

University of Denver

Digital Commons @ DU

---

Electronic Theses and Dissertations

Graduate Studies

---

8-1-2013

## Clinicians' Perceptions of the Mental Health of Gay Clients and the Effects of Diversity Competency and Modern Homophobia

Joseph M. Longo  
*University of Denver*

Follow this and additional works at: <https://digitalcommons.du.edu/etd>



Part of the [Counseling Psychology Commons](#)

---

### Recommended Citation

Longo, Joseph M., "Clinicians' Perceptions of the Mental Health of Gay Clients and the Effects of Diversity Competency and Modern Homophobia" (2013). *Electronic Theses and Dissertations*. 380.  
<https://digitalcommons.du.edu/etd/380>

This Dissertation is brought to you for free and open access by the Graduate Studies at Digital Commons @ DU. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Digital Commons @ DU. For more information, please contact [jennifer.cox@du.edu](mailto:jennifer.cox@du.edu), [dig-commons@du.edu](mailto:dig-commons@du.edu).

CLINICIANS' PERCEPTIONS OF THE MENTAL HEALTH OF GAY CLIENTS AND  
THE EFFECTS OF DIVERISTY COMPETENCY AND MODERN HOMOPHOBIA

---

A Dissertation

Presented to

the Faculty of the Morgridge College of Education

University of Denver

---

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

---

by

Joseph M. Longo

August 2013

Advisor: Ruth (Chu-Lien) Chao, Ph.D.

©Copyright by Joseph M. Longo 2013

All Rights Reserved

Author: Joseph M. Longo

Title: CLINICIANS' PERCEPTIONS OF THE MENTAL HEALTH OF GAY CLIENTS  
AND THE EFFECTS OF DIVERISTY COMPETENCY AND MODERN  
HOMOPHOBIA

Advisor: Ruth (Chu-Lien) Chao, PhD

Degree Date: August 2013

### **Abstract**

Attitudes within the psychological community regarding sexual minorities have evolved over time with a significant history of assigning pathology to lesbian, gay, and bisexual (LGB) clients. Though attitudes have shifted, prejudice has not disappeared. Modern forms of homophobia are less overt and subtler expressions of contempt, disapproval, or discrimination and are rooted in internal conflict. In mental health training programs, LGB clients have historically received little attention, failing to prepare professionals to competently work with this population; encouragingly, this trend is changing. The present study investigated how mental health clinicians assess the level of mental health of gay male clients considering modern homophobia and LGB competency. Specifically, it was hypothesized that less mental health would be assigned to gay clients when compared with heterosexual clients, higher levels of modern homophobia would lead to lower levels of assessed mental health, and LGB competency would moderate both of these associations. Eighty-six mental health trainees and clinicians were randomly assigned a case vignette with either a gay client or a heterosexual client. The vignettes maintained the same symptoms and presenting concerns, yet implied different sexual orientations. Participants completed instruments measuring the mental health of the client, modern homophobia, and diversity

competency. Results revealed that the sexual orientation of the client significantly predicted the level of mental health functioning assigned with more health being ascribed to the heterosexual client; however, LGB competency did not moderate this relationship. Modern homophobia did not significantly predict the extent of mental health assigned nor was it moderated by LGB competency. Post-hoc analyses suggested that there might be a difference in the assessment of mental health versus assessment of pathology, with the latter being significantly related to modern homophobia. Implications of the study for practice and training are discussed.

## **Acknowledgments**

I wish to express my deep appreciation to the many people who not only supported me in this research endeavor, but in my journey to becoming a psychologist and professional. I would like to acknowledge Dr. Ruth (Chu-Lien) Chao, my dissertation advisor, for her persistent encouragement, kindness, and guidance, believing in me and advocating for me throughout my graduate school experience. She has been a great mentor and has helped shape who I am as a researcher. I thank Dr. Kathy Green. She has taught me much about statistics and even more about how to be a good, compassionate, and effective professor and academic. Additionally, I express gratitude to Dr. Eugene Walls who has shared with me how research can advocate and support social change. His thoughtful comments and questions challenged me to think more deeply about the subject and apply its contents to my life and clinical practice. Thank you to Dr. Jennifer Cornish who so enthusiastically and supportively accepted the role of dissertation chair.

Finally, I would like to thank my parents and family who have been steadfast in their support and confidence in me through my successes and struggles. To my cohort members who have become incredible friends: I am thankful to have shared this journey with you and respect each of you deeply. My friends outside my doctoral program, especially Ernest, you have provided a sense of inspiration for me. Lastly, I would like to acknowledge Tom who grounded me, encouraged me, and sustained me throughout this process.

## Table of Contents

<b>Chapter One: Introduction</b> .....	1
Background of the Problem.....	1
Research Hypotheses.....	9
Summary of the Research Procedure.....	10
<b>Chapter Two: Review of Selected Literature</b> .....	12
Overview.....	12
Historical Background of Same-Sex Sexuality.....	13
Sexual Orientation and Clinicians' Perceptions of Mental Health.....	18
Sexual Orientation.....	18
Same-Sex Sexuality.....	21
Heterosexism.....	23
<i>Hypothesis 1</i> .....	29
Perceived Level of Mental Health, Sexual Orientation, and LGB Competency.....	29
LGB Competency.....	29
<i>Hypothesis 2</i> .....	37
Perceived Level of Mental Health of Client and Homophobia.....	37
Homophobia Overview.....	37
“Old Fashioned” Models of Homophobia.....	38
Modern Homophobia.....	43
Homophobia and Therapy.....	47
<i>Hypothesis 3</i> .....	55
LGB Competency and Homophobia.....	55
<i>Hypothesis 4</i> .....	58
<b>Chapter Three: Methodology</b> .....	59
Participants.....	59
Measures.....	62
Vignettes.....	62
Mental Health Inventory-18.....	63
Brief Psychiatric Rating Scale.....	66
Global Assessment of Functioning.....	68
Balanced Inventory of Desirable Responding.....	68
Modern Homonegativity Scale-Gay Men.....	71
The LGB Affirmative Counseling Self-Efficacy Inventory.....	73
Manipulation Check.....	75
Procedure.....	76
General Procedures for Statistical Analyses.....	78
<b>Chapter Four: Results</b> .....	82
Overview.....	82
Data Preparation.....	82
Analysis of Missing Data.....	83

Initial Data Exploration.....	84
Analysis of the Assumptions of Multiple Regression.....	88
Analysis of the Primary Research Hypotheses.....	91
Hypothesis 1.....	91
Hypothesis 2.....	93
Hypothesis 3.....	95
Hypothesis 4.....	96
Post-Hoc Analyses.....	97
<b>Chapter Five: Discussion.....</b>	<b>100</b>
Overview and Discussion of Hypotheses.....	100
Implications.....	113
Limitations.....	118
Future Research.....	120
Concluding Remarks.....	122
References.....	124
Appendices.....	143
Appendix A: Model Illustration.....	143
Appendix B: Key Terms.....	144
Appendix C: Measures.....	150
Clinical Vignette 1.....	150
Clinical Vignette 2.....	151
Manipulation Check.....	152
Global Assessment of Functioning.....	153
Mental Health Inventory-18.....	155
Brief Psychiatric Rating Scale.....	156
Balanced Inventory of Desirable Responding, (IM).....	158
Modern Homonegativity Scale-Gay Men.....	160
LGB Affirmative Counseling Self-Efficacy Inventory.....	161
Demographic Questionnaire.....	165
Informed Consent Form.....	171



## List of Tables

Table 1: Overview of Demographic Variables.....	60
Table 2: Overview of the Independent and Dependent Variables: Means, Standard Deviations, Ranges of Scores, Skewness, Kurtosis, and Cronbach's Alpha.....	85
Table 3: Correlation Coefficients.....	87
Table 4: Skewness and Kurtosis Values of the Residuals for Primary Hypotheses.....	90
Table 5: Hierarchical Regression of Perceived Psychological Health (MHI) on BIDR (IM), Number of LGBT Clients, and Sexual Orientation .....	92
Table 6: Hierarchical Regression of Perceived Psychological Health (MHI) on BIDR (IM), Number of LGBT Clients, Sexual Orientation, LGB-CSI, and Sexual Orientation x LGB-CSI.....	94
Table 7: Hierarchical Regression of Perceived Psychological Health (MHI) on BIDR (IM), Number of LGBT Clients, and MHS-G.....	95
Table 8: Hierarchical Regression of Perceived Psychological Health (MHI) on BIDR (IM), Number of LGBT Clients, Sexual Orientation, LGB-CSI, and Sexual Orientation x LGB-CSI .....	97
Table 9: Hierarchical Regression of Perceived Psychopathology on BIDR (IM), Number of LGBT Clients, Level of Education, and MHS-G.....	99

## **Chapter One**

### **Introduction**

Sexuality is a complex and integral part of human existence rooted in psychology and biology and influenced by culture, politics, and religion. Issues surrounding human sexuality tend to be controversial, provocative, and full of emotion as individuals and societies seek to understand the variations of the sexual continuum (Chernin & Johnson, 2003). Societal structures which assert that male-female relationships and sex practices are the ideal, normal, or preferred way of being or that assume all individuals are heterosexual maintain heterosexist ideology (Chernin & Johnson, 2003). Heterosexism is pervasive, intervening in everyday interactions in oftentimes subtle or indirect ways (Sue, 2010). More directly, in the United States, heterosexism is a politically and religiously sanctioned ideology (Chernin & Johnson, 2003). This is demonstrated by employment discrimination, and until recently, demanding that sexual minority military personnel hide their identity (i.e., Don't Ask Don't Tell) and denying same-sex marriage rights (Defense of Marriage Act), among other discriminatory policies. Likewise, most major world religions condemn same-sex sexual behavior and suggest that it is sinful or wrong (Siker, 2007; Wilcox, 2003;).

Heterosexism influences other societal structures as well. The media historically has had a role in perpetuating stereotypes, previously maintaining that the heterosexual

relationship is healthy and that same-sex relationships are odd or abnormal. Even when not affirming or propagating the pathological stereotype of gay men and lesbian women, the media *had* failed to at least challenge the status quo of heterosexism (as described historically by Martin, 1982). The media has evolved over time to include openly gay characters portrayed in dramas and comedy shows. Initially, these characters were represented in stereotypical ways as flamboyant or sexually charged (Levina, Waldo, & Fitzgerald, 2000). As such, society has had few “healthy” images of sexual minorities which is concerning as research has shown a relationship between unsupportive media and negative attitudes towards lesbian, gay and bisexual (LGB) individuals (Levina, Waldo, & Fitzgerald, 2000). Those images that did arise were frequently related to violence or victimization as “gay-bashings” or hate related crimes rise in the United States and are highly prevalent in countries around the world (Federal Bureau of Investigation, 2012). The nature and motivation for hate crimes against sexual minorities are oftentimes meant to assert masculinity while degrading and out-casting groups that threaten traditional gender-role norms (Tomsen & Mason, 2001). Highly violent, gruesome, and torturous crimes serve as warning to the rest of society to maintain the status quo (Tomsen & Mason, 2001).

Though outward signs of prejudice remain prevalent in society (e.g., hate crimes), it is curious that reports of general population attitudes are neutral if not slightly positive toward gay men and lesbian women, being especially true with younger generations (Herek & Gonzalez-Rivera, 2006). Modern prejudice theory, originally conceptualizing racial prejudice, asserts that “old-fashioned” or overt discrimination has given away to

more subtle forms of denigration of minority groups (originally proposed by McConahay, 1986). Morrison and Morrison (2002) suggest that modern prejudice theory can be appropriately applied to heterosexism and homophobia; “old-fashioned” homophobia motivated by moral/religious concerns and fear has morphed into covert hostility. Across multiple definitions is the idea that modern prejudice is rooted in internal conflict (negative feelings/attitudes toward minority groups and one’s self-perception of being non-racist/sexist/heterosexist) and ambivalence (Morrison & Morrison, 2002). This may result in paternalistic homophobia (“I would prefer that my child is not gay or lesbian because it will be harder for them”), positive stereotypic heterosexism (“Gay men take care of their bodies better than heterosexual men”), and amnesic heterosexism (“There are not inequalities that exist in today’s society between gay men/lesbian women and heterosexual men/women;” Walls, 2008, p. 26-29). Heterosexism and homophobia affect the mental well-being of gay men and lesbian women, increasing experiences of anger and anxiety (Swim, Johnston, & Pearson, 2009).

Microaggressions can be considered a manifestation of covert or modern forms of homophobia. Microaggressions tend to be the result of unconscious attitudes of people who fail to examine their personal biases and deny the significance of differences related to race, gender, or sexual orientation (Sue & Sue, 2008). These seemingly small experiences can impact sexual minorities’ views of society, feeling hostility and negativity from the larger heterosexual community (Swim et al., 2009). Such findings emphasize the connection between the oppression of one’s external environment and how that manifests in internal turmoil.

Mental health professionals and the clients they serve develop within this heterosexist context and subsequently, are affected by it (Greene, 2007). Psychological assessment and the therapeutic interaction can become a reflection of society, incorporating its darkest, most discriminatory practices. In fact, the view of LGB populations by the major organizations of the psychological community shifted as recently as 1984 with the removal of ego-dystonic homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, with the diagnosis of homosexuality being removed just slightly before in 1973 (Boysen, Vogel, Madon, & Wester, 2006; Cramer, Golom, LoPresto, & Kirkley, 2008). Philosophical remnants from the era before these assertions were made by the American Psychiatric Association (APA) still remain as clinicians and clients alike reject the possibility of same-sex sexuality as a normal variant of human sexuality and see it as a mental disorder and personal choice (see, for example, Nicolosi, 1991). After changes were made in the mental health diagnostic structure, bias against sexual minority clients, including homophobia, may have become more covert, consistent with modern prejudice theory (Brown, 1996). In other words, it became unacceptable for clinicians to pathologize LGB clients, and therefore, clinician biases were left to fester without discussion (Brown, 1996). The American Psychological Association's (2011) guidelines for working with LGB clients asserted directly that same-sex attraction, related feelings, and accompanying behaviors are "normal variants of human sexuality" and are to be addressed as such in working with clients.

Even though stereotypes and prejudice continue to exist, one may have expected interventions with the intention of treating or even "curing" gay men and lesbian women

to disappear in 1973 as it no longer was formally pathologized by the psychological community (Haldeman, 2002). There has been a re-emergence of such techniques known collectively as conversion or reparative therapy which suggests that segments of the population and mental health community maintain the view that sexual orientation, specifically a gay or lesbian orientation, is a changeable state, severely abnormal, and morally/religiously objectionable (Haldeman, 2002). Psychology, a discipline that embraces the scientific method, looks to evidence in order to decide the usefulness of therapeutic techniques. Spitzer (2003) conducted a study intended to investigate the success of conversion therapy. He found a decrease in the percentage of people who scored highly on a measure of same-sex attraction, a measure of sexual orientation identity, and in the number of same-sex sexual experiences. An important finding in this research was that there was a sharp decline in participants' perception of distress from the pre to post measures whether or not sexual orientation actually changed (Drescher & Zucker, 2006). The scientific community, however, highly criticized the work of Spitzer for its retrospective methodology, religiously recruited sampling, and unreliable measures (Drescher & Zucker, 2006). Other researchers provided evidence that conversion therapy was actually quite harmful to clients linking its use to long-term sexual dysfunction, lowered self-esteem, and an increase in depression and anxiety (Cramer et al., 2008). These results bring in to question important foundational ethical principles of psychology in relation to the practice of conversion therapy including beneficence and non-maleficence. *Just the Facts about Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel*, a publication endorsed by major

psychological, medical, social service, and educational organizations, opposed the use of conversion tactics on ethical grounds and asserted that counseling can be best utilized to explore openly sexual identity (American Psychological Association, 2008).

With heterosexism and homophobia as a part of the cultural backdrop, psychologists are charged with the responsibility of treating clients who are presenting for mental health concerns and who identify as sexual minorities with competence and ethical practice. The internalization of heterosexist and homophobic attitudes on the part of psychologists may lead to problematic manifestations in the therapeutic process, including over-diagnosis of sexual minority clients.

The APA Committee on Gay and Lesbian Concerns historically commissioned a comprehensive review of psychologists' therapeutic work with gay and lesbian clients, investigating possible biases that may arise in assessment and treatment (Garnets et al., 1991). The review, a landmark investigation in this area, indicated a number of emerging themes during that time period. Specifically, there was a tendency to view same-sex sexuality as psychologically problematic, to over-associate presenting issues with sexual orientation issues, to de-mean or devalue the client's sexual orientation identity, and to misunderstand the potential consequences of coming out. The clinician's understanding of her/his gender and sexual orientation identity interacts with that of the client (Dillon, Worthington, Soth-McNett, & Schwartz, 2008). Therefore, a sexual minority client may serve as a threat to traditional gender-role norms and subsequently, challenge the expectations that the clinician possesses about the social world, creating the potential for discomfort (originally indicated by DeCrescenzo, 1983; Goodman & Moradi, 2008).

Additionally, the LGB client may prompt the clinician to explore her/his gender identity and sexuality (Dillon, Worthington, Soth-McNett, & Schqartz, 2008). The danger is that a client's internal homophobia may go unchallenged as the clinician similarly colludes with such homophobic beliefs (Henke, Carlson, & McGeorge, 2009).

There are a few studies that have investigated the relationship between client sexual orientation and perceived level of mental health as ascribed by clinicians with some conflicting results (see Bowers & Bieschke, 2005; Garfinkle & Morin, 1978; Mohr, Weiner, Chopp, & Wong, 2009; Rubinstein, 2001). A study conducted after the initial removal of ego-dystonic homosexuality from the *DSM* found significant differences in how clinicians rated heterosexual versus gay clients with more pathology assigned to sexual minorities (Garfinkle & Morin, 1978). Rubinstein (2001) found similar results with a sample of Israeli clinicians nearly twenty years after changes were made in the *DSM*. Additionally, there is evidence that an interaction effect between participant gender (clinician gender) and the sexual orientation of the client exists, specifically in regard to the likelihood of threats of harm to others. Male psychologists tended to pathologize more aggressively than female psychologists (Bowers & Bieschke, 2005).

Mental health professionals encounter LGB clients on their caseloads at a rate of about 3%, or one disclosed sexual minority per week (Murphy, Rawlings, & Howe, 2002). This is likely an underestimate as disclosure may be delayed, avoided, or deemed as unimportant to the presenting issue. Since client sexual orientation oftentimes is unknown by the clinician at the time of intake, providing an affirmative approach to counseling all clients is recommended (Matthews, 2007). Competent counseling with



diverse populations begins with good training within graduate programs. Research indicates that increased training in diversity issues reduces counselors' heterosexist biases and increases therapeutic skills in working with the LGB population (Rutter, Estrada, & Diggs, 2008). Phillips and Fischer (1998) studied the extent to which training to work with LGB clients is included in graduate school training models. These authors found a large majority of their graduate student sample felt unprepared to work with sexual minorities and transgender clients as compared to their preparation for treating heterosexual clients. Their report indicated that the modal number of articles read as part of graduate coursework regarding LGB issues, the modal number of LGB clients with whom respondents worked, and the modal number of on-site practicum training related to this issue all were zero. Differential preparation for working with those identifying as gay versus lesbian versus bisexual was investigated. Even within the LGB population, not all were covered equally in training. Specifically, students tend to feel more prepared to counsel gay and lesbian clients as compared to bisexual clients. This trend was consistent with the lack of coursework regarding bisexuality and also reflected the rarity of students' experiences in clinical rotations with bisexual clients (Phillips & Fischer, 1998). Current guidelines to working with LGB clients according to the American Psychological Association (2011) include a call for specific training for students and practicing psychologists through coursework, continuing education, and supervision.

Considering the history of same-sex sexuality in the mental health and medical health professions, issues of heterosexism and modern homophobia, and the current preparation of clinicians in graduate school, the present project seeks to understand how

mental health professionals work with sexual minority clients. The current study will examine the perceived mental health that clinicians attribute to gay clients versus heterosexual clients seeking counseling for the same presenting problem taking into consideration modern homophobia and LGB clinical competency and controlling for impression management. By way of introduction, it is necessary to understand the nature of sexual orientation, heterosexism, and homophobia, as well as the psychological needs of gay men, and the complexity of LGB practitioner competency. Four specific hypotheses will then be tested related to client sexual orientation, level of modern homophobia, and perceived level of mental health functioning.

The following four hypotheses will be discussed individually in light of current literature, and subsequently, will be tested through a hierarchical multiple regression analysis: 1) The sexual orientation of the client will significantly predict the extent of mental health perceived by clinicians controlling for social desirability and level of experience. 2) Level of LGB competency will moderate the relationship between sexual orientation and the mental health perceived by clinicians when social desirability and level of experience are controlled. In other words, there will be an interaction between sexual orientation and LGB competency. Specifically, those with high LGB competency treating a gay client will rate level of mental health as not statistically different than the level of mental health assigned to the heterosexual client while those with low competency will rate the level of mental health as less for the gay client in comparison to the heterosexual client. 3) Level of modern homophobia will significantly predict the extent of perceived mental health by clinicians when social desirability and level of

experience are controlled. 4) Level of LGB competency will moderate the relationship between level of modern homophobia and the extent of mental health perceived by clinicians when social desirability and level of experience are controlled. As in hypothesis two, this means that there will be an interaction between level of homophobia and level of LGB competency. Those with high levels of homophobia will assign less mental health differentially based on level of competency (See Appendix A).

In order to investigate the hypotheses listed above, the following design was adopted. Mental health professionals who were either in training or have completed training in clinical or counseling psychology were invited to participate in this study via the Internet. Upon logging in, participants were randomly assigned to a condition and reviewed the informed consent form. First, the respondents were presented with a short intake report in which all clinical symptoms were held constant across all groups. The only identifying information that was manipulated from the experimental group to the control group was the sexual orientation of the client. After reading the intake report, participants completed the following measures: Mental Health Inventory (MHI; Veit & Ware, 1983), Brief Psychiatric Rating Scale (Overall & Gorham, 1972), Global Assessment of Functioning (GAF; American Psychiatric Association, 2000), Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1991), Modern Homophobia Scale-Gay Men (MHS; Morrison & Morrison, 2002), the Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Scale (LGB-CSI; Dillon & Worthington, 2003), and a demographic questionnaire.

With the resulting data, four hierarchical linear regression analyses were conducted in two to three steps. The first step consisted of control variables including the demographics and the BIDR score. The next step consisted of the variables of interest including the sexual orientation of the fictitious client (the manipulated variable in hypothesis 1 and 2) or the level of homophobia of the participant (hypothesis 3 and 4). The third block consisted of the following interaction effects: sexual orientation by LGB competency (hypothesis 2) and homophobia by LGB competency (hypothesis 4).

## **Chapter Two**

### **Literature Review**

#### **Overview**

The conceptualization of same-sex sexuality has a complex history within the field of psychology with a major paradigm shift occurring in the 1970's (Wilcox, 2003). The initial portion of the literature review will explore the historical background of same-sex sexuality tracing its understanding in psychology from Freud to Stonewall and beyond. As psychology began to organize as a scientific pursuit with roots in philosophy and physiology rather than in religion in the late 1800's and early 1900's, the view of same-sex sexuality was subsequently affected (Schultz & Schultz, 1992). Understanding its background will help to locate historical remnants in present day thought.

The concept of sexual orientation will then be defined and explored. There is a tendency to view sexuality as discrete categories of identities; however, a review of relevant literature indicates that a sexual orientation continuum may better capture the lived experience of humans in general, but sexual orientation minorities in particular (Chernin & Johnson, 2003; Kinsey et al., 1948). As sexual orientation minorities express their identities, society, including mental health professionals, has reactions; therefore, the subsequent section describes heterosexism and its effect on sexual orientation minorities and manifestation in the counseling relationship. The highly related term of

modern homophobia must then be described, emphasizing its oftentimes subtle characteristics.

These discussions set the stage for a review of the literature related to each research hypothesis. Sexual orientation as a predictor of perceived mental health is explored; studies are reviewed that address perceptions in psychology which suggest that clinicians still view same-sex sexuality as a mental illness or a pathological condition (see section titled *Sexual Orientation and Clinicians' Perceptions of Mental Health*; Garnets, 2003; Rubinstein, 2001). Subsequently, an exploration of LGB competency, the state of LGB training in the field and in graduate programs, and the prevalence of LGB clients follows in order to address the hypothesis asserting that LGB competence moderates the relationship between the sexual orientation of the client and the perception of mental health of the client as assessed by the clinician (see section titled *Perceived Level of Mental Health, Sexual Orientation, and LGB Competency*). Homophobia is then explored as a predictor of perceived mental health. Models of “old-fashioned” homophobia, modern prejudice theory, and the ways homophobia affects the therapeutic process are analyzed (see section titled *Perceived Level of Mental Health of Clients and Homophobia*; Kantor, 2009; Morrison & Morrison, 2002). Finally, competence is discussed as a moderating variable in the relationship between homophobia and perceived mental health (see section titled *LGB Competency and Homophobia*).

### **Historical Background of Same-Sex Sexuality**

Same-sex sexuality has been recorded across time and place, reaching into history and across cultures. Ancient cultures like the Greeks and Romans, for example, not only

permitted, but also encouraged same-sex relations (Gramick, 1983). In the early 20<sup>th</sup> century, a “medicalization” of same-sex sexuality took place in which it was seen as an illness to be cured (Wilcox, 2003). Freud, who was practicing and writing about psychoanalysis around that time, was curious, though respectful of gay men, forbidding discrimination in the opportunity for psychoanalytic training based on a same-sex sexual orientation (Lewes, Young-Bruehl, Roughton, Magee, & Miller, 2008). Freud approached this issue with scientific curiosity, rather than moralistic criticism. He was influenced by Darwinism, which saw no evolutionary value in same-sex behavior and subsequently characterized such desire as a biological anomaly (Lewes, Young-Bruehl, Roughton, Magee, & Miller, 2008).

Following the dominant medical and psychological understandings of same-sex sexuality, the United States military developed formal procedures to screen out, for psychiatric reasons, recruits who were demonstrating gay tendencies (Herek & Garnets, 2007). In the aftermath of World War II, psychoanalysis encountered great changes as the cultural landscape evolved. As the concepts and practice of psychoanalysis were transferred to New York City, the theory and its followers became less critical of social norms and more endorsing of them (Lewes et al., 2008). Sandor Rado, a Hungarian-American psychoanalyst and founder of the Columbia University Center for Psychoanalytic Training and Research, asserted in the 1940’s that “homosexuality is a pathological and regrettable result of psychic development gone wrong” (as cited in Lewes et al., 2008, p. 302). His statement was representative of the school of thought of psychoanalysis during that period. In accordance with this perspective, gay clients were

pitied and viewed as individuals with stunted psychological development, a faulty superego (moral capacities), and void of human feeling. Some published work from the psychoanalysis literature of the time called for extreme measures including castration and incarceration of gay men who were seen as detrimental to society (Lewes, et al, 2008). It was during this period that medical doctors and psychoanalysts were charged with the responsibility of treating or even curing same-sex sexuality. The American Psychiatric Association (APA) in 1942 used the term “Psychopathic with Pathologic Sexuality” to describe and categorize gay men and lesbian women. This diagnosis represented a severe personality disturbance and suggested antisocial traits. Silverstein (2007) indicates that during this time in history two questions were asked: “What causes homosexuality and how can we cure it?” (p. 11). This was reflected in the abundance of psychiatric presentations at APA conventions that outlined treatments for gay men and lesbian women (Drescher, 2003). With such a strong anti-gay stance from the most powerful behavioral health organization in the United States, a general sense of distrust of psychiatrists and psychologists by gay men and lesbian women resulted—mental health professionals were seen as the enemy (Silverstein, 2007).

The medical paradigm espoused by the APA seeped into the cultural framework of the United States and became a pervasive attitude not only for mental health professionals, but also for the general public (Wilcox, 2003). The late 1940’s brought the controversy over sexuality to the forefront in the United States with the publication of Kinsey’s revolutionary research on sexual behavior. Though Kinsey was widely criticized for his sampling methods, this study served as an impetus for social change,



especially with his findings that a third of respondents had same-sex sex to the point of orgasm—results that were truly shocking to the public (Silverstein, 2007). It must be noted that this research investigated sexual behavior rather than sexual identity.

Nevertheless, this set the stage for a new understanding of sexuality when the cultural climate would allow it to emerge.

