Examining how lesbian, gay, and bisexual Christian clients' perceptions of therapists' cultural humility contribute to psychotherapy outcomes

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Examining How Lesbian, Gay, and Bisexual Christian Clients’ Perceptions of Therapists’ Cultural Humility Contribute to Psychotherapy Outcomes

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Abstract

Understanding the intersection between sexual and religious identity has important implications for mental health. The lesbian, gay, and bisexual (LGB) community is at high risk for major depression, generalized anxiety disorder, panic disorder, eating disorders, substance abuse issues, and poor self-esteem. Religious culture can further these risks when they create homophobic environments, resulting in LGB individuals‘ struggle to integrate religious and sexual identities (Sherry, Adelman, Whilde, & Quick, 2010).

The present study examined clients’ perceptions of their therapists’ cultural humility and religious commitment in relation to the working alliance and therapeutic outcomes. The specific hypotheses for the present study were: (H1) perceived therapist cultural humility will significantly predict psychotherapy outcomes and the working alliance for LGB Christian clients, (H2) the working alliance will at least partially mediate the relation between cultural humility and psychotherapy outcomes, and (H3) clients’ religious commitment will strengthen the relationship between perceived cultural humility and perceived working alliance.

A sample of 136 LGB Christians from a wide range of denominations who were currently or had been in psychotherapy within the last year participated in the study. Perceptions of their therapists’ cultural humility positively predicted therapeutic outcomes, and the working alliance partially mediated the relation between cultural humility and therapeutic outcomes. Contrary to predictions, self-reported religious commitment did not moderate that relation. Implications are discussed; namely, that the results of this study join existing literature to potentially suggest a systemic shift in psychotherapy training that includes cultural humility.
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Chapter I

Introduction

*The failure of academic feminists to recognize difference as a crucial strength is a failure to reach beyond the first patriarchal lesson. In our world, divide and conquer must become define and empower.*

-Audre Lorde (1979)

Many models of socially constructed identities have contributed to the literature by addressing specific, singular dimensions of identities, such as race (Cross, 1995) and gender (Martin, Ruble, & Szkrybalo, 2002). However, these models typically fail to address co-occurring identities, such as sexual orientation and religion. Furthermore, little research has been conducted on the experiences of individuals whose co-occurring identities are societally and culturally in opposition, or even competition, such as Christian and lesbian, gay, or bisexual (LGB) self-identification.

Psychotherapists tend to rely on multicultural therapy and theory (Sue, Ivey, & Pedersen, 1996) and more specifically, the multicultural orientation model (Owen et al., 2011) for navigating these co-occurring identities within their clients. That is, by taking an other-oriented stance and maintaining an openness and a lack of superiority, therapists are said to be able to help individuals navigate their intersecting identities.

Christian and lesbian, gay, or bisexual (LGB) identification is one example of co-occurring identities that are viewed by society as incongruent (Schuck & Liddle, 2001). Even though the number of American LGB Christians is on the rise (up to 48% in 2015 from 42% in 2013; Pew Research Center, 2015), many individuals who identify as both Christian and LGB
feel as if their sexual orientation excludes them from religious participation due to Christian ideology that is experienced as anti-gay (Sherry, Adelman, Whilde, & Quick, 2010).

Indeed, most sects of Christian denominations regard individuals in the LGB community as an “abomination”, and the expression of same-sex gender attraction or love as “sinful” (Drescher, 2001). Conservative Christians have championed reparative or conversion therapies (Exodus Global Alliance, 2017), which aim to change the sexual orientation of LGB individuals to be consistent with church teachings (Drescher, 2001). These therapies have been shown to be inefficacious, psychologically damaging, and are viewed as unethical and increasingly unlawful (American Psychological Association, 2009; Bancroft, 2003; Duberman, 2001; Ford, 2001).

Moreover, the Christian community is divided over the acceptance of same-sex marriage and the participation of LGB individuals in religious services. In fact, since these issues are among the most controversial facing Christian churches today (Hunt, 2016), individuals who feel caught in the crossfire of this war between the Christian and LGB cultures tend to have a highly difficult path to navigate (Sherry et al., 2010).

Historically, the rhetoric from Christian churches about LGB individuals has been damning as well as isolating (Schuck & Liddle, 2001). Even today, the rhetoric from the majority of Christian churches reflects a lack of acceptance and a negative evaluation of LGB sexuality. For example, in a 2014 statement, the General Council of the Assemblies of God wrote that LGB identities are sinful and LGB-identified individuals are prohibited from having roles in the church. While some denominations and sects of Christianity have recently changed their views to become affirming of an LGB identity and same-sex marriage (Hunt, 2016), this change is not the norm. It is not difficult to recognize the psychological ramifications of these positions for individuals who hold and value both a Christian and an LGB identification.
Historically in the field of psychology, both religious and LGB identities have neither been affirmed nor accepted. A non-heterosexual identity warranted a diagnosis of the disorder “sexual deviation” until the 1970s in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 1980), and it was not until the revised third edition of the manual that the disorder was removed (American Psychiatric Association, 1987).

Individuals with religious identities have traditionally struggled to be respected by psychological theorists. Freud (1953), for example, considered religious beliefs to be the product of an immature mind, Skinner (1986) considered religion to be a form of behavioral control, and Ellis (1980) considered it a form of irrational thinking. While the language has softened thanks to humanistic, existential, and multicultural movements (Bartoli, 2007), religion continues to be contentious in the mental health profession (Young, Cashwell, Wiggins-Frame, & Belaire, 2002). This trend continues despite evidence of the impact of therapists’ willingness to discuss and engage with religion on psychotherapy process (Richards & Bergin, 1997) and outcomes (Koenig et al., 2001).

The purpose of the present study was to investigate whether therapist cultural humility contributes to psychotherapy outcomes and the working alliance for LGB Christian clients. Clients’ religious commitment was also assessed as well in relation to clients' perceptions of their therapists’ cultural humility and the working alliance. The present study is a replication of two studies by Owen et al. (2014) and Hook et al. (2013), which will be described in more detail below.

**Therapist Factors: Cultural Humility**

To fully understand the basis for psychotherapy's effectiveness, more research is needed on therapist factors (e.g., personality characteristics, therapeutic style, way of being, etc.) that
facilitate positive therapeutic outcomes and a stronger working alliance. Wampold and Imel (2015) suggested that effective therapists have characteristics and skills that include acceptance, warmth, verbal fluency, an ability to identify how a client is feeling, and empathy. Indeed, abundant evidence indicates that empathy, congruence, working alliance, genuineness, and positive regard are strongly related to positive client outcomes (Elliott, Bohart, Watson, & Greenberg, 2011; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Flückiger, & Symonds, 2011; Kolden, Klein, Wang, & Austin, 2011).

Which personal characteristics help a therapist to be warm, empathic, or accepting of their clients? A therapist’s *multicultural orientation*, defined as the ability to maintain an open-minded and humble perspective toward others’ social identities, including race, religion, sexual orientation, gender, and socioeconomic status, (Owen, Tao, Leach, & Rodolfa, 2011) has been associated with these therapist characteristics, along with a better working alliance, and better psychotherapy outcomes (Owen et al., 2014; Paniagua, 2005; Wampold, 2007).

To delineate a training program to improve psychotherapy outcomes, the multicultural counseling competencies model (MCC; American Psychological Association, 2003; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982, 1996) was identified as a critical component of graduate training in psychology (American Psychological Association, 2012). The MCC model includes mastering the set of knowledge, attitudes, and skills that are necessary for psychotherapists to work effectively with clients from diverse backgrounds. *Multicultural orientation* (Owen et al., 2011) is a therapist quality that complements MCC. That is, while MCC generally focuses on *what therapists should do* with clients and what they should know, multicultural orientation refers to a mindset, or a *way of being* with clients. Specifically,
Multicultural orientation can be understood as an expansion of the attitude subset of the multicultural counseling competencies model (Owen et al., 2011).

