

Transgender Counseling Attitudes among First Year Graduate Students  
in Counseling and Clinical Psychology

by

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## ABSTRACT

Transgender individuals who seek counseling have diverse experiences, identities, and goals. In keeping with contemporary standards of care for counseling transgender individuals, effective counselors have fluid attitudes towards the treatment of transgender clients and are tolerant of diversity among transgender individuals. This paper explores transgender counseling attitudes among first year graduate students in counseling and clinical psychology, and presents results of an exploratory factor analysis of a scale measuring transgender counseling attitudes, provides data on its psychometric properties, and explores its association with counselors' beliefs in sex differences. Results revealed that the rigidity in transgender counseling attitudes scale was valid and reliable. The study found a significant association between belief in sex differences and transgender counseling attitudes. Additionally, sexual orientation moderated this relation such that higher belief in sex differences among heterosexuals was associated with more rigid transgender counseling. Implications and limitations of the study are discussed.

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## CHAPTER 1

### INTRODUCTION

Transgender individuals range widely in developmental stages, appearance, and mannerisms (Carroll et al., 2002; Steensma et al., 2011). Carroll et al. (2002) explained that while some transgender adults identify as male or female and desire sexual reassignment surgery, others feel *bigendered* or *ungendered* and have no desire to conform to a specific gender. Based on the variety of experiences that transgender individuals face, it is important for mental health professionals to be sensitive when selecting and implementing counseling techniques. Counselors must be flexible in their thinking so as not to assume that one transgender client will be similar to the next. Thus, transgender counseling practices that view transgender individuals as complex beings with diverse experiences and expectations for therapy are important if we are to better serve the needs of this population. The purpose of this paper is to (1) explore transgender counseling attitudes among first year graduate students in counseling and clinical psychology, and to present results of an exploratory factor analysis of a scale measuring transgender counseling attitudes, and (2) to explore the association between transgender counseling attitudes and counselors' beliefs in sex differences.

It is particularly important to explore counseling trainees' views towards transgender clients because these individuals are likely to provide services to transgender clients in the future. Additionally, counseling and clinical education programs can implement more effective training by better understanding trainees' attitudes towards transgender counseling and sex differences, given that

contemporary perspectives on the treatment of transgender counseling endorse a fluid perspective on gender and sexuality. In the following sections, I provide (1) an overview of current practices utilized when counseling transgender clients, and research on gender dysphoria, (2) a discussion of contemporary perspectives that impact counseling practices and attitudes towards transgender clients, finally, I (3) highlight the need for a scale to assess counseling trainees' attitudes toward transgender clients, as well as the importance of exploring the association between transgender counseling attitudes and belief in sex differences.

### **Current Practices Informing Transgender Counseling**

The American Psychological Association (2009) *Report of the Task Force on Gender Identity and Gender Variance* states that the U.S. adult transgender population is estimated to be between 115,000 to 450,000 people. It defines transgender as “the behavior, appearance, or identity of persons who cross, transcend, or do not conform to culturally defined norms for persons of their biological sex” (p. 28). Recent studies in European countries report estimates of the number of people who experience gender dysphoria as high as 1:11,900 for male-to-female individuals and 1:30,400 for female-to-male individuals (World Professional Association for Transgender Health, 2011). The prevalence rates of individuals who attend specialty clinics for gender dysphoria are 0.005% to 0.014% for natal males and 0.002% to 0.003% for natal females (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013). According to the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2013), gender dysphoria can be diagnosed when a person experiences a “marked incongruence between one’s experienced/expressed gender



and assigned gender, of at least 6 months duration” (p. 452) manifested by at least six specific symptoms for children and two specific symptoms for adolescents and adults. The diagnosis of gender dysphoria in the *DSM-5* replaced the diagnosis of Gender Identity Disorder (GID) from the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000).

Therapists have been involved in diagnosing, counseling, and referring many transgender clients with gender dysphoria (World Professional Association for Transgender Health, 2011; American Psychological Association, 2012). The World Professional Association for Transgender Health (WPATH) (2011) *Standards of Care or the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7* is a commonly used guide for mental health professionals working with transgender clients (American Psychological Association, 2009; Stein, 2012). WPATH recommends that mental health professionals play a role in exploring gender roles, discussing the impact of being a sexual minority on a person’s development and mental health, developing interpersonal skills to express gender identity, developing resilience in the face of adversity, and addressing coexisting mental health concerns. Additionally mental health professionals can provide support for family members and friends and address relationship and sexual health issues related to gender identity. However, these techniques are not further described, nor have these recommendations been tested empirically in the extent literature (WPATH, 2011).

Mental health professionals are also involved in evaluating and referring transgender clients who are seeking hormone therapy and sex reassignment surgery. WPATH (2011) recommends that all transgender individuals who seek hormone therapy or breast implants have a well-documented history of gender dysphoria, and if other mental health concerns are present, they should be addressed first by a mental health professional or appropriately trained health care provider. The recommendations for individuals seeking mastectomy and/or genital surgery are the same, in addition to the requirement of one referral letter from a mental health professional for mastectomy, and two letters for genital surgery.

Many transgender youth and adults require increased access to mental health services from practitioners who are familiar with the diversity of the transgender population (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Shipherd, Green, & Abramovitz, 2010). In Bockting et al.'s (2013) study of 1093 transgender adults, 44% reported symptoms of clinical depression, 33% reported symptoms of anxiety, and 27.5% reported symptoms of somatization. These levels compared to the 90th percentile of the community sample they obtained. Additionally the study revealed that when participants reported high levels of enacted and felt stigma, they also reported high levels of psychological distress. In Grossman and D'augelli's (2006) study of transgender youth age 15 to 21 most participants reported they lacked access to mental health providers they could trust, in addition to lacking resources necessary for access such as money and transportation. Shipherd et al.'s (2010) study of 130 transgender adults revealed that 52% of the participants were experiencing symptoms of mental illness but had

not received mental health services in the past year. Over half were concerned with stigmas related to receiving counseling. The latter underscores the importance of aligning counseling practices with the experiences of transgender individuals so as to diminish the stigma associated with receiving counseling services in this population.