On a social level during the 1950's and 1960's (and continuing well-beyond), gay men and lesbian women were held hostage by the fear of being exposed publicly—and for good reason (Silverstein, 2007). Police raided gay bars with reporters in tow to take pictures and publish the names of those found in these establishments; personal and professional ramifications resulted including the revocation of one's ability to practice in certain disciplines, dishonorable discharge from military service, fines, jail time, and threats of violence (Silverstein, 2007). An acceptable legal defense in some cases for hefty charges like interpersonal violence and even murder was any indication that the victim made a same-sex sexual advance toward the perpetrator (Silverstein, 2007).

June of 1969 brought riots at the Stonewall Inn, a gay bar in New York City, as police ransacked and harassed patrons. The enraged clientele fought back by throwing bottles and other objects at the police as aggressive riots ensued (Hall, 2005). Though gay activists were present before this event, the Stonewall riots marked, in a public way, the beginning of the gay liberation movement which continues to be celebrated yearly with highly attended gay pride parades and events (Wilcox, 2003). The message of this new movement was that “homosexuality was not an illness or aberration but a valid innate identity” (Wilcox, 2003, p. 40).

In 1972, gay psychologists began courageously to identify themselves as such. Charles Silverstein (2007) described his presentation at the Association for the Advancement of Behavior Therapy convention. He indicated the importance of this presentation to this particular audience because behavior therapy, including torturous aversion therapy, was being used commonly as a method of psychological “treatment” for gay men and lesbian women (Silverstein, 2007). As an understanding of how the diagnosis of homosexuality had harmed the gay community and as voices of gay psychologists and psychiatrist intensified, the question of whether to include homosexuality in the *DSM* came to discussion amongst the nomenclature committee in 1973. Though psychoanalysts presented a hearty fight in opposition to removing this diagnosis, the ultimate decision was one of compromise (Silverstein, 2007). Clients who demonstrated distress as a result of their same-sex orientation were labeled as having a “Sexual Orientation Disturbance” and those who did not were considered “normal.” “Sexual Orientation Disturbance” later became “Ego-Dystonic Homosexuality” which then was removed entirely from the diagnostic system endorsed by the APA in 1983 (Silverstein, 2007). After its removal, societal attitudes slowly changed, especially for segments of the population who valued scientific opinion (Drescher, 2008). On a legal level, states began to overturn sodomy laws, which were present in all 50 states. As of 2003, a Supreme Court ruling overturned the remaining sodomy laws across the country (Drescher, 2008). The American Psychiatric Association, as indicated by Silverstein (2007), truly was the gatekeeper of societal change. These major historical events affecting the view of same-sex sexuality from a social, political, and psychological

perspective are relatively new advances and therefore, continue to impact the psychological/psychiatric conceptualization of gay men and lesbian women. The American Psychological Association (2011) has recently updated practice guidelines for working with LGB clients. These guidelines clearly state that same-sex sexuality is not abnormal or pathological, that LGB clients experience unique challenges of oppression and discrimination, that families may be alternatively defined, that psychologists can productively assist parents of LGB children, and that education and training is necessary to competently treat LGB clients.

### **Sexual Orientation and Clinicians' Perceptions of Mental Health**

#### **Sexual Orientation**

It is difficult and often ineffective to describe sexual orientations as discrete categories with clearly defined boundaries. The Kinsey Report emphasized the continuum of human sexuality with heterosexuality and homosexuality as the scale extremes (Kinsey, Pomeroy, & Martin, 1948). Chernin and Johnson (2003) point to the almost "limitless possibilities" of sexual feelings (p. 7). Experts in the field suggest conceptualizing sexual orientation as a multidimensional concept in which dichotomous categorizations (heterosexual vs. gay/lesbian) are less than adequate (Fassinger & Arseneau, 2007; Garnets, 2002). The existence of bisexuality, as noted in a number of studies, illustrates the harmfulness of either/or thinking in this area (Garnets, 2002; Rust, 2000). Garnets (2002), for example, places attraction to females and attraction to males on separate dimensions in which a person can have varying levels of each.

Though scholarship indicates the fluidity of sexuality, it is still arguably worthwhile to describe some aspects and characteristics of sexual orientations in order to have a common vocabulary and focus for the present research. Sexuality can be defined as: “A constellation of affective, cognitive, and behavioral characteristics that constitute an individual’s sense of self as a sexual and intimately relational being” (Fassinger & Arseneau, 2007, p. 30). This definition emphasizes the three major psychological components of humanity consisting of thoughts, feelings, and behaviors. Therefore, a man may be attracted to another man not only physically, but emotionally and cognitively as well. This definition indicates that sexuality is an understanding of oneself (self-identity) both as an erotic being and as an intimate, relational being. For example, a man may have sex with another man (behavior), but self-identify as heterosexual, or a man may have emotional and physical attractions to men and women. Garnets (2002) asserted that agreement among sexual identity, behavior, and desire is not always attained due to the complexity of sexuality. One’s genuine self-understanding, therefore, is of utmost importance in defining his/her sexual orientation. With these descriptions of sexuality in mind, normalizing the continuum of sexuality and expanding the terms used for sexual orientation seems to be of importance as all people define their own sexuality and face the internal discovery that this process may involve. Self-identification has profound implications as it activates beliefs about sexuality, constructed schemas, societal expectations, and behavioral manifestations (Fassinger & Arseneau, 2007). Defining one’s sexual orientation does not happen in isolation. For example, a male who is for the

first time publicly identifying as gay, may adopt new ideas about what it means to be gay and how to act as a gay person due to community and societal influences.

Another layer of the process of defining one's sexual orientation is related to culture. In general, Mediterranean and Latin men who are the insertive partner in anal sex do not consider themselves to be gay; however, the receptive partner is viewed with ridicule and disgust (Fassinger & Arseneau, 2007; Gonzalez & Espin, 1996). Some Native American communities celebrate bisexuality and highly respect these individuals as "two spirits" (Fassinger & Arseneau, 2007). Those who are two-spirit have fluid gender roles and are seen as connecting both the spiritual and physical worlds (Chernin & Johnson, 2003). In some East Asian cultures, gender roles indicate that women should remain monogamous in a heterosexual relationship in order to keep the family while men are permitted to take male or female lovers as long as he can support the family and produce a son (Nakajima et al., 1996). Religion, a component of many cultural backgrounds, also influences the ways in which people identify their sexual orientation. In a Christian context, LGB adults tend to experience internal conflicts stemming from religious messages that preach the sinfulness of same-sex attraction, the need for forgiveness for sexual minorities, and the moral requirement of eternal celibacy (Schuck & Liddle, 2001). Sexual minorities, developing within this context, make decisions based on these, oftentimes, dismissive messages.

Sexual orientation is confused with a number of other concepts, which lead to problematic conclusions. Some confusion is due to misinformation while at other times, it is due to "disinformation" (Gonsiorek, Sell, & Weinrich, 1995, p. 40). Misinformation

involves a convoluted understanding of concepts surrounding sexuality including gender identity, social sex roles, cross-dressing, and sexual fetishes. Gender identity refers to one's internal sense of being male or female and serves as a mechanism for organizing interpersonal experiences (Fassinger & Arseneau, 2007). Social sex roles are culturally created norms and expectations of how individuals of a certain sex should behave.

Cross-dressing is an outward expression through clothing of masculinity or femininity that is not congruent in the eyes of society with one's biological sex. Finally, a sexual fetish involves sexual arousal related to non-living objects including undergarments, shoes, or other apparel (American Psychiatric Association, 2000)

Disinformation, on the other hand, may be motivated by political agendas seeking to block access to equal rights for sexual minorities. For example, groups may work to trivialize the size of the gay community in order to make the need for supporting public policy seem to affect an insignificant number of people. The reverse also occurs in which an over-estimate of the size of the gay community is utilized in order to create a sense of threat (Gonsiorek et al., 1995). The prevalence of HIV in the gay male population can be used in such a way as to condemn or vilify the population, saying that HIV is punishment for being gay. Finally, disinformation can be used to create erroneous devastating associations leading to negative impacts (e.g., gay men and pedophilia; Gonsiorek et al., 1995).

### **Same-Sex Sexuality**

The focus of the present project is on male clients who have a suggested psychological and physical attraction to individuals of the same-sex. Based on the

previous discussion, the inadequacy and limitations of such a definition must be acknowledged. The present research project seeks to identify clinicians' initial diagnostic impressions of clients, which are generally based on a brief review of intake materials and a 50 minute clinical interview. A client's identification as gay on the intake form and in the clinical interview is likely the information a psychologist has when making an initial diagnosis. Gonsiorek, et al. (1995) and Fassinger and Arseneau (2007) discuss the terms used for men to denote same-sex attraction including homosexual, queer, and gay. Homosexual as previously used in the DSM tends to have a clinical or pathological undertone and was indeed used for years to indicate a severe departure from "normality" for sexual minorities. It does, however, have descriptive value without implying much about one's identity (Gonsiorek, Sell, & Weinrich, 1995). Since the term homosexual stems from a medicalization of same-sex attraction, it will not be used in the current study. Some sexual minorities refer to themselves as queer which serves as a general term to describe individuals who defy established norms regarding gender and sexuality (Fassinger & Arseneau, 2007). Queer originally was used as a derogatory term in reference to gay males; however, younger generations have adopted the term as a form of empowerment—a semantic shift that is evident in academia and the study of queer theory (Jagose, 1996). Finally, the term gay involves both a same-sex attraction while making an assertion regarding identity. In other words, gay can be seen as a more specific term that involves not merely behaviors, but one's global sense of self. For this reason, the term gay male will also be used throughout this project.

## **Heterosexism**

Heterosexism, the assumption that a heterosexual orientation/lifestyle is the preferred and normal way of being, exists through neglect, omission, and insult (Chernin & Johnson, 2003). Everyday heterosexist hassles affect the mental well-being of sexual minorities and can be related to microaggressions (Swim et al., 2009). Microaggressions are generally subtle and indirect; they tend to confuse the recipient, indicate unconscious attitudes, and occur when well-intentioned people deny the existence of differences based on race, gender, or sexual orientation (Sue & Sue, 2008). People who say, “I don’t see color” or “All sexual orientations are the same” intend to assert the need for equal treatment, though in the same breath, they deny the uniqueness of one’s ethnic or sexual identity. Extending this idea, a micro-insult, a form of microaggression, involves situations or verbal comments that demean a person’s sexuality or gender identity. Sue and Sue (2008) provide a high-profile example by citing Governor Arnold Schwarzenegger’s comment that his political competitors are “girly men” (p. 112). This implies that only those who are traditionally masculine can be effective leaders. Micro-invalidations can also be a result of heterosexism. These involve invalidating a person’s perception of reality by emphasizing the person rather than the context (Sue & Sue, 2008). A gay man who interviews at a law firm that has a largely male staff may explain to his friend that he is concerned that he did not get the job because he is not “butch enough,” may feel disregarded if his friend says, “there probably were just other more qualified candidates” (Sue & Sue, 2008). In the previous example, the friend’s comment



may have some truth; however, it sends the message that he is better able to define his friend's reality.

A defining feature of the concept of heterosexism is that it is an enduring experience of the sexual minority's daily life and may occur in seemingly benign ways (Swim et al., 2009). A couple of examples may help to illustrate the nature of heterosexism. A psychologist at intake may ask his/her client if *he* has a girlfriend or wife rather than a partner. In this instance, a gay client may feel disregarded or become concerned that the therapeutic environment is not a safe place to discuss issues of sexuality. Heterosexist societal systems like adoption agencies may demand that only opposite-sex couples adopt children with the assumption that same-sex couples will not be able to raise healthy, well-adjusted children. Likewise, gay couples in public may have to avoid holding hands or showing affection for fear that they will be targeted, even though similar activities are accepted for heterosexual couples. A high school student may hear peers call others gay or queer to degrade or make fun of classmates who are deemed "weird." A common theme of these examples is that being gay is abnormal or wrong or in clinical terms, *pathological*. These experiences have important implications as they can affect one's mood and one's sense of self (Swim et al., 2009). Specifically, Swim, Johnston, and Pearson (2009) found that greater experiences of daily heterosexism was related to increased anger and anxiety, though it did not relate significantly with depression for gay, lesbian, and bisexual participants. Experiences of heterosexism tend to affect the sexual minority's perception of how society views his/her particular group, bringing to light the perception that society dislikes and mistreats minority sexualities.

These findings emphasize the connection between the oppression experienced in one's external environment and how that manifests in internal turmoil.

Fish (2006) comments on how “humanity and heterosexuality are synonymous” as heterosexism prescribes how one should act, how relationships should be pursued, what displays of affection are appropriate and which ones are considered “disgusting,” and what values one should uphold (p. 11). Likewise, Kitzinger describes the insidious and oppressive nature of heterosexism in the following comment:

When there is no anti-lesbian explosion from your parents because you have dyked your house before their visit; when there is no queer-bashing after an evening's clubbing, because you anticipated trouble and booked a cab home; when you are not dismissed from work because you stayed in the closet; when you are not subjected to prurient questions because you have talked about your partner euphemistically as a friend—when these events slip by as part of many gay men and lesbians' daily routine, has nothing really happened? Rather, heterosexism has been functioning in its most effective and most deadly way (as cited in Fish, 2006, p. 10).

This citation exemplifies the length to which some LGB individuals work to hide their identities out of necessity to survive in a society that does not recognize value or health in people who live outside of heterosexual norms. Sexual minorities do not always hide their orientation out of shame or lack of pride; rather, they may need to adjust their life in order to feel safe, to maintain employment, to keep housing (parents may ask teenagers to leave their homes after disclosure), and to sustain relationships. Heterosexual privilege, the status within society that heterosexual men and women hold based solely on their sexual orientation, can feel so automatic that it is taken for granted (Fish, 2006). This privilege is illuminated by a number of situations that are likely outside of awareness for straight individuals (Fish, 2006). The following are examples: “When I meet someone

for the first time, I do not need to consider whether or not to disclose my heterosexuality;” “I can be almost certain that if I moved houses my neighbors will be neutral or pleasant towards me;” “I can automatically count on the support and understanding of my family and friends when I disclose problems in my heterosexual relationship;” “The media can represent someone of my sexual identity perform an act of intimacy (such as kissing) without being considered remarkable” (p. 12-13).

Linda Garnets (2007), a psychologist and proponent of affirmative psychotherapy, writes of her experience as a lesbian woman who was coming out during her graduate school experience in the forward for the most recent edition of the *Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients*.

She says the following:

I came out when few psychologists questioned the dominant belief that homosexuality was a sign of mental illness. In my first year of graduate school in 1971, after I had just come out to close friends, my professor in a psychopathology course invited two gay men and two lesbians to talk about their lives. After they left the room, the professor spent the rest of the class pointing out each person’s pathology and tying it to his or her gayness. This sent me a powerful message that being lesbian was sick and something I should hide (p. xi).

Her writing depicts the pervasive and deeply affecting view that sexual minorities are distressed and sick. Her professor made great efforts to connect any distress the guest speakers may have disclosed to their sexual orientation, denying the possibility of the impact of the hostile environment or context in which LGBT individuals develop.

There are a few studies that have investigated the relationship between client sexual orientation and perceived mental health as ascribed by clinical professionals with some conflicting results (Bowers & Bieschke, 2005; Garfinkle & Morin, 1978; Mohr, et

al., 2009; Rubinstein, 2001). Garfinkle and Morin (1978) conducted one of the first studies of the kind following the removal of ego-dystonic homosexuality from the *DSM*, providing insight into clinician reactions to this organizational change. These authors found a significant difference between clinician ratings of heterosexual clients versus gay clients. Their findings support the theory that culturally based mental frameworks are used to evaluate and diagnose clients. More specifically, sex-roles prescribe “normal” behaviors for men and women. Gay men and lesbian women are often stereotyped in a way that defies gender roles and subsequently, questions the societal gender structure. With these findings, it may be possible that sex-role defiance, rather than sexuality alone determines over-pathologizing. Interestingly, the activation of stereotypes takes place through labeling the client gay, a factor that may occur in most settings with initial paperwork (Garfinkle & Morin, 1978).

Subsequent studies provide additional insight into the diagnostic process that unfolds. Rubinstein (2001) investigated client perceptions based on sexual orientation with a sample of 470 psychotherapists in Israel. Results indicated that gay clients were perceived to be more pathological than heterosexual clients with the same clinical symptoms. In addition, male professionals tended to attribute greater distress to their clients than their female counterparts. It is important to look at these studies with a historical perspective. Garfinkle and Morin’s (1978) results were just after the removal of homosexuality from the *DSM*, and Rubinstein’s (2001) results were twenty years after its removal with a greater number of participants who had never used the previous diagnostic system. The cultures within which these studies were conducted varied which

must be taken into consideration when drawing conclusions; however, longitudinally, it seems that some remnants of pathology remain in the minds of clinicians as they work with LGB clients.

The gender of the clinician also appears to impact the diagnostic process for the LGB population. Male psychologists are more likely to indicate that LGB clients were a risk of harm to others when compared with a heterosexual client demonstrating similar symptoms (Bowers & Bieschke, 2005). It is suggested that societal gender norms bring special shame to men who exhibit feminine characteristics and therefore, may be a highly active schema for psychologists, particularly those that are male.

Other studies suggest that mental health clinicians both in training and practicing in the field have generally positive attitudes towards gay and lesbian clients (Bowers & Bieschke, 2005; Sand, 1998). It is important to note that these studies did not account for the mental health clinician's propensity for impression management. It is possible that clinicians' cognitively understand that homophobia and poor treatment of sexual minorities are inconsistent with the prevailing sentiment of the psychological community and therefore, may omit such attitudes in overt situations (e.g., research situations) in order to appear affirmative; however, that does not mean that anti-gay sentiments have disappeared in the profession (Brown, 1996). When impression management is controlled for, a different result may manifest. This is exemplified in Gushue's (2004) study in which differences in diagnosis with White compared to racial minority clients only emerged after controlling for social desirability.

Overall, mental health professionals appear to be affected by societal attitudes toward sexual minority populations, though cognitively understand that negative attitudes are not widely accepted within the psychological community as they once had been. With these assertions, it is hypothesized that the client's sexual orientation will predict less perceived psychological health as ascribed by mental health practitioners when controlling for participants attempt to manage their impression to others. Specifically, gay clients will be perceived as having lower level of mental health.

*Hypothesis 1: The sexual orientation of the client will significantly predict the level of mental perceived by clinicians.*

### **Perceived Level of Mental Health, Sexual Orientation, and LGB Competency**

#### **LGB Competency**

Mental health professionals encounter LGB clients frequently on their caseloads. On average, psychologists see about one client a week with a disclosed minority sexual orientation; therefore, the average caseload contained 3% gay and lesbian clients and 1% bisexual clients (Murphy, Rawlings, & Howe, 2002). The true prevalence of LGB clients is difficult to discern as individuals may enter treatment and not initially disclose their minority sexual identity. It is paramount, then, that clinicians approach all clients with diversity competency in order to facilitate a safe environment for client disclosure.

The techniques, knowledge, skills, and personal awareness required to provide ethical mental health services are not static or unchanging from client to client. In other words, diverse clients have unique therapeutic needs of which clinicians must to be able

to respond and adapt as appropriate (Sue & Sue, 2008). Counselor self-efficacy is identified as a main component of general therapeutic competency, and is also applied to diversity competency (Bandura, 1986; Dillon & Worthington, 2003). Self-efficacy is defined as expectations about one's abilities to sufficiently accomplish a task. It is specific to a particular area of projected accomplishment and is related to one's ability to plan and cope with the demands of this domain (Taylor, Peplau, & Sears, 2006).

Perceived self-efficacy in relation to a clinician's work with clients is paramount.

According to Bandura (1986), if an individual feels as though he/she lacks self-efficacy, anxiety and arousal are initiated as that person approaches the specific task. This arousal generally reaches levels that inhibit good performance. The relationship between self-efficacy and performance in counseling is moderated by a number of factors including the counselor's personal experiences, the degree of arousal, and the context (Bandura, 1986). In addition, affective, motivational, and cognitive processes are highly involved in the counselor's ability to possess self-efficacy in working with new and diverse therapeutic situations (Larson & Daniels, 1998). The counselor who possesses high levels of self-efficacy tends to view his/her own anxiety as a challenge, set realistic goals for him/herself as a counselor, and engage in self-aiding thought processes (Larson & Daniels, 1998).

Sue and Sue (2008) identify three main components of competence for clinicians working with diverse populations: personal awareness, knowledge, and skills. First, therapists must have an awareness of their own assumptions, values, and biases. As discussed previously, these ingrained beliefs about human nature, human priorities/goals,

and human normality can seep into the counseling relationship making it ineffective at best and oppressively harmful at worst. This awareness is not only a cognitive understanding of one's societal privileges, but also an affective experience of how the counselor has participated in the oppressive structures of society. This can be a painful and threatening place and therefore, can be overlooked in the development of diversity competency in counseling.

Second, therapists must have knowledge of the worldview of culturally diverse clients. This consists of having a basic understanding of the traditions, history, and experiences of various cultural groups while recognizing that clients may be at different stages of identity development (Sue & Sue, 2008). This is highly applicable to sexual orientation minorities who may engage in an internal "coming out" process and an external, relational "coming out" process (see Cass, 1979). Since disclosing a minority sexual orientation to others can lead to rejection and potential violence, knowledge of external factors of which the client may have to face will contribute to the overall safety and well-being of the client. In addition to having a general knowledge of a group and what they have faced, understanding how the sociopolitical system of the United States has affected the group as a whole is important (Sue & Sue, 2008). For example, discriminatory legislation is sanctioned governmental inequality that affects the options that gay men and women have available to them.

Third, therapists must not only have an understanding of themselves and others, they must be able to select and implement culturally sensitive techniques that enhance the therapeutic process and help facilitate client growth (Sue & Sue, 2008). The diversity of



client backgrounds and experiences suggests that one approach to working with every client cannot be consistently helpful. Utilizing verbal and nonverbal techniques, developing client meaning within a particular cultural framework, advocating for clients beyond weekly sessions, and other means or areas of focus may be necessary in order to effectively treat a minority client (Sue & Sue, 2008). Rodriguez and Walls (2000) presented the concept of “culturally educated questioning” which blends knowledge of specific cultural groups with general counseling skills. The purpose of such a technique is to avoid stereotyping clients of minority backgrounds while using empirical evidence to guide inquiries. For example, it is useful to know that church communities and spirituality *generally* play an important role in the lives of African Americans (Sue & Sue, 2008); however, not all African American’s are spiritual or religious. Rodriguez and Walls (2000) would suggest that the culturally educated question of “What role does church and spirituality play in your life?” be asked (p. 95). This provides the client with permission in an open-ended manner to explore this area of his/her life without assumption. Translating these techniques into training would consist of facilitating knowledge acquisition regarding cultural groups and then arming trainees with specific questions that help to explore cultural issues. Trainees, then, have concrete methods of applying the information learned in didactics (Rodriguez & Walls, 2000).

This leads to the following question: How well are training programs for mental health providers preparing students for competent practice with sexual orientation minorities? Encouragingly, research indicates that increased training in diversity issues reduces counselors’ heterosexist biases and increases therapeutic skills in working with

this population (Rutter et al., 2008). Rutter et al. (2008) conducted an outcome study investigating the effects of a training program on sexual orientation counselor competency. The training program consisted of didactic and experiential components in order to increase awareness, knowledge, and skills. In order to augment skills, coached role-plays were conducted. Results of the pilot study indicated that this type of training model increased student-counselor's knowledge and skills, though had no significant effect on awareness. Other identified methods of increasing competence for clinicians in this area include cross-curriculum integration of diversity issues, dedicated requirements for LGB issues, and personally challenging of heterosexist biases (Phillips & Fischer, 1998).

Though the previous areas of curriculum expansion are demonstrating some effectiveness, the extent to which they are included in doctoral training programs is questionable (Phillips & Fischer, 1998). Strikingly, a large majority of graduate students felt unprepared to work with sexual orientation and gender identity minority clients as compared to their preparation for treating heterosexual clients. Reports indicated that the modal number of articles read as part of graduate coursework regarding LGB issues is zero (Phillips & Fischer, 1998). When considering Sue and Sue's (2008) emphasis on developing multicultural awareness and understanding one's own privilege, it is important to consider the extent to which graduate programs encourage students to think about their own biases. Nearly half of graduate students are reporting that they have never been challenged to contemplate their own heterosexist biases throughout their training (Phillips & Fischer, 1998). Finally, experiences at the student's practicum

placement also need to be assessed. Again, the modal number of LGB clients with whom graduate students worked was zero with the modal number of on-site practicum training related to this issue being zero as well.

Comparisons have been made between doctoral students' coursework and perceived abilities related to working with gay, lesbian, and bisexual clients. Even within the sexual minority population, not all were covered equally in training. Specifically, there is evidence that students feel more prepared to counsel gay and lesbian clients as compared to bisexual clients. This trend was consistent with the lack of coursework regarding bisexuality and also reflected the rarity of students' experiences in clinical rotations with bisexual clients (Fischer & Phillips, 1998).

Predicting a student's success in counseling the diverse range of sexual minorities is dependent on a number of factors related to formal training and both formal and informal experience. Those students with more formal training in LGB issues are more likely to reflect on their personal heterosexist biases (Phillips & Fischer, 1998). This lends to a deeper personal awareness, facilitating higher levels of multicultural competency (Sue & Sue, 2008). In addition, students with increased formal training tend to perceive themselves to be more capable of working with LGB clients (Sue & Sue, 2008). This increased self-efficacy contributes to the sensitivity of the counselor and the quality of services provided (Bandura, 1986). Considering the previous findings collectively, in order for students to feel prepared to work with LGB clients there needs to be specific formal coursework devoted to counseling this population, an opportunity for exploration of personal heterosexist biases which have the potential to enter into the

counseling relationship, and contact with gay, lesbian, or bisexual people and clients (Fischer & Phillips, 1998). Unfortunately, it seems that students in clinical and counseling psychology programs are left to their own initiative to seek out training and gather information regarding counseling sexual minorities.

Beyond the confines of the halls of academia, the graduate student in psychology enters various practical settings where supervision is generally provided by an on-site licensed psychologist or licensed professional counselor. Important training occurs within these settings from supervisors who have the opportunity to foster multicultural competency in the student. The supervisory process, though one step removed from direct client intervention, contributes to the overall quality of client care. The supervisor's own perceptions regarding the nature of same-sex sexuality impact how the supervisee conceptualizes the client (Halpert, Reinhardt, & Toohey, 2007). Halpert et al. (2007) suggest a model of integrative affirmative supervision that facilitates the professional growth and competency of supervisees. First, the supervisor her/himself must demonstrate LGB training and skills, internal awareness of heterosexist biases, and an understanding of the impact of homophobia. This pre-supervision preparation is important as described by these authors; however, it brings into question the preparation of supervisors in the field for working with this issue. For example, if homosexuality was removed completely from the *DSM* 30 years ago and current programs are still under-preparing students for work with minority sexual orientations as previously discussed, then formal programmatic training was likely nonexistent for previous generations of professionals. Breakdown in the pre-supervision stage adversely affects

the subsequent stages of affirmative supervision (Halpert et al., 2007). During the supervision stage, the supervisor's task is to create a safe environment to allow for open discussion of issues of sexuality. At this point, the supervisor facilitates appropriate diagnosis, assessment strategies, and treatment, and monitors the sensitivity of the trainees' conceptualization of the client. These are key areas where supervision colored by homophobia or misinformation could create inappropriate diagnosis or undue pathology. In the advanced stages of affirmative supervision, transference and counter-transference is discussed as the trainee grapples with issues of internalized homophobia and his/her role in the perpetuation of heterosexism (Halpert et al., 2007). This is advanced learning which leads to a decrease in biases; unfortunately, students are reporting that this level of awareness is not occurring in their training (Phillips & Fischer, 1998).

Considering the state of training in multicultural issues in clinical and counseling psychology programs, the perceptions graduate students have regarding self-efficacy in the area, and the call in the literature for affirmative supervision, the following hypotheses are asserted. It is hypothesized that there will be an interaction effect between LGB competency and client sexual orientation in predicting perceived level of mental health. Specifically, those with high perceived LGB competency will assign similar levels of mental health for the gay client and the straight client. On the other hand, those with low LGB competency will tend to assign less mental health for the gay client as compared with the heterosexual client. This is thought to occur because a lack of awareness, knowledge, and skill would allow personal biases to manifest in the

diagnostic process without challenge. With greater competency, a greater ability to buffer and address negative attitudes would likely take place.

