methods of coming out (by letter, in person, or by phone).

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

82. I acknowledge the diversity of sexual behavior among gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

83. I consider heterosexist assumptions in current lifespan development theories in my client assessment procedures.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

84. I encourage gay/lesbian clients to develop relationships with both gay/lesbian and non-gay/lesbian friends.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

85. I encourage gay/lesbian clients to participate in the larger community, both gay/lesbian and non-gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

86. I assist gay/lesbian clients in making decisions about how to come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

87. I actively address my own homophobia in practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

88. I affirm for clients that people who are gay, lesbian, or bisexual can lead fulfilling lives.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

89. I educate myself about the cultural traditions specific to gay/lesbian populations.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

90. I help gay/lesbian clients identify prejudice they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

91. I create a climate that allows for voluntary self-identification by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

92. I acknowledge the differences between gay/lesbian individuals and heterosexuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

93. I acknowledge the ways that prejudice creates problems that gay/lesbian clients may want to address in treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

94. I assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

95. I educate other professionals about gay/lesbian issues.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

96. I use professional development opportunities to improve my practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

97. I acknowledge my personal biases about gay/lesbian individuals when working with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

98. I value the risks gay/lesbian clients take when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

99. I question my values about homosexuality.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

100. I encourage gay/lesbian clients to question society's values about homosexuality.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

101. *I minimize the importance of sexual orientation on gay/lesbian clients' life experiences.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

102. I seek new knowledge about practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

103. I affirm clients' knowledge about gay/lesbian issues.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

104. I support gay/lesbian clients in their decisions regarding to whom to come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

105. I consider very carefully before entering into a contract to eliminate homosexual feelings in a client.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

106. I help gay/lesbian clients identify oppression they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

107. I acknowledge the dangers that gay/lesbian clients may experience when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

108. I facilitate identification of anger by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

109. I continuously reassess my own assumptions about homosexuality.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

110. *I underestimate homophobic behaviors to which gay/lesbian clients are exposed.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

111. I help clients identify their internalized homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

112. I assist clients in working through the stages of the coming out process.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

113. I encourage gay/lesbian clients to establish a gay/lesbian support system.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

114. I encourage clients to question basic assumptions about being gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

115. I help clients reduce shame about homosexual thoughts.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

116. I approve homosexual thoughts reported by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

117. I question homophobic statements expressed by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

118. I encourage less focus on the label "gay" or "lesbian" when clients are struggling with self-identification as a gay/lesbian person.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

119. I refer clients to gay affirmative resources.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

120. I acknowledge to clients that the era in which people grow up influences their experiences of being gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

121. I work to reduce my own homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

122. I acknowledge that my attitudes about homosexuality are relevant to treatment with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

123. I acknowledge to gay/lesbian clients that their lives are affected by discrimination they experience.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

124. I challenge anti-gay comments made by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

125. *I make assumptions about gay/lesbian clients' sexual activities.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

126. *I support a change in sexual orientation as a goal of treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

127. I am open-minded when tailoring treatment for gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

128. I work to develop skills necessary for effective practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

129. I educate myself about gay/lesbian concerns.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

130. I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

131. I assist gay/lesbian clients in making decisions about to whom to come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

132. I accept the diversity of sexual behavior among gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

133. I consider heterosexist assumptions in current lifespan development theories in my practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

134. I affirm for clients that people who are gay, lesbian, or bisexual can lead emotionally healthy lives.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

135. I help gay/lesbian clients identify discrimination they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

136. I create a climate that allows for voluntary self-disclosure by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

137. I acknowledge the ways discrimination creates problems that gay/lesbian clients may want to address in treatment.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

138. I challenge misinformation about gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

139. I use professional development opportunities to improve my practice skills with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

140. I acknowledge the similarities between gay/lesbian individuals and heterosexuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

141. I acknowledge the risks clients take when they come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

142. *I minimize the importance of sexual orientation on gay/lesbian clients' interpretations of their life experiences.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

143. *I underestimate heterosexist behaviors to which gay/lesbian clients are exposed.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

144. I help clients reduce their internalized homophobia.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

145. I actively address my own heterosexism in practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

146. *I assist a client in changing his/her sexual orientation.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

147. I facilitate appropriate expression of anger by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

148. I encourage appropriate expression of affection by gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

149. I help clients reduce shame about homosexual feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

150. I approve homosexual feelings reported by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

151. I question heterosexist statements expressed by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

152. I acknowledge that my lack of knowledge about homosexuality is relevant to treatment with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

153. I acknowledge to clients that the length of time since coming out influences peoples' experiences of being gay/lesbian.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

154. I approve homosexual behaviors reported by clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

155. I assist gay/lesbian clients in making decisions about when to come out.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

156. I educate myself about the rites of passage specific to gay/lesbian populations.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

157. I facilitate identification of anger by gay/lesbian clients about oppression they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