### **Research on Gender Dysphoria**

The causes of gender dysphoria are unknown (Drescher & Byne, 2012; Stein, 2012). Drescher and Byne (2012) stated that the relative roles that environment and biology play in gender dysphoria are unclear. According to Meyer-Bahlburg's (2005) research on 77 adults born with XY chromosomes but assigned a female gender following penile agenesis, cloacal exstrophy of the bladder, and penile ablation, only 17 participants identified as male later in their lives. The participants who were assigned to a female gender were more likely to experience gender dysphoria than the individuals assigned to a male gender, however.

Research has shown that in many cases, gender dysphoria can desist for children and adolescents (Steensma, Biemond, Boer, & Cohen-Kettenis, 2011; Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T., 2013). Steensma et al. (2013) found that 127 adolescents who were referred for gender dysphoria in childhood and had begun socially transitioning to a different gender were more likely to have persisting gender dysphoria. Psychological functioning and the quality of peer relationships were not significant determinants of gender dysphoria persistence or desistence. Steensma et al. (2011) reported in a qualitative study that some children's gender dysphoria intensified when facing

greater social distance between the sexes, while other's dissipated. Going through puberty often distressed persisters, while desisters were more embracing of the experience. Persisters who experienced same sex attraction felt their sexual orientation confirmed their gender identities, while desisters were more likely to question their gender identity during this time.

Gender dysphoria among adults can be alleviated with and without therapeutic or medical intervention. Individuals who previously experienced gender dysphoria often report decreased gender dysphoria and higher measures of psychological well-being after starting hormonal treatment or sexual reassignment surgery (Colizzi, Costa, Pace, & Todarello, 2013; Smith, Van Goozen, & Cohen-Kettenis, 2005). Colizzi et al.'s (2013) study found that participants with gender identity disorder who received hormonal treatment had lower cortisol levels and reported less stress than prior to therapy. In Smith et al.'s (2005) study of 325 participants seeking sexual reassignment surgery, 103 participants left the study during the hormonal treatment phase, and 34 left prior to sexual reassignment surgery. Of the 162 individuals surveyed following sexual reassignment surgery, none reported gender dysphoria after treatment, but two participants expressed regrets about having surgery (Smith et al., 2005). Compared to the general population, however, individuals who have received hormonal treatment or sexual reassignment surgery still report higher levels of psychiatric morbidity (Dhejne, Lichtenstein, Boman, Johansson, Långström, & Landén, 2011).

Smaller studies have demonstrated that counseling techniques that encourage gender fluidity can also be effective in reducing gender dysphoria among

adolescents and adults (Ehrensaft, 2013; Hakeem, 2010; Menvielle, 2012; Rosenberg, 2002). Rosenberg's (2002) analysis of 12 children and adolescents who met criteria for GID showed that individual and group counseling methods that encouraged gender fluid expression and acceptance among the child and his/her parents alleviated or diminished gender dysphoria and allowed for more acceptance of alternative gender expression. Hakeem (2010) successfully utilized group therapy among adults to increase comfort with gender nonconformity by discussing gender stereotypes and discrimination, and encouraging gender fluid expression. It is important to consider how gender identity is formed and influenced by both biological and social factors. Not all individuals seeking therapy for gender dysphoria will respond to the same therapy.

### **Contemporary Perspectives with Implications for Transgender Counseling**

Psychological researchers have demonstrated how people's perceptions of the existence and immutability of biological factors can account for perceived differences between sexes (Martin & Parker, 1995; Smiler & Gelman, 2008). Psychologists often refer to this phenomenon as gender essentialism (Martin & Parker, 1995; Smiler & Gelman, 2008). Smiler and Gelman (2008) stated that "psychological essentialism suggests that categories are stable, fixed at birth, and based on biological factors" (p. 864). Psychological essentialism can be harmful when it leads to stereotyping and discrimination (Smiler & Gelman, 2008). Martin and Parker (1995) researched 464 undergraduate students and found that students who were most likely to perceive differences between men and women most often contributed these differences to biological factors. Furthermore, the more they

perceived biological differences, the more they believed these differences were immutable, or resistant to elimination.

Contemporary counseling researchers challenge assumptions of biological essentialism by describing the variance in the transgender community and stressing the importance of counselors' understanding of the fluidity of gender identity and expression (Carroll, Gilroy, & Ryan, 2002; Ehrensaft, 2013; Hakeem, 2010; Kozee, 2012; Menvielle, 2012; Rosenberg, 2002; Stein, 2012). Binary gender identities of male and female, while commonly accepted, are not appropriate for all individuals (WPATH, 2011). Kozee et al. (2012) explained that binary constructions of gender can pathologize nonconforming individuals who do not desire surgical or hormonal interventions. Some gender variant individuals experience prolonged gender dysphoria but others may never experience distress related to gender identity (WPATH, 2011; American Psychological Association, 2012). Bockting et al. (2013) cited Meyer's minority stress model as way of conceptualizing the impact of social constructions and norms on psychological distress. The results of their study led them to make the following recommendations:

Interventions, advocacy, and public policy initiatives are needed to confront the social structures (e.g., gender-segregated restrooms and social groups), norms (e.g., gender role expectations), and attitudes (e.g., prejudice in the workplace) that produce minority stress to reduce the high rates of psychological distress found among transgender and other minority populations (p. e8).

Counselors can assist transgender clients by understanding the complex societal structures that affect individual experience. While some clients might be comfortable using the bathroom of their assigned sex, others might not. The culture of a client's upbringing or workplace can dramatically affect individuals in different ways. These views are further informed by multicultural, feminist, postmodern, and queer philosophy.