*Hypothesis 2: The LGB competency will significantly moderate the association between client sexual orientation and clinicians' perception of client mental health.*

## **Perceived Level of Mental Health of Clients and Homophobia**

### **Homophobia Overview**

There is much controversy surrounding the definition of homophobia with conceptualizations changing as societal attitudes progress. Chernin and Johnson (2003) suggest that homophobia is an active fear and hatred of sexual minorities—an act of commission rather than omission. Other authors propose that the difference between heterosexism and homophobia is a matter of degree with blatant discrimination and acts of violence captured by the more aggressive term of phobia (Fish, 2006). Fish (2006) outlines a number of problematic implications of the term in the gay and lesbian community. First, the use of the word phobia conjures the clinical diagnosis of an anxiety disorder and implies that homophobes are psychologically sick (emphasizing fearfulness) rather than intolerant. There are reported incidences of interpersonal violence and murder in the United States and United Kingdom where charges were lessened because of the perceived mental illness of homophobia ascribed to the perpetrator (Fish, 2006). If homophobia implies illness, what does the term *internalized homophobia*, the incorporation of heterosexist messages as part of the sexual minority's

self-concept, mean for gay men and lesbian women themselves (Herek, Gillis, & Cogan, 2009)? This is an argument that Fish (2006) employs to illustrate that a similar illness stigma or sense of psychological weakness is placed on the sexual minority who may have internalized homophobia rather than acknowledging the potentially hostile, violent, and dismissive effects of society. The question becomes: is homophobia a fear of gay men and lesbian women or is it another fear altogether? Some authors argue that the true nature of homophobia lies in an intense discomfort with threats to masculinity and the hetero-normative lifestyle (Fish, 2006; Garfinkle & Morin, 1978). Additionally, there is an emerging body of literature that applies modern prejudice theory to the experience of sexual minorities and suggests that present-day homophobia as opposed to old-fashioned homophobia has taken more subtle forms, but is no less harmful (Ellemers & Barreto, 2009; Morrison & Morrison, 2002; Walls, 2008). The subsequent review of the homophobia literature will describe several “old fashioned” models of homophobia that continue to affect present-day thought, explore the mechanisms through which these models are maintained, and then apply the discussion to modern prejudice theory and modern homophobia.

### **“Old Fashioned” Models of Homophobia**

There are several models of homophobia with each having implications for how sexual minorities should be treated. It is important to note that these models are not necessarily representative of a group, but rather represent homophobic justifications coming from various worldviews. First, the medical model has been widely influential in the treatment of sexual minorities from a historical perspective (Kantor, 2009). This

model views sexual minorities as sick/unhealthy and deems gay men and lesbian women as unfit for parenthood or other societal positions. It is important to note that the medical model reached heights in its application in the mid-1900's to a wide variety of issues perceived as mental disorders beyond homosexuality with barbaric treatments like insulin comas, lobotomies, and primitive versions of electroconvulsive therapy in use for anxiety, depression, and psychotic disorders (Comer, 2010). In accordance with this model, sexual minorities should be isolated from others for there is concern of transmission (negative societal effects). The medical model, therefore, espouses treatment in order to correct or heal the gay or lesbian patient (Kantor, 2009).

In response to the medical model and the notion that is an illness, Kantor (2009) states the following:

Homosexuality is not an illness but rather simply one healthy variant, with heterosexuality and homosexuality each traveling the legendary different road, with homosexuality no more abnormal, that is, no more an illness, than is having red hair or being left-handed. (p. 13)

This quotation makes an important distinction regarding the nature of same-sex sexuality. It indicates the difference between same-sex sexuality being a *less common* sexual orientation versus it being an *abnormal* sexual orientation. This subtle distinction is necessary because it affects the core of the medical model. Following this line of logic, red-headed people have a genetic predisposition for this phenotype and have no need to change it, though it is less common than other hair colors (Kantor, 2009).

Second, the Christian religious model of homophobia suggests that gay men and lesbian women are sinners and are a threat to the moral fabric of society. Those who adopt this model of thinking find support and refuge in verses of the Bible, many of



which are not read in context of the culture and history of the time. Religious homophobes tend to put aside essential teachings of their faith like love and compassion in order to uphold church dogma (Kantor, 2009). It must be acknowledged that within faith traditions themselves, there are a number of different beliefs regarding same-sex sexuality with active religious homophobes being oftentimes the extreme in their community (Wilcox, 2003). Kantor (2009), however, suggests that religious homophobia represents an internal pathology of the homophobic individual. The treatment indication for sexual minorities according to this model is repentance, forgiveness, conversion, and celibacy.

The socio-cultural model of homophobia, on the other hand, asserts that sexual minorities are deviant members of a cultural group and undermine the established structure of society. The suggestion that legally allowing same-sex marriage will inherently alter the institution of opposite-sex marriage is indicative of this model. The “treatment” indication is cultural isolation and shunning of sexual minorities from communities altogether (Kantor, 2009). The socio-cultural model can have extreme and violent effects as hate crimes perpetrated against gay men and lesbian women due primarily to issues related to the victim’s sexual orientation are highly prevalent (Tomsen & Mason, 2001). “Gay bashings,” for example, serve a two-fold purpose in which perpetrators are attempting to assert a masculine and heterosexual identity through violence while simultaneously marginalizing and out casting a group that is seen to threaten traditional concepts of masculinity. A few specific illustrations are provided in Tomsen and Mason’s (2001) report. One particular incident occurring in Sydney,

Australia involved a group of young men who violently attacked and killed an identified gay man. After the incident, the main perpetrator was boasting of his manliness in carrying out the attack and revealed that he took such a central role in the crime in order to change his reputation of being “wimpy” or “soft,” labels that are contrary to a stereotypically masculine identity. Such incidences are extreme examples of how internal threats to one’s own gender identity can result in harmful consequences for those who are less gender conforming.

Finally, the criminal model of homophobia reframes the gay or lesbian person as antisocial with the need to be controlled and monitored through laws. Circular logic begins to develop for individuals who endorse behaviors related to this model: same-sex sexuality is a crime because it is against the law and likewise, it is against the law because it is a crime (Kantor, 2009). Those identifying as a sexual minority are essentially trapped in this circuitous thinking and are hopelessly condemned to a life of second-class citizenship. The “treatment” according to this model of homophobia is incarceration or separation (Kantor, 2009).

What psychological mechanisms are used to justify these various models of homophobic thinking? There are a number of underlying assumptions that collective groups employ. Common rationalizations of homophobia and discrimination include human nature arguments, religion, preference, and freedom of speech (Kantor, 2009). The human nature assumption implies that sexuality is meant only for reproduction, which biologically can only take place with a man and woman. It is a denial of the basic tenets of human nature to suggest that two men or two women can possess a meaningful

sexuality (Kantor, 2009). Rationalizations based on religion use the teachings of organized faiths as justification for demoralizing minority sexual orientations. The bible, the pastor, or church documents are relied on to extreme measures to justify one's homophobia (Wilcox, 2003). In the process, passages of the bible that denounce oppression, discrimination, and hatred are regarded as something separate from the matter of sexual minorities and liberation theology is applied selectively (Kantor, 2009). Another way of justifying homophobia is through the argument of preference. People who adopt this justification indicate that humans develop preferences based on free choice that guide behavior and that it is perfectly reasonable to prefer heterosexuals over gay men or lesbian women. This idea is perhaps best illustrated through parents who indicate that they would prefer that their sons or daughters lead heterosexual lives because it would be "easier" for both the child and the parent (this is referred to as paternalistic heterosexism and will be discussed in more detail in the subsequent section; Walls, 2008). This idea of preference feeds into the freedom of speech rationalization. Though freedom of speech is an important part of the democratic process in the United States, it is generally prudent for people to monitor the circumstances and context of effective free speech. This becomes a justification as individuals rely on free speech to proclaim prejudice, hatred, and discrimination as a legally endowed right (Kantor, 2009).

Overall, these models of homophobia represent negative attitudes towards gay men and lesbian women (Brown & Groscup, 2009). Those who endorse higher levels of homophobia are more likely to accept negative stereotypes of sexual minorities regarding their relationships (less serious and less fulfilling) and their personal characteristics (more

promiscuous, less religious, more materialistic, and more dramatic; Brown & Groscup, 2009). Homophobic attitudes are often maintained by rigid styles of thinking, faulty logic, and firmness of convictions (Kantor, 2009). For example, when individuals engage in subjective thinking, they create their own reality and then find evidence to confirm that reality—a social psychological concept referred to as *confirmation bias*. Stereotypes created from highly visible and sometimes extreme gay figures may be prevalent in this type of thinking. Homophobia then thrives on distal knowledge from an unrepresentative sample of the population (Kantor, 2009). Kantor (2009) cites the commonly adopted belief of “love the sinner, hate the sin” or the tendency to generalize that all gay people are pedophiles based on the evidence that some gay men are pedophiles (p. 6). These thoughts become especially problematic when they are upheld with strong certainty. Such inflexible convictions lead to a denial of contrary evidence, even of the most rigorous nature, in order to avoid cognitive dissonance and maintain previously formed conclusions (Kantor, 2009).

### **Modern Homophobia**

Morrison and Morrison (2002) articulated the emerging conundrum for researchers studying societal attitudes towards sexual minorities: there is a notable discrepancy between attitudinal reports (neutral to slightly positive attitudes towards gay men and lesbian women) and behaviors (anti-gay graffiti, incidences of anti-gay violence, sexual minorities’ perceptions of feeling unsafe, etc.). Such discrepancies have been found in relation to issues of racism (McConahay, 1983), and to issues of sexism (Tougas, Brown, Beaton, & Joly, 1995). The social climate in the United States

condemns overt prejudicial behavior; therefore, it becomes important for an individual to uphold a non-prejudiced self-image in order to have a cohesive view of self (O'Brien et al., 2010). What develops is a privileged majority group with little awareness of harmful biases towards the minority population (O'Brien et al., 2010). Like many behaviors, social comparison plays a large role in perpetuating prejudicial persons' non-prejudiced self-image and subsequent actions. The media highlights extreme cases of homophobia which become a benchmark for discrimination against gay men and lesbian women; as long as the individual person is behaving much better than the publicized image, a positive sense of one's self can be upheld (O'Brien et al., 2010). This emphasizes the complex and insidious nature of modern prejudice.

Morrison and Morrison (2002) also put forth complementing hypotheses to O'Brien et al.'s (2010) assertions which account for the discrepancy between proclaimed attitudes and behavioral realities: social desirability, convenience sampling, and/or a lack of measures that are sensitive to more modern forms of homophobia. All three of these possibilities are likely contributors; however, researchers hypothesize that the current findings are best explained by modern homophobia (Cowan, Heiple, Marquez, Khatchadourian, & McNevin, 2005; Morrison & Morrison, 2002; Walls, 2008). In fact, Cowan et al. (2005) found a strong negative correlation between modern heterosexism and the perceived harmfulness of hate speech, indicating that individuals with high modern heterosexism were less likely to perceive hate speech as harmful. This study provides justification for modern prejudice theory as applied to gay men and lesbian women.

There are key conceptual features of the modern “isms” (racism, sexism, and heterosexism). Across multiple definitions is the idea that modern prejudice is rooted in internal conflict (negative feelings/attitudes toward minority groups and one’s self-perception of being non-racist/sexist/heterosexist) and ambivalence. McConahay’s (1983) landmark research emphasizes the role of the context in bringing out the negative side of conflicting attitudes. When the situation is ambiguous, when there are various explanations for discriminatory behavior, and when no known social norm has been established, ambivalence leads to prejudicial behavior. This relationship between ambivalence and prejudice serves as the groundwork for modern homophobia theory. Subsequently, modern or “new” homophobia forgoes justifications based on the models previously presented (medical, religious, criminal, etc.), leaving behind moral protests and natural order in favor of an overwhelming sense of denial that discrimination still exists, a sense of brooding anger for sexual minorities “refusal” to assimilate into heterosexual society, and a sense of frustration for the incessant demands of the gay community (Morrison & Morrison, 2002). The modern homophobe likely espouses acceptance of sexual minorities in the hypothetical while failing to support policies or other tangible measures of support. Such effects have also been noted in the literature in regard to issues of racism and sexism and are referred to collectively as modern prejudice theory (Ellemers & Barreto, 2009; McConahay & Hough, 1976; Swim et al., 1995).

Using modern prejudice theory and research related to racism and sexism, Walls (2008) suggested further delineations in the understanding of modern homophobia incorporating aversive heterosexism (explained above) as identified by Morrison and

Morrison (2002), paternalistic heterosexism, positive stereotypic heterosexism, and amnestic heterosexism. *Paternalistic heterosexism* consists of a constellation of attitudes that express concern for the well-being of sexual minorities while simultaneously increasing stigma (Walls, 2008). For example, expressing a desire that one's own child not be gay because there are a number of things that are more difficult for gay men and lesbian women including threats of harm, social isolation, decreased access to adoption and marital benefits, etc. These concerns have a basis in reality, though the underlying, dismissive message is that heterosexuality is preferred (Walls, 2008). In essence, this type of attitude suggests that the individual needs to change rather than advocating for societal/environmental change. *Positive stereotypic heterosexism* attributes positive characteristics to gay men and lesbian women which are based on generalized assumptions (Walls, 2008). Though desiring to be affirming in nature, this type of heterosexism actually perpetuates stereotypes and is counter-productive to true affirmation. Finally, *amnestic heterosexism* is rooted in denial of the continued struggle that gay men and lesbian women face. In essence, this form of heterosexism seems to block out or forget that severe social and legal sanctions were prevalent in the not too distant past and that current equality is far from realized (Walls, 2008).

Though modern homophobia is seemingly less aggressive when compared to old-fashioned homophobia, it is no less devastating to a minority community and to the entire human community. Tougas et al. (1995), for example, found that modern sexism continues to slow down progress for women in the workplace and beyond into other settings. In light of Cowan et al.'s (2005) research suggesting a negative relationship

between modern heterosexism and perceived harm of hate speech, it is justified to conclude that this acceptance of hate speech may lead to harmful repercussions including hate crimes. The insidious nature of modern homophobia is perhaps even more detrimental because it goes “unchecked” by societal norms.

### **Homophobia and Therapy**

These models of homophobia (old-fashioned and modern) and societal rationalization patterns are applied to the general population; however, it is necessary to consider the effect they have on the attitudes upheld by mental health professionals that impact therapeutic practice. The APA Committee on Gay and Lesbian Concerns commissioned a comprehensive review of psychologists’ therapeutic work with gay and lesbian clients in the early 1990’s, investigating possible biases that may arise in assessment and treatment (Garnets et al., 1991). There are a number of themes regarding practice with this population that were illuminated. First, participants endorsed the idea that same-sex sexuality is a form of pathology, making sweeping generalizations about it being a personality disorder. Competent practice, as suggested by Garnets et al. (1991), would acknowledge the client’s sexual orientation as an important part of his/her identity and not as an inherent indication of pathology. Another tendency was for clinicians to automatically associate presenting issues with the minority sexual orientation status of the client without reason to do so. For example, a client coming to counseling for anxiety may not be related to concerns surrounding his/her sexual orientation; rather, in reality, the anxiety is an unrelated pattern of symptoms. There is a sense of subtlety that must be addressed in regard to this assertion. A clinician may need to help a client explore how



society's tendency to marginalize and discriminate against sexual minorities creates problems for gay and lesbian clients; however, it is the problem of society rather than a problem with the minority individual (Hanna, Talley, & Guindon, 2000). Society, therefore, possesses the pathology. Likewise, asking a client whether or not being gay or lesbian is a central component of the presenting problem and subsequently believing the client's response, is considered exemplary practice. The stress of the process of "coming out" for sexual minority clients can lead to psychological difficulties; however, it is important to distinguish between adjustment problems stemming from coming out or unrelated psychological pathology that is made worse by the stress of disclosing one's minority sexual orientation (Gonsiorek & Rudolph, 1991; Herek & Garnets, 2006).

Other diagnostic and therapeutic issues may arise when a well-intentioned clinician is experienced as demeaning. In an effort to de-emphasize one's identity, the practitioner may make the client's disclosure seem insignificant. Garnets et al. (1991) provides the following example from their qualitative data: "A lesbian client dropped her male therapist who said in vengeance to her disclosure that she was 'into women' that I don't care, I have a client who is 'into dogs'" (p. 967). Other clinicians may deny fully that gay or lesbian clients have experienced any societal oppression as occurs in amnesic homophobia (Walls, 2008). This devalues the impact of both microaggressions and outright discrimination or assault and inevitably attributes any concerns a client may have regarding his/her experience in society to personal pathology. In a similar way, psychologists may misunderstand the severity of the consequences of the decisions that

gay and lesbian clients must make. For example, one participant in Garnets et al. (1991) said the following:

A lesbian friend told me about a male therapist who tried to convince a young gay man (18-20) to come out to his parents—even though his parents were likely to be abusive. The therapist seemed unaffected by knowledge of society's or parents' homophobia (p. 967).

Overall, the misunderstanding of the mental health clinician can have serious impacts on the assessment of the problem of the client, the diagnosis (where does this problem come from?), the subsequent treatment interventions, and the overall safety of the client.

The mental health clinician's perception of his/her own gender and sexuality can affect homophobic attitudes and behaviors in session (Sanchez, Westefeld, Liu, & Vilain, 2010). Gay and lesbian clients can serve as a threat to the gender-role expectations of the therapist, which are highly socialized and reinforced. A LGB client may bring the clinician face to face with his/her own questions surrounding sexuality and gender. For example, a female clinician who identifies as feminine may look to clients who identify as female to confirm and reflect femininity. If a lesbian client is gender non-conforming, a subtle discomfort may arise, impacting therapy (DeCrescenzo, 1983). This may stem from the perception of gender normality as being linked to attraction to the other sex (Greene, 2007). When this is defied, as is the case for LGB clients, the core person is rejected, deemed defective, and seen as inherently wrong (Greene, 2007).

The majority of homophobic attitudes in mental health professionals are operating outside of direct awareness due to socialization (Bowers & Bieschke, 2005). The media serves as a perpetuating force, which has suggested that the "healthy" person is heterosexual; at the very least, the media has historically failed to challenge the status

quo of heterosexism (Martin, 1982). The media has evolved over time to include openly gay characters portrayed in dramas and comedy shows. Initially, these characters often were portrayed in stereotypical ways as flamboyant or sexually charged (Levina, Waldo, & Fitzgerald, 2000). Though change is occurring in this area, mental health clinicians, like the larger society, have historically had few images of healthy gay men and lesbian women and either consciously or unconsciously compare sexual minority clients to a heterosexual “norm.” The danger is that a client’s internal homophobia may go unchallenged as the clinician similarly colludes with such homophobic beliefs (Martin, 1982). The process of challenging homophobic beliefs can be an important part of therapy with sexual orientation minorities (Hanna et al., 2000; Herek & Garnets, 2007)

Modern homophobia manifests in therapy in other ways as well. The client him/herself may have a preoccupation with understanding the origin or etiology of his/her sexual orientation. An aware clinician will help challenge beliefs that are not supported by research and encourage clients to question the stereotypes that they hold about themselves. The etiology conversation can develop into simultaneous assignment of pathology coming from both the client and the practitioner (Martin, 1982). On the other hand, the origin of heterosexuality is not questioned, it is readily accepted. What if same-sex sexuality was not questioned for its pathological roots? A savvy clinician understands that the implied message in an unchallenged exploration of the source of same-sex sexuality is that it is a less than desirable state and severely secondary to heterosexuality (Martin, 1982).

DeCrescenzo (1983) reviewed literature around the time that the APA removed homosexuality from the *DSM* and identified a number of commonly held beliefs. It is important to consider these beliefs because they historically inform the psychological community and persist to varying degrees in the current societal and professional climate (see, for example, Nicolosi, 1991). The following were 10 commonly held beliefs developed from DeCrescenzo's research review:

- 1) [Gay men and lesbian women] of both sexes have a history of disturbed relationships with either or both parents.
- 2) Homosexuality is a neurotic disorder.
- 3) [Gay men and lesbian women] have difficulty in achieving close relationships.
- 4) [Gay men and lesbian women] are sexually promiscuous.
- 5) [Gay men] have unusually close relationships with their mothers.
- 6) [Gay men and lesbian women] adjust poorly psychologically.
- 7) [Gay men and lesbian women] use alcohol and drugs to a greater degree than non-homosexuals.
- 8) Gay men tend to be child abusers.
- 9) Homosexuality can be reversed with adequate psychotherapeutic intervention.
- 10) Homosexuality represents an arrested state of psychosexual development (p. 123-124).

It is important to consider if existing evidence supports any of these assertions because it is these beliefs that could have profound impacts on the perception of clinical distress of sexual minority clients. There is scientific evidence that indicates that there are no significant differences between gay men and heterosexual men on issues of neuroticism, challenging views that same-sex sexuality is a pathological representation of anxiety (Burns, Kamen, Lehman, & Beach, 2012). Likewise, research indicates that there is no statistical abnormality in the relationships between gay men and their mothers (Bene, 1965). Other studies have asserted that gay men are not a greater risk of abusing children than heterosexual men (Herek, 1991; Patterson, 1997; Stevenson, 2000). On the other hand, research does indicate that sexual minority youth have increased likelihood of suicidal thoughts, depression, homelessness, and alcohol/drug abuse (Blake et al., 2001;

Hart & Heimberg, 2001). Considering that stigma and oppression can lead to mental health symptoms and the danger of homelessness, these prevalence rates are not surprising (Swim et al., 2009; Sue & Sue, 2008). The etiology of such mental health symptoms makes a difference.

Another one of the commonly held beliefs identified by DeCrescenzo's (1983) literature review in the 1980s is that gay men and lesbian women can be cured through conversion or reparative therapy. This continues to be present today through religious organizations and psychologists themselves (e.g., Exodus International; Nicolosi, 1991; as researched by Haldeman, 2002). The name "reparative therapy" in itself implies pathology. The psychologist Joseph Nicolosi (1991) exemplifies this particular belief in the following statement in his book about the value of reparative therapy: "Nature made man complementary to woman, and to cling to the sameness of one's own sex is to look at the world with one eye. I do not believe that any man can ever truly be at peace living out a homosexual orientation" (p. 149). In psychology, such an assertion must be supported by scientific evidence as it can have a profound impact on the diagnosis and treatment of sexual minorities. The data related to the effectiveness of conversion therapy has mixed results/interpretations; however, when viewing rigorously designed studies, there is no notable evidence of its effectiveness.

Spitzer (2003) conducted a study of 200 self-selected participants who had experienced a five year sustained change from a primarily same-sex orientation to a primarily heterosexual orientation in response to some form of conversion therapy. With a self-report and retrospective design, participants were asked questions about same sex

attraction, fantasy, yearning, and overt same-sex behavior a year before beginning therapy and at least five years after treatment. He found a decrease in the percentage of people who scored highly on the Same Sex Attraction Scale, the Sexual Orientation Self-Identity Scale, and in the number of same-sex sexual experiences. It is important to note that there was a sharp decline in participants' perception of distress from the pre to post measures whether or not sexual orientation actually changed (Drescher & Zucker, 2006).

The research conducted by Spitzer (2003) became the center of controversy regarding the beneficence of conversion/reparative therapy. A number of researchers responded with their own published work in order to comment on and make known the methodological errors (summarized in Drescher & Zucker, 2006). Some cite his use of measures that lacked reliability and validity data—he used a self-scaling question in order to assess sexual orientation dichotomously with the possibility that some participants were more bisexual in the beginning. Others point out that he was asking participants to make reports about feelings and experiences that happened years ago. The participants themselves were a highly specific group, with most holding strong religious views as this venue was a main means of recruiting participants. Finally, the statistics he reported did not seem to address his original research questions as the statistical comparisons he made were between gender rather than between pre and post data (Drescher & Zucker, 2006). This study, therefore, provides weak support that sexual re-orientation therapy is helpful to clients and even less support of it being effective; therefore, the evidence, or lack thereof, should create considerable doubt for those who espouse the commonly held belief identified by DeCrescenzo (1983) stating that sexual orientation can be changed.

Not only is there little evidence of the effectiveness of conversion therapy, there are also harmful consequences of its use including long-term sexual dysfunction, lowered self-esteem, and an increase in depression and anxiety (Cramer et al., 2008). In addition, there is notable discrepancy between the APA Ethical Guidelines for Working with LGB Clients with the assumptions and tenets of this type of therapy (Cramer et al., 2008). The ethical guidelines address a variety of components that are unique to the LGB population as well as factors that should be universal to all clients. For example, the guidelines state that same-sex sexuality should not be equated with pathology; however, the intent of conversion therapy alone implies that there is something wrong with the client (Cramer et al., 2008). A number of the guidelines deal with prejudice, stigma, and bias in working with this population, demanding that clinicians do not perpetuate these harmful social structures; however, it is argued that conversion therapy places heterosexuality as the ideal existence while failing to acknowledge the value of same-sex relationships, families, and identities (Cramer et al., 2008). Cramer et al.'s work reveal that clinicians who make the assumption that same-sex sexuality is pathological and attempt to change the sexual orientation of even willing clients find increases in pathology rather than decreases; this suggests that pathology is not inherently associated with minority sexual orientations.

With an extensive understanding of homophobia both on a societal level and within the counseling relationship, it is hypothesized that clinician homophobia will predict perceived level of client mental in a population of clinicians. Clinicians with low modern homophobia will assign more mental health to the clients. It is likely that this

group of clinicians will not rely on societal models of homophobia, will not utilize general stereotypical cognitive strategies, will refrain from rationalizing discriminatory practices, and will incorporate more affirmative diagnostic techniques. On the other hand, clinicians with high homophobia will rate significantly less mental health. This group of clinicians is thought to be using the homophobic models of thinking, be unaware of how their own comfort with personal differences like gender and sexuality affect therapy, utilize stereotypes as a means of gleaning information about clients, fail to understand the unique challenges faced by LGB clients, lack acknowledgement of the discrepancies in rights that continue to exist today, and use arbitrary means to measure normality. These thinking patterns are hypothesized to affect the perceived level of mental health attributed to clients presenting with psychological concerns.

*Hypothesis 3: The level of homophobia of the clinician will significantly predict the perceived level of mental health of the client.*

### **LGB Competency and Homophobia**

The question remains of whether or not clinicians can effectively separate their own personal beliefs from accurate diagnosis and effective intervention in therapy. In other words, is it possible for professionals to personally disagree with same-sex sexuality (an elevated level of homophobia), yet set that disagreement aside in order to provide good treatment? In reality, therapists must do this with some aspects of most clients as value differences arise. For example, a highly religious client may decide to stay in a conflict-laden marriage because he/she does not believe in divorce while the



therapist believes that divorce is a good option. Though therapy is commonly viewed as a value-free zone, many authors argue that this is not the case—a truly impossible feat for a therapist to achieve (Barnes & Murdin, 2001; Consoli, Kim, & Meyer, 2008). In support of this assertion, there is evidence that through consistent treatment, the client's values begin to converge with those of the therapist, emphasizing the power that a therapist has in affecting clients' values, both positively and negatively (Beutler, 1981; Kelly & Strupp, 1992). The overall values espoused by the counseling profession are based on Eurocentric values (Consoli et al., 2008). Consoli et al. (2008) compared and contrasted counselor values and four main minority groups in the United States. These authors found convergence on the following values: promotion of harmonious relationships, personal flexibility, and the drive to find meaning and purpose in life. They found divergence on other values including the role of autonomy/independence, the structure of relationships (equality vs. hierarchies), and the importance of conformity (individuality vs. conformity). These discrepancies represent areas in which a potential conflict could arise in counseling at which point, the therapist may need to set aside his/her personal values in support of working within the worldview of the client, a component of diversity competency in counseling.

Though a value-free therapeutic relationship is unlikely to be achieved, most major systems of psychotherapy that are practiced today emphasize a nonjudgmental stance as one of the curative, common factors of psychotherapy (Bergin & Garfield, 1994; Prochaska & Norcross, 2007). Based on Carl Rogers' (1959) conceptualization of unconditional positive regard, the humanity of the client is to be respected and valued no

matter the action or belief of the client. In light of the previously mentioned research (Beutler, 1981; Kelly & Strupp, 1992), true unconditional positive regard is likely an aspirational principle of counseling rather than a given principle. Does high competency, then, allow the clinician to strive for true unconditional positive regard, pursue good diagnosis, and set aside differing values?

