Development of the sexual minority affirmative practice scale

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DEVELOPMENT OF THE SEXUAL MINORITY AFFIRMATIVE PRACTICE SCALE

by

Ryan C. Ebersole

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Table of Contents

Acknowledgements..............................................................................................................ii

Abstract...............................................................................................................................vii

Introduction..........................................................................................................................1

Affirmative Psychotherapy.................................................................................................1

Affirmative Practice.............................................................................................................4

Measurements of Affirmative Psychotherapy......................................................................5

Present Study.......................................................................................................................7

Study 1..................................................................................................................................7

Method.................................................................................................................................7

Item Development...............................................................................................................7

Participants.........................................................................................................................8

Procedure............................................................................................................................9

Results.................................................................................................................................10

Study 2..................................................................................................................................11

Method.................................................................................................................................11

Participants.........................................................................................................................11

Measures.............................................................................................................................12
<table>
<thead>
<tr>
<th>Component</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures</td>
<td>13</td>
</tr>
<tr>
<td>Results</td>
<td>14</td>
</tr>
<tr>
<td>Missing Data</td>
<td>14</td>
</tr>
<tr>
<td>Factorability</td>
<td>14</td>
</tr>
<tr>
<td>Exploratory Factor Analysis</td>
<td>14</td>
</tr>
<tr>
<td>Descriptive Statistics</td>
<td>16</td>
</tr>
<tr>
<td>Discussion</td>
<td>17</td>
</tr>
<tr>
<td>Strengths and Limitations</td>
<td>20</td>
</tr>
<tr>
<td>Implications</td>
<td>23</td>
</tr>
<tr>
<td>References</td>
<td>27</td>
</tr>
<tr>
<td>Table 1: SMAPS Items, Factor Loadings, and Communalities</td>
<td>36</td>
</tr>
<tr>
<td>Figure 1: Scree Plot</td>
<td>41</td>
</tr>
<tr>
<td>Table 2: Factor Correlations, Means, and Standard Deviations</td>
<td>42</td>
</tr>
<tr>
<td>Appendix A: Initial SMAPS Item Pool</td>
<td>43</td>
</tr>
<tr>
<td>Appendix B: Study 1 Email Recruitment Template</td>
<td>49</td>
</tr>
<tr>
<td>Appendix C: Study 1 Informed Consent</td>
<td>50</td>
</tr>
<tr>
<td>Appendix D: Study 1 Demographic Questionnaire</td>
<td>54</td>
</tr>
<tr>
<td>Appendix E: Study 2 Demographic Questionnaire</td>
<td>57</td>
</tr>
</tbody>
</table>
Abstract

Literature on the practice of affirmative psychotherapy with sexual minority (SM) clients has steadily increased over the past two decades in recognition of the unique experiences and mental health needs of this marginalized population. SM-affirmative psychotherapy is an approach to psychotherapy that is culturally-responsive, actively affirms the validity of SM identities and experiences, and promotes the resilience of SM clients in the face of stigma. To date, much of the extant research on SM-affirmative psychotherapy has focused on therapist factors and perspectives. Further, most previous research on SM clients’ experiences in therapy has been qualitative, due in part to the lack of self-report measures to assess these clients’ perspectives in group designs.

To fill this gap, the current research involved developing a new instrument to fill this gap, the Sexual Minority Affirmative Practice Scale (SMAPS), which measures the extent to which SM clients view their therapists as engaging in SM-affirming practices. In Study 1, a content review panel of 32 SM-identified adults with recent psychotherapy experience reviewed a pool of 91 items developed based on the available literature on this topic. Reviewers were asked to rate the extent to which they perceived that each item reflected SM-affirmative practices as well as to provide feedback on item clarity.

Based on the reviewers’ feedback, 76 items were retained, one item was added, and 15 were deleted. In Study 2, exploratory factor analyses with direct oblimin rotation were conducted to assess the underlying factor structure of the SMAPS items. The derivation sample included 316 SM adults with diverse sexual orientation identities who had recent psychotherapy experience. A two-factor solution, with 51 items, was determined to be the best fit of the data. Scales developed from the two factors, called Harmful Practice and Affirmative Practice,
demonstrated strong internal consistency reliabilities, alphas = .98 and .94, respectively. The scales were not significantly correlated, $r = -0.076$, and mean scores suggested that participants viewed their therapists as generally having engaged in much more SM affirming than non-affirming practices.

The theoretical and psychometric contributions of the SMAPS to understanding the unique experiences of SM psychotherapy clients are discussed, along with the suggested use of the measure for clinical practice and in future psychotherapy research.
**Introduction**

Sexual minority\(^1\) (SM; those who identify as lesbian, gay, bisexual, queer, pansexual, or other non-heterosexual orientations; DeBord, Fischer, Bieschke, & Perez, 2017) individuals often bring distinct needs and psychosocial burdens to psychotherapy (American Psychological Association [APA], 2012; Pachankis & Goldfried, 2013). To best meet the needs of this population with competent and helpful psychotherapy services, several scholars have suggested that clinicians must practice affirmatively (e.g., Davies, 1996; Langridge, 2007; Ritter & Terndrup, 2002). O’Shaughnessy and Speir (2018) defined SM-affirmative psychotherapy as:

- therapy that is culturally relevant and responsive to [SM] clients and their multiple social identities and communities: addresses the influence of social inequities on the lives of [SM] clients; fosters autonomy; enhances resilience, coping, and community building; advocates to reduce systematic barriers to mental, physical, relational, and sexual flourishing; and leverages [SM] client strengths. (p. 83)

Several authors noted that research on SM-affirmative psychotherapy is limited by the lack of a psychometrically-sound measure of affirmative practice (Moradi & Budge, 2018; O’Shaughnessy & Speir, 2018). Thus, the aim of the present research program was to develop a self-report instrument that assesses SM clients' perspectives of the extent to which they view their therapists engaging in behaviors reflective of affirmative psychotherapy practice.

**Affirmative Psychotherapy**

Literature on affirmative psychotherapy began in the 1970s and 1980s as a response to the perspectives of SM-identities as pathological and the permeation of heterosexist attitudes in

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\(^1\) The term *sexual minority* (SM) was used in this research as an umbrella term that broadly captures sexual orientations of people who experience societal stigma and oppression (DeBord et al., 2017; Moradi & Budge, 2018).
the psychotherapy literature and in society at large (Langdridge, 2007; Ritter & Terndrup, 2002). Originally referred to as *gay-affirmative therapy* (e.g., Davies, 1996), papers on this topic have expanded to include the experiences of lesbian, bisexual, and other sexual minority clients, as well as their intersecting cultural identities (Moradi & Budge, 2018; Pachankis & Goldfried, 2013).

The core element of SM-affirmative psychotherapy is that it “affirms a lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity” (Davies, 1996; p. 25). Based on this perspective, psychotherapists are encouraged to adopt an actively positive, rather than a neutral, approach toward SM clients’ sexual identities in order to counteract, rather than reinforce, societal oppression of these individuals (Davies, 1996; Paul, 2017). An actively affirmative therapeutic approach is said to include validating clients’ sexual identities, normalizing their developmental experiences, assessing the impact of minority stresses, and challenging their internalized negative societal beliefs (APA, 2012; Proujansky & Pachankis, 2014). This approach also necessitates that therapists be aware of and challenge their own heterosexist attitudes (Paul, 2017).

SM-affirmative therapists are aware of how their behavior can foster an inclusive therapy environment (Heck, Flentje, & Cochran, 2013). Examples of recommended affirmative behaviors include avoiding assumptions about clients’ sexual orientation, using inclusive terminology, adopting the language used by clients to describe themselves and their relationships, and having SM-inclusive therapy forms and reading materials available to clients (Heck et al., 2013; Matthews, 2007).

Practicing SM-affirmative psychotherapy requires therapists to have adequate knowledge of the various unique issues and experiences facing SM individuals (Pachankis & Goldfried,
In fact, SM clients consistently describe therapists having accurate knowledge of the LGBTQ community and SM identities as helpful (O’Shaughnessy & Speir, 2018), whereas therapist ignorance on SM-related topics is seen as unhelpful and alienating (Kelley, 2015). SM-affirmative therapists should be knowledgeable about the unique developmental issues and milestones that SM individuals experience, such as the “coming out” process (APA, 2012; Pachankis & Goldfried, 2013). Further, therapists should be aware of the sociopolitical context in which their SM clients live and recognize the ongoing pervasive impact of societal stigma (Meyer, 2003) on these clients’ lives and on their mental and physical health. Finally, therapists need to recognize when factors related to a client’s SM identity (e.g., minority stress, internalized heterosexism) are relevant to their clinical presentation (Matthews, 2007; O’Shaugnessy & Speir, 2018). An unwarranted focus on SM clients’ sexual orientation may send a message to clients that their sexual orientation is problematic (Shelton & Delgado-Romero, 2011) while also failing to address these clients’ actual psychological concerns.

Affirmative psychotherapy involves not only an awareness of anti-SM oppression, but also a recognition and promotion of SM clients’ strengths and resilience (Paul, 2017). Although minority stress can have a pernicious effect on well-being (Meyer, 2003), psychological problems are not a universal sequela, as noted by Greene (2005): “[P]eople who belong to marginalized groups are not inevitable psychological cripples” (p. 299). Rather, SM-affirmative therapists validate and highlight SM clients’ strengths and encourage development of these clients’ SM-related social connections, which may serve to buffer them against the deleterious effects of minority stress (Goldblum, Baslam, Skinta, Pflum, & Evans, 2015; Moradi & Budge, 2018; Proujanksy & Pachankis, 2014).
SM-affirmative psychotherapy is not a singular theoretical orientation to psychotherapy (Maylon, 1982) but rather is a trans-theoretical approach that is assimilated into any therapeutic approach (Johnson, 2012; Moradi & Budge, 2018). Approaches that can assimilate SM affirmation include cognitive-behavioral treatments (e.g., Pachankis, Hatzenbuehl, Rendina, Safren, & Parsons, 2015), psychodynamic psychotherapy (Alessi, 2014), and attachment-based family therapy for persistently non-accepting parents of SM young adults (Diamond et al., 2013).

Many authors (e.g., Moradi & Budge, 2018) argued that the principles of SM-affirmative therapy should be applied to all clients, especially because not all SM clients disclose their sexual orientations during the first session (Liddle, 1997; Moradi & Budge, 2018; Page, 2004). In fact, many SM clients wait until their therapists demonstrate SM affirmative practices before they open up about their sexual identities (Dorland & Fischer, 2001; Liddle, 1997).

**Affirmative Practice**

Whereas most therapists report having experience with SM clients (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Murphy, Rawlings, & Howe, 2002), the extent to which practitioners engage in affirmative psychotherapy is unknown. In fact, despite recommendations for practice (e.g., APA, 2012), therapists generally receive limited training on SM-related issues (Murphy et al., 2002; Johnson & Feldman, 2014; Rock, Carlson, & McGeorge, 2010). This deficit is problematic, since training on SM-related therapy issues has been associated with therapist self-efficacy as well as reported engagement in SM-affirmative practice behaviors (Alessi, Dillon, & Kim, 2015).