Feminist, postmodern, and queer philosophy have influenced counseling by questioning categorization and opting for spectrums when beneficial for clients (Fausto-Sterling, 2012; Smith, Shin, and Officer, 2012). Smith et al. (2012) stated, "identity categories of race, class, gender, sexual orientation, and (dis)ability are less about reflecting neutral, biological, essential differences in people's abilities, orientations, and intelligences and more about social constructions which serve the primary purpose of promoting social privilege for dominant group" (p. 387). They suggested counselors increase awareness of their own biases for binary categories and avoid language that reinforces them. For instance, some clients might prefer the use of gender-neutral pronouns such as ze, zir, and zem. Fausto-Sterling (2012) encouraged mental health professionals to consider the multiple pathways that can lead to gender identity, some of which include gender stereotypes and oppositional knowledge. From developmental conceptualization to the language of counseling, mental health professionals are encouraged to consider how gender is socially constructed.

## **Measuring Transgender Counseling Attitudes and Belief in Sex Differences**

Existing measures have assisted mental health professionals who work with transgender clients when assessing client identity and clinical symptoms. The *Sex Orientation Scale*, also known as the Benjamin scale, was previously used to rate individuals' levels of gender dysphoria or transexualism (APA, 2000). Its dependence on the Kinsey scale to measure sexual orientation and binary conception of gender are problematic, as previously discussed. Scales such as *Adolescent and Young Adult Gender Nonconformity* (Toomey, Ryan, Diaz, Card & Russell, 2010) allow individuals to retrospectively examine their gender identities as teenagers on a continuum ranging from extremely masculine to extremely feminine. Eyler and Wright's (as cited in Worthington, Savoy, Dillon, & Vernaglia, 2002) *Nine-Point Gender Continuum* includes non-binary gender identities, but one side of the continuum is male and the other female. Hill and Willoughby's (2005) *Genderism and Transphobia Scale* reveals negative attitudes toward gender non-conforming individuals. Practitioners and scholars have utilized these measures to evaluate gender identity or their own biases regarding gender identity.

I selected the Sex Differences and Similarities Questionnaire in order to test for beliefs in gender stereotypes. Most research regarding sexual minorities and biological determinism has focused on how biological determinist views impact heterosexual people's views of homosexuality (Hegarty & Prato, 2008; Haslam, Rothschild, and Ernst, 2002). I did not find any studies that researched how sexual minorities differ from heterosexuals on measures of biological determinism.

Hegarty and Prato (2008) found a relationship between belief in immutability; the



belief that homosexuality is constant throughout the lifespan, and support of biological determinist views about homosexuality. Smiler and Gelman's (2008) study of college students found that male students were more likely to have essentialist beliefs and were more likely to subscribe to masculine stereotypes. Haslam et al. (2002) determined that biological essentialist beliefs are associated with prejudice against homosexuals. Based on this research, I hypothesized that on average, heterosexuals, and more specifically, heterosexual males, would have higher scores than sexual minorities on the Sex Differences and Similarities Questionnaire and Rigidity in Transgender Counseling Attitude Scale.

While taking assessments designed to measure the respondents' attitudes, respondents can also expand their multicultural competencies from the content of assessments. Yeung, Spanierman, and Landrum-Brown (2013) described the experiences of six white students who engaged in intergroup dialogue in class to discuss multicultural issues. Several students described how a meaningful aspect of the course content was reading an (1998) essay by Peggy McIntosh that provided a list of conditions where white people are institutionally privileged. As white people review this list, they can assess whether or not they are privileged and consider conditions of privilege they never previously considered. Similarly, it is my hope that the items in Rigidity in Transgender Counseling Attitudes Scale will elicit individuals with varying amounts of multicultural training to expand their transgender counseling competencies.

The proposed scale can assist counselors and counseling educators by creating awareness of counselors' attitudes toward transgender clients.

Additionally, measuring counselors' beliefs in sex differences can help us understand if there is a significant correlation between rigid transgender counseling attitudes and belief in sex differences.

### **The Present Study**

While many components of the aforementioned scales are useful for counselors and transgender clients, none of them exclusively examine counselors' gender fluid attitudes towards counseling transgender clients. This study developed a scale to evaluate first year counseling trainees' attitudes towards transgender counseling. I sampled first year counseling trainees' within two months of the start of their training in particular, so that the findings of this paper may help inform counseling and clinical educational program practices in addressing the perspectives that students bring to these programs. This research has the potential to inform future training, education and practice guidelines. Practitioners may choose to use the scale to measure their own attitudes about transgender clients, and counseling educators can use the scale to increase students' awareness about transgender counseling attitudes. In particular, the proposed scale assessing counselors' transgender counseling attitudes focuses on attitudes towards choice of pronouns, appearance, mannerisms, vocal intonation, and behaviors.

I present results from an exploratory factor analysis of the proposed items constituting the newly introduced *Rigidity in Transgender Counseling Attitude Scale* (RTCAS). To test convergent validity of the proposed measure, I used a scale assessing sex differences, given that I hypothesize that rigidity in transgender counseling attitudes will be associated positively with belief in sex differences. To

test for discriminant validity I included a measure of life orientation. I then explore the association between sample demographics, participants' endorsement of sex differences and their views on transgender counseling attitudes. Given that sexual minority individuals are in a position that pushes them to consider gender and sexuality beyond binary terms, I hypothesize that sexual minorities may be less likely than heterosexuals to believe in sex differences. At the same time, heterosexuals who do not believe in sex differences may be less likely to endorse rigidity in transgender counseling attitudes compared to heterosexuals who do believe in sex differences. Thus, I explore whether the association between rigidity in transgender counseling attitudes and belief in sex differences is moderated by trainees' sexual orientation.