158. I refer gay/lesbian clients to religious organizations that support them as gay/lesbian individuals.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

159. I support the diversity of sexual behavior among gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

160. I use professional development opportunities to increase my knowledge about practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

161. I consider the coming out stage that gay/lesbian clients are in when planning my interventions with them.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

162. I acquire knowledge necessary for effective practice with gay/lesbian clients.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

163. I help clients reduce shame about homosexual behaviors.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

164. I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

165. I help clients reduce guilt about homosexual thoughts.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

166 I help clients reduce guilt about homosexual feelings.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

167 I help clients reduce guilt about homosexual behaviors.

Not Relevant Somewhat Relevant Quite Relevant Very Relevant

Thank you very much for taking the time to review these items. Please return the questionnaire in the enclosed envelope. If for some reason the envelope is not available, please mail it to:

Catherine Crisp
3412 Primrose Trail
Georgetown, TX 78628

Appendix C: Response Set Questionnaire

COVER LETTER

3412 Primrose Trail
Georgetown, TX 78628
August 1, 2001

Dear University of Texas at Austin School of Social Work graduate;

My name is Catherine Crisp and I am a doctoral student at The University of Texas at Austin School of Social Work. I am writing to ask you to participate in a study of clinicians' attitudes and behaviors in practice with gay and lesbian clients that is part of my dissertation research. You are being asked to participate in the study because you graduated from the University of Texas at Austin with a Master in Science in Social Work. If you participate, you will be one of approximately 300 people in the study.

As you know, with any survey, a certain response rate needs to be achieved to attain meaningful results. I would greatly appreciate it if you would take 15 minutes of time to complete this questionnaire and return it to me in the enclosed postage-paid envelope **no later than August 20, 2001**. Your response is critical to the success of this project and although you do not have to answer every question, doing so will provide helpful information about clinicians' behaviors with gay and lesbian clients. The information you provide is completely anonymous. No one, including myself or other people affiliated with the University of Texas at Austin, will be able to link your responses with your name. Completion and return of the questionnaire implies consent to participate in the study. Your decision to participate or to decide not to participate will not affect your present or future relationship with The University of Texas at Austin, the School of Social Work, or any social work organizations.

Please keep this letter for your records. If you have any questions about the study, please contact me by phone at (512) 863-7212 or by email at ccrisp@mail.utexas.edu or you may call the chair of my dissertation committee, Diana DiNitto, Ph.D., at (512) 471-9227. If you have any questions or concerns about your treatment as a research participant in this study, call Professor Clarke Burnham, Chair of the University of Texas at Austin Institutional Review Board for the Protection of Human Research Participants at 232-4383.

Thank you for taking time to assist with this research.

Sincerely,

Catherine Crisp, MSW
Doctoral Candidate
University of Texas at Austin
School of Social Work

enclosures

DEMOGRAPHIC ITEMS

Please answer the questions below and return in the enclosed envelope along with your responses to the attached questionnaire.

1. How old were you on your last birthday? _____

2. What year did you graduate from the University of Texas at Austin with your MSSW degree? _____

3. Please indicate your gender:

   [ ] Male

   [ ] Female

4. Please indicate your sexual orientation:

   [ ] heterosexual

   [ ] bisexual

   [ ] gay/lesbian

5. How many years have you been engaged in direct practice social work since obtaining your MSSW? _____

6. What percentage of your time do you currently spend providing direct services to clients? _____

LIKERT VERSION OF SCALE SENT TO RESPONDENTS

This questionnaire is designed to obtain information about your practice with gay and lesbian clients. It is not a test, so there are no right or wrong answers. Please indicate how you feel about each statement by circling the appropriate number.

	Item	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1.	I help clients reduce shame about homosexual feelings.	1	2	3	4	5
2.	I help gay/lesbian clients address problems created by societal prejudice.	1	2	3	4	5
3.	I assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.	1	2	3	4	5
4.	I help gay/lesbian clients feel good about themselves as gay/lesbian individuals.	1	2	3	4	5
5.	I assume clients are heterosexual unless directly told otherwise.	1	2	3	4	5
6.	In my practice with gay/lesbian clients, I support the diverse makeup of their families.	1	2	3	4	5

7.	I help gay/lesbian clients overcome negative attitudes about homosexuality.	1	2	3	4	5
8.	I inform clients about gay affirmative resources in the community.	1	2	3	4	5
9.	I assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.	1	2	3	4	5
10.	I assist clients in working through the stages of the coming out process.	1	2	3	4	5
11.	I refer gay/lesbian clients to health care professionals who are sensitive to their needs.	1	2	3	4	5
12.	I facilitate a client's search for his or her sexual identity.	1	2	3	4	5
13.	I assist a client in changing his/her sexual orientation.	1	2	3	4	5
14.	I accept the adoption of a gay/lesbian identity as a positive outcome of any process in which the individual is questioning his/her sexual identity.	1	2	3	4	5