Multicultural orientation is comprised of three facets (Owen et al., 2011): (a) the therapist’s ability to create opportunities to explore and incorporate clients' experiences with diverse identities within the therapy process; (b) the therapist’s comfort with and readiness to engage in these discussions; and (c) the therapist’s cultural humility, which is the core component of adopting a multicultural orientation (Owen, 2013). Cultural humility is defined as, “the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client” (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 354).

Evidence suggests that clients’ perceptions of their therapists’ cultural humility are positively associated with client engagement (willingness to bond and participate in treatment) in the therapeutic process and therapy outcomes. Clients’ perceptions of their therapist’s cultural humility contributes to the process of psychotherapy, particularly for clients whose cultural identity is particularly salient to them (Hook et al., 2013). Consistent with the MCO model, having a therapist who appears to be culturally humble, that is, who is open to different belief systems and willing to engage in discussions on diversity topics is associated with favorable outcomes (Owen et al., 2014). For example, in a study with clients who endorsed higher levels of religious commitment, perceptions of their therapists’ cultural humility was significantly associated with therapy outcomes, whereas for clients with lower levels of religious commitment, the association was not significant (Owen et al., 2014).
Religious Commitment

*Religious commitment* is defined as, “the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living (Worthington et al., 2003, p. 85). Worthington’s (1988) model of high commitment to religious identity, is based on the worldview reflected in the degree to which highly religious people integrate their faith system into much of their life, playing a vital role in how they see the world.

It was reasoned that clients’ perceptions of their therapist’s cultural humility may be particularly important for those who identify as highly committed to their religious identity. While attending to religiosity in psychotherapy is important for both the process (Richards & Bergin, 1997) and outcomes of treatment (Koenig et al., 2001; Richards & Bergin, 2000), many therapists are uncomfortable addressing or exploring religious beliefs (e.g., Frazier & Hansen, 2009; Oxhandler, Parrish, Torres, & Achenbaum, 2015). This lack of attention to religious beliefs is a missed opportunity to enhance the process and effectiveness of therapy with religious clients.

For many LGB Christian clients, these co-occurring social identities are seemingly mutually exclusive, in that neither environment feels like “home” (Bartoli & Gillem, 2008). For individuals struggling to negotiate these identities and fully integrate them into their sense of self, the conflict between Christianity and sexual minority identification can be particularly problematic (Gage Davidson, 2000; Haldeman, 2002; Lease, Horne, & Noffsinger- Frazier, 2005). Indeed, in a study by Lease and colleagues (2005) with 583 LGB individuals, participants who were involved in faith organizations that did not affirm their sexual minority identity had worse psychological health through less religiosity and more internalized homonegativity.
On the other hand, psychologists should not assume that all clients who identify as Christian and LGB are struggling to negotiate a conflict between the two identities (Sherry et al., 2010). Consistent with the multicultural orientation model, therapists should be open to discussing these identities to understand whether they need to be a focus of treatment (Bartoli, 2007).

Despite the fact that 48% of LGB Americans identify as Christian (Pew Research Center, 2015), there is surprisingly little research on this population in general (Sherry et al., 2010), and even less research on their experiences in psychotherapy in particular (Bartoli & Gillem, 2008). Therapists’ understanding the complex intersection between Christianity and LGB identities has significant consequences for these individuals’ quality of life and their mental health. Demographically, one survey with 373 participants found that among LGB respondents who identified as religious, 10.5% rejected God/religion after accepting their sexuality, and 12.4% reported continuing their beliefs but felt shame and guilt, indicating major life changes and/or emotional ramifications of their intersecting identities (Sherry et al., 2010).

Men and women who identify as LGB tend to be at increased risk for depression, substance dependence, eating and anxiety disorders, and low self-esteem, and these individuals are more likely to attempt suicide than their heterosexual counterparts (Haas et al., 2010; King et al., 2008; Woodward, Pantalone, & Bradford, 2013). Indeed, exposure to homophobic environments tends to amplify these risks, and internal conflict between sexual and religious identities has been associated with internalized homophobia, suicidality, depression, guilt, and shame (Lease et al., 2005; Schuck & Liddle, 2001; Sherry et al., 2010). The ability of the therapist to help clients negotiate their religious and sexual identities is crucial for the client’s
mental health, therapeutic outcomes, and development of a strong working alliance (Bartoli, 2007; Lease et al., 2005).

**Working Alliance and Psychotherapy Outcomes**

The *working alliance*, defined as therapist and client agreement on goals and tasks, and a strong emotional bond (Bordin, 1979; Horvath, 2000), is consistently a strong predictor of therapy outcomes (Norcross & Wampold, 2011; Wampold & Imel, 2015). Specifically, the working alliance refers to “the degree to which the therapy dyad is engaged in collaborative, purposeful work” (Hatcher & Barends, 2006, p. 293). Since the working alliance is an important aspect of therapy, understanding therapist characteristics that facilitate its development is both important and meaningful.

Recent evidence suggests that therapists’ cultural humility is one predictor of the working alliance (Hook et al., 2013). Specifically, Hook et al (2013) found that a strong working alliance accounted for the relation between clients’ perceptions of their therapists’ cultural humility and outcomes. Indeed, these authors found that 37.2% of the variance in clients’ improvement was explained by perceptions of their therapist’s cultural humility, a relation accounted for by a strong working alliance.

In another therapy study by Owen et al (2014), participants were clients who had indicated that religion was a central aspect of their identity. More than 75% of the sample reported being Christian. The authors found that clients’ religious commitment strengthened the relation between perceived therapist cultural humility and therapeutic outcomes. That is, among clients who were relatively more committed to their religion, perceptions of their therapists’ cultural humility positively predicted therapeutic outcomes. For clients who were relatively less
committed to their religion, no relationship was found between perceptions of their therapists’ cultural humility and therapeutic outcomes.

The results from Owen et al’s (2014) study suggest that clients’ religious commitment may be an indicator of how perceptions of their therapists’ cultural humility influences sessions. These results may indicate that religious clients value a therapist way of being when it involves acceptance of their faith beliefs and a willingness to explore their religious commitment. The present study replicated and expanded on Owen et al (2014) and Hook et al’s (2013) work by focusing solely on clients who identify as both Christian and LGB, and by employing all the study variables from both the Owen et al and Hook et al studies into the present investigation.

In assessing therapeutic outcomes, many authors have used pre- and post-symptom measures of change. While these data are important for understanding one aspect of psychotherapy effectiveness, the other equally important side is the clients’ perspective on therapeutic improvement. The present study used the same measures used in Hook et al (2013) and Owen et al (2014). It was reasoned that for clients who hold co-occurring identities that are seen as in conflict with one another, their therapists’ cultural humility would be a significant contribution to psychotherapy outcomes. It was hypothesized that the working alliance would at least partially explain the relation between clients’ perceptions of their therapists’ cultural humility and therapeutic outcomes. Moreover, for clients who endorse higher levels of religious commitment, the strength of this relation would be greater. For LGB clients who endorse high levels of commitment to Christianity, it was reasoned that perceptions of the working alliance would be related to perceptions of the therapists cultural humility.
Present Study

The specific research questions for the present study are: For Christian LGB clients, does their perception of their therapists’ cultural humility predict therapeutic outcomes? Does the working alliance mediate the relationship between clients’ perceptions of therapists’ cultural humility and therapeutic outcomes? Finally, does religious commitment moderate the relationship between client-perceived therapist cultural humility and working alliance? The specific hypotheses were: (H1) perceived therapist cultural humility will significantly predict psychotherapy outcomes and the working alliance for LGB Christian clients, (H2) the working alliance will at least partially mediate the relation between cultural humility and psychotherapy outcomes, and (H3) clients’ religious commitment will strengthen the relationship between perceived cultural humility and perceived working alliance (see Figure 1).
Chapter II
Method

Participants

The target population for the present study was adults who self-identify as lesbian, gay, or bisexual and Christian who had individual outpatient psychotherapy within the previous year. Male and female participants were included if they were at least 18 years of age, proficient in English, and residing in the United States. An effort was made to recruit racially and ethnically diverse participants.