## CHAPTER 2

### METHOD

#### **Participants**

One hundred first-year counseling trainees were surveyed in their 1<sup>st</sup> to 2<sup>nd</sup> month of training and were recruited from APA (American Psychological Association)-accredited and CACREP (Council for Accreditation of Counseling & Related Educational Programs)-accredited clinical mental health graduate programs. Sixty-six women (66%) and 34 men (34%) participated in the present study, ranging in age from 22 to 56, with the average age being 28.83. Seventy percent of the respondents were heterosexual, and 30% were sexual minorities. Forty percent of respondents were doctoral students and 60% were students in a master's degree program. Sixty percent of the respondents were in a clinical mental health master's program, 20% were in a counseling psychology doctoral program, and 20% were in a clinical psychology doctoral program. Forty-three percent of the sample had no previous exposure to transgender issues in their current degree program, whereas 57% reported having little to high exposure to transgender issues. I also asked participants to indicate their exposure to transgender issues prior to entering their graduate program. Fifty-eight percent had little or no exposure to transgender issues prior to their degree program, and 42% had moderate to very high amounts of exposure. In their personal lives, 76% had little or no exposure to transgender people, and 24% had moderate to very high amounts of exposure. Eighty-seven percent of the respondents had never counseled a

transgender client before, 10% had counseled between one and three clients, and three percent had counseled more than three clients.

### **Procedure**

About 90% of the participants were recruited online by advertising the survey on clinical and counseling psychology PhD and PsyD listservs, and clinical mental health master's listservs. These participants completed an online version of the survey. The remaining 10% were recruited via specific faculty who taught first year graduate students in clinical mental health graduate programs. These participants completed a paper and pencil version of the survey. The invitation to all participants included information about the study, eligibility, and notification that participants can choose to enter a drawing for a chance to win a gift card. The survey took approximately 15-20 minutes to complete.

### **Measures**

**Rigidity in Transgender Counseling Attitude Scale (RTCAS).** The Rigidity in Transgender Counseling Attitudes Scale contains 20 statements that are intended to measure counselors' attitudes regarding the treatment of transgender clients in terms of use of pronouns, behaviors, mannerisms, appearance, and vocal intonation. Likert-type response options ranged from (1) *strongly disagree*, to (5) *strongly agree*. Examples of items include, "I think it's critical for all transgender clients to learn the proper way to sit for their affirmed sex," and "I think that transgender clients always choose a masculine or feminine gender identity." A higher score in this scale indicates more rigid attitudes towards counseling transgender clients.

Results from an exploratory factor analysis of the proposed items are presented in Table 2. Cronbach's alpha for the final scale was .96.

I created the items based on informal interviews with members from a transgender support group, and the scholarly and popular literature on transgender experiences. I considered topics from essays in Bornstein and Bergman's (2010) *Gender Outlaws: The Next Generation*, Wilchins' (2004) *Queer Theory, Gender Theory: An Instant Primer*, and Stein's (2012) discussion of current issues in the treatment of gender variant and gender dysphoric children and adolescents. My thesis committee reviewed the items and provided feedback on content and structure, culminating in 23 items that were later reduced to 20 items, as described later in the paper.

**Sex differences and similarities questionnaire (SDSQ).** I measured participants' attitudes about gender stereotypes with regards to appearance, interests, and personality by using the Sex Differences and Similarities Questionnaire – Part I (SDSQ; Martin & Parker, 1995). Questions include “To what extent do men and women differ in their interests?” can be answered on a 1 to 7 scale, with 1 being *not at all different* and 7 being *very different*. Higher scores indicate stronger beliefs in sex differences. In the present study, Cronbach's  $\alpha$  was .86 for this scale. This measure was used to test for convergent validity of the Rigidity in Transgender Counseling Attitudes Scale.

**Life orientation test—revised (LOT-R).** To measure discriminant validity, participants answered a single item from LOT-R (Scheier, Carver, & Bridges, 1994). The item “In uncertain times, I usually expect the best” (p. 1073) measures optimism or pessimism using a 5-point Likert scale ranging from “I agree a lot” to “I

disagree a lot.” This measure has been cited over 2500 times on Google Scholar and Scheier et al. (1994) demonstrated convergent and discriminant validity, in addition to test-retest reliability and internal consistency (Cronbach’s  $\alpha = .82$ ) of the full measure that contains this particular item.

**Social Desirability.** The 10-item Marlowe-Crown Social Desirability Scale Short-Version (M-C SDS 2(10)) (Strahan & Gerbasi, 1972) allowed us to identify socially desirable responses. Response options are (1) *true* or (2) *false*. After accounting for five reverse coded items, “true” answers receive a score of 1 and “false” answers receive a score of 0. Scores can range from 0 to 10, with ten being high social desirability and zero being low. Cronbach’s  $\alpha$  was .72.

**Control Variables.** Participants were asked to answer demographic questions such as age, gender, sexual orientation, degree status, exposure to transgender individuals, and exposure to transgender issues in current degree program and prior to their current degree. I controlled for these variables in the data analysis because exposure to more same-sex couples may lead to more fluid views of gender (Richardson, 2007), younger individuals tend to be more open to gender diversity (Kehn & Ruthig, 2013), and sexual minorities tend to be more open to gender fluidity (Richardson, 2007). To measure exposure to same-sex couples and racial/ethnic diversity in participants’ zip codes, I obtained estimates of racial/ethnic diversity by zip code from the U.S. Census Bureau (2010) to determine the percentage of White non-Hispanics in the zip code where each participant resided. In addition, I also used the U.S. Census Bureau (2010) data to determine the percentage of same-sex couples in the zip codes where participants resided, as I

expected that exposure to same-sex couples would correlate negatively with more rigid attitudes towards transgender counseling.