15.	I support the language used by gay/lesbian clients to describe their sexual orientation when they come out.	1	2	3	4	5
16.	I verbalize respect for the lifestyles of gay/lesbian clients.	1	2	3	4	5
17.	I make an effort to learn about diversity within the gay/lesbian community.	1	2	3	4	5
18.	I acknowledge to clients the impact of living in a homophobic society.	1	2	3	4	5
19.	I respond to a client's sexual orientation when it is relevant to treatment.	1	2	3	4	5
20.	I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.	1	2	3	4	5
21.	I work to develop attitudes necessary for effective practice with gay/lesbian clients.	1	2	3	4	5
22.	I provide interventions that facilitate the safety of gay/lesbian clients.	1	2	3	4	5
23.	I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.	1	2	3	4	5

24.	I actively explore my own feelings of homophobia.	1	2	3	4	5
25.	I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.	1	2	3	4	5
26.	I advise gay/lesbian clients to come out even when they are not ready to do so.	1	2	3	4	5
27.	I focus on gay/lesbian clients' sexual orientation in my treatment with them.	1	2	3	4	5
28.	I include the extended families of gay/lesbian clients in treatment when it is appropriate.	1	2	3	4	5
29.	I help gay/lesbian clients understand the multiple sources of stress in their lives.	1	2	3	4	5
30.	I help clients identify their internalized homophobia.	1	2	3	4	5
31.	I educate myself about gay/lesbian concerns.	1	2	3	4	5
32.	I affirm for clients that people who are gay, lesbian, or bisexual can lead emotionally healthy lives.	1	2	3	4	5
33.	I assume that all gay/lesbian clients have similar lifestyles.	1	2	3	4	5

34.	I verbalize acceptance of clients' sexual orientation, regardless of whether the client identifies as gay, lesbian, bisexual, or heterosexual.	1	2	3	4	5
35.	I am open-minded when tailoring treatment for gay/lesbian clients.	1	2	3	4	5
36.	I encourage gay/lesbian clients to establish a gay/lesbian support system.	1	2	3	4	5
37.	I create a climate that allows for voluntary self-identification by gay/lesbian clients.	1	2	3	4	5
38.	I validate the diversity of gay/lesbian relationships for gay/lesbian clients.	1	2	3	4	5
39.	I discuss sexual orientation in a non-threatening manner with clients.	1	2	3	4	5
40.	I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.	1	2	3	4	5

Thank you for taking time to complete this survey. Please return it in the attached envelope by August 20, 2001.

FREQUENCY VERSION OF SCALE SENT TO RESPONDENTS

This questionnaire is designed to obtain information about your practice with gay and lesbian clients. It is not a test, so there are no right or wrong answers. Please indicate how you feel about each statement by circling the appropriate number.

	Item	Never	Rarely	Sometimes	Usually	Always
1.	I help clients reduce shame about homosexual feelings.	1	2	3	4	5
2.	I help gay/lesbian clients address problems created by societal prejudice.	1	2	3	4	5
3.	I assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.	1	2	3	4	5
4.	I help gay/lesbian clients feel good about themselves as gay/lesbian individuals.	1	2	3	4	5
5.	I assume clients are heterosexual unless directly told otherwise.	1	2	3	4	5
6.	In my practice with gay/lesbian clients, I support the diverse makeup of their families.	1	2	3	4	5
7.	I help gay/lesbian clients overcome negative attitudes about homosexuality.	1	2	3	4	5

8.	I inform clients about gay affirmative resources in the community.	1	2	3	4	5
9.	I assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.	1	2	3	4	5
10.	I assist clients in working through the stages of the coming out process.	1	2	3	4	5
11.	I refer gay/lesbian clients to health care professionals who are sensitive to their needs.	1	2	3	4	5
12.	I facilitate a client's search for his or her sexual identity.	1	2	3	4	5
13.	I assist a client in changing his/her sexual orientation.	1	2	3	4	5
14.	I accept the adoption of a gay/lesbian identity as a positive outcome of any process in which the individual is questioning his/her sexual identity.	1	2	3	4	5
15.	I support the language used by gay/lesbian clients to describe their sexual orientation when they come out.	1	2	3	4	5
16.	I verbalize respect for the lifestyles of gay/lesbian clients.	1	2	3	4	5

17.	I make an effort to learn about diversity within the gay/lesbian community.	1	2	3	4	5
18.	I acknowledge to clients the impact of living in a homophobic society.	1	2	3	4	5
19.	I respond to a client's sexual orientation when it is relevant to treatment.	1	2	3	4	5
20.	I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.	1	2	3	4	5
21.	I work to develop attitudes necessary for effective practice with gay/lesbian clients.	1	2	3	4	5
22.	I provide interventions that facilitate the safety of gay/lesbian clients.	1	2	3	4	5
23.	I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.	1	2	3	4	5
24.	I actively explore my own feelings of homophobia.	1	2	3	4	5
25.	I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.	1	2	3	4	5
26.	I advise gay/lesbian clients to come out even when they are not ready to do so.	1	2	3	4	5