Not surprisingly, many SM clients describe negative experiences in psychotherapy (e.g., Israel, Gorcheva, Burnes, & Walther, 2008; Page, 2004; Quiñones, Woodward, & Pantalone, 2017; Shelton & Delgado-Romero, 2011). These negative experiences are especially
problematic, since SM individuals are significantly more likely than their heterosexual peers to experience depressive, anxious, and substance use disorders (Cochran, Sullivan, & Mays, 2003; Rich, Vasilenko, Fish, & Lanza, 2019), due to societal stigma and oppression (Meyer, 2003). Taken together, these findings underscore the need for more attention to SM-affirmative psychotherapy in research, practice, training, and supervision.

While SM-affirmative psychotherapy can be effective in reducing SM clients’ symptoms (e.g., Craig & Austin, 2016; Pachankis et al., 2015), the available studies did not assess the extent to which clients receiving these treatments actually viewed their therapy as affirmative (O’Shaugnessy & Spier, 2018). For example, without being able to account for client-perceived affirmativeness, it remains unclear whether the SM-affirmative adaptations in Pachankis and colleagues’ (2015) randomized controlled trial was an active, specific ingredient that meaningfully contributed to SM participants’ reports of significant symptom reduction.

**Measurement of Affirmative Psychotherapy**

Most of the extant literature examining SM clients’ psychotherapy experiences is qualitative in nature (e.g., Berke et al., 2016; Israel et al., 2008). While these studies provided rich descriptions of SM clients’ perspectives on affirmative psychotherapy, this methodology does not permit a potentially more generalizable examination of relations between SM clients’ perspectives of affirmative therapy practices and potential change mechanisms, like the working alliance, that account for successful therapy outcomes.

Two studies (e.g., Kelley, 2015; Liddle, 1996) used an author-developed measure to assess LGB clients’ perspectives of their therapists’ LGB-related therapy behaviors. The items in Liddle’s original measure were not intended to represent a single construct, but rather to test whether practices identified in a previous study (Garnets et al., 1991) were seen as helpful or
unhelpful by lesbian and gay clients and whether these practices predicted premature termination. Liddle did not report reliability evidence for this measure; Kelley’s (2015) consistency reliability estimate ($\alpha = 88$) was calculated for her sample using an altered item format.

For these reasons, there is minimal evidence to support evidence of validity or reliability of Liddle’s (1996) measure. The use of measures with inadequate attention to psychometric support raises questions about the validity of conclusions drawn from results of these studies, that is, whether the findings accurately and adequately assessed the intended construct (DeVellis, 2017). Overall, the lack of psychometrically-sound measurement precludes both the confirmation and further development of SM-affirmative psychotherapy theory.

To date, measures of SM-affirmative psychotherapy have focused on the perspective of therapists, such as their self-efficacy in providing LGB-affirmative psychotherapy (Dillon & Worthington, 2003) or their perceived affirmative counseling competence (Bidell, 2005). While assessing therapist self-reported competence is valuable, a better understanding of SM-affirmative therapy requires research from the perspective of SM clients themselves. Notably, clients and therapists often have different perspectives on what occurs in the therapy relationship (Fuertes & Nutt Williams, 2017), as was found in research on therapists’ multicultural counseling competence (MCC; Dillon, Odera, Fons-Scheyd, Sheu, Ebersole, & Spanierman, 2016; Fuertes et al., 2006).

As has been done in the MCC literature, SM clients could be asked to evaluate their therapists’ attitudes and behaviors by modifying an existing measure originally designed for therapist self-report, like the Gay Affirmative Practice Scale (Crisp, 2006). However, modification of original item meanings can introduce confounds that might undermine the
measure’s credibility by affecting its content validity (Drianne, Owen, Adelson, & Rodolfa, 2016). Further, such a modification could potentially lower the reliability and construct validity estimates of the measure (i.e., introduce measurement error), if the intended respondents are therapists rather than clients.

In sum, gaps in the relevant literature suggest the need for a psychometrically-supported client-rated measure of their therapists’ SM-affirmative practice behaviors. It was reasoned that such a measure could be useful for studying dyadic counseling processes and outcome (Drianne et al., 2016), such as the relations between perceived SM-affirmative behaviors and other therapy variables of interest. Moreover, assessing SM clients’ perspectives is consistent with the spirit of SM-affirmative psychotherapy, which stresses the importance of therapists striving to understand SM clients’ unique experiences (e.g., APA, 2012; Ritter & Terndrup, 2002).

In brief, the goal of the present research program was to develop a new client-rated measure, to be called the Sexual Minority Affirmative Practice Scale (SMAPS). Development of the SMAPS consisted of two studies: Study 1 involved using the available literature to develop a large item pool, which was then administered to a review panel of SM psychotherapy clients to assess for evidence of the items’ face and content validity. In Study 2, the factor structure underlying the items retained from Study 1 was examined using exploratory factor analysis, and initial psychometric estimates were calculated.

**Study 1: Item Development and Content Review**

**Method**

*Item development.* A pool of 91 items reflecting observable affirmative psychotherapy behaviors was developed based on the extant affirmative psychotherapy literature (Chernin & Johnson, 2002; Crisp, 2006; Davies, 1996; DeBord et al., 2017; Johnson, 2012; Pachankis &
Goldfried, 2013; Ritter & Terndrup, 2002) and qualitative studies of SM clients’ experiences in psychotherapy (Berke et al., 2016; Israel et al., 2008; Malley & Tasker, 2008; Pixton, 2003; Quiñones et al., 2017; Shelton & Delgado-Romero, 2011). The items focused exclusively on behaviors reflective of observable affirmative practice behaviors, such as, “My therapist used terms that were non-judgmental of sexual minorities,” rather than non-observable aspects of psychotherapy, such as the therapist’s self-awareness of SM-related biases, which were reasoned to be beyond a client’s ability to assess (Drianne et al., 2016; Shaw & Shaw-Ridley, 2011). Additionally, observable items were expected to increase the measure’s discriminant validity by reducing potential overlap with other therapy constructs, like transference or the real relationship.

In order to fully capture the construct of therapists’ SM-affirmative practice, 37 items that reflect non-affirmative practice behaviors, such as “My therapist suggested that I try to become heterosexual,” were included in the item pool. Appendix A lists the 91-item pool included in the content review.

Participants. Inclusion criteria included (a) being aged 18 or older, (b) identifying as a SM and cisgender, (c) having participated in at least one psychotherapy/counseling (individual, group, family, couple) session within the past 12 months, and (d) not having worked as a mental health clinician. Due to the SMAPS’s intended exclusive focus on therapist behaviors related to sexual orientation, SM-identified transgender and gender non-conforming (TGNC) individuals were excluded, as these clients bring unique experiences and concerns to psychotherapy (APA, 2015) that were beyond scope of present study.

Among the 63 individuals who volunteered to participate, 31 participants were removed for not meeting inclusion criteria or for failing to complete the study materials. The 32 remaining
participants ranged in age from 18 to 50 ($M = 30.39$ years, $SD = 9.01$); 65.6% ($n = 21$) identified as women and 34.4% ($n = 11$) as men. Most participants (53.1%) identified as gay or lesbian; 6.8% ($n = 6$) identified as queer; 6.8% ($n = 6$) identified as pansexual; 9.4% ($n = 3$) identified as bisexual. Approximately 70% of participants ($n = 23$) identified as White, non-Latina/o; 9.4% ($n = 3$) identified as Hispanic/Latina/o; 6.3% ($n = 2$) identified as Asian American/Asian; 6.3% ($n = 2$) identified as biracial/multiracial; 3.1% ($n = 1$) identified as African American/Black; and 3.1% ($n = 1$) identified as “White/Jewish.”

Nearly 60% ($n = 19$) participants reported current psychotherapy experience at the time of data collection. Almost all participants ($n = 31$) had reported received individual psychotherapy, with fewer participants reporting couple/family therapy ($n = 7$) and group psychotherapy ($n = 2$) within the past 12 months.

**Procedure.** Upon approval from the University at Albany’s Institutional Review Board (IRB), participants were recruited for an online study on “sexual minority individuals’ experiences in therapy” through email announcements (see Appendix B) sent to local SM-related organizations (e.g., community pride centers) and college campus SM-organizations in a small northeast city. As this study was an internet-based procedure, the research announcements directed interested individuals to an online informed consent page, hosted on the website Psychdata, that described the aim of the content review study (see Appendix C). Participants who consented were directed to a demographic questionnaire (Appendix D), followed by the content review materials. Specifically, participants were asked to rate the therapist behavior indicated in each of the initial 91 items on a scale from 1 (*completely non-affirming*) to 9 (*completely*  

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2 Participants were allowed to indicate experience in multiple therapy modalities.
Participants who completed Study 1 were provided a $10 Amazon.com gift card as remuneration for their time.

Consistent with recommended practices for content reviews (DeVellis, 2017), the participants were encouraged to provide feedback on the clarity of each item and to suggest additional items based on their personal experiences in psychotherapy. Additionally, participants were asked to indicate their preference for the use of the term *sexual minority* in contrast to other possible terms, like *LGBQ*+. This question was included in order to be sensitive the fact that SM individuals refer to their identities and the SM community using a range of terms.

Results

Since reverse-scored items were intended to be included in the SMAPS, items that participants rated with both a mean and median score greater than or equal to 7 (*somewhat affirming*) or less than or equal to 3 (*somewhat non-affirming*) were retained. Based on these criteria, 76 (83%) of the original 91 items were retained as clearly representing SM-affirmative (*n* = 42) or non-affirmative (*n* = 34) therapy behaviors.

Based on participants’ suggestions, one additional item, “*My therapist suggested that my sexual orientation is a result of a traumatic sexual experience*” was added. In response to participants’ feedback, minor revisions were made to three items to improve their clarity. The final number of items retained after the content review process was 77.

In response to the question regarding terminology, participants indicated a distinct preference (62.1%) for the term “*LGBQ*+” as opposed to term “*Sexual Minority*” (24.1%), which had been used in the original items. Consequently, the wording of items was revised for Study 2.
Study 2: Exploratory Factor Analysis and Initial Reliability Estimates

Consistent with recommended practices for scale development (e.g., Fabrigar et al., 1999; Worthington & Whittaker, 2006), exploratory factor analysis (EFA) was used to assess the underlying factor structure of the SMAPS based on a new sample of SM adults with recent experience as psychotherapy clients. After the underlying factor structure was identified, internal consistency estimates of the SMAPS subscales were calculated to provide initial evidence of reliability.

Method

Participants. The criteria for inclusion in Study 2 were identical to Study 1. A total of 567 individuals responded to recruitment announcements for participation in a study on “adult gay, lesbian, bisexual, queer, and pansexual individuals’ experiences in therapy/counseling.” Of these volunteers, 251 were excluded for (a) failing to meet the inclusion criteria, (b) not providing consent to participate, (c) failing to participate after responding to the demographic questions, and/or (d) incorrectly responding to at least one of two validity items included to capture random responding.

The final derivation sample consisted of 316 participants who ranged in age from 18 to 65 \( (M = 27.35 \text{ years}, SD = 8.46) \). Approximately 60% of participants identified as women \( (n = 197) \), while 34.8\% \( (n = 110) \) identified as men, 1.6\% \( (n = 5) \) identified as genderqueer, and 0.9\% \( (n = 3) \) selected “other” and provided the following descriptors for their gender identity: “butch”, “femme spectrum,” “woman but disagree with the concept of cis.” One participant indicated that they identified as cisgender but did not respond to the follow-up item about gender identity. In terms of sexual orientation, 49.7\% \( (n = 157) \) identified as gay/lesbian; 22.8\% \( (n = 72) \), as bisexual; 17.7\% \( (n = 56) \), as queer; 6.6\% \( (n = 21) \), as pansexual, and 3.2\% \( (n = 10) \) as another
sexual orientation (e.g., asexual, homoromantic bisexual). The sample was 80.1% \( (n = 253) \) White, non-Latina/o, with 8.9% \( (n = 28) \) identifying as Latina/o, 4.4% \( (n = 14) \) as African American/Black, 3.2% \( (n = 10) \) as Asian/Asian American, 2.2% \( (n = 7) \) as biracial/multiracial, 0.3% \( (n = 1) \) identifying as Native American/Alaska Native, 0.3% \( (n = 1) \) each identifying as Ashkenazi Jewish and “white/Latina,” one participant(0.3%) did not respond to this question.