An a priori power analysis was conducted to determine the number of participants necessary to achieve a power level of .80, with a studywise Type I error rate of .05. A modified Bonferroni correction was used to limit Type I error (Holland & Copenhaver, 1988). With four statistical tests, the initial per-comparison \( \alpha \) was 0.0125. In previous studies, the relation between clients’ perceptions of therapist cultural humility and the working alliance had \( r^2 = .36 \) and \( .55 \) (Hook et al., 2013); the relation between clients’ perceived therapist cultural humility and therapeutic outcomes was \( r^2 = .11 \) (Owen et al., 2014). Moreover, the contribution of religious commitment moderating the relation between perceptions of cultural humility and outcomes was \( r^2 = .23 \) (Owen et al., 2014).

Based on these previous small-to-medium effect sizes, a small-to-medium effect size was assumed (.07) with three independent variables and a per-comparison \( \alpha = .0125 \). A power analysis using G*Power software (Faul, Erdfelder, Lang, & Buchner, 2007) indicated a minimum targeted sample size of 178 participants. This sample size is consistent with recommendations for mediation power analysis suggested by Fritz and MacKinnon (2007).
The final sample consisted of a total of 136 psychotherapy clients who self-identified as lesbian (29.2%), gay (25%), or bisexual (45.8%) and Christian between the ages of 18 and 73 ($M = 33.04$, $SD = 12.93$). Participants overall outness scores ranged from 1 to 7 ($M = 4.24$, $SD = 1.56$), indicating a full range and even distribution of degree of outness. In the first part of the Cultural Humility Scale (Hook et al., 2013), participants were asked to list their three most salient cultural identities. The majority of participants in the present study listed sexual orientation (96.3%) and Christianity (88.2%) as one of their three most important identities. A different identity, such as race or gender, was listed among 15.4% of participants.

The majority of the sample self-identified as White/Caucasian (75%), with 5% Black/African-American, 4.2% East Asian/Pacific Islander, 4.2% multiracial, and 3.3% Latinx. The sample was geographically diverse, with approximately 25% of the sample residing in the northeastern, midwestern, southern, and western regions of the U.S. Complete demographic data is reported in Table 1.

**Design**

The study used an *ex post facto* non-experimental design where observed variables were measured through self-report and no manipulation was performed. The general linear model (GLM) was used as the basis for conducting a moderated mediation analysis using ordinary least squares (OLS) regression to examine the hypothesized associations between cultural humility, religious commitment, working alliance, and therapeutic outcomes (see Fig. 1).

The study included one predictor variable (clients’ perceptions of therapist cultural humility), one moderator variable (clients’ religious commitment), one mediator variable (clients’ perceptions of the working alliance), and one criteria variable (clients’ perceived therapeutic outcome). In this model, the predictor variable is associated with the dependent
variable through three pathways: (a) a direct link between the predictor variable and the criteria variable; (b) an indirect link between the predictor variable and the criteria variable through the mediator; (c) an indirect link between the predictor variable and the dependent variable through the moderated mediator (Hayes, 2013). Thus, for the present study, the relation between clients’ perceptions of their therapists’ cultural humility and therapeutic outcome was hypothesized to be mediated by working alliance. Moreover, the strength of that mediation was hypothesized to be moderated by religious commitment.

In replicating the previous literature on this topic, the same measures from the studies by Owen et al (2014) and Hook et al (2013) were chosen. Cultural humility, the predictor variable, was measured using the Cultural Humility Scale (CHS; Hook et al., 2013; see Appendix B); religious commitment, the moderator variable, was measured using the Religious Commitment Inventory (RCI-10; Worthington et al., 2013; see Appendix D); working alliance, the mediator variable, was measured using the Working Alliance Inventory - Short Form Revised (WAI-SR; Hatcher & Gillaspy, 2006; see Appendix A); and therapeutic outcomes, the criteria variable, was measured using the Patient’s Estimate of Improvement (PEI; Hatcher & Barends, 1996; see Appendix C). Descriptive information (see Appendix E) including age, gender, sexual orientation, ethnicity, level of education, student status, socioeconomic status, religious affiliation, and outness were collected in order to describe the sample. The Outness Inventory (Mohr & Fassinger, 2000; see Appendix F) was used to obtain an index of participants’ overall outness, which was used for descriptive purposes.

**Measures**

**Cultural Humility Scale.** The Cultural Humility Scale (CHS; Hook et al., 2013; see Appendix B) consists of two parts. The first part of the measure asks participants to identify up
to three identities that are most central to them and rate the importance of each on a 5-point scale from 1 (not at all) to 5 (very important). The data collected from this part of the measure was used to describe the present study sample (Table 1). The second part of the measure consists of 12 items related to perceptions of cultural humility, 7 positive and 5 negative. Specifically, participants are instructed to, “Please think about your counselor. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about your counselor. Regarding the core aspect(s) of my cultural background, my counselor…”. Example items include “acts superior” (negative), and “is open-minded” or “is respectful” (positive). Participants rate their agreement or disagreement with each statement on a 5-point scale, 1 (strongly disagree) to 5 (strongly agree).

After reverse scoring of the negative items, the score (sum of item responses), ranges from 12 to 60, with higher scores reflecting more perceived cultural humility. Internal consistency reliability has ranged from $\alpha = .86$ to $.97$ (Hook et al., 2013, 2016; Owen et al., 2014). Scores on the CHS were significantly associated with other measures of multicultural competencies (e.g., the Cross-Cultural Counseling Inventory-Revised; LaFromboise, Coleman, & Hernandez, 1991), suggesting concurrent validity, and predictive validity was supported with both the working alliance and psychotherapy outcomes (e.g., the Patient’s Estimate of Improvement; Hatcher & Barends, 2006) (Hook et al., 2013). A confirmatory factor analysis was conducted with an independent sample and fit indices suggested an acceptable fit with the two-factor structure (Hook et al., 2013). In Owen et al’s (2014) sample of clients who identified religious commitment as an important part of their identity (75.6% identified as Christian), Cronbach’s $\alpha = .92$. Cronbach’s $\alpha = 0.89$ in the present sample.
Religious Commitment Inventory. The Religious Commitment Inventory (RCI-10; Worthington et al., 2013; see Appendix D) is a 10-item measure of commitment and adherence to religion regardless of a respondent’s identification with a particular faith. Items are rated on a 5-point scale ranging from 1 (not at all true of me) to 5 (totally true of me). On the two subscales, Interpersonal Religious Commitment (4 items) and Intrapersonal Religious Commitment (6 items), examples include, “I enjoy spending time with others of my religious affiliation” (Interpersonal) and “My religious beliefs lie behind my whole approach to life” (Intrapersonal). Ranging from 10-50, the total score was used in the present study; higher total scores indicate greater religious commitment.

Internal reliabilities have ranged from $\alpha = .92$ to .98, and test-retest reliability ranged from .84 - .87 (Worthington et al., 2003). In one study, the RCI-10 was used with LGB individuals, with $\alpha = .98$ (Harris, Cook, & Kashubeck-West, 2008). Construct validity was supported by a significant correlation with the Rokeach’s (1967) Value Survey ($r = .74$), and criterion validity was supported by a significant correlation with frequency of attendance of religious activities ($r = .73$) (Worthington et al., 2003). In the present study, Cronbach’s $\alpha = .94$.

Working Alliance Inventory - Short Form Revised. The Working Alliance Inventory - Short Form Revised (WAI-SR; Hatcher & Gillaspy, 2006; see Appendix C), which is based on Bordin’s (1980) tripartite conceptualization of the working alliance, has three subscales: Bond, Goals, and Tasks. This version of the measure was revised from the Working Alliance Inventory (Horvath & Greenberg, 1989), and has 12 items. Clients are asked to reach each item on a 5-point scale ranging from 1 (seldom) to 5 (always). An example item is, “As a result of these sessions I am clearer as to how I might be able to change.” Total scores, which range from 12 to 60, were used; higher ratings indicate a stronger perceived working alliance.
The WAI-SR was validated with confirmatory factor analysis and found to have stronger psychometric properties than the Working Alliance - Short Form (Hatcher & Gillaspy, 2006), such as Cronbach’s $\alpha = .90$. The measure’s convergent validity was shown by a significant correlation with the Helping Alliance Questionnaire (Munder et al., 2010). Confirmatory factory analyses conducted with several independent samples showed that one-, two-, and three-factor models all fit the data well (Falkenström, Hatcher, & Holmqvist, 2015). Another confirmatory factor analysis showed a good model fit for the bond-task-goal model in independent samples (Munder et al., 2010). In a sample of lesbian and gay clients, the WAI-SR had a Cronbach’s $\alpha = .95$ (Kelley, 2015). In the present study, Cronbach's $\alpha = .94$.