### **Analytic Plan**

*Missing data.* My analysis suggested that there was missing data that appeared to be missing at random (MAR; Schafer, 1999). I had complete demographic and near complete data (1% missing) of the items in the focal measure, Rigidity in Transgender Counseling Attitudes Scale. However, the Sex Differences Scale items were each missing about 12% of responses. I addressed missingness by using multiple imputation. This method reduces error by averaging data from many imputations (Grogan-Kaylor, 2005). I created a pooled dataset based on 20 datasets with imputed values arrived at from 200 iterations.

Using the imputed data, I ran an exploratory factor analysis of the newly proposed items. Once an ideal combination of items and respective subscales were obtained, I calculated average scale scores. Then, I explored associations between all study variables using Pearson bivariate correlations. Using hierarchical linear regression, I tested whether belief in sex differences predicted rigidity in transgender counseling attitudes, while controlling for the effects of social desirability, demographics, and exposure to trans issues. Finally, I explored whether this association was moderated by sexual orientation.

Step 1 of the regression model introduced the controls: gender, sexual orientation, degree program, percent of same sex couples living in the zip code (as a measure of exposure to sexual orientation diversity), percent of white non-



Hispanics living in the zip code<sup>1</sup>. In Step 2, I entered participants' exposure to transgender people in current degree program and prior to current degree, previous exposure to transgender people in their lives, and number of transgender clients counseled in order to control for amounts of exposure to trans issues. In Step 3, I entered a control for social desirability. In Step 4, I entered the measure of belief in sex differences. In Step 5, I entered an interaction term between belief in sex differences and sexual minorities to explore if the association between belief in sex differences and rigid trans counseling attitudes is moderated by sexual orientation. Predictors were centered prior to creating the interaction term and this interaction was graphed one standard deviation above and below the mean of the moderator to indicate high and low values.

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<sup>1</sup> A limitation of this study is that race/ethnicity of participant was not available. However, participants provided their residence zip codes, which allowed me to identify the percentage of non-Hispanic whites in their respective area of residence, and which serves as a proxy for exposure to racial/ethnic diversity.

## CHAPTER 3

### RESULTS

#### *Preliminary Results*

Scale development included the creation of 23 items that were subjected to an exploratory factor analysis using principal component analysis and oblimin rotation. I used an oblique rotation method, direct oblimin, because items were correlated with each other, and correlations exceeded .32 (Tabachnick & Fidell, 2007). I determined there was one distinct factor based on examination of scree plots and factor loadings with three items being dropped due to low factor loading (below .4). These items were reverse-coded and measured participants' willingness to support transgender clients' personal preferences for how they walk, talk, and appear. Thus, I reran the exploratory factor analysis with 20 items and derived the single factor scale. These 20 items were then averaged to create one single score. Combined these 20 items yielded strong internal reliability (Cronbach's  $\alpha = .96$ ). The results from this exploratory factor analysis are presented in Table 2.

I compared participants' RTCAS and SDSQ scores based on sexual orientation (heterosexuals  $N=70$  and sexual minorities  $N=30$ ) and gender (male  $N=34$  and female  $N=66$ ). On average, sexual minorities had lower RTCAS scale scores, suggesting less rigid attitudes about counseling transgender clients,  $t(97) = 3.63, p < .001$ , Cohen's  $d = .84$ . Sexual minorities, on average, endorsed fewer beliefs in sex differences compared to heterosexuals,  $t(86) = 3.43, p = .001$ , Cohen's  $d = .76$ . The differences between males and females on RTCAS and SDSQ were not statistically significant,  $t(97) = .20, p = .84$ ;  $t(86) = .55, p = .58$ , respectively (see Table 1).

Results from a Pearson bivariate correlation indicated that there was a positive association between age of participants and exposure to trans issues in the participant's current program. It may be that participants considered their overall life experiences with trans issues when answering the question regarding exposure to trans issues in the program. It could also be that older graduate students are more aware of these issues than younger students. In addition, students in master's programs were less likely than students in doctoral programs to state that they had been exposed to transgender issues in their current degree program. Master's degree students were also less likely to have counseled trans clients compared to students enrolled in doctoral programs in clinical mental health. There were no statistically significant correlations between variables and the measure of discriminant validity, life orientation, with the exception of a positive association between life orientation and social desirability. As expected, sexual minorities were more likely to have been exposed to transgender people in their lives compared to heterosexuals. Sexual minorities were less likely to report rigid attitudes towards counseling transgender clients and beliefs in sex differences compared to heterosexuals. Finally, there was positive association between rigidity in transgender counseling attitudes and belief in sex differences (see Table 3).

#### *Hierarchical Linear Regression Results*

The regression analysis revealed that sexual minority status and prior exposure to transgender issues were both negatively correlated with rigidity in transgender counseling attitudes. Controlling for the effects of age, gender, sexual orientation, percent same-sex couples and percent white non-Hispanic in

participants' zip code, exposure to trans issues in current program, prior to entry in current program, throughout life, and amount of counseling of transgender clients, as well as social desirability, there was a positive association between belief in sex differences and rigid attitudes in counseling transgender clients (at trend level). Sexual orientation, however, significantly moderated this association such that higher belief in sex differences among heterosexuals was associated with more rigid transgender counseling attitudes.