All participants reported having obtained a high school diploma or GED, and 53.2% \( (n = 168) \) reported having completed a bachelor’s degree or higher. Approximately 55% \( (n = 233) \) of participants reported an annual income of less than $50,000; 16.4% \( (n = 52) \) reported an annual income between $50,000 and $99,999; 6.0% \( (n = 19) \) reported an annual income of greater than $100,000; 3.8% \( (n = 12) \) did not respond to this item. Participants’ geographic locations within the U.S. varied, with 28.5% \( (n = 90) \) reported living in the northeast, 28.5% \( (n = 91) \) in the Midwest, 3.2% \( (n = 10) \) in the Rocky Mountain/Mountain West, 16.8% \( (n = 16.8) \) on the Pacific Coast, 11.4% \( (n = 36) \) in the southeast, 8.5% \( (n = 27) \) in the southwest, 0.6% \( (n = 2) \) in Alaska or Hawaii, and 1.5% \( (n = 6) \) who declined to respond to this question.

Most \( (n = 192) \) participants were actively engaged psychotherapy at the time of data collection. The participants’ modal reported number of completed therapy sessions with their current or most recent therapist was 5, with a range of 1 to 500.

**Measures.** Participants completed a demographic questionnaire (see Appendix E), followed by the 77 initial SMAPS items (see Appendix F). Participants were asked to rate the extent to which they agreed that each item (e.g., “My therapist used terms that were nonjudgmental of LGBQ+ people”) was characteristic of their experiences in therapy on a 6-point Likert scale from 1 (completely disagree) to 6 (completely agree).
Procedure. After approval from the University at Albany’s IRB was obtained, announcements describing the online study and requesting participation were emailed to SM-related community organizations (e.g., Pride centers) as well as SM-related college organizations across the country (see Appendix G). In sum, 12 Pride centers and 35 college organizations agreed to post research announcements. After receiving permission from the site moderators, recruitment announcements were also posted on internet-based forums frequented by SM adults, including Reddit (e.g., r/ainbow) and SM-related Facebook pages. Respondent-driven sampling was also employed in that participants were asked to forward the survey link to acquaintances whom they believed met the inclusion criteria.

Individuals interested in participating were directed to an online informed consent page (see Appendix H) explaining the study’s aims, and its approval by the University at Albany’s Office of Research Compliance. Participation was described as voluntary and anonymous, and participants had the right to withdraw from at any point. Consenting volunteers (indicated by having clicked “continue”) were directed to the research materials. Participants first completed a demographic questionnaire; individuals who did not meet the inclusion criteria were removed and thanked for their willingness to participate.

Participants were then directed to rate each of the 77 SMAPS items. To reduce conflation of therapy experiences, participants were directed, “If you have worked with multiple therapists, please use only your experiences with your most recent therapist to answer these questions.” To minimize the impact of random responding two items were added directing participants to endorse a specific response (e.g., “Please select ‘Completely Agree’”).
Individuals who completed the entire survey were offered the opportunity to be entered into a drawing for a $10 Amazon.com gift card. Email addresses provided by these participants were stored separately from the survey responses.

Results

**Missing data.** Approximately 0.02% of data for the 77 SMAPS items were missing overall across the 316 participants. One item with 15.5% missing responses ("My therapist had a written nondiscrimination statement that was inclusive of minority sexual orientations") was deleted prior to analyses due to potential confusion. The amount of missing data for any single item ranged from 0% to 8.2%. The remaining 76 items were factor analyzed, with pairwise deletion specified.

**Factorability.** Bartlett’s test of sphericity (Bartlett, 1950) was significant ($\chi^2 = 26,489.05, p < .000$), which suggested that the data matrix statistically differed from an identity matrix. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was 0.95, which indicated that the sample size was sufficiently large to assess the factor structure. These results support the assumption of factorability (Tabachinick & Fidell, 2001).

**EFA.** Principal axis factoring was used to identify the underlying factor structure by analyzing the communality, or common variance (Kahn, 2006), among the 76 SMAPS items. Direct oblimin rotation was used because the factors were expected to be correlated due to having a common underlying construct (Kahn, 2006; Worthington & Whittaker, 2006).

Consistent with recommended guidelines (e.g., Fabrigar et al., 1999; Worthington & Whittaker, 2006), criteria used to determine factor retention included (a) the scree test (Cattell, 1966), (b) parallel analysis (Horn, 1965), (c) a minimum loading of at least 3 items per factor, and (d) conceptual interpretability. Item retention was based on the following criteria: (a)
minimum factor loading of .40, (b) no cross-loadings greater than .32, (c) the difference between an item’s strongest factor loading and other loadings > .15, and (d) a logical relation among items on the factor (Nunally & Bernstein, 1994; Worthington & Whittaker, 2006).

The scree plot from the initial EFA was reviewed. As seen in Figure 1, the observed break point in the scree plot occurred at the third factor, suggesting the retention of two factors. The results of the parallel analysis suggested the retention of up to three factors.

Additional EFAs were run specifying two- and three-factor solutions. A comparison of the results indicated a two-factor structure as the most interpretable solution. That is, the two-factor structure was more robust than the three-factor solution, with stronger factor loadings and fewer cross-loadings. Further, compared to the three-factor solution, items loading highly on the two-factor solution provided more conceptual clarity. This two-factor solution accounted for 63.27% of the variance.

After the determination of the two-factor solution, 24 items that did not meet the above-specified retention criteria were deleted. An additional EFA was run to assess whether the item deletion altered the factor solution and determine whether the remaining items continued to meet criteria for retention; one item failed to load at least .40 on either factor in this follow-up EFA and was deleted. The 51 retained items and their respective factor loadings and communalities are presented in Table 1.

The first factor accounted for 43.58% of the variance and consisted of 28 items. Examples include, “My therapist expressed beliefs that demeaned my sexual orientation,” “My therapist avoided discussing issues related to my sexual orientation,” and “My therapist minimized my experiences of discrimination.” This factor was termed Harmful Practice, because its items reflected therapist behaviors that were stigmatizing or invalidating of SM clients or
demonstrated therapist discomfort with discussing SM-related topics. One item ("I did not need to teach my therapist about issues related to my sexual orientation") loaded negatively on this factor and therefore was reverse scored in constructing the Harmful Practice scale.

The second factor explained 19.69% of the variance and consisted of 23 items, e.g., “My therapist discussed my sexual orientation when it was relevant,” “My therapist used terms that were non-judgmental of LGBTQ+ people,” and “My therapist’s behavior in session made me feel accepted as a LGBTQ+ person.” This factor was termed Affirmative Practice, because items that loaded on to this factor detailed described therapist behaviors that reflected inclusivity and active affirmation of SM identities.

**Descriptive statistics.** Scale scores were obtained by calculating an average of the item scores for each scale, after reverse scoring one item on the Harmful Practice scale. The use of a mean score places the scale score on the same metric as the individual items, making score interpretation easier (DeVellis, 2003). Scale scores were only calculated if a participant had responded to more than 90% of the items on the respective scales, since this approach provides similar outcomes to other missing data strategies when missing data is minimal (Parent, 2013). Only one case was missing more than 10% of the data on either scale. For this reason, the scale means and standard deviations were calculated based on 315 participants. The results of a paired samples $t$-test indicated a significant difference in participants’ scores for the Harmful Practice ($M = 1.83, SD = 1.26$) and Affirmative Practice scales ($M = 4.77, SD = 0.82$), $t(314) = -33.54, p < .001$. A review of the skewness and kurtosis statistics revealed that the Harmful Practice scale was positively skewed.
The internal consistency reliability estimates based on Cronbach’s alphas were .98 (Harmful Practice) and .94 (Affirmative Practice). These descriptive statistics, including the two scales’ correlation, are presented in in Table 2.

**Discussion**

SM clients bring unique needs, challenges, and experiences to psychotherapy that the profession has often struggled to address (DeBord et al., 2017). While SM-affirmative psychotherapy principles and approaches have developed over the past three decades to help therapists provide competent and helpful services to SM clients, research on this topic has been sorely limited by the absence of a psychometrically sound measure of SM clients’ perspectives.

The aim of the two studies in this research program was to address a gap in the literature on SM-affirmative psychotherapy by developing the Sexual Minority Affirmative Practice Scale (SMAPS) to assess SM clients’ perspectives of the extent to which their therapists engaged in SM-affirmative practice behaviors. The importance of this measure lies in its development process and recommended future use. That is, the SMAPS was developed using the input of a substantial panel of the target population; this approach differs from the typical content review process of seeking professional input (DeVellis, 2017). Currently, the SMAPS is the only measure designed to assess the construct of SM-affirmative psychotherapy from the perspectives of SM clients. Further, by identifying therapist behaviors that SM clients have identified as clearly affirmative or non-affirmative practices, this research program contributes to knowledge about SM affirmative psychotherapy.

The face and content validity for the SMAPS items were supported by their initial development based on theoretical and empirical literature on SM clients’ psychotherapy experiences and by refinement of the item pool based on ratings and feedback from SM
psychotherapy clients. Conducted with a different sample, exploratory factor analysis revealed that the covariance among the SMAPS items was best captured by two distinct factors, which were termed *Harmful Practice* and *Affirmative Practice*. Notably, the scale scores were not significantly correlated, indicating that the behaviors captured by these two scales do not simply reflect opposite ends of a spectrum, but rather are two distinct sets of therapist behaviors. The reliability estimates provided evidence of strong internal consistency for each scale.

The Harmful Practice scale reflects therapist behaviors, including microaggressions or pathologizing views of SM sexual orientations, that SM clients have found to be unhelpful and/or harmful (Eady, Dobinson, & Ross, 2011; Israel et al., 2008; Quiñones et al., 2017; Shelton & Delgado-Romero, 2011). The behaviors indicated in this scale’s items are contrary to current practice guidelines (e.g., APA, 2012) and may even be considered unethical. Higher scores on this scale indicate that the therapist was perceived as having engaged in behaviors that created an unwelcoming or hostile therapy environment for SM individuals. As with the concept of microaggressions (Sheldon & Delgado-Romero, 2011; Sue et al., 2007), it is important to note that some of the items on this scale may reflect behaviors engaged in by well-intentioned therapists who did not intend to harm or demean their SM clients, such as “*My therapist focused only on discussing my sexual orientation, ignoring the other topics that I wanted to explore in therapy,*” and “*My therapist minimized my experiences of discrimination.*” However, as described by Paul (2017), these behaviors may be “potentially recreating the wounding that brought [SM] clients to [therapists’] doors in the first place” (p.132).