**Patient’s Estimate of Improvement.** The Patient’s Estimate of Improvement (PEI; Hatcher & Barends, 1996; see Appendix D) is a 16-item measure that assesses improvement during psychotherapy across a variety of domains: improvement in symptom distress, work or school, general functioning, social and intimate relationships, control of life, feelings about oneself, ability to share feelings that are painful, and the benefit and helpfulness of psychotherapy sessions. Each of 14 items is assessed on a 9-point scale ranging from 1 (*very much worse*) to 5 (*no change*) to 9 (*very much better*). One general item, “To what extent have your original complaints or symptoms improved?” is rated on a 7-point scale ranging from 1 (*not at all*) to 4 (*moderately*) to 7 (*very much*). Finally, one free-response item that asks about treatment was not used for the present study. Total scores were used for the present study. Internal reliability estimates range from $\alpha = .89$ to .96. The PEI has been associated positively with pre-post symptom change (e.g., Owen & Hilsenroth, 2011). In Owen et al (2014), a study that used this measure in relation to clients’ perceptions of therapists’ cultural humility and religious commitment, $\alpha = .96$. In the present study, Cronbach’s $\alpha = .95$. 

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**Demographic questionnaire.** Participants were asked to provide information about their age, gender, sexual orientation, race/ethnicity, socioeconomic status indicators, and geographic region. This demographic information was used to describe the sample and to determine if any demographic variables should be included in the major analyses as covariates.

**Outness Inventory.** The Outness Inventory (Mohr & Fassinger, 2000; see Appendix F) is an 11-item scale that assesses the degree to which lesbian, gay, and bisexual individuals are open about their sexual orientation with individuals in the respondent’s life. Respondents are asked to rate how out they are generally to each group on a 7-point scale from 1 (*person definitely does not know about your sexual orientation status*) to 7 (*person definitely knows about your sexual orientation status and it is openly talked about*).

The OI is used to provide information about the levels of outness in three different life domains: family, everyday life, and religion. Exploratory and confirmatory factor analyses were used to derive the subscales (Mohr & Fassinger, 2000). The inventory is also used to provide an index of overall outness, which was used for the present study as a demographic characteristic. The overall outness is calculated by averaging the three subscales, Out to Family, Out to World, and Out to Religion. Data from a large sample of partnered LGB adults provided solid support for the measure’s reliability (α’s = .89 - .97).

**Procedure**

Participants were recruited through convenience and snowball sampling from a wide range of listservs, social media, public message forums, and message boards through several LGBTQ+ Christian organizations. Participants were also recruited from flyers posted in various public places including college campuses, gyms, cafes, bookstores, libraries, LGBTQ+ Christian conferences, Pride centers, and churches.
Data were collected through a secured online platform, and included an informed consent page (see Appendix G), the demographic questionnaire (see Appendix E), and the measures. Participants accessed the survey through the secure webpage (www.psychdata.com) where they read the inclusion criteria and informed consent, which described the voluntary nature of participation, the anonymity of the data, the right to withdraw at any time, and potential minimal benefits and risks associated with completing the survey. Participants indicated their consent by clicking continue in order to proceed to the survey materials.

Participants who completed the survey were re-directed to a different page where they could provide their email address in order to enter a drawing to win a $20 Amazon gift card. Participants’ email addresses were not linked to their survey responses. Additionally, participants who completed the survey were asked to share the PsychData link with others of their acquaintance who met the inclusion criteria. Participants were provided with the investigator’s name and contact information should they have any questions or concerns, as well as that of the Office of Regulatory and Research Compliance.

**Preliminary Analyses**

Of the 178 surveys collected, 40 (22.4%) participants with greater than 10% missing values were excluded from the final analyses. Tests of the assumptions of normality, homoscedasticity, and homogeneity of variances were conducted as well as case wise diagnostics to detect the presence of outliers and influential cases, i.e., Mahalanobis distance (Tabachnick & Fidell, 2007). Two cases were dropped due to outliers, resulting in a final sample size of 136. Descriptive analyses were performed for participants’ demographic characteristics, as well as for mean scores on each of the study measures, the results of which appear in Table 1 and Table 2,
respectively. Internal consistency reliabilities for all the measures were calculated and are included in Table 2.

The assumption of independence of error terms was tested through a Durbin-Watson test. Homoscedasticity, the assumption that the variance of the error terms are similar across independent variables, was checked by examining a Q-Q plot to compare error terms to a straight line (Cohen et al., 2003). Normality was checked by examining probability plots and the Shapiro-Wilks test.

Linearity was checked through plots of the standardized residuals from the regression model against the predicted values of both the predictor and criterion variables (Tabachnick & Fidell, 2012). The assumption of linearity was met. Multicollinearity was assessed through the Variance Inflation Factor (VIF) and tolerance coefficients. VIFs less than 5 and tolerance coefficients greater than .10 suggested that this assumption had not been violated.

**Major Analyses**

To test these hypotheses, a moderated mediation analysis was performed using the macro PROCESS (Hayes, 2013). Specifically, an ordinary least squares (OLS) regression analysis was conducted to estimate the parameters of the hypothesized statistical model (see Fig. 2), which included: (a) the independent variable (clients’ perceptions of their therapists’ cultural humility, $X$, assessed by scores on the CHS; (b) the mediating variable (the working alliance, $M$, assessed by scores on the WAI-SR); (c) the moderating variable (religious commitment, $W$, assessed by scores on the RCI-10); and (d) the dependent variable (psychotherapy outcomes, $Y$, assessed by scores on the PEI). The equations were the following:

**Equation 1:** $M_{\text{working alliance}} = i_1 + a_1 X_{\text{cultural humility}} + a_2 W_{\text{religious commitment}} + a_3 XW + e_M$

**Equation 2:** $Y_{\text{therapeutic outcomes}} = i_2 + c_1 X + a_2 W + a_3 XW + bM + e_Y$
Consistent with recommendations by Hayes (2013), a conditional process analysis was used to analyze the data. To test the model, regression coefficients were obtained and tested for statistical significance to estimate the indirect (mediated) association between perceptions of cultural humility and therapy outcomes through working alliance and the indirect (moderated) association between perceptions of cultural humility and working alliance.

Mediation was first evaluated by comparing the coefficient that estimates the direct association between clients’ perceptions of their therapists’ cultural humility and therapy outcomes, with the coefficient estimating the association between perceptions of cultural humility and therapy outcomes when working alliance is included in the model. Following traditional significance testing, bootstrapped 95% confidence intervals were used to test the significance of the indirect (mediation) effect in order to respect potential non-normality of the sampling distribution (Preacher et al., 2007). Sobel’s test was not used to test significance, as the data violated the assumption of normality.