27.	I focus on gay/lesbian clients' sexual orientation in my treatment with them.	1	2	3	4	5
28.	I include the extended families of gay/lesbian clients in treatment when it is appropriate.	1	2	3	4	5
29.	I help gay/lesbian clients understand the multiple sources of stress in their lives.	1	2	3	4	5
30.	I help clients identify their internalized homophobia.	1	2	3	4	5
31.	I educate myself about gay/lesbian concerns.	1	2	3	4	5
32.	I affirm for clients that people who are gay, lesbian, or bisexual can lead emotionally healthy lives.	1	2	3	4	5
33.	I assume that all gay/lesbian clients have similar lifestyles.	1	2	3	4	5
34.	I verbalize acceptance of clients' sexual orientation, regardless of whether the client identifies as gay, lesbian, bisexual, or heterosexual.	1	2	3	4	5
35.	I am open-minded when tailoring treatment for gay/lesbian clients.	1	2	3	4	5

36.	I encourage gay/lesbian clients to establish a gay/lesbian support system.	1	2	3	4	5
37.	I create a climate that allows for voluntary self-identification by gay/lesbian clients.	1	2	3	4	5
38.	I validate the diversity of gay/lesbian relationships for gay/lesbian clients.	1	2	3	4	5
39.	I discuss sexual orientation in a non-threatening manner with clients.	1	2	3	4	5
40.	I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.	1	2	3	4	5

Thank you for taking time to complete this survey. Please return it in the attached envelope by August 20, 2001.

Appendix D: Packet Sent to APA and NASW Members

COVER LETTER

January 22, 2002

Dear Colleague;

My name is Catherine Crisp and I am a doctoral student at The University of Texas at Austin School of Social Work. I am writing to ask you to participate in a study of clinicians' attitudes and behaviors in practice with gay and lesbian clients that is part of my dissertation research. You have been chosen as one of a random sample of 3000 psychologists and social workers to receive this survey.

As you know, with any survey, a certain response rate is needed to obtain meaningful results. I would greatly appreciate it if you would take 20-30 minutes of time to complete this questionnaire and return it to me in the enclosed postage-paid envelope no later than **February 15, 2002.**

Your response is critical to the success of this project and although you do not have to answer every question, doing so will provide helpful information about clinicians' behaviors with gay and lesbian clients. The information you provide is completely anonymous and no one, including myself, other people affiliated with the University of Texas at Austin, or any affiliated organizations will be able to link your responses with your name. Your decision to participate or to decide not to participate will not affect your present or future relationship with any of the aforementioned organizations. Completion and return of the questionnaire implies consent to participate in the study.

You may keep this letter for your records. If you have any questions about the study, please contact me by phone at (512) 863-7212 or by email at ccrisp@mail.utexas.edu or you may call the chair of my dissertation committee, Diana DiNitto, Ph.D., at (512) 471-9227. If you have any questions or concerns about your treatment as a research participant in this study, call Professor Clarke Burnham, Chair of the University of Texas at Austin Institutional Review Board for the Protection of Human Research Participants, at (512) 232-4383.

Thank you for taking time to assist with this research.

Sincerely,

Catherine Crisp, MSW, LMSW-ACP
Doctoral Candidate
University of Texas at Austin
School of Social Work

enclosures

QUESTIONNAIRE SENT TO APA AND NASW MEMBERS

Thank you very much for completing this survey. The information you provide will lead to valuable insight about practice with gay and lesbian clients. The survey consists of six pages with questions on both the back and the front of three different sheets of paper. Please complete each page and return the survey by *FEBRUARY 15, 2002,* using the enclosed postage-paid envelope.

Please answer each question by checking a single response option or by writing an answer in the blank provided.

1) What is your gender?

[ ] Male [ ] Female

2) What is your age? _____

3) What is your current relationship status?

[ ] single [ ] married [ ] divorced [ ] widowed

[ ] living with long-term partner

[ ] in long-term relationship but not living together

4) What is your sexual orientation?

[ ] heterosexual [ ] bisexual [ ] gay/lesbian

5) What is your current religious affiliation?

[ ] Baptist [ ] Catholic [ ] Episcopal [ ] Fundamentalist

[ ] Lutheran [ ] Methodist [ ] Presbyterian

[ ] Conservative Jewish [ ] Orthodox Jewish [ ] Reformed Jewish

[ ] Other [ ] None

6) What is your race?

[ ] African American/Black [ ] Asian American [ ] Caucasian/White

[ ] Hispanic/Latino [ ] Mexican American [ ] Native American

[ ] Pacific Islander [ ] Puerto Rican [ ] Other

7) What is the highest degree you have received?

[ ] Bachelor's [ ] Master's [ ] Doctorate [ ] Other

8) What is your current political party?

[ ] Democrat [ ] Republican

[ ] Green [ ] Independent [ ] Libertarian [ ] Reform

[ ] Other [ ] None

9) To which organization do you currently belong?