The final hypothesis explores the question of whether LGB competency can moderate the effects of modern homophobic attitudes on the clinician's perception of level of client mental health. As suggested by Sue and Sue (2008), the clinician who demonstrates multicultural competence has high levels of skill, awareness, and knowledge. Sue and Sue's multidimensional conceptualization of counselor diversity competency is further expanded by Dillon and Worthington (2003) who include advocacy and relationship building with a sexual minority client as a part of LGB competency. Though there are many components to LGB competency, the current project will take all of these into consideration through use of the total score on the competency scale. Total competency is hypothesized to moderate the relationship between homophobia and clinical distress. This is supported by previously mentioned research regarding the idea that modern homophobia is highly dangerous when it goes unacknowledged; therefore, people who have high awareness of their homophobic biases, as a result of LGB competency, may be less likely to use those as a lens for client conceptualization and diagnosis. On the other hand, those with high modern homophobia, are likely to use stereotyped views of clients as a means for conceptualization and diagnosis no matter the sexual orientation of the client. How might

varying levels of competency affect this relationship? It is anticipated that those with high LGB clinical skills and high homophobia will be capable of setting aside stereotyped or prejudicial views in service of their duty as a clinician (e.g. assigning a diagnosis or rating clinical distress). This likely is not the case with low LGB competency and high modern homophobia. Conceptually, it is expected that high modern homophobia will be associated with the fundamental attribution error. This social psychological principle suggests that people tend to overestimate the role of personal factors in a person's presentation at the cost of understanding the contextual factors that may be active (Taylor et al., 2006). High modern homophobic beliefs may represent a propensity to understand a client's "pathology" as character default rather than taking into consideration societal factors that may disadvantage clients. Overall, those with lower homophobia and high LGB competency may have sufficient awareness, knowledge, and skill and may have convergent initial values with the sexual orientation minority so that diagnosis is not clouded by bias. Therefore, it is hypothesized that there will be an interaction effect between homophobia and LGB competency.

*Hypothesis 4: The LGB competency will significantly moderate the association between homophobia and clinician's perception of clients' mental health.*

## Chapter Three

### Method

**Participants.** Participants were 86 mental health clinicians who were in the process of obtaining a degree or had previously obtained a degree in counseling or clinical psychology. Professionals from social work or other related fields were not included in the sample. Respondents had at least one clinical experience as part of their training and held positions in a variety of settings including (but not limited to): community counselors, university counselors/psychologists, hospitalists, private practitioners, school counselors/psychologists, military psychologists, and correctional psychologists. Utilizing the final, cleaned sample, 86 participants provided viable data. The mean age of participants was 34 years with a range from 22 to 81. The majority of the sample identified as Caucasian/White (n=69, 80% of the sample) with 5.8% identifying as Asian (n=5), 1.2% as Black or African American (n=1), 3.5% as Latino/a (n=3), 5.8% Biracial (n=5), and 2.3% (n= 2) indicating another identity. Female participants reflected 79% of the sample (n=68) and 87% of the sample reported being heterosexual (n=75). Most participants identified as Christian (n=40, 40%) or indicated that they had no religious belief (n=34, 39.5 %). In regard to highest education achieved, 59.3% of the sample had obtained their master's degree (n=51), with bachelor's (n= 20, 23.3%) and doctoral (n=14, 16.3%) degrees following respectively. The vast majority

(n=44, 51.2%) had taken 1-2 classes that addressed gay, lesbian, bisexual, and transgender issues in counseling as compared to a sizable majority (n= 35, 40.7%) having 3-4 classes addressing assessment and diagnosis. The participants represented a variety of occupational settings with most having a student status. The majority of the sample reported being liberal leaning in their political affiliation with some variability. See Table 1 below for a complete outline of the demographic characteristics of the sample.

Table 1

*Overview of Demographic Variables*

Characteristic	Frequency	Percentage
Total Viable Participants	86	100
Age		
20-30	51	59.5
31-40	17	19.8
41-50	3	3.4
51-60	9	10.4
61-70	4	4.6
71-80	2	2.3
Gender		
Female	68	79.1
Male	15	17.4
Transgender	1	1.2
Missing	2	2.3
Race/Ethnicity		
Asian or Asian American	5	5.8
Black or African American	1	1.2
Hispanic or Latina/Latino	3	3.5
White	69	80.2
Biracial/Multiracial	5	5.8
Other	2	2.3
Missing	1	1.2

Religion		
Buddhist	4	4.7
Christian	40	40.6
Hindu	1	1.2
Jewish	3	3.5
No Belief/Atheist/Agnostic	34	39.5
Other	3	3.5
Missing	1	1.2
Sexual Orientation		
Bisexual	4	4.7
Gay	1	1.2
Heterosexual	75	87.2
Questioning	2	2.3
Missing	3	3.5
Highest Education Achieved		
Bachelor's	20	23.3
Master's	51	59.3
Doctoral	14	16.3
Missing	1	1.2
Total Classes Taken Addressing LGBT Issues		
0	27	31.4
1-2	44	51.2
3-4	11	12.8
5-6	0	0
7 or more	4	4.7
Total Classes Taken Addressing Assessment/Diagnosis		
0	4	4.7
1-2	25	29.1
3-4	35	40.7
5-6	10	11.6
7 or more	12	14
Occupational Setting		
Community Mental Health	16	18.6
Educational (school)	11	12.8
Forensic	3	3.5
Graduate Student	27	31.4
Hospital	4	4.2
Military	4	4.2
Private Practice	6	7.0
University Counseling Center	9	10.5
University Faculty	1	1.2
Other	4	4.7
Missing	1	1.2

Theoretical Orientation		
Behavioral	3	3.5
Cognitive (CBT included)	25	29.1
Humanistic	15	17.4
Family Systems	7	8.1
Psychodynamic	10	11.6
Integrative	22	25.6
Other	2	2.3
Missing	2	2.3

**Measures.**

*Vignettes.* Two case vignettes were written specifically for this project. Though original vignettes, they were modeled after those described in other studies (Bowers & Bieschke, 2005; Garfinkle & Morin, 1978; Sand, 1998). The vignette represented a moderate level of pathology as assessed by a small sample of 5 doctoral students who had experience with diagnosis who rated the severity of the case as presented in the vignette. This level of pathology was chosen because it represented the type of client that may be seen in a university counseling center and presented the possibility for various clinical impressions. The two vignettes were identical except for the name of the romantic partner of the client (either David or Emily) and the report of the sex of the client’s romantic and sexual partners. These were subtle indicators of the client’s sexual behavior and sexual attraction. The case described a 32-year-old Caucasian man who recently separated from his partner, was struggling to maintain good standing at work, and was questioning his sense of purpose in life. There were a number of symptoms related to depression and anxiety that were mentioned. The client was described as having some suicidal ideation, though implied to be of a passive nature. See Appendix C for review of the vignette.

*Mental Health Inventory-18 (MHI-18; Veit & Ware, 1983).* The MHI-18 is a shortened version of the original *Mental Health Inventory* consisting of 18 items evaluating psychological functioning. The instrument contains statements regarding how a person has felt within the last four weeks. Response options indicate the severity of the statement and are located on a six-point scale ranging from “all of the time” to “none of the time.” The wording of the original measure was intended for the client’s self-report. The MHI has been used for a variety of purposes including research studies with mental health professionals as the sample (consistent with the current project; Pearson, 2008). It also correlates with clinician rated instruments based on the *DSM-IV*, which provides evidence of validity in its use as a clinician-rated instrument (Rumpf, Meyer, Hapke, & John, 2001). As such, the wording of the instrument was slightly altered in order to be consistent with the intent of the current project. In the directions for the measure, the word “you,” referring to the client her/himself, was replaced with “the client.” The altered directions stated: “*Using your best clinical judgment*, the next set of questions are about how you assess how *the client* feels and how things have been for *the client* during the past four weeks.” For each item, the modified introductory clause stated, “During the past four weeks, how much of the time has *the client* [felt a certain way or engaged in a particular behavior].” Sample items include “How much of the time has the client been in firm control of his behavior, thoughts, emotions, feelings?” and “How much of the time has the client felt downhearted and blue?”

The original development of the measure used a large-scale national sample of over 5,000 participants in order to discern the factor structure and validity of the



instrument (Veit & Ware, 1983). Using structural equation modeling, a hierarchical structure was noted which consists of an overall mental health index which can be divided into psychological distress and psychological well-being. Each of these domains consists of the following sub-domains: anxiety, depression, loss of control, general positive affect, and emotional ties. The 18-item version retains four of the subdomains, eliminating the emotional ties scale. Veit and Ware (1983) indicated that the most precise interpretation of the measure involves an understanding of each hierarchical subsection; however, these authors suggested that the mental health index which takes into consideration all of the items is a valid representation of level of mental health and can be used as an overall assessment of functioning.

Reliability estimates of the MHI are notably high with an overall alpha coefficient of .96 and with subscale reliabilities ranging from .81 to .96. The 18-item version is highly correlated with the original measure (Ritvo et al., 1997). In regard to validity, the MHI correlates with a number of other measures of psychological distress or mental functioning. The Positive and Negative Affect Schedule (PANAS) relates in the expected direction with the individual subscales of each measure (Mann & Schnoll, 2001). For example, the anxiety and depression subscale of the MHI correlates positively with the negative affect scale; likewise, the general positive affect subscale of the MHI correlates positively with the positive affect scale. There is also support that the MHI correlates with measures that are based on *DSM-IV* criteria with the highest correlation with mood and anxiety disorders (Rumpf et al., 2001).

There are an abundance of self-report measures of clinical distress that are completed by the client; however, there are very few measures that are intended for clinicians to rate their client's level of mental health based on a current review of the literature. In the psychiatry literature, on the other hand, there are some measures like the Brief Psychiatric Rating Scale (BPRS) and the Clinical Global Impression (CGI) scale that are intended for a psychiatrist or mental health professional to rate the client's functioning. The BPRS showed some viability for the current study, but it was initially designed for the brief assessment of symptoms of more severe mental illness (Foster, Sclan, Welkowitz, Boksay, & Seeland, 1988). The BPRS was included as an adjunct measure with the intent of correlating scores with the MHI. The CGI is a one-question measure that assesses the degree of mental illness of a client and is meant for the psychiatric population. Amongst other self-report measures, the structure of the MHI fit with the intent of this study because it used a scale that was more consistent with level of client mental health rather than behavior/emotion frequency as used in the Brief Symptom Inventory (BSI) and the Center for Epidemiological Studies Depression Scale (CESD). Finally, other studies that have investigated perceived clinical distress have designed questionnaires that do not undergo traditional means of scale development (Gushue, 2004), individual questions (Rubinstein, 1995), or semantic differential measures (Bowers & Bieschke, 2005). These methods have advantages but fail to capture the true nature of the present research question, which is one of the assessment of the level of mental health and not one of impressions alone.

*Brief Psychiatric Rating Scale (BPRS;* Overall & Gorham, 1962; Overall & Gorham, 1972). The BPRS is one of the most widely used, provider-completed symptom rating scales (Schafer, 2005). The measure produces a comprehensive picture of the client across a number of diverse symptom patterns ranging from anxiety, depression, and somatic concerns to severe pathology like hallucinations and delusions. There are 18 symptoms that are rated on a 7-point scale with the lowest point value indicating that the symptom is not present and the highest point value denoting that the symptom is extremely severe. Though originally designed for clinical work with the intent of measuring client progress, it has been adopted wholeheartedly by the research community (Overall & Hollister, 1982). The rating scale provides an overall score of symptom severity with higher scores indicating greater pathology. It is a scale that mimics the medical model of assessment and diagnosis by identifying a constellation of specific symptoms that then inform a diagnosis.

Overall and Hollister (1982), amongst other authors (Schafer, 2005), have asserted that the measure can be used in a prototypic and profile driven manner by considering clusters of symptoms (or factors). For example, a clinician identifying a depressed patient may differ in symptom elevations based on the *type* of depression the person has. An anxious depression would be rated differently than a lethargic depression or a hostile depression (Overall & Hollister, 1982). For the present research, the name of the symptom was provided with a description of what the symptom means according to the author's definition—general protocol for the instrument. For example, *depressive mood* was defined as “despondency in mood, sadness” and *blunted affect* was described

as “reduced emotional tone, apparent lack of normal feeling or involvement.” For a complete listing of the symptoms used and described in this measure, see Appendix C. Subsequent research on the measure has provided clinicians with general cutoff scores that suggest the level of severity of the client. “Mildly ill” is characterized by a score between 31 and 40, “moderately ill” is related to the range of scores between 41 and 52, and “markedly ill” is denoted by a score greater than 53 (Leucht et al., 2005).

The BPRS has demonstrated strong psychometric properties dating back to Hedlund and Vieweg’s (1980) comprehensive review of the measure. These authors suggested that though the initial use of the BPRS was for severe pathology, it has demonstrated usefulness with a more general psychiatric population. Interrater reliability estimates of .94 demonstrate a high degree of concordance between practitioners utilizing this measure (Foster, Sclan, Welkowitz, Boksay, & Seeland, 1988). Additionally, Ligon and Thyer (2000) found similar interrater results amongst a variety of professional backgrounds: social workers and physicians yielded a correlation coefficient of .93, a correlation of .84 between social workers and nurses, and even higher correlations resulting when measured for the same patients at discharge. The BPRS also correlates highly with other measures of psychopathology including the Minnesota Multiphasic Personality Inventory (MMPI) (Newmark, Ziff, Finch, & Kendall, 1978) and the Brief Symptom Inventory (BSI) (Morlan & Tan, 1998). The latter study asserts a significant correlation between the clinician completed BPRS and the client completed BSI, providing support that there may be validity in a clinician completing self-report measures as clinical impressions as utilized with the MHI in this study.

***Global Assessment of Functioning (GAF;*** American Psychiatric Association, 2000). The most recent version of the *Diagnostic and Statistical Manual* recommends a five axis diagnostic procedure with the first four axes reserved for reporting specific disorders, medical problems, and psychosocial stressors. The purpose of this measure is to provide an indication of the overall level of functioning of the client and is rated from 1 to 100 with 10-point incremental descriptions. A score of 1 suggests “Persistent danger of severely hurting self or others or persistent inability to maintain minimum personal hygiene or serious suicidal act with clear expectation of death” while a score of 100 suggests “Superior functioning” with no symptoms. The American Psychiatric Association (2000) recommends starting at the top of the scale and questioning whether severity of symptoms or client’s level of functioning falls below the description in that particular range. The worse of the two (symptom severity or level of functioning) should be the score recorded. The GAF scale itself has text descriptions of each level of functioning.

Reliability estimates for the GAF scale are in the good to excellent range among staff who have mental health training with intraclass correlations extending from .61 to .91 (Aas, 2010; Sonesson, Tjus, & Arvidsson, 2010). The GAF demonstrates concurrent validity with other measures of pathology and symptom severity (see Startup, Jackson, & Bendix, 2002).

***Balanced Inventory of Desirable Responding (BIDR;*** Paulhus, 1984). The BIDR is a 40-item measure that assesses the level of social desirability of the respondent. Social desirability in self-report measures is defined as “the tendency to endorse items in

response to social or normative pressures instead of providing veridical self-reports” (Ellingson, Smith, & Sackett, 2001, p. 121; see also Zerbe & Paulhus, 1987). In this case, culturally accepted ideas will be favored even if the individual does not personally agree. Those opinions that are less socially accepted may be suppressed in service of overall conformity. There are a variety of reasons why such responding may occur, some related to conscious intentions while others are related to unconscious processes (Ellingson, et al., 2001). Socially desirable responding is well researched in relation to organizational psychology and the use of measures in the pre-employment process (Ellingson, et al., 2001; Moorman & Podsakoff, 1992; Zerbe & Paulhus, 1987). The interview and employment seeking is an example of an area where respondents may want to appear more favorable than indicated for intentions of personal gain. In relation to mental health professionals, they may want to manage their professional impression in order to appear to be a good counselor.

The larger issue of social influence may operate as the respondent approaches the self-report task. Social psychology has provided numerous studies regarding the tendency of humans to conform to social or organizational pressures (Asch, 1955; Sherif, 1936). For example, in Asch’s famous line-length studies, participants tended to indicate clearly incorrect answers as a result of social pressure to conform (Asch, 1955). Other studies extended the work of Asch to the evaluation in a pressured social context of absurd opinion statements, judgment tasks, and logic oriented tasks, finding similar effects (Taylor et al., 2006).

Two subscales emerge in order to address the conscious and subconscious forms of desirability. The subscale of self-deceptive positivity assesses honest, though positively biased responding. The subscale of impression management investigates an intended effort to appear more favorably than is appropriate. Each subscale consists of 20-items. Respondents are asked to rate their agreement with items on a seven-point scale (1= not true and 7= very true). Sample items include “I sometimes try to get even rather than forgive and forget,” “I have some pretty awful habits,” and “I sometimes drive faster than the speed limit.” In order to reduce the overall time necessary to complete the full battery of measures and to increase the propensity for participants to complete each measure, the 20 items of the impression management scale were included while the self-deceptive positivity items were omitted. Though both subscales have potential utility for this study, it was decided that it was most important to control for conscious attempts to appear socially desirable. Lanyon and Carle (2007) indicated that this subscale assesses “exaggerated claims of extreme virtue” (p. 860). In the present research, mental health professionals had a conscious motivation to appear virtuous or more healthy than is reasonable because of being in a position of some authority and participating in a study that related to their livelihood. The Modern Homonegativity Scale-Gay Men was used to investigate subtle self-deceptive internal conflicts.

The psychometric structure and properties of the BIDR have been investigated extensively (Lanyon & Carle, 2007; Li & Bagger, 2000). Li and Bagger (2000) conducted a meta-analysis of studies that used the BIDR and reported reliability statistics for the corresponding sample. Results of their analysis revealed Cronbach alphas ranging

from .68 to .86 with a mean of .80 for the overall scale. This represents acceptable reliability. In addition, there is evidence of good construct validity. For example, Lanyon and Carle (2007) conducted validity analyses using a forensics population as well as an undergraduate population. The impression management subscale was significantly correlated with measures of exaggerated virtue for both the undergraduate and forensic population. Self-deceptive positivity was also related to measures of exaggeration of good/poor adjustment.

***Modern Homonegativity Scale-Gay Men (MHS-G; Morrison & Morrison, 2002).***

This 12-item measure assesses participant's level of modern homophobic attitudes. Respondents rate on a five-point Likert-type scale their extent of agreement with a number of statements expressing opinions about gay men or issues related to the gay community. The following are example statements: "Many gay men use their sexual orientation so that they can obtain special privileges," "Gay men do not have all the rights they need," and "In today's tough economic times, American tax dollars shouldn't be used to support gay men's organizations." This instrument was initially developed to address gaps in the literature. Specifically, the authors noted a "floor" effect when previous homophobia measures developed in the 1980s or early 1990s were used with the current population. Likewise, discrepancies between expressed attitudes and behaviors towards gay men and lesbian women suggested that prejudicial attitudes persist, but perhaps in different ways than before (Norris, 1991). This is the basis of modern prejudice theory which asserts that overt racism, sexism, and heterosexism have become socially unacceptable and highly discouraged resulting in sublimated animosity toward



minority groups and manifesting in subtle, yet denigrating attitudes (Morrison & Morrison, 2002). This is contrasted with “old-fashioned” homophobia that oftentimes uses religious and moral justifications for disapproving of the “gay lifestyle” and disparaging same-sex relationships. In fact, in developing this instrument, Morrison and Morrison (2002) factor analyzed items from the MHS and items from the Homonegativity Scale (a measure of negative attitudes) and found distinct factors. Additionally, these authors found that participants’ scores on the MHS were notably higher than scores on more dated measures of homophobia. This suggested that modern homophobia is conceptually different than “old-fashioned” homophobia and is capturing the subtlety of “new” homophobia.

Factor analysis revealed a unidimensional construct with an alpha coefficient of .91. In regards to validity, it was hypothesized that modern homophobia would be positively correlated with other modern prejudices like modern sexism. This was the case in Morrison and Morrison’s (2002) study with the MHS correlating more strongly with a measure of modern sexism than old-fashioned sexism. In addition, employing an experimental design these authors assembled a randomly selected group of participants who scored in the top and bottom quartiles of the MHS to test whether scores on the MHS related to how participants interacted with perceived gay confederates. As hypothesized, those participants who had high scores on the MHS tended to avoid sitting next to the perceived gay confederate while those who had low scores were more likely to sit next to the perceived gay confederate in an ambiguous setting.

This measure presents a number of conceptual and methodological advantages. First, it is consistent with emerging research regarding new manifestations of prejudice—it appears to capture subtle forms of homophobia. Therefore, it is less likely to create a floor effect based on Morrison and Morrison’s (2002) studies. This is particularly important when considering that the population of interest in the present study consists of mental health professionals who tend to have more accepting views of gay men and lesbian women. The sample used in the development and validation of the MHS consisted of university students that may be similar to the proposed sample of graduate students and mental health professionals. Finally, the MHS is not correlated with measures of social desirability; therefore, there is additional confidence that results represent true variability and accurate attitudes rather than an overt attempt to appear more favorably than warranted.

***The Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory*** (LGB-CSI; Dillon & Worthington, 2003). This 38-item measure assesses counselors’ competencies in providing affirmative mental health treatment to gay, lesbian, and bisexual clients. Respondents are asked to indicate on a six-point scale how confident they are in their ability to engage in a number of tasks related to LGB-affirmative counseling. This scale was developed with the following theoretical concepts in mind: self-efficacy and LGB-affirmative counseling.

The LGB-CSI adopts Bandura’s (1986) Social Cognitive Theory which views self-efficacy as a function of the possession of required skills and the belief that one can successfully implement those skills. In regard to counseling, a mental health clinician

needs to possess appropriate therapeutic skills while also having confidence in his/her ability to use those skills to effectively treat a client. A pattern develops in which increased self-efficacy increases performance and decreases barriers to effective counseling like anxiety (Larson & Daniels, 1998).

In regard to affirmative counseling, Dillon and Worthington (2003) utilize the following definition in the development of their scale: “therapy that celebrates and advocates the authenticity and integrity of lesbian, gay, and bisexual persons and their relationships” (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000, p. 328). The affirmative counselor acknowledges one’s sexuality as an important part of identity and does not force heterosexual norms on that identity or marginalize its importance. In addition, the affirmative counselor has an understanding of the effect of heterosexual privilege that is granted without question at both societal and individual levels (Dillon & Worthington, 1998). In extension of the logic of Bandura’s (1986) Social Cognitive Theory, one’s experience with gay, lesbian, and bisexual individuals is seen as a factor that may affect counselor self-efficacy.

Five studies were conducted in order to establish a psychometrically sound scale with sufficient reliability and validity data. A five-factor design was supported with items addressing how confident respondents are in their ability to apply *LGB knowledge* (“Directly apply my knowledge of the coming out process with LGB clients,” “Explain the impact of gender role socialization on a client's sexual orientation/identity development,” and “Assist LGB clients to develop effective strategies to deal with heterosexism and homophobia”), *possess awareness* (“Recognize my attitudes toward

LGB issues and their potential influence on my counseling relationships,” and “Examine my own sexual orientation/identity development process”), *possess advocacy skills* (“Refer a LGB client to affirmative social services in cases of estrangement from their families of origin” and “Provide a client with city, state, federal, and institutional ordinances and laws concerning civil rights of LGB individuals”), *develop a working relationship with an LGB client* (“Establish an atmosphere of mutual trust and affirmation when working with LGB clients” and “Normalize a LGB client's feelings during different points of the coming out process”) and *assess relevant issues of an LGB client* (“Integrate clinical data (e.g., mental status exam, intake assessments, presenting concern) of a LGB client” and “Assess for post-traumatic stress felt by LGB victims of hate crimes based on their sexual orientations/identities”). Coefficient alpha for the total scale is .96 and for subscales ranged from .87 to .96. Specifically, the following coefficient alphas were reported: knowledge (.96), advocacy skill (.93), awareness (.87), relationship (.87), and assessment (.87). Evidence of convergent and discriminant validity was also noted. The LGB-CSI correlated significantly with other similar measures including the Attitudes towards Lesbians and Gay Men Scale (Herek, 1988), the Attitudes regarding Bisexuality Scale (Mohr & Rochlen, 1999), and the Counselor Self-Efficacy Scale (Larson et al., 1992). In general, there were no strong correlations between the LGB-CSI and the BIDR.

***Manipulation Check.*** Much of the design of this study was related to the participants’ understanding of the sexual orientation of the fictitious client. With this in mind, a manipulation check was used. The final question of the survey asked the

participant to think back to the clinical vignette presented earlier and write-in whether the client, John, had primarily same-sex or opposite-sex romantic relationships. This particular wording was used because the sexual orientation of the client was not overtly stated; therefore, it would be unfair to ask the participant to report the sexual orientation of the client because it would have asked participants to make assumptions about identity. The vignette, however, does suggest both a romantic and physical relationship with partners. Those participants who answered this question incorrectly were removed from the sample for analysis. Thirty-seven cases were removed as a result of the manipulation check. See the results section for more information about the removal of these participants.

**Procedure.** A small pilot study was conducted with five doctoral students in Counseling Psychology. The students completed the study as outlined in the initial proposal and provided feedback regarding the extent to which they were able to assess the client from the clinical vignette with the MHI measure, the length of the survey process, and any other weaknesses in the process. Feedback from the pilot study led to slight adjustments to the clinical vignette. Specifically, information about the client's social support and relationship with his family was added.

Subsequently, listserves were obtained from the Colorado Psychological Association. Graduate psychology programs (clinical and counseling programs) both in the West and in the Midwest were contacted in order to gain permission to invite students to participate in the project. Finally, local counseling agencies employing master's and doctoral level clinicians were contacted and clinicians were invited to engage in the

study. After potential respondents were identified, they received an email inviting them to participate in an online survey. The body of the email reported briefly the purpose of the study and the incentives for taking part in the research project. Upon interest in the survey, the respondent was directed to an online program where the survey was administered. The first screen contained the informed consent document (see Appendix B) with another indication of the purpose of the study, a list of any potential risks and benefits from participating, a statement about confidentiality and what data will be used for, the approximate amount of time it takes to complete the survey, and the contact information of the researcher. Potential respondents were asked to indicate their acknowledgement and agreement to participate.

The participant was then directed to an instructions page, which asked them to read a short vignette written in intake form regarding a male client coming for consultation and treatment for mental health issues. Participants were randomly assigned to a condition at this point. Every participant received the same vignette; however, one piece of identifying information was manipulated—the client was either implied to be heterosexual or gay. Next participants were asked to complete the MHI, providing their impressions of the level of mental health of the fictitious client. In addition, a page with the *DSM-IV* global assessment of functioning (GAF) guidelines followed and the participant was asked to assign a GAF score based on the client's intake. After this was complete, the respondent was unable to go back to change or alter previous responses.

The order of the next surveys was counterbalanced to control for order effects. The participants completed the BIDR, the MHS, and the LGB-CSI. The final portion of

the survey was always the demographic questionnaire. At the very end of the demographic questions, the manipulation check was administered. After completing the survey, the respondent was thanked for his/her time and a reminder of the researcher's contact information was presented. In order to increase the sample size, master and doctoral level classes were visited in person and a paper form of the survey was administered in a similar way. See the results section for more information about the use of these surveys in the analysis.

***General Procedures for the Statistical Analyses.*** Initial data preparation consisted of identifying cases with missing data in order to determine whether the data were missing completely at random, missing at random, or not missing at random. In other words, it is important to determine whether the data is systematically missing as a result of the nature of a particular item or is missing with no discernable pattern. A dummy variable was created in order to indicate missing versus non-missing and then used to test mean differences in the independent and dependent variables. Next, a plot of the regression line helped to identify outliers, which can skew results. Further data screening procedures consisted of assessing residuals, including residual plots of predicted scores by errors of prediction, for the assumptions of normality, linearity, and homoscedasticity as suggested by Tabachnick and Fidell (2001). Additionally, coefficient alpha, an indication of reliability, was computed for each measure using the present sample of participants.