The 23 items on the Affirmative Practice scale describe therapist practices that SM clients view as fostering an inclusive, nonjudgmental, and inviting therapeutic space. Broadly, by acknowledging the validity of SM clients’ sexual identities and SM-related experiences the
behaviors described in this scale reflect a challenge not only to societal stigma, but also to clients’ own heterosexist beliefs (Matthew, 2007; Paul, 2017). Examples include using LGBQ-inclusive language, collaborating with SM clients to determine how, if at all, their sexual orientation is related to their presenting treatment concerns, and acknowledging the impact of minority stress on SM clients’ well-being. Further, these affirmative practices are appropriate even when sexual orientation is not a client’s primary treatment concern (Moradi & Budge, 2018).

As mentioned earlier, the two scale scores were not significantly correlated, although they were assumed to share the underlying construct (Kahn, 2006), SM affirmative therapeutic practice. This unexpected finding suggests that providing competent SM-affirmative psychotherapy involves more than simply espousing an accepting attitude of SM orientations and avoiding exhibiting heterosexist, stigmatizing attitudes or behaviors with SM clients (Crisp, 2006; Langdridge, 2007), or any of the other behaviors included in the Harmful Practice scale. Rather, as seen in the items comprising the Affirmative Practice scale, SM-affirmative psychotherapy involves an actively SM-affirmative and collaborative stance in a therapist’s choice of language, interventions, case conceptualization, and overall therapeutic environment (Moradi & Budge, 2018; Pachankis & Goldfried, 2013). Similarly, engaging behaviors like, “My therapist acknowledged the impact of living in a homophobic and biphobic society” necessitates a full understanding of the impact of stigma on SM individuals (Matthew, 2007; Pachankis & Goldfried, 2013).

Scores on the two SMAPS scales suggest that, overall, the participants in Study 2 perceived their therapists as generally practicing SM affirmative psychotherapy. Specifically, scores on the Affirmative Practices scale were relatively high, whereas their scores on the
Harmful Practices were significantly lower. Further, as can be seen in Table 2, the distribution of scores on the Harmful Practices scale was positively skewed, indicating that most participants assessed their therapists as generally not engaging in stigmatizing or otherwise harmful therapy practices. It is possible that this outcome may be a result of the venues used to recruit participants. Several of the Pride centers that distributed information about the study offered some form of psychotherapy services; it is likely that providers at these centers are more likely to than to use an SM affirmative approach or to refer students to local SM-affirmative therapists. Thus, participants in Study 2 may have been more likely than average SM individuals to access affirmative psychotherapy services.

**Strengths and Limitations**

Members of the target population, SM adults with previous therapy experience, were sampled for the item content review process. This methodology was reasoned to maximize the face and content validity of the SMAPS items (Vogt et al., 2004) in their accurate representation of SM-affirmative practices. From a practical standpoint, obtaining feedback from members of the target population on the clarity and wording of items likely improved the validity of the measure by increasing the likelihood that future SMAPS respondents would understand the underlying intent behind items. Further, including SM adults in the content review phase is consistent with the aim and spirit of constructing a scale that fully assesses SM clients’ perspectives.

Limiting the SMAPS items to observable therapist behavior, rather than inferences about therapist attitudes and knowledge, is an additional strength of the measure, by maximizing the construct validity of the measure by focusing on aspects of therapist behavior within the clients’ conscious awareness (Drianne et al., 2016; Shaw & Shaw-Ridley, 2011). Limiting SMAPS items
to behavioral indicators specific to SM-affirmative practices was also reasoned to reduce potential conceptual overlap with other constructs, such as the working alliance or real relationship.

Compared to previous research on the topic of affirmative practice, the proportion of women in both samples as well as the diversity of participants’ reported sexual orientations are additional strengths. Psychotherapy research with SM clients has often focused on treating issues related to gay men/men who have sex with men, such as substance use or unprotected sex, with considerably fewer studies addressing psychotherapy with SM women (O’Shaughnessy & Speir, 2018). Similarly, the inclusion and proportion of bisexual and other non-monosexual identified clients in the present development samples represents an additional strength, since these populations have often been overlooked in the psychotherapy literature (Bostwick & Hequembourg, 2013; Worthington & Strauthausen, 2017). This SM diversity of the present sample strengthens the measure’s potential future use in research with clients of varying sexual identities.

On the other hand, the present psychometric information about the SMAPS is limited. It would be, for example, inappropriate to draw conclusions on the temporal stability of the SMAPS without assessing its test-retest reliability. Similarly, the results of this research program do not provide evidence for the predictive, convergent, or discriminant validity of the SMAPS. Further, caution is warranted in the interpretation of the scale score means, especially given the positive skewness in scores on the Harmful Practice scale. Participants responded to the initial 77-item measure, not the 51 items that comprise the final SMAPS, which may have influenced responses. Replication with the final, 51-item SMAPS is needed to clarify whether the observed means on the two scales are accurate measures of central tendency.
The exclusion of transgender/gender non-binary individuals limits the external validity of the present results. This exclusion criterion was based on the reasoning that relative to cisgender SM individuals, transgender SM individuals bring unique experiences and needs to psychotherapy (APA, 2015). By excluding transgender clients, the internal validity of the SMAPS was maximized. It should be noted, however, that since many transgender/gender non-binary individuals identify as SMs, the SMAPS items may fail to capture these individuals’ experiences in psychotherapy.

Similarly, the demographic characteristics of the derivation sample may limit the applicability of the SMAPS to broader populations. The participants in both Study 1 and Study 2 were mostly White, consistent with the broader SM-affirmative psychotherapy literature (O’Shaughnessy & Speir, 2018). Because SM people of color have unique experiences and face multiple forms of oppression relative to white SMs (Moradi, DeBlaere, & Huang, 2010), the SMAPS may not fully capture these clients’ experiences in psychotherapy.

Additionally, participants in Study 2 were relatively highly educated compared to the general American population, in that more than half of the sample had a bachelor’s degree or higher, compared to 33.40% of American adults (U.S. Census Bureau, 2016). The oversampling of highly educated SM clients may have been due to the recruitment of participants through SM-related organizations on college campuses. It seems likely that compared to their less educated counterparts, college students and graduates may have unique psychotherapy experiences, which may have affected their responses to the SMAPS items. While the sample in Study 2 was recruited nationally, it is unclear as to whether the results of this study would generalize to clients in different geographic regions. Nor is it clear as to whether the SMAPS factor structure would be as applicable to SM clients in urban vs. rural contexts. To be as applicable to as many
sexual minority clients as possible, the items on the SMAPS refer primarily to therapist behaviors in the context of individual psychotherapy and thus were not intended to capture affirmative practice behaviors in other treatment modalities, i.e., couple, group or family therapy.

The use of a non-random sample is an additional limitation due to the possibility of self-selection bias (Kerlinger & Lee, 2000). That is, the SM adults who chose to participate in Studies 1 and 2 may have had different experiences in psychotherapy than individuals who saw the recruitment emails but chose not to take part in the research. Further, many of the items are primarily applicable to SM clients who disclosed their sexual orientation to their therapist. For this reason, the SMAPS may have limited utility for assessing the experience of SM clients who keep their SM-identity hidden from their therapists.

Finally, the sample size of 316 could be considered a potential limitation to these findings, since the participant to item ratio of 4.21 in this sample falls below the 5:1 or 10:1 participant-to-item ratios recommended by some authors (Gorsuch, 1983). However, it should be noted that guidelines regarding adequate sample size for an EFA are quite variable. Many authors suggested that sample sizes greater than 200 are adequate, and that samples of 300 are typically sufficient (Comrey & Lee, 1992; Worthington & Whittaker, 2006).

**Implications**

Replication of the SMAPS factor analysis is needed with a new sample of SM adults who take the final, 51-item measure. A confirmatory factor analysis (CFA; Fabrigar et al., 1999; Worthington & Whittaker, 2006) that supports the present, two-factor structure of the SMAPS would provide further evidence of its factorial and construct validity (Hinkin, 1995; Urbina, 2014). The known-groups validity of the SMAPS could be supported by future research.
demonstrating that SM clients with lower scores on the Harmful Practice scale and higher scores on the Affirmative Practice scale are less likely to drop out of psychotherapy.

Future research with future adequately-sized, independent samples of SM clients is needed to establish evidence for the test-retest reliability as well as convergent and discriminant validity. Evidence of convergent validity, for example, might include significant correlations with measures of the working alliance or real relationship. As previously mentioned, the central tendency scores will need to be replicated with a new sample of SM participants taking the final, 51-item measure. The current length of the SMAPS may limit its ability to be a practical tool in clinical practice. Thus, future studies should include developing a briefer version of the SMAPS.

Future SMAPS studies also should assess diverse samples of SM clients’ perceptions of affirmative practice. It seems important to assess the measurement invariance of the SMAPS’s factor structure with samples of adolescent SM as well as SM clients who identify as transgender/gender non-binary. Similarly, the SMAPS’s factor structure, reliability, and validity should be examined with additional, more inclusive, samples of SM clients, such as adolescents or clients who identify as people of color.

As previously stated, the SMAPS is currently the only client-rated measure of SM-affirmative psychotherapy practices. While SM clients’ psychotherapy experiences could be studied using extant measures, such as the Working Alliance Inventory (Horvath & Greenberg, 1989), these measures do not tap into the psychotherapy experiences unique to SM clients. Using the SMAPS to assess SM clients’ psychotherapy experiences would likely yield more useful and trustworthy results than other, more general measures of SM individuals’ experiences. For example, compared to the Homonegative Microaggressions scale (Wright & Wegner, 2012) the items on the SMAPS are specific to the psychotherapy experiences of SM clients. Further, the
SMAPS provides an opportunity to assess both the harmful and affirmative aspects of psychotherapy with SM clients in a single measure.

The SMAPS (see Appendix F) could be used as a tool in investigations of applications of SM-affirmative psychotherapies in research trials (e.g., Pachankis et al., 2015). For example, the SMAPS could be used to study whether SM clients’ perceptions of the extent to which their therapists engaged in SM-affirmative behaviors predict or mediate the efficacy of psychotherapy interventions. While there is a small, but growing body of literature supporting the effectiveness of psychotherapy with SM clients (e.g., Fals-Stewart, O’Farrell, & Lam, 2009; Pachankis et al., 2015), far less is known about specific mediators explaining that efficacy (Budge, Israel, & Merrill, 2017).

Further, the SMAPS could be used in studies with therapist-rated measures of affirmative practice, such as the Gay Affirmative Practice scale (GAP; Crisp, 2006) to assess whether therapists’ GAP scores are associated with clients’ SMAPS scores; this result may provide evidence for the predictive and construct validity of these therapist-rated measures, for example. Beyond its use in clinical trials, the SMAPS can also be used in retrospective studies of on SM individuals’ experiences in psychotherapy. For example, the SMAPS could be used to investigate whether SM clients’ ratings of previous therapists are associated with their current psychological functioning, satisfaction with past psychotherapy, or willingness to seek mental health treatment in the future.

The SMAPS’s future use in research also has implications for the ongoing expansion of the theoretical literature on SM-affirmative psychotherapy. The current absence of psychometrically-sound assessment has been an impediment in the SM-affirmative psychotherapy literature (O’Shaughnessy & Speir, 2018). The SMAPS can help researchers
obtain important assessments of SM clients’ perspectives on key affirmative psychotherapy practices that have been previously identified in the literature. Assessing SM clients’ psychotherapy perspectives is critical, as these clients are the primary stakeholders in the identification of SM-affirmative practice. Further, as demonstrated in the broader psychotherapy literature, clients often have different perspectives from their therapists (Fuertes & Nutt Williams, 2017). Thus, research with the SMAPS can contribute to the literature by informing theory about relationships between SM-affirmative psychotherapy and other critical psychotherapy processes.