It was hypothesized that working alliance mediated the relation between perceptions of cultural humility and clients’ therapeutic outcomes, particularly across participants who endorsed higher levels of religious commitment. Religious commitment scores were tested as a moderator of the relation between perceptions of cultural humility and working alliance, (e.g., that the contribution of the working alliance to therapeutic outcomes would differ depending on levels of religious commitment), while including the working alliance as a mediator between perceptions of cultural humility and therapeutic outcomes. Hayes (2013) conditional process analysis approach does not counter more classic approaches to tests of mediation (e.g., Baron & Kenny, 1986).
Hayes (2013) recommended testing the significance of the mediating effect (the working alliance) at several values of the moderator (religious commitment), allowing for the opportunity to determine the exact point at which this effect becomes significant. Specifically, the conditional indirect effect was tested at three values of religious commitment: one standard deviation below the mean (-1), at the mean (0), and one standard deviation above the mean (1). The conditional indirect effect refers to the indirect (i.e., mediated by working alliance) relationship between clients’ perceptions of their therapists’ cultural humility and therapeutic outcomes at conditional values of religious commitment (the moderator). This conditional process analysis was conducted using the PROCESS procedure in SPSS, which generated bias-corrected bootstrap confidence intervals based on 10,000 bootstrap samples, and estimated both conditional and unconditional direct and indirect effects in order to determine whether the hypotheses were supported by the data.
Chapter III

Results

Preliminary Analyses

The data were screened prior to analyses for the assumptions underlying the regression model. The assumption of normality was not supported in that the error terms were not normally distributed as indicated by a histogram and normal probability plot of standardized residuals. The assumption of independence of error terms was met based on the study design and the source of data, which was not paired nor collected through repeated-measures. The assumption of linearity was supported by the linear relation observed in a scatterplot of the variables. Examination of the scatterplot of standardized residuals with the standardized predicted values indicated that variability of the error terms was evenly and symmetrically dispersed across all levels of the independent and dependent variable, thus supporting the assumption of homoscedasticity. Finally, examination of case wise diagnostics, box plots, normal probability plots, centered leverage, and Mahalanobis distance for the presence of possible outliers indicated there were two cases exerting an undue influence on the overall model. The two cases were deleted from the sample. Therefore, the model’s ability to predict the hypothesized relationships between variables appeared to be adequate.

Preliminary analyses also tested the presence of differences across participant demographic groups on each of the study variables. Results indicated no significant differences among participants based on degree of overall outness, race/ethnicity, age, or gender. To minimize possible order effects, participants were randomly assigned to three possible orders of the study materials. One-way ANOVAs were conducted to assess the influence of administration
Descriptive statistics for all measures (means, standard deviations, skewness, and kurtosis) are shown in Table 2.

**Tests of Hypotheses**

In support of Hypothesis 1, a significant positive relation was found between CHS and PEI, such that higher clients’ perceptions of their therapists’ cultural humility predicted greater therapeutic outcomes ($B = 1.04, t_{(134)} = 6.16, p < .001$). Therapists’ cultural humility uniquely accounted for 24% of the variance in therapeutic outcomes ($F_{(1, 134)} = 37.88, p < .001; R^2 = .24$). Furthermore, a significant positive relation was found between CHS and the WAI, such that higher clients’ perceptions of their therapists’ cultural humility predicted higher working alliance ($B = .71, t_{(134)} = 6.69, p < .001$). Examination of $R^2$ indicated that therapists’ cultural humility uniquely accounted for 27% of the variance in the working alliance ($F_{(1, 134)} = 44.71, p < .001$).

In support of Hypothesis 2, the working alliance partially mediated the association between therapists’ cultural humility and clients’ therapeutic outcomes ($B = .39, t_{(133)} = 2.40, p = .018; 95\% \text{ CI } [.069, .715]$). Examination of $R^2$ indicated that therapist’s cultural humility mediated through the working alliance was found to uniquely account for 49% of the variance in clients’ therapeutic outcomes ($F_{(2, 133)} = 56.77, p < .001$).

Contrary to Hypothesis 3, clients’ religious commitment did not moderate the relation between CHS and WAI ($B = 0.004, t_{(132)} = 0.54, p = .59; 95\% \text{ CI } [-0.01, 0.02]$). Examination of the indirect effects of moderated mediation of clients’ religious commitment at three levels of the moderator religious commitment (one SD below the mean = .62, at the mean = .66, and one SD above the mean = .71). The bootstrapped confidence intervals for the estimated effects ranged from -0.01 (lower level CI) to 0.23 (upper level CI), signaling that this null finding was not likely due to the study being underpowered. Rather, the effects were similar at different levels of the
moderator. Path coefficients for the model are displayed in Figure 3, and results of the major analyses appear in Table 3.
Chapter IV

Discussion

Consistent with theory and prior research that supported the importance of therapists’ cultural humility (e.g., Hook et al., 2013), the present study found a significant positive association between LGB Christian clients’ perceptions of their therapists’ cultural humility and the working alliance. Additionally, cultural humility was positively associated with clients’ therapeutic outcomes. Specifically, when controlling for the other major variables, cultural humility uniquely accounted for 24% of the variance in therapeutic outcomes. Both findings are consistent with extant literature conducted with other client populations (Hook et al., 2013; Owen et al., 2014).

Also in accordance with previous research and theory and supporting the present study hypotheses, a significant positive relation was found between the working alliance and therapeutic outcomes. Furthermore, the working alliance partially mediated the relationship between therapists’ cultural humility and clients’ therapeutic outcomes. Specifically, the mediated model uniquely accounted for 49% of the variance in therapeutic outcomes. These findings are consistent with a wealth of prior literature in highlighting the importance of the working alliance for enhancing therapeutic outcomes (Norcross & Wampold, 2011; Wampold & Imel, 2015).

In contrast to prior research and the present hypotheses, however, results indicated that clients’ religious commitment did not moderate the mediation of working alliance between therapists’ cultural humility and clients’ outcomes. That is, the present participants’ level of religious commitment did not significantly strengthen the mediated relationship of the working alliance between therapists’ cultural humility and clients’ outcomes. This finding is not
consistent with prior research conducted with populations that were not restricted to LGB Christians (Owen et al., 2014). Owen et al. (2014) found that clients’ religious commitment strengthened the relationship between therapist cultural humility and therapeutic outcomes. That is, for clients who were relatively more committed to their religion, the perception of their therapists’ cultural humility predicted better therapeutic outcomes. For clients who were relatively less committed to their religion, no relation was found between perceptions of therapists’ cultural humility and therapeutic outcomes.

An initial concern was that the null findings in the present study were due to the study being underpowered; however, a closer examination of the indirect effects at three levels of the moderator religious commitment and the bootstrapped confidence intervals, signaled that this null finding is not likely due to the study being underpowered, but rather the effects being similar at different levels of the moderator. Hayes (2013) noted that the bootstrapping method provides some advantages to the commonly used Sobel’s test recommended by Preacher and Hayes (2004) primarily by increasing power.

The current results, therefore, point to the importance of therapists’ cultural humility and the working alliance for LGB Christian clients of varying levels of religious commitment. However, this finding is inconsistent with the theoretical underpinning of Worthington et al.’s (2003) model of religious commitment, and with previous literature supporting the importance of attending to religiosity in psychotherapy (Koenig et al., 2001; Richards & Bergin, 2000).

The unexpected finding indicating that clients’ religious commitment did not moderate the mediation of working alliance between therapists’ cultural humility and clients’ outcomes has several possible interpretations. One possibility requires a consideration of the participants in the present sample, who had an average age of 33. With a younger sample, it is possible that the
clients represented have a more progressive background, in which religiosity does not interfere with their sexual identification. Indeed, there has been a growing sect of liberal, progressive Christianity among younger populations (Griswold, 2018).

Additionally, Worthington et al.’s (2003) development of the RCI-10 included a sample of nearly 2,000 people and suggested that the normative mean for a general sample of U.S. adults is 26. Samples of professing Christians from churches, Christian agencies, students at Christian universities, and therapists at Christian agencies had means ranging from 37-46, supporting Worthington's (1988) theorizing and other research (Worthington et al., 1996). However, the present sample of Christian clients had $M = 30.35$, which is lower than Worthington et al.’s (2003) normative samples of professing Christians from various settings, but higher than the normative mean for a general sample of U.S. adults. Thus, it is reasoned that the present sample is not as religiously committed compared to a general sample of Christians, which could explain the nonsignificant findings. Of note, Mohr and Fassinger’s (2000) development of the Outness Inventory included a normative sample of nearly 1,000 lesbian and gay adults with an overall outness score of $M = 5.15$, $SD = 1.69$. The present sample of LGB Christian clients had $M = 4.24$, $SD = 1.56$, indicating a slightly less degree of outness compared to the normative sample.