After data cleaning was complete and the assumptions tested, hierarchical multiple regression analyses were conducted. In this study, covariate variables

(demographic variables and impression management) were statistically controlled in order to address potentially confounding effects on the dependent variable (clinicians' impressions of client mental health). With a hierarchical analysis, variables are entered into the equation in a specified order with covariates entered in step one, variables of interest in step two, and interaction terms entered in step three (Tabachnik & Fidell, 2001). Regression coefficients and significance values are then reviewed in order to understand which terms are significantly contributing to the prediction of the dependent variable.

When conducting regression analyses using interaction terms, multicollinearity or correlations among the independent variables, is a general concern and can be addressed by centering the independent variables (Tabachnik & Fidell, 2001). After this was completed, interaction terms of sexual orientation  $\times$  LGB counseling competency, and level of homophobia  $\times$  LGB counseling competency, were computed. At this point, all variables were prepared for analysis including covariates, predictor variables, the moderating variable, and interaction terms.

A hierarchical linear regression was conducted in order to investigate the relationship between the independent variables (sexual orientation, modern homophobia, and LGB counseling competency) and the dependent variable (perceived clinical distress). Refer to Appendix A. To test Hypothesis 1, the analysis indicated whether client sexual orientation was positively associated with clinicians' perceived clinical distress. The covariate variables were entered at Step 1, and the client sexual orientation was entered at Step 2. To test Hypothesis 2, the covariate variables were entered at Step



1, client sexual orientation and LGB counseling competency was entered at Step 2, and the interaction term of client sexual orientation  $\times$  LGB counseling competency was entered at Step 3. If the regression coefficient for the two-way interaction of client orientation  $\times$  LGB counseling competency was statistically significant, the next step would be to interpret the interaction or test the moderator effect. A strategy suggested by other researchers (Aiken & West, 1991) consists of examining the moderator's effect at two levels (i.e. lower levels of LGB competency and higher levels of LGB competency) by plotting LGB competency scores for client sexual orientation of one standard deviation above and below the mean. Using a simple regression analysis, the slopes of the lines would be tested to see whether the slope at each level is significantly different from zero.

To test Hypothesis 3, covariate variables were entered in step 1. In Step 2, modern homophobia was entered in the regression equation. To test Hypothesis 4, covariate variables were entered in step 1 followed by modern homophobia and LGB counseling competency in step 2. In Step 3, a two-way interaction of homophobia  $\times$  LGB counseling competency was entered to predict clinicians' perceived level of client mental health. If the regression coefficient for the two-way interaction of homophobia  $\times$  LGB counseling competency was statistically significant, the next step, as mentioned before, would be to interpret the interaction or to test the moderator effect. In the same manner as used for testing Hypothesis 2, the moderator's effects would have been compared at two levels (i.e., lower levels of LGB counseling competency and higher levels of LGB counseling competency) by plotting LGB competency scores for homophobia scores of one standard

deviation above and below the mean (Aiken & West, 1991). Simple regression analyses would have been conducted to check whether the slopes of simple regression lines at high and low LGB counseling competency were significantly differ from zero.

## Chapter Four

### Results

**Overview.** Data analysis consisted of data preparation and cleaning, an exploration of missing data, preliminary analyses, a report of the composition of the sample, and an analysis of the four primary hypotheses. All statistical tests utilized a two-tailed approach with an alpha level of  $p < .05$ .

**Data preparation.** Upon closure of the online survey, all participants that did not attempt to complete the four major variables of the study (MHI-18, BIDR, MHS-G, and LGB-CSI) were eliminated from the sample. These participants, in general, agreed to participate, but completed little more than the informed consent page. This resulted in the deletion of 87 cases, reducing the sample size from 242 to 155 participants. Next, an examination of the manipulation check was conducted in which the vignette presented to the participant was compared with their recollection of the sexual orientation of the client. Thirty-seven cases either entered incorrectly the sexual orientation (wrote that the client primarily had male-female romantic and sexual relationships when the vignette suggested a same-sex orientation or vice versa) or wrote some version of the following: “I don’t know,” “It’s not my place to decide,” or “I don’t remember.” Since these cases may not have paid attention to the manipulated variable or may have confused the manipulated variable, they posed a significant threat to the purity of the data, potentially

confounding the results. As such, these cases were dropped from the data set, leaving 118 viable cases. Finally, there were two types of survey formats utilized. The primary administration tactic was online; however, in order to boost sample size, in-person invitations and paper administration were used, with 117 completed responses to the online version and 41 completed responses to the in-person version. In order to justify the homogeneity of the sample across type of administration, an independent-samples t-test was conducted. On average, participants assigned significantly greater mental health to the client when taking the survey in-person versus online,  $t(105) = -2.055, p < .05$ . There may have been some heightening of the effect of social desirability or another possible explanation for such a result. There are two viable considerations to address such a matter: utilize the most sizable sample as the sample for analysis or include the survey type as a control variable. In support of theoretical purity, the online survey format, the majority of the sample, was used for analysis.

The data were initially examined for consistency, acceptable values/ranges, and coding fidelity. Any data that had a value that was above the highest possible score or below the lowest possible score was examined for data entry errors. Demographic variables for which the participant entered an “other” response were reviewed. For example, for religious identity, a response marked “other” with the specification “Catholic” was recoded as Christian, an available choice for the participant.

**Analysis of missing data.** Guidelines for exploring the pattern of missing data and dealing with missing data have been outlined by Tabachnick and Fidell (2007) and were utilized for the current research. All items of the survey had less than 5% missing

and upon further analysis indicated a nonsystematic pattern of absent values. Specifically, each of the predictor variables were dummy coded (missing versus non-missing) and used to conduct a t-test regarding significant differences on the dependent variable. No significant differences were found. This indicates several options for addressing the missing values. Deleting cases listwise involves dropping all cases that have missing values. In the absence of more sophisticated means of estimating missing data, this is oftentimes used (Tabachnick & Fidell, 2007). Due to the reduction in sample size that this would create, it was not chosen as a method. Mean substitution is a way of estimating the values of missing data. This preserves cases that have missing data, but has the risk of reducing variance in the sample. With small amounts of missing data, this can be seen as a conservative method (Tabachnick & Fidell, 2007). Since each item had negligible amounts of missing data (less than 5%), the mean of the scale was calculated and then imputed in place of the missing item. In order to address the concern surrounding the type of procedure used, both were used to conduct the analyses and compared. Mean substitution revealed similar results to listwise deletion while maintaining more cases for the analysis. Therefore, this procedure was used to handle missing data.

**Initial data exploration.** In the initial exploration of the data, the means, standard deviations, ranges of scores of main measures, skewness, kurtosis, and Cronbach's alpha were calculated. These calculations do not include mean imputation, but rather are based on completed items. Refer to Table 2. The MHI-18 ( $\alpha = .77$ ), the BPRS ( $\alpha = .82$ ), the BIDR impression management subscale ( $\alpha = .77$ ), the MHS-G ( $\alpha =$

.91), and the LGB-CSI ( $\alpha = .98$ ) all revealed reliability coefficients within an acceptable range.

Table 2

*Overview of Independent and Dependent Variables: Means, Standard Deviations, Ranges of Scores, Skewness, Kurtosis, and Cronbach's Alpha*

Variable	N	Mean	(s)	Range	Skewness	Kurtosis	$\alpha$
<i>BIDR*</i>	80	76.75	17.00	35-112	-.33	-.29	.82
<i>MHS-G</i>	86	19.37	7.73	12-50	1.59	2.78	.91
<i>LGB-CSI</i>	80	142.3	40.00	59-226	-.15	-.35	.98
<i>MHI-18</i>	76	24.41	8.79	6.67-46.67	.14	-.61	.77
<i>BPRS</i>	83	46.37	10.38	26-83	.72	1.61	.82
<i>GAF</i>	86	52.58	8.73	31-75	-.20	.30	**

\*Scored continuously. \*\*Cronbach's Alpha cannot be calculated with a single item.

In order to provide support for the use of the MHI as a valid measurement for the clinician's rating of the mental health of the client in the vignette, it was necessary to calculate the correlations among the MHI-18, BPRS, and GAF. The BPRS and GAF scales were validated specifically as clinician rating instruments. It was expected that the MHI and BPRS would be significantly negatively correlated as the higher the MHI score the greater the mental health of the client while the higher the BPRS total score, the greater the pathology. The MHI-18 and the GAF scale have a similar orientation. The MHI-18 was significantly negatively correlated with the BPRS ( $r = -.541, p < .01$ ) and significantly positively correlated with the GAF scale ( $r = .252, p < .05$ ). Thus, there was

support for the valid use of the MHI-18 as a scale for a clinician's rating of a client rather than solely a client's rating of him/herself for the purposes of this study.

There was a significant positive correlation between the sexual orientation of the client presented in the vignette and the MHI-18 score, with the heterosexual client being perceived as more psychologically healthy than the gay client, ( $r = .32, p < .01$ ).

Additionally, there was a significant positive correlation between the MHS-G and the BPRS ( $r = .25, p < .05$ ). This suggests that as a clinician's modern homophobia increased their rating of pathology for clients in general increased. The MHS-G and the LGB-CSI revealed a significant negative correlation ( $r = -.30, p < .01$ ), which indicated that as a clinician's modern homophobia increased, their diversity competency decreased. Such findings are generally consistent with the spirit of the research hypotheses. See Table 3 for a more complete listing of the correlation coefficients and their significance values.

Table 3

<i>Correlation Coefficients</i>								
Variable	1	2	3	4	5	6	7	8
1. MHI-18	--							
2. BPRS	-.53**	--						
3. GAF	.24*	-.40**	--					
4. BIDR (IM)	-.12	.07	.00	--				
5. Sexual Orientation	.32**	-.14	.20	-.06	--			
6. LBG-CSI	.10	-.02	.20	.15	.14	--		
7. MHS-G	-.09	.25*	-.09	.04	-.07	-.30**	--	
8. LGBT Clients	.26*	.04	-.04	-.28	-.06	.08	.06	--

Note: MHI-18 = *Mental Health Inventory*, BPRS = *Brief Psychiatric Rating Scale*, GAF = *Global Assessment of Functioning*, BIDR (IM) = *Balanced Inventory of Desirable Responding (Impression Management subscale)*, LBG-CSI = *The Lesbian, Gay, and Bisexual Affirmative Counseling Self-efficacy Inventory*, and MHS-G = *Modern Homophobia Scale-Gay Men*.

\* $p < .05$ . \*\* $p < .01$ .

In preparation for the regression analyses, it was necessary to decide which demographic variables would be included as controls. There were two variables that were utilized for theoretical reasons: level of education and experience with LGB clients. These variables were used as controls to reduce the presumed effects of education and experience working with this unique population on the diagnostic process. Several other variables have been shown to have an effect on attitudes toward sexual minorities including gender (Bowers & Bieschke, 2005), sexual orientation (Newman, Dannenfelser, & Benishek, 2002), religious affiliation, political identification (Grollman, 2008), and ethnicity (Herek & Gonzalez-Rivera, 2006). In order to determine their



effects on the current data independent samples t-tests and ANOVAs were conducted. None of these variables demonstrated a significant effect on the dependent variable, the MHI. Specifically, there was no significant difference in gender,  $t(69) = -.23, p = .33$ , sexual orientation dichotomized as sexual minorities and heterosexual participants,  $t(69) = .33, p = .30$ , religious affiliation,  $F(5, 66) = .47, p = .80$ , political identification,  $F(4, 68) = 1.13, p = .35$ , and ethnicity (due to sample size dichotomized as white and nonwhite),  $t(74) = 1.88, p = .06$ . Similar to the results found in the present study, Satcher and Schumacker's (2009) study of professional counselors found that gender and race were not significant predictors of modern homophobia.

**Analysis of the assumptions of multiple regression.** In order to conduct analyses that produce accurate results, it is important to explore the basic assumptions of parametric statistical tests, tests that rely on the normal distribution (Field, 2009). Multiple regression is most robust when the assumptions of normality of residuals, linearity, homogeneity of variance, non-multicollinearity, and mean independence are met (Tabachnick & Fidell, 2007). Since each hypothesis involved a unique combination of variables, the assumptions were tested for all four main analyses. This section outlines how the assumptions were tested and includes the general results. Deviations or atypical cases are mentioned directly in the section reporting the results for each hypothesis.

First, it was necessary to examine any unduly influential cases that would serve to bias the regression analysis. Mahalanobis distance was used to identify multivariate outliers. These values are an indicator of the distances from the means of the vector of predictor variables and, it is recommended that with a small to medium sample size, a

value greater than 15 suggests an outlier (Field, 2009). A limited number of cases were found and deleted per the distance values for each regression. In regard to normality, standardized residuals plots including a histogram and normality plot were examined. Visual inspection of residuals using the histogram revealed an approximately normal distribution. In addition, the normal probability plot graphs observed residuals in relation to a straight line, with the line indicating the normal distribution (Field, 2009). It is expected that the observed residuals will lie primarily on the straight line, which was the case for the present data. Table 4 below reports the skewness and kurtosis of the residuals for each of the primary hypotheses. The Kolmogorov-Smirnov test was used to formally test the normality of the residuals. This statistic indicates whether or not the residuals significantly differ from a normal distribution. In order to support normality of the residuals, one would expect this test to be non-significant, which was the case for each of the hypotheses. The following is a listing of the significance tests for each hypothesis: hypothesis 1,  $D(85) = .05, p = .20$ , hypothesis 2,  $D(85) = .05, p = .20$ , hypothesis 3,  $D(84) = .05, p = .20$ , and hypothesis 4,  $D(83) = .08, p = .20$ .

Table 4

*Skewness and Kurtosis Values of the Residuals for Primary Hypotheses*

Hypothesis	Skewness	Kurtosis
Hypothesis 1	.17	.081
Hypothesis 2	.16	.019
Hypothesis 3	.15	-.29
Hypothesis 4	.18	-.25

In order to assess the assumption of linearity and homoscedasticity, the scatterplot of the standardized residuals by the standardized predicted values was examined. The plotted data illustrated a relatively even dispersion of points around zero with no discernable pattern or funneling shape. Though not an assumption of multiple regression, multicollinearity can impact the results of this type of analysis and therefore, was investigated. Multicollinearity is an issue when multiple variables used for the regression analysis are too closely correlated and confound the results. Though some correlation is expected, high correlations can reduce the accuracy of the regression coefficients, may affect the R-value, and may confound the interpretation of which individual predictors are most highly contributing to the explanation of the dependent variable (Field, 2009). There are two diagnostics that assist with determining the presence of multicollinearity: the variance inflation factor (VIF) and the tolerance statistic. Various authors provide recommendations for appropriate values for these diagnostics suggesting concerns when the value is greater than 10 (Myers, 1990) with others suggesting that the average VIF

should be around 1.0 (Bowerman & O'Connell, 1990). It is suggested that tolerance, the reciprocal function of the VIF, should be no less than .1 (Menard, 1995). All collinearity diagnostics for the current data meet these requirements, suggesting that the variables were not highly multicollinear.

Finally, the assumption of independent errors suggests that the residuals of the regression analysis should not be correlated. Tabachnick and Fidell (2007) recommend using the Durbin-Watson statistic as a means of assessing this assumption. Specifically, a value near 2 suggests that the residuals are not correlated (Field, 2009). No problematic correlation of residuals was detected ( $d=2.015$ ).

#### **Analysis of the primary research hypotheses.**

*Hypothesis 1.* Hypothesis 1 stated that the sexual orientation of the client presented in the vignette would significantly predict the clinical distress perceived by mental health providers, controlling for social desirability and level of experience. A hierarchical regression analysis was conducted with block 1 consisting of the control variables (BIDR, level of education, and number of LGBT clients) and block 2 consisting of the sexual orientation of the client. Tabachnick and Fidell (2007) recommend centering variables used for regression analyses that involve the examination of interaction effects in order to reduce multicollinearity. Subsequent hypotheses involved the examination of interaction effects. Utilizing Mahalanobis distance, 2 multivariate outliers of concern were noted and removed. Table 5 displays the unstandardized regression coefficients (B) and intercept, standard errors, the standardized regression coefficients ( $\beta$ ), and  $R^2$ . Examination of the regression equation indicated that when

controlling for impression management and level of education, the sexual orientation of the client significantly predicted the perceived psychological distress of the client,  $F(4, 84) = 3.15, p = .02$ . Specifically, less psychological health was ascribed to the gay client as compared to the heterosexual client. Block 1, consisting solely of the control variables, produced an  $R^2$  of .04,  $p = .30$  accounting for 4% of the variance of perceived psychological health. Block 2, containing the variables of interest in addition to Block 1 variables, produced an  $R^2$  value of .14, accounting for about 14% of the variance in the dependent variable. This represented a significant increase in predictive value ( $p = .01$ ).

Table 5

*Hierarchical Regression of Perceived Psychological Health on BIDR (IM), Number of LGBT Clients, and Sexual Orientation*

	B	SE B	$\beta$	p
<b>Block 1</b>				
BIDR (IM)	-.61	.93	-.08	.51
Highest Level of Education	-.67	1.57	-.05	.67
Number of LGBT Clients	1.46	.94	-.19	.12
<b>Block 2</b>				
BIDR (IM)	-.29	.90	-.04	.74
Highest Level of Education	.08	1.52	.01	.96
Number of LGBT Clients	1.66	.90	.22	.07
Sexual Orientation	5.05	1.73	.31**	.005

*Note.* \*\* $p < .01$ . For block 1,  $R^2 = .04, p = .30$ , and for block 2,  $R^2 = .14, p = .005$ ;  $\Delta R^2 = .09, p < .01$ , and adjusted  $R^2 = .09$ .

**Hypothesis 2.** Hypothesis 2 predicted that the level of LGB competency would moderate the relationship between sexual orientation and the clinical distress perceived by mental health clinicians when social desirability, level of education, and number of LGBT clients are controlled. One multivariate outlier was detected through the use of Mahalanobis distance and removed from the analysis. The initial block of the regression equation similarly consisted of the control variables of the BIDR, level of education, and the number of LGBT clients. In the second block, the sexual orientation of the client was included along with the total score on the LBG-CSI. Finally, in the third block the interaction effect was entered into the equation calculated by multiplying the sexual orientation coded value by the LGB-CSI total score. Table 3 displays the unstandardized regression coefficients (B) and intercept, standard errors, the standardized regression coefficients ( $\beta$ ), and  $R^2$ . Results revealed significant models with the combination of variables in the second block,  $F(5, 84) = 2.50, p = .04$  as well as the combination of the variables in the third block,  $F(6, 84) = 2.22, p = .05$ . The sexual orientation of the client remained the only significant coefficient in the prediction of the assessment of the client's mental health ( $p = .004$ ). Specifically, less psychological health was ascribed to the gay client as compared with the heterosexual client. Block 1 produced an  $R^2$  value of  $.03, p = .42$ . The  $R^2$  value for block 2 was  $.14, p = .04$ , representing a statistically significant increase in predictive ability as a result of adding the variables in this block ( $p = .05$ ). In other words, 14% of the variance in the dependent variable was explained by the combination of independent variables in this equation. The interaction entered in block 3 did not statistically significantly increment prediction with an  $R^2$  value of  $.15$ ,

$p = .36$ . See Table 6 for unstandardized regression coefficients (B) and intercept, standard errors, the standardized regression coefficients ( $\beta$ ),  $R^2$ , and  $p$ -values.

Table 6

*Hierarchical Regression of Perceived Psychological Health (MHI) on BIDR (IM), Number of LGBT Clients, Sexual Orientation, LGB-CSI, and Sexual Orientation x LGB-CSI*

Block 1	B	SE B	$\beta$	$p$
BIDR (IM)	-.43	.93	-.05	.65
Highest Level of Education	-.77	1.67	-.06	.65
Number of LGBT Clients	2.28	1.54	.19	.14
Block 2				
BIDR (IM)	-.20	.89	-.03	.82
Highest Level of Education	.14	1.64	.01	.94
Number of LGBT Clients	1.76	1.49	.15	.24
Sexual Orientation	5.22	1.76	.32**	< .001
LGB-CSI	.233	.85	.03	.79
Block 3				
BIDR (IM)	-.29	.90	-.04	.75
Highest Level of Education	.06	1.65	.01	.97
Number of LGBT Clients	1.86	1.50	.16	.22
Sexual Orientation	5.24	1.76	.32**	< .001
LGB-CSI	2.44	2.54	.31	.34
Sexual Orientation x LGB-CSI	-1.60	1.73	-.30	.36

*Note.* \*\* $p < .01$ . For block 1,  $R^2 = .03$ ,  $p = .42$ . For block 2,  $R^2 = .14$ ,  $\Delta R^2 = .10$ , and  $p = .01$ . For block 3,  $R^2 = .15$ ,  $\Delta R^2 = .009$ , and  $p = .05$ . Adjusted  $R^2 = .08$ .

**Hypothesis 3.** Hypothesis 3 stated that level of modern homophobia would statistically significantly predict the clinical distress perceived by mental health clinicians when social desirability, level of experience, and number of GLBT clients are controlled. Two multivariate outliers were detected and deleted from the sample for this analysis. The regression analysis revealed no statistically significant result,  $F(4, 83) = .77, p = .55$ . See Table 7 for unstandardized regression coefficients (B) and intercept, standard errors, the standardized regression coefficients ( $\beta$ ), and  $R^2$ .

Table 7

*Hierarchical Regression of Perceived Psychological Health (MHI) on BIDR (IM), Number of LGBT Clients, and MHS-G*

	B	SE B	$\beta$	p
<b>Block 1</b>				
BIDR (IM)	-.42	.93	-.05	.65
Highest Level of Education	-.65	1.72	-.05	.71
Number of LGBT Clients	2.23	1.56	.19	.16
<b>Block 2</b>				
BIDR (IM)	-.40	.94	-.05	.67
Highest Level of Education	-.87	1.80	-.07	.62
Number of LGBT Clients	1.95	1.35	.16	.14
MHS-G	-.53	.95	-.06	.58

*Note.* For block 1,  $R^2 = .034, p = .43$  and for block 2,  $R^2 = .37, \Delta R^2 = .004, p > .05$ . Adjusted  $R^2 = -.01$ .



***Hypothesis 4.*** The final hypothesis surmised that level of LGB competency would moderate the relationship between modern homophobia and the clinical distress perceived by mental health clinicians when social desirability and level of experience are controlled. Three multivariate outliers were detected and deleted from the sample for this analysis. The regression analysis revealed no statistically significant result,  $F(6, 82) = .98, p = .44$ . See Table 8 for unstandardized regression coefficients (B) and intercept, standard errors, the standardized regression coefficients ( $\beta$ ),  $R^2$ , and  $p$ -values.

Table 8

*Hierarchical Regression of Perceived Psychological Health (MHI) on BIDR (IM), Number of LGBT Clients, Sexual Orientation, LGB-CSI, and Sexual Orientation x LGB-CSI*

Block 1	B	SE B	$\beta$	<i>p</i>
BIDR (IM)	-.01	.96	-.001	.99
Highest Level of Education	.25	1.52	.02	.49
Number of LGBT Clients	2.60	1.56	.22	.10
Block 2				
BIDR (IM)	.03	.97	.003	.98
Highest Level of Education	-1.63	1.80	-.12	.37
Number of LGBT Clients	2.57	1.59	.22	.11
MHS-G	-.23	1.00	-.03	.82
LGB-CSI	.99	.96	.12	.31
Block 3				
BIDR (IM)	.04	.96	.01	.97
Highest Level of Education	-2.08	1.83	-.16	.26
Number of LGBT Clients	2.86	1.60	.24	.08
MHS-G	-.63	1.04	-.08	.55
LGB-CSI	.78	.97	.10	.43
MHS-G x LGB-CSI	-1.26	1.00	-.15	.22

*Note.* For block 1,  $R^2 = .04$ ,  $p = .41$ . For block 2,  $R^2 = .05$ ,  $\Delta R^2 = .017$ ,  $p > .50$ . For block 3,  $R^2 = .07$ ,  $\Delta R^2 = .02$ ,  $p = .21$ . Adjusted  $R^2 = -.001$ .

**Post-hoc analyses.** The following analyses are adjunct to the central hypotheses of this study. Those reported provide a means to understand the phenomena more fully and suggest additional areas for future research. These utilize the same predictor variables as investigated above; however, the BPRS was used as the dependent variable. It is important to note that the BPRS investigates the level of psychological dysfunction of a client while the MHI-18 final score tends to rate the client's level of psychological

health. Both conceptually and empirically (based on the correlations figured in this study), these concepts are highly related, though there may exist a subtle difference. As such the four previously mentioned hypotheses were tested utilizing the same dependent variables, now predicting the total score in the BPRS. The first two hypotheses did not produce a significant result; however, the third hypothesis demonstrated significance with the MHS as a significant predictor of psychological dysfunction. Two multivariate outliers were discarded from the sample for analysis. Controlling for impression management, number of LGBT clients, and level of education, modern homophobia significantly predicted assigned clinical distress,  $F(4, 83) = 2.73, p = .04$ . Specifically, the higher the modern homophobia, the greater the clinical distress assigned to the client. Block 1 produced an  $R^2$  value of .041,  $p = .33$ . The  $R^2$  value for block 2 represented a significant increase in predictive ability to a value .131 ( $p=.01$ ) with a significant overall model,  $p = .04$ . In other words, 13.1% of the variance in the dependent variable was explained by the combination of independent variables in this equation. See Table 9 for unstandardized regression coefficients (B) and intercept, standard errors, the standardized regression coefficients ( $\beta$ ),  $R^2$ , and  $p$ -values. In utilizing the BPRS in testing hypothesis 4, there was not a significant interaction effect or increase in predictive power when the interaction was included.

Table 9

*Hierarchical Regression of Perceived Psychopathology (BPRS) on BIDR (IM), Number of LGBT Clients, Level of Education, and Modern Homophobia*

Block 1	B	SE B	$\beta$	<i>p</i>
BIDR (IM)	.043	.07	.07	.55
Number of LGBT Clients	.13	.09	.20	.13
Level of Education	-3.27	2.14	-.20	.13
Block 2				
BIDR (IM)	.03	.07	.05	.62
Number of LGBT Clients	.10	.08	.15	.23
Level of Education	-1.98	2.12	-.12	.35
MHS-G	.43	.16	.29**	.01

*Note.* \*\* $p < .01$ . For block 1,  $R^2 = .041$ ,  $p = .33$ . For block 2,  $R^2 = .122$ ,  $\Delta R^2 = .08$ ,  $p < .001$ . Adjusted  $R^2 = .07$ .

## Chapter Five

### Discussion

**Overview and discussion of hypotheses.** Clinical assessment and diagnosis are multifaceted, complex processes that mental health professionals engage in on a frequent, if not daily, basis. The extent of psychological health or distress assigned to the client and the diagnosis finally recorded can have lasting impacts and therefore, must not be taken lightly. Decisions regarding course of treatment, hospitalization, school status, fitness to stand trial, and others, are made based on these clinical impressions and other relevant data. Though mental health professionals are trained to make criteria-driven diagnoses, there is seldom a precise formula that captures the presentation of each client. Likewise, the clinician her/himself is human, carrying past experiences, personal identity, attitudes, beliefs, and assumptions into the counseling relationship. As such, it is imperative to comprehend the factors that contribute to how clinicians make psychological diagnoses. The current study sought to understand how aspects of diversity influence this decision-making process and the role competency plays in moderating the relationship between the client's sexual orientation and the level of mental health assigned to the client. In addition, it is important to consider underlying beliefs or assumptions, including those that may have become covert, and how those predict the assessment of psychological health for the client. Finally, this study explored

the extent to which modern homophobia affects the diagnosis of clients and how competency may moderate this relationship.