Finally, the SMAPS may be a useful tool in clinical practice. Therapists can administer the SMAPS to their SM-identified clients to assess the extent to which these clients view their therapy experiences as SM-affirmative. In addition to obtaining information about their clients’ perceptions, reviewing a client’s item responses to the SMAPS could prompt client-therapist discussions around the therapeutic relationship. Since the SMAPS items are clearly affirmative or not affirmative, it may be useful for to discover which non-affirming behaviors, perhaps the subtler ones, tend to be endorsed even when most of the affirmative items are rated highly.
References


Table 1

*Final SMAPS Items, Factor Loadings, and Communalities*

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>$h^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>My therapist expressed beliefs that demeaned my sexual orientation</td>
<td>My therapist expressed beliefs that demeaned my sexual orientation</td>
<td>.955</td>
<td>-.108</td>
<td>.915</td>
</tr>
<tr>
<td>My therapist suggested that my sexual orientation was a sign of mental illness</td>
<td>My therapist suggested that my sexual orientation was a sign of mental illness</td>
<td>.944</td>
<td>.123</td>
<td>.923</td>
</tr>
<tr>
<td>My therapist claimed that my sexual orientation was actually different from how I identify myself (for example, therapist said you are “really” a lesbian when you are bisexual)</td>
<td>My therapist claimed that my sexual orientation was actually different from how I identify myself (for example, therapist said you are “really” a lesbian when you are bisexual)</td>
<td>.944</td>
<td>.050</td>
<td>.902</td>
</tr>
<tr>
<td>My therapist suggested that I try to become heterosexual</td>
<td>My therapist suggested that I try to become heterosexual</td>
<td>.934</td>
<td>.084</td>
<td>.892</td>
</tr>
<tr>
<td>My therapist suggested that I change how I identify my sexual orientation to better fit how they viewed my sexual orientation</td>
<td>My therapist suggested that I change how I identify my sexual orientation to better fit how they viewed my sexual orientation</td>
<td>.933</td>
<td>.073</td>
<td>.886</td>
</tr>
<tr>
<td>My therapist expressed a belief that my sexual orientation was just a temporary phase I was going through</td>
<td>My therapist expressed a belief that my sexual orientation was just a temporary phase I was going through</td>
<td>.932</td>
<td>.004</td>
<td>.872</td>
</tr>
<tr>
<td>My therapist addressed my sexual orientation using negative language</td>
<td>My therapist addressed my sexual orientation using negative language</td>
<td>.930</td>
<td>-.050</td>
<td>.864</td>
</tr>
<tr>
<td>My therapist reacted negatively when learning of my sexual orientation</td>
<td>My therapist reacted negatively when learning of my sexual orientation</td>
<td>.928</td>
<td>-.160</td>
<td>.872</td>
</tr>
<tr>
<td>My therapist focused only on discussing my sexual orientation, ignoring the other topics that I wanted to explore in therapy</td>
<td>My therapist focused only on discussing my sexual orientation, ignoring the other topics that I wanted to explore in therapy</td>
<td>.924</td>
<td>.082</td>
<td>.873</td>
</tr>
<tr>
<td>My therapist made a negative facial expression when learning of my sexual orientation</td>
<td>My therapist made a negative facial expression when learning of my sexual orientation</td>
<td>.921</td>
<td>-.080</td>
<td>.849</td>
</tr>
<tr>
<td>My therapist made demeaning comments (such as “what a waste” or “you don’t look gay”) about my sexual orientation</td>
<td>My therapist made demeaning comments (such as “what a waste” or “you don’t look gay”) about my sexual orientation</td>
<td>.917</td>
<td>.082</td>
<td>.860</td>
</tr>
</tbody>
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Table 1, cont.

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
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</tr>
</thead>
<tbody>
<tr>
<td>After I disclosed my sexual orientation, my therapist referred me to another therapist</td>
<td>.908</td>
<td>.195</td>
<td>.887</td>
</tr>
<tr>
<td>My therapist suggested that my sexual orientation is a result of a traumatic sexual experience</td>
<td>.908</td>
<td>-.064</td>
<td>.825</td>
</tr>
<tr>
<td>My therapist questioned or challenged my experiences of discrimination</td>
<td>.901</td>
<td>-.079</td>
<td>.812</td>
</tr>
<tr>
<td>After I disclosed my sexual orientation, my therapist refused to see me</td>
<td>.898</td>
<td>.227</td>
<td>.885</td>
</tr>
<tr>
<td>When I brought up issues related to my sexual orientation, my therapist seemed uncomfortable</td>
<td>.893</td>
<td>.123</td>
<td>.838</td>
</tr>
<tr>
<td>My therapist blamed my sexual orientation as the cause of my mental health concerns</td>
<td>.888</td>
<td>.025</td>
<td>.795</td>
</tr>
<tr>
<td>My therapist told me that my sexual orientation was the cause of my problems</td>
<td>.886</td>
<td>-.115</td>
<td>.789</td>
</tr>
<tr>
<td>My therapist framed my sexual orientation solely in terms of sex acts</td>
<td>.884</td>
<td>-.132</td>
<td>.787</td>
</tr>
<tr>
<td>My therapist’s words or actions made me feel judged for my sexual orientation</td>
<td>.881</td>
<td>-.228</td>
<td>.808</td>
</tr>
<tr>
<td>My therapist lacked basic knowledge about issues related to LGBQ+ people</td>
<td>.877</td>
<td>-.227</td>
<td>.800</td>
</tr>
<tr>
<td>After learning about my sexual orientation, my therapist’s toward me changed noticeably</td>
<td>.871</td>
<td>-.162</td>
<td>.770</td>
</tr>
<tr>
<td>My therapist expressed a belief that my sexual orientation was invalid</td>
<td>.862</td>
<td>.024</td>
<td>.749</td>
</tr>
<tr>
<td>My therapist referred to me as a “homosexual”</td>
<td>.778</td>
<td>.020</td>
<td>.609</td>
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Table 1, cont.

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<thead>
<tr>
<th>Item</th>
<th>1</th>
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</tr>
</thead>
<tbody>
<tr>
<td>My therapist avoided discussing issues related to my sexual orientation</td>
<td>.753</td>
<td>- .281</td>
<td>.623</td>
</tr>
<tr>
<td>My therapist’s office made me feel uncomfortable as a LGBQ+ person</td>
<td>.745</td>
<td>- .097</td>
<td>.558</td>
</tr>
<tr>
<td>My therapist minimized my experiences of discrimination</td>
<td>.730</td>
<td>- .166</td>
<td>.547</td>
</tr>
<tr>
<td>I did not need to teach my therapist about issues related to my sexual orientation</td>
<td>- .581</td>
<td>.240</td>
<td>.380</td>
</tr>
<tr>
<td>My therapist discussed my sexual orientation when it was relevant</td>
<td>.014</td>
<td>.755</td>
<td>.573</td>
</tr>
<tr>
<td>My therapist seemed willing to discuss the positive and negative aspects of being a LGBQ+ person</td>
<td>.013</td>
<td>.740</td>
<td>.551</td>
</tr>
<tr>
<td>My therapist’s behavior in session made me feel accepted as a LGBQ+ person</td>
<td>- .241</td>
<td>.734</td>
<td>.590</td>
</tr>
<tr>
<td>My therapist did not appear hesitant to discuss my sexual orientation</td>
<td>- .129</td>
<td>.729</td>
<td>.539</td>
</tr>
<tr>
<td>My therapist communicated a belief that my sexual orientation is just as valid as being heterosexual</td>
<td>- .115</td>
<td>.727</td>
<td>.534</td>
</tr>
<tr>
<td>My therapist acknowledged the impact of living in a homophobic and biphobic society</td>
<td>- .046</td>
<td>.716</td>
<td>.513</td>
</tr>
<tr>
<td>My therapist demonstrated knowledge about LGBQ+ related resources such as books, magazines, websites, and local organizations</td>
<td>.024</td>
<td>.706</td>
<td>.503</td>
</tr>
<tr>
<td>My therapist used terms that were non-judgmental of LGBQ+ people</td>
<td>- .173</td>
<td>.702</td>
<td>.511</td>
</tr>
<tr>
<td>My therapist acknowledged how my sexual orientation relates to the other aspects of my identity</td>
<td>.008</td>
<td>.702</td>
<td>.495</td>
</tr>
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Table continues
Table 1, cont.

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>$h^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>My therapist explored how my sexual identity relates to the other aspects of my identity (e.g., my race/ethnicity, religion, nationality, career).</td>
<td>.226</td>
<td>.696</td>
<td>.552</td>
</tr>
<tr>
<td>My therapist encouraged me to identify my sexual orientation as I understand it</td>
<td>-.018</td>
<td>.683</td>
<td>.468</td>
</tr>
<tr>
<td>My therapist recognized when my sexual orientation was related to the issues I was working on in therapy</td>
<td>-.288</td>
<td>.679</td>
<td>.523</td>
</tr>
<tr>
<td>My therapist helped me identify positive aspects of my sexual orientation</td>
<td>-.220</td>
<td>.634</td>
<td>.436</td>
</tr>
<tr>
<td>My therapist suggested resources that were relevant to my sexual orientation such as books, websites, or local organizations</td>
<td>.062</td>
<td>.631</td>
<td>.409</td>
</tr>
<tr>
<td>When discussing my sexual orientation, my therapist did not pressure me to label myself</td>
<td>-.052</td>
<td>.628</td>
<td>.395</td>
</tr>
<tr>
<td>My therapist asked for my opinion on how my sexual orientation was related to the concerns that brought me to therapy</td>
<td>.063</td>
<td>.616</td>
<td>.390</td>
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<tr>
<td>My therapist used sexual orientation-inclusive terms (e.g., “partner” vs. assuming partner’s gender)</td>
<td>-.257</td>
<td>.609</td>
<td>.420</td>
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<tr>
<td>My therapist described my sexual orientation as being one part of my overall identity</td>
<td>-.199</td>
<td>.608</td>
<td>.396</td>
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<tr>
<td>My therapist’s waiting room, office, and/or website were LGBTQ-inclusive</td>
<td>.134</td>
<td>.523</td>
<td>.301</td>
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<tr>
<td>The paperwork that I filled out at my therapist’s office was inclusive of my sexual orientation</td>
<td>-.059</td>
<td>.503</td>
<td>.254</td>
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<tr>
<td>My therapist was interested in knowing about aspects of my identity other than my sexual orientation (e.g., my race/ethnicity, religion, nationality, career)</td>
<td>-.276</td>
<td>.474</td>
<td>.286</td>
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Table continues
Table 1, cont.