Another potential explanation includes LGB-affirmative psychotherapy. It was reasoned that LGB-affirmative psychotherapy encompasses aspects of cultural humility (Moradi & Budge, 2018). Given the salience of participants’ sexual orientation, and that affirmative psychotherapy has been found to predict outcomes (Pepping, Lyons, & Morris, 2018), therapists’ cultural humility may have had a sufficiently strong impact on therapy outcome regardless of religiosity.

In one of the studies that was replicated (Owen et al., 2014), religious commitment was found to moderate the relationship between cultural humility and therapeutic outcomes. In the
present study, the model included religious commitment moderating the relation between cultural humility and the working alliance. That is, it was hypothesized that the effect on therapeutic outcomes would be through the mechanisms of bond, agreement on tasks, and agreement on goals. This hypothesis was rooted in Worthington et al.’s (2003) theory of religious commitment, which posits that individuals who are highly committed to their religious beliefs integrate their faith system into much of their daily life, which would therefore reasonably influence their tasks and goals of psychotherapy (Owen et al., 2014). Another possible explanation for this non-significant finding is that religious commitment may moderate the relationship between cultural humility and therapeutic outcomes, or moderate the relationship between working alliance and therapeutic outcomes. While cultural humility is still new in psychotherapy, future research should consider testing other models with these variables.

**Strengths and Limitations**

The present study has several limitations. To be included in this study, participants must have identified as both Christian and lesbian, gay, or bisexual. People who engaged in same-sex sexual behavior but do not identify as LGB were not recruited, as well as people who did not identify as Christian but engaged in those cultural practices or religious activities. Some LGB Christians may not have felt comfortable disclosing their sexual identity in an online survey, despite seeking services for psychotherapy; therefore, their participation was not accessed.

The sample was collected through convenience and snowball sampling; the lack of random sampling is an additional limitation due to self-selection bias. Participants who volunteered may have valued the importance of this topic more so than people who decided not to participate in the study, which may have had an impact on the validity of the findings.
Another limitation is the reliability of self-report data, and problems inherent in self-report measures, such as mono-method bias and common-method bias. These biases may have threatened the validity of the inferences that could be drawn from the results. Participants’ self-reports may not have been reliable indicators of the constructs. However, it is likely that the clients’ perceptions are what is most important in the psychotherapy process literature (Fuertes & Nutt-Williams, 2017). If clients do not perceive their therapists to be culturally humble, it is not relevant to the clients’ experience in psychotherapy (and indeed, their therapeutic outcomes and perceptions of the working alliance) if that same therapist were to self-report a high degree of cultural humility.

Despite these limitations, the present study had many strengths. There is little research on people who identify as both Christian and lesbian, gay, or bisexual (Sherry et al., 2010). Indeed, there is even less research on this population’s experiences in psychotherapy (Bartoli & Gillem, 2008). Since cultural humility is a new construct in the psychotherapy literature (Hook et al., 2013), this study adds to the research literature with a population and therapist characteristic that are relatively unknown, making it an important contribution to the literature.

Additionally, the proportion of bisexual-identified participants (37.9%) in the sample is a strength of this study, due to the history of what has been called bi-erasure in the psychotherapy literature (Israel, 2018). The sample also represents a fairly diverse population of LGB Christians in terms of Christian denomination, geographic location within the U.S., and overall outness.

Implications for Theory, Research, and Practice

The present study adds to the multicultural orientation literature (Owen et al., 2011) in which cultural humility is a relatively new construct in psychotherapy, and previous research
suggests that it plays a role in psychotherapy effectiveness (Hook et al., 2013; Owen et al., 2013, 2014). The present study provides further evidence of the importance of cultural humility by replicating significant findings with a new sample. Understanding the relationship of clients’ perceptions of therapists’ cultural humility to therapeutic outcomes with Christian and lesbian, gay, or bisexual individuals has consequences for treatment. As more is understood about the significance of cultural humility to the psychotherapy process with different populations, the question arises of how trainees learn to be culturally humble. The results of this research add to the literature in potentially suggesting a systemic shift in psychotherapy training that includes cultural humility. Indeed, perhaps cultural humility should be added to the common factors model of psychotherapeutic efficacy (Norcross & Wampold, 2011).

This study has important implications for practice because psychotherapists are often not equipped to, trained in, or comfortable working with either religious clients (Frazier & Hansen, 2009; Oxhandler et al., 2015; Post & Wade, 2009) or sexual minority clients (Johnson & Feldman, 2014; Rock, Carlson, & McGeorge, 2010). Holding both of these identities can multiply these concerns. Furthermore, less is known about religious sexual minority client populations. Identifying therapist characteristics that may strengthen the working alliance and outcomes for individuals in general, and particularly for populations who have not been thoroughly studied, such as LGB Christians, is important for practice and for growth of the profession. The present study seeks to fill a gap in the literature by understanding more about a marginalized population and their experiences in psychotherapy.

The purpose of the present study was to expand on the knowledge about individuals who identify as both Christian and lesbian, gay, or bisexual and their experiences in psychotherapy. There is little information about this group, despite some evidence that the number of lesbian,
gay, or bisexual individuals who identify as Christian is on the rise (Pew Research Center, 2015). The specific mental health challenges to which LGB individuals are susceptible to (Cochran et al., 2003), and the magnification of those challenges when exposed to homophobic environments (Lease et al., 2005; Schuck & Liddle, 2001), is alarming. Individuals who identify as Christian and lesbian, gay, or bisexual are particularly at risk for these mental health challenges (Sherry et al., 2010), so that understanding the factors that facilitate psychotherapy effectiveness is paramount for these clients’ well-being and quality of life.

**Directions for Future Research**

Future research in this area should continue to investigate the roles of religious commitment and the working alliance to cultural humility and therapeutic outcomes. Specifically, it would be important to attempt to replicate the present findings with other, more diverse samples of LGB Christians, especially in terms of gender identity diversity. This may produce more robust findings regarding the nature of the observed relationships. It would furthermore be prudent to include measures of other potential mediators and moderators, such as outness, number of psychotherapy sessions, and self-compassion. A final potential moderator could be salience of cultural identities as assessed in the initial part of the CHS (Hook et al., 2013).

Moreover, it may be especially fruitful to investigate the same study hypotheses but include participants representing major religions other than Christianity (e.g., Islam, Judaism, etc.). Understanding how religious identification influences these phenomena would be important to better understand various client populations and the factors that facilitate positive therapeutic outcomes. Additionally, using a measure of identification with political liberalism or conservatism could be a potential moderator for the present model, as more conservative
ideologies tend to reinforce negative ideals about sexual minorities and could be internalized by clients from various backgrounds. Including a measure of political liberalism or conservatism could help further understand the null finding of the moderation effects of religious commitment.

Finally, the results of this research join the literature in suggesting a systemic shift in psychotherapy training that includes cultural humility (Fisher-Borne, Cain, & Martin, 2015). Future research should include investigation of cultural humility as a state versus a trait, as this study and other relevant literature pertaining to cultural humility have begun to raise the question: Can cultural humility be taught? Furthermore, is it something that could be implemented in psychology training programs? This remains to be seen, and could be an important next step in the growth and promotion of psychotherapy effectiveness.
References


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Mahoney, D. M. (2001, Oct. 1). Gods and gays: As the church debate swirls, some congregations open their arms. *Columbus (OH) Dispatch, 1C.*


### Tables

#### Demographic Characteristics

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Note. \( N = 136 \)
Table 2

Descriptive Statistics for the Study Variables and Intercorrelations

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<th>3</th>
<th>4</th>
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<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
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<td>0.449**</td>
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</tbody>
</table>

Note. N = 136; ** p < .01, (two-tailed); CHS = Cultural Humility Scale (Hook et al., 2013); RCI = Religious Commitment Inventory (Worthington et al., 2013); WAI-SR = Working Alliance Inventory - Short Form Revised (Hatcher & Gillaspy, 2006); PEI = Patient’s Estimate of Improvement (Hatcher & Barends, 1996)
Table 3