Examination of the correlation coefficients revealed significant relationships among several of the variables measured. It was expected and subsequently supported that the sexual orientation of the client would be related to the MHI-18 total score with higher scores relating to a heterosexual identity. This supports the idea that greater health is ascribed to males endorsing a heterosexual identity and behaviors. This relationship is explained more fully in regard to the regression analysis. Additionally, there was a significant negative relationship between the modern homophobia scale (MHS-G) and the diversity competency scale (LGB-CSI). Clinicians who had higher levels of diversity competency were less endorsing of modern homophobia. Such a finding emphasizes that true competency in working with clients of diverse backgrounds is difficult to achieve without examining the clinician's assumptions and biases. This has been documented in regard to working with ethnic minorities (Sue, 2008), and may be an important component of feeling capable to assist LGB clients. For example, believing that gay men are too aggressive in their search for equal rights or that gay men are using their identity to gain special advantages or that coming out is an unremarkable process, may relate to a lack of comfort or ability to empathize with a gay client, to understand the unique challenges faced by this population, to seek consultation when needed, and to fully understand the effect one's own sexual orientation may have on the client. Graduate programs and clinical supervisors have a unique opportunity to help developing clinicians to uncover covert forms of homophobia that may interfere with competent work. As

Worthington, Dillon, and Becker-Schutte (2005) suggest, affirmative competency is paramount, consisting of several dimensions including knowledge, awareness, rapport building, assessment of population specific mental health needs, and advocacy skills. Some of these dimensions are learned, while others are reflected upon, felt, and discovered. What might illuminate modern homophobia biases and subsequently reduce their impact on the work of mental health professionals? Utilizing techniques that have become prevalent in the racial prejudice literature may provide a basis for graduate programs as more begin to develop specific classes surrounding counseling sexual minority clients (Herek & Capitanio, 1996; Pettigrew & Troop, 2006). An important part of the argument of scholars in this area is that both an understanding of the minority group and productive contact with the group are necessary components for the reduction of prejudice and by extension, modern homophobia (Pettigrew & Troop, 2006). More specifically, Fischer (2011) recommends sharing of knowledge, affective connection, and self-reflection as facilitative diversity tools, which can be applied to mental health professionals in training. This line of research suggests that in order to truly reduce modern homophobia or other conceptualizations of gay men and lesbian women as pathological, it may be necessary to build relationships with this population, have meaningful contact, and work with them clinically.

Four related hypotheses were proposed and tested utilizing multiple regression analyses. The first hypothesis stated that when controlling for impression management and demographic variables, the sexual orientation of the client would significantly predict the level of mental health assessed. This hypothesis was supported as the regression

model was statistically significant with the sexual orientation of the client being a significant predictor. This suggests that there is a difference in the way in which clinicians perceive the mental health of clients across sexual orientation. There are a number of explanations for such findings. First, though attitudes of mental health professionals toward gay men are becoming increasingly neutral to positive rather than disparagingly prejudicial (Bowers & Bieschke, 2005), there still remains some discrepancy in perception within the mental health community. It may be a function of the historical remnants of same-sex sexuality being included in the *DSM* with a history of behaviorists and psychoanalysts asserting the inherent dysfunction and changeability of same-sex attraction. It is interesting to note that the vignettes used for this study made mention of the romantic *and* sexual relationships of the client which is generally consistent with information collected upon intake. It is possible that this activates a different line of stereotypic thinking or assumptions. For example, the “love the sinner, hate the sin” mentality endorsed by some major world religions may not be able to be upheld when the client is reporting same-sex sexual contacts. A less delineated version of this concept is the following idea: “I am okay with gay men as long as they don’t become too descriptive of their lives.” In other words, there may be a difference between a client identifying demographically as gay and the client sharing about his romantic and sexual life. A heterosexual male client who is disclosing his romantic and sexual life may fit what is expected and even glorified for his straight identity. This then creates the distinction that one client is doing what he is “supposed” to do as a heterosexual male and the gay client is doing what society is “afraid” he is doing (See discussion below



regarding reactions to intellectual versus erotic disclosures). Further research is needed to more fully support this emerging idea. The results maintain the idea that underlying psychological forces, assumptions, or biases are leading the clinician to see the client as less psychologically healthy. Research has documented enduring attitudes of mental health professionals as believing same-sex sexuality is a mental disorder, even a personality disorder, rather than a normal variant of sexuality (Garnets, Hancock, Goodchilds, & Peplau, 1998). Future research could investigate identity versus behavior in its effect on diagnosis.

In addition, everyday vernacular may infiltrate the mind of the mental health professional when assessing clients by viewing a gay identity as encountering an “identity crisis” or believing that same-sex sexual exploration is a phase rather than an identity (Sue, 2010). In addition, the implication of an active sex life for the client may have played into a common microaggression directed toward gay men: oversexualization. Specifically, this microaggression implies that people view gay men in sexual terms rather than as whole people. This tendency to oversexualize can be an impetus for people who are afraid that allowing gay men into locker rooms is threatening or that fear that gay men may get the “wrong message” from a straight male friend. Research conducted in the 1990’s indicated that counselors tended to be intellectually accepting of gay men and lesbian women, but had negative reactions when erotic interactions were described (Rudolf, 1990). It is possible that this microaggression can lead to misunderstanding and the assignment of unwarranted pathology (Sue, 2010).

There may also be an alternative understanding of these results. Though there is research that asserts that same-sex sexuality does not imply inherent psychological pathology, there is considerable research that indicates that sexual minorities are at an increased risk for a variety of psychological problems like substance abuse, anxiety, depression, and suicide (Amadio & Chung, 2004; Burns, Kamen, Lehman, & Beach, 2012; Shields, et al., 2012). The essential distinction is that these disorders are a result of societal pressures rather than a product of being gay (Sue, 2010). It is possible that clinicians misinterpret this correlation, leading to errors in the assessment of psychological health. Mental health professionals may recognize the same symptoms across clients, but assemble the symptoms differently based on knowledge that sexual minorities are at greater risk. This misattribution can have detrimental implications because it confuses the point of intervention and repeats the oppressive cycle of the client's outside world. The client may already be battling stereotypes within work environments, family systems, and the larger community. Though well intentioned, the counselor's ability to avoid sweeping generalizations is important for successful treatment. Likewise, this is not to say that sexual minorities do not exhibit diagnosable disorders.

Hypothesis 2 assessed the extent to which diversity competency moderated the relationship between the sexual orientation of the client and perceived level of psychological health. Though the overall model was significant and the sexual orientation of the client remained a significant predictor, diversity competency and the resulting interaction was not significant. Examining the correlation coefficients, there

was not a significant relationship between competency and perception of the mental health of the client. This is a surprising finding as previous research has demonstrated the impact that training and competency can have on the fair treatment of minority clients (Fischer & Phillips, 1998; Rutter, et al., 2008) and it would be expected that those with less competency would tend to make differential diagnoses based on internal conflict and implicit biases. The results indicate that across levels of LGB competency, similar diagnostic scores were assigned, meaning that those who were highly competent assigned similar levels of mental health as those who felt like they were less competent. The non-significant interaction coefficient implies that diversity competency does not ameliorate the differential assessment of the client's level of mental health. There may be a component to working with diverse clients that is un-teachable and lies primarily within the person of the clinician and his/her life experiences. This is not to say that diversity competency and training are not significant pieces of providing meaningful, helpful, and de-stigmatizing clinical services to clients as has been asserted in several research studies (Phillips & Fischer, 1998; Rudolf, 1989; Rutter et al., 2008). It is possible that a clinician's diversity competency has less of an impact on the assessment of the mental health of the client and sexual orientation and more of an impact on the treatment process.

There are many aspects of competency, several of which were combined in the current study to create an overall competency indicator. Though beyond the scope of this project, it will be important to assess how varying types of competency affect the relationship between the sexual orientation of the client and the perceived level of mental

health. For example, clinicians demonstrating high levels of *knowledge* regarding sexual minority populations or having strong *advocacy skills* may have differential moderation of the relationship between the sexual orientation of the client and distress than a clinician with high *awareness* of her/himself. Future research can focus on how each of these types of competency affects the diagnostic and treatment process.

The instrument used to measure LGB competency is primarily a self-efficacy instrument, noting the clinician's comfort with counseling sexual minority clients and the perceived knowledge, skill, and awareness to do so. It is important to note that true competency working with sexual minority populations is different than one's perceived comfort or self-efficacy. Research indicates that self-assessments can be influenced by a number of important variables, especially for counseling students (Little, Packman, Smaby, & Maddux, 2005), and therefore, clinicians may not be the best assessors of their own competencies. In order to account for the tendency to over-report the extent of competency, the impression management control variable was used; however, a different result may emerge if supervisors or clients themselves rated the competency of the clinician. It would be helpful to conduct a study in which people knowledgeable about the clinician's work rate competency and compare that to the results in this study. Such research approaches have limitations and potential confounds as well.

Hypothesis 3 took into consideration the effects of modern homophobia in the diagnostic process. This hypothesis asserted that modern homophobia would predict the perceived level of mental health of the client. Specifically, it was expected that higher levels of modern homophobia would lead to less health assigned to the client. This

hypothesis was not supported. Though the scores on the MHS-G ranged from 12 to 50 with 60 being the highest value, the vast majority of participants (82%) scored below 25. These are heartening results that suggest that the attitudes of mental health professionals, including covert attitudes, are generally positive and supportive of sexual minorities. The vast majority of the sample (60%) reported that they were between the ages of 20 and 30, representing early career and new mental health professionals in the field. On average, this age group is more accepting of sexual minority populations and is more likely to have friends or family who identify openly in this way (Herek & Gonzalez-Rivera, 2006). It does not appear that endorsing modern homophobia leads to an overarching tendency to assign less mental health to clients, particularly sexual minority clients. It was expected that denying that gay men do not have full societal rights, negating that they have unique challenges, and asserting that they are too focused on differences may lead to a potential to see gay men as problematic, prone to psychological instability. This may look like attributing a client's "pathology" to internal character structure rather than taking into consideration societal factors that may disadvantage groups (Taylor et al., 2006). As such, it is possible that the role of modern homophobia may have a greater effect on the conceptualization of the client's problem rather than the assessment of mental health. Reflecting back on the themes identified originally by DeCrescenzo (1983) after same-sex sexuality was removed from the *DSM*, many of the identified beliefs were related to the origin of the "problem" of being gay, searching for the answer in the client's family dynamic or in the supposed arrested stage of development. This line of reasoning may indicate that those with greater homophobia may not be inclined to

assemble symptoms and assess the client's health differentially, but understand the origin of the problem in a more covertly prejudiced, stigmatized fashion. Modern homophobia tends to disassociate the unique struggles of sexual minorities from the lived experience. For example, if a clinician believes that it does not take courage to be oneself in the face of societal contempt or that celebrating one's identity is of little value, he/she may miss the deeper struggles that most clients have with overcoming, belonging, and facing institutional adversity. In other words, the assessment of the level of mental health may be consistent across levels of modern homophobia as discovered in the present research, but the assessment of the source of the problem (theoretical conceptualization) may be affected—a question left for clarification in future exploration. However, these assertions must be tempered in light of the post-hoc analyses employing the BPRS as the dependent variable.

Using the BPRS, modern homophobia was a significant predictor of client pathology. This is an interesting finding that may emphasize an important subtlety in the relationship that is being investigated. The MHI-18 is created in such a way that it assesses the level of mental health of the client. The BPRS, on the other hand, is constructed to indicate that extent of symptomology/pathology of the client. Though these concepts are highly related and empirically correlated, this study provides evidence that they may measure distinct constructs. Theoretically, what difference is there in measuring the extent of mental health versus the extent of mental dysfunction? The BPRS has a list of 18 problematic symptoms—abilities that the person is lacking, negative emotions that the person is experiencing, and psychic oddities. The MHI-18

assesses those states as well, but also includes the person's experience of being loved, feeling cheerful, and feeling stable. Comparing the wording of these measures, subjectively there is a medicalization that may occur with the BPRS. In fact, the BPRS was designed originally from the medical model for psychiatric use and later adopted in the realm of psychology (see Overall & Gorham, 1962 for information about the origin of the measure). In summary of the results in light of these distinctions, when considering the mental health of the client (MHI-18), less health is ascribed to the gay client versus the heterosexual client. Conversely, when considering the extent of pathology, there is no difference in the assignment of distress. Furthermore, a reverse phenomenon is found when looking at the role of modern homophobia. Only when the extent of what may be viewed as pathology is predicted does the significant role of modern homophobia emerge.

The BPRS could be interpreted as a more overt measure of pathology. With changing and evolving opinions of sexual minorities within the mental health community (Bowers & Bieschke, 2005), overt prejudice has reduced in frequency, falling out of acceptance. The implication from the current findings is that the internal conflict of modern homophobia can lead to explicit expressions of pathology, especially for sexual minorities, when given permission to do so. On the other hand, when looking at the extent of health, the sexual orientation of the client matters. It may be more acceptable to say that sexual minorities are less healthy versus asserting that this population is more pathological. Additionally, modern homophobic beliefs do not affect the assessment of the extent of mental health for clients; however, modern homophobia and the

fundamental attribution error might be gripping to the diagnostic mindset of mental health professionals when assessing pathology and connecting the problem with sexual orientation. Moreno and Bodenhausen (2001) asserted that individuals with ambivalence or even internal conflict regarding a minority population tend to demonstrate behavioral manifestations (unfair treatment or discrimination) when the context provides social permission (as discussed in Martinez, 2011). This is additionally reminiscent of research conducted by Hayes and Erkis (2000) that investigated therapist homophobia, sexual orientation, and source of HIV infection on clinician reactions to clients. Results indicated a positive relationship between homophobia and the assignment of responsibility for the client's problems, tending to make the problem more personal with higher levels of homophobia. In other words, with higher prejudicial beliefs, clinicians were more likely to hold the person responsible for the problem (HIV infection). This may lead to a negation of contextual factors and be encouraged by a problem-focus. It is important to note that though the effect of modern homophobia is significant in predicting pathology, the regression coefficient is somewhat small in magnitude. The standardized regression coefficient of .29 suggests that as modern homophobia increases by one standard deviation, pathology increases by .29 standard deviations when other variables are held constant. In other words, for every 7.73 point increase in modern homophobia (MHS-G score), a 3.01 increase in pathology (BPRS score) is assigned. The possible scores on the BPRS range from 18 to 126.

It may be additionally useful to look at the various types of modern homophobia that can emerge to see if paternalistic, amnesic, or positive stereotypic heterosexism



impacts diagnostic decisions regarding clients. This is interesting, for example, because a positive stereotypic form of heterosexism may lead to an under-assessment of the client's mental health, which has its own set of ramifications. In summary, this study may indicate subtleties in the relationship between modern homophobia and the assessment of client mental health. Though hypothesis 3 did not support the idea that modern homophobia affects perception of client mental health, that does not mean that modern homophobia does not impact the therapeutic process. It may manifest when the diagnostic environment assumes a more symptoms-driven, medical model approach to assessment. If not in that way, it is possible that it manifests in ways not assessed in this study. Just as psychologists adopt feminist approaches to working with clients of every gender (not just those identifying as female), psychologists can also choose to adopt theoretical approaches that are affirmative of sexual identity for all clients. This may not impact diagnosis, but as asserted by many authors, can impact the subsequent therapeutic process (Bowers, Plummer, Minichiello, 2005; Garnets et al., 1991).

The final hypothesis for this study examined the role of LGB competency in moderating the relationship between modern homophobia and perceived level of mental health. Hypothesis 4 was not supported by the results. Though the simple correlations revealed a negative relationship between modern homophobia and LGB competency, there was no significant prediction of perceived mental health of the client and no significant interaction between modern homophobia and LGB competency. These results are surprising, as previous research has demonstrated that training and competency make a difference in counseling diverse clients (Phillips & Fischer, 1998; Sue & Sue, 2008).

This suggests that across varying levels of modern homophobia there was no systematic relationship with perceived level of mental health that was changed or altered by level of LGB competency. LGB competency in all analyses did not make a difference in the decisions regarding clinical distress including a comprehensive outlook considering both the MHI-18 and the BPRS. Considering the results utilizing the BPRS, non-significance for the interaction effect while the MHS-G remained significant, suggests that LGB competency could not ameliorate the effects of modern homophobia in the diagnostic process with a more medical model approach. Training that increases LGB competency still remains rare in graduate programs (Phillips & Fischer, 1998). The current sample provides some evidence that this trend is changing with only 30% having no official coursework in the area and with over 50% having had 1-2 classes in this area.

**Implications.** The results of this study have implications for clinical practice as well as for the training and education of mental health clinicians. First, there is evidence that mental health providers are attributing less mental health to gay clients when compared to heterosexual clients. This propensity to see gay clients in this way may lead counselors to be less hopeful regarding recovery, insert stereotypes into the clinical picture, and repeat oppressive patterns rather than create a healing experience for the client. Counselors in training and those already in the field need to consider that oppression is oftentimes coped with by psychological survival tactics, some of which could be seen as dysfunctional for clients coming from other, less oppressive contexts (Dworkin, 1992). Having one's identity consistently disregarded, feeling unsure of when or if to disclose, and living in fear of being "discovered" can create profound mental

distress. These contextual factors must be accounted for in the diagnostic process and be seen as a normal reaction to a stressful situation. In other instances, a gay client may manifest severe pathology or lack of mental health that is not related to his sexual orientation, the coming out process, or oppression. The counselor is given the responsibility of being able to differentiate these two situations and training programs need to address this directly. Sometimes, the interaction of both oppression and genuine pathology is indeed present and confounding. In the present study, the vignettes presented the same client with the same symptoms, background, family relationship, and romantic history yet with a different sexual orientation. The sexual orientation made the difference. In essence, counselors have to integrate an understanding of diversity with traditional psychological conceptualizations (Dworkin, 1992). It is important to know the research on the prevalence rates of disorders with minority populations, but it is not justification for a diagnosis in and of itself. Culturally educated questioning consists of utilizing research in order to explore in an open-ended way the potential areas of struggle for clients from various backgrounds (Rodriguez & Walls, 2000).

Taking this a step further, the research that is used for diagnosis and assessment of client mental health must be considered for its rigor and true applicability. Historically, erroneous conclusions have been made based on biased sampling techniques. Chernin and Johnson (2003) provide an example from research conducted with the Rorschach in which gay male psychiatric patients were compared with gay male prison inmates. Not surprisingly, this norming sample was not applicable to the general population of gay men or even an outpatient population at that. Findings, however,

indicated a pattern of pathological responses by gay men to the Rorschach cards. The Minnesota Multiphasic Personality Inventory (MMPI-II), one of the most widely used and respected personality assessment instruments today, continues to have a masculinity-femininity scale, a scale once used to diagnose “homosexuality.” Though the use of this scale for interpretive purposes has largely fallen out of practice and it is not considered a clinical scale, it continues to be reproduced on interpretive profiles amidst clinical scales like schizophrenia, paranoia, depression, mania, psychasthenia (anxiety), etc. (Chernin & Johnson, 2003). The client rarely, if ever, would see this profile, however, the clinician is exposed to it. This indirectly implies that gender incongruity and same-sex attraction are pathological—a tangible remnant of the past, still present today. Clinicians and researchers need to push for the inclusion of information regarding sexual orientation regarding the norming sample for formal assessment instruments.

The post-hoc analyses implied that there is a difference between assessing mental health and assessing pathology. In the assessment of pathology, the current findings indicated that higher levels of modern homophobia led to more pathological interpretations of clients. This was not evident when considering the clients mental health (MHI-18). Evidently, the prejudicial beliefs of the clinician make a difference in the treatment of gay clients when rating pathology. It can be argued that all mental health professionals need to be well educated and personally aware of underlying prejudicial beliefs because they relate to how clients in general are treated. In the extremely rare case that a mental health counselor does not work with LGB clients, they too need this training. It is likely that holding covert, prejudicial beliefs about gay men and lesbian

women may also relate to covert beliefs about other minority groups, misunderstanding of other forms of oppression, and by extension, hinder an ability to empathize with other life struggles. Each client has some form of diversity to be considered. Though LGB competency is unrelated to perceptions of client mental health in the current study, it must not be abandoned as a necessary pursuit for professionals.

The disparate results that surfaced upon post-hoc analysis give credence to the use of positive psychology in working with clients. In fact, rather than looking for dysfunction in minority clients, there is value in looking for health. Such an approach may lend less easily to the emergence of covert negative attitudes, as they may be less cognitively “primed” in the clinician’s mind; however, this did not appear to withstand the effects of sexual orientation on clinical impressions. A burgeoning area of research is emphasizing the positive aspects to being gay or lesbian and the post-coming out growth that can occur (Riggle, Whitman, Olson, Rotosky, & Strong, 2008; Vaughan & Waehler, 2010). A positive psychology approach to assessment and treatment would capitalize on coping resources, innate strength, and evidence of resiliency and may help to the clinician to balance research that asserts the higher prevalence of some mental disorders in marginalized populations.

With this awareness, how can changes be made and how are they already being enacted? The results of this study demonstrate that progress is happening both in attitudes and formal training, especially considering that a sizable portion of the sample had not completed their graduate programs and still had exposure to coursework examining sexual orientation. Therefore, there no longer is a question of whether issues

of counseling sexual minorities *should* be included in counseling program curriculums, but *how* these issues should be addressed so as to encourage accurate assessment of mental health and client pathology, provide affirmative and effective psychotherapy, and perpetuate faith that the psychological community can be helpful to minority clients (as suggested by Pearson, 2003). There is a tendency for graduate programs to relegate issues of diversity to a specific class whether that be a class dedicated primarily to diversity issues as a whole or a class addressing primarily issues related to sexual minorities (Pearson, 2003). This may not be sufficient for developing counselors and psychologists to unearth the insidious influences of modern homophobia in their personal lives and in their clinical practices. Rather, infusing diversity across the curriculum is necessary. Practicum classes, psychopathology classes, assessment classes, development classes, research classes, supervision classes, etc. must take responsibility to consistently address diversity. Even when diversity is covered in each individual class, there may be the tendency to have one day when diversity issues are applied to the overall subject matter. Though knowledge is important, true exploration of modern homophobic beliefs may not occur until the counselor has personal experience with sexual minorities or becomes immersed in their experiences on an emotional level (Phillips, 2000).

Pearson (2003) presented a method of training counselors that incorporates both informational and experiential components. The knowledge component of the training program consisted of a discussion of homophobia directly, a dialogue about the elevated mental health risks for sexual minorities as a result of minority stress, and an exploration of sexual identity and coming out models. She presented experiential factors as well as

utilized poems, song, and other media written by or about sexual minorities. These techniques may also be useful as continuing education workshops for those who have been in the field but have had little to no formal training in this area. As counselors begin working with clients, it is important that this contact is supervised well and facilitated effectively. Effective supervision invites self-exploration in regard to personal issues pertinent to work with clients. This can be an important formative contact. In the current study, it was evident that increased work and contact with LGB clients was significantly correlated with a higher rating of mental health. This idea is echoed in a number of studies, which assert that productive contact with the minority group can lead to deeper understanding, and reduce covert prejudices (Gurin, et al., 2004; Pettigrew & Tropp, 2006). Such contact could be facilitated within the classroom environment in which minority students come to share their stories with the class and have time afterwards to meet and ask questions of the panelists. Diagnostic courses may benefit from taking a mental health perspective rather than a pathology perspective while also examining both research on the prevalence rates of disorders in various minority groups as well as the resiliency and coping that can emerge from oppressive life circumstances.

**Limitations.** Several factors should be taken into consideration when utilizing and interpreting the results of the study. First, the sampling method was convenience sampling. It cannot be considered fully representative of the larger population of mental health professionals in clinical and counseling psychology. Though the selection of the listservs used was designed to target both students and professionals at varying levels in their training and career, the sample consisted mostly of younger or early career

psychologists. This is important to keep in mind because the assessment of pathology for gay clients is linked inevitably to the historical context within which the practitioner developed. The sample also consisted of 80% Caucasian participants with 20% of the participants coming from minority backgrounds. It may have been helpful to have more professionals of color participating. It is important to repeat this study with a greater number of participants in order to ascertain more generalizable results.

Some participants provided feedback stating that they found it difficult to make clinical judgments about the client presented because they needed more information. This concern was predicted and initially addressed through the pilot study in which doctoral students were given the measures, asked to complete them, and provided feedback about their ability to make clinical judgments. As a result, some additions to the vignette were made regarding the family relationships of the client. This was a difficult balance of providing enough information to make a clinical judgment while also not providing too much information. The study was designed in such a way to allow participants to fill in the missing information as clinicians often do in real life settings. Nevertheless, participants who felt unsure of how to assess the client because they believed insufficient information was provided may have been inclined to enter guesses rather than genuine clinical impressions. The study was an analogue study operating on the assumption, as many studies do, that the vignette provided is similar to actually assessing a client in person. There are a host of other factors that are active in an actual clinical setting and therapeutic contact that cannot be captured through the use of a



vignette. There may be a greater sense of empathy when hearing directly the story of a client whereas that empathy may not be ignited through reading about a client.

In regard to the measures used, the MHI-18 is generally used as a client-completed survey about the client's own symptomology. It was adapted to be a clinician-completed survey for this study. In order to provide evidence that this was a valid use, the BPRS was also administered to participants and correlated. This revealed a statistically significant result in the direction expected, providing support for the validity of its use. However, this may serve as a confounding factor as it was not initially designed for this purpose. It was chosen because it provided a more direct analogue for clinical diagnosis rather than using semantic differential procedures as commonly used in past studies (Bowers & Bieschke, 2005; Sands, 1998). Self-report measures in general are bound by the accuracy and truthfulness of the participant. This is especially relevant when participants are asked to rate how competent they are at an area that they may feel they should be competent. Though social desirability was controlled for, there may be some inaccuracy in how competent one perceives him/herself to be and how competent he/she actually is. An objective measure completed by the counselor, a supervisor, and a client might be an option to address this concern in future research.

**Future Research.** It is recommended that future research further delineate the role of LGB competency in the diagnosis and treatment of sexual minority clients. There are several forms of competency as identified by Dillon and Worthington (2003) including LGB knowledge, personal awareness, advocacy, therapeutic relationship building, and assessment of relevant issues. Though the overall competency score did

not have a moderating effect, it is important to note whether the subscales may have a more notable effect in altering the relationship between the sexual orientation of the client and perceived level of mental health. Furthermore, it may be helpful to explore which types of competency are most related to modern homophobia as the overall competency score was negatively correlated with modern homophobia. It may be beneficial to extend this study beyond diagnosis into conceptualization and treatment planning. LGB competency did not demonstrate a strong relationship with issues relating to diagnosis, but it may have an impact on how the clinician chooses to understand the development of the client's distress.

Since the present study demonstrated that there is a difference in how clinicians are viewing gay clients in comparison to their heterosexual counterparts, examining where the discomfort comes from is highly needed because in regard to assessing mental health, it does not appear to stem from modern homophobia. For example, creating vignettes in which the clients have various sexual orientations and various forms of gender expression could help to uncover the primed stereotypes or prejudices. The sexual activity of the client may also be a factor; so, comparing a highly sexually active gay male with a gay client who is not sexually active could determine if sexual activity (more than just the mention of it) is making a difference in the clinicians' perceptions. This type of research may also create vignettes that are stereotype consistent versus stereotype inconsistent. The "promiscuous gay man" could be compared to the "monogamous gay man" or the "appearance conscious, attractive gay man" (positive stereotype) could be compared to the "non-appearance conscious gay man."

Finally, the difference between assessing mental health versus assessing psychological pathology that was illustrated in the post-hoc analysis is well situated for further research. Is it possible that the mere expectation of assessing pathology leads to over-pathologizing minority clients, specific sexual minority clients. It would be interesting to note what differences arise when sexual minority clients are assessed for their resiliency and coping resources rather than their deficits. Assessing modern homophobia's relationship with these disparate types of diagnostic tasks would further the understanding of attitudinal factors that are at work. In addition, it may be important to expand this research to other healthcare providers who work with sexual minority clients. Psychiatrists by training operate from the medical model of assessment and treatment and may be influenced differently by the sexual orientation of the client.

### **Concluding Remarks**

Accurate, attentive, and compassionate diagnoses can be a building block for good, healing, and transformative therapy. It is in fully understanding the ways in which mental health clinicians navigate their own humanity, their own prejudices, and their own internal conflicts that the psychological community can better train professionals and better treat diverse populations. Sexual minority clients seek refuge within the therapy room from a sense of oppression that can permeate—covertly, insidiously—their experience of the outside world. Therefore, it is paramount that therapy is a different experience in which clients are lifted up and strengthened. The individual clinician is important, but each clinician is a part of the larger mental health community. The American Psychiatric Association and the American Psychological Association, amongst

many other related organizations, serve as guides to the larger society of how to view and whether to pathologize various conditions or populations. Attitudes, therefore, of this community of psychologists and counselors must be understood and the ways in which attitudes change and morph over time must never be underestimated. Robert F. Kennedy said:

Each time a [person] stands for an ideal, or acts to improve the lot of others, or strikes out against injustice, he[/she] sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy, and, daring those ripples, build a current which can sweep down the mightiest walls of oppression and resistance.