## CHAPTER 4

### DISCUSSION

My hypotheses were correct that rigidity in transgender counseling attitudes had a strong and positive correlation with belief in sex differences (providing evidence of construct validity), and a weak correlation with life orientation (providing evidence of discriminant validity). Considering Haslam et al.'s (2002) finding that essentialist beliefs are correlated with anti-gay attitudes, and Norton and Herek's (2013) finding that negative attitudes toward transgender people are strongly correlated with negative attitudes toward gay people, we can see how biological essentialism might play a role in counseling trainees' attitudes toward transgender people. Program of study (master's vs. doctoral) and current exposure to transgender issues was correlated, with doctoral students reporting more exposure to transgender issues in their current degree programs. This is unexpected because both doctoral students and master's students were recruited in the early stages of graduate training in counseling and clinical psychology (only direct admit doctoral students were eligible to participate in the study so that the study represents new graduate students in counseling and clinical psychology). It could be that doctoral students are taking multicultural or other courses that address diversity early in their programs, and/or that they have spent more time thinking about these issues prior to applying to a doctoral program compared to master's program applicants. Counseling and clinical psychology educators may want to address these potential disparities early in their program by fostering greater awareness of transgender issues among graduate students, especially students at

the master's level. Additionally, sexual minorities were more likely to have been exposed to transgender people in their lives compared to heterosexuals. Though transgender individuals vary in sexual orientation, they have often found supportive communities among LGB people (Swain, 2007). While acknowledging the diversity of sexual orientation among transgender people, it is worthwhile to consider how transgender and LGB communities interact and generate awareness for minority groups.

The relatively low means on the rigidity in transgender counseling attitudes scale for both sexual minorities and heterosexuals, at 1.54 and 2.08 (range 1 to 5) respectively, suggest that the counseling and clinical psychology graduate students sampled for the present study did not possess highly rigid attitudes toward counseling transgender clients. This might indicate that counseling and clinical psychology graduate students are sensitive to the diversity of transgender clients, even in the early stages of a graduate program. This pattern may be reflective of a national trend advancing equality for gender and sexual minorities (Baunach, 2010). As expected, sexual minorities had a lower average score on the rigidity in transgender counseling attitudes scale compared to heterosexuals. Sexual minorities also had a statistically significantly lower mean on the measure of belief in sex differences, at 3.48 compared to 4.37 for heterosexuals (range 1.0 to 6.5). One of the reasons that graduate students in counseling and clinical psychology who identify as a sexual minority may be more tolerant of fluid gender roles among transgender individuals is because of the gender variance among the LGB community and the inclusion of transgender people in the LGBT movement (Gordon

& Meyer, 2008). Another explanation could be that sexual minorities are less likely to essentialize gender, as demonstrated by the fact that sexual orientation moderated the association between belief in sex differences and rigidity in transgender counseling attitudes, which I discuss in greater detail below.

As expected, the regression analysis revealed that sexual minority status and prior exposure to transgender issues were both negatively correlated with rigidity in transgender counseling attitudes. I expected males to have more rigid attitudes in transgender counseling compared to females because researchers have demonstrated significant differences between males and females on measures of belief in sex differences (with males reporting greater belief in sex difference; see Martin & Parker, 1995). However, this pattern was not detected among this sample of graduate clinical and counseling psychology students. This could indicate changing attitudes toward sex differences among males in general (Boudet, Petesch, & Turk, 2013). On average, there are more women than men in counseling degree programs (Michel, Hall, Hays, & Runyan, 2013), so women's favorable attitudes toward changing gender roles (Boudet et al., 2013) could be influencing male counseling trainees as well. Alternatively, the strong associations between sexual orientation and counseling attitudes, in addition to sample size, could be limiting the potential for gender differences to be significant.

Sexual orientation moderated the relation between belief in sex differences and rigid transgender counseling attitudes, such that heterosexual participants who reported having higher belief in sex differences had higher rigidity in transgender counseling attitudes, and heterosexuals who had low beliefs in sex differences had

lower rigidity in transgender counseling attitudes. Norton and Herek's (2013) study of heterosexuals' attitudes toward transgender people found that heterosexuals who endorsed binary views of gender were more likely to have negative attitudes toward transgender people, and people who were more exposed to sexual minorities were less likely to endorse negative attitudes toward transgender people. My data supports this finding, as binary views of gender are a critical aspect of belief in sex differences (Martin & Parker, 1995). Counseling and clinical psychology programs should consider challenging and questioning assumptions about, and beliefs in, sex differences to promote more openness and fluidity in transgender counseling. This could be accomplished, for example, by encouraging students to volunteer with LGBT organizations to promote their understanding and tolerance of sexual minorities' issues and concerns. Additionally, educators can assign readings or discuss research that illuminates the negative consequences of biological determinist views, such as the study by Haslam et al. (2002). They can also raise awareness about fluid gender identities by selecting gender nonconforming clients for case conceptualizations, class discussions, and video examples.

This study sampled first-year students in counseling and clinical graduate programs to help training programs understand transgender counseling attitudes of students who are just starting graduate programs in counseling and clinical psychology. Although the scale is not normed, the content (i.e., items) of the measure in of itself may be used as a means of starting a conversation about these issues with students and to encourage counseling and clinical trainees to consider new and/or important aspects of transgender counseling. For instance, educators



can ask students if they have ever considered talking to clients about their pronoun preferences, or discuss gender stereotypes involving body language. Based on these findings, counseling educators can evaluate how they approach gender identity training among heterosexuals in particular. As counseling and clinical psychology educators have learned from multicultural research, it can be very difficult for privileged groups to acknowledge and relinquish their dominance (McIntosh & Cyrus, 1998). Carefully crafted class discussions, media, readings, and assignments can help heterosexuals understand how biological determinist views benefit their own group while oppressing others.

This study also allows us to understand that counseling trainees vary in their understanding of transgender counseling issues, as participants' rigidity in transgender counseling attitudes average scores ranged from 1 (the lowest possible score) to 4 (out of 5, with 5 being highly rigid), even if, on average, the graduate students sampled in the present study tended to score low on this scale. The rigidity in transgender counseling attitudes scale can help counseling and psychology educators gauge the transgender counseling attitudes of their students.