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>$h^2$</th>
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<td>My therapist indicated that my sexual orientation is <em>not</em> the cause of my problems</td>
<td>.155</td>
<td><strong>.468</strong></td>
<td>.252</td>
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<tr>
<td>My therapist asked about my family’s reaction when I “came out,” or how I thought my family would react were I to “come out” to them</td>
<td>.123</td>
<td><strong>.430</strong></td>
<td>.207</td>
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</tbody>
</table>

*Note.* Items presented in order of factor loading strength. $h^2 =$ item communality; (R) indicates reverse scoring. Unique factor loadings greater than .40 are in bold.
Figure 1

Scree Plot
Table 2

*Descriptive Statistics*

<table>
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<tr>
<th>Scale</th>
<th>Harmful</th>
<th>Affirm</th>
<th>M</th>
<th>SD</th>
<th>α</th>
<th>Skewness</th>
<th>Kurtosis</th>
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<tr>
<td>Harmful</td>
<td>1.00</td>
<td>-0.076†</td>
<td>1.83</td>
<td>1.26</td>
<td>.98</td>
<td>1.99 (.137)</td>
<td>2.656 (.273)</td>
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<td>Affirm</td>
<td>-0.076†</td>
<td>1.00</td>
<td>4.77</td>
<td>0.82</td>
<td>.94</td>
<td>-0.962 (.137)</td>
<td>0.962 (.274)</td>
</tr>
</tbody>
</table>

*Note.* $N = 315$. Standard errors are in parentheses. Harmful = Harmful Practice; Affirm = Affirmative Practice. †$p = .18$
Appendix A: Initial SMAPS Item Pool

1. My therapist asked about whether I experienced any discrimination due to my sexual orientation
2. My therapist blamed my sexual orientation as the cause of my mental health concerns
3. My therapist validated my sexual orientation as being just as normal as being heterosexual (“straight”)
4. My therapist made stereotypical assumptions about what it means to identify as sexual minority group member
5. My therapist made stereotypical assumptions about me based on my sexual orientation
6. My therapist encouraged me to consider how my sexual orientation is related to the problems or concerns I’m experiencing
7. My therapist pressured me to discuss issues or topics related to my sexual orientation
8. When discussing my sexual orientation, my therapist used positive, non-judgmental language
9. My therapist used sexual orientation-inclusive terms (e.g., partner”)
10. My therapist used terms that were nonjudgmental of sexual minorities
11. My therapist was interested in knowing about aspects of my identity other than my sexual orientation (e.g., my race/ethnicity, religion, nationality, career).
12. My therapist explored how my sexual identity relates to the other aspects of my identity (e.g., my race/ethnicity, religion, nationality, career)
13. My therapist acknowledged how my sexual identity relates to other aspects of my identity
14. My therapist asked about my family’s reaction when I “came out”, or how I thought my family would react were I to “come out” to them
15. My therapist asked about whether I am “out” or open about my sexual orientation with others

16. My therapist expressed a belief that my sexual orientation was invalid

17. My therapist expressed a belief that my sexual orientation was just a temporary phase I was going through

18. My therapist expressed that my sexual orientation is natural and normal

19. My therapist addressed my sexual orientation in a negative manner

20. My therapist avoided discussing issues related to my sexual orientation

21. My therapist encouraged me to establish a support system with other sexual minority individuals

22. My therapist mentioned the importance of having a support system of sexual minority peers

23. My therapist encouraged development of my same-sex relationships

24. When I brought up issues related to my sexual orientation my therapist seemed uncomfortable

25. My therapist suggested that my sexual orientation was a sign of mental illness

26. My therapist expressed prejudicial beliefs about my sexual orientation

27. My therapist told me that my sexual orientation was the cause of my problems

28. My therapist told me that my sexual orientation was not the cause of my problems

29. When we discussed my sexual orientation, my therapist seemed to have an open mind

30. My therapist focused on my sexual orientation more than I thought was needed

31. My therapist and I disagreed on how much we should discuss my sexual orientation in my therapy
32. My therapist gave me information about sexual minority-related resources in my area
33. My therapist described my sexual orientation as being one part of my overall identity
34. My therapist suggested that I try to become heterosexual
35. My therapist framed my sexual orientation solely in terms of sex acts
36. My therapist asked about my sexual orientation during our first meeting together
37. My therapist’s waiting room, office, and/or website were LGBTQ-inclusive
38. The paperwork that I filled out at my therapist’s office was inclusive of my sexual orientation
39. The forms I filled out at my therapist’s office asked me about my sexual orientation
40. My therapist affirmed my sexual orientation
41. My therapist treated my sexual orientation with respect
42. My therapist disclosed my sexual orientation to other people without my consent
43. After learning about my sexual orientation, my therapist’s attitude toward me changed noticeably
44. After learning my sexual orientation, my therapist treated me differently
45. I did not need to teach my therapist about issues related to my sexual orientation
46. The way in which my therapist discussed topics related to my sexual orientation made me feel safe
47. My therapist brought up my sexual orientation only when it felt relevant to the topic we were discussing
48. My therapist expressed that my sexual orientation is as healthy as a heterosexual orientation
49. The way my therapist discussed sexual orientation was non-threatening
50. When discussing topics related to my sexual orientation, my therapist appeared comfortable.

51. When discussing my sexual orientation, my therapist did not pressure me to label myself.

52. My therapist acknowledged the impact of living in a homophobic and biphobic society.

53. My therapist assumed that I was heterosexual.

54. My therapist lacked basic knowledge about sexual minority people.

55. My therapist lacked basic knowledge about issues related to sexual minorities.

56. My therapist demonstrated knowledge about sexual minority related resources such as books, magazines, websites, and local organizations.

57. My therapist suggested resources that were relevant to my sexual orientation such as books, websites, or local organizations.

58. My therapist discussed my sexual orientation when it was relevant.

59. After I disclosed my sexual orientation my therapist refused to see me.

60. After I disclosed my sexual orientation my therapist referred me to another therapist.

61. My therapist did not appear hesitant to discuss my sexual orientation.

62. My therapist recognized when my sexual orientation was related to the issues I was working on in therapy.

63. My therapist suggested that I change how I identify my sexual orientation to better fit how they viewed my sexuality.

64. My therapist claimed that my sexual orientation was actually different from how I identify myself (for example, the therapist said that you are “really” a lesbian when you are bisexual).

65. My therapist’s office made me feel uncomfortable as a sexual minority.
66. My therapist had a written nondiscrimination statement that was inclusive of minority sexual orientations

67. My therapist encouraged me to identify my sexual orientation as I understand it

68. My therapist communicated a belief that my sexual orientation is just as valid as being heterosexual

69. My therapist referred to my sexual orientation as a “lifestyle” or a “choice”

70. My therapist expressed beliefs that demeaned my sexual orientation

71. My therapist asked about how my experience of discrimination due to my sexual orientation may be related to why I sought professional help

72. My therapist asked me about whether I have been discriminated against, such as being bullied, abused verbally or physically, or being isolated due to my sexual orientation

73. My therapist indicated that my sexual orientation is not the cause of my problems

74. My therapist’s behavior in session made me feel accepted as a sexual minority

75. My therapist reacted negatively when learning of my sexual orientation

76. My therapist made a negative facial expression when learning of my sexual orientation

77. My therapist made demeaning comments (such as “what a waste,” or “you don’t look gay”) about my sexual orientation

78. My therapist seemed willing to discuss the positive and negative aspects of being a sexual minority

79. My therapist seemed comfortable working with me

80. The way my therapist spoke to me made it feel safe to be a sexual minority in therapy

81. My therapist made me feel safe to be a sexual minority-identified person in the therapy relationship
82. My therapist’s actions made me feel supported as a sexual minority
83. My therapist’s words or actions made me feel judged for my sexual orientation
84. My therapist asked about how my family responded to my sexual orientation or might respond if they learned of my sexual orientation
85. My therapist helped me identify positive aspects of my sexual orientation
86. My therapist asked for my opinion on how my sexual orientation was related to the concern that brought me to therapy
87. My therapist focused only on discussing my sexual orientation, ignoring the other topics that I wanted to explore in therapy
88. My therapist referred to me as “homosexual”
89. My therapist minimized my experiences of discrimination
90. My therapist questioned my experiences of discrimination
91. My therapist didn’t seem to understand why some sexual minority individuals feel shame
Appendix B: Study 1 Email Recruitment Template

Dear [Representative of Organization],

I am the principal investigator of a study of lesbian, gay, bisexual, pansexual, queer, and other sexual minority individuals’ experiences’ in therapy. The ultimate goal of this study is to develop a questionnaire that can help researchers and therapists understand sexual minority clients’ perceptions of their therapy experiences. This project is being conducted through the University at Albany, State University of New York and is being supervised by Myrna Friedlander, Ph.D.

Currently, I am reaching out to agencies and organizations, such as [Name of Organization], to help recruit a diverse sample of adults who identify as a sexual minority (lesbian, gay, bisexual, queer, pansexual, etc.). To participate in this study, one must be age 18 or older, reside in the United States, identify as a member of a sexual minority group, and have participated in at least one therapy/counseling session within the past 12 months. Those who participate may be eligible to receive a $10 gift card from Amazon.com as compensation for their time.

Would it be possible for [Name of Organization] to help spread the word about this study to potential participants? I have attached a flyer announcement to this email and our online survey can be found at: [LINK]

Thank you and please let me know if you have any questions,

Ryan C. Ebersole, M.S.
Ph.D. Candidate
Division of Counseling Psychology
University at Albany, State University of New York
Appendix C: Study 1 Informed Consent

This research study is being conducted by Ryan Ebersole, M.S. as part of a doctoral dissertation for a Ph.D. in Counseling Psychology from the University at Albany, State University of New York and is being supervised by Myrna L. Friedlander, Ph.D. (Professor of Counseling Psychology at the University at Albany/State University of New York). This project has been approved by the University at Albany Institutional Review Board. Approval of this project only signifies that the procedures adequately protect the rights and welfare of the participants. Please note that absolute confidentiality and anonymity cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when you have finished so no one will be able to see what you have been doing.

**Purpose of the Study**

We are conducting a study of lesbian, gay, bisexual, and other non-heterosexual individuals’ experiences’ in therapy. The ultimate goal of this study is to develop a questionnaire that can help researchers and therapists understand sexual minority clients’ perceptions of their therapy experience. At this current phase of the study, we are looking for assistance in evaluating a proposed questionnaire for each item’s relevance to sexual minority people’s experience in therapy or counseling.

**Who can participate?**

You are eligible to participate in this study if you are (a) an adult age 18 or older, (b) live in the United States, (c) identify as lesbian, gay, bisexual, queer, pansexual, or otherwise non-
heterosexual, (d) identify as cisgender, and (e) you have had at least one counseling or therapy session within the past 12 months.

**What will I be asked to do? How long will it take?**

If you agree to participate in this study, you will be asked to answer demographic questions (on the next page) to determine if you are eligible to participate. If you are eligible you will then be directed to the study materials. You will be asked to review a series of questions and rate the extent to which you find the therapist/counselor behavior indicated in each question to be affirmative/non-affirmative of sexual minority individuals. You will also be asked to provide feedback on whether any questions were hard to understand. This process should take you about 20-25 minutes to complete.

Your participation in this research study is completely voluntary. Even after you agree to participate in the research you may decide to leave the study at any time without penalty or without loss of benefits to which you may otherwise have been entitled. I will retain and analyze the data you have provided up to the point you left the study. Given the anonymous nature of the study, I will be unable to destroy or otherwise delete your individual responses.

**What are the risks or inconveniences of the study?**

There are no anticipated physical or mental risks to participation in this study. No personally-identifiable information will be collected as part of the research process. Eligible participants who complete the study will be given the option to provide an email address in order to receive a small financial compensation for their time. However, this email address will be stored separately from your responses to the research items.
What are the benefits of the study?

This study is expected to generate important information about therapist practices and training with lesbian, gay, bisexual, queer, pansexual, and other non-heterosexual clients. Study findings may inform future endeavors to improve therapist training and practices. On an individual level, our prior experience indicates that most participants find the research process interesting and rewarding.