The psychological community, clinicians, and researchers have participated in such movements in the past and are poised to create ripples of hope with clients and with society as a whole in the future.

## References

- Aas, I. M. (2010). Global Assessment of Functioning (GAF): Properties and frontier of current knowledge. *Annals of General Psychiatry, 9*(20), 1-11.
- Aiken, L. S., & West, S. G. (1991). *Multiple Regression: Testing and Interpreting Interactions*. Newbury Park, CA: Sage Publications.
- Amadio, D. M., & Chung, Y. B. (2004). Internalized homophobia and substance use among lesbian, gay, and bisexual persons. *Journal of Gay and Lesbian Social Services, 17*, 83-101.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> ed.). Arlington, VA: American Psychiatric Association.
- American Psychological Association. (2011). *Practice guidelines for LGB clients*. Retrieved from <http://www.apa.org/pi/lgbt/resources/guidelines.aspx?item=1>.
- Amhad, S., & Bughra, D. (2010). Homophobia: An updated review of the literature. *Sexual and Relationship Therapy, 25*(4), 447-455.
- Asch, S. E. (1955). Opinions and social pressure. *Scientific American, 19*, 31-35.
- Bandura, A. (1986). Self-efficacy. In A. Bandura (Ed), *Social foundations of thought and action: A social cognitive theory* (pp. 390-453). Englewood Cliffs, NJ: Prentice Hall.
- Barret, R. L., & Robinson, B. E. (1994). Gay dads. In A. E. Gottfried & A. W. Gottfried (eds.). *Redefining Families: Implications for Children's Development*.
- Barnes, F. P., & Murdin, L. (Eds.) (2001). *Values and ethics in the practice of psychotherapy and counselling*. Buckingham, England: Open University.

- Beutler, L. E. (1981). Convergence in counseling and psychotherapy: A current look. *Clinical Psychology Review, 1*, 79-101.
- Bergin, A. E. & Garfield, S. L. (1994). *Handbook of psychotherapy and behavior change* (4<sup>th</sup> ed.). New York: John Wiley & Sons, Inc.
- Bowers, A. M. & Bieschke, K. J. (2005). Psychologists' clinical evaluations and attitudes: An examination of the influence of gender and sexual orientation. *Professional Psychology: Research and Practice, 36*(1), 97-103.
- Bowerman, B. L. & O'Connell, R. T. (1990). *Linear statistical models: An applied approach* (2<sup>nd</sup> ed.) Belmont, CA: Duxbury.
- Bowers, R., Plummer, D., & Minichiello, V. (2005). Homophobia in counseling practice. *International Journal for the Advancement of Counseling, 27*(3), 471-489.
- Boysen, G. A., Vogel, D. L., Madon, S., & Wester, S. R. (2006). Mental health stereotypes about gay men. *Sex Roles, 54*, 69-82.
- Brown, L. (1996). Preventing heterosexism and bias in psychotherapy and counseling. In E. D. Rothblum & L. A. Bond (Eds.), *Preventing heterosexism and homophobia* (pp. 36-58). Thousand Oaks, CA: Sage Publications.
- Brown, L. S. (1996). Ethical concerns with sexual minority patients. In R. Cabaj & T. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 897-916). Washington, DC: American Psychiatric Press.
- Brown, M. J. & Groscup, J. L. (2009). Homophobia and acceptance of stereotypes about gays and lesbians. *Individual Differences Research, 7*(3), 159-167.

- Bufka, L. F. & Camp, N. (2010). In M. Anthony & D. Barlow (Eds.), *Handbook of assessment and treatment planning for psychological disorders* (pp. 62-94). New York: The Guilford Press.
- Burns, M. N., Kamen, C., Lehman, K. A., & Beach, S. R. (2012). Minority stress and attributions for discriminatory events predict social anxiety in gay men. *Cognitive Therapy Research, 36*, 25-35.
- Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4*(3), 219–235.
- Chernin, J. N. & Johnson, M. R. (2003). *Affirmative psychotherapy and counseling for lesbians and gay men*. Thousand Oaks, CA: Sage Publications.
- Comer, R. J. (2010). *Abnormal psychology* (7<sup>th</sup> ed.). New York: Worth Publishers.
- Consoli, A. J., Kim, B. S., & Meyer, D. M. (2008). Counselors' values profile: Implications for counseling ethnic minority clients. *Counseling and Values, 53*, 181-197.
- Constantine, M, & Gainor, K. (2001). Emotional intelligence and empathy: Their relation to multicultural knowledge and awareness. *Professional School Counseling, 5*(2), 131-137.
- Cowan, G., Heiple, B., Marquez, C., Khatchadourian, D., & McNevin, M. (2005). Heterosexuals' attitudes toward hate crimes and hate speech against gays and lesbians: Old-fashioned and modern heterosexism. *Journal of Homosexuality, 49*(2), 67-81.

- Cramer, R. J., Golom, F. D., LoPresto, C. T., & Kirkley, S. M. (2008). Weighing the evidence: Empirical assessment and ethical implications of conversion therapy. *Ethics & Behavior, 18*(1), 93-114.
- DeCrescenzo, T. (1983). Homophobia: A study of the attitudes of mental health professionals toward homosexuality. *Journal of Social Work and Human Sexuality, 2*(2), 115-136.
- Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine, 13*, 595-605.
- Dillon, F. R. & Worthington, R. L. (2003). The lesbian, gay, and bisexual affirmative counseling self-efficacy inventory (LGB-CSI): Development, validation, and training implications. *Journal of Counseling Psychology, 50*(2), 235-251.
- Dillon, F. R., Worthington, R. L., Soth-McNett, A. M., & Schwartz, S. J. (2008). Gender and sexual identity-based predictors of lesbian, gay, and bisexual affirmative counseling self-efficacy. *Professional Psychology: Research and Practice, 39*(3), 353-360.
- Drescher, J. (2003). Gold or lead? Introductory remark on conversions. *Journal of Gay and Lesbian Psychotherapy, 7*(3), 1-13.
- Drescher, J. & Zucker, K. J. (Eds.). (2006). *Ex-gay research: Analyzing the Spitzer study and its relation to science, religion, politics, and culture*. New York: Harrington Park Press.
- Dworkin, S. H. (1992). Some ethical considerations when counseling gay, lesbian, and bisexual clients. In S. H. Dworkin, & F. J. Gutierrez (Eds.), *Counseling gay men*



- and lesbians: A journey to the end of the rainbow* (pp. 325-334). Alexandria, VA: American Counseling Association.
- Ellemers, N. & Barreto, M. (2009). Collective action in modern times: How modern expressions of prejudice prevent collective action. *Journal of Social Issues*, 65(4), 749-768.
- Ellingson, J. E., Smith, D.B., & Sackett, P. R. (2001). Investigating the influence of social desirability on personality factor structure. *Journal of Applied Psychology*, 86(1), 122-133.
- Fassinger, R. E. & Arseneau, J. R. (2007). "I'd rather get wet than be under that umbrella": Differentiating the experiences and identities of lesbian, gay, bisexual, and transgender people. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and transgender clients* (pp. 19-49). Washington DC: American Psychological Association.
- Federal Bureau of Investigation. (2011). *Hate Crime Statistics*. Retrieved from <http://www.fbi.gov/about-us/cjis/ucr/hate-crime/2011/hate-crime>.
- Field, A. (2009). *Discovering statistics using SPSS*. Thousand Oaks, CA: Sage Publications.
- Fischer, M. J. (2011). Interracial contact and changes in the racial attitudes of white college students. *Social Psychology of Education*, 14, 547-574.
- Fish, J. (2006). *Heterosexism in health and social care*. London: Palgrave Macmillan.

- Foster, J. R., Selan, S., Welkowitz, J., Boksay, I., & Seeland, I. (1988). Psychiatric assessment in medical long-term care facilities: Reliability of commonly used rating scales. *International Journal of Geriatric Psychiatry, 3*, 229-233.
- Garfinkle, E. M., & Morin, S. F. (1978). Psychologists' attitudes towards homosexual psychotherapy clients. *Journal of Social Sciences, 34*(3), 101-112.
- Garnets, L. D. (2007). Foreword: The “coming of age” of lesbian, gay, bisexual, and transgender-affirmative psychology. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and transgender clients* (pp. 19-49). Washington DC: American Psychological Association.
- Garnets, L. D. (2002). Sexual orientations in perspective. *Cultural Diversity and Ethnic Minority Psychology, 8*(2), 115-129.
- Garnets, L. D., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbian and gay men: A survey of psychologists. *American Psychologist, 46*(9), 964-972.
- Garnets, L. D., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1998). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. In D. R. Atkinson & G. Hackett (Eds.), *Counseling Diverse Populations* (pp. 297-316). Boston: McGraw-Hill.
- Gonsiorek, J. C., Sell, R. L., & Weinrich, J. D. (1995). Definition and measurement of sexual orientation. *Suicide & Life - Threatening Behavior, 25*, 40-51.

- Gonzalez, F. & Espin, O. (1996). Latino men, Latina women, and homosexuality. In R. P. Cabaj and T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 563-582). Washington DC: American Psychiatric Press.
- Goodman, M. B. & Moradi, B. (2008). Attitudes and behaviors toward lesbian and gay persons: Critical correlates and mediated relations. *Journal of Counseling Psychology, 55*(3), 371-384.
- Gramick, J. (1983). Homophobia: A new challenge. *Social Work, 28*(2), 137-141.
- Greene, B. (2007). Ethical psychological services to LGB clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and transgender clients* (pp. 181-200). Washington DC: American Psychological Association.
- Grollman, E. (2008). Old-fashioned and modern homonegativity within an American college student sample. *Journal of Undergraduate Research and Creative Works, 9*, 76-101.
- Gurin, P., Nagda, B., & Lopez, G. E. (2004). The benefits of diversity in education for democratic citizenship. *Journal of Social Issues, 60* (1), 17-34.
- Gushue, G. V. (2004). Race, color-blind racial attitudes, and judgments about mental health: A shifting standards perspective. *Journal of Counseling Psychology, 51*(4), 398-407.
- Haldeman, D. C. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice, 33*(3), 260-264.

- Halpert, S. C., Reinhardt, B. & Toohey, M. J. (2007). Affirmative Clinical Supervision. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and transgender clients* (pp. 181-200). Washington DC: American Psychological Association.
- Hall, D. E. (2005). A brief slanted history of homosexual activity. In I. Morland & A. Willox (Eds.), *Queer Theory* (pp. 96-114). New York: Palgrave MacMillan.
- Hamner, K. (1992). Gay-bashing: A social identity analysis of violence against lesbians and gay men. In G. M. Herek & K. T. Berrill (Eds.), *Hate crimes: Confronting violence against lesbians and gay men* (pp. 179-190). Thousand Oaks, CA: Sage Publications.
- Hanna, F. J., Talley, W. B., & Guindon, M. H. (2000). The power of perception: Toward a model of cultural oppression and liberation. *Journal of Counseling and Development, 78*, 430-441.
- Hayes, J. A., & Erkis, A. J. (2000). Therapist homophobia, client sexual orientation, and source of client HIV infection as predictors of therapists' reactions to clients with HIV. *Journal of Counseling Psychology, 47*, 71-78.
- Hayes, J. A., & Gelso, C. J. (1993). Male counselors' discomfort with gay and HIV-infected clients. *Journal of Counseling Psychology 40*(1), 86-93.
- Henke, T., Carlson, T. S., & McGeorge, C. R. (2009). Homophobia and clinical competency: An exploration of couple and family therapists' beliefs. *Journal of Couple & Relationship Therapy, 8*, 325-342.

- Herek, G. M. (1984). Attitudes towards lesbians and gay men: A factor analytic study. *Journal of Homosexuality, 10*, 39-51.
- Herek, G. M. (1988). Heterosexuals attitudes toward lesbians and gay men: Correlates and gender differences. *Journal of Sex Research, 25*, 451–477.
- Herek, G. M. (1991). Myths about sexual orientation: A lawyer’s guide to social science research, *Law & Sexuality, 1*, 133-172.
- Herek, G. M. & Capitano, J. P. (1996). “Some of my best friends”: Intergroup contact, concealable stigma, and heterosexual’s attitudes toward gay men and lesbians. *Personality and Social Psychology Bulletin, 22*, 412-424.
- Herek, G. M. & Garnets, L. (2007). Sexual orientation and mental health. *The Annual Review of Clinical Psychology, 3*, 353-375.
- Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology, 56*(1), 32-43.
- Herek, G. M., & Gonzalez, M. (2006). Attitudes toward homosexuality among U.S. residents Mexican descent. *Journal of Sex Research, 43*(2), 122-135.
- Jagose, A. (1996). *Queer Theory*. Melbourne, Australia: University of Melbourne Press.
- Just the Facts Coalition. (2008). *Just the facts about sexual orientation and youth: A primer for principals, educators, and school personnel*. Washington, DC: American Psychological Association.
- Kantor, M. (2009). *Homophobia: The state of sexual bigotry today* (2<sup>nd</sup> Ed). Westport, CT: Greenwood Publishing Group.

- Kelly, T. A., & Strupp, H. H. (1992). Patient and therapist values in psychotherapy: Perceived changes, assimilation, similarity, and outcome. *Journal of Consulting and Clinical Psychology, 60*, 34-40.
- Kinsey, A.C., Pomeroy, W.B., & Martin, C.E. (1948). *Sexual behavior in the human male*. Philadelphia: W.B. Saunders.
- Kite, M. (2001). Gender stereotypes. In J. Worrel (Ed.), *Encyclopedia of women and gender: Sex similarities and differences and the impact of society on gender* (pp. 561-570). San Diego, CA: Academic Press.
- Lanyon R. I., & Carle, A. C. (2007). Internal and external validity scores on the Balanced Inventory of Desirable Responding and the Paulhus Deception Scales. *Educational and Psychological Measurement, 67*(5), 859-876.
- Larson, L. M. & Daniels, J. A. (1998). Review of counseling self-efficacy literature. *The Counseling Psychologist, 26*(2), 179-217.
- Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology, 1*, 105-120.
- Leucht, S., Kane, J. M., Etschel, E., Kissling, W., Hamann, J., & Engel, R. R. (2006). Linking the PANSS, BPRS, and CGI: Clinical implications. *Neuropsychopharmacology, 31*, 2318-2325.
- Levina, M., Waldo, C., & Fitzgerald, L. (2000). We're here, we're queer, we're on TV: The effects of visual media on heterosexuals' attitudes toward gay men and lesbians. *Journal of Applied Social Psychology, 30*(4), 738-758.

- Lewes, K., Young-Bruehl, E., Roughton, R., Magee, M., & Miller, D. (2008). Homosexuality and psychoanalysis I: Historical perspectives. *Journal of Gay and Lesbian Mental Health, 12*(4), 299-323.
- Li, A. & Bagger, J. (2007). The Balanced Inventory of Desirable Responding (BIDR): A reliability generalization study. *Educational and Psychological Measurement, 67*(3), 525-544.
- Ligon, J. & Thyer, B. A. (2000). Interrater reliability of the brief psychiatric rating scale used at a community-based inpatient crisis stabilization unit. *Journal of Clinical Psychology, 56*(4), 583-587.
- Little, C. Packman, J., Smaby, M. & Maddux, C. (2005). The skilled counselor training model: Skills acquisition, self-assessment, and cognitive complexity. *Counselor Education and Supervision, 44*, 189-200.
- Martin, A. (1982). Some issues in the treatment of gay and lesbian patients. *Psychotherapy: Theory, Research, and Practice, 19*(3), 341-348.
- Matthews, C. (2007). Affirmative lesbian, gay, and bisexual counseling with all clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and transgender clients* (pp. 181-200). Washington DC: American Psychological Association.
- McConahay, J. B. & Hough, J. C. (1976). Symbolic racism. *Journal of Social Issues, 32*(2), 23-45.

- McConahay, J. B. (1983). Modern racism and modern discrimination: The effects of race, racial attitudes, and context on simulated hiring decisions. *Personality and Social Psychology Bulletin*, 9(4), 551-558.
- Menard, S. (1995). *Applied logistic regression analysis*. Sage university paper series on quantitative applications in social sciences. Thousand Oaks, CA: Sage Publications.
- Meyer, M. D. (2005). Drawing the bisexuality card: Teaching, researching, and living bisexuality. *Sexuality and Culture*, 9(1), 3-13.
- Mohr, J. J., & Rochlen, A. B. (1999). Measuring attitudes regarding bisexuality in lesbians, gay male, and heterosexual populations. *Journal of Counseling Psychology*, 46, 353-369.
- Mohr, J. J., Weiner, J. L., Chopp, R. M., & Wong, S. J. (2009). Effects of client bisexuality on clinical judgment: When is bias most likely to occur? *Journal of Counseling Psychology*, 56(1), 164-175.
- Moorman, R. H., & Padsakoff, P. M. (1992). A meta-analytic review and empirical test of the potential confounding effects of social desirability response sets in organizational behaviour research. *Journal of Occupational and Organizational Psychology*, 65, 131-149.
- Moreno, K. N. & Bodenhausen, G. B. (2001). Intergroup affect and social judgment: Feelings as inadmissible information. *Group Processes and Intergroup Relations*, 4, 21-29.
- Moriarty, H. J., Carroll, R., & Cotroneo, M. (1996). Differences in bereavement



- reactions within couples following death of a child. *Research in Nursing and Health*, 19, 461-469.
- Morlan, K. K. & Tan, S. (1998). Comparison of the Brief Psychiatric Rating Scale and the Brief Symptom Inventory. *Journal of Clinical Psychology*, 54(7), 885-894.
- Morrison, M. A., & Morrison, T. G. (2002). Development and validation of a scale measuring modern prejudice toward gay men and lesbian women. *Journal of Homosexuality*, 43(2), 15-37.
- Murphy, J. A., Rawlings, E. I., & Howe, S. R. (2002). A survey of clinical psychologists on treating lesbian, gay, and bisexual clients. *Professional Psychology: Research and Practice*, 33(2), 183-189.
- Myers, R. (1990). *Classical and modern regression with applications* (2<sup>nd</sup> ed.). Boston, MA: Duxbury.
- Nakajima, G., Chan, Y., & Lee, K. (1996). Mental health issues for gay and lesbian Asian-Americans. In R. P. Cabaj and T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 563-582). Washington DC: American Psychiatric Press.
- Newman, B., Dannenfelser, P., & Benishek, L. (2002). Assessing beginning social work and counseling students' acceptance of lesbians and gay men. *Journal of Social Work Education*, 38(2), 272-288.
- Newmark, C. S., Ziff, D. R., Finch, A. J., & Kendall, P. C. (1978). *Journal of Consulting and Clinical Psychology*, 46(1), 53-61.

- Nicolosi, J. (1991). *Reparative therapy of male homosexuality*. New Jersey: Jason Aronson Inc.
- Norris, W. P. (1991). Liberal attitudes and homophobic acts: The paradoxes of homosexual experience in a liberal institution. *Journal of Homosexuality, 24*, 81-120.
- O'Brien, L.T., Crandall, C. S., Horstman-Reser, A., Warner, R., Alsbrooks, A., & Blodorn, A. (2010). But I'm no bigot: How prejudiced White Americans maintain unprejudiced self-images. *Journal of Applied Social Psychology, 40*(4), 917-946.
- Overall, J. E. & Gorham, D. R. (1962). The brief psychiatric rating scale. *Psychological Reports, 10*, 799-812.
- Overall, J. E. & Hollister, L. E. (1982). Decision rules for phenomenological classification of psychiatric patients. *Journal of Counseling and Clinical Psychology, 50*(4), 535-545.
- Paulhus, D. (1984). Two-component model of socially desirable responding. *Journal of Personality and Social Psychology, 46*(3), 598-609.
- Paulhus, D. L. (1991). Measurement and control of response bias. In *Measures of personality and social psychological attitudes* (pp. 17–41). New York: Academic Press.
- Patterson, C. J. (1997). Children of lesbian and gay parents. In T. H. Ollendick & R. J. Prinz (eds.). *Advances in Clinical Child Psychology, 19*, 235-282.
- Pettigrew, T. F. & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory.

*Journal of Personality and Social Psychology*, 90 (5), 751-783.

- Phillips, J. C. & Fischer, A. R. (1998). Graduate students' training experience with lesbian, gay, and bisexual issues. *The Counseling Psychologist*, 26(5), 712-734.
- Phillips, J. C. (2000). Training issues and considerations. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 337-358). Washington, D. C.: American Psychological Association.
- Preston, N. J. & Harrison, T. J. (2003). The Brief Symptom Inventory and the Positive and Negative Syndrome Scale: Discriminate validity between a self-reported and observational measure of psychopathology. *Comprehensive Psychiatry*, 44, 20-226.
- Prochaska, J. O. & Norcross, J. C. (2007). *Systems of psychotherapy: A transtheoretical analysis* (6<sup>th</sup> ed.). Belmont, CA: Thomson Higher Education.
- Riggle, E., Whitman, J. S., Olson, A., Rotosky, S., & Strong, S. (2008). The positive aspects of being a lesbian or gay man. *Professional Psychology: Research and Practice*, 39(2), 210-217.
- Ritvo, P. G., Fischer, J. S., Miller, D. M., Andrews, H., Paty, D. W., & LaRocca, N. G. (1997). *Multiple Sclerosis Quality of Life Inventory. A user's manual*. New York: National Multiple Sclerosis Society.
- Rodriguez, R. R., & Walls, N. E. (2000). Culturally educated questioning: Toward a skills-based approach in multicultural counselor training. *Applied and Preventative Psychology*, 9, 89-99.

- Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships as developed within the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science*. New York: McGraw-Hill.
- Rubinstein, G. (1995). The decision to remove homosexuality from the DSM: Twenty years later. *American Journal of Psychotherapy*, 49(3), 416-427.
- Rudolph, J. (1989). Effects of a workshop on mental health practitioners' attitudes toward homosexuality and counseling effectiveness. *Journal of Counseling and Development*, 68, 81-85.
- Rudolf, J. (1990). Counselor's attitudes toward homosexuality: Some tentative findings. *Psychological Reports*, 66(2), 1352-135
- Rumpf, H., Meyer, C. Hapke, U., & John, U. (2001). Screening for mental health: Validity of the MHI-5 using DSM-IV axis I psychiatric disorders as gold standard. *Psychiatry Research*, 105(3), 243-253.
- Rutter, P. A., Estrada, D., Ferguson, L. K., Diggs, G. A. (2008). Sexual orientation and counselor competency: The impact of training on enhancing awareness, knowledge and skills. *Journal of LGBT Issues in Counseling*, 2(2), 109-125.
- Rust, P. C. (2000). Bisexuality: A contemporary paradox for women. *Journal of Social Issues*, 56, 205-221.
- Satcher, J. & Schumacker, R. (2009). Predictors of modern homonegativity among professional counselors. *Journal of LGBT Issues in Counseling*, 3, 21-36.
- Schafer, A. (2005). Meta-analysis of the brief psychiatric rating scale. *Psychological Assessment*, 17(3), 324-335.

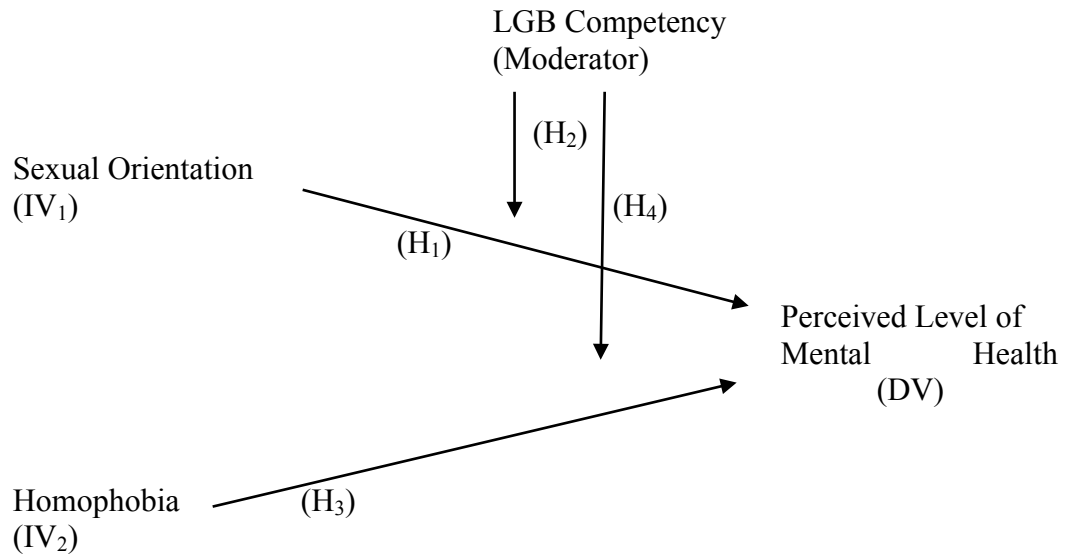
- Sherif, M. (1936). *The psychology of social norms*. New York: Harper.
- Shields, J. P., Whitaker, K., Glassman, J., Franks, H. M., & Howard, K. (2012). Impact of victimization on risk of suicide among lesbian, gay, and bisexual high school students in San Francisco. *Journal of Adolescent Health, 50*, 418-420.
- Siker, J. S. (Ed.). (2007). *Homosexuality and religion: An Encyclopedia*. Westport, CT: Greenwood Press.
- Silverstein, C. (2007). Wearing two hats: The psychologist as activist and therapist. *Journal of Gay and Lesbian Psychotherapy, 11*(3), 9-35.
- Sonesson, O., Tjus, T., & Arvidsson, H. (2010). Reliability of a functioning scale (GAF) among a psychiatric ward staff. *Nordic Psychology, 62*(1), 53-64.
- Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior, 32*(5), 403-417.
- Startup, M., Jackson, M., & Bendix, S. (2002). The concurrent validity of the Global Assessment of Functioning (GAF). *British Journal of Clinical Psychology, 41*, 417-422.
- Stevenson, M. R. (2000). Public policy, homosexuality, and the sexual coercion of children. *Journal of Psychology and Human Sexuality, 12*(4), 1-19.
- Sue, D. W. & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5<sup>th</sup> ed.). Hoboken, New Jersey: John Wiley & Sons.
- Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, New Jersey: John Wiley & Sons, Inc.

- Swim, J. K., Johnston, K., & Pearson, N. B. (2009). Daily experiences with heterosexism: Relations between heterosexist hassles and psychological well-being. *Journal of Social and Clinical Psychology, 28*(5), 597-629.
- Tabachnick, B. G. & Fidell, L. S. (2001). *Using multivariate statistics* (4<sup>th</sup> ed.). Needham Heights, MA: Allyn and Bacon.
- Taylor, S. E., Peplau, L. A., & Sears, D. O. (2006). *Social Psychology* (12<sup>th</sup> ed.). Upper Saddle River, NJ: Pearson Prentice Hall.
- Tomsen, S. & Mason, G. (2001). Engendering homophobia: Violence, sexuality, and gender conformity. *Journal of Sociology, 37*(3), 257-273.
- Tougas, F., Brown, R., Beaton, A. M., & Joly, S. (1995). Neosexism: Plus ca change, plus c'est pareil. *Personality and Social Psychology Bulletin, 21*, 842-850.
- Vaughan, M. D., & Waehler, C. A. (2010). Coming out growth: Conceptualizing and measuring stress-related growth associated with coming out to others as a sexual minority. *Journal of Adult Development, 17*, 94-109.
- Veit, C. T. & Ware, J. E. (1983). The structure of psychological distress and well-being in general populations. *Journal of Consulting and Clinical Psychology, 51*(5), 730-742.
- Walls, N. E. (2008). Toward a multidimensional understanding of heterosexism: The changing nature of heterosexism. *Journal of Homosexuality, 55*(1), 20-70.
- Wilcox, M. M. (2003). *Coming out in Christianity: Religion, identity, and community*. Bloomington, Indiana: Indiana University Press.

- Worthington, R. L., Dillon, F. R., & Becker-Schutte, A. M. (2005). Development, reliability, and validity of the lesbian, gay, and bisexual knowledge and attitudes scale for heterosexuals (LGB-KASH). *Journal of Counseling Psychology, 52*(1), 104-118.
- Zerbe, W. J. & Paulhus, D. L. (1987). Socially desirable responding in organizational behavior: A reconception. *Academy of Management Review, 12*(2), 250-264.