Furthermore, counseling educators can utilize the study results and the scale to inform their curriculum and supervision. For instance, if the measure is administered to all incoming counseling and clinical psychology trainees, educators can consider the variance and average of rigidity in transgender counseling attitudes among the students in the class in order to determine how much time should be dedicated to the topic. They can also use the measure as a pre- and post-test to examine whether the course helped students understand transgender

counseling issues. Additionally, practicum supervisors can utilize the scale when talking to trainees in supervision about how they interact with gender nonconforming clients.

## CHAPTER 5

### LIMITATIONS

This study was based on a convenience sample of university graduate students in counseling and clinical programs, and therefore is not generalizable to other populations. Given that the study was advertised as a transgender counseling survey, the people who decided to participate in the study might have already been more open to fluid transgender counseling than the average counseling student. While I had data on racial/ethnic diversity in participants' zip codes, data on participants' actual race/ethnicity was not available. Additionally, a second study will be needed to run a confirmatory factor analysis of the newly introduced scale measuring transgender counseling attitudes. Although social desirability was measured and controlled for in the present analysis, the study relies on self-report, and as such, is bound to limitations associated with this method of data collection. Future studies may want to triangulate this data by comparing instructors' report of students' attitudes towards transgender counseling with students' self-report (e.g., within the context of classes that teach diversity in counseling). Given the cross-sectional nature of the data collected, no inferences about causal relations among study variables can be drawn from this study. Future studies may want to test the associations presented here using a longitudinal design.

## CHAPTER 6

### CONCLUSION AND IMPLICATIONS

The analysis presented in this article reveals preliminary evidence that the rigidity in transgender counseling attitudes scale is a valid and reliable measure to evaluate counselors-in-trainings' attitudes about counseling transgender clients, which can be used as a means of fostering discussion and thinking about transgender issues among clinical and counseling psychology graduate students. This study demonstrated that sexual minorities compared to heterosexuals, reported significantly lower rigidity in transgender counseling attitudes towards transgender clients, as well as significantly lower belief in sex differences. There was also a positive association between belief in sex differences and rigidity in trans counseling attitudes; and this relation was moderated by sexual orientation such that heterosexuals who reported greater levels of belief in sex differences, also reported more rigid attitudes towards trans counseling. Counseling and clinical educators should consider how sexual orientation and belief in sex differences intersect to influence attitudes regarding sex differences and transgender counseling. Addressing counseling and clinical graduate students beliefs in sex differences may be a fruitful avenue through which more fluid attitudes towards the treatment of transgender clients can be achieved, in addition to conferring other benefits (e.g., seeing sex differences as less rigid can also afford tolerance and openness to diversity among heterosexual and LGB clients).

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Table 1. Differences Between Study Variables by Sexual Orientation and Gender (*N* = 70 heterosexuals, 30 sexual minorities; 66 women, 34 men)

	Heterosexuals		Sexual Minorities		Cohen's <i>d</i>	Males		Females		Cohen's <i>d</i>	Overall	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		<i>M</i>	<i>SD</i>
Rigidity in Transgender Counseling Attitudes Scale <sup>2</sup>	2.08*	.74	1.54	.52	.84	1.89	.70	1.92	.75	-.04	1.92	.73
Sex Differences & Similarities Questionnaire <sup>3</sup>	4.37*	1.03	3.48	1.29	.76	4.02	1.37	4.16	1.06	-.11	4.11	1.18

Notes: \*  $p < .01$

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<sup>2</sup> 1-5 scale

<sup>3</sup> 1-7 scale

Table 2. *Rigidity in Transgender Counseling Attitudes*

*Scale*

(Overall  $\alpha = .965$ )

Item	Factor loading	<i>M</i>	<i>SD</i>
1. I think that transgender clients always choose a masculine or feminine gender identity.	.69	2.18	1.00
2. I think it is critical for all transgender clients to choose a male or female pronoun.	.78	1.98	1.01
3. I should understand that some clients benefit from not choosing a male or female pronoun	.66	1.85	.83
4. I should understand that some clients benefit from not choosing a male or female gender identity	.68	1.85	.82
5. I think it is critical for all transgender clients to learn the proper way to sit for their assigned sex.	.78	1.70	.93
6. I think it is critical for transgender clients to participate in activities that are traditional for their assigned sex.	.78	1.61	.82
7. I should help transgender clients learn the proper way to walk for their assigned sex.	.76	1.62	.80
8. I think transgender clients should use pronouns associated with their assigned sex.	.85	1.90	1.03

9. In order for transgender clients to be treated effectively, I think transgender clients should learn to identify with their assigned sex.	.77	1.99	1.15
10. I should make sure that transgender clients who identify as men but were born women emphasize a feminine appearance	.80	1.66	.84
11. I should make sure that transgender clients who identify as women but were born men emphasize a masculine appearance.	.80	1.64	.77
12. I think it is critical for transgender clients who identify as women but were born men to practice speaking with strong voices.	.82	1.67	.77
13. I think it is critical for transgender clients who identify as men but were born women to practice speaking with soft voices.	.82	1.65	.99
14. I think it is critical for transgender clients to participate in activities that are traditional for their affirmed sex.	.79	2.17	.90
15. I think it is critical for all transgender clients to learn the proper way to sit for their affirmed sex.	.83	2.04	.90
16. I should help transgender clients learn the proper way to walk for their affirmed sex.	.79	2.02	.90

17. I should make sure that transgender clients who identify as women but were born men emphasize a feminine appearance.	.72	2.08	.99
18. I should make sure that transgender clients who identify as men but were born women emphasize a masculine appearance.	.81	2.06	.97
19. I think it is critical for transgender clients who identify as men but were born women to practice speaking with strong voices.	.83	2.03	.93
20. I think it is critical for transgender clients who identify as women but were born men to practice speaking with soft voices.	.85	2.01	.91