Will I receive payment for participation? Are there costs to participate?

Yes. Eligible participants who complete the study items will receive a $10 gift card from Amazon.com for their time. You are not responsible for any costs to participate in this study.

How will my personal information be protected?

Data from this study will be stored on a password-protected computer. No personally-identifiable information (e.g., name, IP address) will be collected or stored. If you choose to provide your email address, it will be separated from your responses prior to data analysis. Further, all collected data will be analyzed and reported in aggregate form to ensure that your responses are anonymous.

Whom do I contact if I have questions about the study?

Take as long as you’d like before you make a decision. We will be happy to answer any question you have about this study. If you have any questions about this study, please contact the Ryan Ebersole, Ph.D. Candidate in counseling psychology at the University at Albany, State University of New York (rebersole@albany.edu). You may also contact Myrna Friedlander,
Ph.D., professor of counseling psychology at the University at Albany, State University of New York at mfriedlander@albany.edu or (518) 442-5049.

**Whom do I contact if I have questions about my rights as a study participant?**

Research at the University at Albany involving human participants is carried out under the oversight of the Institutional Review Board (IRB). This research has been reviewed and approved by the IRB. If you have questions concerns you may contact University at Albany Office of Regulatory & Research Compliance at 1-800-857-5459 or hsconcerns@albany.edu.

Please read the above carefully. Due to the online nature of this study, the University at Albany’s Institutional Review Board has waived the requirement to sign a consent form. By clicking “Next” below, you are consenting to participate in this study.
Appendix D: Study 1 Demographics Questionnaire

1. I am an adult aged 18 or older
   a. Yes
   b. No
   c. Prefer not to answer

2. What is your age, in years?

3. Which options best describes your gender?
   a. Man
   b. Woman
   c. Trans male/Trans man
   d. Trans female/Trans woman
   e. Gender queer or non-binary
   f. Prefer not to answer
   g. Other (please specify)

4. Which option best describes your sexual orientation?
   a. Straight/heterosexual
   b. Gay/Lesbian
   c. Bisexual
   d. Queer
   e. Pansexual
   f. Prefer not to answer
   g. Other (please specify)
5. Have you participated in at least one session of therapy or counseling within the past 12 months?
   a. Yes
   b. No
   c. Prefer not to answer

6. Are you currently in therapy or counseling?
   a. Yes
   b. No

7. Please estimate the number of therapy/counseling sessions you completed with your current or most recent therapist:

8. Which type of therapy/counseling have you participated in?
   a. Individual
   b. Group
   c. Couple/family

9. What is your racial/ethnic heritage?
   a. African American/Black
   b. Asian American/Asian
   c. Hispanic/Latina(o)
   d. Native American or Alaska Native
   e. Native Hawaiian/Other Pacific Islander
   f. White non-Hispanic/European American
   g. Biracial/Multiracial
   h. Other (please specify)
10. Are you currently or have you ever worked as a therapist/mental health counselor?
   a. Yes
   b. No
   c. Prefer not to answer
Appendix E: Study 2 Demographics Questionnaire

1. I am an adult aged 18 or older
   a. Yes
   b. No
   c. Prefer not to answer

2. What is your age, in years?

3. Which option best describes your racial/ethnic identity?
   a. African American/Black
   b. Asian/Asian American
   c. Hispanic/Latina/o
   d. Native American or Alaska Native
   e. White, Non-Latina/o
   f. Biracial/Multiracial
   g. Prefer not to respond
   h. Other (please specify)

4. Which option best describes your sexual orientation?
   a. Heterosexual/straight
   b. Gay/Lesbian
   c. Bisexual
   d. Queer
   e. Pansexual
   f. Prefer not to respond
   g. Other (please specify)
5. Which option best describes your gender identity?
   a. Man
   b. Woman
   c. Genderqueer/ Gender non-binary
   d. Prefer not to respond
   e. Other (please specify)

6. Does your gender identity match the sex you were assigned at birth? (i.e., do you identify as cis-gender?)
   a. Yes
   b. No
   c. Prefer not to respond

7. Have you participated in at-least one session of therapy or counseling within the past 12 months?
   a. Yes
   b. No
   c. Prefer not to respond

8. Please estimate the length of time, in weeks, since your last therapy session (if less than 1 week, enter 0):

9. Please estimate the number of therapy/counseling sessions you completed with your current therapist or most recent therapist

10. Are you currently receiving therapy/counseling sessions? (i.e., are you currently “in therapy?”)
    a. Yes
b. No

11. Please briefly describe the main issue that brought you to therapy/counseling (e.g., depression, anxiety, grief, relationship problems, sexual identity concerns, etc.):

12. Are you or have you ever worked as a therapist/mental health counselor?

13. Which option best describes your current relationship status?
   a. Single/not in a relationship
   b. In a relationship but not married or living together
   c. Cohabitating (living together but not married)
   d. Married/Civil partnership
   e. Widow/Widower
   f. In a polyamorous relationship
   g. Other (please specify)

14. Which option best describes your romantic partner’s gender identity?
   a. I am not currently in a romantic relationship/do not have a romantic partner
   b. Man
   c. Woman
   d. Genderqueer/gender non-binary
   e. Other (please specify)

15. Please estimate your annual income, in dollars:
   a. Less than $10,000
   b. $10,000 to $14,999
   c. $15,000 to $24,999
   d. $25,000 to $34,999
e. $35,000 to $49,999
f. $50,000 to $74,999
g. $75,000 to $99,999
h. $100,000 to $149,000
i. $150,000 to $199,999
j. $200,000 or more

16. What is your highest attained education level?
   a. Less than high school diploma
   b. High school diploma or GED
   c. Associate’s degree
   d. Some college
   e. Bachelor’s degree
   f. Master’s degree
   g. Doctorate/professional degree (J.D., Ph.D., M.D., etc.)
   h. Other (please specify)

17. Do you currently live in the United States of America?
   a. Yes
   b. No
   c. Other (please specify)

18. Which option best describes your current geographic region in the United States?
   a. Northeast
   b. Midwest
   c. Rocky Mountain/Mountain West
d. Pacific Coast  
e. Southeast  
f. Southwest  
g. Noncontiguous (Alaska, Hawaii)  
h. American territories and commonwealths (e.g., Guam, Puerto Rico)  
i. Other (please specify)
Appendix F: Revised SMAPS Items Pool and Instructions

In this questionnaire, the term LGBQ+ refers to individuals who identify as lesbian, gay, bisexual, queer, pansexual, or otherwise non-heterosexual.

Take a moment to think about your experience in therapy. If you have worked with multiple therapists, please use only your experiences with your most recent therapist to answer these questions.

Below is a list of statements that may describe LGBQ+ individuals’ experiences in therapy.

As you read each statement, please rate the extent to which you agree that these statements are characteristic of your experiences in therapy on the following scale:

1 (completely disagree) 2 (disagree) 3 (somewhat disagree) 4 (somewhat agree) 5 (agree) 6 (completely agree)

1. My therapist blamed my sexual orientation as the cause of my mental health concerns
2. My therapist validated my sexual orientation as being just as normal as being heterosexual ("straight")
3. My therapist made stereotypical assumptions about what it means to identify as a LGBQ+ individual
4. My therapist made stereotypical assumptions about me based on my sexual orientation
5. When discussing my sexual orientation, my therapist used positive, non-judgmental language
6. My therapist used sexual orientation-inclusive terms (e.g., “partner” vs. assuming partner’s gender)
7. My therapist used terms that were nonjudgmental of LGBQ+ people
8. My therapist was interested in knowing about aspects of my identity other than my sexual orientation (e.g., my race/ethnicity, religion, nationality, career).

9. My therapist explored how my sexual identity relates to the other aspects of my identity (e.g., my race/ethnicity, religion, nationality, career).

10. My therapist acknowledged how my sexual orientation relates to other aspects of my identity.

11. My therapist asked about my family’s reaction when I “came out”, or how I thought my family would react were I to “come out” to them.

12. My therapist asked about whether I am “out” or open about my sexual orientation with others.

13. My therapist expressed a belief that my sexual orientation was invalid.

14. My therapist expressed a belief that my sexual orientation was just a temporary phase I was going through.

15. My therapist expressed that my sexual orientation is natural and normal.


17. My therapist avoided discussing issues related to my sexual orientation.

18. My therapist encouraged development of my same-sex relationships.

19. When I brought up issues related to my sexual orientation my therapist seemed uncomfortable.

20. My therapist suggested that my sexual orientation was a sign of mental illness.


22. My therapist told me that my sexual orientation was the cause of my problems.

23. When we discussed my sexual orientation, my therapist seemed to have an open mind.
24. My therapist described my sexual orientation as being one part of my overall identity
25. My therapist suggested that I try to become heterosexual
26. My therapist framed my sexual orientation solely in terms of sex acts
27. My therapist’s waiting room, office, and/or website were LGBTQ-inclusive
28. The paperwork that I filled out at my therapist’s office was inclusive of my sexual orientation
29. My therapist affirmed my sexual orientation
30. My therapist treated my sexual orientation with respect
31. After learning about my sexual orientation, my therapist’s attitude toward me changed noticeably
32. After learning my sexual orientation, my therapist treated me differently
33. I did not need to teach my therapist about issues related to my sexual orientation
34. The way in which my therapist discussed topics related to my sexual orientation made me feel safe
35. My therapist brought up my sexual orientation only when it felt relevant to the topic we were discussing
36. My therapist expressed that my sexual orientation is as healthy as a heterosexual orientation
37. The way my therapist discussed my sexual orientation was non-threatening
38. When discussing topics related to my sexual orientation, my therapist appeared comfortable
39. When discussing my sexual orientation, my therapist did not pressure me to label myself
40. My therapist acknowledged the impact of living in a homophobic and biphobic society
41. My therapist assumed that I was heterosexual

42. My therapist lacked basic knowledge about LGBQ+ people

43. My therapist lacked basic knowledge about issues related to LGBQ+ people

44. My therapist demonstrated knowledge about LGBQ+ related resources such as books, magazines, websites, and local organizations

45. My therapist suggested resources that were relevant to my sexual orientation such as books, websites, or local organizations

46. My therapist discussed my sexual orientation when it was relevant

47. After I disclosed my sexual orientation my therapist refused to see me

48. After I disclosed my sexual orientation my therapist referred me to another therapist

49. My therapist did not appear hesitant to discuss my sexual orientation

50. My therapist recognized when my sexual orientation was related to the issues I was working on in therapy

51. My therapist suggested that I change how I identify my sexual orientation to better fit how they viewed my sexuality

52. My therapist claimed that my sexual orientation was actually different from how I identify myself (for example, the therapist said that you are “really” a lesbian when you are bisexual)

53. My therapist’s office made me feel uncomfortable as a LGBQ+ person

54. My therapist had a written nondiscrimination statement that was inclusive of minority sexual orientations

55. My therapist encouraged me to identify my sexual orientation as I understand it
56. My therapist communicated a belief that my sexual orientation is just as valid as being heterosexual

57. My therapist referred to my sexual orientation as a “lifestyle” or a “choice”

58. My therapist expressed beliefs that demeaned my sexual orientation

59. My therapist indicated that my sexual orientation is not the cause of my problems

60. My therapist’s behavior in session made me feel accepted as a LGBQ+ person

61. My therapist reacted negatively when learning of my sexual orientation

62. My therapist made a negative facial expression when learning of my sexual orientation

63. My therapist made demeaning comments (such as “what a waste,” or “you don’t look gay”) about my sexual orientation

64. My therapist seemed willing to discuss the positive and negative aspects of being a LGBQ+ person

65. My therapist seemed comfortable working with me

66. The way my therapist spoke to me made it feel safe to be a LGBQ+ person in therapy

67. My therapist made me feel safe to be a LGBQ+ -identified person in the therapy relationship

68. My therapist’s actions made me feel supported as a LGBQ+ person

69. My therapist’s words or actions made me feel judged for my sexual orientation

70. My therapist helped me identify positive aspects of my sexual orientation

71. My therapist asked for my opinion on how my sexual orientation was related to the concerns that brought me to therapy

72. My therapist focused only on discussing my sexual orientation, ignoring the other topics that I wanted to explore in therapy
73. My therapist referred to me as a “homosexual”

74. My therapist minimized my experiences of discrimination

75. My therapist questioned or challenged my experiences of discrimination

76. My therapist did not seem to understand why some LGBQ+ individuals feel shame

77. My therapist suggested that my sexual orientation is a result of a traumatic sexual experience
Appendix G: Study 2 Email Recruitment Announcement

Dear [Representative of organization],

Please let me know if I should direct this email to a different individual.