Moderated Mediation Results

$R^2 = 0.493$, $MSE = 139.42$

<table>
<thead>
<tr>
<th></th>
<th>$B$</th>
<th>$SE$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>47.78</td>
<td>6.55</td>
<td>7.296**</td>
<td>0.000</td>
</tr>
<tr>
<td>CHS</td>
<td>0.39</td>
<td>0.16</td>
<td>2.399**</td>
<td>0.018</td>
</tr>
<tr>
<td>WAI-SR</td>
<td>0.92</td>
<td>0.12</td>
<td>7.584**</td>
<td>0.000</td>
</tr>
<tr>
<td>$CHS \times WAI-SR$</td>
<td>1.04</td>
<td>0.17</td>
<td>6.155**</td>
<td>0.000</td>
</tr>
</tbody>
</table>

**Note.** **$p < .01$, (two-tailed); CHS = Cultural Humility Scale (Hook et al., 2013); WAI = Working Alliance Inventory - Short Form Revised (Hatcher & Gillaspy, 2006).**
Figure 1

Hypothesized moderated mediation model
Figure 2

Statistical model depicting the coefficients to be tested for moderated mediation.
**Figure 3**

Path coefficients obtained for the statistical model. **$p < .01$, (two-tailed).**
Appendices

Appendix A: Working Alliance Inventory – Short Form Revised (Hatcher & Gillaspy, 2006)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of ______ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.
   ① Seldom  ② Sometimes  ③ Fairly Often  ④ Very Often  ⑤ Always

2. What I am doing in therapy gives me new ways of looking at my problem.
   ⑤ Always  ④ Very Often  ③ Fairly Often  ② Sometimes  ① Seldom

3. I believe___likes me.
   ① Seldom  ② Sometimes  ③ Fairly Often  ④ Very Often  ⑤ Always

4. ___and I collaborate on setting goals for my therapy.
   ① Seldom  ② Sometimes  ③ Fairly Often  ④ Very Often  ⑤ Always
5. ___ and I respect each other.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very Often</th>
<th>Fairly Often</th>
<th>Sometimes</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

6. ___ and I are working towards mutually agreed upon goals.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very Often</th>
<th>Fairly Often</th>
<th>Sometimes</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

7. I feel that ___ appreciates me.

<table>
<thead>
<tr>
<th></th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

8. ____ and I agree on what is important for me to work on.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very Often</th>
<th>Fairly Often</th>
<th>Sometimes</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

9. I feel ____ cares about me even when I do things that he/she does not approve of.

<table>
<thead>
<tr>
<th></th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very Often</th>
<th>Fairly Often</th>
<th>Sometimes</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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</tbody>
</table>

11. ____ and I have established a good understanding of the kind of changes that would be good for me.

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<th></th>
<th>Always</th>
<th>Very Often</th>
<th>Fairly Often</th>
<th>Sometimes</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
12. I believe the way we are working with my problem is correct.

    ①  ②  ③  ④  ⑤
    Seldom   Sometimes   Fairly Often   Very Often   Always

Note: Items copyright © Adam Horvath. Goal Items: 4, 6, 8, 11; Task Items: 1, 2, 10, 12; Bond Items: 3, 5, 7, 9
Appendix B: Cultural Humility Scale (Hook et al., 2013)

DIRECTIONS: There are several different aspects of one’s cultural background that may be important to a person, including (but not limited to) race, ethnicity, nationality, gender, age, sexual orientation, religion, disability, socioeconomic status, and size. Some things may be more central or important to one’s identity as a person, whereas other things may be less central or important.

Please identify the aspect of your cultural background that is most central or important to you:

How important is this aspect of your cultural background?

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>Somewhat important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

If there is a 2nd aspect of your cultural background that is important to you, please list:

How important is this aspect of your cultural background?

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>Somewhat important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
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<td>3</td>
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<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

If there is a 3rd aspect of your cultural background that is important to you, please list:

How important is this aspect of your cultural background?

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>Somewhat important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Please think about your counselor. Using the scale below, please indicate the extent to which you agree or disagree with the following statements about your counselor.

<table>
<thead>
<tr>
<th>Regarding the core aspect(s) of my cultural background, my counselor…</th>
<th>Strongly Disagree (1)</th>
<th>Mildly Disagree (2)</th>
<th>Neutral (3)</th>
<th>Mildly Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is respectful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Is open to explore.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Assumes he/she already knows a lot</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Is considerate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Is genuinely interested in learning more</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Acts superior</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Is open to seeing things from my perspective</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Makes assumptions about me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Is open-minded</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Is a know-it-all</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Thinks he/she understands more than he/she actually does</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Asks questions when he/she is uncertain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix C: Patient’s Estimate of Improvement (PEI; Hatcher & Barends, 1996)

Please circle the number that corresponds with the best answer to the question.

1. How unhelpful or helpful has therapy been to you?

<p>| | | | | | | | | |</p>
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<tr>
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<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Very Unhelpful</td>
<td>Moderately Unhelpful</td>
<td>Neither Unhelpful nor Helpful</td>
<td>Moderately Helpful</td>
<td>Very Helpful</td>
<td></td>
<td></td>
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</tbody>
</table>

2. How much worse or better do you think you are getting along now, compared to when you began your therapy?

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<tbody>
<tr>
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<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Very Much Worse</td>
<td>Moderately Worse</td>
<td>Neither Worse nor Better</td>
<td>Moderately Better</td>
<td>Very Much Better</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. To what extent have your original complaints or symptoms improved?

|   |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Not at all | A little | Somewhat | Moderately | Quite | Quite | Very |
| A bit | A lot | Much |

If your symptoms and complaints improved markedly, how soon after entering therapy did you experience this change? Please choose (i.e., place an X by) one timeframe.

_____ Weeks   _____ Months   _____ Years

4. How much do you feel you have benefited from or been harmed by your therapy?

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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Harmed</td>
<td>Moderately Harmed</td>
<td>Neither Harmed nor Benefited</td>
<td>Moderately Benefited</td>
<td>Very Much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A great deal Benefited</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

57
5. To what extent have your intimate relationships improved or gotten worse over the course of therapy?

<table>
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<tr>
<th>1</th>
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<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have Gotten Much Worse</td>
<td>Moderately Worse</td>
<td>Neither Worse nor Better</td>
<td>Moderately Better</td>
<td>Have Gotten Much Better</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. To what extent has your general social life improved or gotten worse over the course of therapy?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have Gotten Much Worse</td>
<td>Moderately Worse</td>
<td>Neither Worse nor Better</td>
<td>Moderately Better</td>
<td>Have Gotten Much Better</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

7. To what extent have your work and/or studies improved or gotten worse over the course of therapy?

<table>
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<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have Gotten Much Worse</td>
<td>Moderately Worse</td>
<td>Neither Worse nor Better</td>
<td>Moderately Better</td>
<td>Have Gotten Much Better</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. How much do you feel your feelings about yourself have changed as a result of psychotherapy?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changed A Lot but for the Worse</td>
<td>Changed Moderately for the Worse</td>
<td>Did Not Change</td>
<td>Changed Moderately for the Better</td>
<td>Changed A Great Deal for the Better</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. How much do you feel your behavior has changed as a result of psychotherapy?

<table>
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<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changed A Lot but for the Worse</td>
<td>Changed Moderately for the Worse</td>
<td>Did Not Change</td>
<td>Changed Moderately for the Better</td>
<td>Changed A Great Deal for the Better</td>
<td></td>
<td></td>
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</tbody>
</table>
10. How much do you feel you are able to take control of your own life at this time, in comparison to before treatment?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I take Much Less Control</td>
<td>I take Less Control</td>
<td>I take the Same Amount of Control</td>
<td>I take More Control</td>
<td>I take Much More Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. How much tolerance for painful feelings (e.g., guilt, shame, anxiety, sadness) do you have now in comparison to when you started therapy?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I have Much Less Tolerance for painful feelings</td>
<td>I have Less Tolerance for painful feelings</td>
<td>I have the Same Tolerance for painful feelings</td>
<td>I have More Tolerance for painful feelings</td>
<td>I have Much More Tolerance for painful feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Do you feel that you have become more or less free to share your feelings about your therapist directly with him/her over the course of therapy?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I have found that I shared A Lot Less of my feelings</td>
<td>I have found that I shared Less of my feelings</td>
<td>I have found that I stayed the Same in this regard</td>
<td>I have found that I shared More of my feelings</td>
<td>I have found that I shared A Lot More of my feelings</td>
<td></td>
<td></td>
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</table>

13. Overall, how satisfied or dissatisfied have you been with the therapy?

<table>
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<tr>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Dissatisfied</td>
<td>Moderately Dissatisfied</td>
<td>Neither Dissatisfied Nor Satisfied</td>
<td>Moderately Satisfied</td>
<td>Very Satisfied</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14. In general, how productive do you feel the sessions have been with your therapist?