[ ] American Psychological Association

[ ] National Association of Social Workers

10) What is your primary role at your agency or institution?

[ ] Provider of direct services [ ] Supervisor of direct practice staff

[ ] Administrator [ ] Educator [ ] Researcher [ ] Other

11) What percent of your work time is spent in *direct practice* to clients? _____

12) What is your primary area of practice (please check only one category)?

[ ] addiction/substance abuse [ ] adolescents [ ] aging

[ ] child welfare/family [ ] health [ ] international [ ] mental health

[ ] school practice [ ] other

13) How many workshops have you attended that had *a specific focus* on gay and/or lesbian issues? _____

14) How many workshops have you attended that *included content* on gay and/or lesbian issues? _____

15) How many gay or lesbian *friends* do you currently have? _____

16) How many gay or lesbian *family members* do you currently have? _____

17) How many gay or lesbian *clients* do you currently have? _____

18) What *percent* of your clients are gay or lesbian? _____

19) Where would you place your feelings about ***lesbian women*** on the feeling thermometer below? _____

Feeling Thermometer

WARM	**100**	_____	**Warm or very favorable feeling**
↑	**85**	_____	**Good warm or favorable feeling**
	70	_____	**Fairly warm or favorable feeling**
	60	_____	**A bit more warm or favorable than cold feeling**
---------	**50**	_____	**No feeling at all**
	40	_____	**A bit more cold or unfavorable feeling**
	30	_____	**Fairly cold or unfavorable feeling**
↓	**15**	_____	**Quite cold or unfavorable feeling**
COLD	**0**	_____	**Very cold or unfavorable feeling**

20) Where would you place your feelings about ***gay men*** on the feeling thermometer below? _____

Feeling Thermometer

WARM	**100**	_____	**Warm or very favorable feeling**
↑	**85**	_____	**Good warm or favorable feeling**
	70	_____	**Fairly warm or favorable feeling**
	60	_____	**A bit more warm or favorable than cold feeling**
---------	**50**	_____	**No feeling at all**
	40	_____	**A bit more cold or unfavorable feeling**
	30	_____	**Fairly cold or unfavorable feeling**
↓	**15**	_____	**Quite cold or unfavorable feeling**
COLD	**0**	_____	**Very cold or unfavorable feeling**

Please circle the single option that best expresses your level of agreement with each of the items below using the following scale:

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
SA	A	N	D	SD

21) Practitioners should focus on gay/lesbian clients' sexual orientation in their treatment with them.	SA	A	N	D	SD
22) In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families.	SA	A	N	D	SD
23) Practitioners should inform clients about gay affirmative resources in the community.	SA	A	N	D	SD
24) Practitioners should acknowledge to clients the impact of living in a homophobic society.	SA	A	N	D	SD
25) Practitioners should help clients identify their internalized homophobia.	SA	A	N	D	SD
26) Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.	SA	A	N	D	SD
27) Practitioners must address their own homophobia in order to be effective with gay/lesbian clients.	SA	A	N	D	SD
28) Practitioners should assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.	SA	A	N	D	SD
29) Practitioners should help gay/lesbian clients understand the multiple sources of stress in their lives.	SA	A	N	D	SD
30) My attitudes about gay/lesbian people affect my practice with gay/lesbian clients.	SA	A	N	D	SD
31) Practitioners should provide interventions that facilitate the safety of gay/lesbian clients.	SA	A	N	D	SD
32) Practitioners should make an effort to learn about diversity within the gay/lesbian community.	SA	A	N	D	SD
33) Practitioners should be knowledgeable about gay/lesbian resources.	SA	A	N	D	SD

34) Practitioners should **not** make an issue of sexual orientation when it is **not** relevant to treatment.	**SA**	**A**	**N**	**D**	**SD**
35) Practitioners should educate themselves about gay/lesbian lifestyles.	**SA**	**A**	**N**	**D**	**SD**
36) Practitioners should display gay affirmative materials in the places where they interact with clients.	**SA**	**A**	**N**	**D**	**SD**
37) Practitioners should be knowledgeable about laws affecting gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
38) Practitioners should be knowledgeable about health issues affecting gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
39) Practitioners' attitudes about homosexuality are relevant to treatment with gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
40) Practitioners' lack of knowledge about homosexuality is relevant to treatment with gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
41) Practitioners should assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.	**SA**	**A**	**N**	**D**	**SD**
42) Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.	**SA**	**A**	**N**	**D**	**SD**
43) Practitioners should challenge misinformation about gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
44) Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
45) Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals.	**SA**	**A**	**N**	**D**	**SD**
46) Practitioners should be knowledgeable about issues unique to gay/lesbian couples.	**SA**	**A**	**N**	**D**	**SD**
47) Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
48) Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**

49) Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
50) Adoption of a gay/lesbian identity is a positive outcome of any process in which the individual is working on his/her sexual orientation.	**SA**	**A**	**N**	**D**	**SD**
51) Practitioners should assist clients in working through the stages of the coming out process.	**SA**	**A**	**N**	**D**	**SD**
52) Practitioners should help clients reduce shame about homosexual feelings.	**SA**	**A**	**N**	**D**	**SD**
53) I am knowledgeable about gay/lesbian resources.	**SA**	**A**	**N**	**D**	**SD**
54) Practitioners should help gay/lesbian clients change their sexual orientation.	**SA**	**A**	**N**	**D**	**SD**
55) Practitioners' attempts to change the sexual orientation of a gay/lesbian client are detrimental to the client.	**SA**	**A**	**N**	**D**	**SD**
56) Discrimination creates problems that gay/lesbian clients may need to address in treatment.	**SA**	**A**	**N**	**D**	**SD**
57) My beliefs about gays/lesbians have **no** relevance to my practice with gay/lesbian clients.	**SA**	**A**	**N**	**D**	**SD**
58) Practitioners' value systems about gay/lesbian individuals do **not** affect their practice with them.	**SA**	**A**	**N**	**D**	**SD**
59) Practitioners should assume clients are heterosexual unless directly told otherwise.	**SA**	**A**	**N**	**D**	**SD**
60) Practitioners should respond to a client's sexual orientation when it is relevant to treatment.	**SA**	**A**	**N**	**D**	**SD**

Please circle the single option that best describes how frequently you engage in each of the behaviors below using the following scale:

Never	Rarely	Sometimes	Usually	Always
N	R	S	U	A

61) I help clients reduce shame about homosexual feelings.	**N**	**R**	**S**	**U**	**A**
62) I help gay/lesbian clients address problems created by societal prejudice.	**N**	**R**	**S**	**U**	**A**
63) I assist the families of gay/lesbian clients when they need education or support about gay/lesbian issues.	**N**	**R**	**S**	**U**	**A**
64) I help gay/lesbian clients feel good about themselves as gay/lesbian individuals.	**N**	**R**	**S**	**U**	**A**
65) I assume clients are heterosexual unless directly told otherwise.	**N**	**R**	**S**	**U**	**A**
66) In my practice with gay/lesbian clients, I support the diverse makeup of their families.	**N**	**R**	**S**	**U**	**A**
67) I help gay/lesbian clients overcome negative attitudes about homosexuality.	**N**	**R**	**S**	**U**	**A**
68) I inform clients about gay affirmative resources in the community.	**N**	**R**	**S**	**U**	**A**
69) I assess gay/lesbian clients without presuming that their sexual orientation is directly related to their presenting problems.	**N**	**R**	**S**	**U**	**A**
70) I assist clients in working through the stages of the coming out process.	**N**	**R**	**S**	**U**	**A**
71) I refer gay/lesbian clients to health care professionals who are sensitive to their needs.	**N**	**R**	**S**	**U**	**A**
72) I facilitate a client's search for his or her sexual identity.	**N**	**R**	**S**	**U**	**A**
73) I assist a client in changing his/her sexual orientation.	**N**	**R**	**S**	**U**	**A**
74) I accept the adoption of a gay/lesbian identity as a positive outcome of any process in which the individual is questioning his/her sexual identity.	**N**	**R**	**S**	**U**	**A**
75) I support the language used by gay/lesbian clients to describe their sexual orientation when they come out.	**N**	**R**	**S**	**U**	**A**
76) I verbalize respect for the lifestyles of gay/lesbian clients.	**N**	**R**	**S**	**U**	**A**

77) I make an effort to learn about diversity within the gay/lesbian community.	**N**	**R**	**S**	**U**	**A**
78) I acknowledge to clients the impact of living in a homophobic society.	**N**	**R**	**S**	**U**	**A**
79) I respond to a client's sexual orientation when it is relevant to treatment.	**N**	**R**	**S**	**U**	**A**
80) I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.	**N**	**R**	**S**	**U**	**A**
81) I work to develop attitudes necessary for effective practice with gay/lesbian clients.	**N**	**R**	**S**	**U**	**A**
82) I provide interventions that facilitate the safety of gay/lesbian clients.	**N**	**R**	**S**	**U**	**A**
83) I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.	**N**	**R**	**S**	**U**	**A**
84) I actively explore my own feelings of homophobia.	**N**	**R**	**S**	**U**	**A**
85) I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.	**N**	**R**	**S**	**U**	**A**
86) I advise gay/lesbian clients to come out even when they are **not** ready to do so.	**N**	**R**	**S**	**U**	**A**
87) I focus on gay/lesbian clients' sexual orientation in my treatment with them.	**N**	**R**	**S**	**U**	**A**
88) I include the extended families of gay/lesbian clients in treatment when it is appropriate.	**N**	**R**	**S**	**U**	**A**
89) I help gay/lesbian clients understand the multiple sources of stress in their lives.	**N**	**R**	**S**	**U**	**A**
90) I help clients identify their internalized homophobia.	**N**	**R**	**S**	**U**	**A**
91) I educate myself about gay/lesbian concerns.	**N**	**R**	**S**	**U**	**A**
92) I affirm for clients that people who are gay, lesbian, or bisexual can lead emotionally healthy lives.	**N**	**R**	**S**	**U**	**A**
93) I assume that all gay/lesbian clients have similar lifestyles.	**N**	**R**	**S**	**U**	**A**
94) I verbalize acceptance of clients' sexual orientation, regardless of whether the client identifies as gay, lesbian, bisexual, or heterosexual.	**N**	**R**	**S**	**U**	**A**
95) I am open-minded when tailoring treatment for gay/lesbian clients.	**N**	**R**	**S**	**U**	**A**