Table 3. Correlations, Means, and Standard Deviations of Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	<i>M</i>	<i>SD</i>
1. Age	--														10.83	7.77
2. Male <sup>1</sup>	.15	--													.34	.48
3. Sex Min. <sup>2</sup>	.12	.36	--												.30	.46
4. Degree Program <sup>3</sup>	.10	-.10	-.13	--											.60	.49
5. % Same-Sex	.19	.08	.14	.33**	--										.90	.46
6. % White	-.10	-.17	-.01	.16	-.18	--									66.26	18.56
7. Exposure trans issues current program	.41**	.12	.11	-.23**	.17	-.19	--								1.90	1.00
8. Exposure trans issues prior to program	-.20	-.02	.17	.01	.05	-.03	-.17	--							2.41	1.00
9. Exposure trans people in life	.05	-.06	.35**	-.13	.09	-.06	.23*	.20*	--						2.23	1.07
10. Counseled trans clients	.23*	-.02	.12	-.33**	.16	.00	.52**	-.22*	.39**	--					1.22	.64
11. Social Desirability	.02	.04	-.06	.27*	-.06	-.06	-.11	-.02	-.11	-.22*	--				4.52	2.39
12. Rigidity Trans Counseling Attitude Scale	-.10	-.02	-.35**	.09	-.03	-.13	-.13	-.25*	-.38**	-.28**	.17	--			1.91	.73
13. Sex Diff & Similarities	.05	-.06	-.35**	.04	-.08	.01	.07	-.20	-.10	.04	.00	.29**	--		4.11	1.18
14. Life Orientation	-.01	.16	.06	-.04	.10	-.01	-.14	-.05	-.00	-.11	.26*	-.01	-.12	--	3.39	1.16

Notes: \*  $p < .05$ , \*\*  $p < .01$

<sup>1</sup>0 = female, 1 = male; <sup>2</sup>0 = heterosexual, 1 = sexual minority; <sup>3</sup>0 = doctoral, 1 = master's

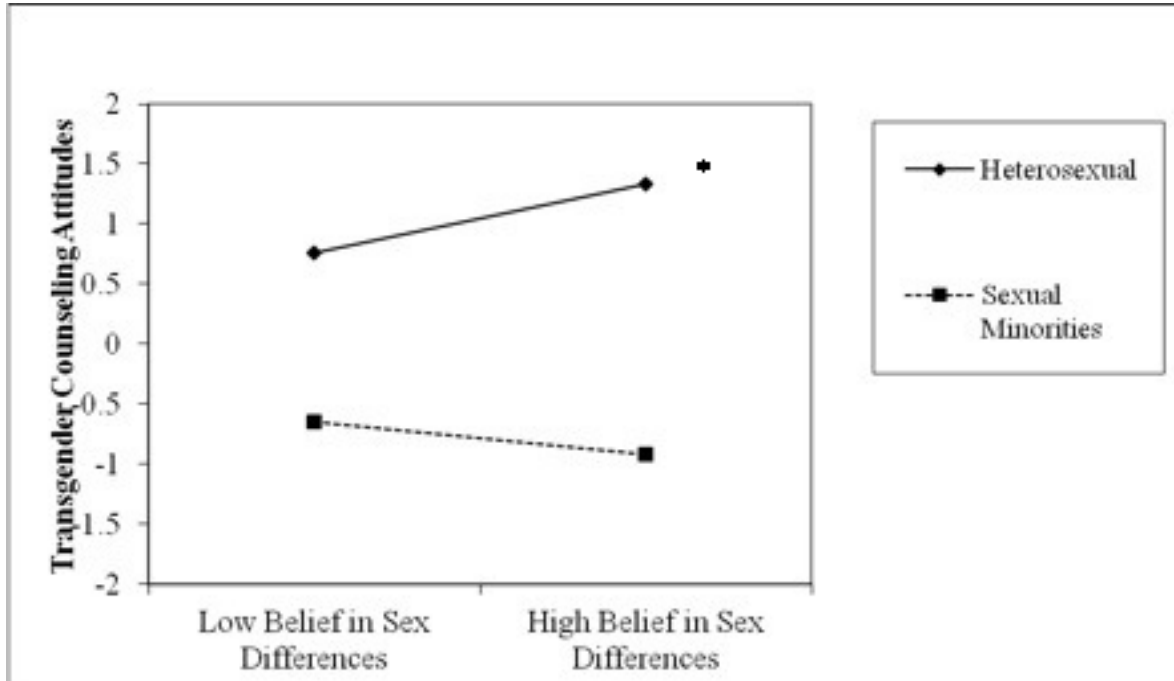
Table 4. Demographics Predicting RTCAS Scale Score ( $N = 73$ )

	$\beta$	$R^2$	$R^2$ Change	F Change	$df$
Step 1: Age	-.01	.20	.20	2.27*	73
Male <sup>1</sup>	.17				
Sexual Minority <sup>2</sup>	-.58**				
Degree Program <sup>3</sup>	.13				
Percent same sex couples in zip code	.04				
Percent white non-Hispanic in zip code	-.01				
Step 2: Exposure trans in program	.01	.35	.15	3.39**	69
Exposure trans prior to program	-.18*				
Exposure trans in life	-.11				
Amount counseled trans clients	-.25 <sup>†</sup>				
Step 3: Social desirability sum score	.03	.35	.00	.13	68
Step 4: Belief in sex differences	.10 <sup>†</sup>	.39	.04	4.47*	67
Step 5: Sex differences x sexual minority	-.41**	.45	.06	7.57**	66

Notes: \*  $p < .05$ , \*\*  $p < .01$ , <sup>†</sup>  $.06 \leq p \leq .10$

<sup>1</sup>0 = female, 1 = male; <sup>2</sup>0 = heterosexual, 1 = sexual minority; <sup>3</sup>0 = doctoral, 1 = master

Figure 1. RTCAS and SDSQ Moderated by Sexual Orientation



Note: \*  $p < .01$