I was hoping to reach out to speak to someone with the [Organization] about disseminating a call for research participants. I am the principal investigator of a study of lesbian, gay, bisexual, queer, pansexual, and otherwise non-heterosexual (LGBQ+) individuals' experiences in therapy. The aim of this study ("Development of the Sexual Minority Affirmative Practice Scale") is to develop a measure that assesses LGBQ+/sexual minority therapy clients' perceptions of the extent to which their clinicians provided LGBQ-affirming services. Ultimately, it is my hope that the results of this study will help facilitate improved training for future clinicians and thus improved mental health services for LGBQ+ individuals. This project is my doctoral dissertation, was approved by the University at Albany's IRB, and is being supervised by Myrna Friedlander, Ph.D.

This study is anonymous, takes 10-15 minutes, and those who complete the study have the choice to enter a drawing for one of 60 $10 Amazon.com gift cards as compensation for their time. To participate in this anonymous study, one must be a) an adult age 18+, b) identify as LGBQ+, c) identify as cisgender, and d) have participated in at least one therapy/counseling session (including group counseling) within the past 12 months.

Would it be possible for [Organization] to help spread the word about this study? I have attached a recruitment flyer to this email in both PDF and JPG formats, and the online survey can be found at: https://goo.gl/oirFxt I would be happy to provide any other information or documentation you may require.

Thank you and please let me know if you have any questions or require additional information,
Ryan C. Ebersole, M.S.
Ph.D. Candidate
Division of Counseling Psychology
University at Albany, State University of New York
Appendix H: Study 2 Informed Consent

This research study is being conducted by Ryan Ebersole, M.S. as part of a doctoral dissertation for a Ph.D. in Counseling Psychology from the University at Albany, State University of New York and is being supervised by Myrna L. Friedlander, Ph.D. (Professor of Counseling Psychology at the University at Albany/State University of New York). This project has been approved by the University at Albany Institutional Review Board. Approval of this project only signifies that the procedures adequately protect the rights and welfare of the participants. Please note that absolute confidentiality and anonymity cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when you have finished so no one will be able to see what you have been doing.

Purpose of the Study

We are conducting a study of lesbian, gay, bisexual, queer, pansexual and other non-heterosexual (LGBQ+) individuals’ experiences’ in therapy. The ultimate goal of this study is to develop a questionnaire that can help researchers and therapists understand LGBQ+ clients’ perceptions of their therapy experience.

Who can participate?

You are eligible to participate in this study if you are (a) an adult age 18 or older, (b) live in the United States, (c) identify as lesbian, gay, bisexual, queer, pansexual, or otherwise non-heterosexual, (d) identify as cisgender, and (e) you have had at least one counseling or therapy session within the past 12 months. Individuals who have worked as therapists/mental health counselors are not eligible to participate in this study.
What will I be asked to do? How long will it take?

If you agree to participate in this study, you will be asked to answer demographic questions to determine if you are eligible to participate. Next, you will be asked to respond to several items related to your experiences with your therapist/counselor. In total, it is estimated that this survey will take about 15 minutes to complete. Please note, that as the goal of this study is to develop a questionnaire, you will be asked to complete all items before moving on.

Your participation in this research study is completely voluntary. Even after you agree to participate in the research you may decide to leave the study at any time without penalty or without loss of benefits to which you may otherwise have been entitled. I will retain and analyze the data you have provided up to the point you left the study. Given the anonymous nature of the study, I will be unable to destroy or otherwise delete your individual responses.

What are the risks or inconveniences of the study?

There are no anticipated physical or mental risks to participation in this study. No personally-identifiable information will be collected as part of the research process. Eligible participants who complete the study will be given the option to provide an email address in order to be entered into a raffle for a $10 gift card. However, this email address will be stored separately from your responses to the research items.

What are the benefits of the study?

This study is expected to generate important information about therapist practices and training with LGBQ+ clients. Study findings may inform future endeavors to improve therapist training
and practices. On an individual level, our prior experience indicates that most participants find the research process interesting and rewarding.

**Will I receive payment for participation? Are there costs to participate?**

*Yes.* Eligible participants who complete the study items will be given the option to participate in a drawing for a $10 gift card from Amazon.com for their time.

You are not responsible for any costs to participate in this study.

**How will my personal information be protected?**

Data from this study will be stored on a password-protected computer. No personally-identifiable information (e.g., name, IP address) will be collected or stored. If you choose to provide your email address, it will be separated from your responses prior to data analysis. Further, all collected data will be analyzed and reported in aggregate form to ensure that your responses are anonymous.

**Whom do I contact if I have questions about the study?**

Take as long as you’d like before you make a decision. We will be happy to answer any question you have about this study. If you have any questions about this study, please contact the Ryan Ebersole, Ph.D. Candidate in counseling psychology at the University at Albany, State University of New York (rebersole@albany.edu). You may also contact Myrna Friedlander, Ph.D., professor of counseling psychology at the University at Albany, State University of New York at mfriedlander@albany.edu or (518) 442-5049.

**Whom do I contact if I have questions about my rights as a study participant?**
Research at the University at Albany involving human participants is carried out under the oversight of the Institutional Review Board (IRB). This research has been reviewed and approved by the IRB. If you have questions concerns you may contact University at Albany Office of Regulatory & Research Compliance at 1-800-857-5459 or hsconcerns@albany.edu.

Please read the above carefully. Due to the online nature of this study, the University at Albany's Institutional Review Board has waived the requirement to sign a consent form. By clicking "Next" below, you are consenting to participate in this study.
Appendix I: Complete SMAPS with Instructions

Instructions:

Take a moment to think your experience in therapy. If you have worked with multiple therapists, please use only your experiences with your most recent therapist to answer these questions. Below is a list of statements that may describe LGBQ+ individuals’ experiences in therapy.

As you read each statement, please rate the extent to which you agree that these statements are characteristic of your experiences in therapy on the following scale:

1 (completely disagree) 2 (disagree) 3 (somewhat disagree) 4 (somewhat agree) 5 (agree) 6 (completely agree)

1. My therapist blamed my sexual orientation as the cause of my mental health concerns*
2. My therapist used sexual orientation-inclusive terms (e.g., “partner” vs. assuming partner’s gender) †
3. My therapist used terms that were non-judgmental of LGBQ+ people†
4. My therapist was interested in knowing about aspects of my identity other than my sexual orientation (e.g., my race/ethnicity, religion, nationality, career). †
5. My therapist explored how my sexual identity relates to the other aspects of my identity (e.g., my race/ethnicity, religion, nationality, career) †
6. My therapist acknowledged how my sexual orientation relates to other aspects of my identity†
7. My therapist asked about my family’s reaction when I “came out”, or how I thought my family would react were I to “come out” to them †
8. My therapist expressed a belief that my sexual orientation was invalid *
9. My therapist expressed a belief that my sexual orientation was just a temporary phase I was going through*
10. My therapist addressed my sexual orientation using negative language*
11. My therapist avoided discussing issues related to my sexual orientation*
12. When I brought up issues related to my sexual orientation my therapist seemed uncomfortable*
13. My therapist suggested that my sexual orientation was a sign of mental illness*
14. My therapist told me that my sexual orientation was the cause of my problems*
15. My therapist described my sexual orientation as being one part of my overall identity †
16. My therapist suggested that I try to become heterosexual*
17. My therapist framed my sexual orientation solely in terms of sex acts*
18. My therapist’s waiting room, office, and/or website were LGBTQ-inclusive †
19. The paperwork that I filled out at my therapist’s office was inclusive of my sexual orientation †
20. After learning about my sexual orientation, my therapist’s attitude toward me changed noticeably*
21. I did not need to teach my therapist about issues related to my sexual orientation(R)*
22. When discussing my sexual orientation, my therapist did not pressure me to label myself †
23. My therapist acknowledged the impact of living in a homophobic and biphobic society †
24. My therapist lacked basic knowledge about issues related to LGBQ+ people †
25. My therapist demonstrated knowledge about LGBQ+ related resources such as books, magazines, websites, and local organizations†

26. My therapist suggested resources that were relevant to my sexual orientation such as books, websites, or local organizations†

27. My therapist discussed my sexual orientation when it was relevant†

28. After I disclosed my sexual orientation my therapist refused to see me*

29. After I disclosed my sexual orientation my therapist referred me to another therapist*

30. My therapist did not appear hesitant to discuss my sexual orientation†

31. My therapist recognized when my sexual orientation was related to the issues I was working on in therapy†

32. My therapist suggested that I change how I identify my sexual orientation to better fit how they viewed my sexuality*

33. My therapist claimed that my sexual orientation was actually different from how I identify myself (for example, the therapist said that you are “really” a lesbian when you are bisexual)*

34. My therapist’s office made me feel uncomfortable as a LGBQ+ person*

35. My therapist encouraged me to identify my sexual orientation as I understand it†

36. My therapist communicated a belief that my sexual orientation is just as valid as being heterosexual†

37. My therapist expressed beliefs that demeaned my sexual orientation*

38. My therapist indicated that my sexual orientation is not the cause of my problems†

39. My therapist’s behavior in session made me feel accepted as a LGBQ+ person†

40. My therapist reacted negatively when learning of my sexual orientation*
41. My therapist made a negative facial expression when learning of my sexual orientation*

42. My therapist made demeaning comments (such as “what a waste,” or “you don’t look gay”) about my sexual orientation*

43. My therapist seemed willing to discuss the positive and negative aspects of being a LGBQ+ person†

44. My therapist’s words or actions made me feel judged for my sexual orientation*

45. My therapist helped me identify positive aspects of my sexual orientation†

46. My therapist asked for my opinion on how my sexual orientation was related to the concerns that brought me to therapy†

47. My therapist focused only on discussing my sexual orientation, ignoring the other topics that I wanted to explore in therapy*

48. My therapist referred to me as a “homosexual” *

49. My therapist minimized my experiences of discrimination*

50. My therapist questioned or challenged my experiences of discrimination*

51. My therapist suggested that my sexual orientation is a result of a traumatic sexual experience*

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Note. *Harmful Practice; †Affirmative Practice. (R) reverse-scored; scale scores are calculated as the mean of the items on each respective scale.