<p>| | | | | | | | | |</p>
<table>
<thead>
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<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Very Unproductive</td>
<td>Moderately Unproductive</td>
<td>Neither Productive Nor Unproductive</td>
<td>Moderately Productive</td>
<td>Very Productive</td>
<td></td>
<td></td>
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</tbody>
</table>

15. Please estimate your change in therapy so far. Endorse a number below.

<p>| | | | | | | | | |</p>
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>-4</td>
<td>-3</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Very Much Worse</td>
<td>Much Worse</td>
<td>Moderately Worse</td>
<td>Slightly Worse</td>
<td>No Change</td>
<td>Slightly Better</td>
<td>Moderately Better</td>
<td>Much Better</td>
<td>Very Much Better</td>
</tr>
</tbody>
</table>

Hatcher & Barends, 1996
**Appendix D: Religious Commitment Inventory (RCI-10; Worthington et al., 2013)**

**Instructions:** Read each of the following statements. Using the scale to the right, CIRCLE the response that best describes how true each statement is for you.

<table>
<thead>
<tr>
<th>Not at all true of me</th>
<th>Somewhat true of me</th>
<th>Moderately true of me</th>
<th>Mostly true of me</th>
<th>Totally true of me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I often read books and magazines about my faith.

2. I make financial contributions to my religious organization.

3. I spend time trying to grow in understanding of my faith.

4. Religion is especially important to me because it answers many questions about the meaning of life.

5. My religious beliefs lie behind my whole approach to life.

6. I enjoy spending time with others of my religious affiliation.

7. Religious beliefs influence all my dealings in life.

8. It is important to me to spend periods of time in private religious thought and reflection.

9. I enjoy working in the activities of my religious affiliation.

10. I keep well informed about my local religious group and have some influence in its decisions.
Appendix E: Demographic Questionnaire

1. What is your age? ___________

2. What is your gender?
   a. Man
   b. Woman
   c. MTF Trans woman
   d. FTM Trans man
   e. Other: ______________

3. What is your sexual orientation?
   a. Gay or Lesbian
   b. Bisexual
   c. Straight
   d. Other: ______________

4. What denomination of Christianity best describes you?
   a. Catholic
   b. Protestant
   c. Mormon
   d. Orthodox
   e. Baptist
   f. Methodist
   g. Lutheran
   h. Non-denominational
   i. Other: __________

5. What is your ethnic background?
   a. American-Indian/Alaskan Native
   b. Black/African-American
   c. East Asian/Pacific Islander
   d. Hispanic or Latino/a
   e. Middle Eastern/ West Asian
   f. Multiracial
   g. South Asian
   h. White/Caucasian
   i. Other ______________

6. What is your highest level of education completed?
   a. Some high school, no diploma
   b. High school graduate, diploma or the equivalent
   c. Some college, no degree
   d. Trade/Technical/Vocational training
   e. Associate degree
f. Bachelor’s degree  
g. Master’s degree  
h. Professional degree  
i. Doctoral degree  

7. Are you currently enrolled as a student full-time?  
a. Yes  
b. No, I am enrolled part-time  
c. No, I am not a student  

8. What is your socioeconomic status?  
a. Upper class  
b. Upper-middle class  
c. Middle class  
d. Lower-middle class  
e. Lower class  

9. What is your relationship status?  
a. Married  
b. Single  
c. In a committed relationship  

10. Which of these best describes where you live?  
a. Urban setting  
b. Suburban setting  
c. Rural setting  

11. In which of these regions in the United States do you currently reside?  
a. Northeast (New England and Mid-Atlantic)  
b. Midwest (East North Central and West North Central)  
c. South (South Atlantic, East South Central, West South Central)  
d. West (Mountain and Pacific)
Appendix F: Outness Inventory (Mohr & Fassinger, 2000)

Use the following rating to indicate how open you are about your sexual orientation to the people listed below. Try to respond to all of the items, but leave items blank if they do not apply to you. If an item refers to a group of people (e.g., work peers), then indicate how out you generally are to that group.

1 = person definitely does NOT know about your sexual orientation status
2 = person might know about your sexual orientation status, but it is NEVER talked about
3 = person probably knows about your sexual orientation status, but it is NEVER talked about
4 = person probably knows about your sexual orientation status, but it is RARELY talked about
5 = person definitely knows about your sexual orientation status, but it is RARELY talked about
6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
0 = not applicable to your situation; there is no such person or group of people in your life

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. mother</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>2. father</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>3. siblings (sisters, brothers)</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>4. extended family/relatives</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>5. my new straight friends</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>6. my work peers</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>7. my work supervisor(s)</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>8. members of my religious community (e.g., church, temple)</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>9. leaders of my religious community (e.g., church, temple)</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>10. strangers, new acquaintances</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>11. my old heterosexual friends</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0</td>
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</tbody>
</table>
Appendix G: Informed Consent

Investigator Identification: This research study, Lesbian, Gay, and Bisexual Christian Clients' Experiences in Counseling, is being conducted by Kelsey A. Kangos in the division of Counseling Psychology at the University at Albany, State University of New York. This project is under the supervision of Dr. Alex L. Pieterse, who is serving as dissertation chair.

Study Description: The purpose of this research is to investigate the experiences of LGB Christian persons in psychotherapy or counseling. As part of this study you will be expected to complete several questionnaires that ask for demographic information and information about your beliefs and experiences as a LGB Christian. Completing the questionnaires should take approximately 25 minutes.

Compensation: After completing the questionnaires you will be re-directed to another database where you can choose to provide your contact information in order to enter a raffle to win one of ten $20 Amazon.com gift cards as compensation for your time. Your contact information will not be linked to your data, and will be destroyed at the end of the study.

Possible Risks and Benefits: Potential risks and benefits for participating in this study are small. A possible risk for this study involves experiencing discomfort when filling out the questionnaires while reflecting on your experiences. A possible personal benefit of this study is that by filling out the questionnaires you will gain more insight and awareness into your experiences. As with all online surveys, there is a risk of a breach of confidentiality and data security concerns. PsychData has their own security policy, which can be viewed here: https://www.psychdata.com/content/security.asp

Participant Information: Your participation in this research is completely voluntary. You may discontinue your participation in the study at any time without penalty. You may also choose to not answer any question(s) that you do not wish to, for any reason. The information that you provide will be anonymous. Your name will not appear anywhere on the questionnaires. If you provide any demographic information that could be identifying (e.g., the only member of a particular ethnic group), then this information will be combined with other participants.

On-Line Data Collection: 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 cannot be guaranteed due to the limited protections of internet access. All information obtained in this study is strictly confidential unless disclosure is required by law. In addition, the Institutional Review Board and University or government officials responsible for monitoring this study may inspect these records.

Contact Information: If you have any questions about this study or problems completing the questionnaires, please contact Kelsey A. Kangos at kkangos@albany.edu, or Dr. Alex L. Pieterse
at apieterse@albany.edu. If you would like a copy of this consent form, you should print it before clicking “Continue” below.

**IRB contact about your rights in the study or to report a complaint:** Research at the University 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 any questions concerning your rights as a research subject or if you wish to report any concerns about the study, you may contact University at Albany Office for Pre-Award and Compliance Services at 1-866-857-5459 or hsconcerns@albany.edu.

By clicking “Continue” below, you will be taken to the survey questionnaires and you are stating: “I have read the information about this study. I hereby consent to participate in the study.”

Kelsey A. Kangos
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Division of Counseling Psychology
University at Albany
kkangos@albany.edu