96) I encourage gay/lesbian clients to establish a gay/lesbian support system.	**N**	**R**	**S**	**U**	**A**
97) I create a climate that allows for voluntary self-identification by gay/lesbian clients.	**N**	**R**	**S**	**U**	**A**
98) I validate the diversity of gay/lesbian relationships for gay/lesbian clients.	**N**	**R**	**S**	**U**	**A**
99) I discuss sexual orientation in a non-threatening manner with clients.	**N**	**R**	**S**	**U**	**A**
100) I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.	**N**	**R**	**S**	**U**	**A**

Please circle the single option that indicates if you think the below statement is true or false using the following scale:

True	False
T	**F**

101) I'm always willing to admit when I make a mistake.	**T**	**F**
102) I always try to practice what I preach.	**T**	**F**
103) I never resent being asked to return a favor.	**T**	**F**
104) I have never been irked when people expressed ideas very different from my own.	**T**	**F**
105) I have never deliberately said something that hurt someone's feelings.	**T**	**F**
106) I like to gossip at times.	**T**	**F**
107) There have been some occasions when I took advantage of someone.	**T**	**F**
108) I sometimes try to get even rather than forgive and forget.	**T**	**F**
109) At times I have really insisted on getting my own way.	**T**	**F**
110) There have been occasions when I felt like smashing things.	**T**	**F**

Please circle the single option that best expresses your level of agreement with each of the items below using the following scale:

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
SA	**A**	**N**	**D**	**SD**

111) Lesbians just can't fit into our society.	**SA**	**A**	**N**	**D**	**SD**
112) State laws regulating private, consenting lesbian behavior should be loosened.	**SA**	**A**	**N**	**D**	**SD**
113) Female homosexuality is a sin.	**SA**	**A**	**N**	**D**	**SD**
114) Female homosexuality in itself is no problem, but what society makes of it can be a problem.	**SA**	**A**	**N**	**D**	**SD**
115) Lesbians are sick.	**SA**	**A**	**N**	**D**	**SD**
116) I think male homosexuals are disgusting.	**SA**	**A**	**N**	**D**	**SD**
117) Male homosexuality is a perversion.	**SA**	**A**	**N**	**D**	**SD**
118) Just as in other species, male homosexuality is a natural expression of sexuality in human men.	**SA**	**A**	**N**	**D**	**SD**
119) Homosexual behavior between two men is just plain wrong.	**SA**	**A**	**N**	**D**	**SD**
120) Male homosexuality is merely a different kind of lifestyle that should *not* be condemned.	**SA**	**A**	**N**	**D**	**SD**
121) I enjoy the company of homosexuals.	**SA**	**A**	**N**	**D**	**SD**
122) It would be beneficial to society to recognize homosexuality as normal.	**SA**	**A**	**N**	**D**	**SD**
123) Homosexuals should not be allowed to work with children.	**SA**	**A**	**N**	**D**	**SD**
124) Homosexuality is immoral.	**SA**	**A**	**N**	**D**	**SD**
125) Homosexuality is a mental disorder.	**SA**	**A**	**N**	**D**	**SD**
126) All homosexual bars should be closed down.	**SA**	**A**	**N**	**D**	**SD**
127) Homosexuals are mistreated in our society.	**SA**	**A**	**N**	**D**	**SD**
128) Homosexuals should be given social equality.	**SA**	**A**	**N**	**D**	**SD**
129) Homosexuals are a viable part of our society.	**SA**	**A**	**N**	**D**	**SD**

130) Homosexuals should have equal opportunity employment.	**SA**	**A**	**N**	**D**	**SD**
131) There is no reason to restrict the places where homosexuals work.	**SA**	**A**	**N**	**D**	**SD**
132) Homosexuals should be free to date whomever they want.	**SA**	**A**	**N**	**D**	**SD**
133) Homosexuality is a sin.	**SA**	**A**	**N**	**D**	**SD**
134) Homosexuals do need psychological treatment.	**SA**	**A**	**N**	**D**	**SD**
135) Homosexuality endangers the institution of the family.	**SA**	**A**	**N**	**D**	**SD**
136) Homosexuals should be accepted completely into our society.	**SA**	**A**	**N**	**D**	**SD**
137) Homosexuals should be barred from the teaching profession.	**SA**	**A**	**N**	**D**	**SD**
138) Those in favor of homosexuality tend to be homosexuals themselves.	**SA**	**A**	**N**	**D**	**SD**
139) There should be no restrictions on homosexuality.	**SA**	**A**	**N**	**D**	**SD**
140) I avoid homosexuals whenever possible.	**SA**	**A**	**N**	**D**	**SD**