## Appendix A

Figure 1: Model Illustration



H<sub>1</sub>: Hypothesis 1

H<sub>2</sub>: Hypothesis 2

H<sub>3</sub>: Hypothesis 3

H<sub>4</sub>: Hypothesis 4



## Appendix B

### Key Terms

**Affirmative therapy.** Affirmative therapy is a model of psychological treatment of LGBT clients that involves valuing the expressed identity of the client through maintaining a safe and supportive therapeutic climate, using appropriate language, and utilizing therapeutic techniques that uphold the client's identity (Chernin & Johnson, 2003). Affirmative therapy begins before the client discloses his/her sexual orientation or gender identity and is initially reflected in gender and orientation neutral intake forms and clinical assessments (Matthews, 2007).

**Bisexual.** This term describes affective, physical, and cognitive attraction to both same-sex and other-sex partners. When considering a continuum of sexuality from heterosexual to homosexual, those identifying as bisexual may be considered close to the middle of the spectrum (Fassinger & Arseneau, 2007). Societal stereotypes coming from both the heterosexual and the homosexual community are pervasive. Such stereotypes involve the conception that bisexuality represents sexual confusion, is a step to exclusive homosexual behavior, and is a phase that will come to an end (Meyer, 2005).

**Conversion therapy.** Conversion therapy is a method of psychotherapy with the explicit goal of changing a client's sexual orientation from homosexual to heterosexual (Haldeman, 2002). There are a number of techniques that are employed including behavioral re-conditioning, defining and encouraging masculine behaviors (for gay men), and identifying and correcting maladaptive relationship patterns with members of one's same sex (see, for example, Exodus International). The American Psychological

Association (APA) discourages the use of conversion techniques and indicates that they are in direct opposition to the guidelines released by the organization for working with LGBT clients. Additionally, the APA and other authors cite scientific evidence of its potential to harm clients (see, for example, Cramer, et al., 2008).

**Gay, Lesbian.** Term used to describe an affective, cognitive, physical, and behavioral attraction to the same gender. Gay is generally used to indicate attraction between two people who identify as male whereas lesbian is generally used for attraction between two people who identify as female. These terms tend to have a less clinical implication than the term homosexual (Chernin & Johnson, 2003).

**Gender identity.** Gender identity can be described as a combination of affective, cognitive, and behavioral traits that inform one's sense of who they are as male or female (Fassinger & Arseneau, 2007). This includes a number of factors that can be viewed on a continuum. Society, for example, prescribes characteristics that are assigned to various gender roles. Gender becomes a general and pervasive organizational structure for society in various cultures and has been shown to be one of the most automatic categorizations that individuals make when encountering new people (Kite, 2001). Chernin and Johnson (2003) clarify that gender identity refers to one's experience of being male or female rather than one's sex organs or chromosomal gender. In addition, they cite the continuum of gender identity to be a helpful conceptualization as both those identifying as male or female incorporate traits that are societally associated with the other gender. This middle area on the gender continuum is referred to as androgyny (Chernin & Johnson, 2003). Fassinger and Arseneau (2007) argue that individuals

engaging in sexual activity with the same sex are seen in the social environment as “gender transgressors” because gender norms are so highly associated with the sex of one’s sexual partner (p. 27). Therefore, these authors indicate that the LGB community is related to the transgender community by the common thread of gender defiance.

**GLBT/LGBT.** This acronym stands for gay, lesbian, bisexual, and transgender identities and refers to the collective gay or queer community. Though identities within this acronym are highly variable, there are binding features including gender deviance (simply by being attracted to one’s same sex), oppression, discrimination, and invisibility (Fassinger & Arseneau, 2007). When considering therapeutic and advocacy work with the LGBT community, an understanding of the experience of each of the individual identities is necessary. Discrete categorization of sexual orientation minorities into four categories (LGBT) is problematic in itself as it reduces fluid concepts into rigid groupings; however, such definitions are often necessary for the purpose of general understanding and research (Fassinger & Arseneau, 2007).

**Heterosexual privilege.** Privilege is an established advantage for one group over another based on a characteristic or a constellation of characteristics. Heterosexual privilege allows those who identify as heterosexual to access a number of resources that are denied to those who are homosexual (Fish, 2006). Fish (2006) states that privilege is “an invisible package of unearned assets which can be cashed in daily” (p. 12). Heterosexual privilege may involve seemingly normal everyday activities like holding hands with one’s partner in public to lack of legal rights like marriage and workplace protection.

**Heterosexism.** Heterosexism, the assumption that a heterosexual orientation/lifestyle is the preferred and normal way of being, exists through neglect, omission, and insult (Chernin & Johnson, 2003). It can exist as micro-aggressions or as overt discrimination (both socially/legally sanctioned and otherwise). A defining feature of heterosexism is that it is an enduring experience of the sexual minority's daily life and may occur in seemingly benign ways (Swim, et al., 2009). Heterosexism prescribes how one should act, how relationships should be pursued, what displays of affection are appropriate and which ones are considered disgusting, and what values one should uphold (Fish, 2006).

**Homosexuality/Same-Sex Sexuality.** Attraction to a member of the same sex based on affective, cognitive, physical, and behavioral characteristics (Fassinger & Arseneau, 2007). The term *homosexual* tends to have a clinical tone; therefore, terms such as gay, lesbian, or queer may be used for everyday purposes (Chernin & Johnson, 2003).

**Microaggression.** Microaggressions are short, everyday, sometimes ambiguous expressions of hostility, invalidation, or insult that oftentimes leaves the victim hurt, confused, and discriminated against. These experiences are outward manifestations of internal biases including racism/sexism/heterosexism and are oftentimes based on denial of differences between individuals (Sue & Sue, 2008). Microaggressions are not necessarily enacted in a vicious manner, but can be highly affecting, degrading, and invalidating to the recipient (Sue & Sue, 2008).

**MSM.** This acronym stands for men who have sex with men. It is an inclusive term that focuses on behavior rather than identity. Research studies that are interested in sexual behavior (HIV studies for example) generally use this term.

**Queer.** Some sexual minorities prefer the term queer, which encompasses all those who defy existing norms regarding gender and sexual orientation (Fassinger & Arseneau, 2007). Queer originally was used as a derogatory term in reference to gay males; however, younger generations have adopted the term as a form of empowerment, a semantic shift which is evident in academia and the study of queer theory (Jagose, 1996).

**Sexual Orientation.** Fassinger and Arseneau (2007) define sexuality as the following: “A constellation of affective, cognitive, and behavioral characteristics that constitute an individual’s sense of self as sexual and intimately relational being” (p. 30). This definition emphasizes the three major psychological components of humanity consisting of thoughts, feelings, and behaviors. Therefore, a man may be attracted to another man not only physically, but emotionally and cognitively as well. In addition, this definition indicates that sexuality is an understanding of oneself (self-identity) both as an erotic being and as an intimate, relational being.

**Sexual Orientation Continuum.** The Kinsey et al. (1948) Heterosexuality-Homosexuality Scale expands the idea of dichotomous sexuality and views sexual behavior and attraction on a scale. Kinsey et al.’s report suggested that humans have varying same-sex and other-sex attractions, which may manifest to varying degrees at

different points over the course of the lifespan. Overall, this research supports the concept of fluidity in sexual orientation.

**Transgender.** This term refers to individuals whose gender identity is different from the socially defined characteristics that accompany one's biological sex. Those identifying as transgender may dress in clothing that is consistent with their felt gender identity, engage in hormone treatments, or complete reconstructive surgery. Identifying as transgender does not indicate a particular sexual orientation; transgender individuals may identify as heterosexual, homosexual, or bisexual (Fassinger & Arseneau, 2007).

## Appendix C

### Measures

---

#### Clinical Vignette 1

Instructions: Please read the following synopsis of an intake report as if this client has come to your office for a consultation. After reading the vignette you will be asked to provide clinical impressions of the case using the scales that will be subsequently presented.

---

John is a 32-year-old, Caucasian male who presented for consultation for feelings of sadness and overwhelming worry. He was dressed in a shirt and tie and appeared to be maintaining adequate grooming. He is employed by a large national bank, though his work performance has been slipping in the last 3 months. Additionally, his partner, David, recently ended their two-year relationship, citing frequent conflicts and divergent visions of the future as reasons for the separation. He has had several male sexual partners since the relationship, though has found these interactions to be unfulfilling, leaving him with a sense of loneliness and emptiness. His brother and close friends who live nearby have expressed concern for him. He has a distant relationship with his parents. He reported a tendency to ruminate on “things that go wrong” in his life, especially regarding the end of his last serious relationship. While explaining this, he became tearful and subsequently seemed embarrassed for his sudden overwhelming emotion. He expressed with desperation that he is beginning to question his purpose, feels tired constantly, has trouble concentrating, has an unsettled stomach, and has little desire to eat. He mentioned in the consultation interview that he feels like he has nothing to look forward to in life and thinks things would be easier if he were no longer around. In setting goals for treatment, John reported that he wants to feel less depressed, more energetic, and live with purpose.

---

## Clinical Vignette 2

Instructions: Please read the following synopsis of an intake report as if this client has come to your office for a consultation. After reading the vignette you will be asked to provide clinical impressions of the case using the scales that will be subsequently presented.

---

John is a 32-year-old, Caucasian male who presented for consultation for feelings of sadness and overwhelming worry. He was dressed in a shirt and tie and appeared to be maintaining adequate grooming. He is employed by a large national bank, though his work performance has been slipping in the last 3 months. Additionally, his partner, Emily, recently ended their two year relationship, citing frequent conflicts and divergent visions of the future as reasons for the separation. He has had several female sexual partners since his last relationship, though has found these interactions to be unfulfilling, leaving him with a sense of loneliness and emptiness. His brother and close friends who live nearby have expressed concern for him. He has a distant relationship with his parents. He reported a tendency to ruminate on “things that go wrong” in his life, especially regarding the end of his last serious relationship. While explaining this, he became tearful and subsequently seemed embarrassed for his sudden overwhelming emotion. He expressed with desperation that he is beginning to question his purpose, feels tired constantly, has trouble concentrating, has an unsettled stomach, and has little desire to eat. He mentioned in the consultation interview that he feels like he has nothing to look forward to in life and thinks things would be easier if he were no longer around. In setting goals for treatment, John reported that he wants to feel less depressed, more energetic, and live with purpose.



### **Manipulation Check**

Thinking back to the clinical vignette presented earlier, did the client, John, primarily have same-sex or opposite-sex romantic relationships? Please fill in your response in the text box below.

---

---

## Global Assessment of Functioning

Instructions: Using the GAF scale below taken from the *Diagnostic and Statistical Manual of Mental Disorders-IV TR* as a guide, write the number of the current GAF score of John based on the information provided and your professional opinion.

---

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health to illness. Do not include impairment in functioning due to physical (or environmental) limitations.

### **100-91**

Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

### **90-81**

Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).

### **80-71**

If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g. temporarily failing behind in schoolwork).

### **70-61**

Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

### **60-51**

Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

### **50-41**

Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

### **40-31**

Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family,

and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

**30-21**

Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

**20-11**

Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

**10-1**

Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

**0**

Inadequate information.

Current GAF Score for John: \_\_\_\_\_

---

## Mental Health Inventory (MHI)

---

Using your best clinical judgment, the next set of questions are about how you assess the client's feelings, and how things have been for the client during the past 4 weeks. Please indicate your response using the following scale.

---

**During the past 4 weeks, how much of the time...**

1-----2-----3-----4-----5-----6  
ALL OF MOST OF A GOOD BIT OF SOME OF A LITTLE BIT OF NONE OF  
THE TIME THE TIME THE TIME THE TIME THE TIME THE TIME

- \_\_\_\_ 1. has the client's daily life been full of things that were interesting to him?
- \_\_\_\_ 2. did the client feel depressed?
- \_\_\_\_ 3. has the client felt loved and wanted?
- \_\_\_\_ 4. has the client been a very nervous person?
- \_\_\_\_ 5. has the client been in firm control of his behavior, thoughts, emotions, feelings?
- \_\_\_\_ 6. has the client felt tense or high-strung?
- \_\_\_\_ 7. has the client felt calm and peaceful?
- \_\_\_\_ 8. has the client felt emotionally stable?
- \_\_\_\_ 9. has the client felt downhearted and blue?
- \_\_\_\_ 10. was the client able to relax without difficulty?
- \_\_\_\_ 11. has the client felt restless, fidgety, or impatient?
- \_\_\_\_ 12. has the client been moody, or brooded about things?
- \_\_\_\_ 13. has the client felt cheerful, light-hearted?
- \_\_\_\_ 14. has the client been in low or very low spirits?
- \_\_\_\_ 15. was the client a happy person?
- \_\_\_\_ 16. did the client feel he had nothing to look forward to?
- \_\_\_\_ 17. has the client felt so down in the dumps that nothing could cheer him up?
- \_\_\_\_ 18. has the client been anxious or worried?

---

## Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962)

---

This form consists of 18 symptom constructs, each to be rated on a 7-point scale of severity ranging from 'not present' to 'extremely severe'. Indicate the number headed by the term that best describes the client's present condition.

1-----2-----3-----4-----5-----6-----7  
NOT VERY MILD MODERATE MODERATELY SEVERE  
EXTREMELY MILD SEVERE  
PRESENT SEVERE

1. \_\_\_\_\_ **Somatic concern**  
Degree of concern over present bodily health.
  
2. \_\_\_\_\_ **Anxiety**  
Worry, fear, or over-concern for present or future.
  
3. \_\_\_\_\_ **Emotional withdrawal**  
Deficiency in relating to others.
  
4. \_\_\_\_\_ **Guilt**  
Over-concern or remorse for past behavior.
  
5. \_\_\_\_\_ **Tension**  
Physical and motor manifestations of nervousness and heightened activation level.
  
6. \_\_\_\_\_ **Mannerisms and posturing**  
Unusual and unnatural motor behavior, they type of motor behavior which may cause a client to stand out in a group of people.
  
7. \_\_\_\_\_ **Grandiosity**  
Exaggerated self-opinion, conviction of unusual ability of powers.
  
8. \_\_\_\_\_ **Depression**  
Despondency in mood, sadness.
  
9. \_\_\_\_\_ **Hostility**  
Animosity, contempt, belligerence, disdain for other people.

10. \_\_\_\_\_ **Suspiciousness**  
Belief that others have now, or have had in the past, malicious or discriminatory intent toward the patient.
11. \_\_\_\_\_ **Hallucinations**  
Perceptions without normal stimulus correspondence.
12. \_\_\_\_\_ **Motor retardation**  
Reduction in energy level evidenced in slowed movements.
13. \_\_\_\_\_ **Uncooperativeness**  
Resistance, unfriendliness, resentment, and lack of readiness to cooperate.
14. \_\_\_\_\_ **Unusual thought content**  
Unusual, odd, strange, or bizarre thought content.
15. \_\_\_\_\_ **Disorientation**  
Confusion or lack of proper association for person, place, or time.
16. \_\_\_\_\_ **Conceptual disorganisation**  
Degree to which thought processes are confused, disconnected, or disorganized.
17. \_\_\_\_\_ **Blunted affect**  
Reduced emotional tone, apparent lack of normal feeling or involvement.
18. \_\_\_\_\_ **Excitement**  
Heightened emotional tone, agitation, increased reactivity.







---

## Modern Homonegativity Scale-Gay Men (MHS-G)

---

Please use the scale below to indicate the extent of your agreement or disagreement with the following statements.

---

1-----2-----3-----4-----5  
STRONGLY DISAGREE                      DON'T KNOW                      STRONGLY AGREE

- \_\_\_\_\_ 1. Many gay men use their sexual orientation so that they can obtain special privileges.
- \_\_\_\_\_ 2. Gay men seem to focus on the ways in which they differ from heterosexuals, and ignore the ways in which they are the same.
- \_\_\_\_\_ 3. Gay men do not have all the rights they need.
- \_\_\_\_\_ 4. The notion of universities providing students with undergraduate degrees in Gay and Lesbian Studies is ridiculous.
- \_\_\_\_\_ 5. Celebrations such as “Gay Pride Day” are ridiculous because they assume that an individual’s sexual orientation should constitute a source of pride.
- \_\_\_\_\_ 6. Gay men still need to protest for equal rights.
- \_\_\_\_\_ 7. Gay men should stop shoving their lifestyle down other people’s throats.
- \_\_\_\_\_ 8. If gay men want to be treated like everyone else, then they need to stop making such a fuss about their sexuality/culture.
- \_\_\_\_\_ 9. Gay men who are “out of the closet” should be admired for their courage.
- \_\_\_\_\_ 10. Gay men should stop complaining about the way they are treated in society, and simply get on with their lives.
- \_\_\_\_\_ 11. In today’s tough economic times, American tax dollars shouldn’t be used to support gay men’s organizations.
- \_\_\_\_\_ 12. Gay men have become far too confrontational in their demand for equal rights.

---

## Lesbian, Gay, & Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI)

---

**INSTRUCTIONS:** Below is a list of activities regarding counseling/psychotherapy. Indicate your confidence in your current ability to perform each activity by marking the appropriate answer below each question ranging from NOT AT ALL CONFIDENT TO EXTREMELY CONFIDENT. Please answer each item based on how you feel now, not on your anticipated (or previous) ability. I am interested in your actual judgments, so please be HONEST in your responses.

---

### HOW CONFIDENT AM I IN MY ABILITY TO....?

---

1-----2-----3-----4-----5-----6

NOT AT ALL CONFIDENT EXTREMELY CONFIDENT

- \_\_\_\_\_ 1. Directly apply sexual orientation/identity development theory in my clinical interventions with lesbian, gay, and bisexual (LGB) clients.
- \_\_\_\_\_ 2. Directly apply my knowledge of the coming out process with LGB clients.
- \_\_\_\_\_ 3. Identify specific mental health issues associated with the coming out process.
- \_\_\_\_\_ 4. Understand the socially constructed nature of categories and identities such as lesbian, bisexual, gay, and heterosexual.
- \_\_\_\_\_ 5. Explain the impact of gender role socialization on a client's sexual orientation/identity development.
- \_\_\_\_\_ 6. Work with the issues that are specific and unique to gay men.
- \_\_\_\_\_ 7. Apply existing American Psychological Association guidelines regarding LGB affirmative counseling practices.

## HOW CONFIDENT AM I IN MY ABILITY TO....?

---

1-----2-----3-----4-----5-----6  
NOT AT ALL CONFIDENT EXTREMELY CONFIDENT

- \_\_\_\_\_ 8. Use current research findings about LGB clients' critical issues in the counseling process.
- \_\_\_\_\_ 9. Assist LGB clients to develop effective strategies to deal with heterosexism and homophobia.
- \_\_\_\_\_ 10. Evaluate counseling theories for appropriateness in working with a LGB client's presenting concerns.
- \_\_\_\_\_ 11. Help a client identify sources of internalized homophobia and/or biphobia.
- \_\_\_\_\_ 12. Select affirmative counseling techniques and interventions when working with LGB clients.
- \_\_\_\_\_ 13. Assist in the development of coping strategies to help same sex couples who experience different stages in their individual coming out processes.
- \_\_\_\_\_ 14. Work with the issues that are specific and unique to lesbian clients.
- \_\_\_\_\_ 15. Facilitate a LGB affirmative counseling/support group.
- \_\_\_\_\_ 16. Recognize my attitudes toward LGB issues and their potential influence on my counseling relationships.
- \_\_\_\_\_ 17. Recognize when my own potential heterosexist biases may suggest the need to refer a LGB client to a LGB affirmative counselor.
- \_\_\_\_\_ 18. Examine my own sexual orientation/identity development process.

## HOW CONFIDENT AM I IN MY ABILITY TO....?

---

1-----2-----3-----4-----5-----6  
NOT AT ALL CONFIDENT EXTREMELY CONFIDENT

- \_\_\_\_\_ 19. Identify the specific areas in which I may need continuing education and supervision regarding LGB issues.
- \_\_\_\_\_ 20. Identify my own feelings about my own sexual orientation and how it may influence a client.
- \_\_\_\_\_ 21. Recognize my real feelings versus idealized feelings in an effort to be more genuine and empathic with LGB clients.
- \_\_\_\_\_ 22. Provide a list of LGB affirmative community resources, support groups, and social networks to a client.
- \_\_\_\_\_ 23. Refer a LGB client to affirmative social services in cases of estrangement from their families of origin.
- \_\_\_\_\_ 24. Refer LGB clients to LGB affirmative legal and social supports.
- \_\_\_\_\_ 25. Provide a client with city, state, federal, and institutional ordinances and laws concerning civil rights of LGB individuals.
- \_\_\_\_\_ 26. Help a same-sex couple access local LGB affirmative resources and support.
- \_\_\_\_\_ 27. Refer a LGB elderly client to LGB affirmative living accommodations and other social services.
- \_\_\_\_\_ 28. Refer a LGB client with religious concerns to a LGB affirmative clergy member.
-

## **HOW CONFIDENT AM I IN MY ABILITY TO....?**

---

1-----2-----3-----4-----5-----6  
NOT AT ALL CONFIDENT EXTREMELY CONFIDENT

- \_\_\_\_\_ 29. Integrate clinical data (e.g., mental status exam, intake assessments, presenting concern) of a LGB client.
- \_\_\_\_\_ 30. Complete an assessment for a potentially abusive same sex relationship in a LGB affirmative manner.
- \_\_\_\_\_ 31. Assess for post-traumatic stress felt by LGB victims of hate crimes based on their sexual orientations/identities.
- \_\_\_\_\_ 32. Assess the role of alcohol and drugs on LGB clients social, interpersonal, and intrapersonal functioning.
- \_\_\_\_\_ 33. Establish an atmosphere of mutual trust and affirmation when working with LGB clients.
- \_\_\_\_\_ 34. Normalize a LGB client's feelings during different points of the coming out process.
- \_\_\_\_\_ 35. Examine whether my rapport building skills allow LGB clients to feel supported in counseling.
- \_\_\_\_\_ 36. Establish a safe space for LGB couples to explore parenting.
- \_\_\_\_\_ 37. Work with the issues that are specific and unique to bisexual women.
- \_\_\_\_\_ 38. Work with the issues that are specific and unique to bisexual men.

## Demographic Questionnaire

---

1. What is your age?
  
2. What is your gender?
  - a. Male
  - b. Female
  - c. Transgender
  
3. How would you describe your race/ethnicity?
  - a. American Indian or Alaska Native
  - b. Asian or Asian American
  - c. Black or African American
  - d. Hispanic or Latino/Latina
  - e. Native Hawaiian or other Pacific Islander
  - f. White
  - g. Biracial/Multiracial
  - h. Other
  
4. What religion do you consider yourself to be?
  - a. Buddhist
  - b. Christian
  - c. Hindu
  - d. Islamic
  - e. Jewish
  - f. No religious belief/agnostic/atheist
  - g. Other

5. Which of the following best describes you?
  - a. Bisexual
  - b. Gay
  - c. Lesbian
  - d. Heterosexual
  - e. Not Sure/Questioning
  - f. Pansexual
  - g. Other
  
6. What is the highest level of education that you have completed?
  - a. Less than high school
  - b. High school/GED
  - c. Some college
  - d. Associates (2-year) degree
  - e. Bachelors (4-year) degree
  - f. Master's Degree
  - g. Doctoral Degree (MD, PhD, PsyD, JD)
  
7. What is your political orientation?
  - a. Liberal
  - b. Moderately Liberal
  - c. Neutral
  - d. Moderately Conservative
  - e. Conservative

8. How would you describe your Socioeconomic Status (SES)?
  - a. Low
  - b. Low-middle
  - c. Middle
  - d. Middle-upper
  - e. Upper class
  
9. How many years have you been providing counseling/psychotherapy to clients directly (including practica, internships, and employment)? Please round to the nearest whole number year.
  
10. Throughout your career and/or practica/internships, how many clients have you counseled in individual therapy that identified as gay, lesbian, bisexual, or transgender?
  
11. Throughout your career and/or practica/internships, how many gay, lesbian, bisexual, or transgender counseling **groups** have you facilitated/co-facilitated? This refers to the total number of groups, rather than the total number of clients in those groups.
  
12. Throughout your career and/or practica/internships, how many workshops or outreach programs have you facilitated on gay, lesbian, bisexual, or transgender issues?



13. In your graduate training, how many credits did you take that addressed ethnic diversity issues in counseling? How many total classes was this?
- a. 0
  - b. 1-3
  - c. 4-6
  - d. 7-9
  - e. 10 or above
14. In your graduate training, how many credits did you take that addressed gay, lesbian, bisexual, and transgender issues in counseling? How many total classes was this?
- a. 0
  - b. 1-3
  - c. 4-6
  - d. 7-9
  - e. 10 or above
15. In your graduate training, how many credits did you take that specifically focused on clinical assessment, diagnosis, or formal assessment?
- a. 0
  - b. 1-3
  - c. 4-6
  - d. 7-9
  - e. 10 or above

16. Are you licensed as a professional counselor (LPC)?

- a. Yes
- b. No

17. Are you a licensed psychologist?

- a. Yes
- b. No

18. In what type of setting do you primarily work?

- a. Community Mental Health Center/Community Agency
- b. Corporate Setting
- c. Educational Setting (k-12 education, school psychologist, school counselor)
- d. Forensic setting (department of corrections, offender treatment, competency evaluator, etc.)
- e. Hospital
- f. Military
- g. Private Practice
- h. University Counseling Center
- i. University Faculty
- j. Other

19. What is your main theoretical orientation?

- a. Behavioral
- b. Cognitive
- c. Humanistic (e.g., Rogerian, Existential, Gestalt)
- d. Family Systems
- e. Psychoanalytic/Psychodynamic
- f. Other (please indicate) \_\_\_\_\_

20. In what area is your academic training as a mental health professional?

- a. Clinical psychology
- b. Counseling psychology
- c. Mental health counseling
- d. Social work
- e. Other (please indicate)\_\_\_\_\_

## PROJECT INFORMATION SHEET

### ***Introduction***

You are invited to participate in a study that will explore issues related to counseling and diagnosis. The study is conducted by Joseph Longo, MA. Joseph Longo can be reached at [joseph.longo@du.edu](mailto:joseph.longo@du.edu) or by phone at (303) 328-8269. This project is supervised by Dr. Ruth Chao, Department of Counseling Psychology, University of Denver, Denver, CO 80208, [Chuen.Lien.Chao@du.edu](mailto:Chuen.Lien.Chao@du.edu) or (303) 871-2556. This project has been approved by the Institutional Review Board of the University of Denver.

### ***Description of Procedures***

Participation in this study should take about 25 minutes of your time. Partaking in this study will involve reading a case vignette and answering questions related to how you assess the client. Subsequent questions will ask you about your personal ideas or background. Participation in this project is strictly voluntary. The risks associated are minimal. If, however, you experience discomfort you may discontinue the survey at any time. We respect your right to choose not to answer any questions that may make you feel uncomfortable. Refusal to participate or withdrawal from participation will involve no penalty or loss of benefits to which you are otherwise entitled. At the end of the survey, you will be invited to enter a drawing for a \$50 gift certificate to Amazon.com.

### ***Use of Data***

Your responses will be anonymous. That means that no one will be able to connect your identity with the information you give. Please do not write your name anywhere on the questionnaire. Your return of the questionnaire will signify your consent to participate in this project. Only the researcher will have access to your individual data and any reports generated as a result of this study will use group averages and paraphrased wording. However, should any information contained in this study be the subject of a court order or lawful subpoena, the University of Denver might not be able to avoid compliance with the order or subpoena. Although no questions in this interview address it, if information is revealed concerning suicide, homicide, or child abuse and neglect, it is required by law that this be reported to the proper authorities.

### ***Questions or Concerns***

If you have any concerns or complaints about how you were treated during the survey process, please contact Cathryn Potter, Chair, Institutional Review Board for the Protection of Human Subjects, at 303-871-2913, or write to the University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121.

You may print this page for your records. Please indicate below that you understand and agree to the above. If you do not understand any part of the above statement, please contact the researcher.

---

I have read and understood the foregoing descriptions of the study. I agree to participate in this study, and I understand that I may withdraw my consent at any time.

I have read the above statement and agree to participate in this study.

I decline participation in this study.