Thank you very much for completing Page 6, the final page of the survey. Your participation in this study will lead to valuable insight about practice with gay and lesbian clients. Please return the survey in the enclosed postage-paid envelope by *FEBRUARY 15, 2002.*

Appendix E: Final Version of the GAP

Gay Affirmative Practice Scale (GAP)

This questionnaire is designed to measure clinicians' beliefs about treatment with gay and lesbian clients and their behaviors in clinical settings with these clients. There are no right or wrong answers. Please answer every question as honestly as possible.

Please rate how strongly with you agree or disagree with each statement about treatment with gay and lesbian clients on the basis of the following scale:

SA = Strongly agree
A = Agree
N = Neither agree nor disagree
D = Disagree
SD = Strongly disagree

1. In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families. _____
2. Practitioners should verbalize respect for the lifestyles of gay/lesbian clients. _____
3. Practitioners should make an effort to learn about diversity within the gay/lesbian community. _____
4. Practitioners should be knowledgeable about gay/lesbian resources. _____
5. Practitioners should educate themselves about gay/lesbian lifestyles. _____
6. Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals. _____
7. Practitioners should challenge misinformation about gay/lesbian clients. _____
8. Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients. _____
9. Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals. _____

10. Practitioners should be knowledgeable about issues unique to gay/lesbian couples. _____
11. Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients. _____
12. Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients. _____
13. Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients. _____
14. Practitioners should help clients reduce shame about homosexual feelings. _____
15. Discrimination creates problems that gay/lesbian clients may need to address in treatment. _____

Please rate how frequently you engage in each of the behaviors with gay and lesbian clients on the basis of the following scale:

A = Always
U = Usually
S = Sometimes
R = Rarely
N = Never

16. I help clients reduce shame about homosexual feelings. _____
17. I help gay/lesbian clients address problems created by societal prejudice. _____
18. I inform clients about gay affirmative resources in the community. _____
19. I acknowledge to clients the impact of living in a homophobic society. _____
20. I respond to a client's sexual orientation when it is relevant to treatment. _____
21. I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation. _____
22. I provide interventions that facilitate the safety of gay/lesbian clients. _____

23. I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation. _____

24. I demonstrate comfort about gay/lesbian issues to gay/lesbian clients. _____

25. I help clients identify their internalized homophobia. _____

26. I educate myself about gay/lesbian concerns. _____

27. I am open-minded when tailoring treatment for gay/lesbian clients. _____

28. I create a climate that allows for voluntary self-identification by gay/lesbian clients. _____

29. I discuss sexual orientation in a non-threatening manner with clients. _____

30. I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced. _____

Scoring instructions: using the chart below, please give each answer the indicated number of points. After all questions have been answered, add up the total number points. Higher scores reflect more affirmative practice with gay and lesbian clients.

Items 1-15	Items 16-30	Points
Strongly agree	Always	5
Agree	Usually	4
Neither agree nor disagree	Sometimes	3
Disagree	Rarely	2
Strongly disagree	Never	1

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Vita

Catherine Lau Crisp was born on August 2, 1965, in Mobile, Alabama, to Clara Sue Arnold Crisp and Robert Monroe Crisp, Jr. After spending most of her childhood in Fayetteville, Arkansas, she moved to Haddonfield, New Jersey, where she graduated from high school in 1983. She attended Rutgers University in New Brunswick, New Jersey, and graduated in 1983 with a Bachelor of Arts degree in Sociology. After graduating, she worked for Women Aware and Catholic Charities in New Brunswick, New Jersey. In 1990, she moved to Kansas City, Missouri, to pursue her Master of Social Work degree at the University of Kansas, which she received in 1993. Following receipt of this degree, she remained in Kansas City, Missouri, to work with people with mental illnesses and substance abuse issues. In 1995, Catherine moved to Richmond, Virginia, where she worked as a clinical social worker on an in-patient psychiatric unit at the Medical College of Virginia Hospital. In 1997, she became a Licensed Clinical Social Worker (L.C.S.W.) in the state of Virginia. Later that year, she moved to Georgetown, Texas, to pursue her Ph.D. in Social Work at the University of Texas at Austin. While a doctoral student, Catherine published articles on research with lesbian women, dual diagnoses (mental illness and substance abuse) in women, and chemical dependency in lesbians and gay men. She also taught classes in introductory social work and practice with gays and lesbians. In 2001, she received the Texas Excellence Teaching Award for Outstanding Graduate Instructor in the School of Social Work. Immediately upon

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